HEALTH & GROUP BENEFITS
NEWS & DEVELOPMENTS

An Employer Benefits Update

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AN EMPLOYER'S 2017 GUIDE TO THE ACA

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As with any new White House administration, change is inevitable. Given newly elected President Trump's platform, the Patient Protection and Affordable Care Act (ACA) has been a hot topic–and on many employers' minds. While we wait for specific legislative proposals to wind their way through the enactment process, we are following the issues attentively. Listed below are some key considerations that could affect employer-sponsored insurance (ESI) programs.

- While much has been discussed, we are still waiting for definitive legislative and regulatory action related to repeal, delay, or replacement of the ACA. The President's recent executive orders don't appear to change that view, but we are closely monitoring the potential impacts of all executive orders. Preserving ESI still appears to be a key principle of the new administration's agenda. Given that, as it stands today, there is no compelling reason to deviate from your current strategy, but we believe flexibility is prudent.
- Certain taxes and mandates could potentially be unwound / altered / repealed.
  - A repeal or modification of the employer mandate could have a significant impact on staffing strategies (i.e., full-time vs. part-time employees) if employers no longer need to consider the "30-hour" rule.
  - A repeal or modification of the "Cadillac plan" excise tax would be a welcome change for employers, especially those in higher-cost geographies. Even a modification, such as exempting all Health Savings Account (HSA) contributions from counting toward the excise tax thresholds, could provide relief.
  - A repeal of other taxes and fees (such as the health insurance provider fee, device manufacturer fee, etc.) will ultimately trickle down and result in lower costs for plan sponsors.
- There is discussion about potentially capping the tax exclusion of employer-provided healthcare benefits and "leveling the playing field" by allowing individuals to deduct health insurance premium payments on their personal federal income tax returns. Both of these issues could have a broad impact on the manner in which employers deliver healthcare benefits to employees.
- The new administration appears to be in favor of less onerous reporting requirements that could minimize the burden on employers.
  - However, 2017 employer reporting still applies until we hear differently.
- Expanding the use of HSAs and Health Retirement Accounts (HRAs) appears to be a key philosophy. If, for example, active employees could use the funds from these accounts to pay insurance premiums, more employers might consider a change in their benefits strategy.
- Other key proposed changes (some of which would have a greater impact on the individual market, Medicare, and Medicaid) could have a trickle-down impact on ESI and your overall strategy.
  - Delay or repeal of federal/state exchange premium tax credits for individuals.
  - Delay or repeal of Medicaid expansion for the 31 states (and Washington, D.C.) that made such an election.
  - Expanded age-rating bands from 3:1 to 5:1, resulting in higher premiums for older insureds and lower premiums for younger insureds, could potentially encourage younger workers to seek coverage outside of the employer's plan.
  - Modification of the 10 essential health benefits list.
  - Changes to the definition of preventive care (e.g., contraceptive care).
  - Requirement of further price transparency from providers and health plans.
  - Increased scrutiny on pharmaceutical costs.

It appears as though modifications to ACA law are unlikely to occur in one event, but instead through a series of changes through a budget bill, administrative action, and a later series of individual bills. In addition, it's likely that the timing of these changes will extend through much of 2017 and possibly beyond. Change seems inevitable—but when and how is still a guess. Employers will need to closely monitor the developments.

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THE IMPORTANCE OF EVALUATING RDS AND EGWP TRENDS TO OPTIMIZE PLAN VALUE

Michelle N. Angeloni, FSA, MAAA | **Tracy A. Margiott**, FSA, MAAA

Financial dynamics and an evolving regulatory environment in the group retiree pharmacy benefits market continue to influence the relative values of Employer Group Waiver Plans (EGWPs) and Retiree Drug Subsidy (RDS) plans. Plan sponsors should periodically monitor and evaluate emerging trends in these programs to optimize plan value in this still-changing market.

This summer, for example, the Centers for Medicare and Medicaid Services (CMS) announced a large decrease in the monthly direct subsidy revenue to EGWPs. Additionally, the Medicare Payment Advisory Commission (MedPAC) recently proposed changes to the Medicare program with major implications for EGWP costs.

Figure 1 summarizes key recent and proposed market and regulatory dynamics that are already impacting the relative values of EGWPs and RDS plans—and which could potentially influence further shifts in these values.

FIGURE 1: TRENDS AND CHANGES AFFECTING THE GROUP RETIREE PHARMACY BENEFITS MARKET SINCE 2013

CHANGE	FINANCIAL IMPACT ON EGWPS	FINANCIAL IMPACT ON RDS PLANS[1]
Reductions to the Part D direct subsidy.	Reduces the EGWP risk-adjusted direct subsidy revenue.	No effect. Not applicable to RDS program.
Increasing pharmacy costs from specialty medications.	Mitigated due to 80% federal reinsurance protection for catastrophic claim costs.	Generally reduces the value of RDS plans relative to EGWPs from a plan sponsor's perspective due to the maximum cost limit on the RDS.
Changes to the EGWP claim adjudication methodology.[2]	Generally increases plan liability while reducing federal reinsurance, compared with prior methodology used by many pharmacy benefit managers (PBMs).	No effect. Not applicable to RDS program.
Proposed change to Part D federal reinsurance program.[3]	Would decrease federal reinsurance and increase direct subsidies.	No effect. Not applicable to RDS program.
Proposed change to the treatment of Part D Coverage Gap Discount Program (CGDP) payments.[4]	Would lengthen the time spent in the coverage gap and potentially increase the plan's overall claim liability under the current Part D benefit.	No effect. Not applicable to RDS program.
Proposed change to accounting standards for public sector EGWPs.[5]	Would increase the other post-employment benefit (OPEB) liability for public sector EGWPs.	No effect. Public sector entities currently cannot reduce the OPEB liability for RDS savings.

Drivers of the shift from RDS plans to EGWPs

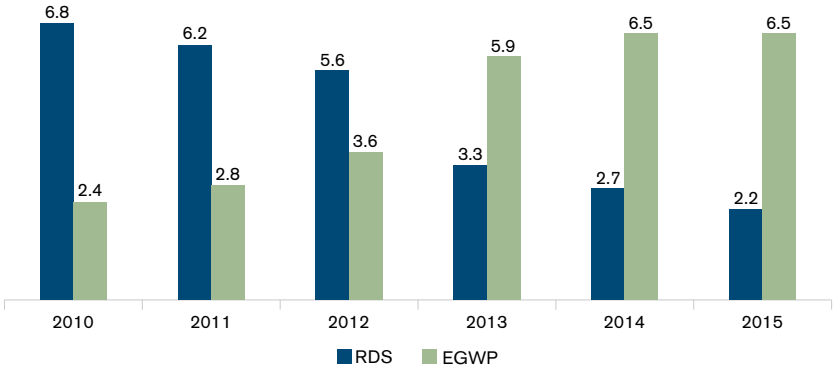
Since 2013, the number of beneficiaries covered by EGWPs has outnumbered those covered by RDS plans. When Medicare Part D was first introduced in 2006, the typical plan sponsor savings under EGWPs and RDS plans was comparable for a non-taxable entity. But, at that time, RDS plans were typically more favorable for taxable plan sponsors because of their tax-favored treatment.

Until the passage of the Patient Protection and Affordable Care Act (ACA), plan sponsors could deduct health benefit costs reimbursed by the RDS from their taxable income. However, starting in 2013, plan sponsors were no longer permitted to deduct health benefit costs reimbursed by the RDS, eliminating its once tax-free status and eroding one of its key advantages over EGWPs.

The ACA also introduced the Part D Coverage Gap Discount Program (CGDP) in 2011. Under this program, pharmaceutical manufacturers pay 50% of the cost of eligible brand medications in the coverage gap phase of the Part D benefit for non-low-income beneficiaries. EGWPs receive these CGDP payments, while RDS plans do not.

The elimination of the tax-favored treatment of RDS plans, combined with the increase in EGWP savings through the CGDP, made EGWPs a more attractive option for many plan sponsors. These changes prompted a relatively large shift from RDS plans to EGWPs in 2013, as plan sponsors reevaluated the financial opportunities associated with their group retiree pharmacy benefits. Figure 2 illustrates this enrollment shift from 2010 to 2015.[6]

FIGURE 2: RDS AND EGWP ENROLLMENT (MILLIONS)



Future outlook

Since 2013, regulatory and market dynamics continue to alter the group retiree pharmacy benefits landscape. These include the following changes described in Figure 1, among others:

- Reductions to the Part D direct subsidy
- Increasing pharmacy costs from specialty medications
- Regulatory clarifications regarding the EGWP claim adjudication methodology
- Recent proposals with the potential to affect EGWP revenue items and accounting

While EGWPs may continue to be more favorable than the RDS for a typical retiree plan in the current environment, these comparative values could change for some plan sponsors as a result of current proposals and future trends.

The group retiree pharmacy benefits market continues to evolve, with potential impacts on the relative financial values of RDS plans and EGWPs. The only constant in this market may be change. Plan sponsors should closely monitor their options. Periodic evaluations will likely help optimize plan sponsor value in this market.

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1 While some changes do not directly impact the financial position of RDS plans, any change that impacts the defined standard Part D benefit may affect RDS / creditable coverage testing, which may result in required changes to RDS benefits or pricing.

2 In December 2013, CMS issued claim adjudication guidance effective in 2014 that generally delays EGWP claims from reaching the catastrophic phase: CMS (December 2013), *Prescription Drug Event (PDE) reporting examples for benefit year 2014*, p. 34. Retrieved July 29, 2016, from **http://www.csscoperations.com/internet/cssc3.nsf/files/2014%20PDE%20Reporting%20Guidance%2012-13-2013.pdf/$File/2014%20PDE%20 Reporting%20Guidance%2012-13-2013.pdf**.

3 MedPAC recommended reducing the federal reinsurance subsidy from 80% to 20%. MedPAC (June 2016) *Report to the Congress: Medicare and the Health Care Delivery System*. Retrieved July 29, 2016, from **http://medpac.gov/docs/default-source/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0**.

4 MedPAC proposed that CGDP payments no longer count toward the member's accumulation of costs toward reaching the catastrophic phase of the Part D benefit. Ibid.

5 The Governmental Accounting Standards Board (GASB) proposed that public sector entities cannot reduce the OPEB liability for Part D EGWP subsidies from CMS. Implementation Guide No. 201X-X, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, p. 45. Retrieved October 20, 2016, from **http://gasb.org/jsp/GASB/Document_C/GASBDocumentPage?cid=1176168530441&acceptedDisclaimer=true**.

6 Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (June 22, 2016). 2016 Annual Report, p. 145. Retrieved July 29, 2016, from **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf**.

CONSIDERATIONS FOR STOP-LOSS COVERAGE

Mehb Khoja, FSA, MAAA

Plan sponsors who self-insure their healthcare expenses gain certain benefits not available to those who fully insure. These include gaining complete access to their data and greater flexibility in designing an optimal plan while avoiding being subject to state premium tax. But with these benefits comes added risk in the form of cash flow volatility and exposure to catastrophic claims. To offset this exposure, many plan sponsors purchase stop-loss insurance.

Stop-loss insurance can be confusing. And with over 50 carriers in the market, plan sponsors are constantly bombarded by competing cost-saving options. This article shares the basics of stop-loss coverage. My objective is to help plan sponsors better understand the coverage they're quoted.

Coverage types

Stop loss typically comes in two forms: individual (also called specific) and aggregate.

Individual coverage is meant to protect the employer from any one individual exceeding a set threshold. This threshold is referred to as the individual deductible or the individual retention. *Aggregate coverage* is designed to protect the entire population from exceeding a set total cost of medical care, for example, 125% of expected claims.

Of the two, individual coverage is more common. That's because the likelihood of exceeding the corridor diminishes as a plan sponsor grows in size. Aggregate coverage is seen most often with organizations that have less than 1,000 employees (roughly 2,500 total members in the plan). Individual deductibles range widely. The low end is often limited by state regulators—typically to around $20,000. High deductibles can reach up to $1M in coverage.

Defining claims

As plan sponsors consider various stop-loss proposals, they should understand how a claim is defined—either incurred or paid—and if there are limits to the lag allowed in payment time. Contracts are defined by the number of months covered by run-in or run-out claims.

Paid contracts (15/12, 18/12, 24/12, 36/12) are meant to cover claims paid in a calendar year and cap how far back these claims can be incurred, such as the date of a hospital admission prior to the policy year. For example, an 18/12 contract allows six months of run-in claims for a given policy year. A calendar year 2017 policy that has an 18/12 contract basis would cover claims paid in 2017 and incurred as far back as July 1, 2016.

Incurred contracts (12/15, 12/18, 12/24) cover no claims incurred prior to the policy year of coverage. Instead, they cover claims incurred in a policy year and put a cap on the run-out time for these claims to be paid. For example, a 12/18 contract allows six months of run-out claims for a given policy year. A calendar year 2017 policy that has a 12/18 contract basis would cover claims incurred in 2017 and paid through June 30, 2018. A 12/12 policy only covers claims incurred and paid in a policy year. This significantly limits its effectiveness, as large claims can take several months to be adjudicated. The tradeoff of this type of policy is reduced premiums: A 12/12 policy's premium is approximately 80% of a 24/12 policy.

Key terms

Other terms characteristic of this market to be aware of when purchasing stop-loss coverage include:

- **Plan mirroring:** Stop-loss contracts may contain several exclusions or limits. If not aligned to the plan sponsor's plan document, these could create a gap in coverage. Plan mirroring ensures no gap in coverage, as the stop-loss carrier affirms the plan document as the source of determining a claim's eligibility for reimbursement.
- **Lasering:** Upon underwriting, stop-loss carriers have the right to decline coverage on an entire group, or decline coverage on a specific member. Lasering is the term that refers to a carrier either denying coverage on a specific member or treating that member with a heightened stop-loss deductible. For example, a member with a known transplant surgery scheduled in the future may be lasered at a $500,000 deductible, while all other members have a $100,000 deductible. This does not affect the member's health coverage, only the employer's coverage under the stop-loss policy. Policies with lasers require additional scrutiny by the plan sponsor, including accurately budgeting for the additional expenses related to the lasered participant.

- **Rate caps:** Many carriers offer rate caps upon renewal. While these are valuable, plan sponsors should understand whether the cap is available for consecutive renewals or at the first renewal only. Typical rate caps seen in the market range from 30%–55%.
- **Aggregating specific:** If understanding individual and aggregate coverage wasn't hard enough, an aggregating specific adds additional complexity. This is a fixed deductible that must be met, in aggregate, after the individual stop-loss deductible is met. Once the aggregating specific deductible is met, the insurance company accepts ongoing responsibility.

  For example, consider a plan sponsor that has a $50,000 individual deductible and a $100,000 aggregating specific that has three claims, each of which are $100,000. Under traditional stop loss, the employer's liability for each of the claims would be capped at $50,000 with the carrier assuming $150,000 in total. With a $100,000 aggregating specific deductible, the employer is responsible for the first $100,000 that would traditionally have been reimbursed. Under this scenario, the carrier reimburses $50,000. Carriers offer aggregating specifics as a way to shift risk back to employers. Employers will typically consider the option if the reduction in premium is aligned with the additional risk assumed.

Interest in both self-funding and stop loss is rising

In the stop-loss marketplace, individual coverage has been historically most prevalent with organizations sized at between 250 and 10,000 employees. A significant minority of employers with 100-250 employees has chosen to self-insure and purchase stop-loss coverage. However, changes brought on by the Affordable Care Act (ACA) have created interest in stop loss for plan sponsors on both sides of the range. Due to heightened taxes on fully insured coverages, plan sponsors whose employees number 250 or less have considered self-insuring with stop-loss coverage.

In its *2015 Employer Health Benefits Annual Survey*,[7] Kaiser Permanente indicated that the prevalence of self-funding has increased to 63%, up from 59% in 2010, and from 49% in 2000. Larger employers who previously did not need any form of stop loss are considering individual stop loss due to the removal of annual and lifetime maximums as mandated by the ACA. Sun Life reports an annual increase of 25% in claimants in excess of $1M since 2012,[8] which further supports the need for employers of all sizes to consider stop-loss protection.

With more than 50 carriers fighting for stop-loss business, and with annual increases typically in the double digits, now is a good time to review your stop-loss policy and premium. Our health plan strategists here at Milliman can perform high-cost claim evaluations and advise your plan on your best options for stop-loss procurements.

To learn more, please contact Mehb Khoja at mehb.khoja@milliman.com.

7 Claxton, Gary, Matthew Rae, Michelle Long, Nirmita Panchal, and Anthony Damico. Employer Health Benefits 2016 Annual Survey (2015). The Kaiser Family Foundation and Health Research and Educational Trust. Retrieved February 21, 2017, from **http://files.kff.org/attachment/report-2015-employer-health-benefits-survey**.

8 Top ten catastrophic claims conditions (Spring 2016). Sun Life Financial®. Retrieved February 21, 2017, from **https://www.myhealthguide.com/images/2016_Sun_Life_Top_Ten_Catastrophic_Claims_Conditions_Report.pdf**.

PLAN SPONSOR 2017 COMPLIANCE KEY DATES

FEBRUARY 28, 2017

- 2016 form 1099-R to IRS
- 2016 forms 1095-B and 1095-C to IRS, if filing on paper

MARCH 1, 2017

- Rx drug coverage disclosure to CMS
- Summary of Benefits Coverage (SBC) must be provided to employees (for plan year beginning April 1)

MARCH 31, 2017

- 2016 electronic form 1099-R
- 2016 forms 1095-B and 1095-C to IRS, if filing electronically

JULY 31, 2017

- File form 720 and payment of Patient-Centered Outcomes Research Institute (PCORI) fee
- 2016 form 5500 Annual Return/Report

SEPTEMBER 30, 2017

- Summary Annual Report (SAR) to employees

OCTOBER 14, 2017

- Notice of Rx drug creditable coverage to employees

DECEMBER 1, 2017

- Summary of benefits and coverage (calendar-year plans without open enrollment)

DECEMBER 31, 2017

- Election notice of opt-out from certain HIPAA portability requirements

REGULATORY ROUNDUP

SUMMARIES OF RECENT RELEASES AND ANNOUNCEMENTS

MILLIMAN EMPLOYEE BENEFITS RESEARCH GROUP

During the first few days of the Trump Administration, the President signed an executive order[9] aimed at minimizing the economic burden of the Affordable Care Act pending repeal. Since then, the House GOP leaders have unveiled the ACA Repeal and Replacement Proposal. This proposal is calling for expanded health savings accounts (HSAs), healthcare tax credits, restructuring Medicaid to cap federal payments, and funding for state "high risk" pools. In addition, this proposal is calling to repeal the ACA's taxes, including for the employer and individual mandates.

The IRS released Chief Counsel Memorandum 201703013[10] on the tax treatment of cash payments paid by employer-sponsored fixed-indemnity health plans (including wellness programs). According to the CCM, such amounts are taxable if the premium paid for the coverage was excluded from the employee's gross income and wages (i.e., via employer pre-tax contributions or employee salary reduction contributions under a cafeteria plan).

The Department of Health and Human Services published the 2017 annual poverty guidelines.[11] The 2017 poverty guidelines for a family of four increased 1.2% from $24,300 to $24,600. The guidelines are used to determine which individuals qualify for cost assistance when buying insurance through the State-based or Federal Health Insurance Marketplaces.

The Congressional Budget Office issued "*How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums*",[12] which provides estimates of the potential impacts of leaving the ACA's insurance market reforms in place while repealing the law's mandate penalties and subsidies. According to the report, partially repealing the law would lead to 18 million uninsured Americans and increase premiums in the individual insurance market by 20%-25% in the first year.

President Obama signed into law the *21st Century Cures Act* (P.L. 114-255)[13] on December 13, 2016. The new law provides significant funding for biomedical research, opioid addiction treatments, and a cancer "moonshot" initiative, as well as mental health/substance use disorder parity provisions. The law also exempts health reimbursement accounts (HRAs) sponsored by qualified small employers from the Affordable Care Act's penalties applicable to "group health plans," allowing for the funds to purchase health insurance on the individual market, with a cap set for HRA payments to any given employee at $4,950 ($10,000 for family coverage), to be indexed for inflation.

To learn more, please contact Maria Saavedra at maria.saavedra@milliman.com.

9 Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal (January 20, 2017). The White House. Retrieved February 21, 2017, from **https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and**.

10 Tackney, Stephen. Memorandum to Jeremy Fetter, Area Counsel. Tax Treatment of Benefits Paid by Fixed-Indemnity Health Plans. (January 20, 2017). Office of Chief Counsel Internal Revenue Service. Number: 201703013. Retrieved February 21, 2017, from **https://www.irs.gov/pub/irs-wd/201703013.pdf**.

11 U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Programs (January 26, 2017). Office of the Assistant Secretary for Planning and Evaluation (ASPE). Retrieved February 21, 2017, from **https://aspe.hhs.gov/poverty-guidelines**.

12 How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums (January 2017). Congressional Budget Office. Retrieved February 21, 2017, from **https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52371-coverageandpremiums.pdf**.

13 The 21st Century Cures Act (P.L. 114-255) is at: **https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.pdf**.