HEALTH & GROUP BENEFITS
NEWS & DEVELOPMENTS

An Employer Benefits Update

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HEALTH SAVINGS ACCOUNTS (HSAs): A MORE SUBSTANTIAL RETIREMENT SAVINGS TOOL

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Health savings accounts (HSAs) have been in the news recently and for good reason. First introduced in 2003, the HSA is a tax-advantaged medical savings account available to taxpayers in the United States who enroll in a qualified high-deductible health plan (HDHP). Since their introduction, these savings accounts have proven to be valuable for participants as they offer a number of tax advantages for qualified health benefit expenses. Recent changes proposed within the Senate and House bills during the effort in 2017 to repeal and replace the Patient Protection and Affordable Care Act (ACA)[1] are supporting further expansion of HSAs, creating even more of an advantage. With these changes, HSAs stand to compete with other standard retirement savings mechanisms, such as tax-deferred 401(k) savings plan contributions, potentially even pushing them into the forefront.

The tax code places certain annual limits on contributions to HSAs, as well as the HDHP's deductible and out-of-pocket maximum. For individual coverage for 2018, the maximum contribution to an HSA is $3,450, the minimum deductible is $1,350, and the maximum out-of-pocket limit is $6,650. These limits are doubled for family coverage. The standard advantages for HSA participants have not changed since they were first introduced in 2003:

- Contributions to HSAs are tax-exempt.
- Those same contributions can be invested and any investment income and appreciation are also tax-exempt.
- Withdrawals are tax-exempt as long as participants use the withdrawal to pay for qualified medical expenses, such as doctor's visits, prescription drugs, and dental care.
- HSA funds roll over and accumulate year to year if they are not spent. They are owned by the individual.
- HSA plan contributions are not subject to Federal Insurance Contributions Act (FICA) tax whereas 401(k) plan contributions are.

Some of the recent bills introduced in 2017 have proposed even further expansion for HSAs, as outlined below, creating even more advantages for employees if these bills are passed and become law.

- Allowing spouses to make catch-up contributions to a single HSA.
- Permitting reimbursements from an HSA for qualified medical expenses incurred before HSA-qualified coverage begins, as long as the HSA is established within 60 days.
- Permitting participants to use their HSAs to pay for over-the-counter medications. This was originally restricted under the ACA.
- Lowering the tax penalty if you use an HSA to pay for unqualified medical expenses to 10% from 20%.
- Increasing the annual limit on HSA contributions to match the annual deductible and out-of-pocket expenses under the HDHP. In other words, the HSA contribution limit could be $6,650 for individuals and $13,300 for families (consistent with 2018 HDHP maximum out-of-pocket limits).
- Eliminate the requirement that a participant in an HSA be enrolled in a high-deductible healthcare plan.

1 The full text of the proposed Health Savings Account Expansion Act of 2017 is available at: **https://www.congress.gov/bill/115th-congress/senate-bill/28**.

Employers also stand to gain from offering HSA plans. Some of these advantages include:

- HSAs can help with attracting and retaining employees if employees understand their full benefits.
- HSAs offer flexibility around how much employers want to contribute to HSA accounts.

The adoption of HSAs and HDHPs is growing regardless of what Congress is doing.[2] However, for retirees who plan to use a portion of their retirement savings accounts to pay for healthcare, these proposed expansions will make HSAs even more valuable. For example, increasing the contribution limits to be consistent with the HDHP maximum out-of-pocket limits stands to double plan contributions while lowering taxable income, including amounts subject to FICA tax. Retirees with both healthy HSAs and retirement accounts such as 401(k)s will provide even more financial security and stability rather than just relying on 401(k) accounts alone.

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EMPLOYERS COPE WITH RISING HEALTHCARE COSTS

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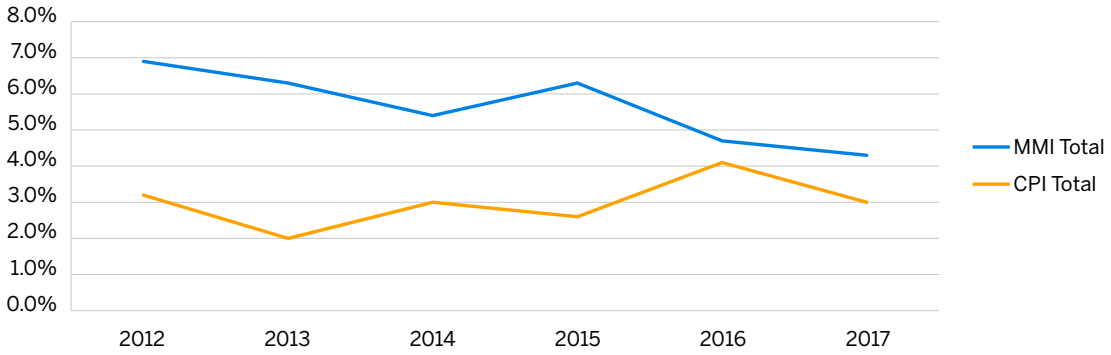
In May 2017, Milliman released its 2017 Milliman Medical Index (MMI), which measures the cost of healthcare for a typical American family of four receiving coverage from an employer-sponsored preferred provider organization (PPO) plan. The MMI increased $1,118 (4.3%) to $26,944, including a 3.6% increase in average medical expenditures and an 8.0% increase in prescription drug expenditures. This increase of more than $1,100 (a continuation of similar annual increases in the index since 2001) shows that federal healthcare reform efforts, which have mainly targeted the individual insurance market and Medicaid, have had little effect on reducing employers' costs. Although this year's MMI saw the lowest annual percentage increase in healthcare costs for a family of four with employer coverage since at least 2001, healthcare cost increases continue to outpace consumer price index (CPI) inflation trends, as shown in the chart below.

FIGURE 1: MMI FAMILY OF FOUR TREND VS. CPI



Sources: Bureau of Labor Statistics for CPI and 2017 Milliman Medical Index.

2 Employee Benefit Research Institute (September 19, 2017). Health Savings Account Balances, Contributions, Distributions, and Other Vital Statistics, 2016: Statistics From the EBRI HSA Database. Issue Brief. Retrieved December 6, 2017, from https://www.ebri.org/pdf/briefspdf/EBRI_IB_438_HSAs.19Sept17.pdf.

Employers have responded by:

- *Gradually transferring more of the cost to employees through contributions and plan design*

  Over the past five years, the MMI has increased 30%, while the employers' share of healthcare costs has increased 25.7%. As a result employees are paying about 43% of the MMI, up from 41% in 2012.

- *Putting more pressure on vendors*

  For example, employers sponsoring self-insured prescription drug plans should be regularly reviewing pharmacy benefits manager (PBM) arrangements through requests for proposals (RFPs) and market checks.

- *Managing utilization of benefits and cost shifting by providers through strategies such as narrow networks and proactive medical management*

- *Staying ahead of the prescription drug pipeline*

  Over the past few years, prescription drug trends have been greatly influenced by the entry of extremely expensive, curative hepatitis C treatments. While it looks like these treatments are no longer driving prescription drug trends, it is important to monitor the status of the prescription drug pipeline to understand what employers can expect to spend on prescription drugs in the coming years. Employers can stay ahead of the curve through strategies like utilization management, including prior authorization, step therapy, and pursuing specialty pharmacy rebates.

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COST CONTROL MEASURES FOR GROWING EMPLOYER MEDICAL AND PHARMACY EXPOSURE

Elaine Britt, Health & Group Benefits Consultant

Rising prescription drug costs are old news. What is new, however, is just how high they have gone. Take the recent case of a member whose annual pharmacy spend is expected to exceed *$7 million* per year. That is the *annual* spend for *one* member. It turns out the medication is for a life-threatening, chronic, hereditary condition, and the medication will be needed for the remainder of the member's life. This means no end in sight for the employer-sponsored insurance plan.

In the first year, the stop-loss coverage will cover the majority of this cost; however, there is the potential for a 40% to 60% increase in stop-loss premiums the following year, and even so, this member will be lasered out of any coverage in following years. In other words, the employer-sponsored health plan will be liable for this full amount going forward, plus any additional costs for this individual for medical or other pharmacy expenses (e.g., emergency room visits, hospitalizations, etc.).

Can employer-sponsored plans afford to absorb that kind of additional, annual spend in their healthcare budgets? In this particular case, the drug keeps the member alive, so not covering the medication is not an option, morally or ethically. But if this cost potentially bankrupts the plan, there will be no coverage for this member anyway.

So what can employers do to protect against this claim and others?

1. STOP-LOSS COVERAGE

First, for those self-funded employers, make sure there is stop-loss insurance in place, even if it is at an individual limit of $750,000 to $1 million. It may seem like the smart move to exclude this additional cost from the bottom line (especially for larger employers), until that $10 million claim hits. In addition, make sure the stop-loss policy covers the pharmacy expenses. Sometimes, when an external pharmacy benefits manager (PBM) is used, pharmacy costs are excluded from the carrier's stop-loss coverage. It is always prudent to shop around and find a policy that will cover both medical and pharmacy expenses. Many of these extremely high prescription drug claims are related to specialty medications. It will be important to understand how the stop-loss policy will coordinate with these specialty medications and how they will want front-end coordination of claims as they develop.

The stop-loss policy may only be a stop-gap measure (especially if the member is later lasered out of future coverage), but such a policy will give you time to reassess your claim issues and make a plan for future cost containment.

2. NOTIFICATION OF LARGE CLAIMS

Alongside reinsurance, the plan should be sure to have the appropriate triggers in place for notification of high-dollar claims—pharmacy or medical. It is better to be informed in order to research the situation and prognosis. Do these participants need extra support from Human Resources (HR) or should they work with the carrier care management team, including large claim management or clinical review? Is assistance with disability or other benefits necessary? As in all cases, but specifically large claims, be mindful of HIPAA guidelines when working through large claim management.

3. PRUDENT GOVERNANCE

It is typical for both the medical carrier and PBM to pay claims on behalf of the employer-sponsored plan. Thus, it is important to gain a full understanding of how the medical carrier and PBM are controlling costs on behalf of the plan. Are they acting as good fiduciaries of the plan? Speaking with them at least quarterly will ensure the plan is up to date on the latest medications and programs to curtail expenses. In addition, receiving monthly or quarterly reports on plan activity is sensible.

Other prudent considerations to be contemplated could be:

- What incentives does the carrier or PBM have that might impact their decisions (i.e., rebates)?
- Is there formulary management?
- Would step therapy be a practical option for the plan?
- Should a mandatory generic drug requirement be applied?
- Is there a high-cost radiology plan in place?
- Does the plan have an external review process for high-cost cases?
- What provisions are in the plan in terms of case management or other navigation/assistance programs?
- Should the plan offer a second-opinion service and even be mandatory for high-cost claims?
- Consider looking to the manufacturer for any discount programs or other assistance for high-cost medications. Most of these programs are aimed on the member side, but sometimes the manufacturer will work with employers to get the lowest price possible. Be sure the PBM is also getting the best deal and understand the rebates, if any. What portion of rebates, if any, does the PBM retain? Could they actually be incentivized by these payments to approve coverage for certain medications?
- Stay on top of the carrier's policies and procedures for the most expensive tests and medications. This will help to address the member questions as well as understand how the plan covers these certain high-cost medical and pharmacy claims.

4. NARROW NETWORKS

Narrow networks are increasingly used across employer-sponsored plans to assist in controlling costs for both medical and pharmacy spend. Narrow networks may not work for all employers, but for those in metropolitan areas where high-performance networks or accountable care organizations (ACOs) are prevalent, it is definitely a strategy to consider. For employers with large employee concentrations in rural areas or in cities where certain pharmacy chains or provider networks are not in play, this strategy may not work as well. However, the plan may also consider mandatory mail order programs as an alternative for maintenance medications.

5. MEMBER OUTREACH

Member waste can be a significant issue. For medications that can have high adverse reactions, the plan may want to consider a trial period, such as a two-week supply versus a 90-day supply. During this period, a determination of medication effectiveness and tolerance will be made before continuing forward. For injectable medications, assistance could be provided to make sure they are administered properly and to address any storage or other potential contamination issues.

6. "COSTS" TO COST CONTROL

As with all of these savings measures, you need to also gauge the "noise" factor relative to the cost savings. For a minimal projected savings, the increased member phone calls may not be worth it. Reviewing the plan's population against its current claim activity will provide a measure of disruption and identify any potential red flags.

In addition, most PBMs and carriers charge for these cost-savings measures. Periodically review the effectiveness of the programs for which you choose to pay. Don't be shy about digging in and asking how they *really* saved you money. If they cannot prove savings (not just number of phone calls), then stop paying them for this service and consider third-party alternatives.

There may be members who want a certain procedure or medication that is not covered under the plan for their particular situations. Be sure you know how to assist them with navigating non-covered services and negotiating down these costs.

7. OUTLOOK

With medical and prescription drug claim costs at all-time highs, employers and plan participants have the potential to bear the related expenses. It has never been more important for employers to be asking more of their medical carriers and PBMs. Asking questions and digging in when necessary is only prudent for the long-term financial stability of the plan, and Milliman can be the partner to assist on these issues.

To learn more, please contact Elaine Britt at elaine.britt@milliman.com.

REGULATORY ROUNDUP

SUMMARIES OF RECENT RELEASES AND ANNOUNCEMENTS

MILLIMAN EMPLOYEE BENEFITS RESEARCH GROUP

Social Security adjusts taxable wage base and related figures for 2018

The Social Security Administration (SSA) announced key 2018 Social Security numbers, including a taxable wage base of $128,400. The SSA has now received a national payroll service provider's data with corrected Internal Revenue Service (IRS) Forms W-2 ("Wage and Tax Statement"), which lowers the national average wage index for 2016, which in turn reduces the 2018 Social Security taxable maximum amount (also known as the taxable wage base or the contribution and benefit base), the primary insurance amount (PIA) "bend points" used to calculate benefits, and the family maximum bend points.

HHS proposes Notice of Benefit and Payment Parameters for 2019

The U.S. Department of Health and Human Services (HHS) released a proposed rule that includes the benefit and payment parameters for 2019, and several of other proposed insurance market and exchange-related rules. In particular, the rule would propose an increase in the maximum annual limitation on cost sharing for 2019 to $7,900 for self-only coverage and $15,800 for other than self-only coverage (compared to $7,350 and $14,700, respectively, for 2018). The rule also proposes to substantially change the medical loss ratio (MLR) standards and would make changes to enhance the role of states as related to essential health benefits (EHBs) and qualified health plan (QHP) certification.

Medicare announces COLAs for 2018

The Centers for Medicare and Medicaid Services (CMS) announced the 2018 Medicare Parts A and B premiums and deductibles. For 2018, the rates will be as follows:

- Part A inpatient hospital deductible: $1,340 (up from $1,316 in 2017).
- Part A daily coinsurance amounts: $335 for the 61st through 90th days of hospitalization in a benefit period (up from $329), $670 for lifetime reserve days (up from $658), and $167.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period (up from $164.50).
- Part A premium to purchase coverage: $422 (up from $413 in 2017), and for those entitled to a reduced monthly premium, $232 (up from $227 in 2017).
- Part B deductible: $183 (unchanged from 2017).
- Part B standard monthly premium: $134 (unchanged from 2017).

The following chart shows the 2018 Medicare Part B monthly premiums based on 2016 income tax filings*:

2016 INDIVIDUAL INCOME	2016 JOINT INCOME	2018 PART B PREMIUM
$85,000 or less	$170,000 or less	$134.00
$85,001 - $107,000	$170,001 - $214,000	$187.50
$107,001 - $133,500	$214,001 - $267,000	$267.90
$133,501 - $160,000	$267,001 - $320,000	$348.30
Above $160,000	Greater than $320,000	$428.60

* For 2018 and subsequent years, the income thresholds are modified by recent statutes, most recently by the 2015 Medicare Access and CHIP Reauthorization Act (MACRA, P.L.114-10). Consequently, the three highest-income categories have reduced income ranges, thereby requiring Medicare beneficiaries in those reduced income-range categories to pay larger Part B premiums than in 2017.

IRS and DOL announce 'Extension of Time Frames' for employee benefit plans, participants, and beneficiaries affected by Hurricane Maria

The U.S. Department of the Treasury and U.S. Department of Labor (DOL) announced extensions of certain timeframes for group health plans, disability and other welfare plans, pension plans, participants and beneficiaries of these plans, and group health insurance issuers directly affected by Hurricane Maria.

PLAN SPONSOR 2018 COMPLIANCE KEY DATES

JANUARY 31, 2018
- 2017 Form W-2 to employees and to the Social Security Administration
- 2017 Form 1099-R to recipients of retirement plan distributions
- Extended deadline for various filings, payments and group health plan requirements due to recent disasters

FEBRUARY 28, 2018
- 2017 Form 1099-R to IRS
- 2017 Forms 1094-C and 1095-C (paper) to IRS

MARCH 1, 2018
- Rx Drug Creditable Coverage Disclosure to CMS

MARCH 2, 2018
- 2017 Form 1095-C to employees of "applicable large employers"

APRIL 2, 2018
- 2017 Form 1099-R (electronic) to IRS
- 2017 Forms 1094-C and 1095-C (electronic) to IRS

JULY 31, 2018
- Send Form 720 to IRS for payment of the Patient-Centered Outcomes Research Institute (PCORI) fee (plan year ending before 10/1/2018)
- 2017 Form 5500 Annual/Return Report, unless extension applies

SEPTEMBER 30, 2018
- Summary Annual Report (SAR) to employees

OCTOBER 14, 2018
- Rx Drug Creditable Coverage Notice to Medicare Part D-eligible individuals

DECEMBER 1, 2018
- Summary of Benefits and Coverage (plans without open enrollment) to employees

DECEMBER 31, 2018
- Notice of election to opt out of certain HIPAA portability requirements to CMS and to enrollees

DOL issues FAQs for participants and beneficiaries following Hurricanes Harvey, Irma, Maria, and the California wildfires

The DOL released two sets of frequently asked questions (FAQs)—**FAQs for Participants and Beneficiaries Following Hurricane Maria and FAQs for Participants and Beneficiaries Following Hurricanes Harvey, Irma, and the California Wildfires**—which assist employee benefit plans, plan sponsors, employers, and employees who were impacted by the devastation caused by the hurricanes and wildfires to better understand their rights and responsibilities under ERISA with respect to their ERISA-covered employee benefit plans.

Health plan choice and premiums in the 2018 federal health insurance exchange

The HHS Assistant Secretary for Planning and Evaluation (ASPE) published an Issue Brief, "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange," which presents information on qualified health plans (QHPs) available in the exchange for states that use the HealthCare.gov platform, including estimates for issuer participation, health plan options, premiums, and subsidies in the upcoming open enrollment period (OEP), and trends since the first OEP.

CAB 17-4R: COLAs for retirement, Social Security and health benefits for 2018

With the release of the September 2017 Consumer Price Index (CPI) by the Bureau of Labor Statistics, the Social Security Administration (SSA) and the IRS have announced cost-of-living adjustment (COLA) figures for Social Security and retirement plan benefits, respectively, for 2018. The 2018 adjusted figures for high-deductible health plans (HDHPs) and health savings accounts (HSAs) included in this Client Action Bulletin (CAB) were released by the IRS earlier this year and are provided here for convenience. Note: The SSA in late November updated some of its October figures based on corrected, underlying data. This revised CAB includes the agency's amended figures. None of the other figures have changed. EBRG has replaced the original CAB with this update on the Milliman website.

Chart containing ACA Indexed Dollar Amounts*

The chart below contains 2017 and 2018 Affordability Safe Harbor Thresholds, Applicable Large Employer Tax Penalty Amounts, and Out-of-Pocket Maximums:

	2018	2017
FPL Affordability Safe Harbor	$96.08	$95.93
4980H(b) Affordability Threshold	9.56%	9.69%
4980H(b) – Penalty for Failure to Offer Affordable Minimum Value Coverage	$3,480 ($290/mo.)	$3,390 ($282.50/mo.)
4980H(a) – Penalty for Failure to Offer Coverage	$2,320 ($193.33/mo.)	$2,260 ($183.33/mo.)
Out-of-Pocket Maximums (Self-Only)	$7,350	$7,150
Out-of-Pocket Maximums (Family)	$14,700	$14,300

* Revenue Procedures **2016-24** and **2017-36**, the **Final Rule on Benefit and Payment Parameters for 2017**, and the **Final Rule on Benefit and Payment Parameters for 2018**.

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