

Benchmarking, Best Practices and Strategies

 **Milliman** September 15, 2017

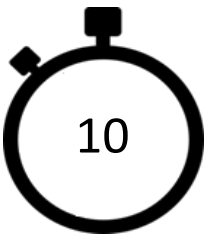
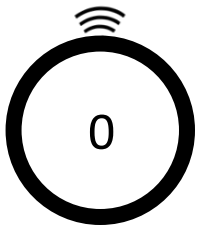
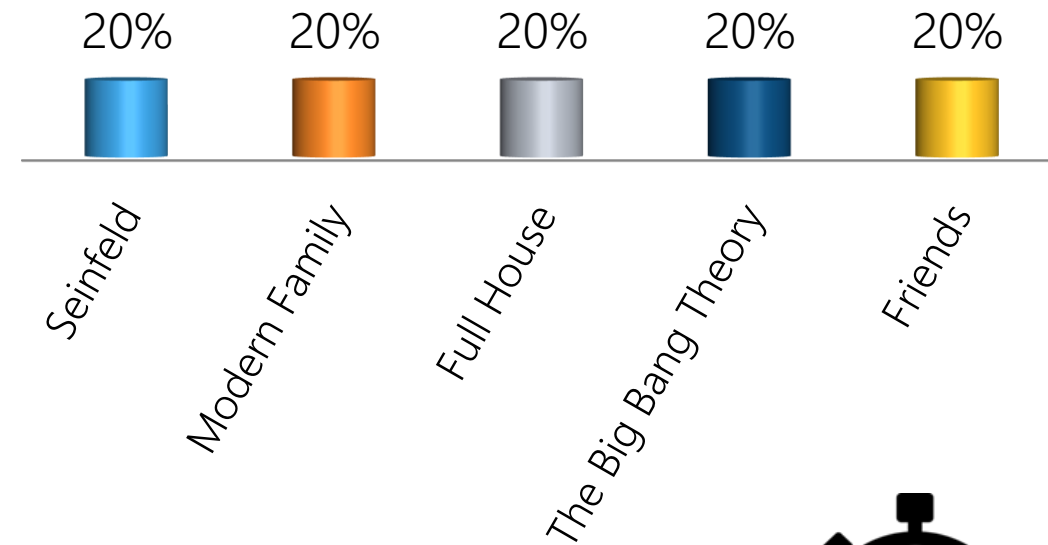


AUDIENCE POLL



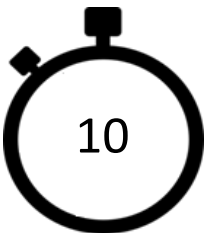
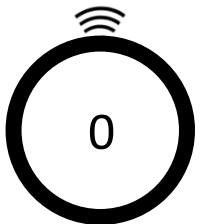
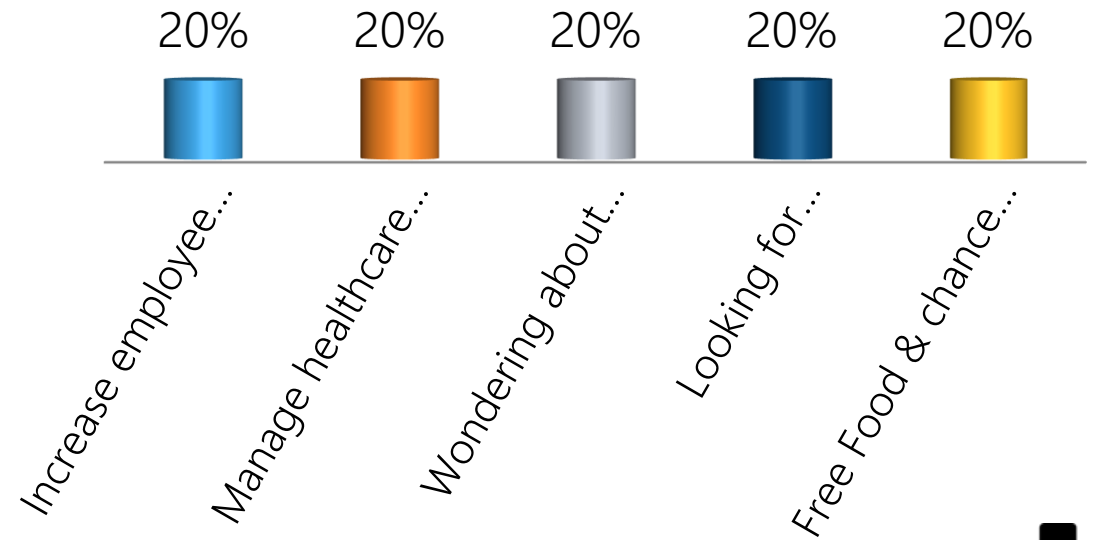
If you could live in any sitcom, which one would it be?

1. Seinfeld
2. Modern Family
3. Full House
4. The Big Bang Theory
5. Friends



What is your primary motivation today?

1. Increase employee retention
2. Manage healthcare costs
3. Wondering about self-funding
4. Looking for strategies to better our business practices
5. Free Food & chance to meet Ron Cornwell





Delivering Insight for a Select Network
of Health Insurance Agencies

MILLIMAN OVERVIEW VIDEO



147

companies participating

79,364

employees represented

947.3 million
healthcare dollars spent

MID-ATLANTIC BENCHMARKING SURVEY

NATIONAL

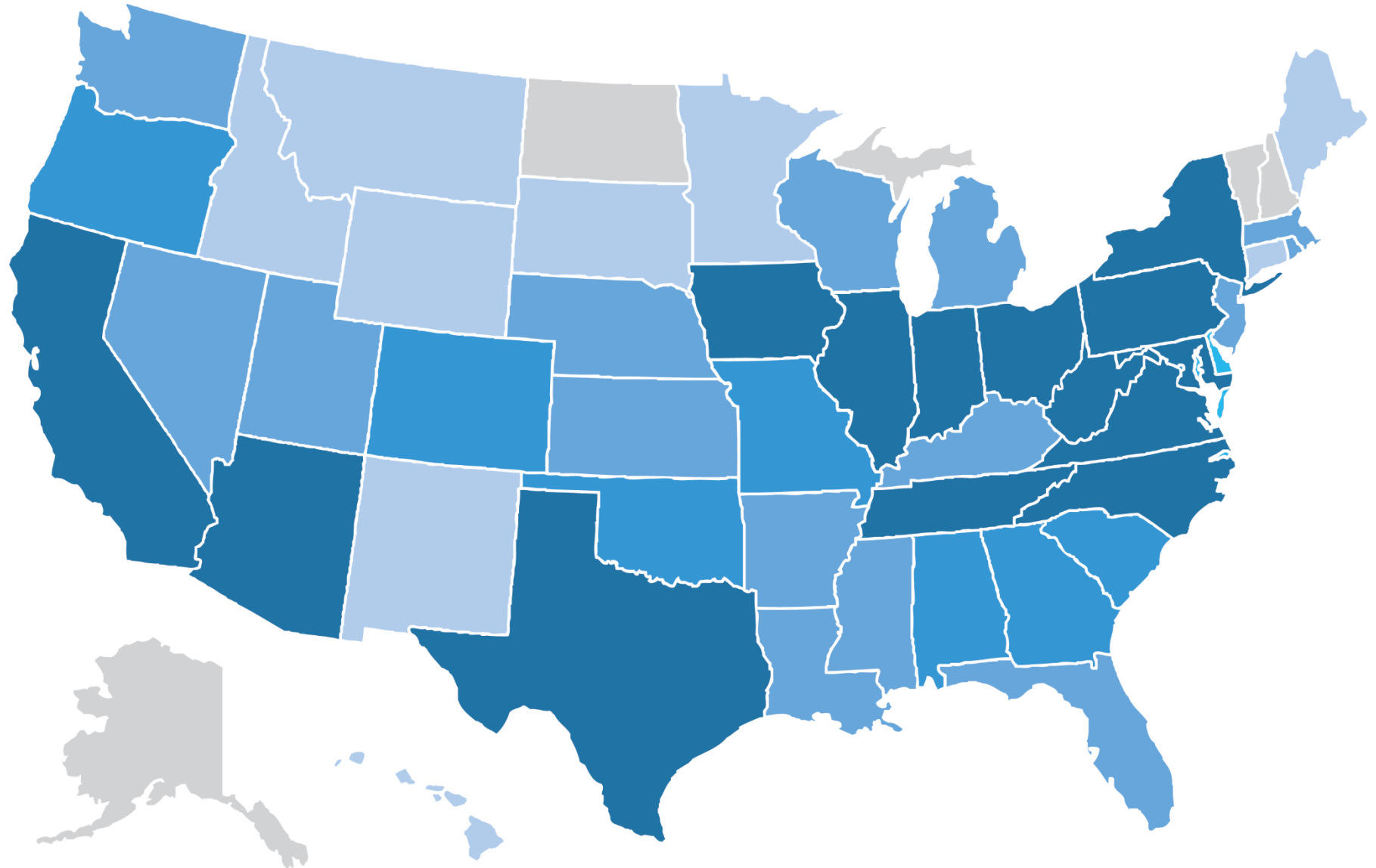
6,427

companies participating

2.2 million
employees represented

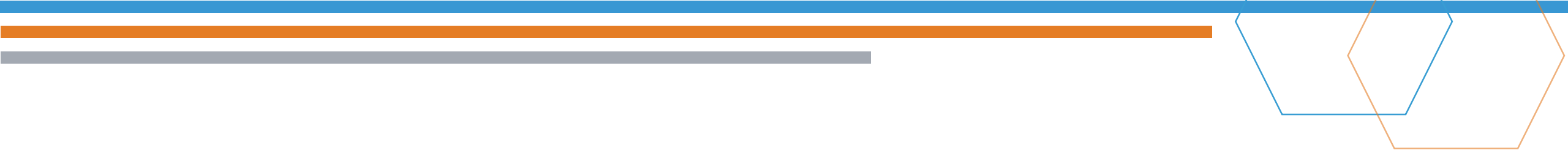
24.1 billion
healthcare dollars spent

2016 AREAS SURVEYED



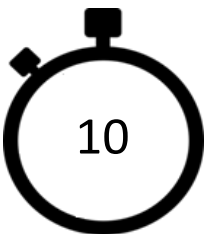
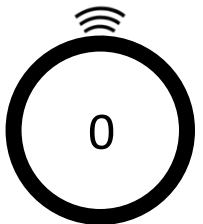
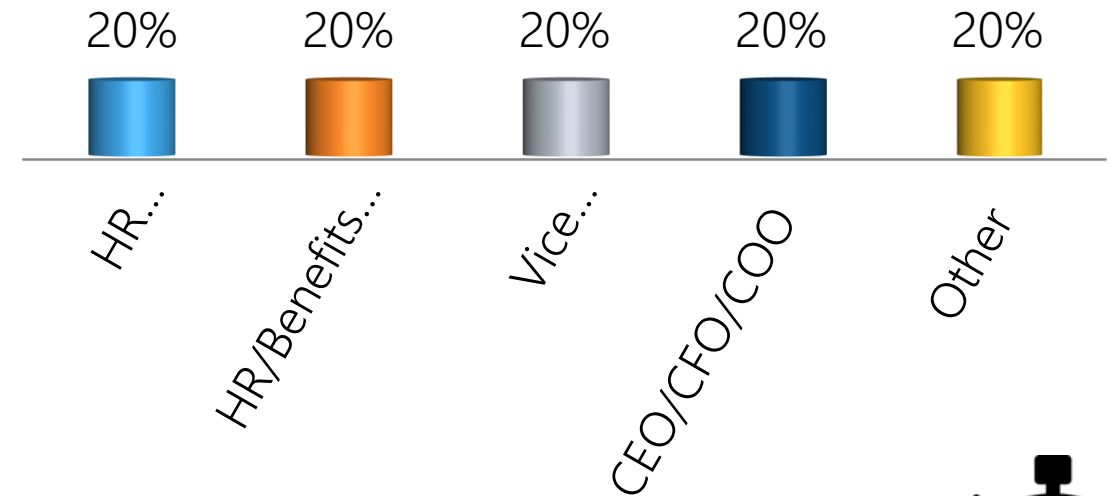
5 or less surveys 25 or less surveys 100 or less surveys >100 surveys

AUDIENCE POLL



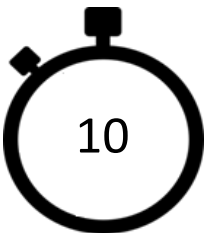
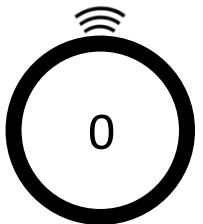
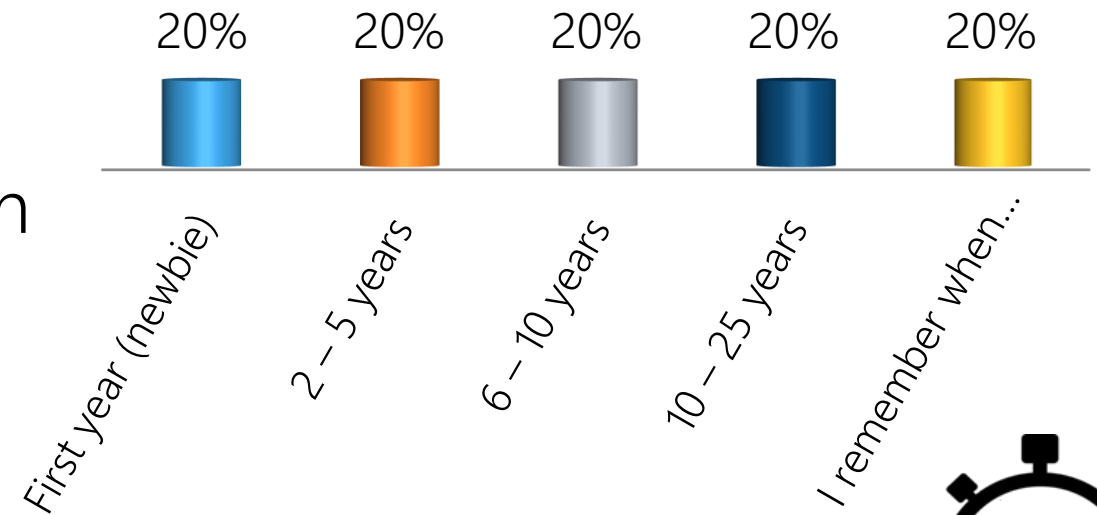
What is your current position in your company?

1. HR Assistant/Generalist
2. HR/Benefits Manager
3. Vice President/Director of HR
4. CEO/CFO/COO
5. Other



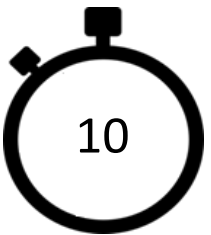
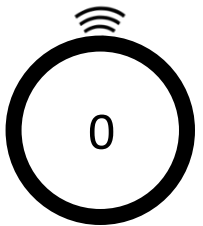
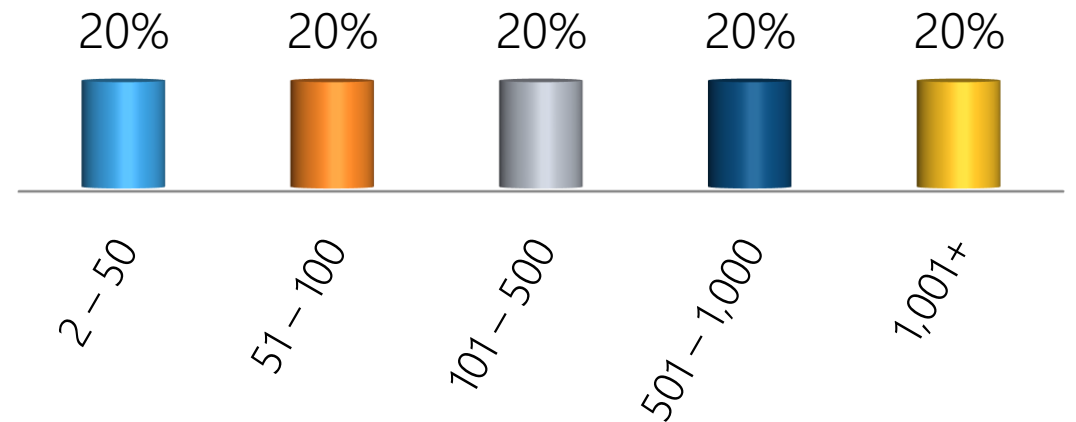
What is your tenure in benefits?

1. First year (newbie)
2. 2 – 5 years
3. 6 – 10 years
4. 10 – 25 years
5. I remember when Hillary led Health Care Reform in the 1990s



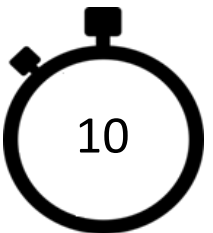
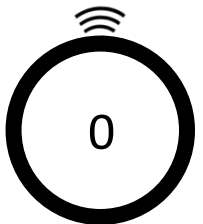
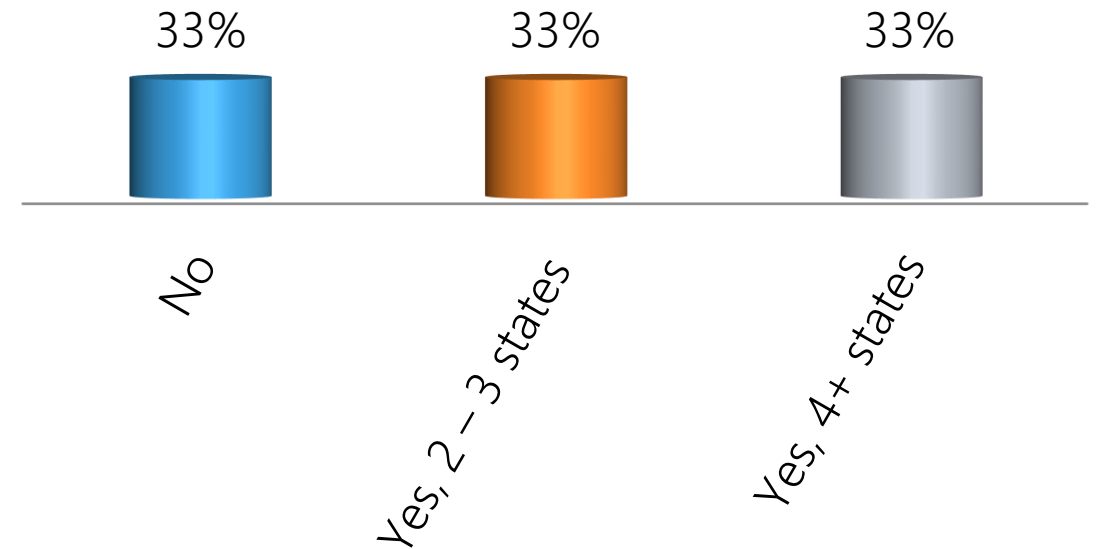
How many of your company's employees are eligible for your benefits program?

1. 2 – 50
2. 51 – 100
3. 101 – 500
4. 501 – 1,000
5. 1,001+



Do you have employees located in multiple states?

1. No
2. Yes, 2 – 3 states
3. Yes, 4+ states





PLAN DESIGNS



PREMIUM RATES



FUTURE OF HEALTHCARE



ALTERNATIVE FUNDING



CONSUMERISM



Rx DRUG PRICES



ALTERNATIVE FORMS OF HEALTHCARE

AGENDA



PLAN DESIGNS

How do my plan designs compare?



MEDICAL PLAN PREVALENCE



48% HDHP

22% PPO

22% HMO/EPO

8% POS

NUMBER OF PLANS OFFERED



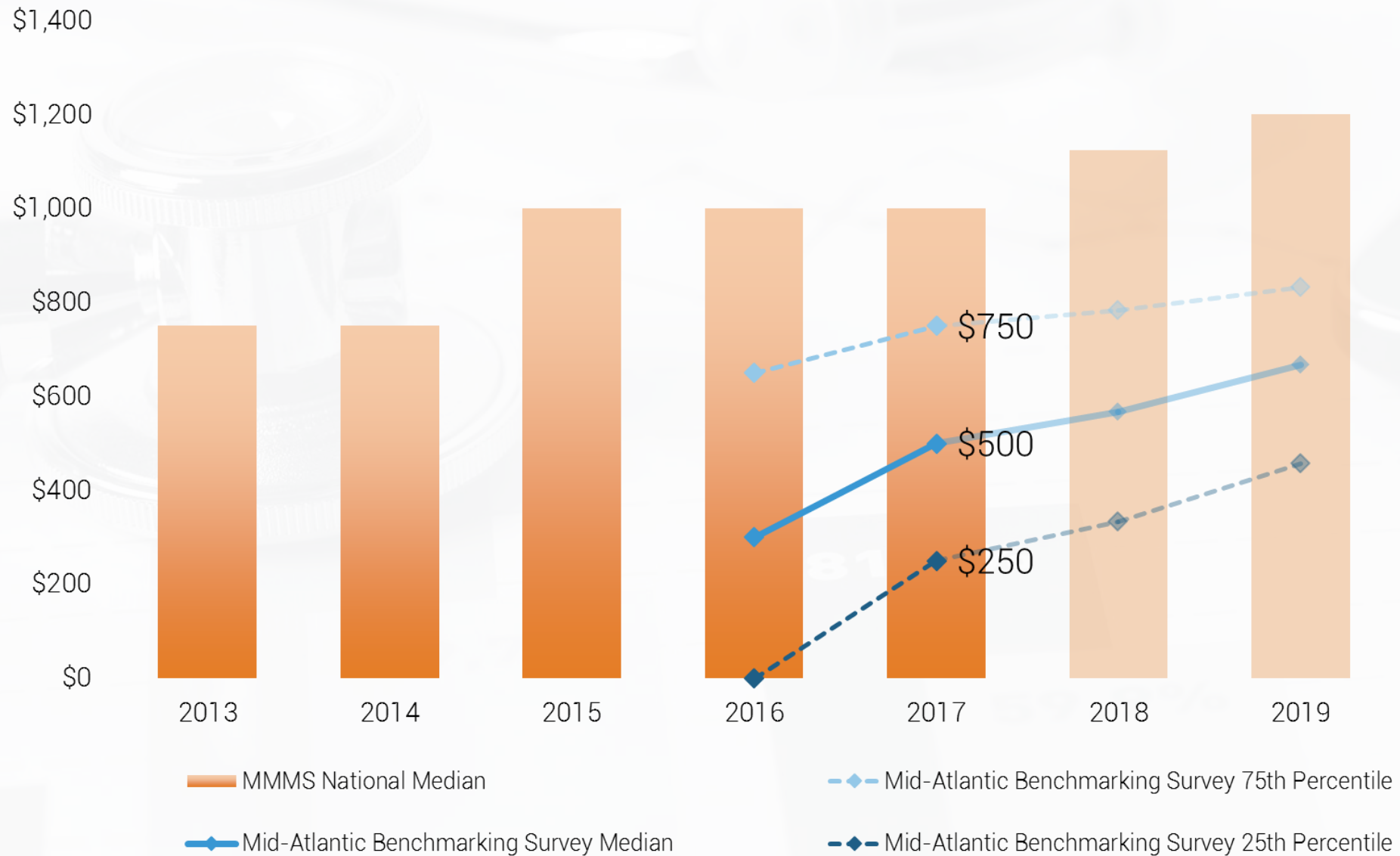
16% 1 Plan

25% 2 Plans

47% 3 Plans

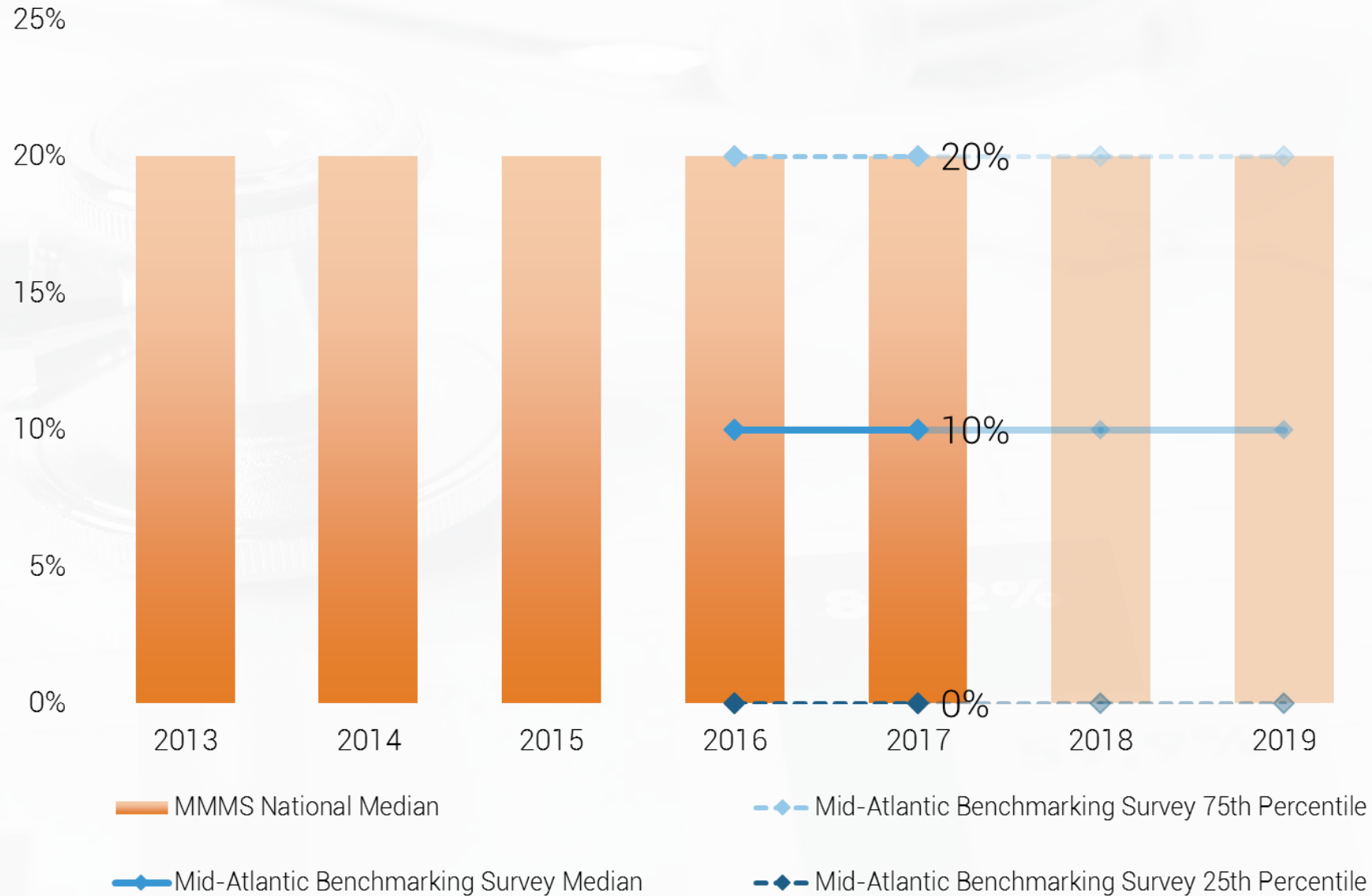
13% 4+ Plans

Deductible | PPO Plans (In-Network)



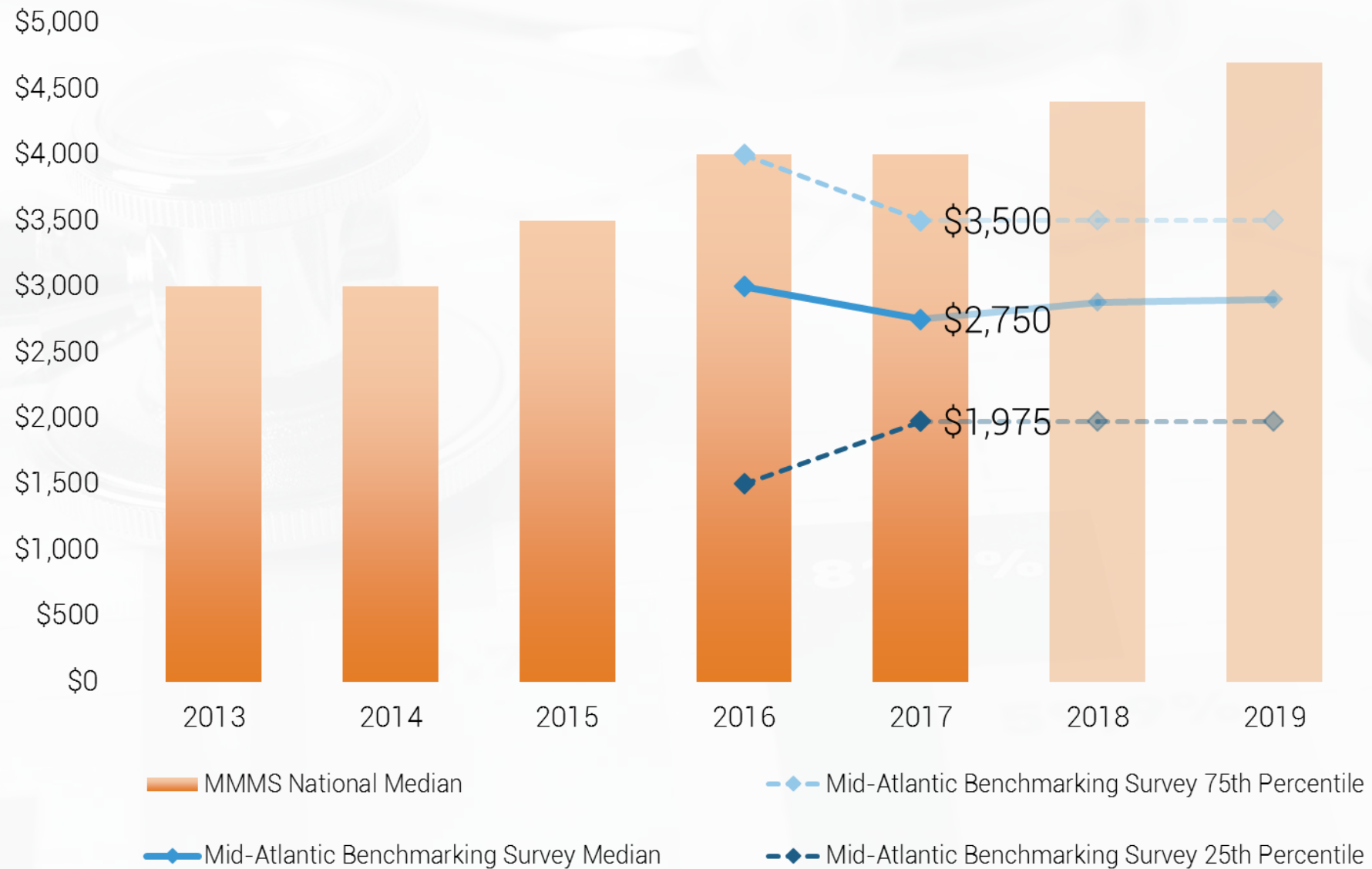
2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Coinsurance | PPO Plans (In-Network)



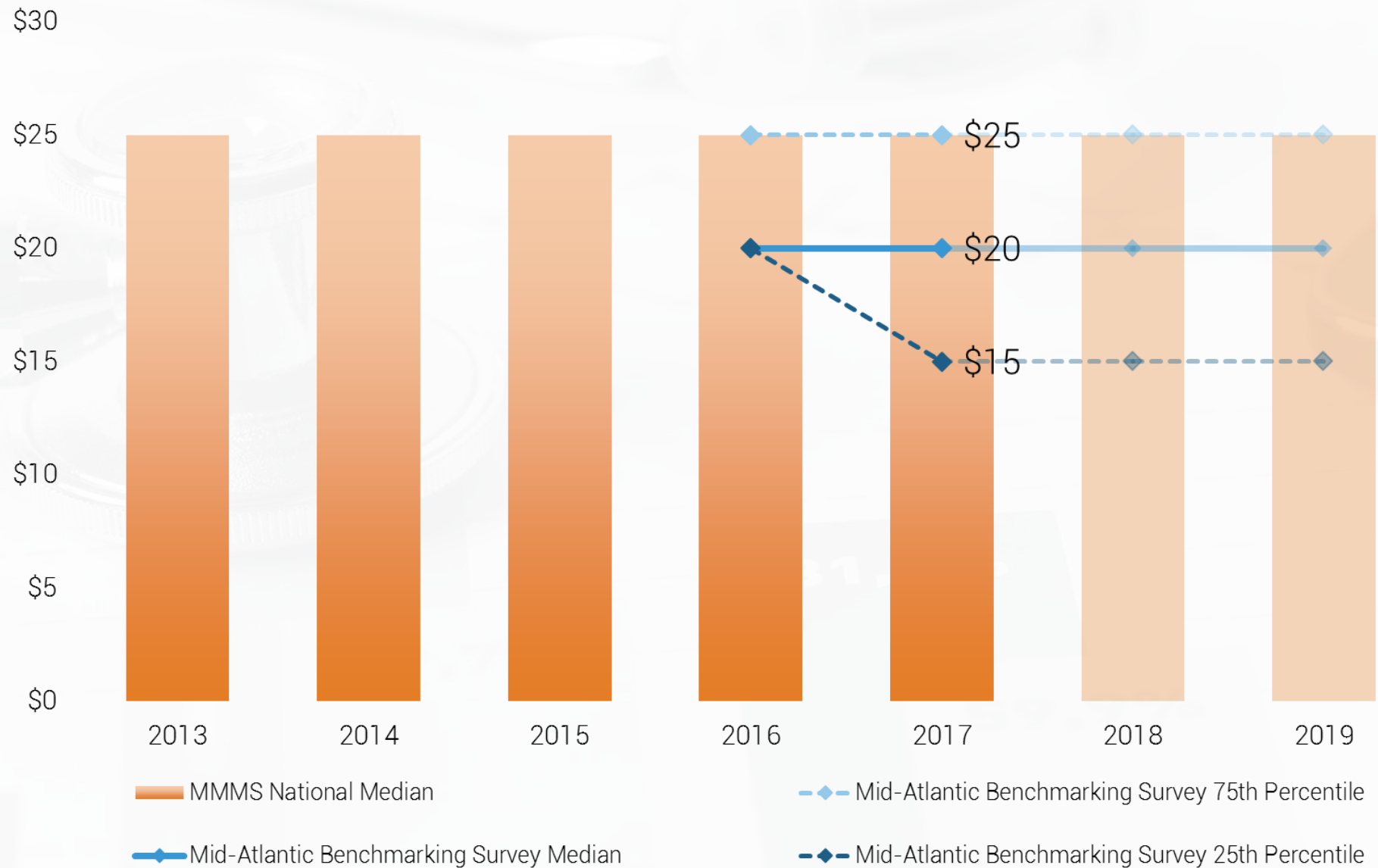
2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Out-of-Pocket Maximum | PPO Plans (In-Network)



2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Office Visit Copay | PPO Plans (In-Network)



2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures



Medical Plan Summary

PPO Plan Medians

2017 Mid-Atlantic
Benchmarking Survey

2017 National

Deductible

\$500/\$1,000

\$1,000/\$2,000

Coinsurance

10%/30%

20%/40%

OOP Max

\$2,750/\$4,500

\$4,000/\$8,000

Office Visit Copay

\$20

\$25

Specialist Copay

\$30

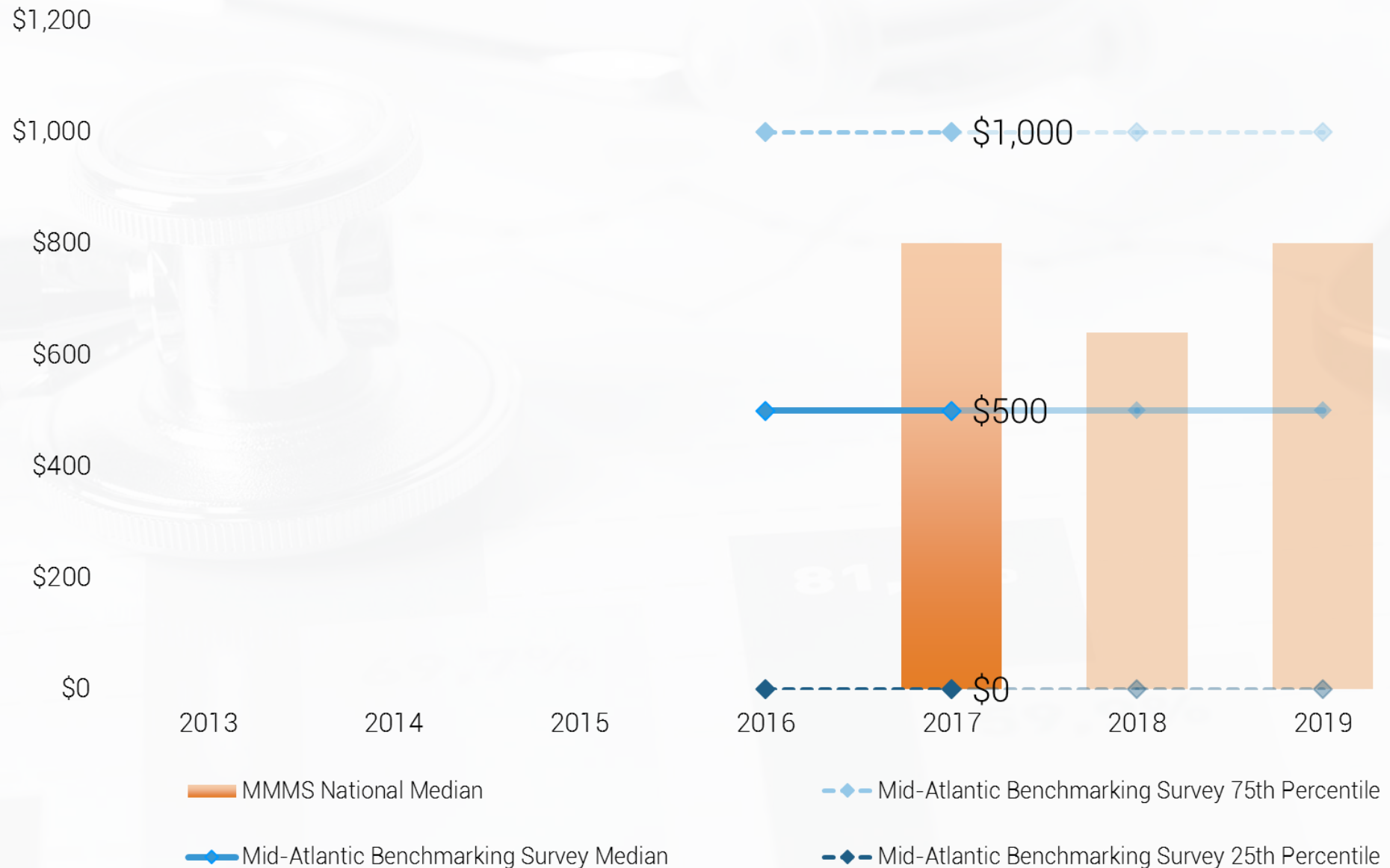
\$40

Rx Copays (retail)

\$13/\$35/\$60/\$75

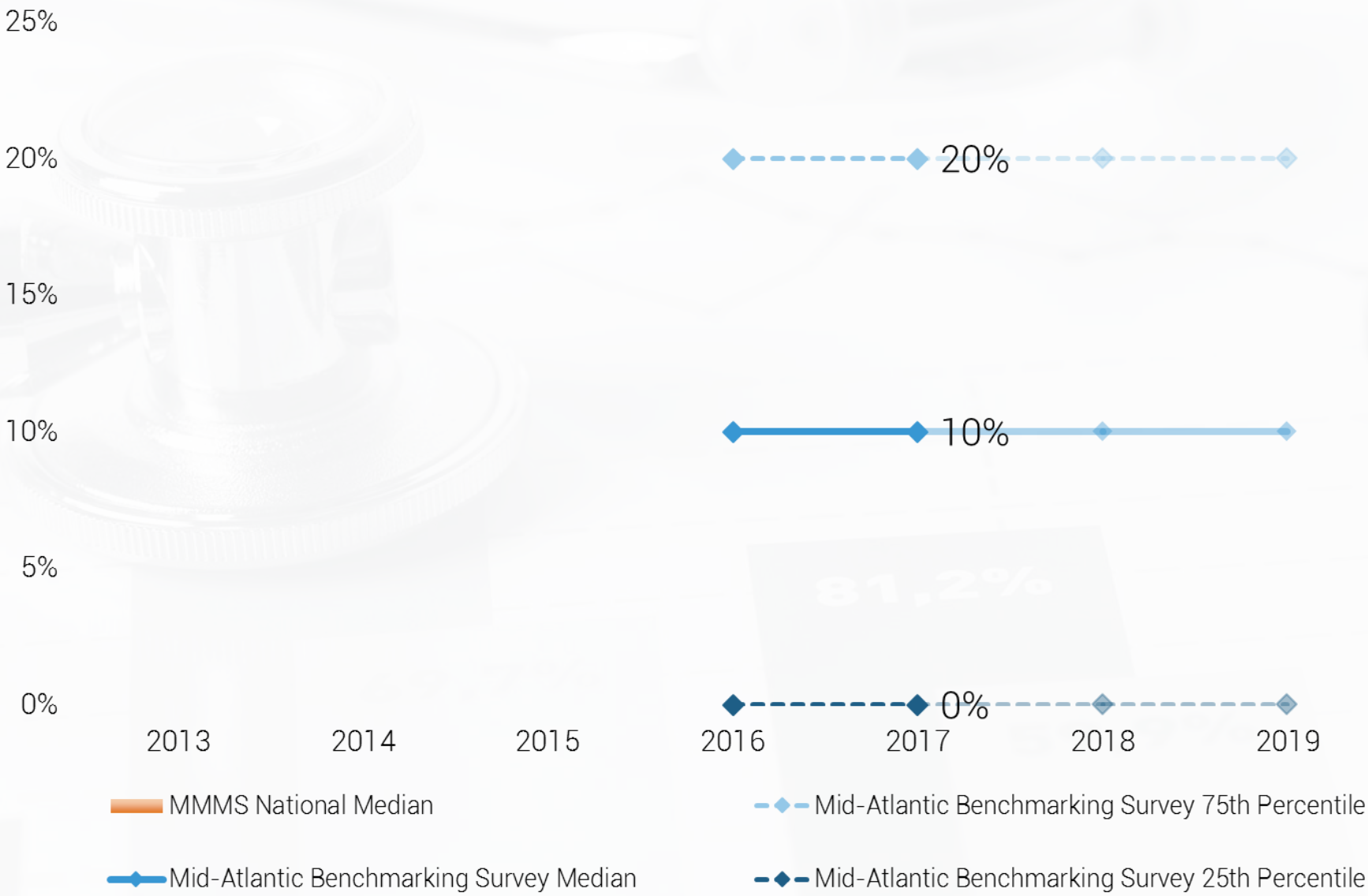
\$10/\$30/\$50/\$100

Deductible | HMO/EPO Plans (In-Network)



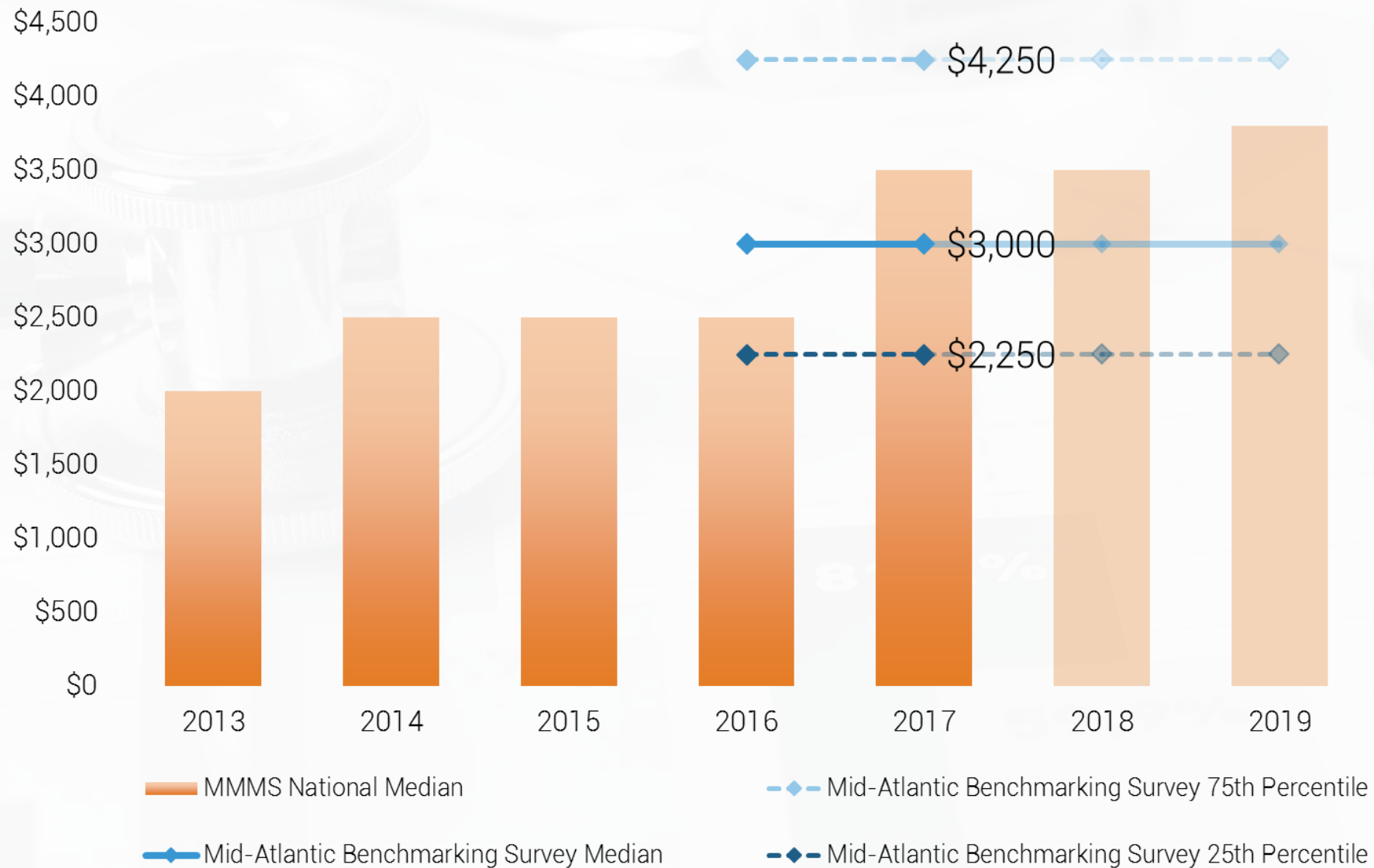
2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Coinsurance | HMO/EPO Plans (In-Network)



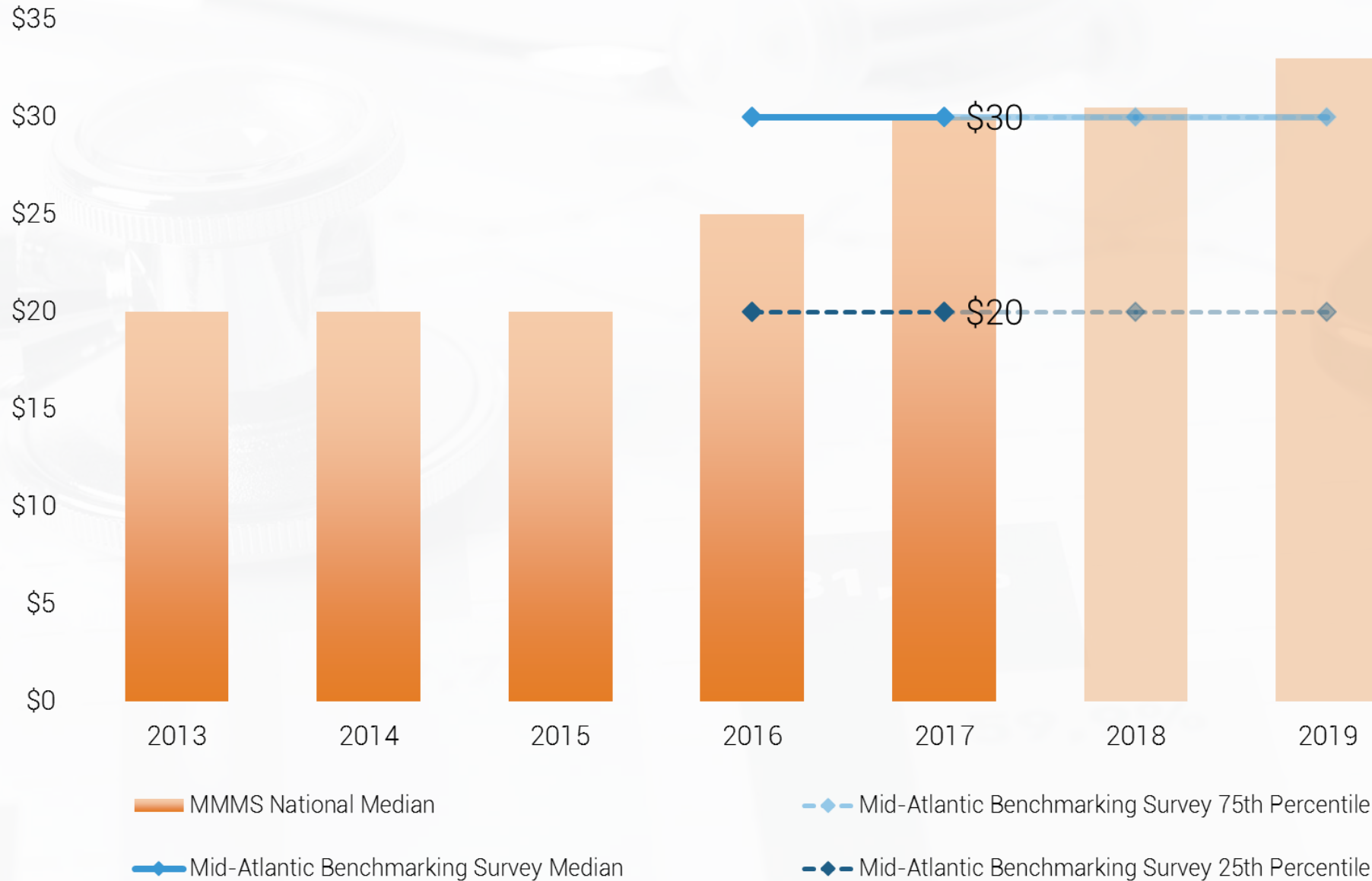
2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Out-of-Pocket Maximum | HMO/EPO Plans (In-Network)

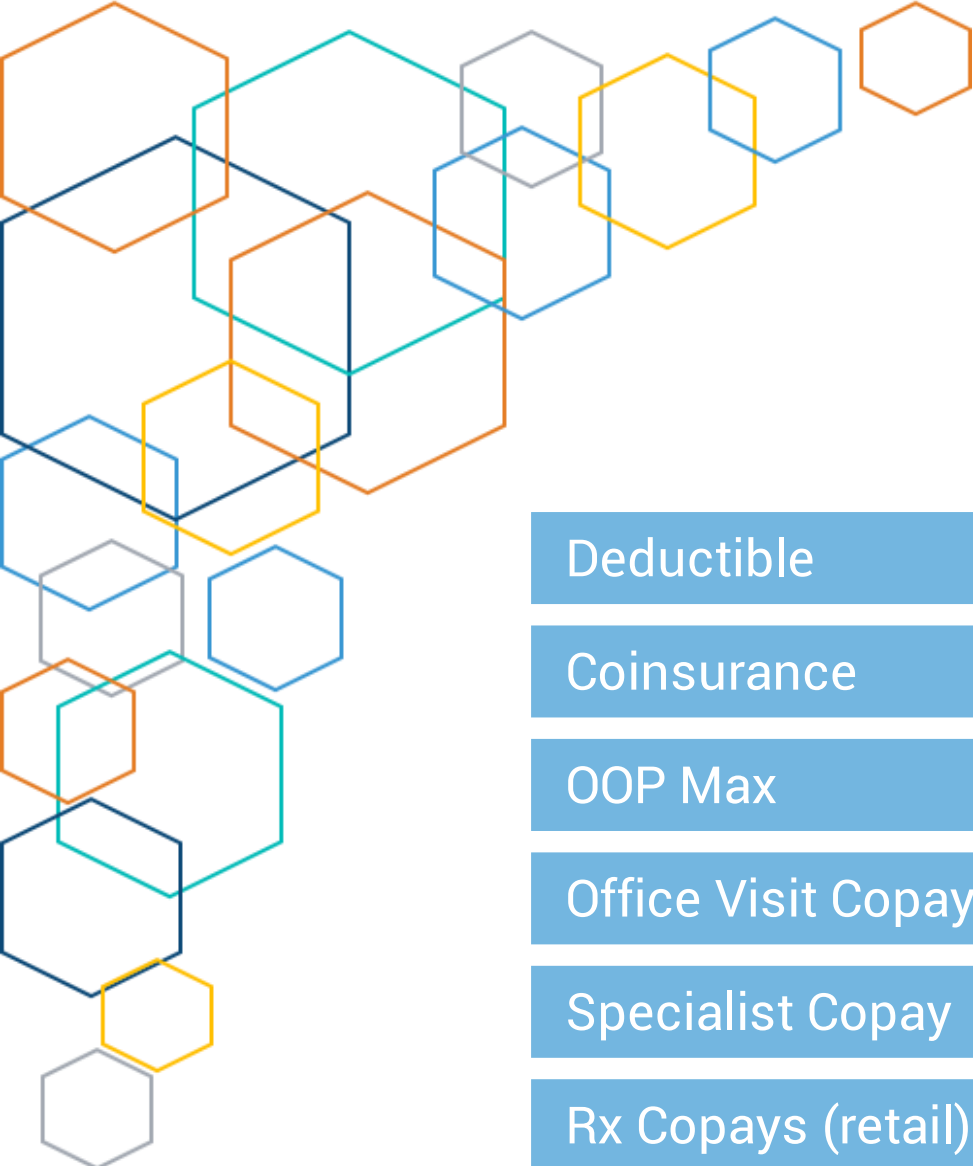


2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Office Visit Copay | HMO/EPO Plans (In-Network)



2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

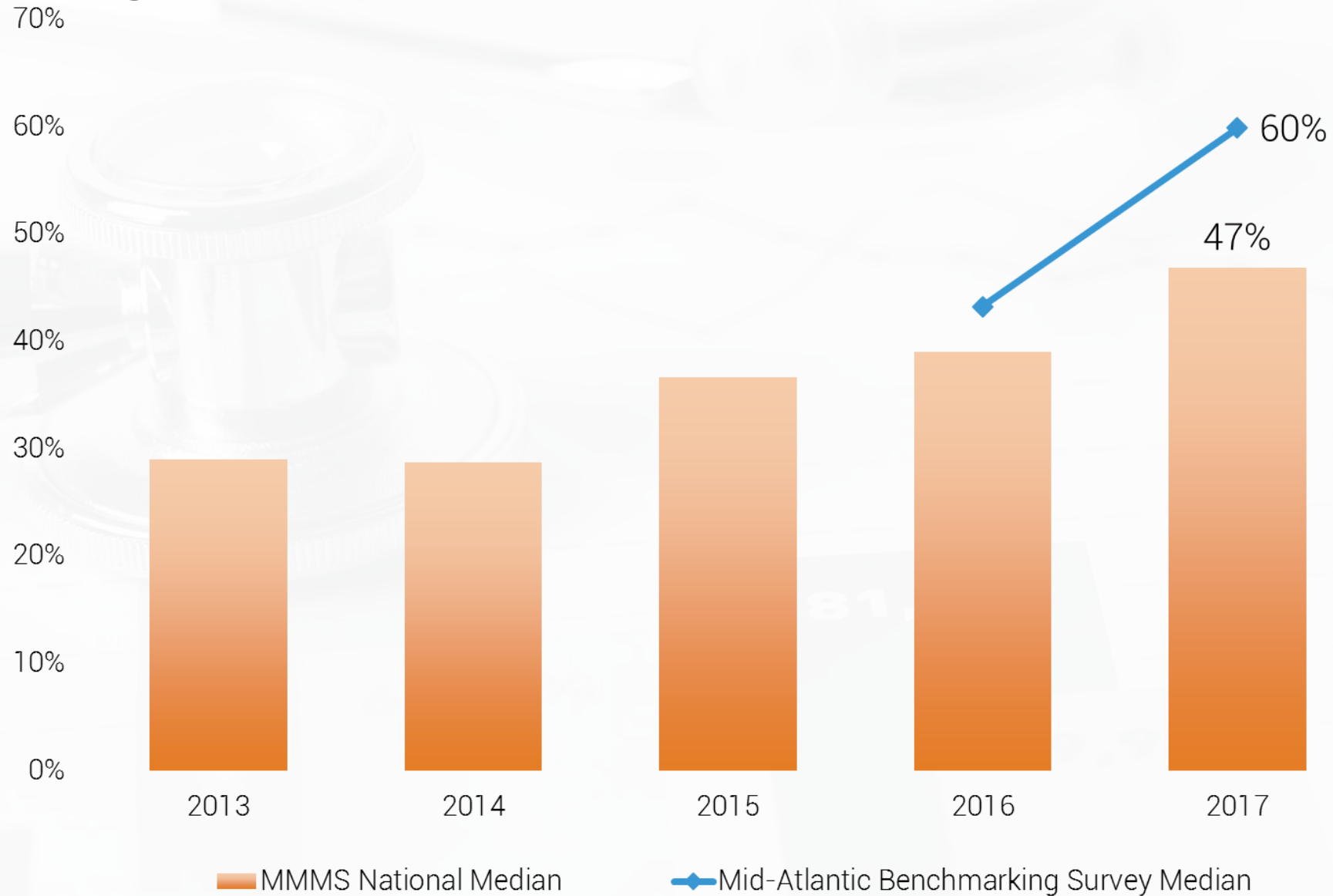


Medical Plan Summary

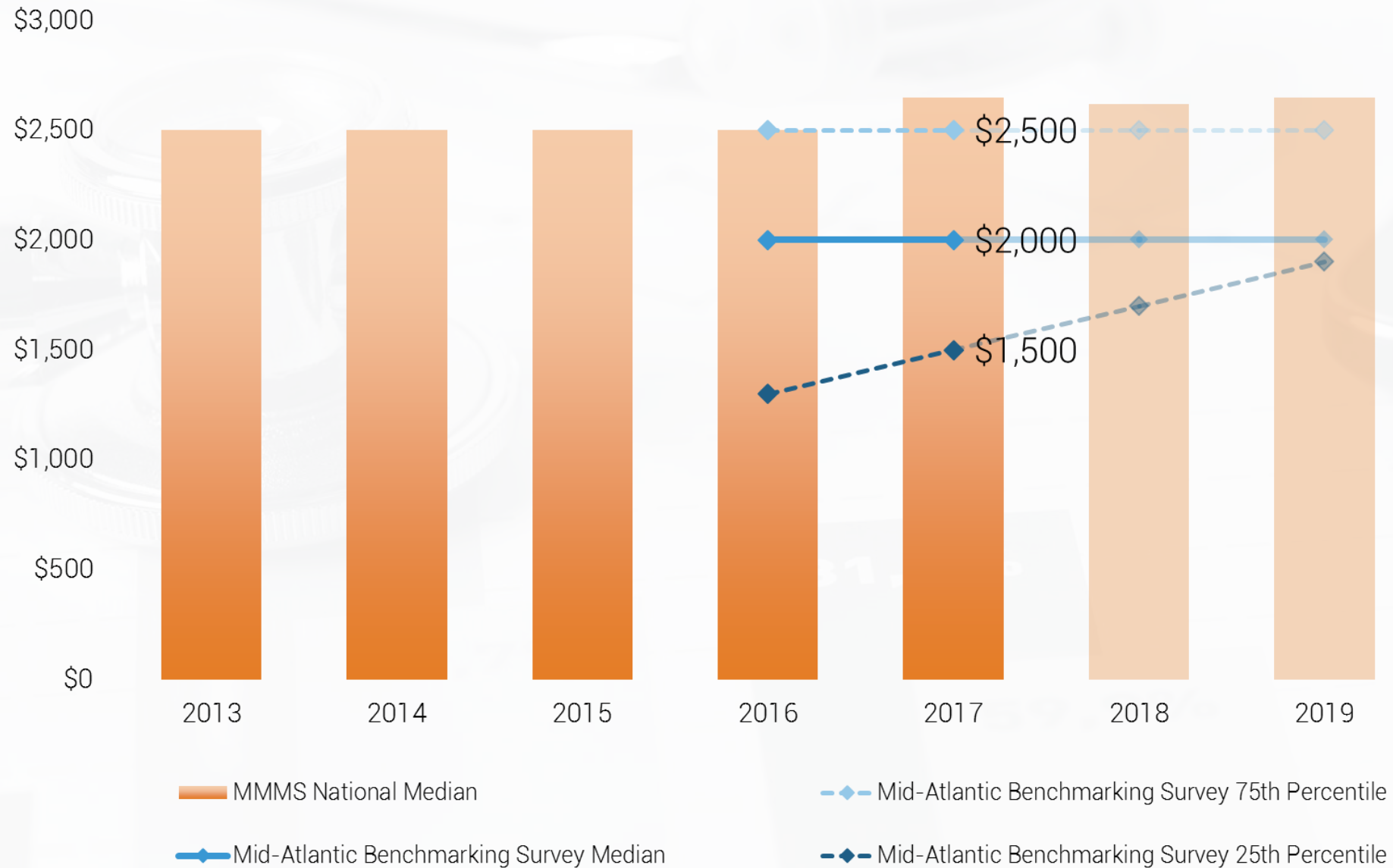
HMO/EPO Plan Medians

	2017 Mid-Atlantic Benchmarking Survey	2017 National
Deductible	\$500	\$800
Coinsurance	10%	0%
OOP Max	\$3,000	\$3,500
Office Visit Copay	\$30	\$30
Specialist Copay	\$40	\$50
Rx Copays (retail)	\$15/\$35/\$60/\$60	\$10/\$35/\$50/\$75

High Deductible Health Plans | Currently Offer

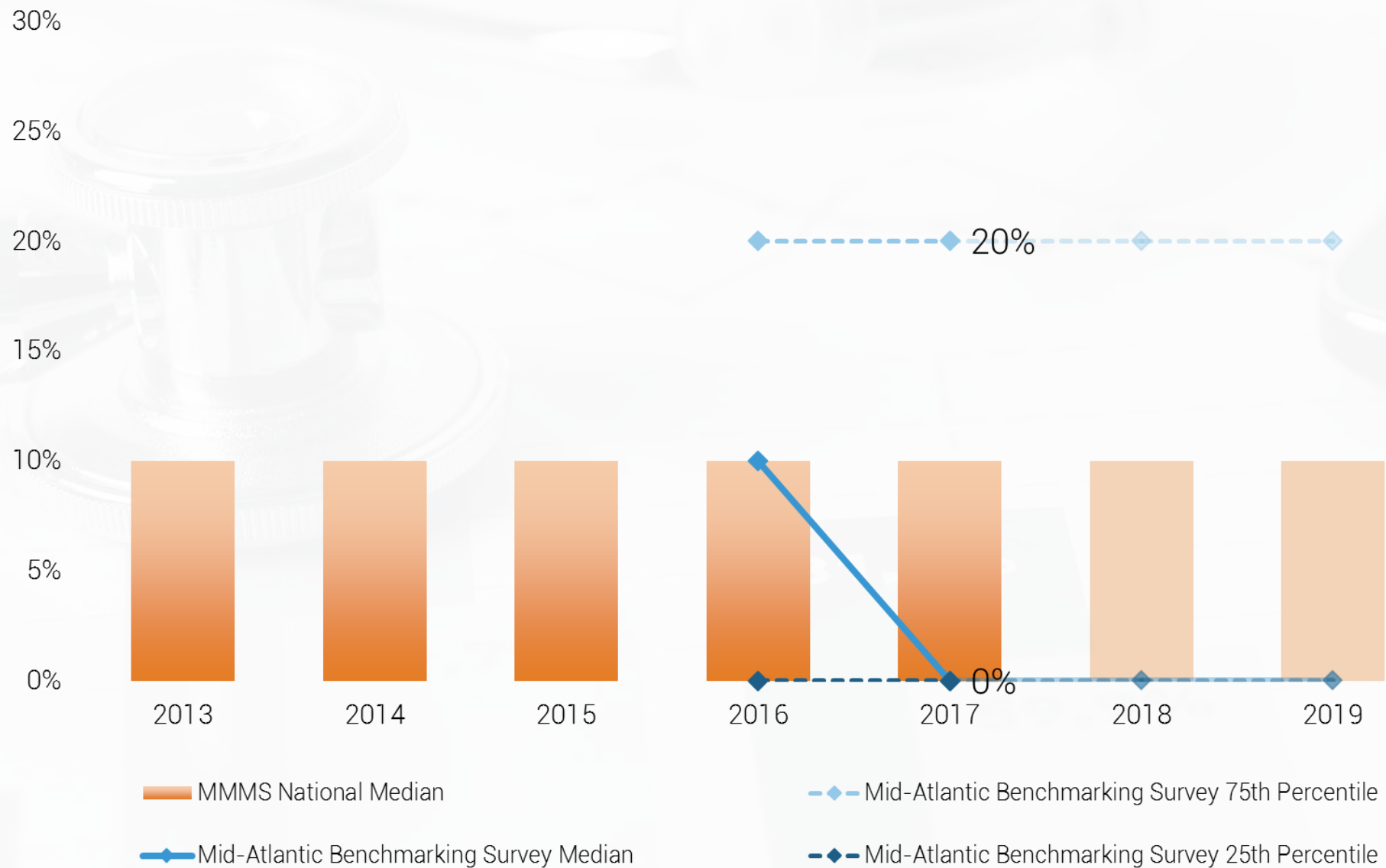


Deductible | HDHP Plans (In-Network)



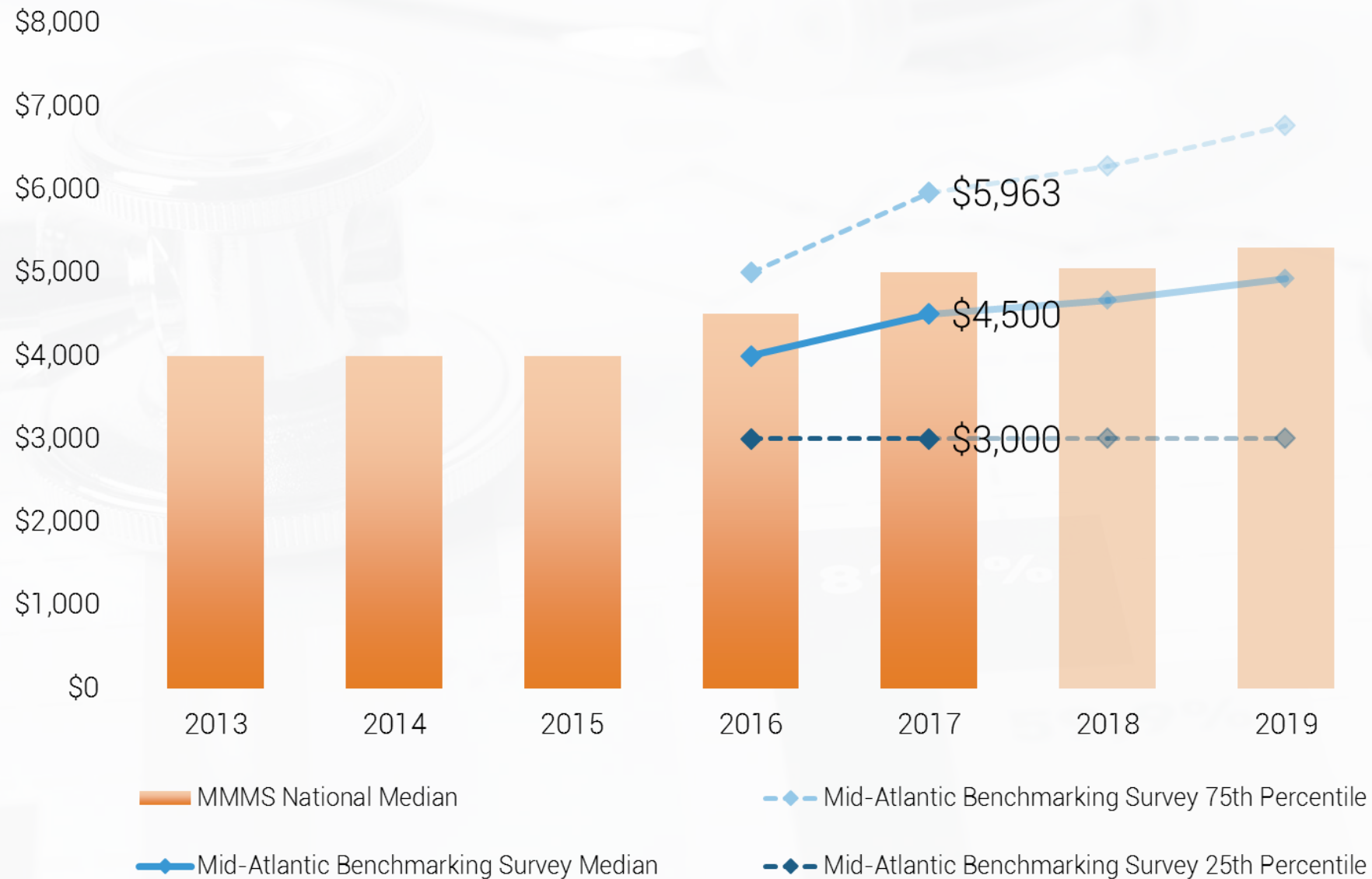
2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Coinsurance | HDHP Plans (In-Network)

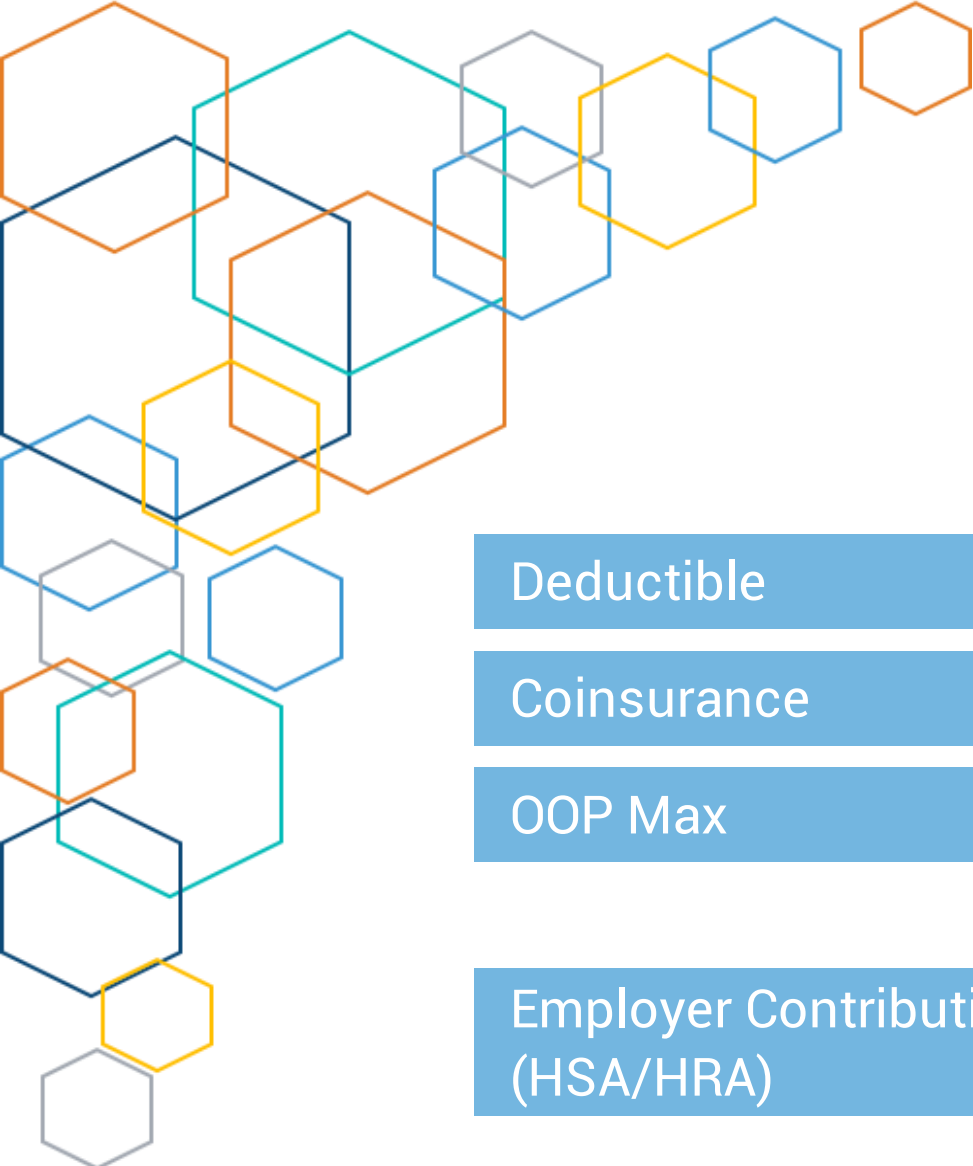


2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures

Out-of-Pocket Maximum | HDHP Plans (In-Network)



2018-2019 Mid-Atlantic Benchmarking Survey and National are forecasted figures



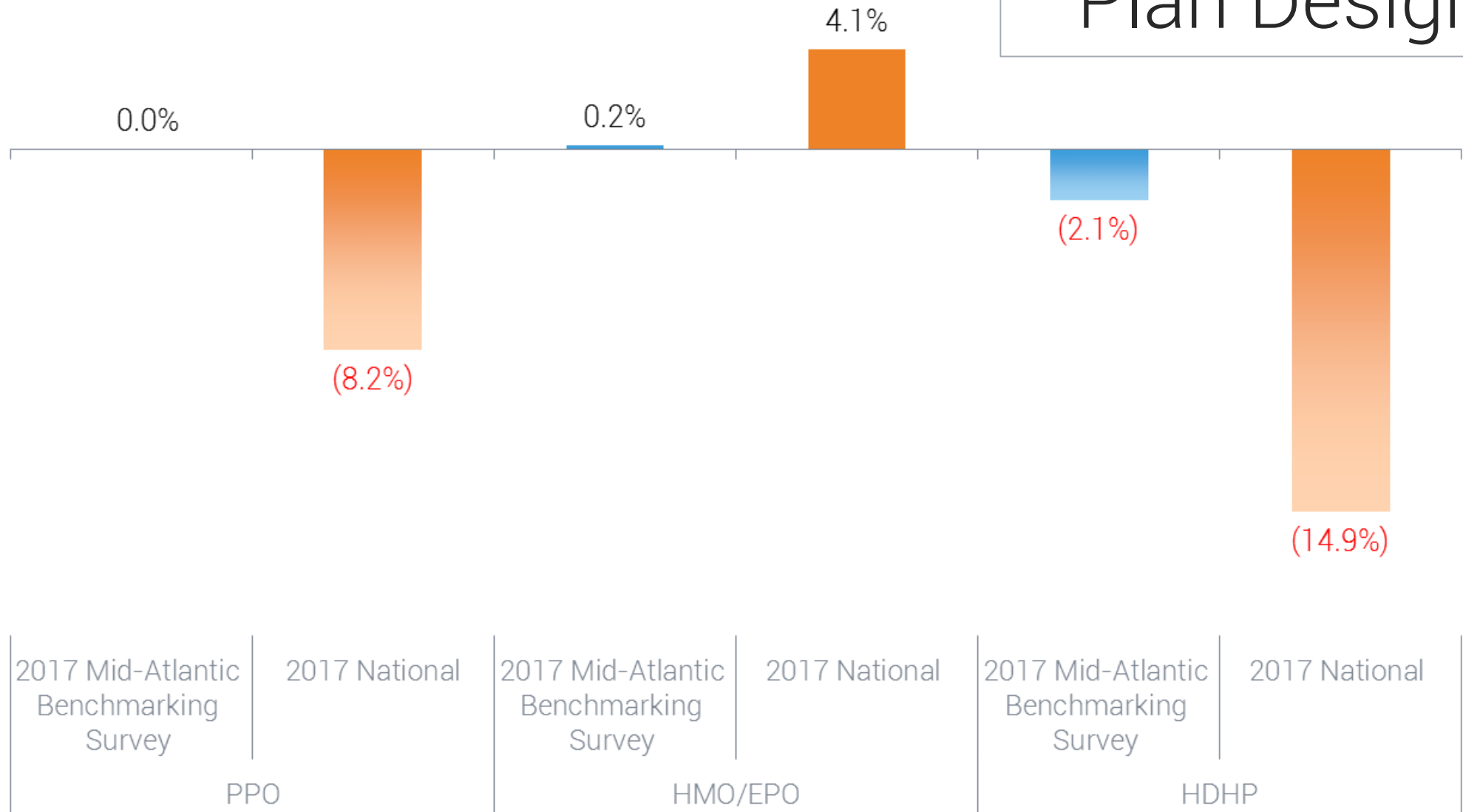
Medical Plan Summary

HDHP Plan Medians

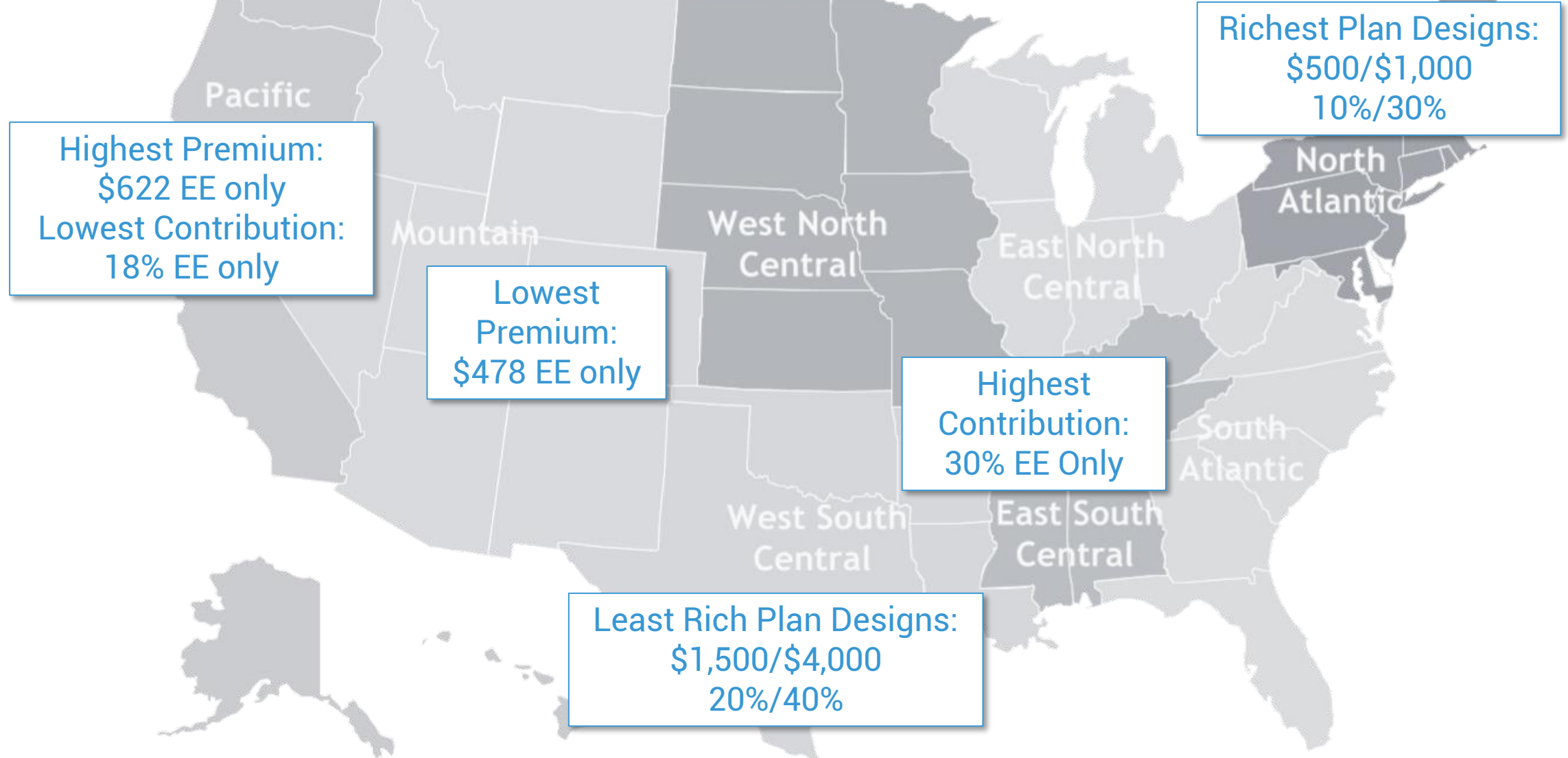
	2017 Mid-Atlantic Benchmarking Survey	2017 National
Deductible	\$2,000/\$3,000	\$2,650/\$4,500
Coinsurance	0%/30%	10%/40%
OOP Max	\$4,500/\$6,000	\$5,000/\$9,000
	Employee Only/Family	Employee Only/Family
Employer Contribution (HSA/HRA)	\$1,000/\$1,550	\$720/\$1,200

Relative Value of Plan Designs

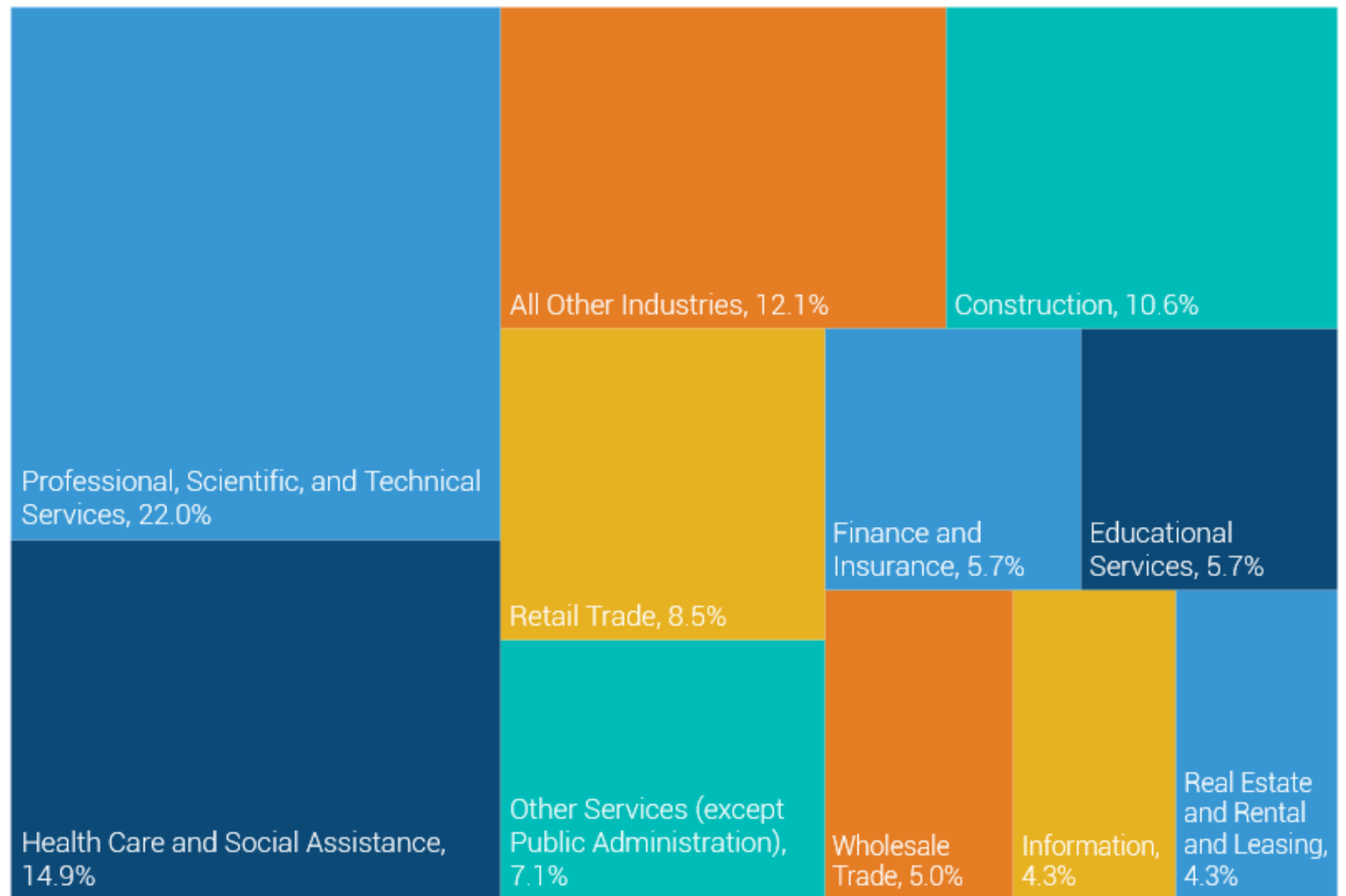
Relative Value Difference



2016 Regional Summary

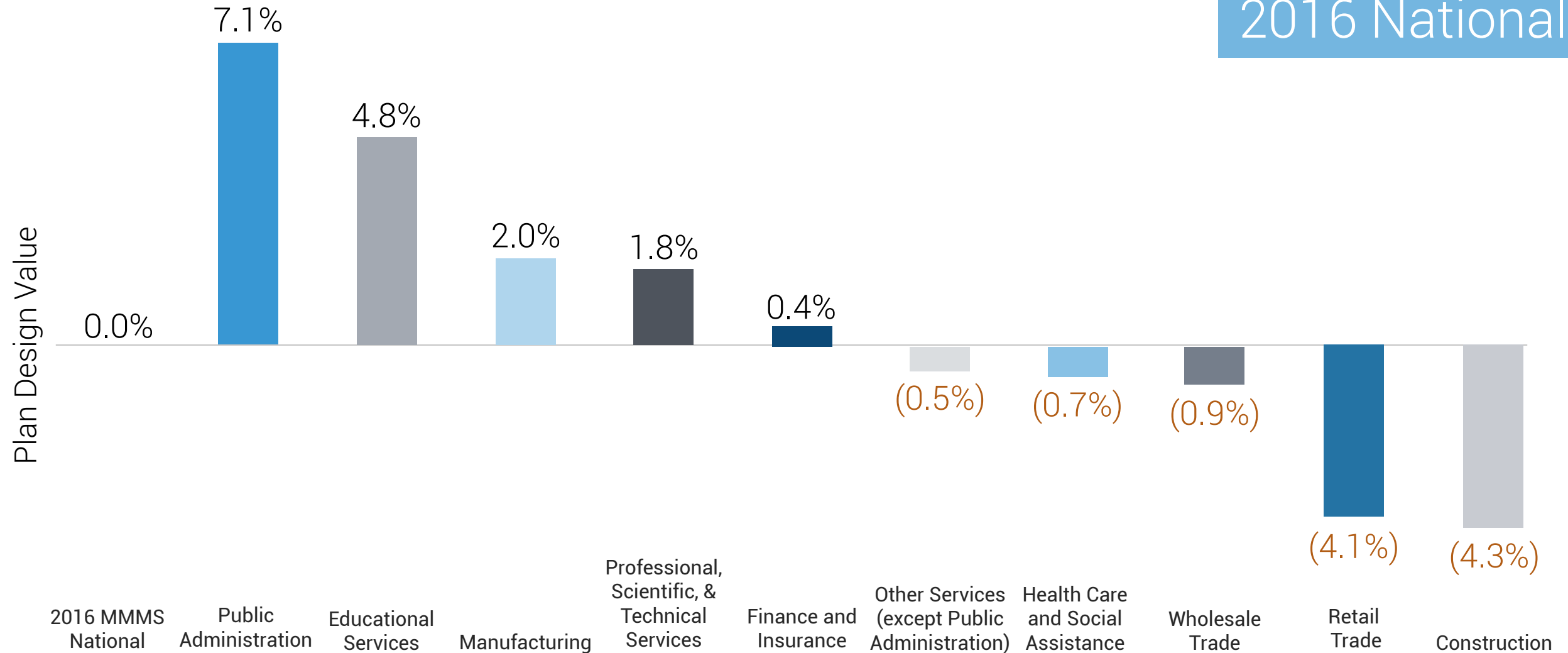


Industries Represented



Industry PPO Relative Values

2016 National





Dental Plan Summary

DPPPO Plan Medians

2017 Mid-Atlantic
Benchmarking Survey

2017 National

Deductible		\$50/\$50	\$50/\$50
Coinsurance	Preventative	0%	0%
	Basic	20%	20%
	Major	50%	50%
	Orthodontia	50%	50%
Annual Max		\$1,500/\$1,500	\$1,500/\$1,250
Ortho Max		\$1,000/\$1,000	\$1,000/\$1,000

Analysis of Potential Plan Design Changes - Medical

Sample Company

			Expected Change in Total Annual Medical & Rx Claims ¹		
			Percent Change - First-Year	Dollar Change - First-Year	Dollar Change - Mature
Base PPO Alternatives (75% Self-Insured Enrollment)					
Benefit Element	Current	Proposed			
1. Deductible - EE	\$500	\$1,000	(2.79%)	(\$229,302)	(\$275,162)
1. Deductible - Family	\$1,000	\$2,000			
2. Out-of-pocket maximum - EE	\$2,000	\$3,000	(1.31%)	(\$107,329)	(\$128,794)
2. Out-of-pocket maximum - Family	\$4,000	\$6,000			
3. Rx copays			(0.36%)	(\$29,879)	(\$35,855)
Retail - Generic	\$10	\$10			
Retail - Brand Formulary	\$20	\$30			
Retail - Brand Non-Formulary	\$35	\$50			
Mail - Generic	\$20	\$20			
Mail - Brand Formulary	\$40	\$60			
Mail - Brand Non-Formulary	\$70	\$100			
Total Base PPO Changes (#1, 2 & 3)²			(4.70%)	(\$386,068)	(\$463,282)
Buy-Up PPO Alternatives (25% Self-Insured Enrollment)					
Benefit Element	Current	Proposed			
1. ER copay	\$50	\$100	(0.01%)	(\$622)	(\$747)
2. Rx copays			(0.12%)	(\$10,091)	(\$12,109)
Retail - Generic	\$10	\$10			
Retail - Brand Formulary	\$20	\$30			
Retail - Brand Non-Formulary	\$35	\$50			
Mail - Generic	\$20	\$20			
Mail - Brand Formulary	\$40	\$60			
Mail - Brand Non-Formulary	\$70	\$100			
Total Buy-Up PPO Changes (#1 and 2)²			(0.13%)	(\$10,713)	(\$12,856)
All Medical Alternatives Combined²			(4.8%)	(\$396,782)	(\$476,138)

1. All Expected Changes refer to the portion of claims paid by the plan

2. Not necessarily additive

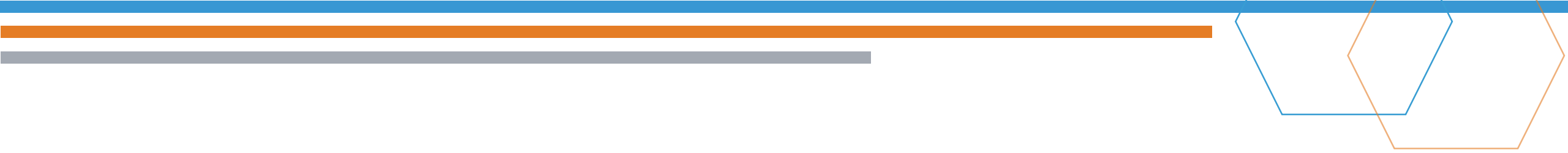
*Values are derived from Milliman's actuarial pricing model, Health Cost Guidelines, using standard actuarial principles.

PLAN

DESIGN

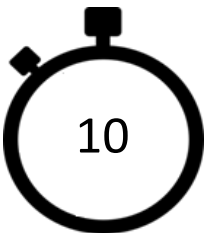
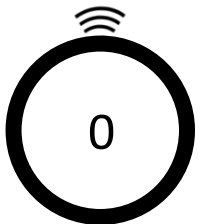
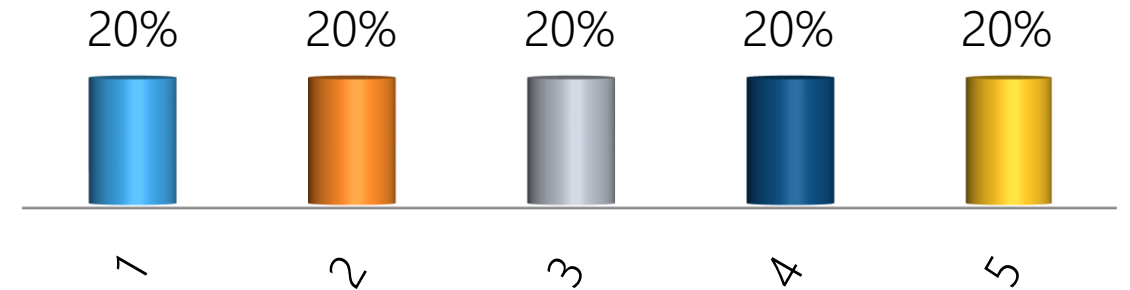
ANALYSIS

AUDIENCE POLL



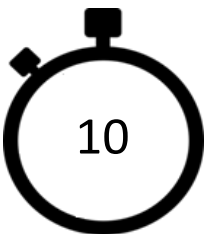
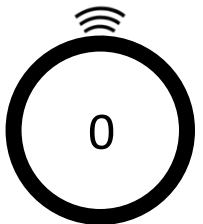
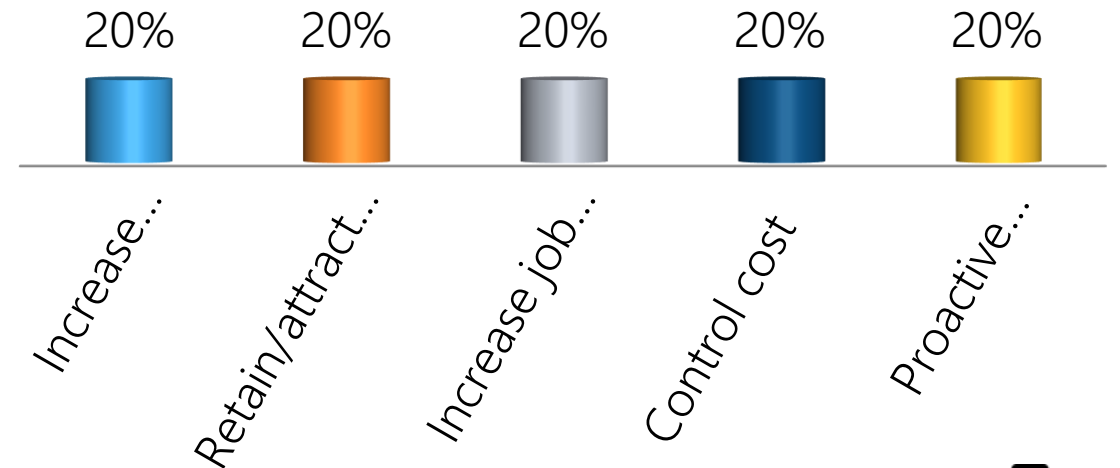
On a scale of 1-5 (5 being the best), how would you rate your health plans?

- 1. 1
- 2. 2
- 3. 3
- 4. 4
- 5. 5



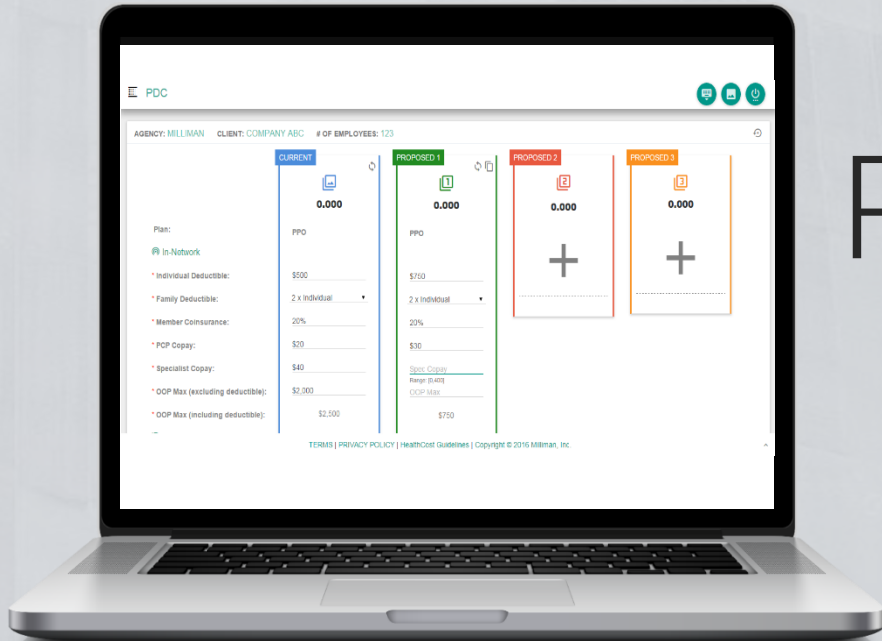
What is the most important objective for your benefits package in 2017-2018?

1. Increase productivity
2. Retain/attract employees
3. Increase job satisfaction
4. Control cost
5. Proactive management of employee's health

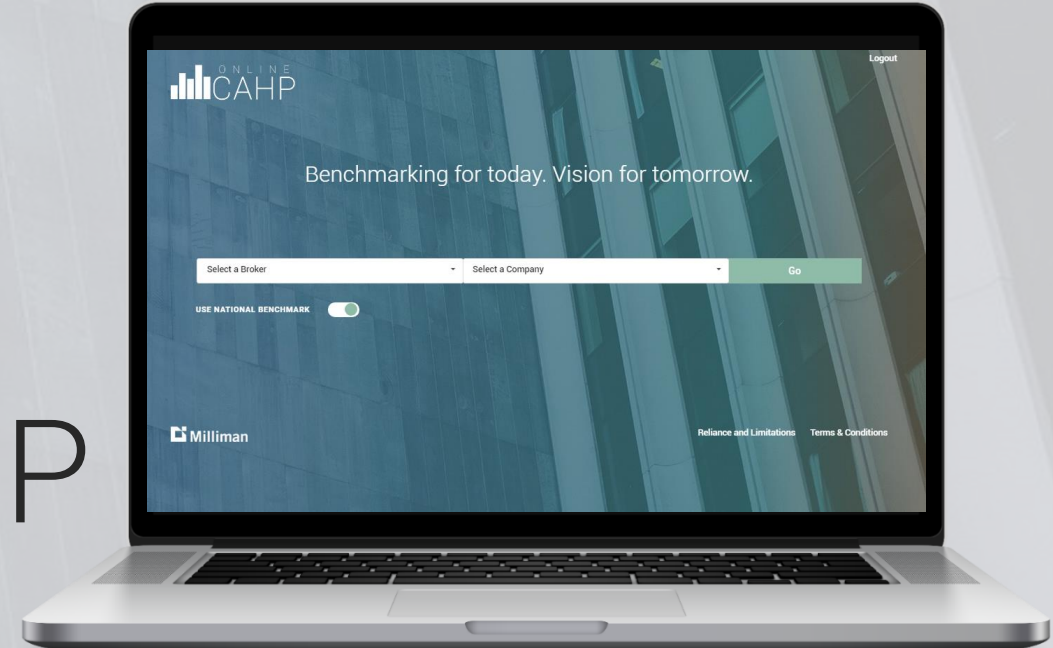


ONLINE TOOLS

Plan Design Calculator



Online CAHP





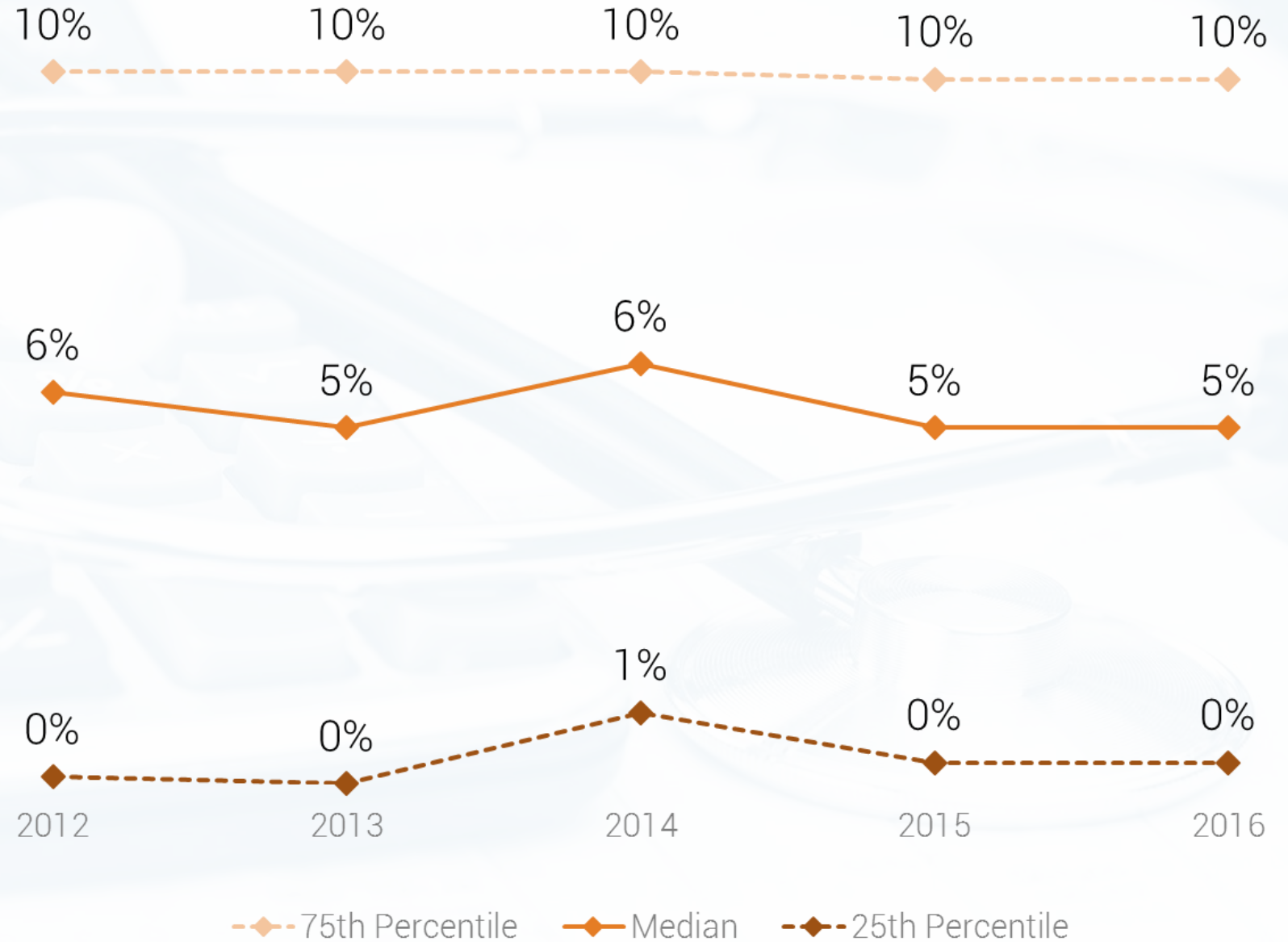
PREMIUM RATES

How do my premium rates compare?



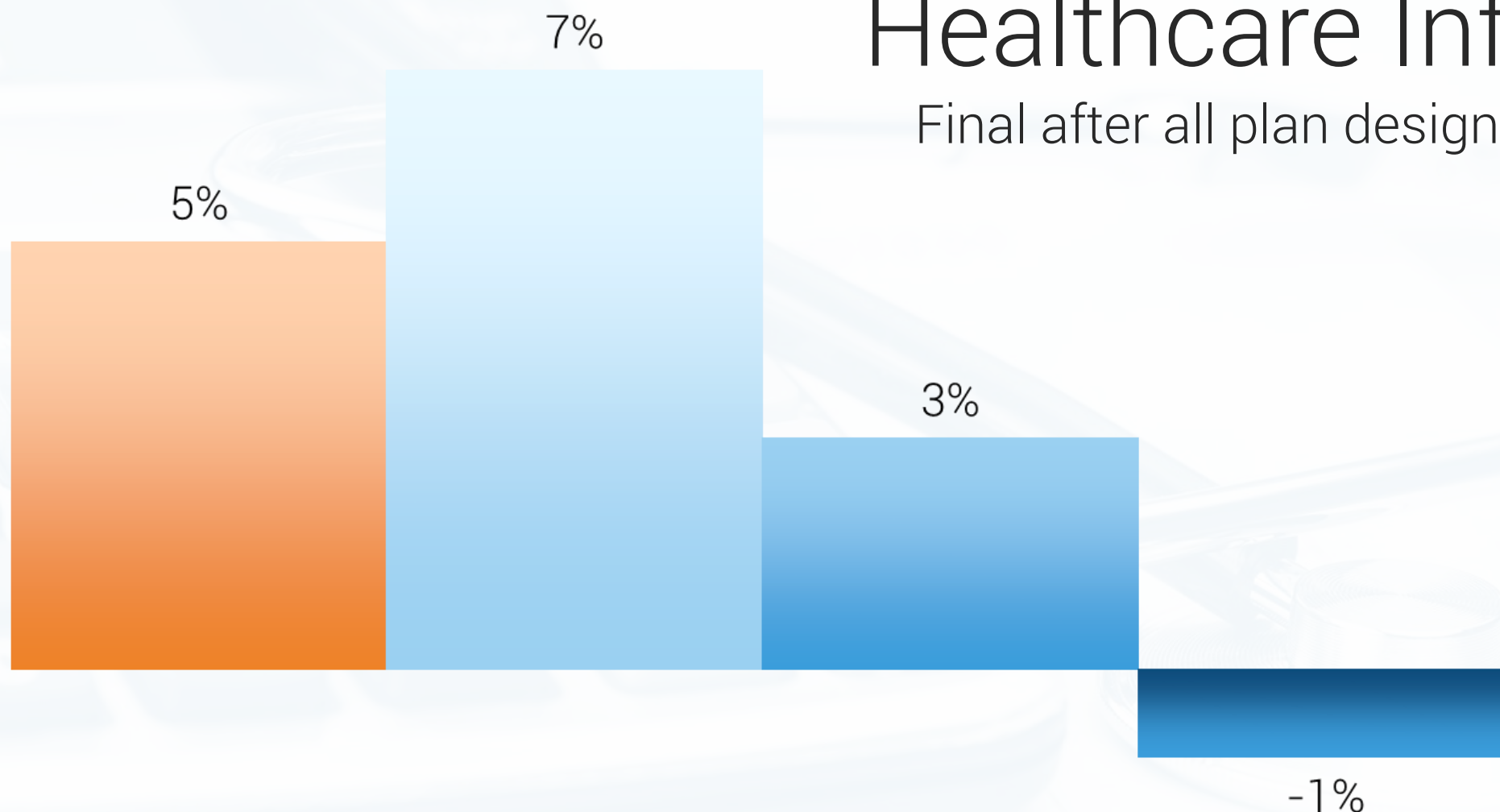
Healthcare Inflation

National Historical



Healthcare Inflation

Final after all plan design changes



■ 2017 MMMS National Median

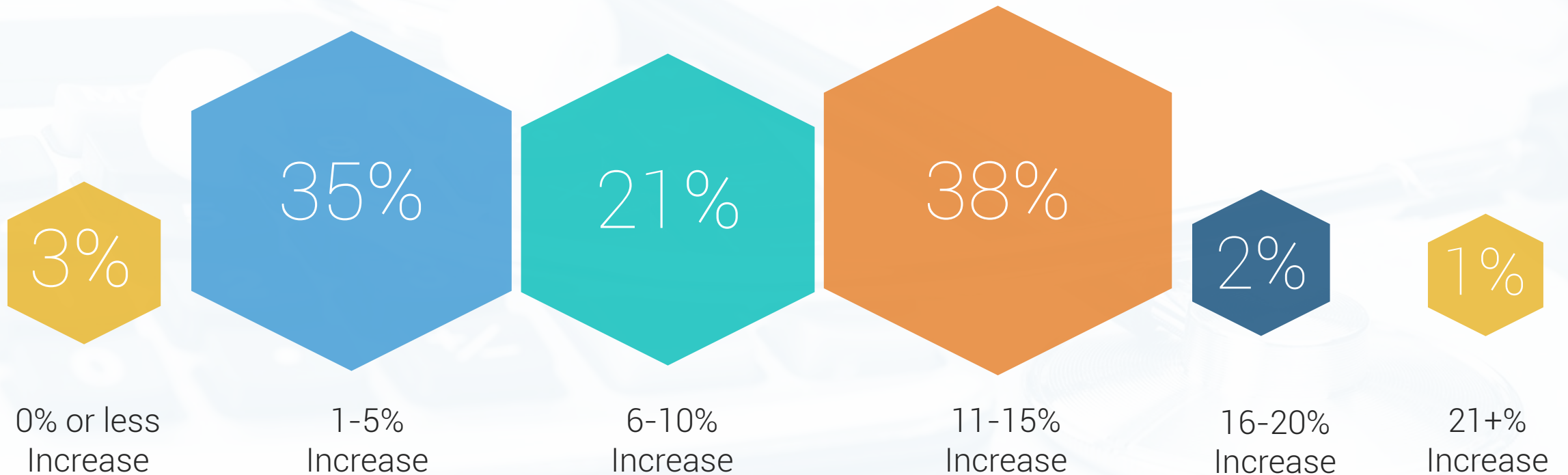
■ 2017 Mid-Atlantic Benchmarking Survey Median

■ 2017 Mid-Atlantic Benchmarking Survey 75th Percentile

■ 2017 Mid-Atlantic Benchmarking Survey 25th Percentile

Healthcare Inflation

2018 Expected



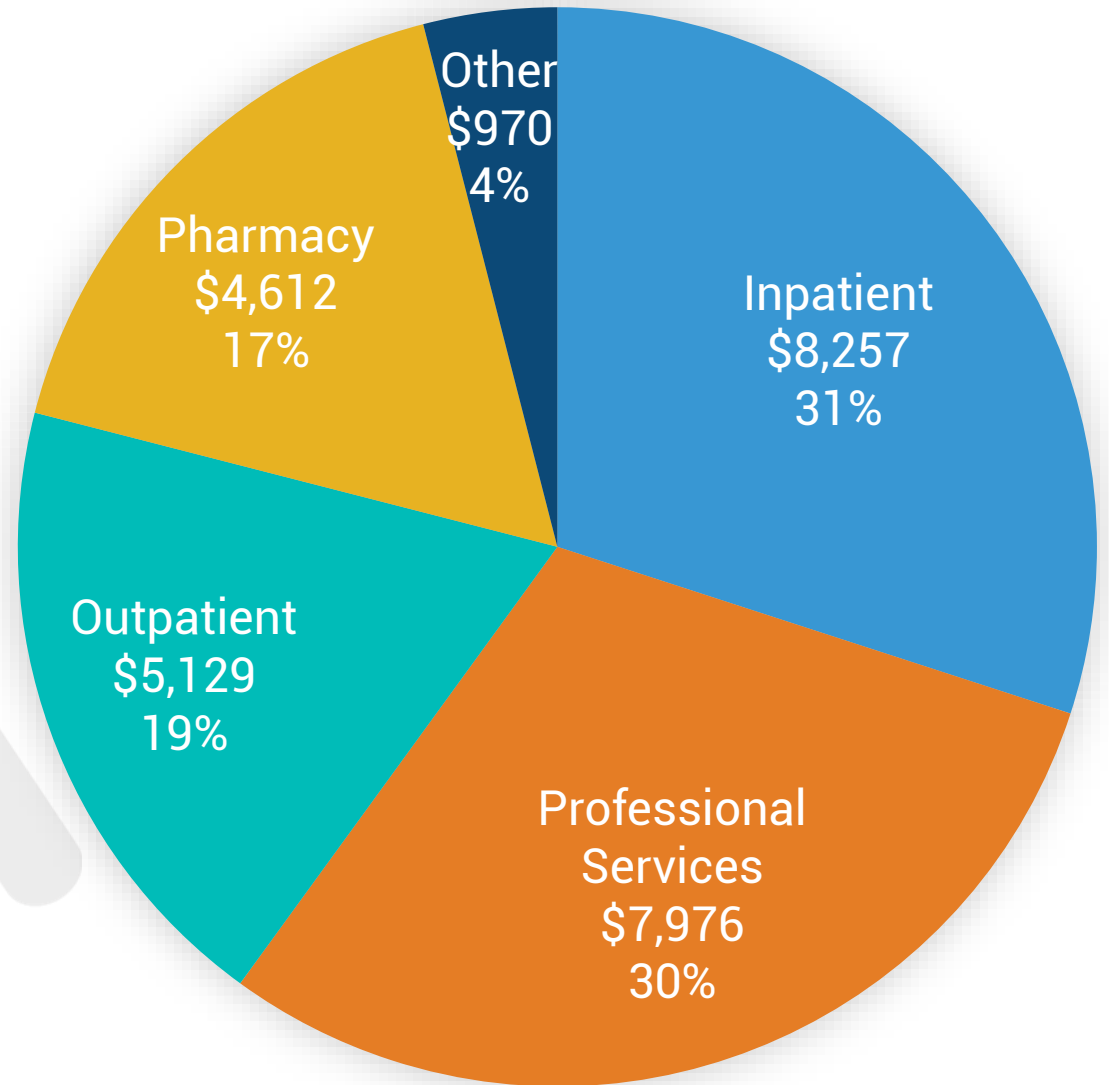
Based on the 2017 Mid-Atlantic Benchmarking Survey responses

A stylized, light gray silhouette of a family of four. It includes a large figure for a parent, a smaller figure for a child, and two more figures for the other parent and child. The figures are simple, rounded shapes with no facial features.

According to Milliman's Medical Index (MMI), in 2017, the cost of healthcare for a typical American family of four is

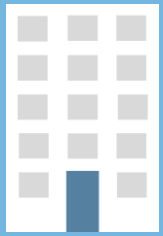
\$26,944

COMPONENTS OF SPENDING



RELATIVE PROPORTIONS OF 2017 MEDICAL COSTS

Employer Contribution
\$15,259



57%

Employee Contribution
\$7,151



27%

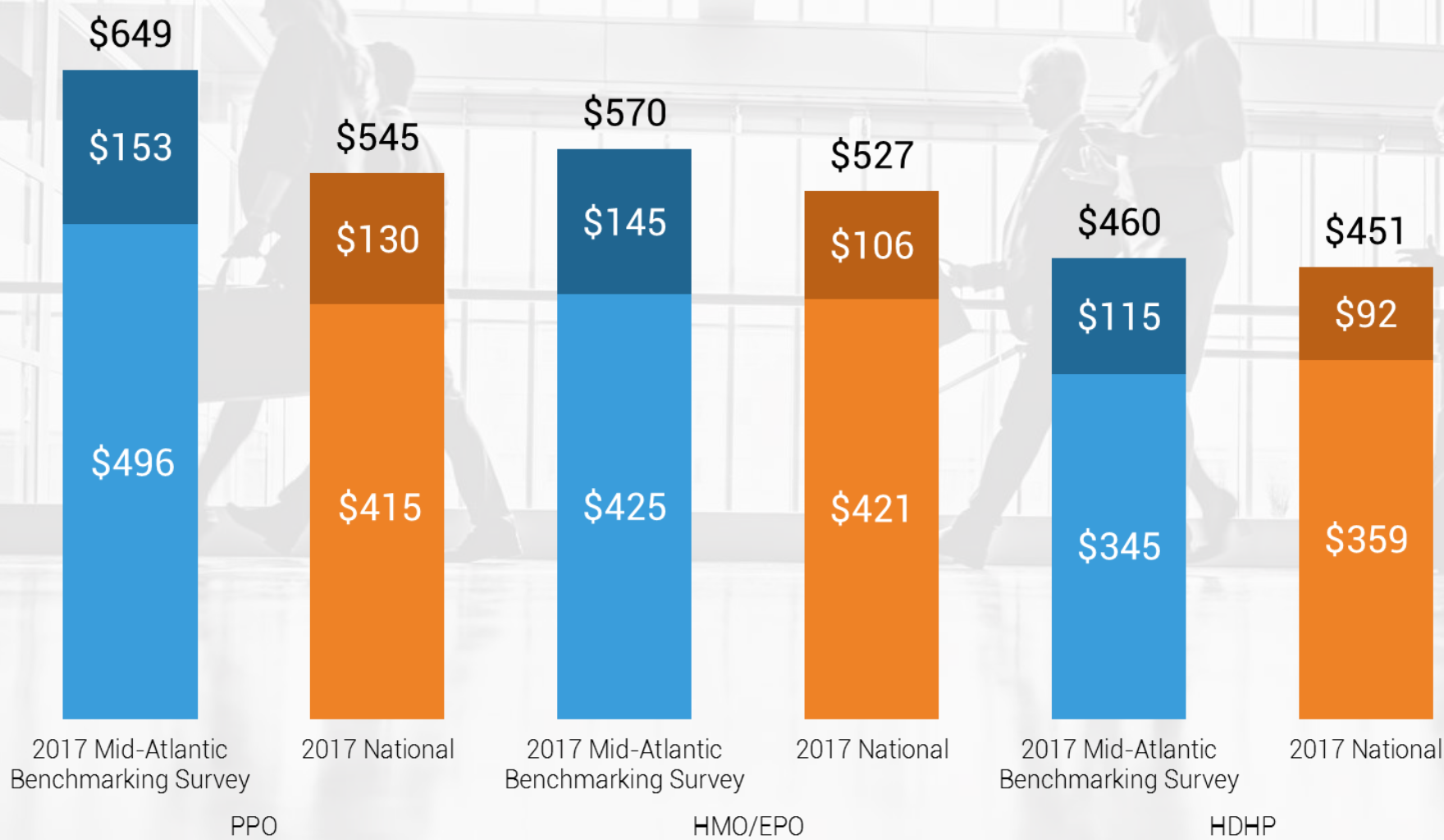
Employee Out-of-Pocket
\$4,534



17%

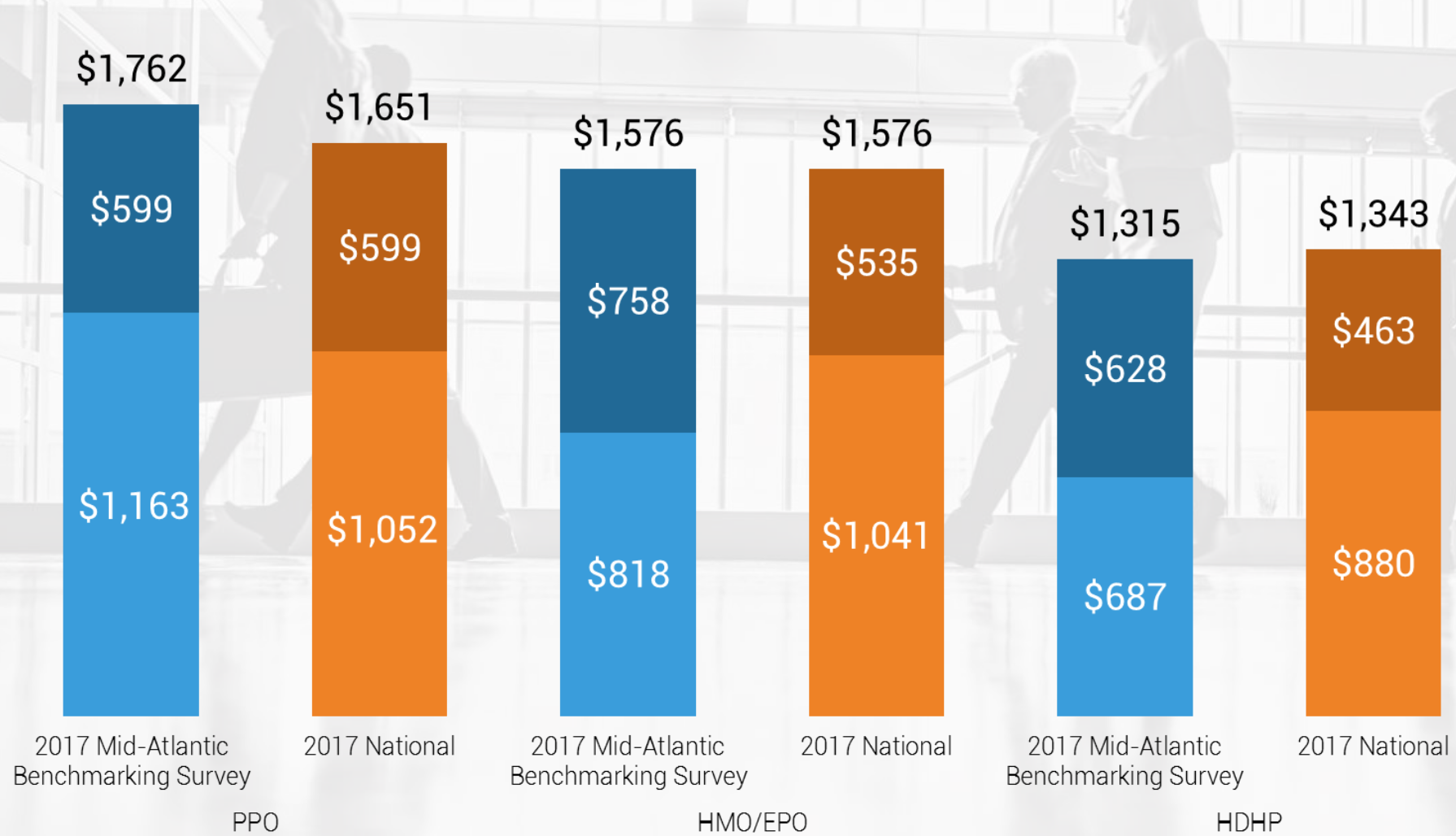
Percentages do not add to 100% due to rounding

Comparison of Total Premium by Plan Type | Employee Only



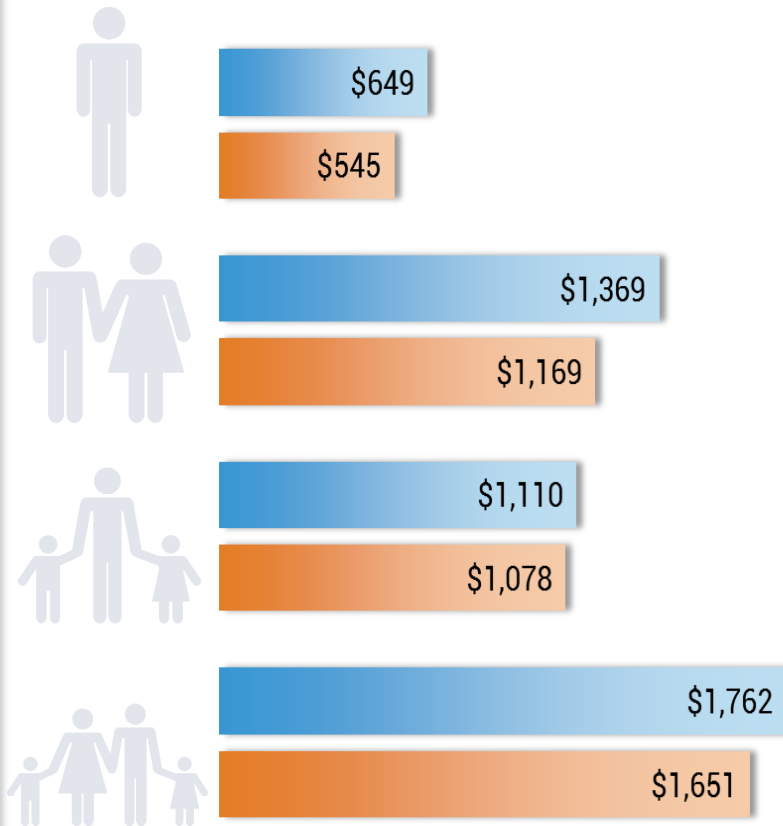
Top Portion: EE Contribution; Bottom Portion: ER Contribution

Comparison of Total Premium by Plan Type | Family

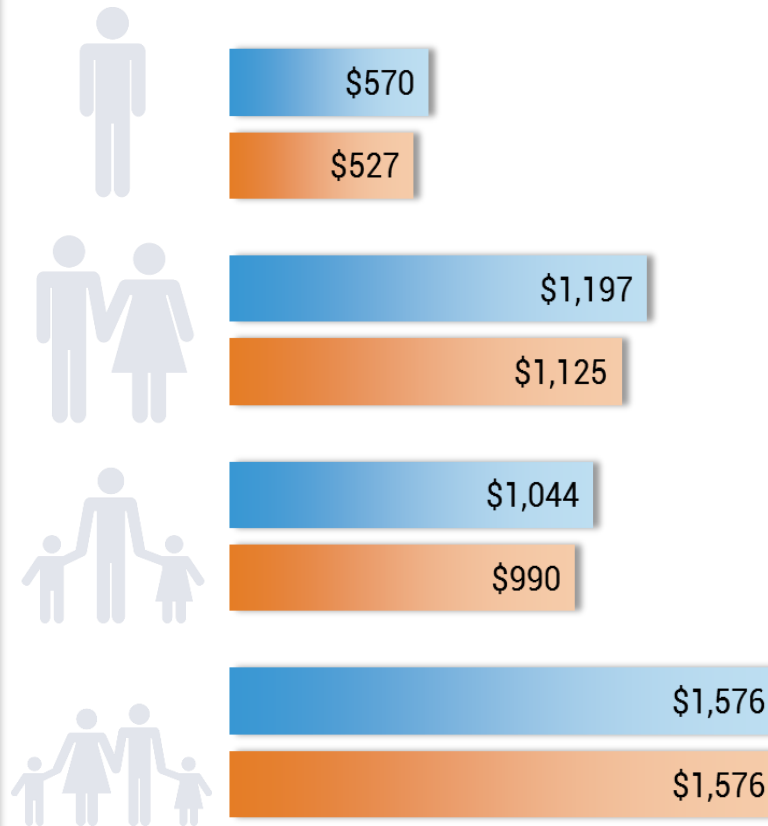


Top Portion: EE Contribution; Bottom Portion: ER Contribution

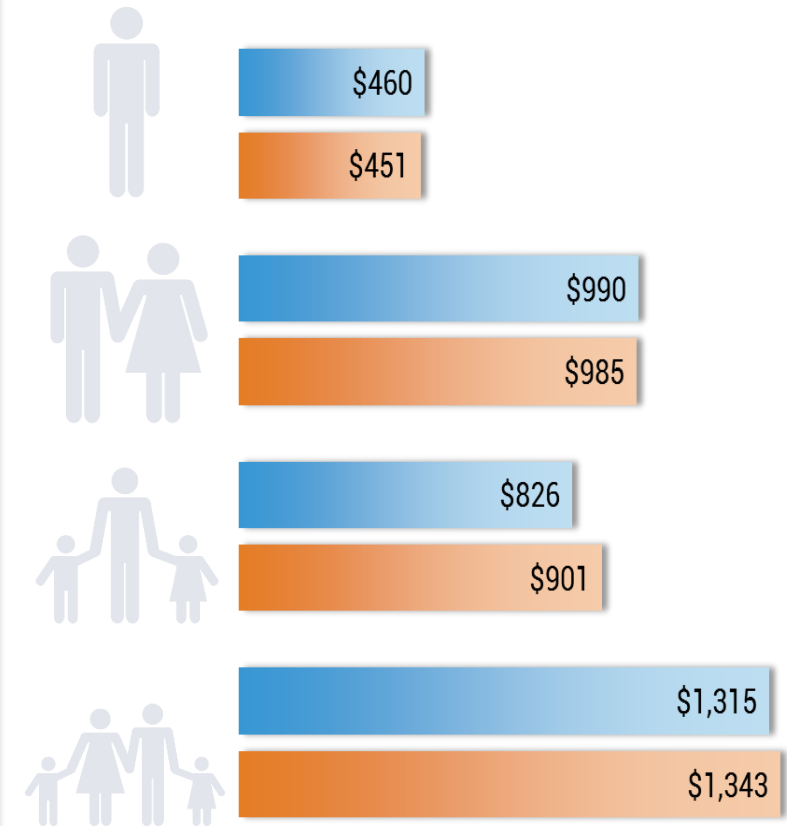
PPO



HMO/EPO

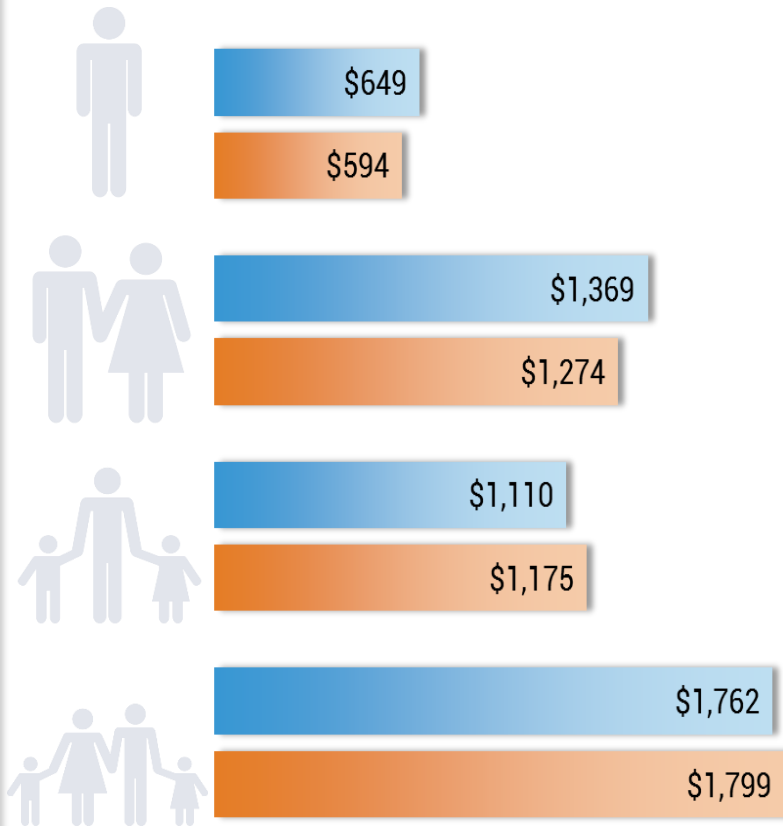


HDHP

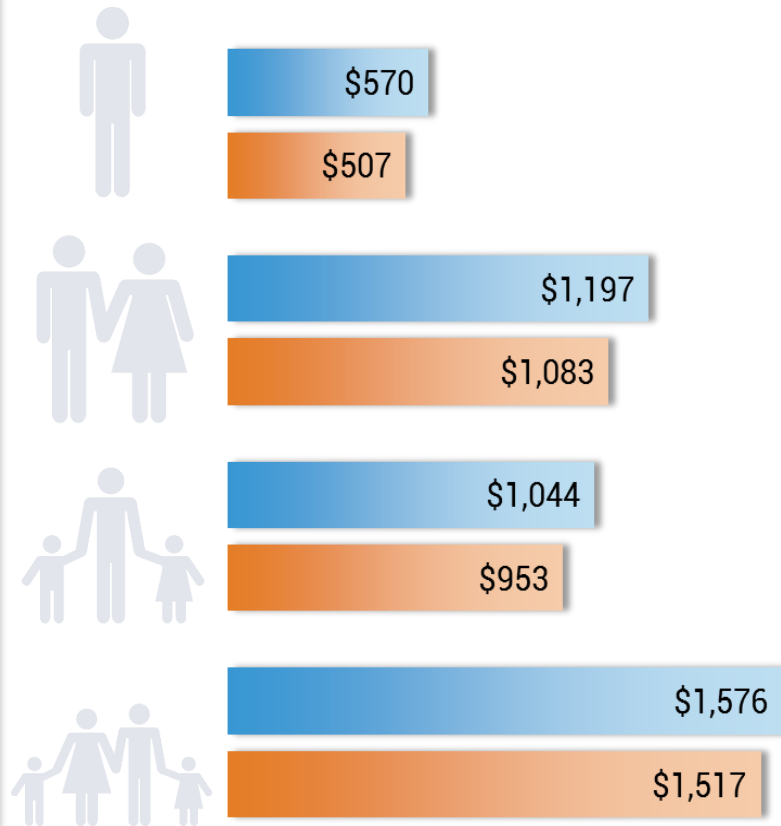


Medical Premium Summary By Plan Type

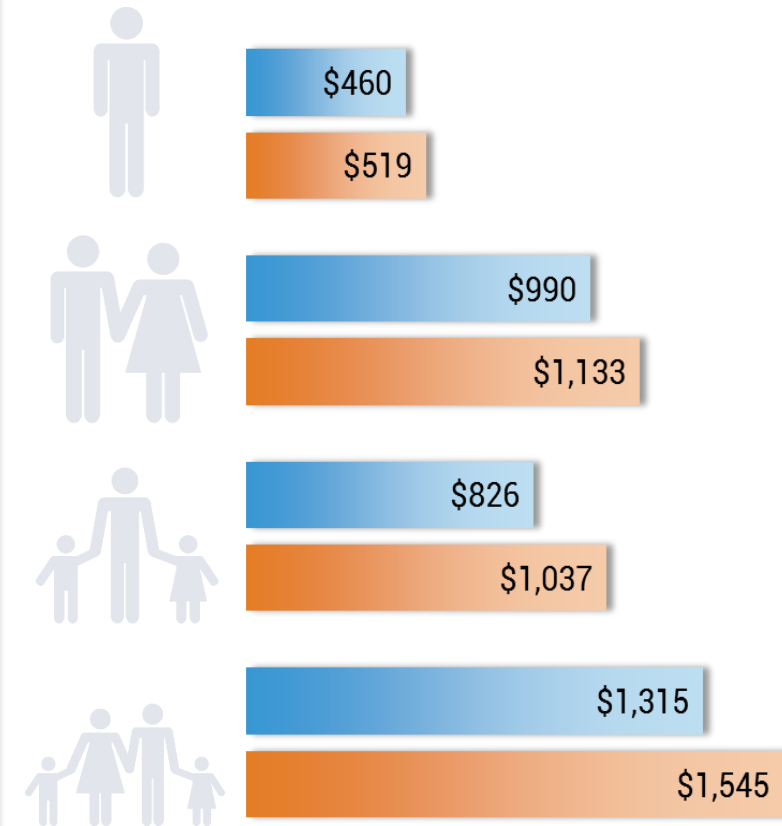
PPO



HMO/EPO



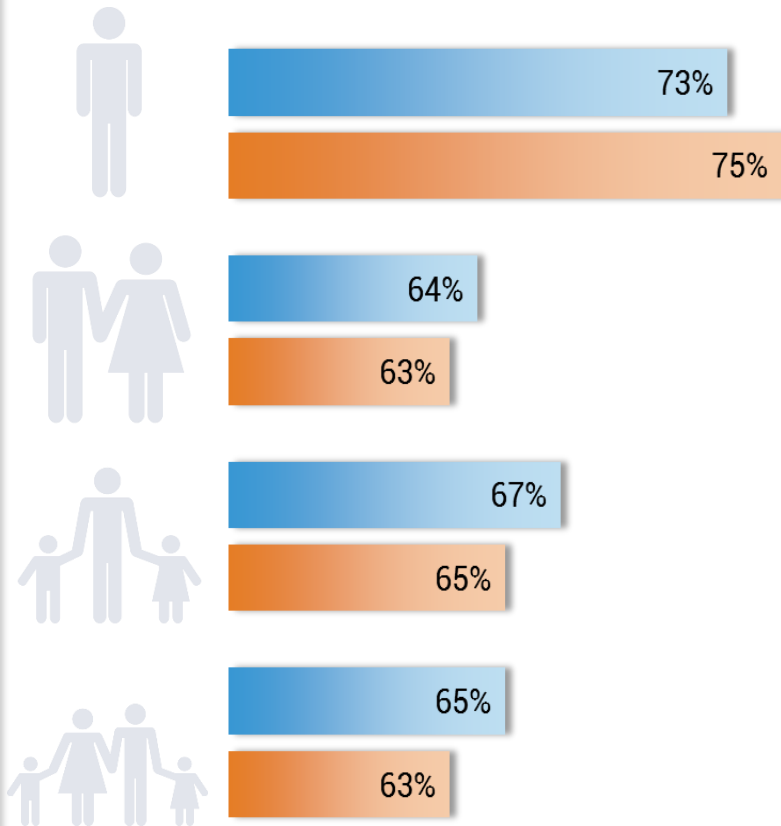
HDHP



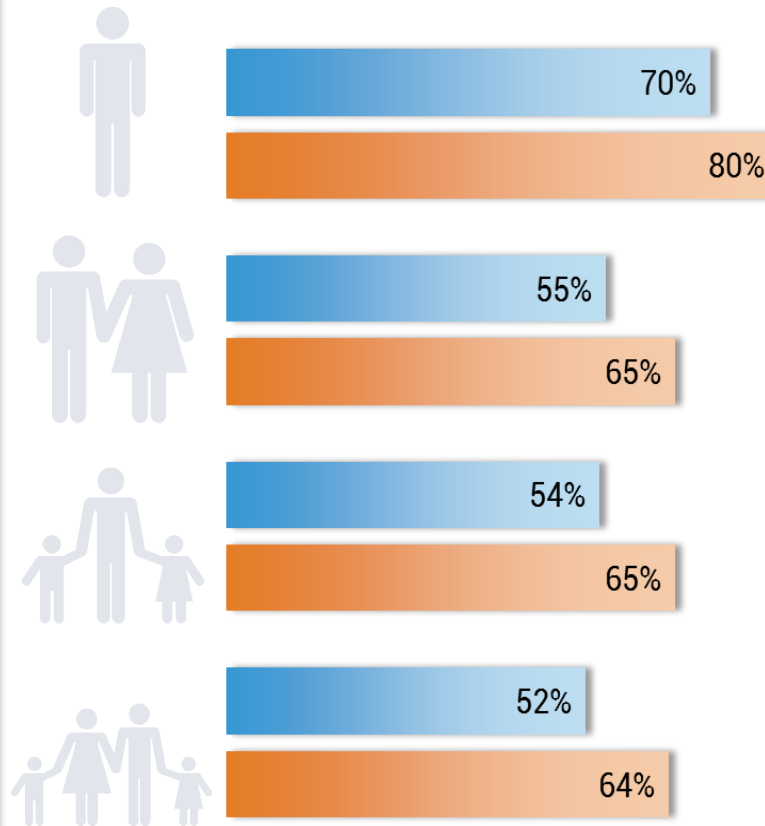
Medical Premium Summary | Normalized

National premiums adjusted to local plan designs

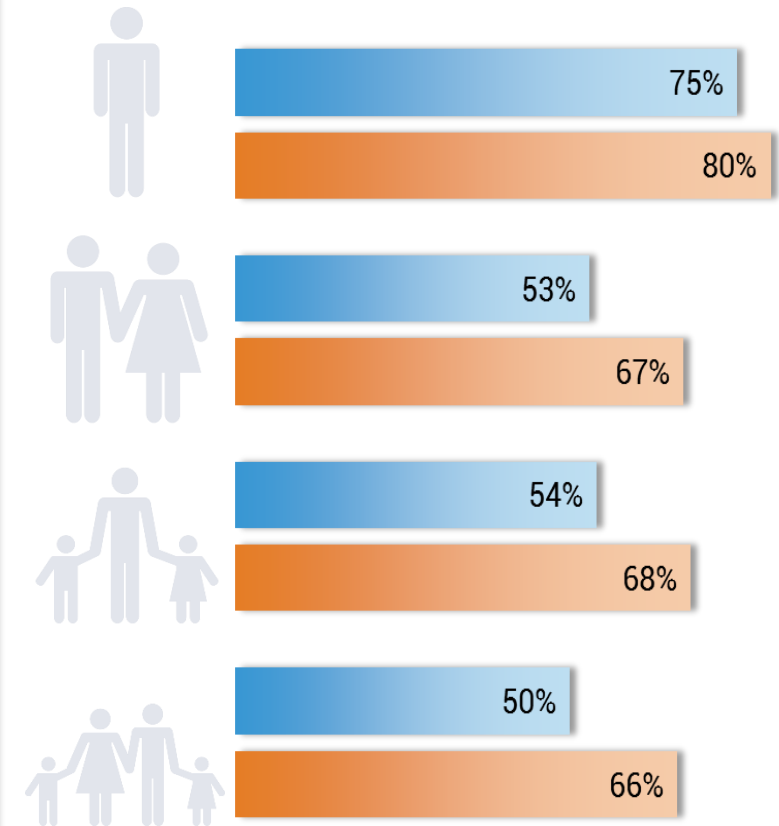
PPO



HMO/EPO



HDHP

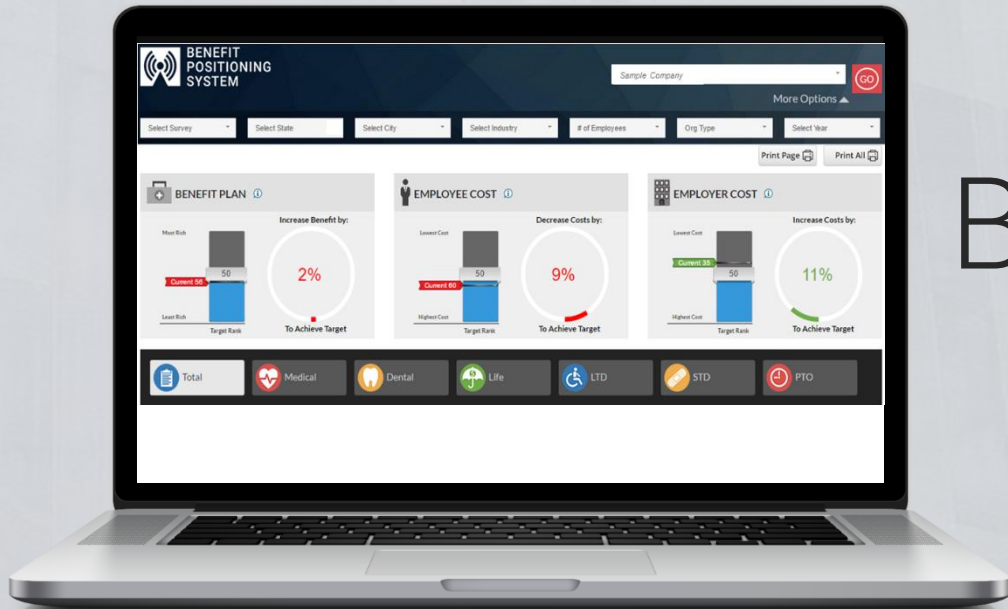


Medical Contribution Summary By Plan Type



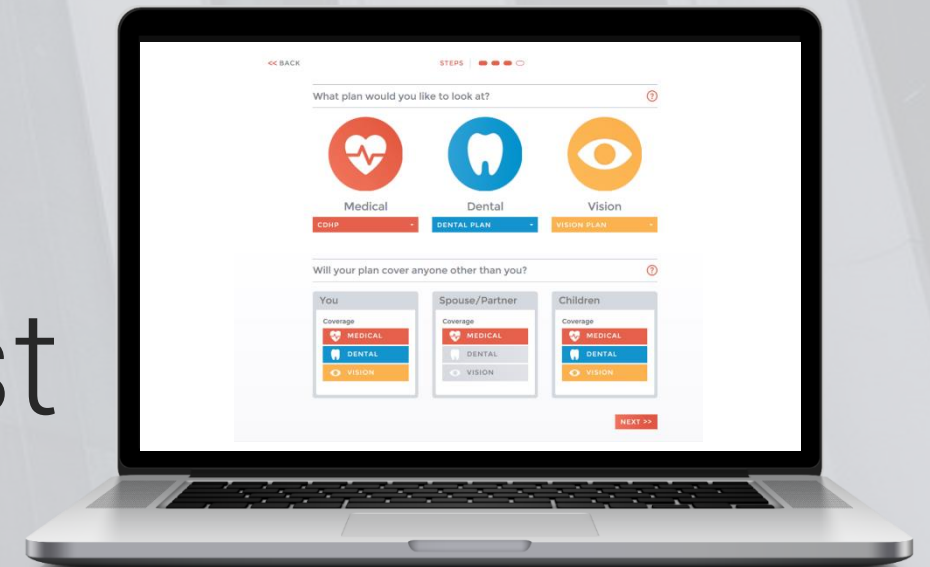
Based on the 2017 Mid-Atlantic Benchmarking Survey responses

ONLINE TOOLS



Benefit Positioning System

Health Plan Assist



Best in Benefits

The Best in Benefits award recognizes employers who offer the best benefit plans relative to their peers. Using the plan designs, premiums, and contributions from the Mid-Atlantic Benchmarking Survey employers in the Benefits Benchmarking Survey, we calculate the benefit value and cost for each plan with Milliman's Health Cost Guidelines™. We then rank the plans by the lowest cost-highest benefit metric to determine who is Best in Benefits.

TOP 15

JMI Management, Inc.

RK&K

Atlantic General Hospital

MOI

Campbell & Company

Praxis Engineering Technologies, Inc.

Shalom Baranes Associates, P.C.

RLJ Entertainment

Edgeworth Economics, LLC

COPT

Hamilton Associates, Inc.

Johnson, Mirmiran and Thompson

Sinclair Broadcast Group

The Maryland School for the Blind

WaveStrike





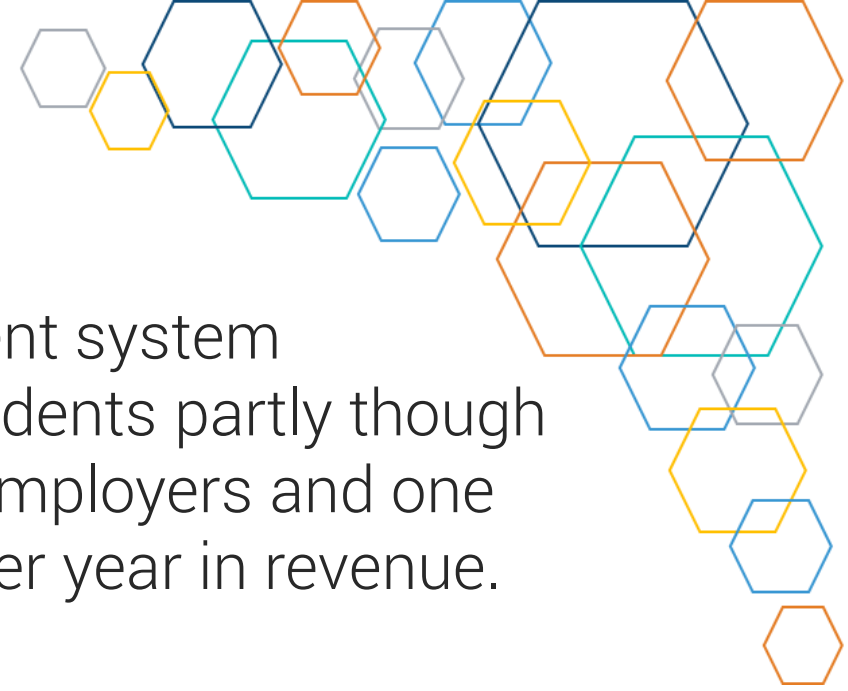
FUTURE OF HEALTHCARE

Where do you see healthcare in 5 years?



Amendment 69 was on the November 7, 2016 ballot in Colorado as an initiated constitutional amendment.

The idea was to create ColoradoCare, a healthcare payment system designed to finance universal healthcare for Colorado residents partly through an additional 10 percent payroll tax – two thirds paid by employers and one third by employee – providing approximately \$25 billion per year in revenue.

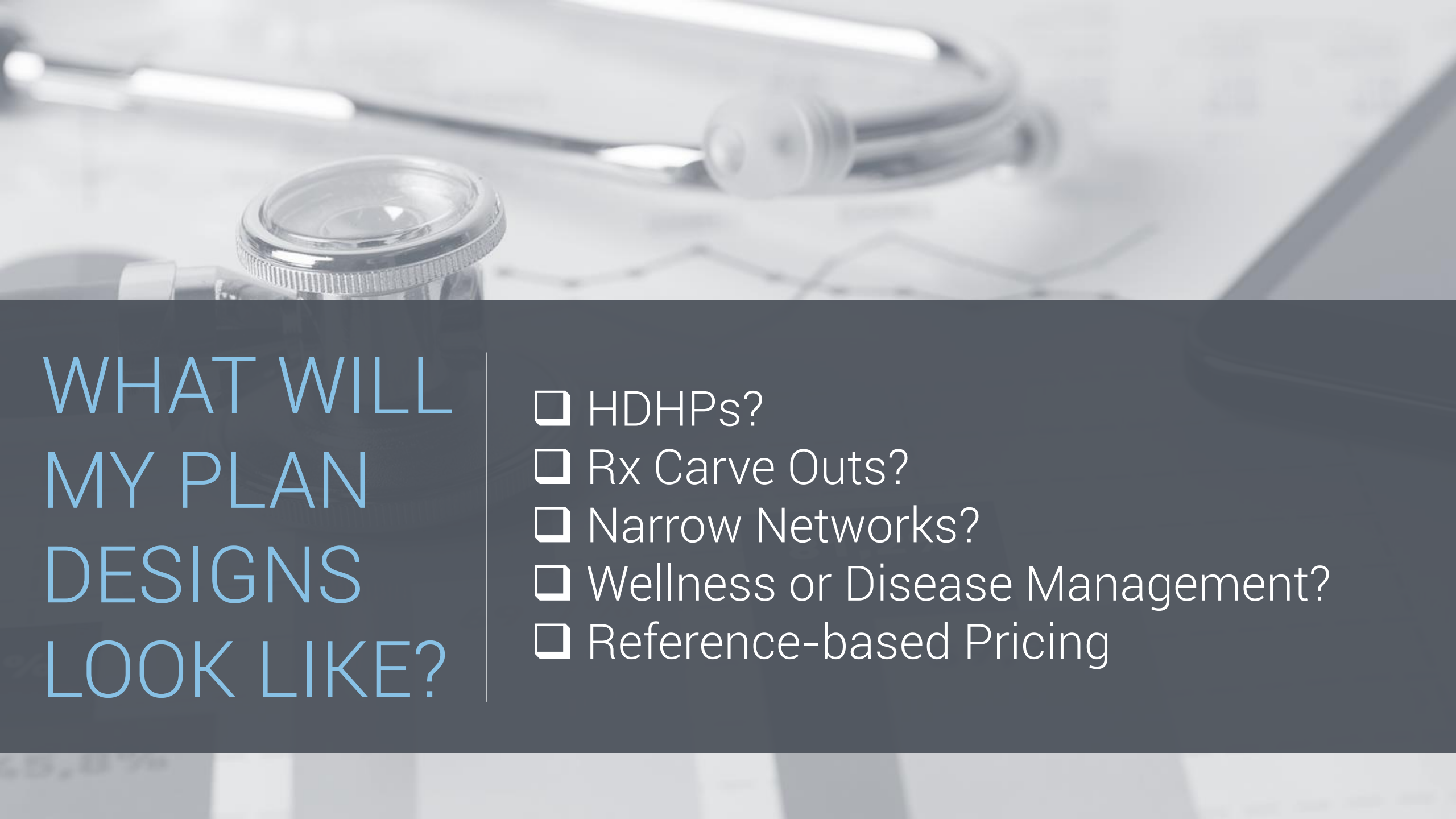


The Results?

Amendment 69 was *defeated*

79% voted NO

21% voted YES

A grayscale background image featuring medical equipment. In the foreground, a stethoscope is visible, with its chest piece and tubing. Behind it, a syringe is partially visible. The background is slightly blurred, emphasizing the text in the foreground.

WHAT WILL MY PLAN DESIGNS LOOK LIKE?

- ☐ HDHPs?
- ☐ Rx Carve Outs?
- ☐ Narrow Networks?
- ☐ Wellness or Disease Management?
- ☐ Reference-based Pricing

THE AFFORDABLE CARE ACT...

...was not financially
feasible

Two Lowest Cost Obamacare Exchange Plans

Family of Four; Mom and Dad Age 40; Location: Chicago

Simple Choice

Cigna Healthcare · Cigna US-IL Connect 6650

Bronze | HMO | Plan ID: 53882IL0040003

Estimated monthly premium \$805.54	Deductible \$13,300 <small>Family Total</small>	Out-of-pocket maximum \$14,300 <small>Family Total</small>	Copayments / Coinsurance Emergency room care: 50% Coinsurance after deductible Generic drugs: \$35 Primary doctor: \$45 Copay before deductible/50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible	Estimated total yearly costs EDIT	DOCTORS, FACILITIES & DRUGS COVERED EDIT
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[QUICK VIEW](#) [DETAILS](#) [COMPARE](#) [LIKE THIS PLAN](#)

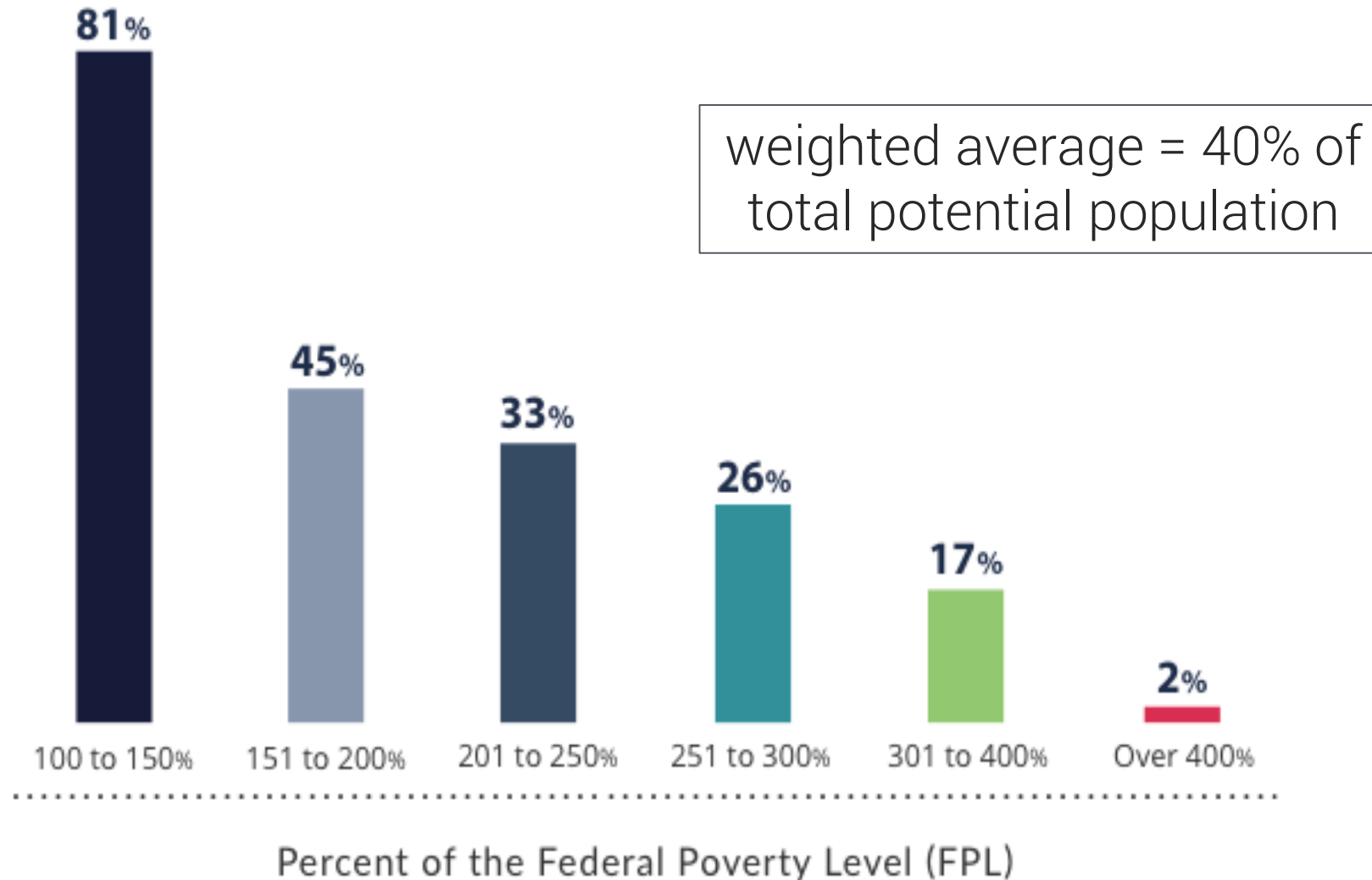
Cigna Healthcare · Cigna Connect HSA 5500

Bronze | HMO | Plan ID: 53882IL0040001

Estimated monthly premium \$831.40	Deductible \$11,000 <small>Family Total</small>	Out-of-pocket maximum \$13,100 <small>Family Total</small>	Copayments / Coinsurance Emergency room care: 50% Coinsurance after deductible Generic drugs: 50% Coinsurance after deductible Primary doctor: 50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible	Estimated total yearly costs EDIT	DOCTORS, FACILITIES & DRUGS COVERED EDIT
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[QUICK VIEW](#) [DETAILS](#) [COMPARE](#) [LIKE THIS PLAN](#)

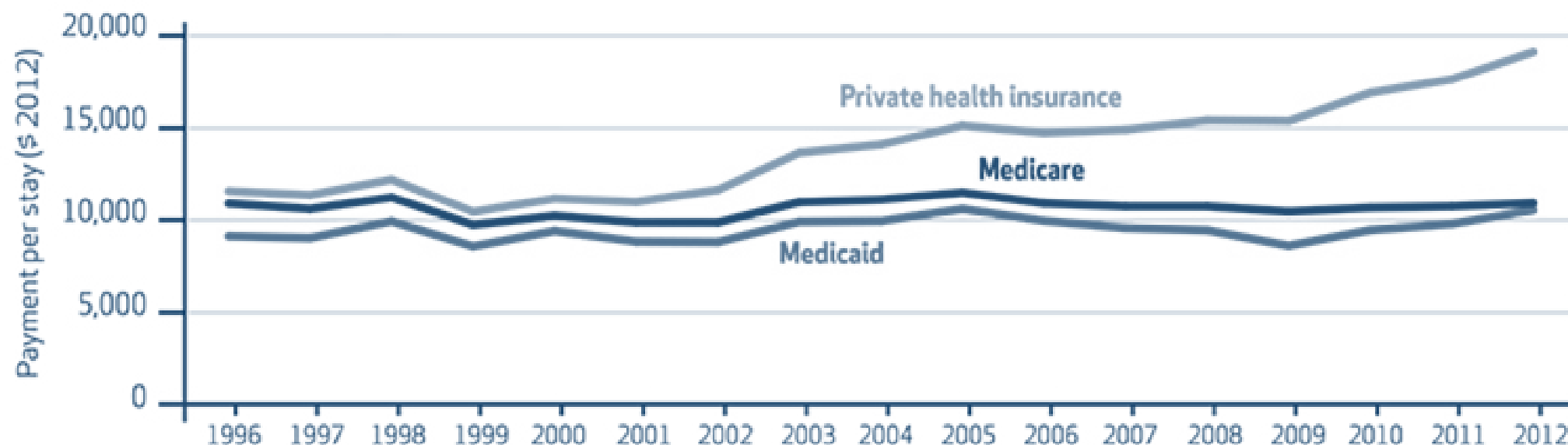
Percent of potential exchange population making marketplace plan selections in 2016



SINGLE-PAYER SYSTEM...

...is not financially
feasible

Average Standardized Payment Rates Per Inpatient Hospital Stay, By Primary Payer, 1996-2012



SOURCE Authors' analysis of data for 1996-2012 from the Medical Expenditure Panel Survey. **NOTES** The average payment rates were computed as if each primary payer paid for all nonmaternity adult stays in a given year. Payments were adjusted for inflation and standardized across payers in terms of patient's age, sex, race/ethnicity, geography, household income as a percentage of the federal poverty level, conditions, charges, length-of-stay, and whether or not a surgical procedure was performed. They were not standardized for changes over time in the bundles of treatments and services provided during inpatient stays. Estimates and standard errors can be found in online Appendix F and Appendix Table F.1 (see Note 9 in text).

HealthAffairs

Copyright ©2015 Health Affairs by Project HOPE - The People-to-People Health Foundation, Inc.

BROKERS AND ADVISORS...

...will still have a significant
role for the next 10, 20... years

Affordable Care Act

The CBO's Long-Term Budget Outlook

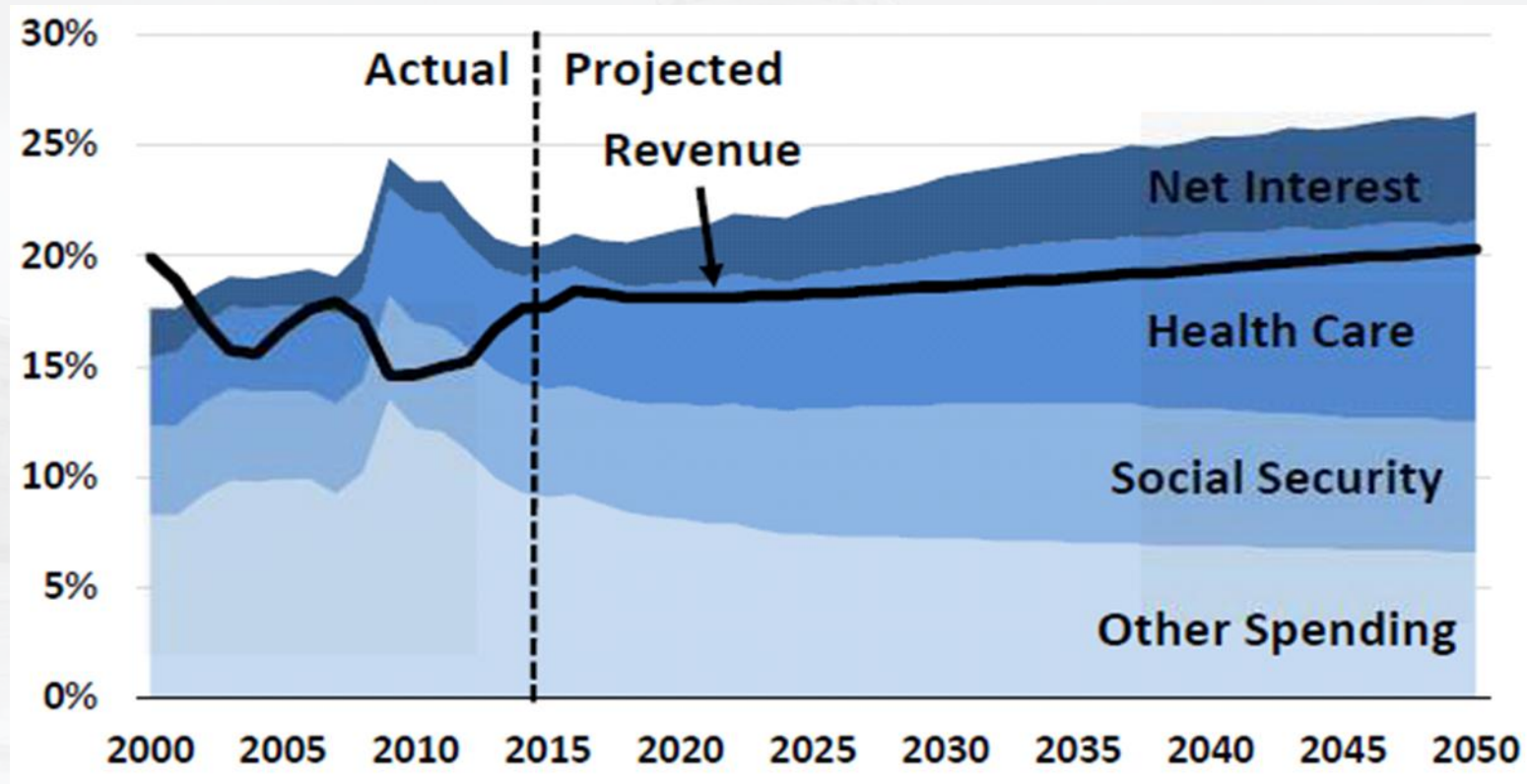
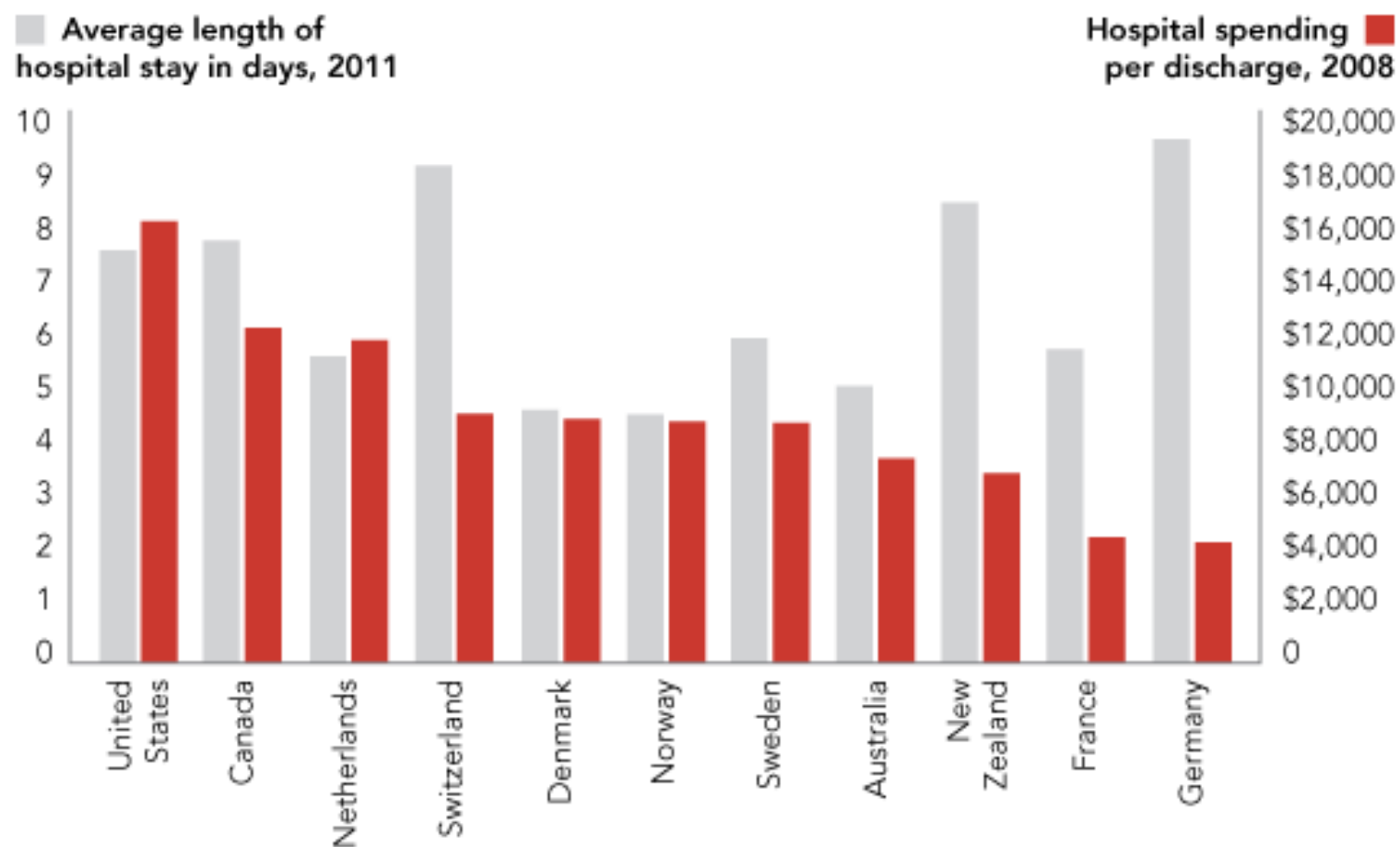


Fig. 3: Composition of Spending and Revenue as a Percent of GDP

FOCUS
ON
PRICES...

...not only utilization

Hospital stays in the U.S. aren't long but cost more than those in other countries.

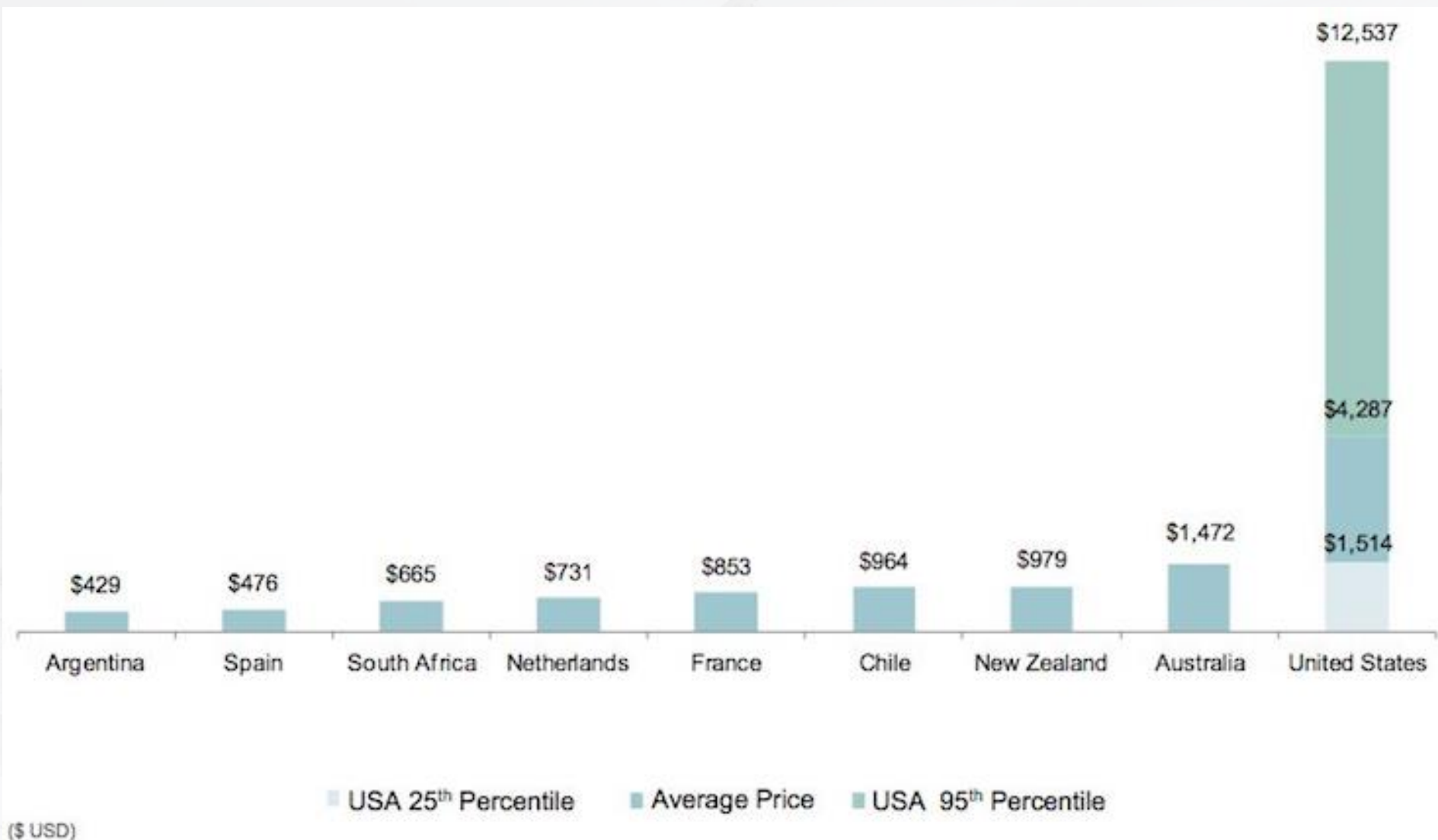


Notes: Acute care is curative care generally provided in a hospital (as opposed to long-term care, which is generally provided in a nursing home). Data is from 2008 and 2011 or nearest year.

Sources: OECD Health Data 2010, OECD Health Data 2013, Congressional Research Service, The Commonwealth Fund

THE HUFFINGTON POST


2012 COST PER HOSPITAL DAY



AFFORDABLE CARE ACT

- ✓ Repeal and replacement of the ACA will cause volatility
 - CBO estimates that repeal without replace could result in the loss of insurance for 18 million people in 2018 and eventually as many as 32 million.
- ✓ Look for quick repeal (defunding)
- ✓ Expect the ACA to be more fixed than replaced



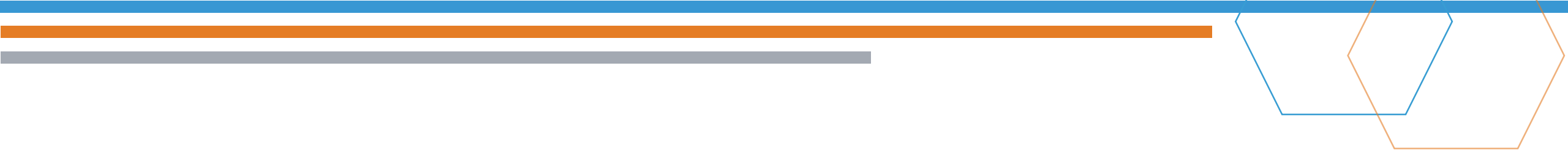


HEALTHCARE

Twenty years from now, health care will still be the biggest single “industry” in America. Your success will be tied to being one step ahead day by day and year by year.

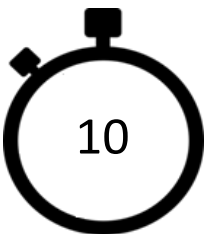
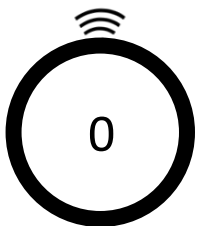
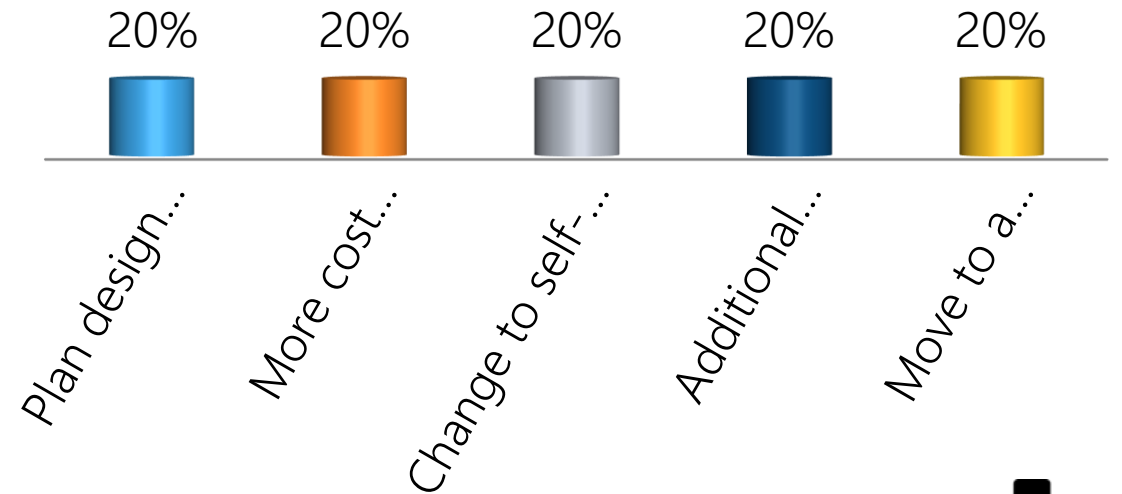
“Companies and business models will continue to come and go, but there will always be a need for health care and the industry. No one can predict exactly what the “winning” business models will be, but what we can do is remain flexible and able to adapt.” – Robert Laszewski

AUDIENCE POLL



What is your top strategy to combat the increases in healthcare in 2017?

1. Plan design changes/implement HDHP
2. More cost sharing with employees
3. Change to self-funded arrangement
4. Additional emphasis on wellness
5. Move to a narrow network plan



ALTERNATIVE FUNDING



Should I be considering Self-Insurance, an ACO, Private Exchange, or Captive?



FUNDING STRATEGIES

	Self-Insured Plans	Fully Insured Plans
1-49 employees	14%	86%
50-199 employees	4%	96%
200-499 employees	44%	56%
500-999 employees	56%	44%
1,000+ employees	75%	25%
All Plans	25%	75%

Let's take a hypothetical group of 313 employees...

	ENROLLMENT	PREMIUM RATES
EE	125	\$450
EE + Spouse	63	\$900
EE + Child(ren)	31	\$650
Family	94	\$1,250
	Composite	\$800.64

Total Annual Spend = \$3 million

FULLY INSURED

Claims Cost	\$527.16
Claims Administration, Margin, & Commission	\$148.96
Pooling Charge	\$79.44
Premium Tax	\$19.86
ACA (Insurer Fee)	\$24.82
ACA (PCORI Fee)	\$0.40

Total Premium: \$800.64
(PEPM)

SELF-INSURED

Claims
Cost
\$527.16

Claims
Administration
\$81.22

Broker
Consulting Fee
\$27.07

Stop-Loss Premium
\$72.19

ACA
(PCORI Fee)
\$0.40

Total Premium: \$708.04
(PEPM)

Annual savings of approximately \$348,000

AGGRESSIVE PROJECTION

FULLY INSURED

Claims Cost	\$527.16
Claims Administration, Margin, & Commission	\$148.96
Pooling Charge	\$79.44
Premium Tax	\$19.86
ACA (Insurer Fee)	\$24.82
ACA (PCORI Fee)	\$0.40

Total Premium: \$800.64
(PEPM)

SELF-INSURED

Claims
Cost
\$473.82

Claims
Administration
\$81.22

Broker
Consulting Fee
\$27.07

Stop-Loss Premium
\$72.19

ACA
(PCORI Fee)
\$0.40

Total Premium: \$654.70
(PEPM)

Annual savings of approximately \$548,000

CONSERVATIVE PROJECTION

FULLY INSURED

Claims Cost	\$527.16
Claims Administration, Margin, & Commission	\$148.96
Pooling Charge	\$79.44
Premium Tax	\$19.86
ACA (Insurer Fee)	\$24.82
ACA (PCORI Fee)	\$0.40

Total Premium: \$800.64
(PEPM)

SELF-INSURED

Claims
Cost
\$653.20

Claims
Administration
\$81.22

Broker
Consulting Fee
\$27.07

Stop-Loss Premium
\$72.19

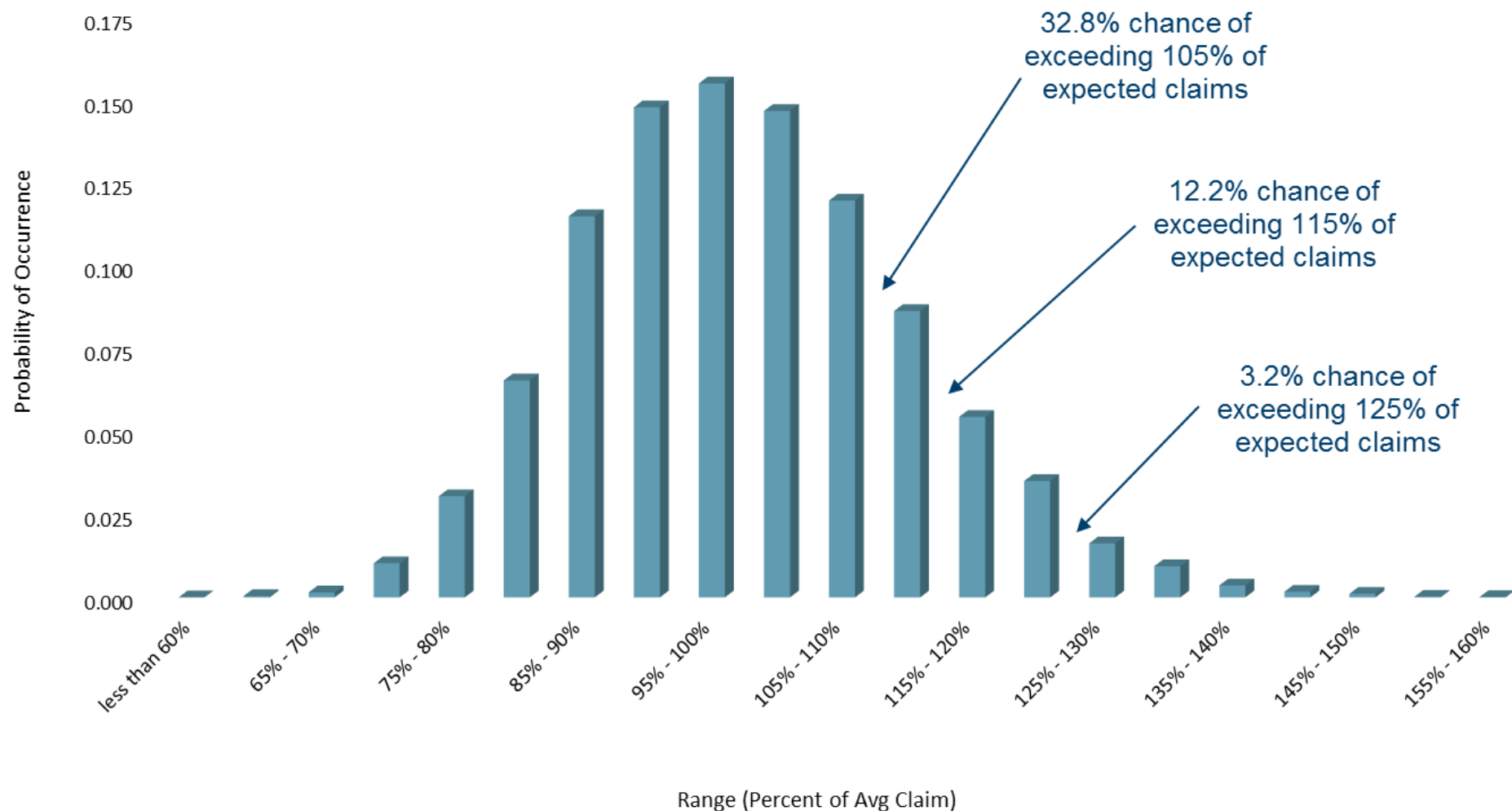
ACA
(PCORI Fee)
\$0.40

Total Premium: \$833.08
(PEPM)

Annual cost of approximately \$122,000

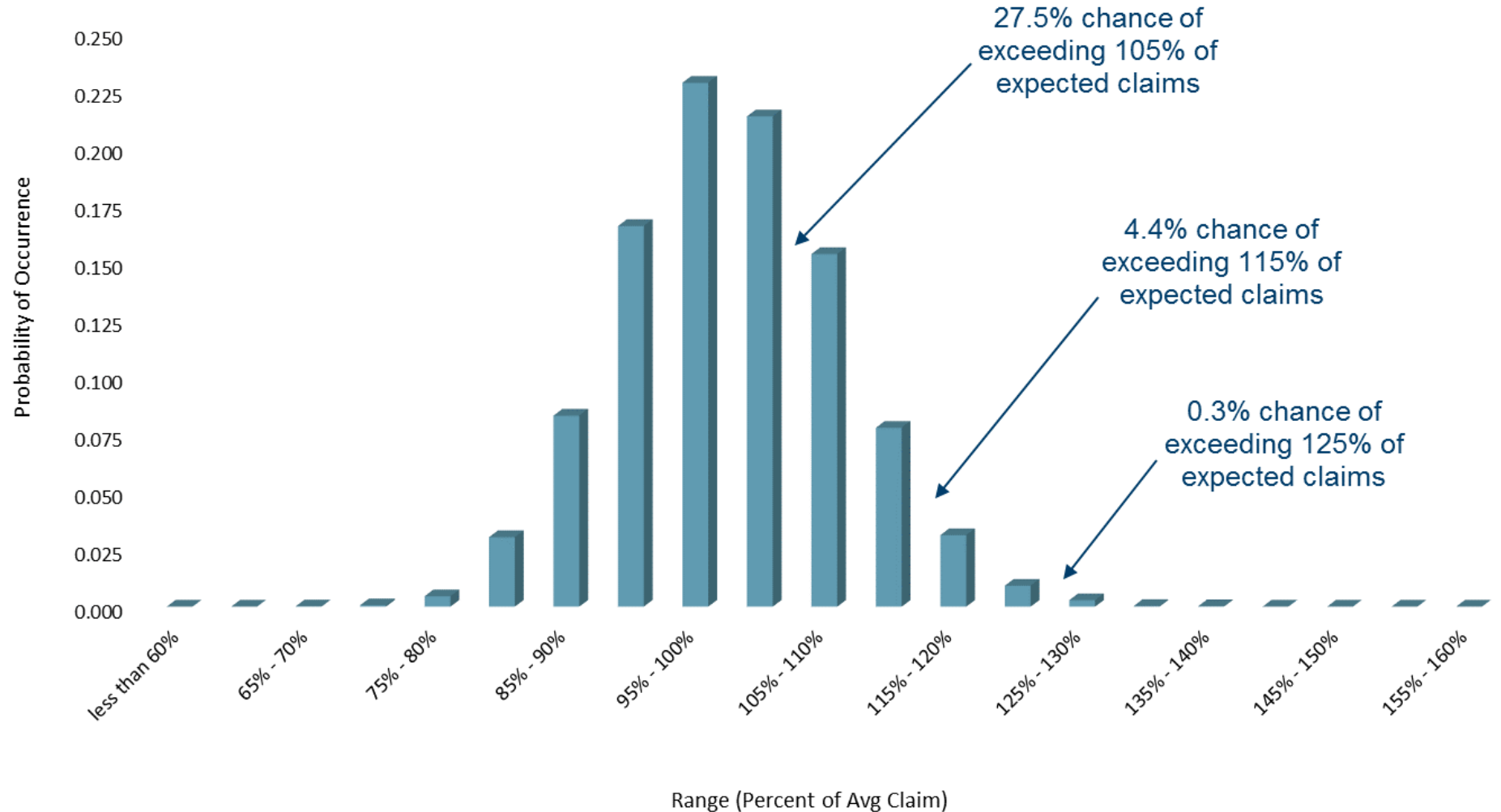
SELF-INSURED FEASIBILITY ANALYSIS

Analysis of
Aggregate Claim
Variability: \$250,000
Individual Stop-Loss



SELF-INSURED FEASIBILITY ANALYSIS

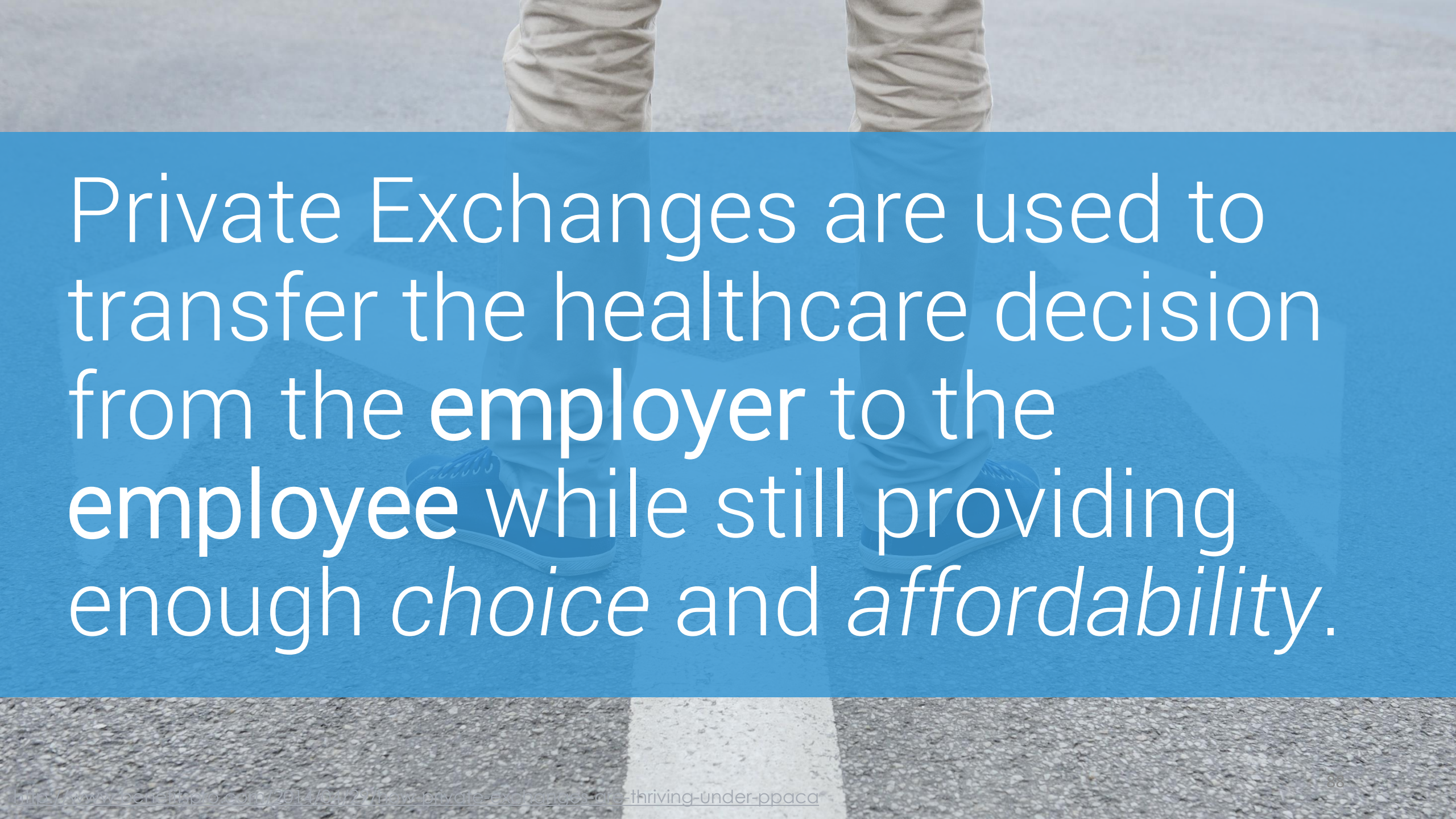
Analysis of
Aggregate Claim
Variability: \$50,000
Individual Stop-Loss



Double-digit increases in medical and prescription costs are causing a number of employers to consider self-funding

Factors to consider for mid-market employers:

- Consortium arrangements
- Limited or performance networks
- Additional strategies may include:
 - Disease Management
 - Wellness programs
 - Dependent eligibility audits
 - Spousal programs
 - Consumer driven health plans/value-based insurance design



Private Exchanges are used to transfer the healthcare decision from the **employer** to the **employee** while still providing enough *choice* and *affordability*.

Private Exchanges are a great option for some employers but definitely not for everyone

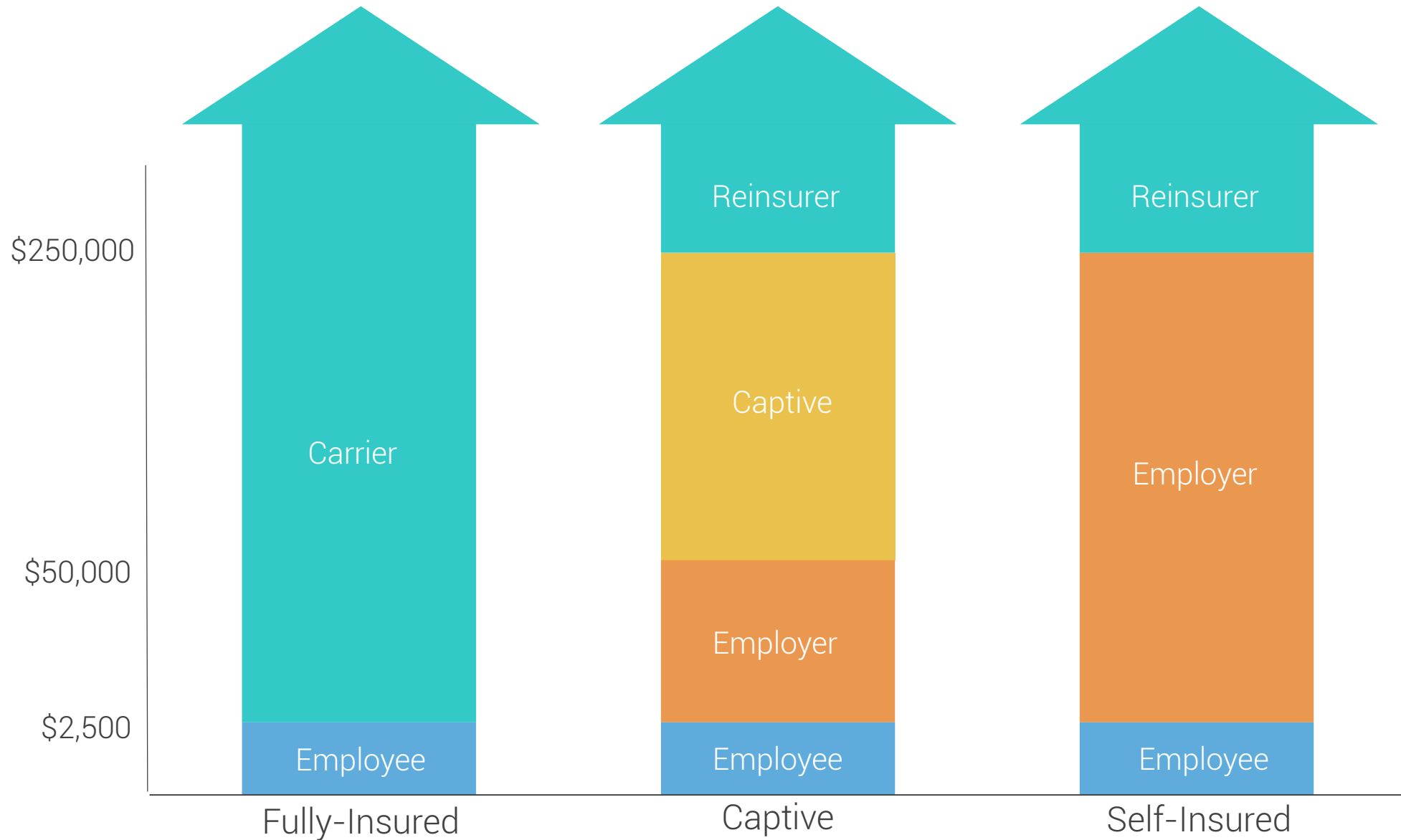
Advantages:

- Enhanced technology
- Decision support tools for employees
- Defined contribution funding approach
- Potential for more choice
- Less management of your plan
- Potential for lower costs

Disadvantages:

- Potential for over-hype
- Potential conflicts of interest
- Some brokers and carriers have made a significant investment and need to show a high level return on that investment
- Potential for perceived cost shifting to employees
- Potential for less choice
- Loss of control
- Potential for higher costs

HOW DO CAPTIVES WORK?



WHAT ARE WE HEARING IN THE MARKET?



- Smaller fully insured groups are most interested (75-200 EEs)
- They desire to go self-funded, but the risk is too much for smaller employers
- They desire to pool SOME of their large medical claims with other like-minded companies
- Almost all chose to use a captive manager instead of building it themselves
- They rely on other experts to manage the risk, acquire TPA, purchase the stop-loss, set premium and reserve levels, and onboard clients

Are captives right for me?

You should consider a captive if:

- You are a smaller fully insured group with the desire for potential long-term cost savings
 - You want to avoid ACA Insurer Fee
 - You want to avoid ACA plan design requirements
 - You want to avoid premium tax
 - You want to reduce insurer profit margin
- You want to hold your own reserves – earn interest
- You want access to data to understand network differentials, utilization patterns and wellness.
- You are not worried about upfront capital requirements being a burden
- You don't mind a long-term commitment to realize savings; Not a year-to-year decision

CY 2016 Pricing Calculation - Medical Plans

~ Sample Company ~

	Medical				Prescription Drugs				Medical & Rx Combined
	9/12-12/12	1/13-12/13	1/14-12/14	1/15-7/15	9/12-12/12	1/13-12/13	1/14-12/14	1/15-7/15	
I. Claims Experience (Paid Basis)									
Total Paid Claims	\$1,838,075	\$1,410,574	\$1,454,544	\$854,710	\$379,813	\$372,919	\$420,154	\$220,890	
Catastrophic Claims (Claims greater than \$40,000)	(\$1,247,341)	(\$274,334)	(\$549,113)	(\$509,075)	N/A	N/A	N/A	N/A	
Net Claims	\$590,734	\$1,136,240	\$905,431	\$345,635	\$379,813	\$372,919	\$420,154	\$220,890	
Enrollment	250	245	242	230	254	244	241	229	
Months of Experience	12	12	12	7	12	12	12	7	
Incurred Claim Cost (PEPM)	\$191.11	\$387.13	\$372.22	\$217.87	\$124.79	\$127.15	\$146.88	\$137.82	
II. Adjustments to Incurred Claim Cost									
1. Trend									
Annual Trend Rate	6.6%	6.6%	6.6%	6.6%	7.1%	7.1%	7.1%	7.1%	
Number of Months (from midpt to midpt)	48.0	36.0	24.0	14.5	48.0	36.0	24.0	14.5	
Trend Factor	1.293	1.213	1.137	1.081	1.317	1.229	1.148	1.087	
2. Benefit Plan Design Factor ¹	0.930	1.032	1.032	1.000	0.916	1.001	0.999	1.000	
3. Health Care Reform Adjustment ²	1.002	1.000	1.000	1.000	1.002	1.002	1.000	1.000	
4. Provider Discount Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
5. Maturity Factor	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
Final Adjustment Factor	1.266	1.254	1.173	1.081	1.268	1.234	1.148	1.087	
Expected Claims Cost after Adjustments	\$230.50	\$485.80	\$386.33	\$235.15	\$150.91	\$156.94	\$166.95	\$149.77	
Catastrophic Claims (Amount below Deductible, PEPM)		\$54.51	\$96.55	\$101.64	N/A	N/A	N/A	N/A	
Total Expected Claims	\$372.88	\$540.12	\$482.88	\$336.79	\$150.91	\$156.94	\$166.95	\$149.77	
Credibility (Blending) Factor	10%	20%	30%	40%	10%	20%	30%	40%	
III. CY 2016 Experience Rated Claims Cost (PEPM)				\$418.89				\$166.42	\$575.31
Manual Rate from Milliman's Health Cost Guidelines v2015									\$504.55
Credibility to Manual Rate									25.0%
IV. CY 2016 Expected Claims Cost									\$577.82
V. Captive Policy Summary ³									
Maximum Captive Risk Premium (\$40,000 to \$250,000)									\$161.38
Premium for Claims above \$250,000									\$26.36
Expected Captive Net Risk Premium									\$187.73
VI. Expenses ³									
ACA Fees (PCORI and Transitional Reinsurance)									\$5.77
Claims Administration									\$41.30
Carrier P&L									\$47.17
Broker Commission									\$15.77
Captive & Program Management									\$20.76
Taxes									\$5.17
Total Expenses									\$141.95
VII. Total Expenses (V + VI)									\$329.68
VIII. CY 2016 Projected Premium (PEPM)									\$907.30
Fully-Insured Renewal (PEPM) ⁴									\$1,053.58
Calculated Actuarial Increase(Decrease) Over Fully-Insured Renewal									(13.9%)
Current Fully-Insured Premium (PEPM)									\$990.60
Calculated Actuarial Increase(Decrease) Over Current Fully-Insured Premium									1.9%

1. Based on historical plan design changes and/or enrollment shifts provided by Sample Company.

2. Health Care Reform Adjustment accounts for change in plan design necessary to be consistent with the most recent regulations. Assumes plan is not grandfathered.

3. Expenses used in this calculation were provided by broker.

4. Based on fully-insured renewal provided by Sample Carrier.


Milliman has completed 22 Captive Feasibility Reports

Of those 22 reports, 5 did not show a financial incentive

The remaining reports showed an average cost savings of 6.0%



WHAT IS AN ACO?

- Organization of providers that operates a **team-based model** to coordinate care.
 - Relies on technology for greater coordination of care between providers and patients.
 - The ACO is accountable to the patients and the third party payer for the quality, appropriateness and the efficiencies of healthcare provided.
 - There is an effort to tie provider reimbursements to quality metrics.
 - Overall goal is better quality with a reduction in total costs.
 - Financially, providers can **share in profits** but are also at risk for losses depending on the ACO's performance vs. targets.
 - ACOs range from fully-owned providers to networks of professionals joining together to joint ventures between physician groups and hospitals.
- 

ACO TRENDS

838 active ACOs across the country with service areas in all 50 states

The count of ACOs has grown by 94 over the past year, an increase of 12.6%

An estimated **28.3 million Americans** are now covered by an ACO

About **6 million Medicare beneficiaries** are now in an ACO

More than $\frac{2}{3}$ of Americans live in localities served by ACOs

More than **40%** live in areas served by two or more ACOs

<http://industryview.cdwcommunit.com/index.php/2014/06/23/aco-infographic/>

<http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/>

<http://khn.org/news/aco-accountable-care-organization-faq/>

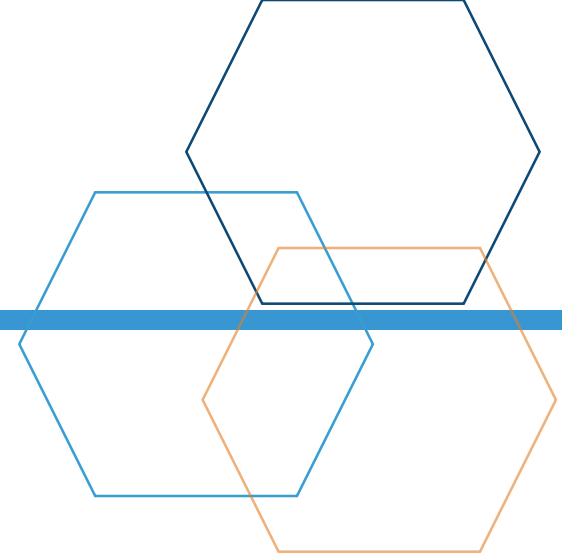


CONSUMERISM

How can I make my
employees better consumers?

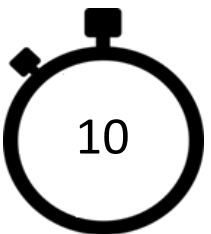
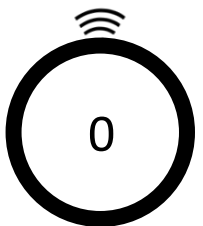
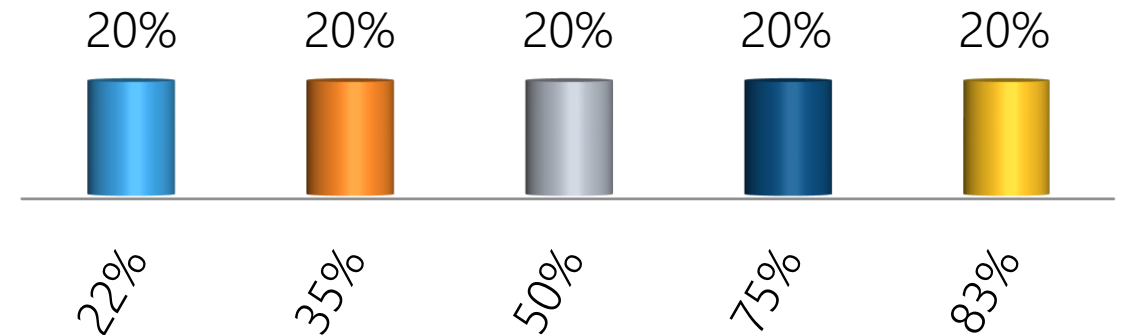


AUDIENCE POLL



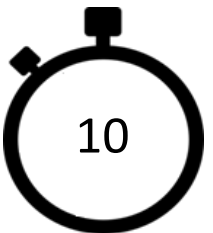
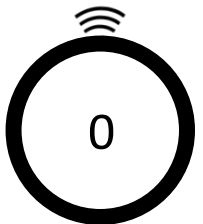
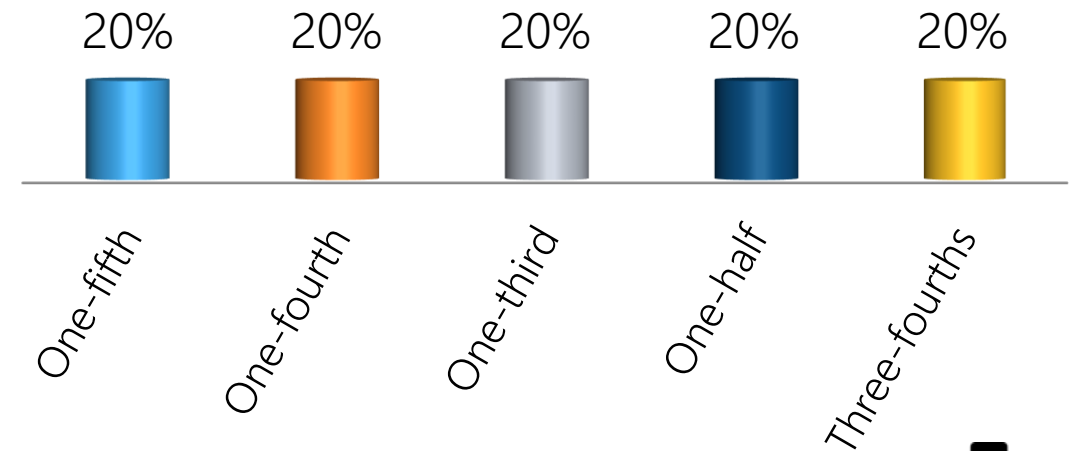
By 2030, Millennials (currently 19-35), will make up what percent of our workforce?

1. 22%
2. 35%
- ✓ 3. 50%
4. 75%
5. 83%



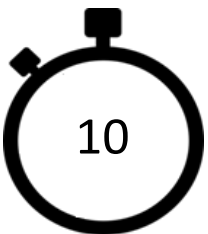
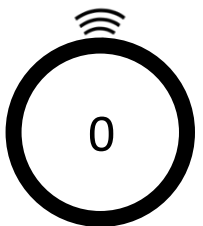
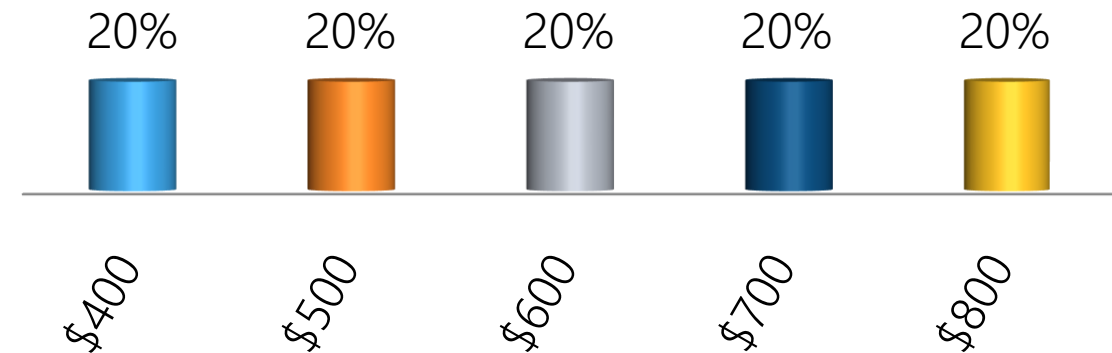
More than what fraction of millennials feel “not very” or “not at all” informed about the health insurance options available to them.

1. One-fifth
2. One-fourth
- ✓ 3. One-third
4. One-half
5. Three-fourths



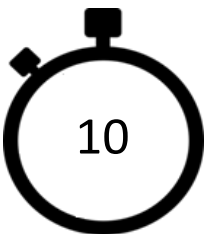
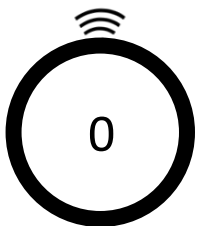
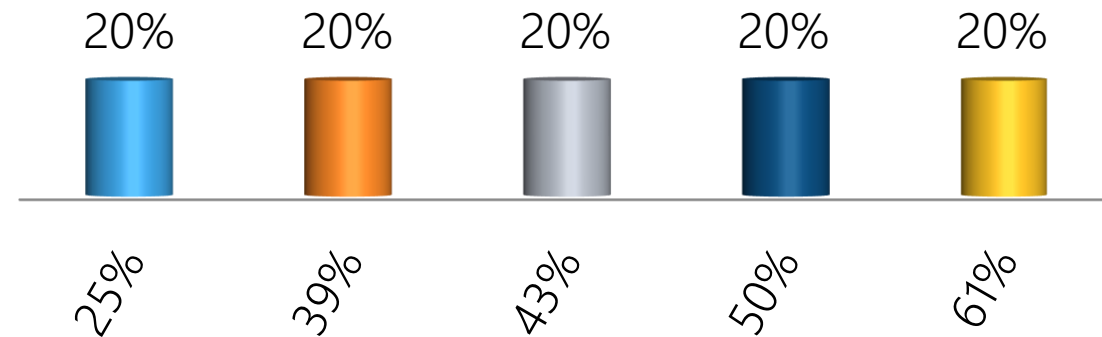
Nearly how much are employers spending per employee on employee engagement programs associated to health care?

1. \$400
2. \$500
3. \$600
- ✓ 4. \$700
5. \$800



According to the Benefits Benchmarking Survey, what percentage of organizations offered an HDHP plan in 2016?

- 1. 25%
- ✓ 2. 39%
- 3. 43%
- 4. 50%
- 5. 61%



According to consumers....



$\frac{1}{2}$

Didn't know their plan coverage or their health care costs for the year




$\frac{2}{3}$

Feared they may not be paying the right amount for service when they pay a bill



$\frac{1}{3}$

Compare prices on medical services



“The health care industry is shifting towards individual responsibility for health care costs. Consumers will require substantial support to manage their ever-growing financial responsibilities – as they learn how to become savvy health consumers,” said Steve Auerbach, Alegeus CEO.

Making open enrollment the best experience for everyone

- Communicate with your employees in the mode they're most likely to respond to.
- Use analytical tools to show which plan offers the best value specifically for them.
- Apply predictive analytics to help employees stay engaged with their benefits throughout the year, starting with open enrollment.



Hit “send” on the right Platform



Even the most clever and compelling message won't mean a thing if your employees aren't reading it.

Employees differ by age, gender, education, lifestyle and preferences. The key is knowing each employee on an individual basis – what they want, where they are looking and what is most likely to bring about a positive response.

95% Of employers have failed to assess their employee's communication preferences.

HOTTEST TRENDS



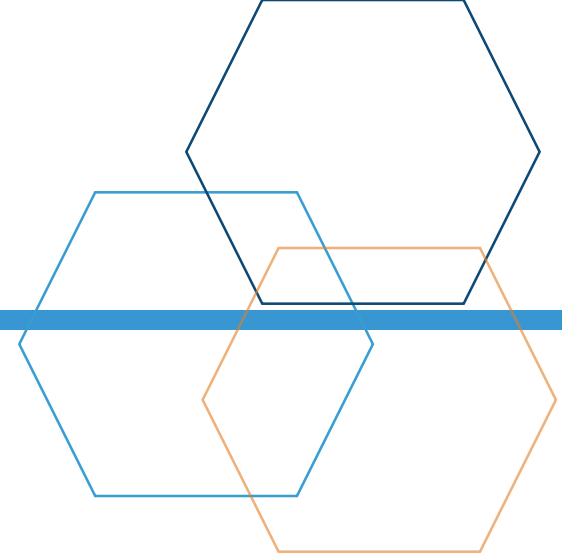


Rx DRUG PRICES

Should I consider carve out, Rx coalitions, or specialty?

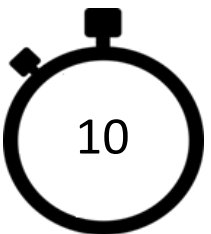
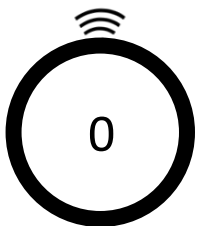
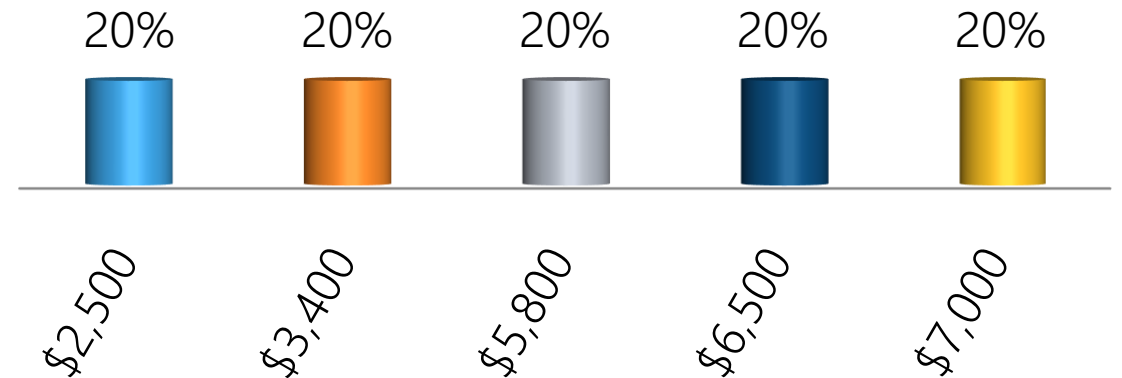


AUDIENCE POLL



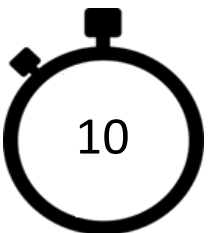
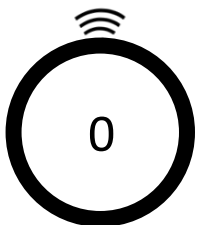
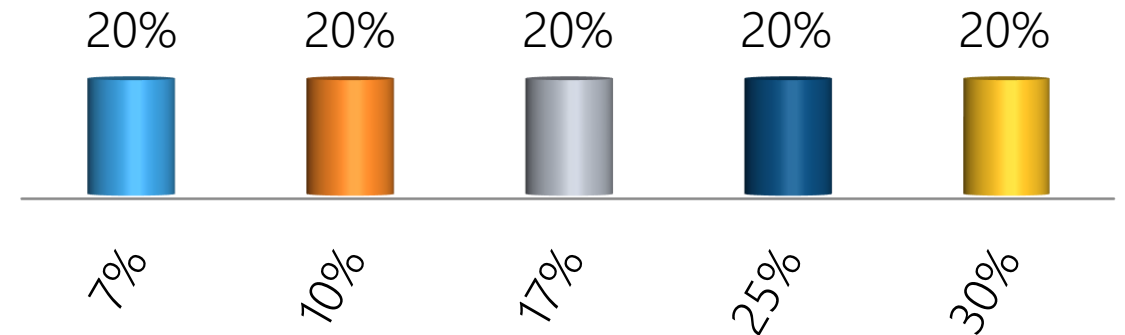
According to a report by AARP, the average yearly cost for one brand name drug used on a chronic basis now surpasses what dollar amount?

1. \$2,500
2. \$3,400
- ✓ 3. \$5,800
4. \$6,500
5. \$7,000



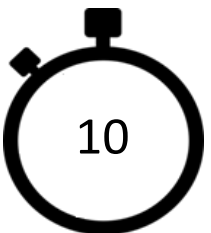
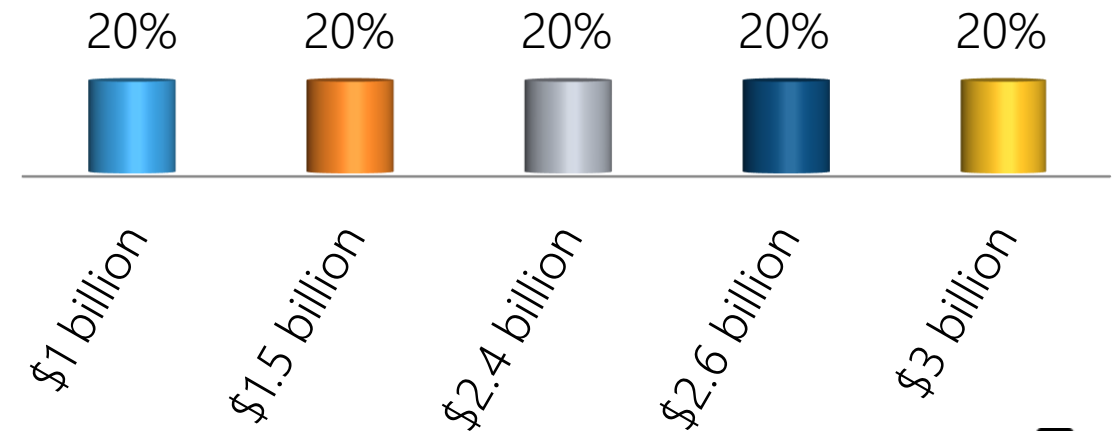
According to the Milliman Medical Index, prescription drugs are nearly what percentage of total healthcare spend?

1. 7%
2. 10%
- ✓ 3. 17%
4. 25%
5. 30%



According to the Pharmaceutical Researchers and Manufacturers of America, how much does it cost to develop one new drug?

1. \$1 billion
2. \$1.5 billion
3. \$2.4 billion
- ✓ 4. \$2.6 billion
5. \$3 billion



BASIC TERMINOLOGY

Wholesale Acquisition Cost (WAC)

- Price paid by a wholesaler, distributor and other direct accounts for drugs purchased from the wholesaler's supplier.

Average Wholesale Price (AWP)

- A published national average of list prices charged by wholesalers to pharmacies. Average wholesale price (AWP) is not an actual price that purchasers or PBMs normally pay. It is used by most PBMs for setting prices reimbursed by outpatient pharmacies and prices charged to plan sponsors.
- AWP is equal to 120% of WAC.

Rebates

- Payments paid by the manufacturer to PBM and shared with the employer/health plans to incentivize them to put their brand on formulary status.

Copay Coupons & Patient Assistance Programs

- Payment by a third party to reduce the patient's copay. Often used to help patients pay for expensive prescription drugs whose plan design uses a coinsurance.

BASIC TERMINOLOGY

National Average Drug Acquisition Cost (NADAC)

- Designed to create a national benchmark that is reflective of the prices paid by retail community pharmacies to acquire prescription and over-the-counter covered outpatient drugs.

Brand Name Drug

- A patented drug generally manufactured and sold by a drug labeler (single source brand name). There are instances in which more than one labeler may produce a brand name drug. These types of brand name drugs are referred to as multi-source brand name drugs.

Generic Drug

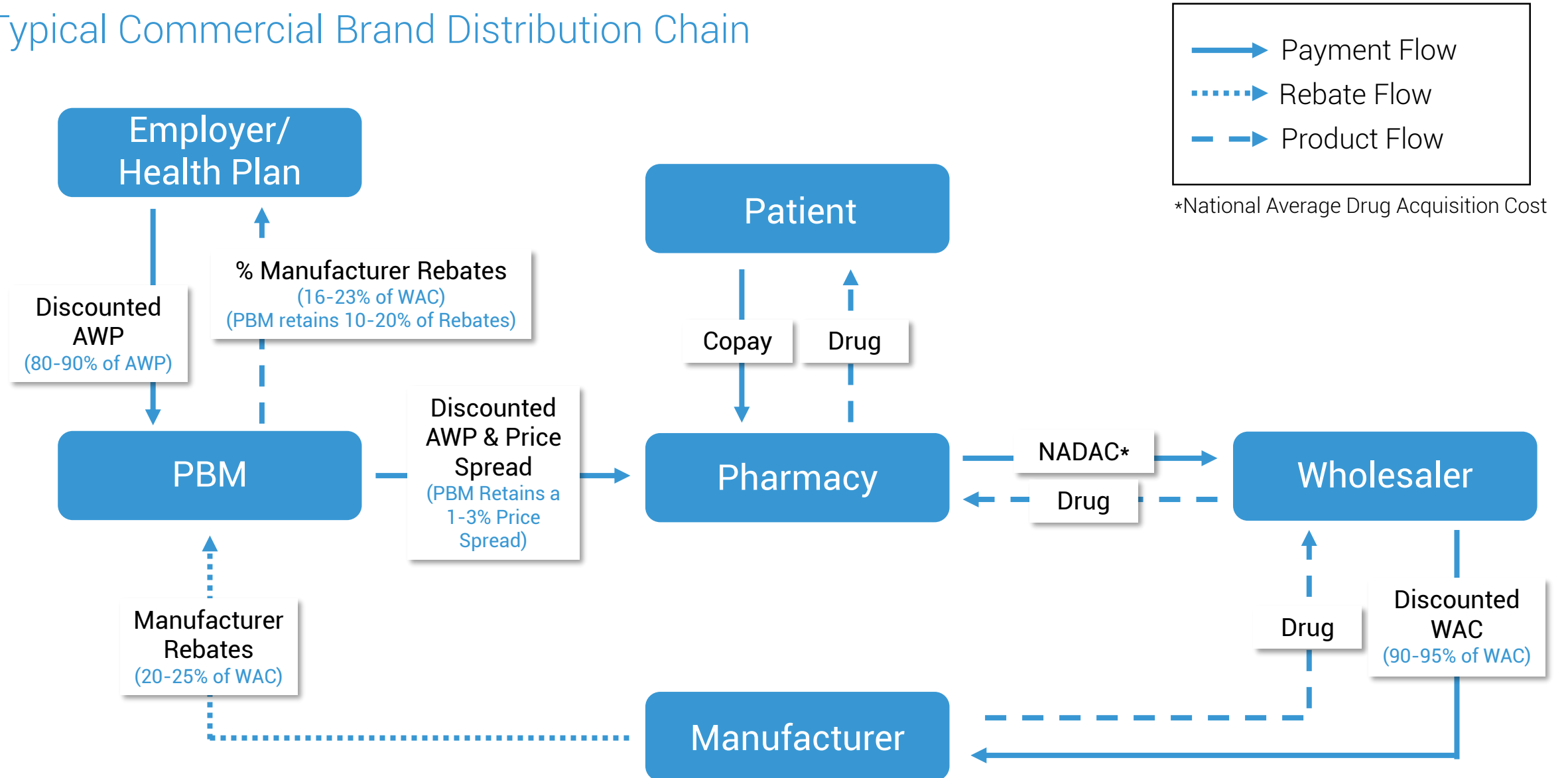
- Generic drug is a drug that is no longer protected by a patent. Generic alternative drugs are not chemically identical to the brand in question, but are in the same therapeutic class and intended to treat the same conditions as the brand in question.

Specialty Drug

- Specialty drugs are pharmaceutical products that are typically expensive and require special handling and monitoring. Many are biologically developed (biologics) and can be used to treat chronic, life threatening, and rare conditions. There is not an industry standard definition of a specialty drug; each PBM tends to have its own definition and list of specialty drugs.

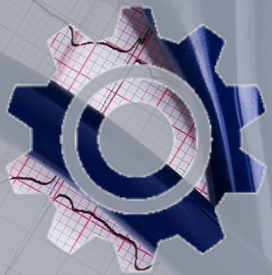
FLOW OF GOODS & MONEY

Typical Commercial Brand Distribution Chain



Insurer Spending On Drugs Up Sharply Since 2010, Study Finds.

According to the Detroit News, a study by the national Blue Cross Blue Shield Association “has found that its affiliates are spending 73 percent more on prescription drugs than in 2010, and the majority of those expenses are on brand drugs, despite a growing acceptance of generic drugs across the country.” The study, released May 3, 2017, “provided a seven-year analysis of prescription drug utilization, price changes and costs, and showed that drug prices have increased about 10 percent annually for the insurance group.”

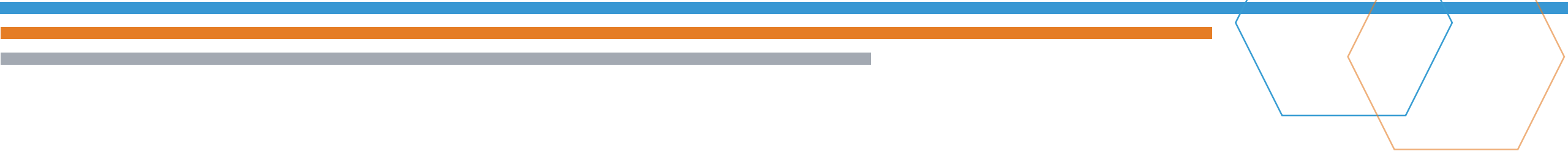


ALTERNATIVE FORMS OF HEALTHCARE

Should I consider alternative forms
of delivering healthcare?

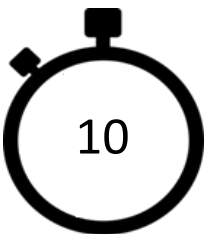
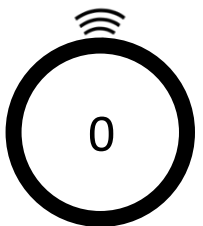
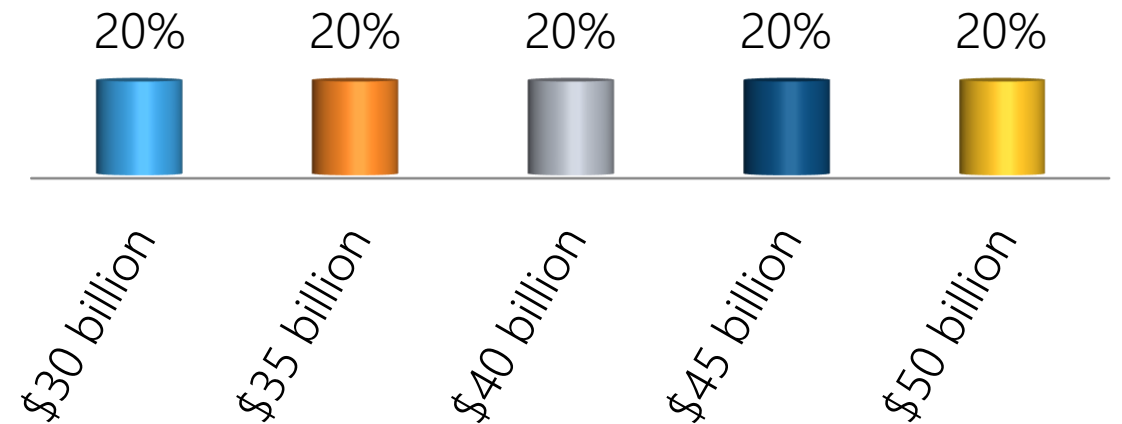


AUDIENCE POLL



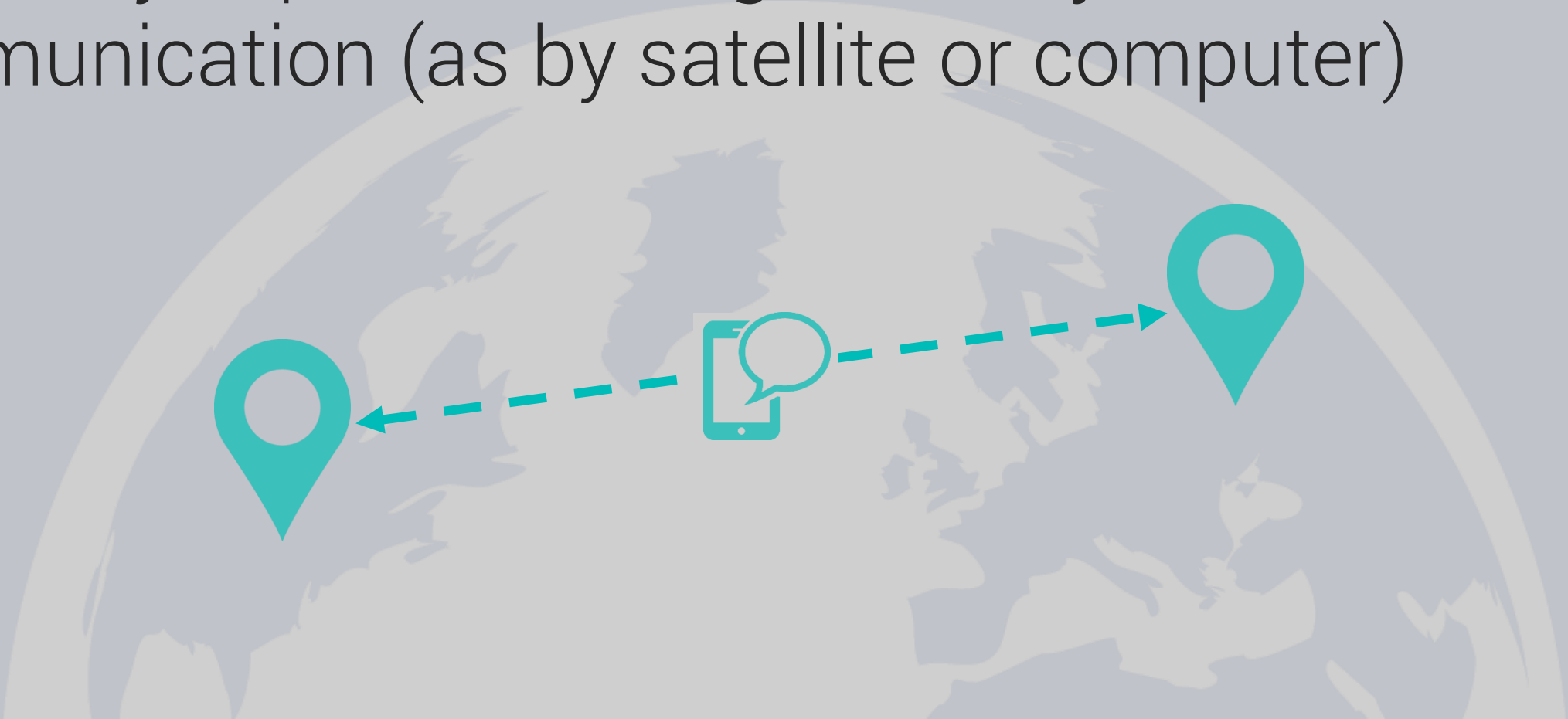
The virtual health care market was estimated at \$17.9 billion in 2015. According to a Research and Markets study, what is the projection for 2021?

1. \$30 billion
2. \$35 billion
3. \$40 billion
- ✓ 4. \$45 billion
5. \$50 billion



TELEMEDICINE

The practice of medicine when the doctor and patient are widely separated using two-way voice and visual communication (as by satellite or computer)



ONSITE CLINICS

Core measures that should be included in any major health clinic assessment:

- Utilization
- Clinical services by procedure group
- Financial overview
- Demographics
- Quality of care and outcomes
- Staff configuration

REFERENCED-BASED PRICING

- Referenced-Based Pricing (RBP) represents a different type of cost-sharing arrangement for participants
- Employers base benefits on an independent “reference” point, such as Medicare or an RBRVS scale
 - Typically, the reference is set higher than Medicare, such as 120%-150% of Medicare
 - Most effective if participants and providers can find reference easily, even on Google
- This is most effective for procedures that have a wide cost variation (ex. knee and hip replacement surgeries)
- Allows for more transparency and broader communication, resulting in more consumerism and lower costs

Willing Buyer



MORE EFFICIENT MARKET

Willing Seller



A background image showing a group of healthcare professionals, including a woman and a man, looking down at something, possibly a patient or a document. The image is slightly blurred and has a dark overlay.

ADVANTAGES

Referenced-Based Pricing

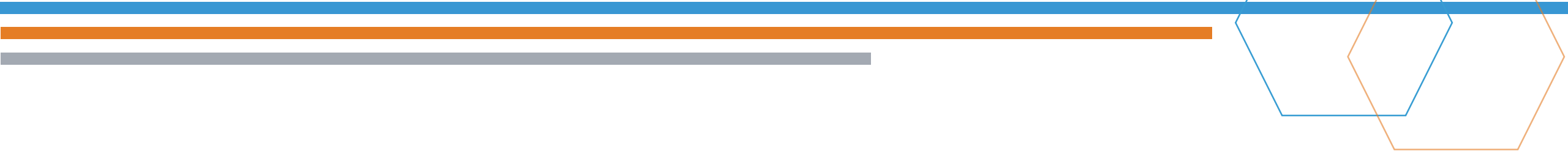
- ✓ The goal of RBP is to reduce, or at least limit, health care spending by the employer, while at the same time creating a more engaged health care consumer
- ✓ Allows employers to manage costs and benefits more efficiently
- ✓ Allows patients to understand costs and make informed decisions
 - ✓ Thus allowing patients to have more choice
- ✓ Hospitals can have much more efficient billing processes, especially for large claims

- ✓ Creates an incentive for physicians to learn the prices of the services they recommend to their patients
 - ✓ Only one-fifth of doctors correctly estimate the cost of an implantable device (Okike, et al. 2014)
 - ✓ Contractual agreements may even prevent them from obtaining such information
- ✓ Allows for a broader communication of prices in order to be more competitive

OTHER FACTORS

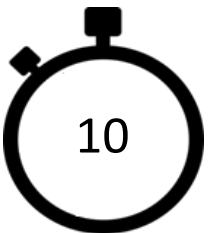
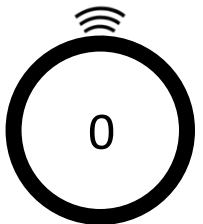
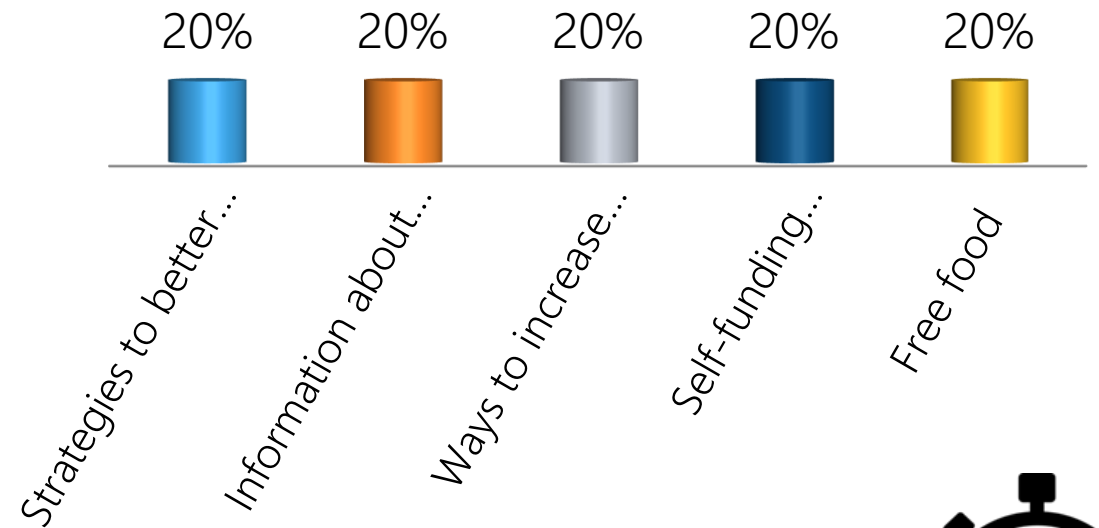
Referenced-Based Pricing

AUDIENCE POLL



What is your take-away for today?

1. Strategies to better our business practices
2. Information about healthcare costs
3. Ways to increase employee attraction and retention
4. Self-funding information
5. Free food



NEXT STEPS

Refer to the ICR &
Mid-Atlantic Healthcare Report



For more information,
contact your SIG
representative

STANDARD CAVEATS

In performing our analysis, we relied on data provided to us by SIG. We have neither verified nor audited the accuracy of the data contained in the files. If the underlying data is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Where practicable, the data was reviewed for consistency and reasonableness. Due to the nature of any medical block of business, results are highly variable. As such, actual results may vary from the results provided in this report.

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