Medical Stop-Loss: Fundamentals and Current Marketplace

American Special Risk Association

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Biography of Michael L. Frank

- President & Actuary, Aquarius Capital
  - Actuarial and insurance/reinsurance consulting firm for US and International Organizations
- Adjunct Professor, Columbia University, M.S., Actuarial Science
  - Global Perspective of Health Insurance Market – Studies systems of US and 24 other countries
  - Employee Benefits, Retiree Health Valuations, Provider Contracting & Insurance/Reinsurance
- Experience: Insurance/Reinsurance/Employee Benefits (30+ Years of Experience)
  - Appointed Actuary: Insurance Companies (e.g., Berkshire Hathaway), HMOs, & Reinsurers
  - Consulted more than 500 municipalities & 100 private equity/hedge funds
  - Healthcare Provider & Managed Care Carve-Out Consulting
  - Consult other organizations serving the insurance industry (regulators, accounting firms, brokers)
  - Expert Witness
  - Prior Employment: Prudential, Coopers & Lybrand, The Segal Company, Physicians Health Services, Coordinated Care Solutions/Careguide, Transamerica Reinsurance/MFC Re
- Served as President, Actuarial Society of Greater New York (ASNY)
- Various Actuarial, Insurance, Reinsurance and Healthcare Reform Committees
- Regular Industry Guest Speaker and Publisher of Articles
- Society of Actuaries LEARN Program – Instructor, Reinsurance for Insurance Regulators
- Other Credentials & Designations
  - Licensed life, accident & health broker and reinsurance intermediary
  - Board of Directors, Capstone Healthcare Econometrics Research Foundation
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Objectives of Seminar

- History of Healthcare in the US
- Current Trends in the Stop Loss Market
- Changes in Healthcare Provider Practices
- Recent Legislation in Healthcare (Examples)
- Special Considerations in the Self-Funded Area

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Brief History for Health Insurance

- 1912: Theodore Roosevelt includes national health insurance in its platform, but Roosevelt loses the election.
- 1915: President Woodrow Wilson, recommends a national system of workers' health insurance.
- 1929: During Great Depression, Baylor University Hospital agrees to provide 1,500 Dallas school teachers up to 21 days of hospital care each year for a prepayment of $6 per person ($0.50 per month).
  - Other hospitals adopt similar arrangements, leading to what would become Blue Cross hospital insurance.
  - The nonprofit plans' success persuades for-profit life insurers to offer health insurance; unlike Blue Cross, for-profit insurers base premiums on customers' age and health.
  - Several years later, physician groups establish similar prepayment plans, which become known as Blue Shield.

Brief History for Health Insurance (Cont.)

- 1942: During World War II, Congress limits wage increases but allows employers to offer health coverage (growth in employer-sponsored plans)
- 1945: McCarran–Ferguson Act, a federal law passes that exempts the business of insurance from most federal regulation.
- 1965: President Lyndon Johnson signs into law the creation of two government sponsored health insurance programs - Medicare and Medicaid.
- 1973: The HMO Act enacted spawning growth in HMOs
- 1974: ERISA law passed placing self-funded plans out of state jurisdiction.
- 1977: Health Care Financing Administration (HCFA) created to manage Medicare and Medicaid (separately from Social Security Administration)
- 1985: COBRA law passed allowing workers to continue health insurance coverage after leaving employment.
- 1993: Proposed Health Security Act of 1993 – Bill does not get voted in

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Brief History for Health Insurance (Cont.)

- 1996: Health Insurance Portability and Accountability Act (HIPAA) and Mental Health Parity laws
- 2000: Healthcare Reform Act introduces HealthyNY product to NY residents. Objective was to provide affordable and comprehensive benefits to small groups and individuals.
  - Individual HealthyNY market was eliminated in 2014 with the introduction of health insurance exchanges.
- 2003: President George W. Bush approves law adding prescription drugs to Medicare. (The birth of Medicare Part D pharmacy benefits.)
- 2010: Patient Protection and Affordable Care Act (PPACA) signed into law aimed at reducing uninsured individuals.
- 2016: CMS Report on US Healthcare
  - National Health Expenditures (NHE) is $3.3 trillion
    - Pharmacy is approximately $329 billion
  - $10,348 annual cost per person
  - 17.9% of Gross Domestic Product (GDP)

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History of the Reinsurance

- 1370: First recorded reinsurance contract covered Marine Voyage from Genoa to Harbor of Bruges
- 1688: Edward Lloyd Coffee House Established
- 1820: First Automatic Reinsurance Treaties covering fire risks in Germany, primarily written by Direct writing companies
- 1844: The first life reinsurance coverage offered in England
- 1846: Cologne Reinsurance was the first independent reinsurance company
- 1919: Metropolitan Life Insurance Company (MET) organized a separate Reinsurance Division.
- 1940-80's: Large increase in new capacity
- 1990-Today: Mergers & Acquisitions

Source: Society of Actuaries LEARN Program

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History of Accident & Health Reinsurance Market

- Profitable Period (Late 1980's – early 1990's)
  - Less Capacity; Purchaser less focused on cost of reinsurance
- Unprofitable Period (mid 1990's- 2000)
  - Excess Capacity - Capacity in mid 90's significantly greater than the early 90's (Market Pressure drives rates downward)
  - Pricing Issues - Minimal Analytics; Ineffective underwriting and pricing for managed care; Sold rates were "materially" below manual rates; Uncontrolled Expenses
  - Reserve strengthening (loss "true up") from prior underwriting years resulted in large exiting of market of major reinsurers
  - Retrocessionaires lose $ in pools
  - Result is significantly more audits by reinsurers of claims and underwriting
- Mixed Results Period (mid - 2004 to today)
  - Reinsurance Managing General Underwriters (MGUs) becoming extinct (not direct MGUs)
  - Limited HMO reinsurance/provider excess writers
  - Limited fully insured quota share capacity
  - Change in the "finite risk" or financial reinsurance market
  - Reinsurance agreement language much more detailed.

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Sample Rate Increases – New York Small Group Market for 2019 as of 11/16/18

(Source: https://myportal.dfs.ny.gov/web/prior-approval/summary-of-2019-requested-rate-actions)

Company Name	2019 Requested Rates	DFS Final Approved 2019 Rates	DFS Modification as a Percent of Total Requested	Market Share
Aetna Life	16.2%	7.9%	-51.6%	4.1%
CDPHP	6.7%	0.0%	-100.0%	0.4%
CDPHP UBI	6.1%	1.5%	-75.4%	2.0%
Crystal Run Health Insurance Company	11.5%	8.9%	-23.0%	0.2%
Crystal Run Health Plan, LLC	12.5%	9.8%	-21.4%	0.1%
Emblem	12.0%	9.8%	-18.3%	1.5%
Empire Healthchoice Assurance	6.0%	5.0%	-17.0%	1.7%
EmpireHealthchoice HMO	5.2%	9.2%	75.2%	0.2%
Excellus*	3.8%	3.8%	-0.8%	16.6%
Healthfirst Health Plan, Inc.	21.0%	16.0%	-23.6%	0.0%
Healthfirst Insurance Company, Inc.	7.0%	6.4%	-9.1%	0.6%
Healthnow New York	-0.1%	0.3%	383.6%	7.4%
IHBC*	3.8%	4.7%	24.0%	3.7%
MetroPlus*	4.7%	9.6%	103.5%	0.1%
MVP Health Plan	7.0%	6.6%	-6.1%	0.2%
MVP Health Service Corp*	10.3%	9.1%	-11.8%	6.6%
Oscar	3.0%	2.0%	-34.5%	0.8%
Oxford Health Insurance Inc*	8.3%	3.0%	-64.0%	53.6%
UnitedHealthcare Ins Company of New York	7.2%	-1.0%	-113.3%	0.1%
Weighted Average	7.5%	3.8%	-50.0%	100.0%

* Indicates the Company offers products on the NY State of Health Marketplace.

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Empire Plan Health (NYSHIP) Insurance Premiums (Approximately 800 Employers, 1.2 million lives)

	Empire Plan (Formerly:Core Plus All Enhancements)									
	Individual Planprime		Family Planprime		Individual Mediprime		Family 1 Mediprime		Family 2 or More Mediprime	
Year	Monthly Premium	% Change	Monthly Premium	% Change	Monthly Premium	% Change	Monthly Premium	% Change	Monthly Premium	% Change
1993	194.64		426.35							
1994	197.39	1.41%	446.94	4.83%						
1995	193.54	-1.95%	440.35	-1.47%						
1996	207.66	7.30%	459.16	4.27%	131.72		383.23		307.07	
1997	240.22	15.68%	489.22	6.55%	129.28	-1.85%	378.82	-1.15%	267.15	-13.00%
1998	246.07	2.44%	503.78	2.98%	151.34	17.06%	409.76	8.17%	314.25	17.63%
1999	261.18	6.14%	531.89	5.58%	175.61	16.04%	447.05	9.10%	360.66	14.77%
2000	286.53	9.71%	590.16	10.96%	214.25	22.00%	518.52	15.99%	445.51	23.53%
2001	314.26	9.68%	651.09	10.32%	239.94	11.99%	577.95	11.46%	502.37	12.76%
2002	344.66	9.67%	723.97	11.19%	253.82	5.78%	633.13	9.55%	542.29	7.95%
2003	384.89	11.67%	811.41	12.08%	297.50	17.21%	724.05	14.36%	636.67	17.40%
2004	438.15	13.84%	924.74	13.97%	334.22	12.34%	820.82	13.37%	716.88	12.60%
2005	478.49	9.21%	1,013.68	9.62%	331.93	-0.69%	867.09	5.64%	720.53	0.51%
2006	529.76	10.71%	1,126.19	11.10%	338.88	2.09%	935.32	7.87%	744.45	3.32%
2007	564.84	6.62%	1,198.07	6.38%	333.18	-1.68%	966.44	3.33%	734.81	-1.29%
2008	592.38	4.88%	1,258.78	5.07%	360.41	8.17%	1,026.86	6.25%	794.94	8.18%
2009	598.58	1.05%	1,282.17	1.86%	359.22	-0.33%	1,042.81	1.55%	803.45	1.07%
2010	612.34	2.30%	1,330.93	3.80%	367.37	2.27%	1,085.94	4.14%	840.98	4.67%
2011	693.92	13.32%	1,513.92	13.75%	405.64	10.42%	1,225.62	12.86%	937.31	11.45%
2012	712.75	2.71%	1,562.80	3.23%	419.24	3.35%	1,269.28	3.56%	975.77	4.10%
2013	767.98	7.75%	1,686.56	7.92%	399.33	-4.75%	1,317.93	3.83%	949.28	-2.71%
2014	771.54	0.46%	1,714.19	1.64%	408.77	2.36%	1,351.42	2.54%	988.69	4.15%
2015	805.05	4.34%	1,808.86	5.52%	401.84	-1.70%	1,405.68	4.02%	1,002.46	1.39%
2016	849.01	5.46%	1,926.21	6.49%	452.79	12.68%	1,530.00	8.84%	1,133.77	13.10%
2017	944.39	11.23%	2,160.64	12.17%	421.40	-6.93%	1,637.63	7.03%	1,114.63	-1.69%
2018	1,014.98	7.47%	2,348.15	8.68%	444.39	5.46%	1,777.54	8.54%	1,206.95	8.28%
2019	1,042.85	2.75%	2,412.77	2.75%	403.27	-9.25%	1,773.19	-0.24%	1,133.57	-6.08%

Note: Excludes NYSHIP Admin Fee.

Average Increase - Annualized

Last 5 Years	6.21%	7.08%	-0.27%	5.58%	2.77%
Last 10 Years	5.71%	6.53%	1.16%	5.45%	3.50%
Last 15 Years	6.87%	7.54%	2.05%	6.15%	3.92%
Last 20 Years	7.17%	7.85%	4.24%	7.13%	5.89%

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Self-Funding vs. Fully Insured

- Benefits of Self-Funding
  - Avoid state mandated benefits (governed under ERISA)
  - Avoid premium tax and certain profit margins
  - Flexibility in plan design and administration across state borders
  - Exempt from certain PPACA fees
  - Flexibility in program design (unbundled administration)
  - Simplify collective bargaining having one set of benefits
- Benefits of Fully Insured
  - Cost predictability (less volatility)
  - Potential ease of administration (fewer parties)
  - Less need for robust reporting from carrier

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New York Self-Funding Rules & Definitions of Small/Large Groups

- Minimum Specific (Per Person) Stop Loss Deductible ($25,000)
  - Not a written requirement but has been in practice by the NYSDFS and applied to stop loss insurance carriers (not employers)
- Minimum Aggregate Stop Loss Deductible – No Requirement
- Minimum number of employee lives for self-funding option
  - No requirement in NY for minimum lives (small groups can self-insure)
  - Definition of Large Group (51 increases to 101 in 2016) for fully insured
    - https://www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm
    - Insurance carriers are inconsistently applying definitions of a small group based on what defines a covered employee in the smaller groups

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Regulation of Association Health Plans (AHP) Insurance Circular Letter No. 10 (2018), July 27, 2018

Sample Language from Circular (See Circular for More Detail):

- The recent U.S. Department of Labor ("DOL") final rule ("AHP Rule") expressly does not preempt the New York Insurance law which strictly limits the associations or groups of employers that may sponsor a health insurance plan.
- Fully Insured Associations: Regardless of the AHP Rule, for a group or association of employers to sponsor a group health plan in New York, the group or association must meet specific requirements to be recognized as a group under the Insurance Law.
- Self-Funded Associations: The AHP Rule also does not modify the existing ERISA regulatory framework that allows states to regulate self-funded associations. An association that self-funds health insurance benefits for the New York employees of its members would be doing an insurance business in New York as defined in Insurance Law § 1101.
- Self-funded associations doing the business of insurance in New York are subject to New York requirements such as solvency, premium rate review, state benefit mandates and consumer protections

source: https://www.dfs.ny.gov/insurance/circltr/2018/cl2018_10.htm

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Snapshot of the Stop Loss Insurance Market (Source: www.myhealthguide.com, April 2019)

Stop-loss Premium Ranking Based on Carrier's 2017 Statutory Report			
New Rank (2017)	Entity Name	Prior Rank (2016)	Stop Loss Premium Earned (2017) Thousands
1	Cigna Corp.	1	$2,832,188
2	UnitedHealth Group Inc.	2	$1,419,482
3	Sun Life Financial Inc.	4	$1,205,524
4	Tokio Marine	3	$1,135,756
5	Anthem Inc.	5	$1,071,563
6	Voya Financial Inc.	6	$972,110
7	Highmark (HM Insurance Group)	9	$865,391
8	Aetna Inc.	8	$823,945
9	HlthCare Svc Corp. a Mutual	10	$639,330
10	Symetra	7	$635,965

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Who Purchases Reinsurance? Accident & Health

Insurance Carriers

- Program Managers on Behalf of Carrier Clients
- Managing General Underwriters (MGUs)
- Third Party Administrators (TPAs)
- Marketing Entities/General Agencies

Reinsurers/Retrocessionaires

Captive Insurance Companies

Health Maintenance Organizations (HMOs)

Medical Provider Groups ("Risk Taking")

Employer Groups ("Self-Funded")

Disease Management Companies

Accountable Care Organizations (ACOs)

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Reinsurance Structures – Accident & Health Market

- Quota Share
- Variable Quota Share
- Yearly Renewable Term (YRT)
- Excess of Loss
  - Specific (Per Person) Stop Loss
  - Aggregate Stop Loss
- Retrospective Premium Adjustments ("Swing Rate")
- Contracts with Maximum Limit Caps
- Insolvency Coverage
- Letter of Credit
- Surety Bond
- Parental Guarantees ("Keepwell" Agreement)

- *Note: A&H market borrowed many concepts from P&C market!*

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Employer Stop Loss Insurance - Definitions

Many employers (nearly all large employers) "self-fund" the healthcare benefits for their employees

But they limit their risk exposure by purchasing Employer Stop Loss Insurance

Specific Stop Loss – covers the risk that any one individual's claims exceed a given $$ threshold (the "Specific Deductible") in one year

Aggregate Stop Loss – covers the risk that total claims for the group exceed a given $$ threshold (the "Aggregate Attachment Point") in one year

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Market Breakdown – Potentially Defined in Agreement

- Some carriers specific to a market (not in all 50 states)
- Others may be exclusive to a product segment
  - Group size
  - Industry
    - Some may require collective bargaining
    - May exclude METs, MEWAs, Employee Leasing, 1099 Employees
  - Specific to groups moving from fully insured to self-funding (healthcare)
  - Product offering
  - Other
- Sample markets
  - Insurance carriers – Some carriers may front and use MGUs
    - Some may be reinsurers or retrocessionaires
  - Multiple Carriers partner with Multiple MGUs and Visa Versa
  - Managing general underwriters (MGUs)
    - Some may take risk through a captive
    - Some may be owned by insurance companies

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Risk Mitigation Strategies – Disclosure Statements

What information is requested on a typical disclosure statement?

- Individuals currently disabled or confined in a medical facility/hospital
- Individuals pre-certified for admission within the last three months
- Individuals that received medical services during the current plan year the cost of which exceeds the lesser of 50% of the lowest Specific Retention Amount applied for or $50,000, and for which bills have been received and processed by the by the Claims Administrator (TPA) and entered into their Claims System
- Individuals that have been identified as a candidate for Case Management and as having the potential to exceed during the policy period the lesser of 50% of the lowest Specific Retention Amount applied for, or $50,000
- Individuals that have been diagnosed during the current plan year with a condition represented by any of the ICD-9 codes contained in [an attached list] and have also received medical services costing $5,000 during the same period

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Risk Mitigation Strategies – Aggregating Specific Deductibles (ASDs)

Additional deductible or retention for self-funded employer – serves to reduce premium

Transfer of a layer of otherwise-covered specific stop loss claims risk back to the policyholder

No claims in excess of the specific stop loss deductible will be covered under the stop loss policy until the sum of those claims exceeds the aggregating specific deductible

Aggregating deductible traditionally a multiple of the specific stop loss deductible (e.g., 2, 3 or 4 times specific deductible)

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Risk Mitigation Strategies – Lasers

Additional deductible or retention for ceding company, *for specifically identified individual(s)*

- Functions as cost shifting exercise to reduce premium
- Lowers plan costs by increasing individual deductibles
- Underwriting tool to combat anti-selection, separating "known" versus "unknown" risk
- Traditionally used on new business, but becoming common on renewals as well

May be viewed negatively by some market participants

- "Singling out individuals is not insurance"
- The alternative might be reinsurers not quoting or rating up to cover this "known" risk
- Employer/policyholder may request quotes with lasers in order to reduce premium

Lasers may be placed separately or in combination

- Combination lasers may resemble ASDs or be contingent upon factors such as loss ratio

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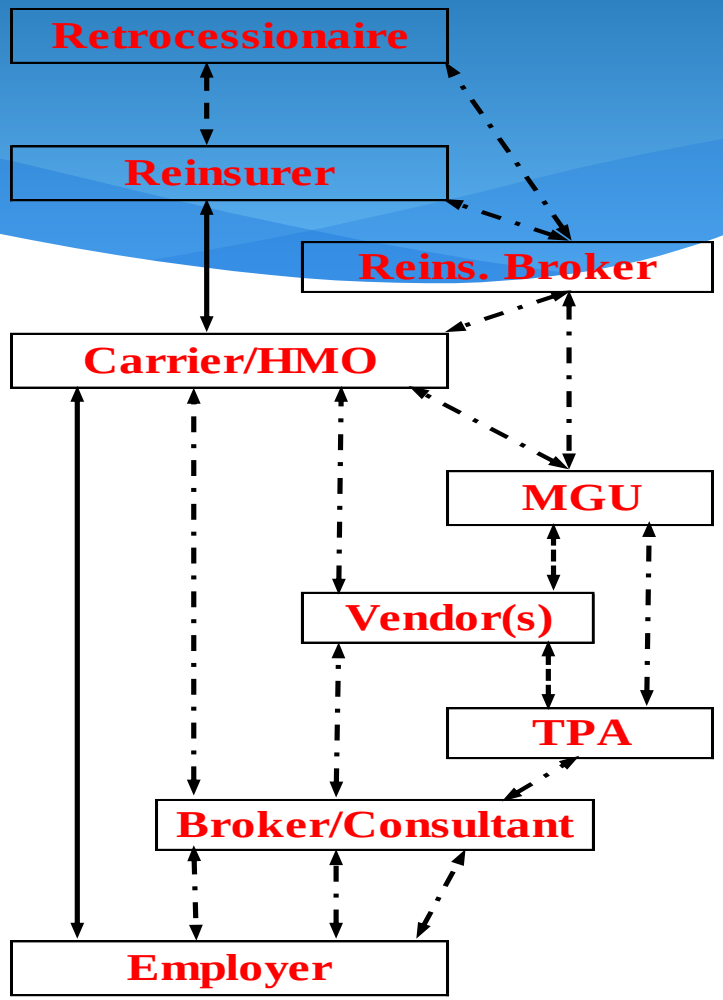
Stop Loss Claim Adjudication – "Food Chain"

- Each may be responsible to provide information in order for the employer to be reimbursed for a specific or aggregate claim
- Require proof of eligibility, covered services/plan summary, and copies of adjudicated claims and specific medical management pre-certifications
- May be multiple party signoffs (reinsurers/retrocessionaires) or "lead" reinsurer signoff
- By definition these are often complex, high-cost and catastrophic medical claims
- *Reinsurance Agreement: Required Data; Required Turnaround Times; Required Sign-offs*



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Loss Adjustment Expenses

- Third Party Fees
  - Network Access Fees (PPO Fees)
    - Fixed Dollar or Percentage of Claims saving to obtain an additional discount
  - Auditing Fees
  - Legal
  - Claim Adjusters
  - Investigator Expenses

***Note**: Reinsurance agreements may have limits/requirements for LAE or require reinsurer approval.*

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Claim Audits

- Eligibility Verification
  - Qualified Life Events
  - Terminations
  - Dependent Audits
- Claim Adjudication – Verification if any of the following:
  - Undiscounted claims paid in-network
  - Duplicate claims
  - Incorrect payment of loaded plan designs
  - Not processing of Coordination of Benefits (e.g., Medicare, Subrogation)
  - Fraud - - More involved steps needed to determine and confirm
  - Other
    - Handling of FMLA, Internal Signoff Procedures
    - Inconsistent practices for bundling/unbundling and coding
    - Issues with emerging treatments and technologies and experimental/investigation plan language

Note: The above issues have not changed over the years, but technology has to validate the above.

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Other Reinsurance Considerations

- Counsel and Concur: Reinsured company's obligation to obtain the counsel and concurrence of the reinsurer in making claims decisions.
  - Usually applies to claims decisions made in connection with extra contractual obligations or judgments (losses to be paid) in excess of policy limits coverages.
  - Ceding company might be required to make payments due to intentional or negligent conduct, so does a reinsurer required to follow this as well?
- "Follow the Fortunes" Provision: Reinsurer generally required to indemnify the ceding company for all claims paid in good faith and reasonably within the coverage provided under the reinsured policy and not to second guess the settlement decisions made by the ceding company.
  - Doesn't necessarily create coverage where no coverage would otherwise exist under the ceding company's policy
- Utmost Good Faith: Has this been fulfilled in the placement/underwriting of business and the submission of claims to a reinsurer?
- Ambiguities: How are ambiguities handled in the agreement?
- Representations: What was represented by ceding company, reinsurer and other parties?

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Self-Insured Plan Fiduciary Responsibilities

- Audit: Need to confirm TPA properly paying claims and eligibility
  - Eligibility: Confirm terminations are processed and processed timely
  - Claims:
    - Confirm payments not being done for ineligibles, duplications, monitored for COB/subrogation
    - Audit for application of discounts for in-network claims and even out of network costs
    - Pharmacy claims review (e.g., discounts/spread pricing, appropriate AWP, proper administration of brand vs. generic, copays/cost sharing, rebates)
    - Audit for Fraud
  - Determine that plan meeting fiduciary benchmarks for accuracy, including review of service guarantees
- Risk Management:
  - Ensure appropriate risk management (e.g., appropriate rate setting for budgets, reserves, COBRA administration, reinsurance review)
  - Ensure proper communication of benefits to employees
  - Ensure procedures in place to handle employee issues (e.g., denials, fraud, etc.)

Note: Fully insured plans will also need to consider many of the items above.

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Health Insurance - Cost Containment Initiatives

- Plan Design Changes
  - Encourage preventative care
- Tiered Contribution Schedules
  - Smoker/Non-Smoker Contribution Rates
- Tier Copays (Life Style Coverages)
- Prescription Drug Formularies
  - Other Changes: Step Therapy
- Cost shifting services to lower cost facilities and providers
- Biometric Measures
- Health Risk Assessments
- Healthcare Coaches
- Disease Management
- Medical Tourism
- Corporate Wellness (e.g., healthy steps program, knowledge transfer)
- Implementation of Patient-Centered Medical Homes (PCMHs)
  - Goals: Better Access, Increased Patient Satisfaction, Improve Health
- Telemedicine (e.g., General, Dermatology, Behavioral Health)
- Technology
  - Today: Online Information, Integrated Data, Phone Apps
  - Potential Future: Pricing Transparency, Claims Validation (Fraud Prevention) and Investigation

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Captive Domicile Locations

Top Ten Locations	
Domicile	2016
Bermuda	776
Cayman	711
Vermont	593
Utah	462
Delaware	385
Guernsey	321
Anguilla	287
Nevis	285
Barbados	246
Luxembourg	208

Sample Reasons for Formation:

- Reduce or stabilize costs
- Increase capacity and provide access to reinsurance
- Exert control and provide coverage
- Provide Freedom of rate and form
- Recapture Investment income.
- Take advantage of tax deductibility
- Take advantage of favorable regulations.
- Support strategic partners
- Make a profit

Note: Puerto Rico is now one of the fastest growing captive markets.

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Source: SOA LEARN Program

Captive Insurance Companies

- Additional Vehicles for Ceding Companies to Retain Risk
  - Stop Loss carriers may participate by either structuring a reinsurance agreement back to captive
    - Employers, MGUs and others may use captives as well to manage risk.
  - Captive might assume layer prior to stop loss carrier
    - Layer 1: Employer
    - Layer 2: Captive Insurance Company
    - Layer 3: Stop Loss Carrier (catastrophic layer)
    - *Stop Loss Carriers are exploring potentially switch layers 2 and 3.*

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Consumer Purchasing Considerations

- Price – Per Member Per Month (PMPM) basis
- Services Covered/Excluded
- Carrier Security (e.g., A.M. Best rating)
- Reputation
  - Handling of claims reimbursement
  - Renewal terms (e.g., rate increases, lasering, etc.)
- Quote Contingencies (e.g., pending reinsurance, etc.)

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Food Chain – TPA

Traditional TPA	ASO (UHC, Cigna, Aetna, BCBS)
• Contract with provider network (PPO) and employer group. • Direct relationship with self-funded employer group. • Receives administrative fee on a per EE basis or % of premium. • Pays claims and places stop loss reinsurance for fund. • Medical management services directly or through another vendor. • Provides reporting to fund, MGU, Carrier/Reinsurer.	• Contract with employer group. • Direct relationship with employer group or its broker/consultant. • Receives administrative fee on a per EE basis. • Provides stop loss directly to fund or shopped by broker/consultant. • Network management and claim payment. • Provides reporting to fund, MGU, Carrier/Reinsurer. • Have their own stop loss product.

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Aetna Signature Administrators (Twenty Administrators with Aetna's PPO Network)

Sample List is Subject to Vary Based on Timing

Allied Benefit Systems

AmeriBen

Assurant Health

Boon-Chapman

Chesterfield Resources, Inc. (Administrator for The Salvation Army)

Christian Brothers Services (Made available by Allied Benefit Systems)

CNIC Health Solutions, Inc.

Colonial Medical Insurance Company

Continental Benefits

Employee Benefit Management Services (EBMS)

Government Employees Health Association (GEHA)

HealthSCOPE Benefits

HealthSmart® Benefit Solutions, Inc.

INDECS

Nippon Life Benefits® (NLIA)

1199SEIU Funds

PreferredOne® Administrative Services, Inc.

Trustmark Companies (Trustmark, CoreSource, FMH CoreSource, NGS CoreSource, Starmark)

WebTPA

WellSpan Population Health Services

Source: https://www.aetnaeducation.com/ihtml/application/upload/8527.pdf

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Underwriting Considerations

Preferred vendors (special underwriting credit?)

- Brokers
- TPAs
- PPO Networks
- Disease management programs
- Wellness programs

Adequate pricing assumptions

- Starting claim cost
- Contract basis (12|15, Paid, etc.)
- Demographic adjustments
- Industry and geographical adjustments
- Leveraged trend?

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Underwriting Considerations (cont.)

Appropriate reserving methodologies	• Chain ladder method (development/completion factors) • Bornhuetter Ferguson method – combines results from chain ladder method with expected claim loss ratios.
Appropriate claim frequency & severity distributions	• Has the frequency of claims at different claim intervals changed? • Has the severity or intensity of these claims changed?
Preferred networks (special underwriting credit?)	• Strength of geographical discounts • Adequate access to network providers • Tertiary networks or "Centers of Excellence"

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Leveraged Trend – Example

- Year 1

  Ground-up claim = $100,000
  Specific deductible = $50,000
  Claim in excess of deductible = $50,000
  1st dollar trend = 13.5%

- Year 2

  Ground-up claim = $113,500 ($100,000 * 1.135)
  Specific deductible = $50,000
  Claim in excess of deductible = $63,500

Trend on excess portion of claim = 27% ($63,500 / $50,000 – 1)

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Product Filings through SERFF

System for Electronic Rate and Form Filing

- Introduced by NAIC for 2001 filings with 3,694 filings in the first year.
- Purpose to provide a cost-effective method for facilitating the submission, review and approval of product filings between regulators and insurance companies.
- Through 2015, there were 637,717 rate filings used SERFF

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How are providers reimbursed?

- Physicians
  - Resource-based relative value scale (RBRVS) Fee Schedule
  - Procedure Code: CPT (Current Procedural Terminology) code or HCPCS (Health Care Common Procedure Coding System)
  - Capitation
- Hospitals
  - Inpatient: Diagnostic Related Groups (DRGs) or Per Diems
  - Outpatient: ASC (Ambulatory Surgical Codes)
- Other Reimbursement Arrangements
  - Discount Fee for Service
  - Withholds & Bonus Pools
  - Capitation & "Shadow" Capitation
  - Prescriptions:
    - Spread pricing, including classifications of brand vs. generic
    - % of Average Wholesale Price (AWP)
    - Rebates
    - Dispensing fees

Risk Adjustment - NYSDFS Announcement in 2016

- 9/9/16: The new regulation provides NYSDFS authority to create a market stabilization pool for the small group health insurance market for the 2017 plan year. The new regulation follows a June 28, 2016 letter to Health and Human Services Secretary Sylvia Burwell in which Superintendent Vullo expressed concern that the CMS risk adjustment program has created inappropriately disparate impacts and unintended consequences among health insurers in New York.
- The highly complex risk adjustment program is intended to result in financial transfers among insurers to account for the health of the insured populations.
  - The transfers are supposed to even out the claims experience of insurers so that insurers with relatively less healthy members can compete with those with relatively healthier members.
  - Under the new regulation, after CMS makes its 2017 risk adjustment program calculations, DFS will determine if the CMS calculations will have an adverse impact on New York's small group health insurance marketplace.
- In New York State, Oxford Health Insurance, which is part of UnitedHealthCare and controls roughly 70 percent of the small group market, is set to receive $315 million from the program. CareConnect, the insurance arm of Northwell Health, owes $13 million, roughly 30 percent of its revenue, according to company CEO Alan Murray. In effect, the risk adjustment program is forcing CareConnect, a new, small insurer, to subsidize one of the state's most stable players.
- These new emergency regulations allow Vullo to decide if a payment is too big and will have an "adverse impact" on the health of the market. If it does, the regulations require insurers who benefited from the risk adjustment program to pay into a fund that will be administered by the DFS. That money will then be transferred back to the insurers who paid into the program. The DFS is giving itself the authority to undo the program and just move a chunk of the money back.
- The amount paid into this new pool cannot exceed 30 percent of the total amount an insurer received from the federal program.
- Details are highlighted in the link below.
  - http://www.politico.com/states/new-york/albany/story/2016/09/cuomo-administration-moves-to-protect-smaller-insurers-from-federal-risk-adjustment-program-105338

Ten Common Healthcare Provider Fraud Schemes (Association of Certified Fraud Examiners, 2013)

- Billing for services not rendered.
- Billing for a non-covered service as a covered service.
- Misrepresenting dates of service.
- Misrepresenting locations of service.
- Misrepresenting provider of service.
- Waiving of deductibles and/or co-payments.
- Incorrect reporting of diagnoses or procedures (includes unbundling).
- Overutilization of services.
- Corruption (kickbacks and bribery).
- False or unnecessary issuance of prescription drugs.

Source: www.acfe.com

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Survey Discussion -You be the "Judge" on Fraud (Samples)

- Primary Care Visits (e.g., code 992XX) billed at higher intensive and expensive code than the service actually provided
- Specialty Services billed additional services
  - Pulmonary: Code 94060-Respiratory Test Measuring Air Speed w Medicine
  - Cardiology: Stress test with additional physician office charge
  - ENT: Code 31231-Diagnostic Exam of Nasal Passages Using a Scope
- Hospitalization:
  - Sample Procedures with Billing Abuses: Infusion, Implantable Supplies, Rehabilitation (PT/OT)
- Durable Medical Equipment: Is equipment being used? Medically necessary? Kickbacks to Providers?
- Home Care: Providing services to individuals that don't meet the requirements to get care.
- Lab and Blood Work
  - Bills greater than $2,000 that are considered paid in full for less than $50.
  - Potential impacts of Stark Act (e.g., physicians referring to labs that they have ownership in).

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False Claims Act

- Referred to as the "Lincoln" Law (1863)
- Criteria
  - Services not rendered;
  - Services performed on non-existing or phantom patients;
  - Upcoding: Procedures more expensive than those actually performed ("up-coding" or "code creep");
  - Unbundling: Itemizing billing services that should be bundled (e.g., Medicare);
  - Non-medically necessary services being performed;
- Individuals can be prosecuted for violating this (e.g., Department of Justice, State Government)
- "Qui Tam" Action:
  - Private individuals known as "relators" could pursue this remedy through a "qui tam" action
  - "Whistleblowers" are also entitled to financial remedy

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Other Laws Regarding Fraud

- 1872 (Approximately): Mail Fraud Laws
- 1914 (and Updated 1938): The Federal Trade Commission Act to prohibit unfair/deceptive acts and practices in commerce.
- 1970: Racketeer Influenced and Corrupt Organizations (RICO) Act of the Organized Crime Control Act
- 1995: Stark Act prohibited physicians from referring Medicare/Medicaid patients to providers (initially labs) that the physician owned or had a family member.
- *Should the False Claims Act applies to all members of all plans?*

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How does the Law and Insurance Apply?

- "Account Stated"
  - When a provider sends a bill, you are obligated to object in writing within a reasonable time if you are to dispute or believe in error (e.g., 30 days).
  - When a provider defers you to an insurance company then is the provider waiving their rights to enforce this requirement?
  - It is not consistent with the appeals process for medical plans (fully insured or self-funded).
- Sample Fully Insured Claim Denial Language
  - "If you do not agree with the final decision, you have the right to bring civil action under Section 502(a) of ERISA within two years of the decision."
    - Does this mean federal laws trump state laws for insurance disputes?

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Increases in Large (Jumbo) Claims in Healthcare

- Tokio Marine HCC – Stop Loss Group (TMHCC), a leading provider of medical stop loss insurance, continues to see the number of claims in excess of $1M rise at an unprecedented rate.
- 9.9% growth rate of employee lives.
- 28.3% average annual growth rate of claimants in excess of $1M.
- 2018 data by Primary Diagnosis
  - Perinatal/Neonatal claims represent 20.7% of all claims and 22.2% of the claim spend on $1M or higher claims.
  - Malignant Neoplasms/Cancers also represent 20.7% of all $1M or higher claims and 20.1% of the claims spend.
  - Injury/Poisoning/External Causes, which includes Burns and Trauma, represents 12.6% of the number of claims and 11.0% of the claim spend.

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Source: Tokio Marine HCC announcement 4/30/19

NY: Protection from Surprise Bills and Emergency Services (Effective March 31, 2015)

- Protects consumers from surprise bills when services are performed by a non-participating (out-of-network) doctor at a participating hospital or ambulatory surgical center in your HMO or insurer's network or when a participating doctor refers an insured to a non-participating provider.
- The new law also protects all consumers from bills for emergency services.
- Hold Harmless Protections for Insured Patients - Do not have to pay non-participating provider charges for emergency services (typically for services in a hospital emergency room) that are more than your in-network copayment, coinsurance or deductible.
- Disputes between providers and health plans over the fee charged for medical services will go through an independent review process.
- Law only addresses out of network claims, not excessive or fraudulent in-network claims.
  - In-network claims will be a bigger issue with higher deductibles and member coinsurance cost sharing.
    - In general, more claims in-network rather than out-of-network
  - Bill does not protect patient from being sued, nor requires a healthcare provider to notify the patient of the lawsuit.

Visit link - https://www.dfs.ny.gov/consumer/hprotection.htm

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Excessive Healthcare Provider Bills in the News (5 Examples)

- Sample #1: A Texas hospital that charged a teacher $108,951 for care after a 2017 heart attack told the patient Thursday it would slash the bill to $332.29. This is after insurance paid the hospital nearly $56,000 for his four-day hospitalization and the procedures to clear his blocked artery. (Source: National Public Radio, 2018)
- Sample #2: Oklahoma patient gets bill for $15,076 for 4 Tiny Screws. Total bill was $115,527 for a three-day hospital stay, including $15,076 for four tiny screws. (National Public Radio, 2018)
- Sample #3: Individual has three-hour neck surgery in New York City for herniated disks and received significant bills from $56,000 from hospital, $4,300 from the anesthesiologist and $133,000 from his orthopedist. Individual then receives $117,000 from an "assistant surgeon" that individual never met. (Source: NYTimes, 2014)
- Sample #4: NY Post highlighting a $1 billion scam with one patient highlighted in the article receiving more than $1.2 million in hospital bills, including out of network claims and balance billing. (Source: NY Post, 2018)
- Sample #5: New York City hospital (NYU-Langone) bills patient and insurance company more than $138,000 combined for routine two hour hip surgery and one day length of stay. More than half the charges are for implantable devices. (Source: Propublica, National Public Radio and Wall Street Journal, 2018)

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Note: There are too many to list in this presentation

Sample #5: Large Claim for Discussion (December 2015)

- Patient had one night hospital stay for partial hip replacement (resurfacing) at NYU-Langone
  - Admit Day: Friday, December 11, 2015
  - Discharge Day: Saturday, December 12, 2015
  - Billed Charges: $138,000+; Approved Charges: $76,000+
- All services were billed as in-network and services were pre-authorized.
  - Patient Coverage: $4,000 deductible, 10% coinsurance, $12,000 out of pocket limit.
- Patient disputed bills with hospital and insurance company for multiple reasons:
  - Specific services identified as not provided;
  - Specific services identified upcoded;
  - Bill had visible errors (e.g., services listed had names of other patients on it, bills had incorrect services coded, etc.);
  - Bills were not transparent (e.g., no units, etc.) and appeared very excessive.

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Sample#5 In-Network Bill – Partial Hip Replacement (Resurfacing) for One Day Hospital Stay in December 2015

NYU Billed Amounts for One Day Length of Stay (December 2015):

	NYU Service Category	NYU Langone Reported Units	NYU-Langone Billed Charges
1	0121-MED-SURG-GY/2 BED	1	$ 4,564.00
2	0270-MED-SUR SUPPLIES	2	$ 300.61
3	0272-STERILE SUPPLY	1	$ 185.37
4	0278-SUPPLY/IMPLANTS	11	$ 70,456.48
5	0279-SUPPLY/OTHER	15	$ 6,789.92
6	0301-LAB/CHEMISTRY	1	$ 106.00
7	0305-LAB/HEMATOLOGY	1	$ 97.00
8	0320-DX X-RAY	1	$ 288.42
9	0360-OR SERVICES	1	$ 21,890.00
10	0370-ANESTHESIA	170	$ 1,024.85
11	0420-PHYSICAL THERP	4	$ 1,118.00
12	0424-PHYS THERP/EVAL	1	$ 734.00
13	0434-OCCUP THERP/EVAL	1	$ 785.00
14	0636-DRUGS DETAIL CODE	395	$ 5,574.27
15	0710-RECOVERY ROOM	1	$ 3,506.94
16	Private Duty Room	Not Available	$ 390.00
17	Surgeon (NYU Employee)	Not Available	$ 17,500.00
18	Anesthesiology (NYU Employee)	Not Available	$ 3,200.00
19	Lab (NYU Lab)	Not Available	$ 245.00
20	**GRAND TOTAL**	**606**	**$ 138,755.86**

Aetna Adjudicated Claims and Calculation of Member Cost in 2016:

Aetna Paid Claims	Patient Billed Amount (Cost)	NYU-Langone Approved Payment
$ 33,944.01	$ 3,771.56	$ 37,715.57
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
$ 25,721.41	$ 2,857.93	$ 28,579.34
$ 2,478.78	$ 275.42	$ 2,754.20
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
$ 1,649.99	$ 183.33	$ 1,833.32
Part of Case Rate	Part of Case Rate	Part of Case Rate
$ -	$ 390.00	$ 390.00
$ 2,305.84	$ 256.21	$ 2,562.05
$ 1,930.50	$ 214.50	$ 2,145.00
$ -	$ 122.50	$ 122.50
$ 68,030.53	**$ 8,071.45**	**$ 76,101.98**

Aetna Approved Payment Amount as a % of Billed Charges ==>	54.8%
Aetna % Discount off of Billed Charges ==>	45.2%

Note: Reflects services provided on afternoon of 12/11/15 to morning of 12/12/15. Excludes pre-op and DME expenses plus invoices of other patients.

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Sample #5 (Continued) - Implantable Device Cost for Dec 2015 Hip Surgery

Line No.	Description	1 Implantable Device Units	2 NYU-Langone Billed Charges	3 Aetna Approved Cost as Implantable Device at $2,600 per Device Rate	4 Member Cost Share @ 10%	5 Aetna Cost
1	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
2	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
3	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
4	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
5	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
6	MIXER CEMENT BONE EVAC III	1	$ 531.66	$ 2,600.00	$ 260.00	$ 2,340.00
7	DRILL BIT QC STER 3.2*145MM	1	$ 874.20	$ 2,600.00	$ 260.00	$ 2,340.00
8	CEMENT BONE SIMPLEX RADIOPAQUE	1	$ 957.30	$ 2,600.00	$ 260.00	$ 2,340.00
9	TISSEL FROZEN 10 ML	1	$ 4,290.82	$ 2,600.00	$ 260.00	$ 2,340.00
10	*IMPACTOR BHR 54MM	1	$ 28,697.45	$ 2,600.00	$ 260.00	$ 2,340.00
11	*HEAD BHR 48 MM	1	$ 34,235.55	$ 2,600.00	$ 260.00	$ 2,340.00
12	Subtotal	11	$ 70,456.48	$ 28,600.00	$ 2,860.00	$ 25,740.00
13	Aetna Explanation of Benefits Calculated Discount 1 - [Column (4), Line (12)] / [Column (3), Line (12)]			**59.4%** off billed charges		
14	Ratio of Total to Amount Paid by NYU (12) / $1,500		4697%	1907%	191%	1716%

**Note: Per NYU Langone staff and the manufacturer, lines 10 and 11 cost NYU less than $1,500 combined and NYU received rebates for the device.*

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Top 10 Medical Device Technologies Market worth above $400 Billion by 2020 (Source: MarketsandMarkets, November 15, 2018)

- The global top 10 medical device technologies market is fragmented in nature. Prominent players in this market include:
  - Johnson & Johnson (U.S.),
  - GE Healthcare (U.K.),
  - Siemens Healthcare (Germany),
  - Medtronic (U.S.),
  - Philips Healthcare (Netherlands),
  - Roche Diagnostics (Switzerland),
  - Abbott Laboratories Inc. (U.S.),
  - Smith & Nephew plc (U.K.),
  - Stryker Corporation (U.S.),
  - Boston Scientific Corporation (U.S.).
- The growth in the top 10 medical devices industry is mainly driven by the rising prevalence of chronic lifestyle diseases like cardiovascular, diabetes, hypertension, cancer, and respiratory problems.
- Similarly, the rising acceptance of newer technologies by physicians & hospitals and growing geriatric population are also driving the overall growth of the top 10 medical devices market.
- However, factors such as uncertainty in reimbursement and the imposition of the medical device excise tax in the U.S. are restraining the growth of this market.

Outside Data Sources (Healthcare Blue Book & Fair Health)

- Sample #6 - Wall Street Journal (7/13/18): Another NYU-Langone hospital patient came forward and writes article on his own large claims
  - Patient received billed charges of $175,000 and $180,000 for similar hip surgeries in the beginning and end of 2016.
  - The insurer reimbursed $75,000 and $77,000, respectively for those two claims.
  - Sample #6 patient also discusses experiences of Sample #5 patient.
- Fair Health (https://www.fairhealthconsumer.org/) estimated costs at less than $30,000 for in-network and less than $73,000 for out of network. The above claims were all in-network.
  - Fair Health was formed in 2009 by the New York Attorney General to provide consumers with pricing information for all types of services.
  - Impacted by reporting of market data so will include fraud in the experience
  - Evolved from complaints and litigations around out-of-network claims cost
- Other sample cost information resources are:
  - Healthcare Blue Book (https://www.healthcarebluebook.com/)
    - Will also include market data and impacted by fraud (increase fraud will increase these costs)
  - Medicare

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Medicare is not "immune" to abuse

Sample #7

- 2018: Medicare patient in Florida has bypass surgery with medical bills in excess of $512,000 for hospital stay of 12 days.
  - Out of pocket cost was approximately $300.00.
  - American tax payers paid the rest.
- Bill was easy to read, since only two line items, but not transparent.
  - First line was $44,525.02 for room and board
  - Second one was $468,303.93 for ancillary charges
  - No other details (e.g., summary of services, units, cost for item)
  - The above costs does not include all the rehabiliation costs or other eldercare expenses.

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Improper Medicare Payments Hit Lowest Level in Nearly a Decade (Source: Modern Healthcare 11/16/18)

- More targeted enforcement actions by CMS has led to the lowest improper payment rate for Medicare in nearly a decade, according to new federal data.
- The CMS doled out an estimated $31 billion in improper payments in fiscal 2018, which is around 8.12% of all claims paid during that period, according to a report issued Friday. That's down from $36.2 billion or 9.51% of Medicare claims in fiscal 2017.
- Improper payments include fraudulent claims, payments distributed to the wrong recipient or for the wrong amount, payments with insufficient documentation, and those when the recipient uses the funds improperly.
- The CMS calculations include all claims incorrectly paid between July 1, 2016, and June 30, 2017. This is the lowest rate of improper payments for Medicare fee-for-service since 2010 and the second time since 2013 that the rate fell below 10%.

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Who is one of the Most Famous Large Claimants? Steve Austin – Six Million Dollar Man (Source: Wikipedia, November 30, 2018)

Sample #8

- Original TV Series: Aired 1974 to 1978
- When NASA astronaut Colonel Steve Austin is severely injured in the crash of an experimental lifting body aircraft, he is "rebuilt" in an operation that costs $6 million (equivalent to $33 million in 2017).
- What was repaired?
  - Right arm
  - Both legs
  - Left eye
- Did the costs include PT/OT, pharmacy/infusion, DME, long term rehab?
- Were the services pre-authorized?
- Was Colonel Austin balance-billed?

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Emerging Trends with Hospitals & Large Physician Healthcare Practices

- Growth in Mergers & Acquisitions
  - Acquisitions of Hospitals and Healthcare Providers
  - Some government organizations subsidized transactions (ultimately higher taxes) for large healthcare providers to acquire smaller or non-performing ones.
  - Many transactions subsidized through fee schedule changes (ultimately higher member cost sharing with provider and higher insurance premium rates)
- Changes in Risk Management Practices
  - Hospitals have increase in accounts payable and collections staff to address higher deductible plans.
  - Organizations are getting larger so assuming more risk and retaining higher percentage of risk per patient.
  - Customer satisfaction surveys

Laws Pertaining to Hospital Transparency

- Hospitals to provide access to charge masters
- Need for additional requirements
  - Consumers Need Access to Contracts Between Hospitals and Payers - Reimbursements are not based on master charges or billed services (well usually not), but instead based on the contract arrangement between the hospital and the health plan (and/or TPA and/or PPO)
  - Access to Number of Units and Frequency - Without knowing what units (frequency) was billed, a consumer will not know what services provided, how much provided and at what intensity level. EOBs should include these items.
  - Provide consumers a "base case" estimation, since the data exists on what items should cost.
  - Change the permissible loss ratio to include administrative expenses to combat fraud as part of the state minimum loss ratio.
  - Create an independent advocacy group that will actually review and re-adjudicate claims for a consumer.

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What Should Employers Do?

- Update Plan Documents to Focus on "Advocacy" for its employees and their covered dependents
  - Also include separate communications on Advocacy
  - Guidance for disputes in-network vs. out-of-network
  - Cost Estimates Prior to Procedures – Who to contact for estimates prior to healthcare delivery
  - The employer has more leverage than a covered member to require appropriate actions.
- Claim Audits
  - This should include electronic audits of all claims and claim fields, plus access to provider contracts
  - Develop process to recover claims for pre-payment and post-payment audits
  - Self-Funded Plans: Use of "Prudent Person" rules under ERISA
- Survey Employees about claims issues
- Potential Plan Changes (May impact "collective bargaining" agreements)
  - Removal of copays so consumers know the "true cost" of care.
  - Potential changes in PPO arrangements (e.g., potential exclusions of costly facilities)
- Require more complete Explanation of Benefits (EOBs)
  - Information to be more clear to patient
    - Require insurance company or TPA to put units (utilization) on EOB so the document "explains" what happened.
  - Require patient to confirm accuracy of bills
  - Report Discount Rates but not against billed charges, but an industry benchmark
    - Paid/Approved Costs as a % of Medicare
  - Require EOBs for pharmacy (e.g., brand/generic, % discounts off AWP, rebates, spread pricing)

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Recent Actions by Large Employers

- Medical Tourism: Walmart requires its employees to use certain hospitals for costly spine surgeries, an effort to weed out unnecessary procedures and lower its health-care spending. (Wall Street Journal – November 2018)
- Google hires CEO of Geisinger (HMO) to run health benefits
- Berkshire Hathaway, Chase and Amazon team up to manage healthcare benefits
- Retiree Benefits – Private sector has mostly eliminated obligations for retiree benefits despite the government incentives offered under Obamacare.
  - Will rising healthcare costs result in material changes in retiree benefit offerings?
  - US National Debt is in the "trillions" and does not reflect retiree medical benefit obligations, so actual debt is much higher.
  - Will public sector make more changes (e.g., benefit reductions) with implementation of GASB75 even in collective bargaining environments?
    - How will municipalities manage the increase in liabilities recognized for financial statements for retiree medical benefits?

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Committee for a Responsible Federal Budget (crfb.org)

- Experts from the Brookings Institution and the American Enterprise Institute have released a joint list of recommendations
  - Limit the exclusion for employer-provided insurance
  - Increase resources for antitrust enforcement
  - Allow states to create claims databases
  - Encourage repeal of state laws prohibiting insurance networks
  - Encourage repeal of state laws regulating hospital expansions
  - Protect patients from surprise physician billing
  - Expand site-neutral outpatient payments
  - Re-balance Medicare physician fees toward patient visits
  - Reform Medicare cost-sharing and Medigap policies
  - Increase flexibility for Part D "protected classes"
  - Reduce Part D reinsurance payments to insurers
  - Reform Part B drug payments
  - Encourage the use of generic drugs in Part D
  - Mandate bundled payments where they've been tested
  - Provide a comprehensive Medicare plan comparison tool
  - Enact the CREATES Act to boost generic drugs
  - Restrict the orphan drug designation
  - Tie the 340B program to patients rather than facilities

Other Websites to Know!

- Self-Insurance Institute of America (www.SIIA.org)
- Kaiser Family Foundation (www.kff.org)
- MyHealthGuide (www.myhealthguide.com)
- Fair Health (www.fairhealthconsumer.org)
- Healthcare Blue Book (www.healthcarebluebook.com)
- Centers for Medicare & Medicaid Services (www.cms.gov)
- Society of Actuaries Reinsurance Section (www.soa.org/sections/reinsurance)

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Questions - Thank You

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