From: Robert Sudler
To: Naegele, Ernie N.
Subject: FW: Operators
Date: Wednesday, July 24, 2019 7:23:45 PM

Hey Ernie:

Per your request, please see the following details on the reporting for International Union of Operating Engineers Local 487. Number of outpatient surgeries, average length of hospital stays/total days and members/dependents reaching the out of pocket max of $2,500 are key indicators of higher claims. However all categories are higher than the norm except Virtual visits.

1. Inpatient hospital days.
    - 70 total admissions
    - 396 total days
    - $36,313 paid per admission
    - Top 5 Primary Conditions
        - Trauma
        - Congestive Heart Failure
        - Coronary Artery Disease
        - Asthma
        - Diabetes

2. Average length of stay per Hospital stay.
    5.7 days for average length of stay

3. Outpatient visits with cost and diagnosis for each claimant.
    - ER Visits: 348
    - Urgent Care: 387
    - Virtual Visits: 18
    - Surgeries: 154

4. Pcp number of visits and diagnosis for each claimant.
    - Primary Care Physician: 1,893
    - Top 5 Primary Conditions by PCP Visits
        - Asthma
        - Behavorial/Chemical Depression
        - Benign Neoplasm
        - Burns
        - Cancer

5. Specialist number is visits and diagnosis for each claimant.
    - Specialist Physician: 2,036
    - Top 5 Primary Conditions by Specialist Visits
        - Asthma
        - Behavorial/Chemical Depression
        - Benign Neoplasm

- Burns
- Cancer

6. Members (including dependents) reaching Max Out of Pocket of $2,500: 85

Please let me know if this helps.
Thanks,
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July 18, 2019

Bill to Repeal the Affordable Care Act's Excise Tax on High-Cost Plans Passes House

A House bill (HR 748) to permanently repeal the Affordable Care Act's 40 percent excise tax on high-cost health plans, often referred to as the "Cadillac tax," passed the House of Representatives by a vote of 419-6 on July 17, 2019. A similar bill in the Senate (S 684) has 42 bipartisan sponsors but is not scheduled for further action at this time.

Brief Background

The 40 percent excise tax was initially scheduled to take effect in 2018. The effective date was delayed twice. The most recent delay, to January 1, 2022, was part of a Continuing Resolution to fund the federal government in 2018 (Public Law 115-120).

In May 2019, the Congressional Budget Office (CBO) and Joint Committee on Taxation projected (https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf) that revenue from the tax would total $193 billion for the 10-year period from 2020 through 2029. Many plan sponsors argue that the CBO's potential revenue impact is flawed, because the projection assumes an increase in taxable wages as a result of employers cutting health benefits and transferring employee benefits to a wage package. Nevertheless, the large budget impact projection makes permanent repeal of the excise tax a difficult hurdle, particularly in the Senate, where Senators of both parties have expressed concern about repealing the excise tax without a revenue offset.

The excise tax will be imposed on the value of employer-sponsored health plans that exceed certain high thresholds. The CBO estimates that the thresholds would be $11,200 for individual coverage and $30,100 for family coverage in 2022. The impact of the excise tax on employer-sponsored plans will be significant. A Kaiser Family Foundation study released in July 2019 (https://www.kff.org/private-insurance/issue-brief/how-many-employers-could-be-affected-by-the-high-cost-plan-tax/) found that in 2022, 21 percent of employers offering health benefits will have at least one plan whose cost would exceed the individual threshold.When health Flexible Spending Account (FSA) contributions are included, the percentage climbs to 31 percent. The percentage of employers with a plan reaching the threshold grows rapidly over time, to 37 percent in 2030, and 46 percent if FSA contributions are included. If not repealed, plan sponsors may raise already increasing deductibles and coinsurance or employee contributions to premiums in order to offset the cost of the tax.

Implications for Plan Sponsors

In addition to watching for the delay or repeal of the excise tax, sponsors of insured plans should continue to monitor any congressional action related to a delay in the imposition of the health insurance premium tax. The health insurance premium tax, also part of the Affordable Care Act, imposes a tax on insured plans based on the book of business of the particular insurer and the amount necessary to be raised from all insured plans in the aggregate. While the tax was suspended for 2019 through the Continuing Resolution, it is slated to take effect in 2020. The health insurance premium tax generally adds 2 percent or more to the cost of an insured health plan. If the tax is not suspended, sponsors of insured health plans will see these fees again for 2020. Insurers are expected to be currently filing 2020 rates based on the assumption that the tax will take effect.

Plan sponsors should expect continued activity concerning these Affordable Care Act taxes in the next few months, and may see delay or repeal of the excise tax later this year as Congress continues its budget and appropriations process.

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Trends News for Multiemployer Health Plans

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Third Quarter 2019

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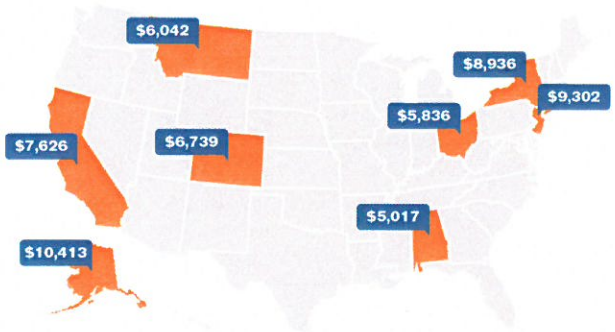
Key Statistics

Cost of Childbirth Varies among States | According to data from Fair Health, a nonprofit organization, there is wide price variability for childbirth among states. The average cost for vaginal birth ranges from $5,017 (Alabama) to $10,413 (Alaska). Medical price variations could be a result of the cost of attracting doctors to work in rural hospitals, regulatory differences among states and market distortions caused by the presence of a large health care system (an area with a large health care system tends to have higher prices).

Average Price for Vaginal Delivery by State



Source: Rebala, Pratheek. "Find Out How Much it Costs to Give Birth in Every State." *Money* Magazine. October 17, 2017

High-Dollar Medical Claims | The increasing severity of high-dollar ("shock") medical claims continues to place an outsize burden on plan sponsors (see below). Stop-loss insurance helps reduce the impact of unanticipated catastrophic claims and makes costs predictable, especially for smaller groups or groups with modest cost reserves.

*Zolgensma® is an FDA-approved therapy (one time-treatment) for treating spinal muscular atrophy.

What Plan Sponsors Are Doing to Manage Plans: Selected Strategies

Bundled Payment Model for Maternity Care | According to the Centers for Disease Control and Prevention, the U.S. has the highest mortality rate for pregnancy-related deaths among developed countries. Three out of five pregnancy-related deaths are preventable. Pregnancy is also one of the most common reasons for hospitalization. Bundling of maternity-care services has the potential to improve quality and reduce costs for pregnancy and childbirth services. Under a bundled payment arrangement, a single negotiated payment is made to a provider for an episode of care. That gives providers an incentive to eliminate unnecessary services, improve coordination of care and achieve better outcomes. Vendors, such as Cigna, Humana and UnitedHealthcare, have already introduced this bundled option. Plan sponsors who are considering a bundled payment model need to review potential issues that may arise in plan design, network access, performance measures, communications and compliance.

Increase in Approved Gene Therapies | Gene therapy involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease or turning off genes that cause medical problems. The number of investigational new drug applications in cell and gene therapies have significantly increased over the past year. Gene therapy is a high-cost treatment and is considered a prescribed medical therapy (not a prescription drug). If plan sponsors are considering adding gene therapies to their health plan, they should review a number of factors including cost, the population that can benefit from them, the limited number of facilities approved to provide these therapies and the risks involved in the therapies themselves. If plan sponsors decide to add gene therapy, they should consider revising the precertification process, determining if care will need to be provided out-of-network, including travel benefits and adding a stop-loss insurance policy.

Average Cost of Emergency Room (ER) Visits Surge | According to the Health Care Cost Institute, the average cost of an ER visit increased 176 percent between 2008 to 2017. The report examined five successive Current Procedural Terminology codes for ER visits that were based on medical complexity. The average price for the higher-severity codes rose at a faster rate than the lower-severity codes. This resulted in increased out-of-pocket costs for patients despite little change to the overall number of ER visits. President Trump also addressed this issue recently calling upon Congress to take action on "surprise" medical bills sent to patients (including bills from out-of-network ERs). Plan sponsors should consider strategies such as direct contracting, using tiered or narrow networks, using reference-based pricing and implementing a stronger communications strategy (*e.g.,* communicating which hospitals are in- or out-of-network) as a way to help reduce costs for both participants and plan sponsor.

Compliance News

Final Rule Expanding Permitted Types of Health Reimbursement Arrangements (HRAs) | A final rule expanding the use of HRAs by employers and plan sponsors was released by the Departments of Labor, Health and Human Services, and Treasury. The new rule creates two new types of HRAs including an individual coverage HRA and an excepted benefit HRA.

Medicare Part D and Retiree Drug Subsidy (RDS) Increase Slightly | The Medicare Part D standard defined benefit will increase for 2020 (less than 5 percent for the deductible but 24 percent for the out-of-pocket threshold, which is sometimes called the true out-of-pocket cost or "TrOOP"). The RDS amounts that the Centers for Medicare & Medicaid Services pays to sponsors of group health plans that provide prescription drug coverage to Medicare-eligible retirees will also be higher in 2020. The cost threshold will increase almost 5 percent while the cost limit increase will be more than 5 percent.

Segal Consulting released a summary of Affordable Care Act dollar amounts and percentages (that are indexed to various measures of inflation or that change from year to year). An updated comparative chart was also released to help trustees of multiemployer health plans and fund administrators decide which individual account option is best for their plain.

For previous issues of *Trends* or other Segal publications, please visit Segal's website.

To discuss the implications for your plan, contact your Segal consultant or get in touch via our website: www.segalco.com/#Multiemployer