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A World of Risk Management and Insurance Expertise

Healthcare Update and Cost Containment Strategies

presented by

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Agenda

Affordable Care Act Update

Benefits Landscape

Prescription Drug Trends

Dependent Eligibility Verification

Questions

Affordable Care Act

ACA Recap Since January 20, 2017

January 20th – Inauguration Day – The New President Signed an Executive Order

Allows HHS and other agencies to waive, defer, grant exemptions from, or delay the implementation of:

- A cost, fee, tax, penalty or regulatory burden under the ACA, which would impact individuals, health insurers or purchasers of health insurance

Examples of Impact of the Executive Order:

- IRS would not reject an individual tax return for not certifying coverage on a Form 1040 when filing – essentially allowing them to not enforce the Individual Mandate
- It does not specifically mention employers – only “purchasers of health insurance”, possibly suggesting self-funded plans are not impacted at all
- Conveys the intent to repeal and replace the ACA
- Provides discretion to federal agencies to not enforce, or delay enforcement of ACA regulations
- A lesser known provision which sets a goal toward the sale of health insurance across state lines

Source: www.whitehouse.gov

The Executive Order Did Not Do the Following:

- Eliminate employers requirement to comply with ACA provisions that impact group health coverage, such as dependents to age 26, preventive services covered in full, elimination of annual and lifetime maximums on Essential Health Benefits
- Eliminate the “Pay or Play” penalty
- Eliminate reporting requirements – Forms 1095-C and 1094-C

Source: www.whitehouse.gov

What Followed the Executive Order?

In April, HHS issued final rules intended to stabilize the individual and small group markets:

- Created shorter enrollment periods, more closely resembling the length of time for group and Medicare open enrollment periods
- Reduce fraud and abuse by requiring better supporting documentation for special enrollment periods – this action should keep people enrolled all year, reduce gaps and eliminate the practice of enrolling in coverage only when coverage is need
- Promote continuous coverage – reduce adverse selection in market pools
- Adds more flexibility in products offered on exchanges – provides a range for actuarial value for Bronze, Silver, Gold and Platinum – Allows +/- 2% of range

Source: Centers for Medicare and Medicaid and National Association of Health Underwriters

The American Health Care Act (AHCA) – Its Path

- Originally scheduled to be voted on by the House on March 24th
- Bill was pulled due to not enough Republican votes to pass
- Modified to include compromises to satisfy the Freedom Caucus – Conservative wing of the Republican Party
- Republicans seeking to pass it with a simple majority in the Senate – 51 votes needed under Budget Reconciliation Rules
- Budget Reconciliation Rules allows the Senate to pass with 51 votes as long as the bill includes budgetary changes only – no other substantive changes
- On May 4th, the AHCA passed the House of Representatives by one vote needed – 217 to 213 (216 were needed to pass)

Impact of AHCA on the ACA – Summary of Changes

- Individual Mandate penalty reduced to \$0 retroactively to 1/1/16 – does not eliminate the mandate but gets you to the same place
- Employer Mandate penalty reduced to \$0 retroactively to 1/1/17 – again does not eliminate provision but has the same impact
- Repeal most taxes including the 3.8% tax on investment income over a certain amount, .09% Medicare tax for high wage earners, insurance carriers' premium tax
- Does not repeal the Cadillac Tax – delayed until 2026 – but another Executive Order signed by Trump prevents any new regulations from being written. Regulations on Cadillac Tax had not been written, so while not repealed it is essentially frozen
- Remove the limits on FSA contributions
- Increases HSA contribution limits and reduce the penalty for non-qualified distributions
- Allows states to charge older individuals more on the individual market (5:1 ratio vs 3:1 under the ACA)
- Replaces income based Premium Tax Credits with aged based tax credits
- **Tax credits unavailable if employee is eligible for employer or government coverage**

ACA Provisions Not Impacted by the AHCA

Does not eliminate the prohibition of enforcing waiting periods for pre-existing conditions, however:

- It imposes a 30% premium penalty for 1 year, for failure to maintain continuous coverage (no more than a 63 day break in coverage)
- States may apply for a waiver allowing them take health status into consideration – basically navigates around the pre-existing clause
- States must offer assistance in those instances

Does not eliminate the reporting requirements for employers however,

- By reducing the Employer Mandate penalties to \$0, the IRS could reduce or simplify reporting if no penalties are imposed

Does not eliminate “Essential Health Benefits” (EHB) however,

- Allows states to set their own specific definition of EHB, possibly leading to more skinny plans

What is Ahead for Employers?

If premium tax credits are not available to an employee **eligible** for group or government programs then:

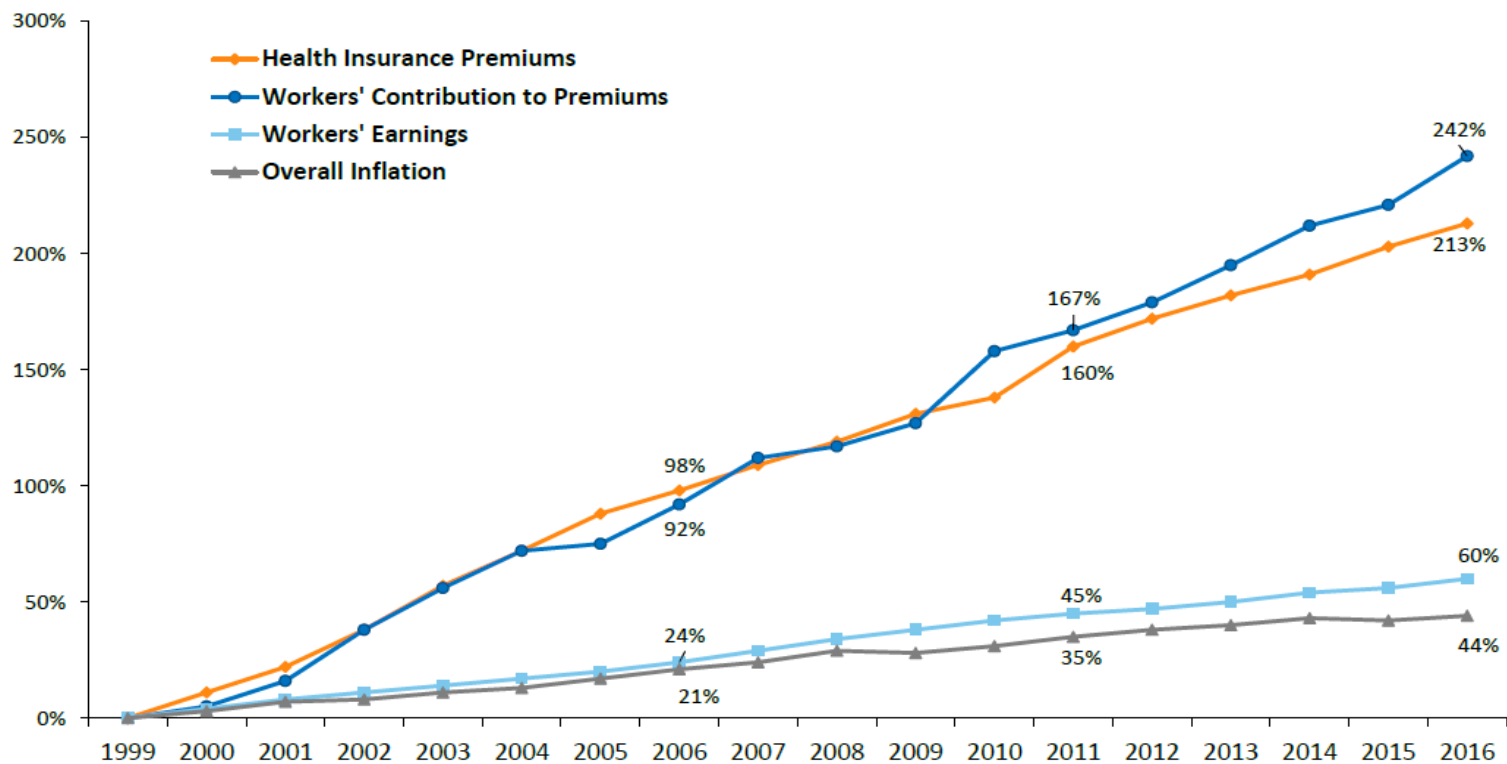
- Affordability test for contributions could be eliminated
- Employer 1095-C and 1094-C reporting would likely be simplified – would need to show employee is eligible for coverage in some fashion
- Discussion taking place to integrate that on to Form W-2
- Modify list of preventive benefits that would eliminate the need to cover contraception in full without religious exemption
- Senate Majority Leader, Mitch McConnell, pushing for a vote on a bill no later than July 4th
- Areas of greatest concern for the Senate: How to structure premium tax credits (age or income), Medicaid expansion or block grants, state waivers for pre-existing conditions in individual market

Benefits Landscape and Prescription Drug Trends

Landscape

Health Insurance Costs

Cumulative Increases in Health Insurance Premiums, Employee Contributions to Premiums, Inflation and Employee Earnings (1999-2016)



Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2016

Landscape

What is Driving U.S. Healthcare Costs?

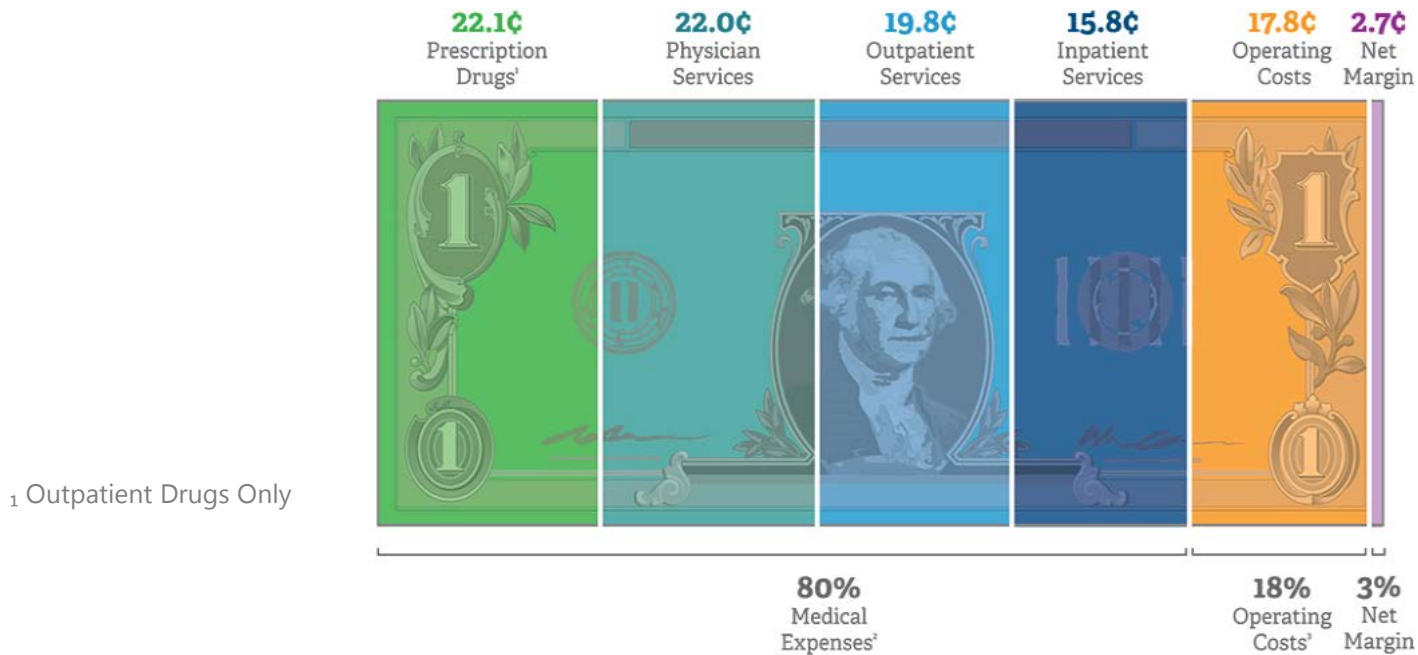
Clinical management: Seven factors driving U.S. health care costs

1	2	3	4	5	6	7
Increased Utilization	Aging Population	Biologics and New Technologies	Behavior and Lifestyle	Pharmaceutical Costs	System Inefficiencies	Medical Malpractice
Demand, new treatments, defensive medicine, and aging population with poor lifestyles	Longevity dictates prolonged and increased health care costs	Expensive drugs, technologies, services and procedures to prolong/improve quality of life	Choices leading to long-term chronic and associated managing treatments	More utilization, new and expensive medications, specialty drugs, fewer manufacturers that control price	Procedure duplications, preventable mistakes, unnecessary treatments and prescriptions, technological inefficiencies	Higher insurance rates, practice of defensive medicine

Source: National Association of Health Underwriters, "Healthcare Cost Drivers" June 2015

Landscape

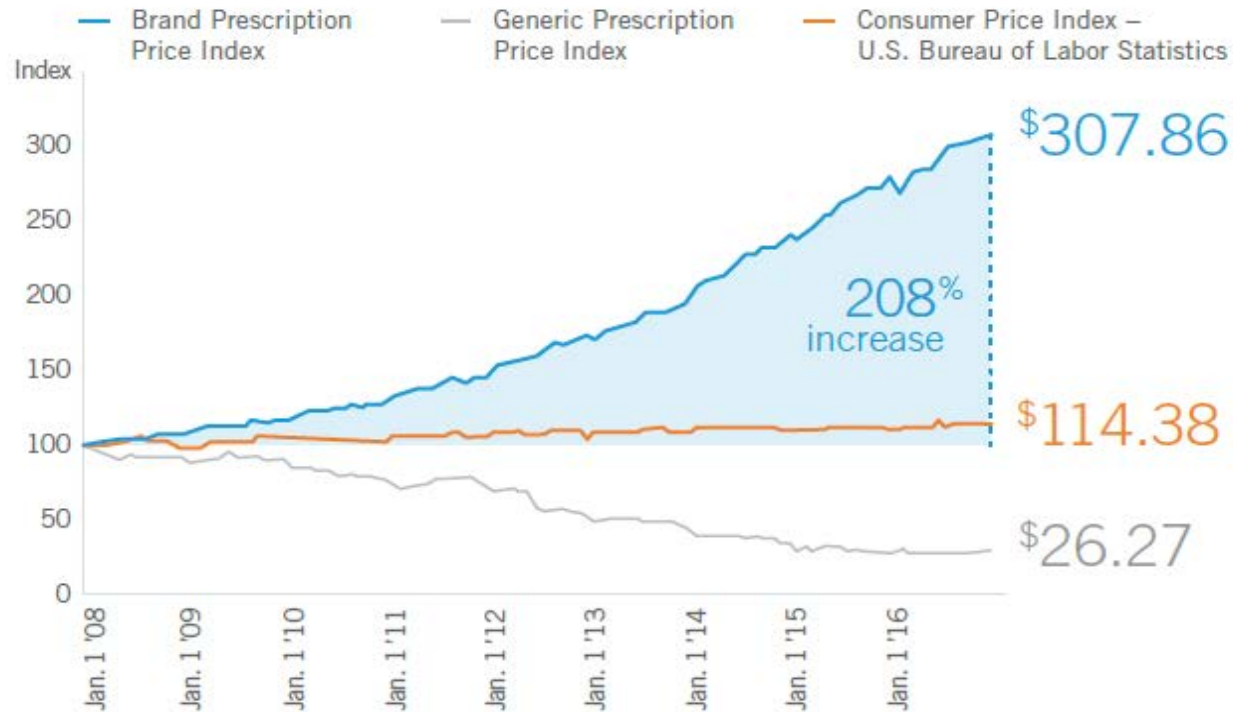
Rising prescription drug costs account for more than 22% of every premium dollar – outpacing physician, inpatient, and outpatient hospital services. This figure would have been even higher if medications administered during inpatient hospital stays were included.



Source: America's Health Insurance Plans, (AHIP), 2017

Trends

Generic drug prices have declined while brand drug prices have nearly doubled in price



Source – Express Scripts Drug Trend Report, 2016

Trends

Prescription Drug Claim Trends – What's Driving This?

Several factors are driving the increase in costs:

1. Manufacturers raising prices and the changing the composition of drugs
2. Growth in specialty medications
3. Consolidation of pharmacy benefit managers (PBMs)
4. Increased utilization driven by poor overall health

Source – Wells Fargo, 2016 Benefits Survey Results

What are groups doing to contain costs?

Top Strategies:

1. Use specialty pharmacy management
2. Expand prior authorization 
3. Evaluate pharmacy management programs
4. Expand step therapy programs 
5. Promote cost savings opportunities such as mail order

Source – Segal 2016 Plan Survey Results

Trends

Depending upon clinical management programs implemented, increases will vary year over year

- 9.1% lightly managed edits
- 5.4% average edits
- 2.6% for tightly managed edits

Source: Express Scripts 2016 Drug Report

Utilization Management Programs

Prescribing and using medications appropriately can effectively improve patient outcomes and reduce expenses, even as drug costs rise.

Examples:

Prior Authorization

Step Therapy

Generic Advantage (Penalty Programs)

What is Prior Authorization?

Prior authorization (PA) is a requirement that your physician obtain approval from the plan to prescribe a specific medication. PA is a technique for ensuring prescribed medications are appropriately prescribed based upon FDA and manufacturer guidelines, medical literature and benefit design. It results in minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by the insurance company.

60% of the requests for a drug on the standard formulary list are approved. The remaining requests will result in members choosing lower cost alternatives or members avoiding the use of medications not clinically appropriate for them.

Source: Excellus BlueCross BlueShield, 2017 claims data

Possible Ways to Reduce Pharmacy Spend

What kinds of drugs need prior authorization?

Drugs that have dangerous side effects

Drugs that are harmful when combined with other drugs

Drugs that you should use only for certain health conditions

Drugs that are often misused or abused

Drugs that a doctor prescribes when less expensive drugs might work better

How Does Prior Authorization Work?

Physicians submit the PA paperwork on behalf of the member. When the member goes to the pharmacy to pick up the prescription, the authorization process has generally already taken place. If the medication is not approved, the physician may supply supporting reasons or prescribe an alternative medication that would also be reviewed for safety and efficacy.

Example of a Prior Authorization List

Category * Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹	Formulary Options
<i>Allergic Reaction (Anaphylaxis) Treatment *</i>	ADRENALICK	AUVI-Q, EPIPEN, EPIPEN JR
<i>Allergies *</i> Nasal Steroids / Combinations	BECONASE AQ OMNARIS QNASL RHINOCORT AQUA VERAMYST ZETONNA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, NASONEX</i>
	DYMISTA	<i>flunisolide spray, fluticasone spray, triamcinolone spray, or NASONEX WITH azelastine spray or PATANASE</i>
<i>Allergies *</i> Ophthalmic	LASTACFT	<i>azelastine, cromolyn sodium, PATADAY, PATANOL</i>
<i>Anti-infectives, Antivirals *</i> Herpes Agents	VALTREX	<i>acyclovir, valacyclovir</i>
<i>Asthma *</i> Beta Agonists, Short-Acting	PROVENTIL HFA VENTOLIN HFA XOPENEX HFA	PROAIR HFA

Source: Caremark, 2016 Prior Authorization Listing

What is Step Therapy and How Does it Work?

Step Therapy - In some cases, the insurance carrier requires members to first try certain drugs to treat their medical condition before it will cover another drug for that condition.

For example, if Drug A and Drug B both treat the medical condition, Drug B may not be covered unless the patient tries Drug A first. If Drug A does not work for the patient, Drug B will be covered.

The process is handled between the provider and pharmacist behind the scenes in most cases.

Step Therapy from a Legal Perspective

Overview

Considerations

Example of A Step Therapy List

Commercial 3Tier Step Therapy List

The following prescription drugs have STEP THERAPY applied

Before certain medications are covered, we require that a generic or cost-effective alternative be tried first. For example, if Drug A and Drug B can both be used to treat a medical condition, Drug B may not be covered unless Drug A is tried first. If Drug A does not work, we will then cover Drug B.

Alzheimer's

ARICEPT 23MG

Required Prerequisite Drug(s): Donepezil 10mg

Asthma

Inhaled Beta Agonists/ Inhaled Respiratory Drugs

DALIRESP

Required Prerequisite Drug(s): Inhaled corticosteroid or long acting beta agonist

Inhaled Steroids

PULMICORT NEBULIZER; BUDESONIDE NEBULIZER

Required Prerequisite Drug(s): Children ages 4-8 require a trial and failure to an inhaled steroid (Asmanex, Flovent, QVAR)

Attention Deficit Disorder

SIMCOR; PRAVACHOL; MEVACOR; ADVICOR; ALTOPREV; LESCOL; ZOCOR; LIPITOR; LESCOL XL

Required Prerequisite Drug(s): atorvastatin, lovastatin, pravastatin, or simvastatin

VYTORIN

Required Prerequisite Drug(s): simvastatin and Crestor

Antihypertensive Combinations / Miscellaneous

HYZAAR; MICARDIS HCT; TEVETEN HCT; ATACAND HCT

Required Prerequisite Drug(s): Losartan/HCTZ, Valsartan HCT, Irbesartan/HCTZ

TEKAMLO; TEKTURNA; TEKTURNA HCT; AMTURNIDE

Required Prerequisite Drug(s): ACE inhibitor or ARB and one other antihypertensive medication

Beta Blockers (high blood pressure)

COREG CR

Source: Excellus BlueCross BlueShield, 2017 Drug List

What are Generic Advantage Programs and How Do They Work?

Generic Advantage – These programs promotes the use of generic medications. If a member fills a brand name medication where there is a generic equivalent available, the member will pay the generic copayment in additional to the difference between the cost of the more costly brand name medication and PBM's price for the less expensive generic medication.

Actual program details may vary by carrier or PBM.

Estimated Savings

Prescription Drug Savings will vary depending on drug mix, however, here are savings estimates (for prescription drug premium):

Prior Authorization - 6-9%

Step Therapy – 4-6%

Generic Advantage Penalty Programs – 2-4%

Other Programs

There are other programs that are being offered by PBM's to provide savings:

Opioid Management

Specialty Drug Management Programs for various conditions (examples):

- Asthma
- Bleeding Disorders
- Cystic Fibrosis
- HIV
- Oncology
- Multiple Sclerosis
- Immune Disorders

Trends

PBMs are offering Specialty Support Programs

Many have resource centers with disease focused, specialty trained clinicians.

Disease-focused clinical interventions by specialized clinicians, including:

- Patient assessments
- Proactive adherence support
- Outcomes tracking
- Patient advocacy and education
- Detailed reporting
- Support for the prescriber-patient relationship and plan of care

Trends

Opioid Management - key statistics relative to this epidemic:

- Only 3 percent of opioids are prescribed by pain specialists
- Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids
- \$53 billion in annual economic burden costs
- 2 million Americans are addicted to prescription narcotics

PBM's are offering Opioid management solutions to combines opioid management addressing physician, pharmacy and patient touchpoints - available this fall, depending on PBM offering.

In a recent pilot study of members new to opioid therapy, a 38% reduction in hospitalizations and 40% reduction in emergency room (ER) visits was observed.

Source: Express Scripts, June 2017

MULTIPLE SCLEROSIS

A dangerous path

Patients diagnosed with multiple sclerosis (MS) face unpredictable and increasingly debilitating symptoms. Nonadherence can make these adverse events more costly and dangerous.

Care

Proper therapy helps slow the progression of MS. But as the population increases, lack of adherence is becoming a bigger problem.

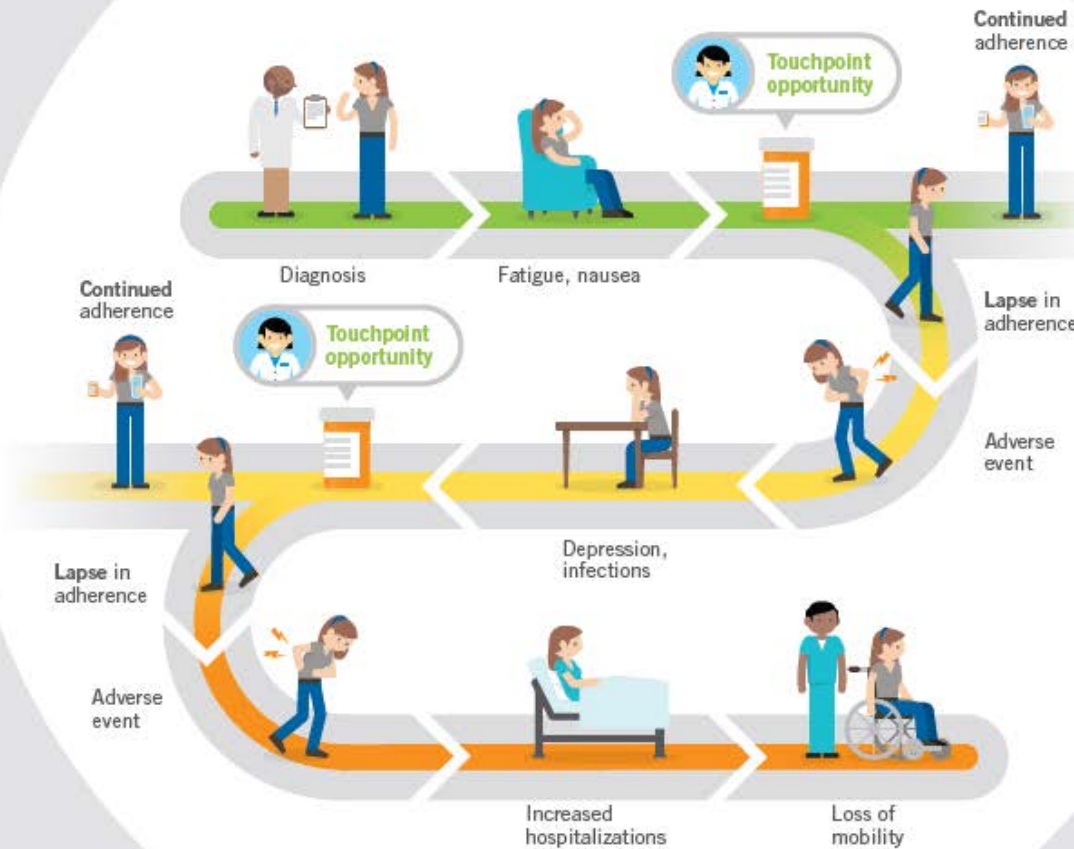
Growing population
>400K
 Americans have MS and 200 more are diagnosed every week¹

Poor adherence
>25%
 discontinue treatment in the first 3 months²

More options than ever
15%
 of patients have an effective therapy option in 2017 for the first time

The path of nonadherence

The side effects of MS medicine can be challenging, but proper treatment greatly increases long-term quality of life. However, the path of nonadherence is **unforgiving and irreversible**.



Cost \$

A 10% year-over-year trend increase for the next three years is expected due to a growing patient population with low adherence rates.³

Costly care
\$70K+
 per patient per year³

Driving up trend
#4
 drug trend driver³

The price of nonadherence
\$5,400
 additional annual cost per nonadherent patient⁴

Source: Express Scripts, 2017

Other Programs

Additional Programs for Specialty Drug Cost Management

In conjunction with Specialty Drug PBM, there may be copay assistance or are discount programs that impact the member and plan cost.

Dependent Eligibility Verification

Dependent Eligibility Verification

What is a Dependent Eligibility Verification?

- Verification process
- Confirms eligibility of spouse and dependents enrolled in plan
- Discover ineligible spouse and dependents currently on plan

Dependent Eligibility Verification

What are the benefits of conducting one?

- Maintain or reduce the cost of health benefits
 - 5-7% of dependents may not be eligible for the Plan (estimate)
 - Currently, common scenarios for ineligible dependents include ex-spouses, or nieces or nephews living with an employee.
- Potential savings to school districts and employees
- Compliance – maintain integrity of the plan

Dependent Eligibility Verification - Savings

Savings will vary by group, however based upon benchmark data, the following reflects possible savings:

Total enrolled dependent count: 500

Average Annual Cost per dependent: \$3,500

Potential Savings Scenarios		
Results	Ineligible Dependents Removed	Potential Annual Savings
Below Average	10	\$35,000
Average	15-25	\$52,500 - \$87,500
Above Average	30-50	\$105,000 - \$175,000

This estimate presumes on average 2.1 dependents covered per employee with dependents.

Source: BMI, 2017

Dependent Eligibility Verification

Reasons for participants covering ineligible dependents:

- Failure to notify school district of qualifying event (forgot to remove)
- Misunderstanding of plan's eligibility requirements
- Miscommunication
- Negligence

Dependent Eligibility Verification

When planning an audit, an employer should consider the following:

- What message will be communicated to employees and how will it be communicated?
- Are all plan documents consistent in defining dependents?
- What will the scope of the audit be and who will perform it?
- What documents will satisfy proof of eligibility for various types of dependents?
- How will employees perceive an audit?
- Are there other employee relations issues that need to be addressed prior to the audit (collective bargaining)?

Dependent Eligibility Verification

Importance of Communication

Employees should be informed well in advance of the verification so they can gather the proper documentation. Reminders should be issued frequently throughout the audit period to ensure the highest possible participation rate.

Use a familiar method for communicating the message, including your intranet, e-mail, bulletin board postings, payroll stuffers, meetings, etc.

Communication initiatives should include:

- Support by Leadership Team, including union leadership. This is crucial to the success of your dependent eligibility verification. They need to be able to answer questions.
- Education of Personnel and Benefits Staff. All details of the audit must be understood and communicated properly. More importantly, they need to be able to communicate why the audit is important and necessary in the first place.
- Explanation to employees. Employee communications should explain that the district's health plan exists to provide coverage for employees and their eligible dependents only. The health plan's ability to provide for those who it aims to benefit is significantly compromised when ineligible persons receive benefits. It impacts the cost for all participants.

Dependent Eligibility Verification Process

Once a vendor is selected, they will:

- Distribute communication materials
- Make documentation request and handle document collection and verification
- Provide a Verification Call Center or Service Center
- Provide employee assistance
- Provide Custom web portal, as applicable
- Provide secure documentation storage and disposal

Dependent Eligibility Verification

Documentation Requirements

Members may be asked to provide:

- Marriage certificate
- Birth certificate
- Federal tax return issued within last 2 years (redacted)
- Court-order divorce decree and custody agreement

Dependent Eligibility Verification - Process

The Vendor will review documentation to determine if:

- Dependents are eligible
- Dependents are ineligible
- More documentation is required

Employees will be notified of all outcomes via mail.

Reporting will be provided to school district.

Questions?

This is not intended to be exhaustive nor should any discussion or opinions be construed as legal or tax advice.
Contact legal counsel for legal advice and/or tax professional for tax advice.