THE TOP BENEFIT TRENDS FOR 2017 AND BEYOND

Presented By | Steve Pasdiora
Employee Benefits Consultant, Cottingham & Butler

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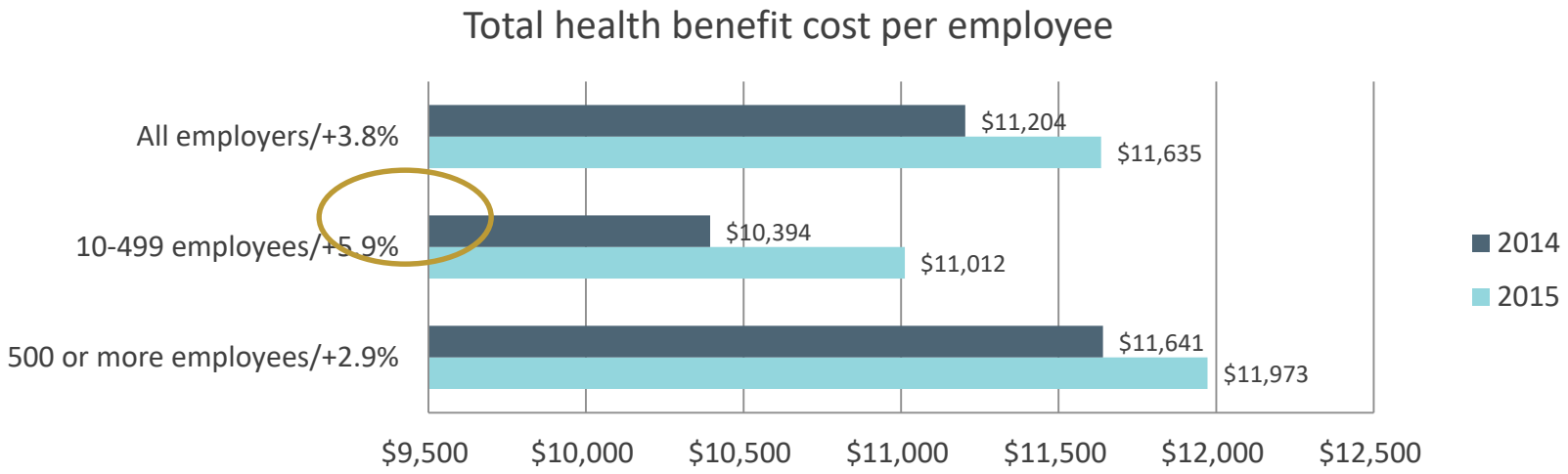
TOP BENEFIT TRENDS FOR 2016 AND BEYOND

Today's Agenda

- Learn about the Top Benefit Trends for 2016 and how your company should monitor them to protect the financial well being of your health plan.
- Find out what percentage of other employers are implementing or plan to implement these benefit trends.
- Come away with strategies you can execute in order to support your employee benefits and organizational goals.

COSTS ARE UP… AT A SLOWER PACE

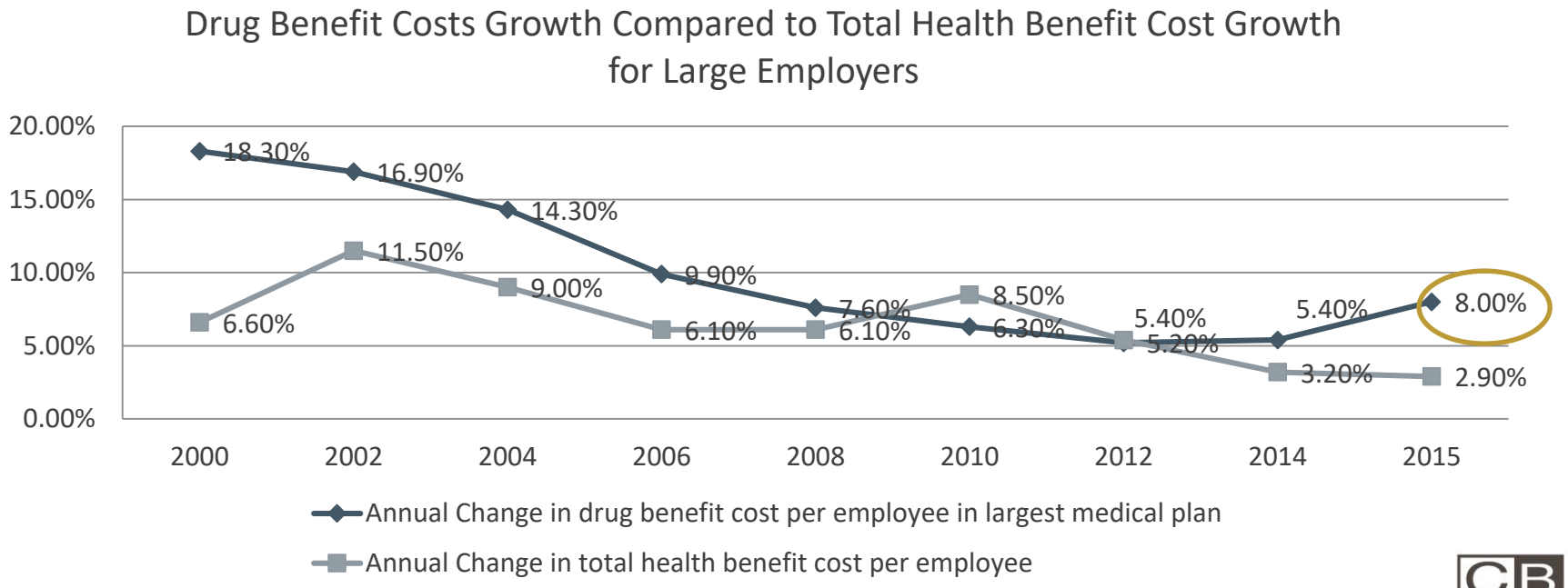
- The average total health benefit cost per employee rose from $11,204 in 2014 to $11,635 in 2015; a 3.8% overall average increase
- This amount includes employer and employee contributions for medical, dental and other health coverage for employees and their covered dependents
- Employers predict that in 2016 health benefit cost per employee will rise by 4.3%. This estimate reflects changes employers will make to reduce costs – changing plan designs and moving employees into lower cost plans. With no changes the estimated increase is over 6%
- About half of employers indicated that they will make medical plan changes in 2016



Source: Mercer 2015 Annual Survey

MEDICAL VS. RX: A TALE OF 2 CLASSES

- Prescription drug benefit cost growth is accelerating, driven largely by high-cost specialty drugs.
- Following several years of increases averaging around 5%, drug benefit cost per employee jumped by 8% in 2015 for large employers
- New drugs for treating complex diseases like cancer, multiple sclerosis and hepatitis C top the list of cost drivers
- Among the 49% of large employers that track specialty drug spend, the average increase in 2015 was 22%.



Source: Mercer 2015 Annual Survey

TOP BENEFIT TRENDS FOR 2016 AND BEYOND

Program Design	Workforce Health	Care Delivery and Infrastructure	And Don't Forget
Offer CDHPs	Spousal Provisions	Telemedicine	Communication Strategies
Health Savings Accounts	Worksite Health Programs	Performance Networks	Enrollment Tools
Voluntary Benefits	Wellness Programs and Incentives	Surgical Centers of Excellence	HR Concierge Services
Referenced-based Pricing	Smoker Surcharges	Accountable Care Organizations	Compliance
Funding Strategy		Private Health Benefits Exchange	
Pharmacy Design			

PROGRAM DESIGN AND INFRASTRUCTURE

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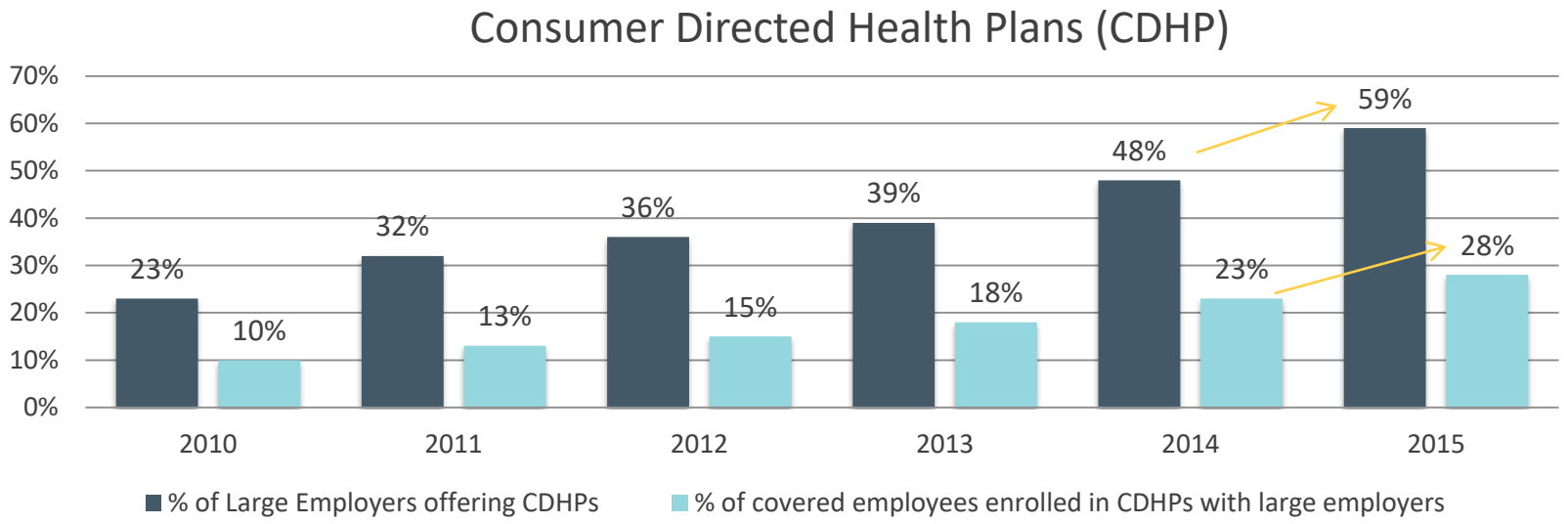
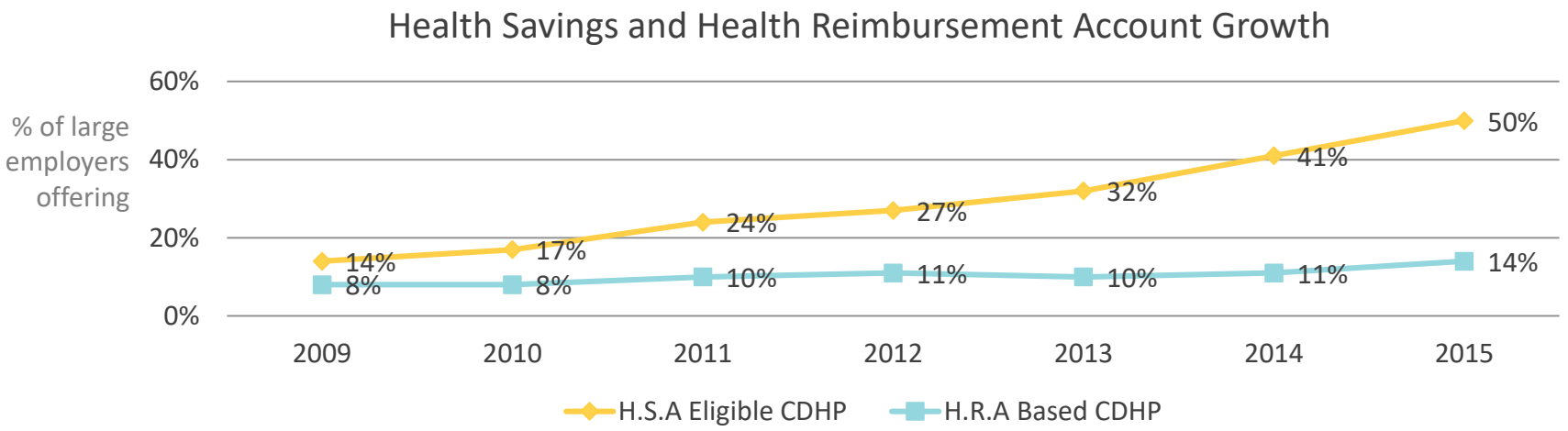
ALMOST EVERYONE IS DOING IT



- In 2015, offerings of CDHPs by large employers jumped from 48% to 59% and enrollment rose from 23% to 28%
- By 2018, three out of four large employers say they will offer a CDHP
- Currently, only 11% of employers offer a CDHP as the only plan available to employees although this is expected to rise to 21% by 2018

Source: Mercer 2015 Annual Survey

HSA PLANS ARE WINNING THE CDHP POPULARITY CONTEST



HRA Plans

- Generally offer richer benefits than HSAs as there is no IRS mandated deductible
- Accounts are always funded by the employer
- Average enrollment rate is typically higher for an HRA than an HSA eligible plan when offered alongside other medical plan choices

HSA Plans

- Accounts may or may not be funded by the employer
- Accounts can be funded by the employee
- Employees own the account and can take the money in the account even if they change jobs
- Unused money at the end of the year rolls over to the next year
- Account contributions are not subject to federal tax at the time of deposit or withdrawal (if used for qualified expenses.
- HSA funds can be invested and earn tax-free interest
- Saves employers large dollars on FICA

Source: Mercer 2015 Annual Survey

FUND IT AND THEY WILL COME

Full replacement HSA plans remain relatively uncommon; most HSA sponsors – 90% - offer the HSA alongside another medical plan choice.

The decision to fund employees' accounts drives enrollment.

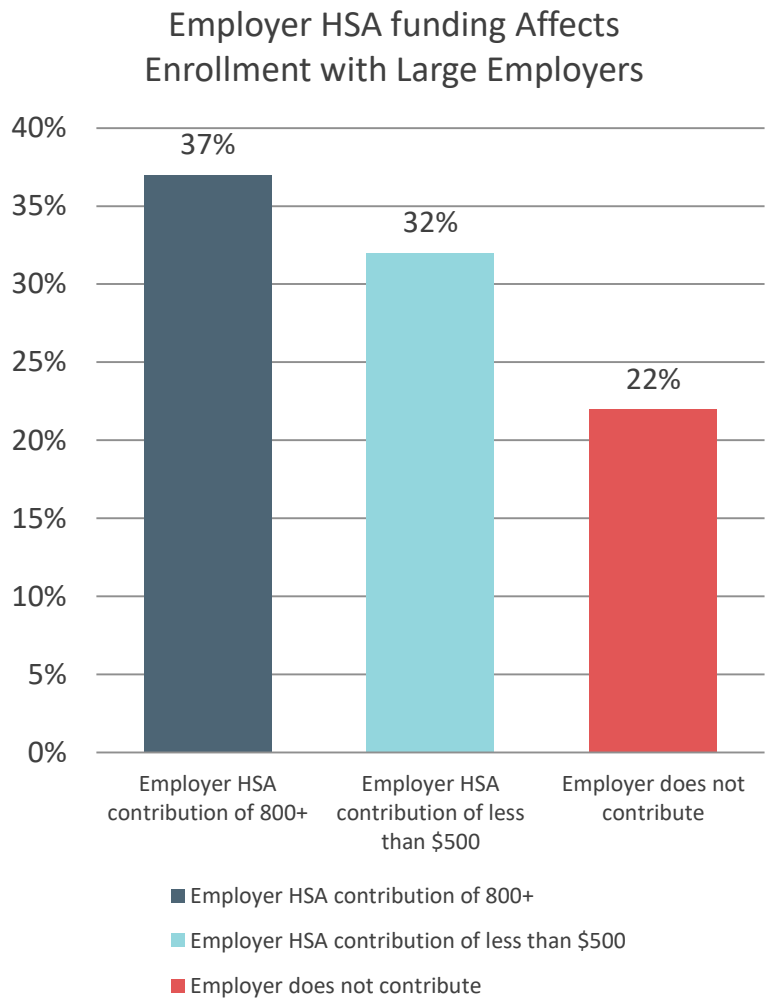
- Among plans when the employer contributes $800 or more, average enrollment rate is 37% of eligible employees
- Among plans when the employer contributes less than $500, average enrollment is 32%
- Among plans when the employer does not contribute, average enrollment is 22%

Employee communication is also critical

- Just over 50% of HSA sponsors say they provide extensive or very extensive communication - they have average enrollment of 35% compared to 24% among those companies providing less extensive communication.

Employee reaction

- 66% largely positive
- 30% mixed positive and negative
- 3% largely negative



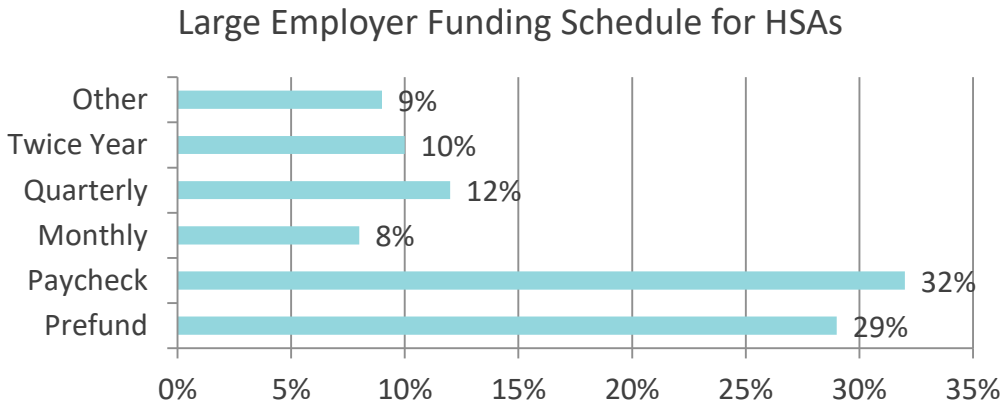
Source: Mercer 2015 Annual Survey

HOW MUCH SHOULD I CONTRIBUTE?

- Percentage of Employers making an HSA contribution
  - Large: 72%
  - Small 55%
- For large employers the median employer contribution was $500 for employee-only and $1000 for family coverage. This remained unchanged from 2014.
- Employers can choose when to fund the employees accounts
  - Some prefund so that employees can access the funds on the first day of the plan year.
  - Because prefunding puts the employer at risk if the employee leaves early in the year, some employers contribute on a schedule.

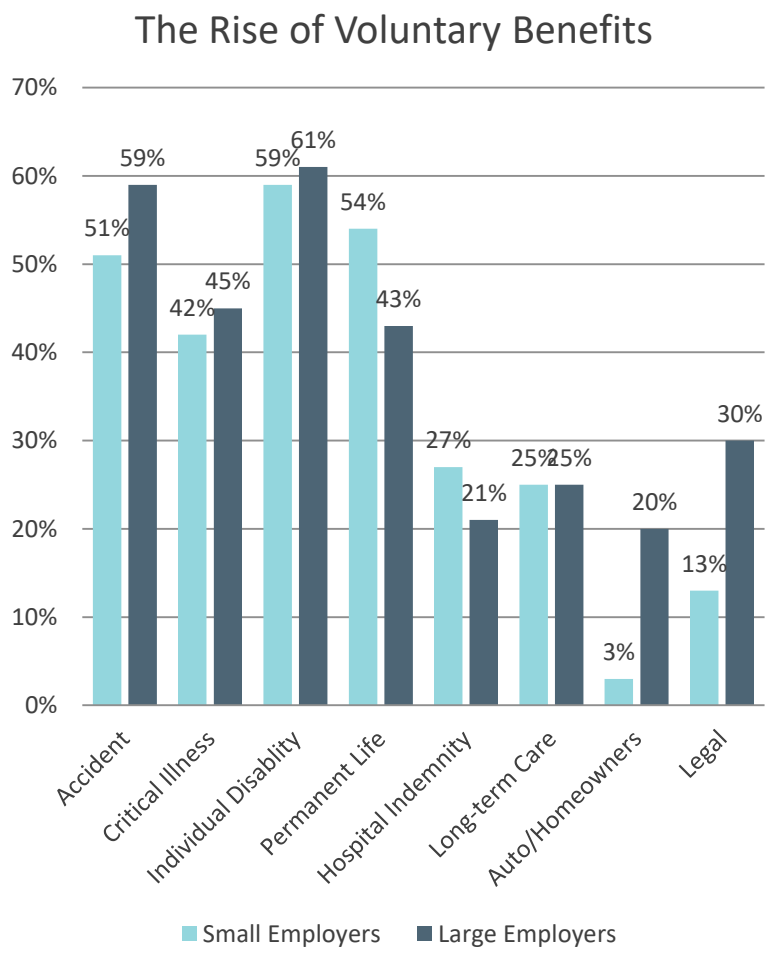
Employer Account Contributions	Large	Small
Employers making a contribution	72%	55%
Employers not making a contribution	28%	45%

Median Employer Contribution Amount (Annual)	Large	Small
Employee only	$500	$1000
Family	$1000	$1250



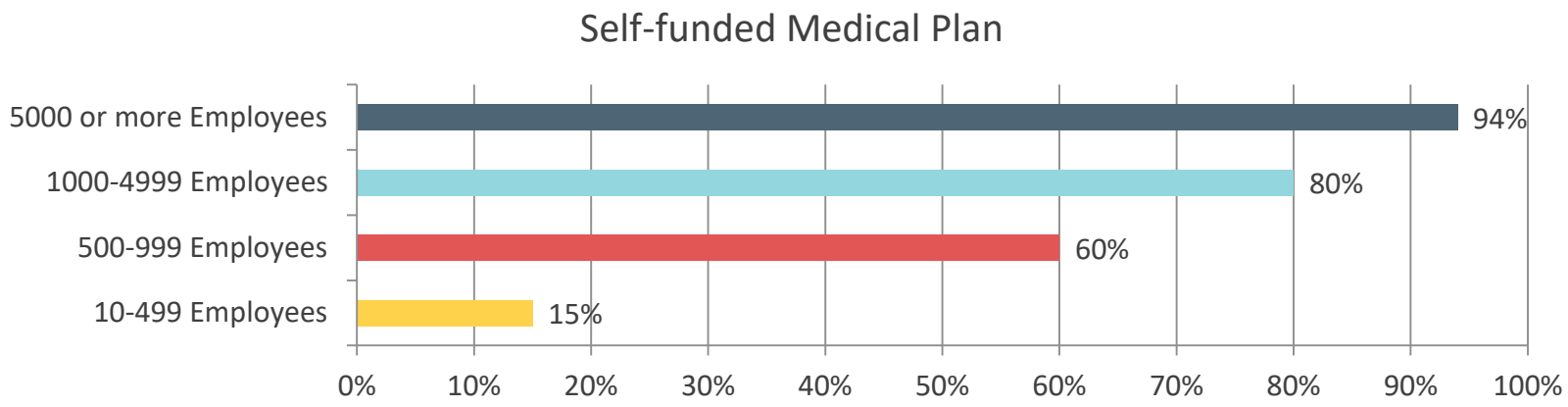
VOLUNTARY BENEFITS COST YOU NOTHING… AND FILL A GAP

- About three-fourths (75%) of employers say that giving employees the opportunity to fill gaps in core benefits is an important objective
- Today, these benefits are working together with the major medical plan as a portfolio of benefits



Source: Mercer 2015 Annual Survey

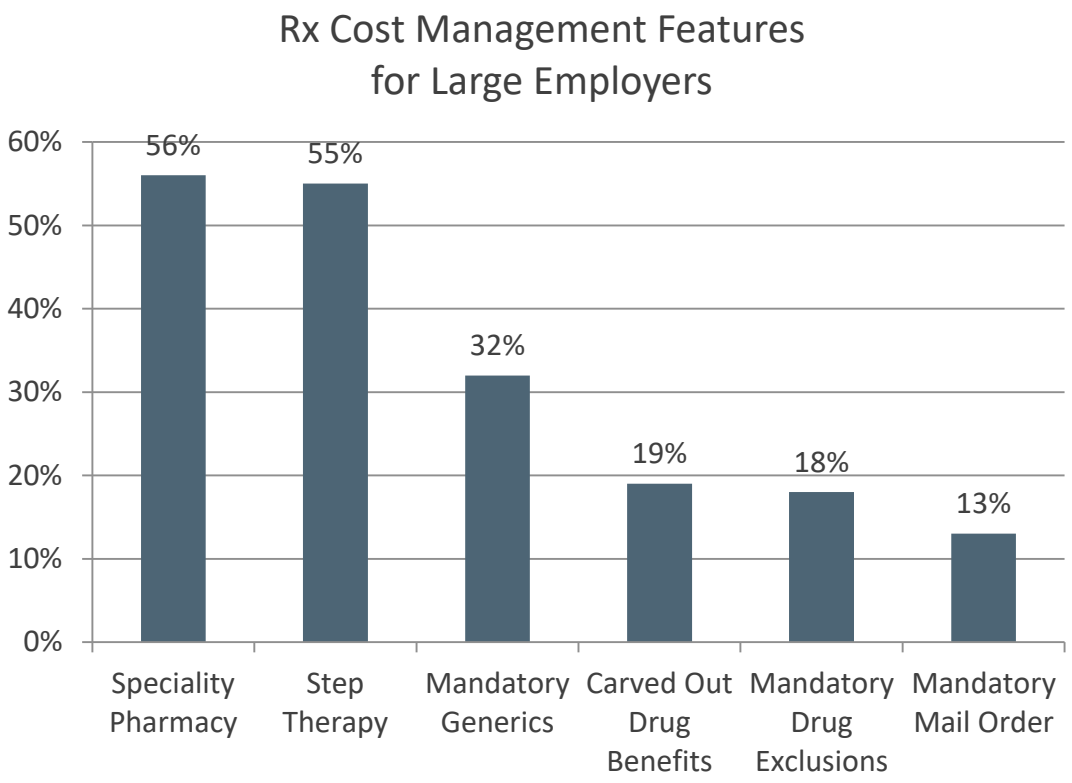
FUND IT YOURSELF



- Most small employers fully insure their primary medical plan, while the majority of large employers are self-funded
- There has been some movement to self-funding among employers with 10-499 and 500-999 employees, perhaps as a way to avoid ACA provisions and fees
- There is a strong trend toward self-funding as a cost management strategy. You'll also gain transparency and control over plan management
- What was once viewed as an approach for larger businesses is growing increasingly popular among smaller, fully insured originations for the flexibility it dives to tailor more cost-efficient employee benefit programs

Source: Mercer 2015 Annual Survey

A PRESCRIPTION FOR LOWER RX SPENDING

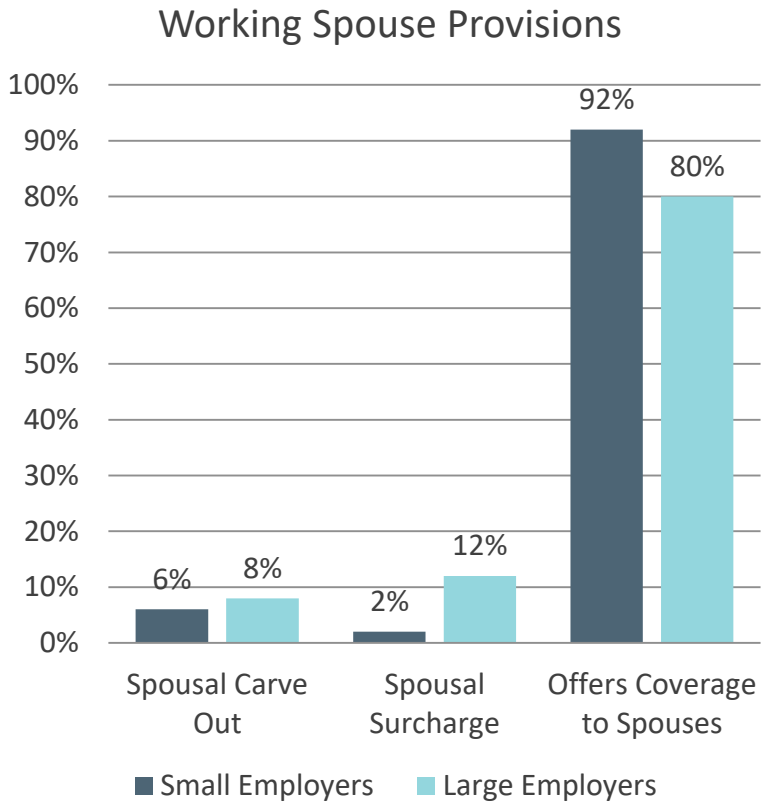


- 78% of large employers have some type of cost management feature in place with their prescription drug plan
- Just over half of large employers (56%) use some method to encourage their employees to fill specialty medications through a specialty pharmacy
- The majority (81%) of employers continue to offer prescription drugs through the medical plan, though the larger the employer, the more likely it is to have carved out the Rx benefit to a PBM

Source: Mercer 2015 Annual Survey

SHOULDN'T ANOTHER CEO BE RESPONSIBLE?

- Employers are not required to offer insurance to spouses (ACA)
- Some employers are putting in provisions that exclude/charge more to spouses with other coverage available (Working Spouse Provisions)
- Removing 1 spouse can save an employer approximately $6k annually
- Most spousal surcharges are the cost of single coverage at the competition ($100-$150/month)



Source: Mercer 2015 Annual Survey

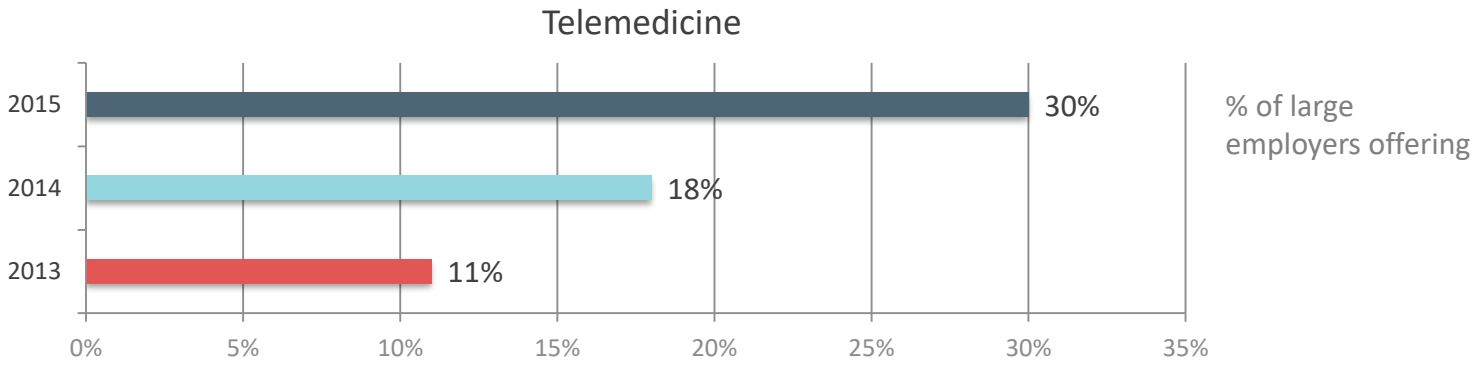
SHOW ME THE $

- About half of large employers (49%) offered financial incentives in connection with their health and well-being programs. Only 29% of small employers offer incentives.
- Incentives are most commonly used to encourage employees to participate in programs (79%)
- Only 21% of employers provide outcomes based incentives for achieving, maintaining or showing progress toward a specific health status target
- Employers are recognizing that including spouses can build better participation and engagement.
  - 62% of Large employers make some element of the well-being program available to spouses
  - 50% of Small employers make some element of the well-being program available to spouses
  - Of the program that include spouses, only half make spouses eligible for incentives

Program Incentives (Large Employers)	% Large Employers
Provide Incentive for completing the health assessment	54%
•Median premium reduction	$360
•Median cash/gift card amount	$50
Provide incentive for completing the biometric screening	40%
Median premium reduction	$415
Median cash/gift card amount	$50
Provide incentive for participating in lifestyle coaching program	27%
Median premium reduction	$360
Median cash/gift card amount	$100

Source: Mercer 2015 Annual Survey

SKIP THE LINE AND PAY LESS



- As we encourage employees to be smart shoppers, the pressure is on to provide real, and financially substantive “shopping choices”
- Employers are moving quickly to implement telemedicine services – telephonic or video access to providers – as a low cost alternative to an ER or office visit for some types of non-acute care
- Why pay $125 for an average office visit, when you can pay $40 for an average telemedicine visit?
- Offers the convenience of being treated quickly while staying in the comfort of home
- Utilization remains modest, but more than a fourth of employers offering telemedicine services reported utilization of 5% or higher

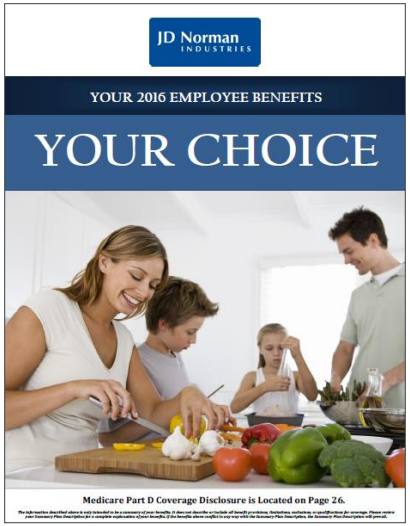
Source: Mercer 2015 Annual Survey

AND DON'T FORGET

TALK, TALK, TALK, TALK, TALK

- An employees perceived value of their benefits plan can either be enhanced or diminished by the communication strategy

	Above Average Benefits Plan	Below Average Benefits Plan
Effective Communication Strategy	**84%** of employees respond favorably regarding their benefits	**76%** of employees respond favorably regarding their benefits
Ineffective Communication Strategy	**26%** of employees respond favorably regarding their benefits	**22%** of employees respond favorably regarding their benefits



- Communicate early, often, and in a variety of ways. Use written, visual, in-person, and electronic varieties – enrollment guides, educational videos, postcards, flyers, texts, email, meetings

- Make communication easy to understand and fun – web portals, animated videos, decision support tools
- Discover new resources – call center enrollment, online enrollment, videos, patient advocacy resources

Source: MetLife 2013 Annual Survey

NO MORE PAPER PLEASE

BENEFITS OF ONLINE ENROLLMENT

- Reduces over-insurance by illustrating best-fit plan options for each individual
- Increases employee participation in tax-advantaged healthcare savings accounts
- Improves employee satisfaction and instills confidence in their decisions
- Educates employees on the true cost of healthcare and value of employer contributions
- Provides insight to employers on consumer choice and engagement during benefit selection
- Eases HRs administration saving time and reducing errors

1-800 ASK HR

- Many employers are receiving free HR services as part of their employee benefits brokerage services
- The HR services include same day HR advice by a licensed HR professional, a document database, online training courses, and legislative updates

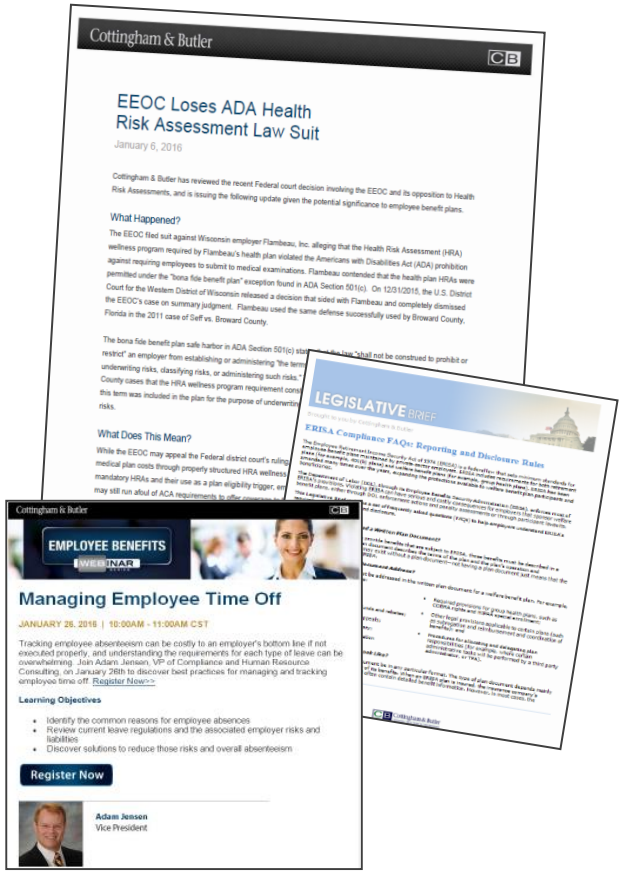
THE COMPLIANCE TSUNAMI

Employers will continue to struggle with a slew of increasing compliance burdens that are set to expand dramatically in 2016 and beyond

- ACA Reporting
- FSLA White Collar Exemption Reclassification
- Form 5500 Proposed Changes
- EEOC updated Wellness Regulations
- EEO-1 Reporting
- DOL Health Plan Violation Fee Increases

Are you receiving help and support in order to ensure your company avoids compliance fines and audits?

- Regular Compliance Notifications
- Compliance Webinars
- Mock DOL Audits
- Handbook Reviews

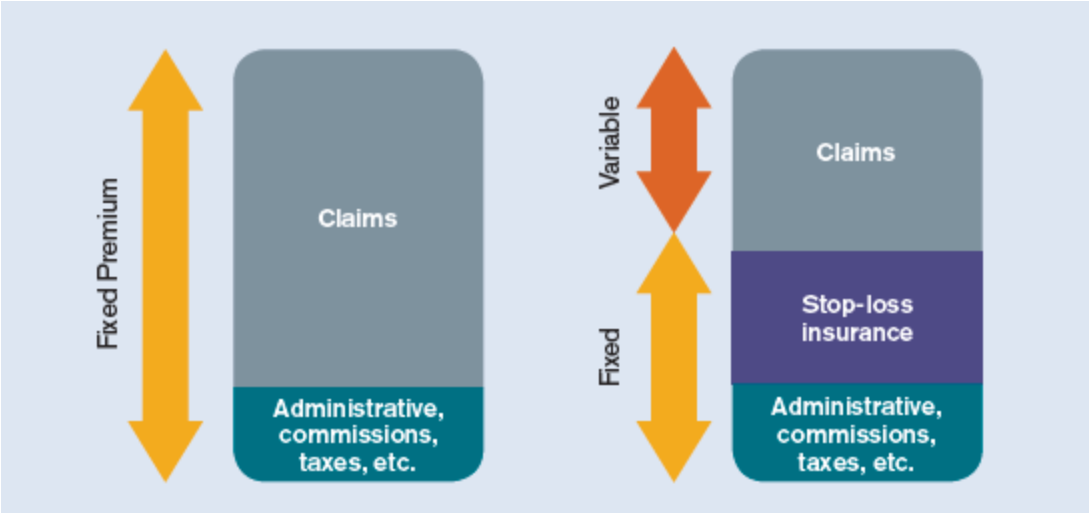


AND DON'T FORGET

SELF-FUNDING FOR SMALLER GROUPS

Carriers are self-funding groups of smaller sizes:

- UHC has All-Savers for groups >25 lives
- BCBSIL has Blue Balance Fund for groups with 2-50, and additional products for larger groups
- TPAs have self-funded small groups for years.
  - SISCO has recently seen an uptick in small group business (2-20 lives)



CHRONIC ILLNESS COMPLIANCE MANAGEMENT

- Clients are successfully managing their chronic population, and it's paying off
- The below client is a case study of strong compliance management. As a result, they have decreased their overall cost over the last 5-years.

Members in the Program	2011	2012	2013	2014	2015
Total Participants	510	493	455	789	815
Number of Noncompliant Participants	105	64	53	102	106
Percentage Noncompliant	20%	13%	11%	11.3%	13%

Condition	Baseline	2011	2012	2013	2014	2015	National Average*
Asthma	52.7%	82%	93%	92%	98.4%	96.7%	37% [1]
COPD	0%	-	-	-	100%	100%	
Diabetes	12.9%	70%	73%	73%	77.5%	76.0%	34% [2]
Hypertension	51.4%	83%	92%	96%	89.8%	88.9%	39% [3]
Heart Failure	20%	-	-	-	100%	100%	
Ischemic Heart Disease	38.5%	-	-	-	87.5%	100%	
High Cholesterol	23.8%				93.1%	86.9%	
Total Condition Management Candidates	58%	80%	87%	89%	88.7%*	86.2%	38%

*Please note that in 2014, the client added the following new disease states: COPD, Heart Failure, High Cholesterol and Ischemic Heart Disease.

COST PLUS

Many clients are moving to a Cost-Plus version of self-funding and are finding significant savings

Question: Are the discounts you receive through your carrier good or bad?

- Consider: A $100,000 claim is submitted to your carrier. Because of discount negotiations, your carrier gets you a 42% discount. The plan pays $58,000 to the provider.
- Is this a good deal?
- What if you learn that the Cost of the procedure is actually $30,000?

Cost Plus programs eliminate facility networks (but keep provider networks)

Under Cost Plus, the plan pays the greater of 12% above Cost or 20% above Medicare

COST-PLUS AUDITING EXAMPLE

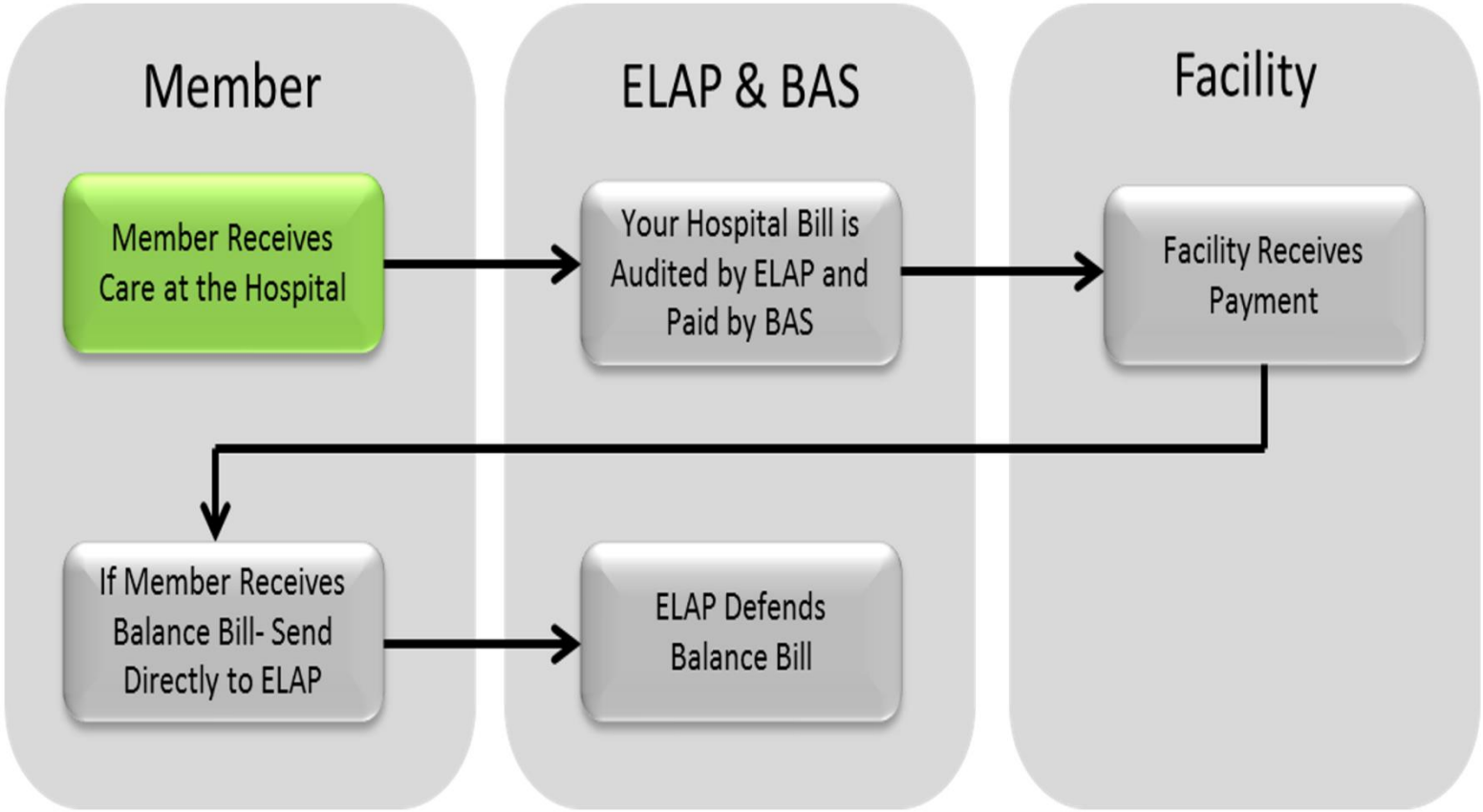
TPA
Group
Claim #
Provider Acute Care Outpatient Hosp in Greenville, NC
Patient
Pt Act #
DOS
NPI #:

Audit Completion Date

Total Amount Billed	**$**	**43,191.38**
Reduction	**$**	**42,153.71**
Allowable Claim Limit Total	**$**	**1,037.67**

REV or POS Code	Item Description	CPT / NDC	QTY	Total Charge	Cost Each	C-C/R Adjusted Allowance	Medicare OPPS Adjusted Allowance	Adj. Code(s)	
250	Carboplatin 10mg/ml Soln		24	$ 822.00	$ 34.25	$ -	$ -	N	Z
250	Dexamethasone 4mg/ml Soln		24	$ 90.00	$ 3.75	$ -	$ -	N	Z
250	Docetaxel 20mg/2ml 10ml		280	$ 18,198.76	$ 65.00	$ -	$ -	N	Z
250	Palonosetron 0.25mg/5ml		20	$ 3,115.38	$ 155.77	$ -	$ -	N	Z
250	Sodium Chloride Non PVC		5	$ 145.00	$ 29.00	$ -	$ -	N	Z
250	Trastuzumab 440mg solr		80	$ 7,768.24	$ 97.10	$ -	$ -	N	Z
250	Pegfilgrastim 6mg/0.6ml		2	$ 9,516.00	$ 4,758.00	$ -	$ -	N	Z
		Total		**$ 39,655.38**		**$ -**	**$ -**		
258	Sodium Chloride 0.9% Solp		10	$ 290.00	$ 29.00	$ 90.10	$ -	H	
		Total		**$ 290.00**		**$ 90.10**	**$ -**		
260	Ther/proph/diag iv inf addon	96366	1	$ 198.00	$ 198.00	$ 37.46	$ 31.94	H	
260	Tx/pro/dx inj new drug addon	96375	1	$ 152.00	$ 152.00	$ 28.75	$ 46.27	H	
260	Ther/proph/diag inj sc/im	96372	1	$ 96.00	$ 96.00	$ 18.16	$ 46.27	H	
260	Ther/proph/diag inj sc/im	96372	1	$ 96.00	$ 96.00	$ 18.16	$ 46.27	H	
		Total		**$ 542.00**		**$ 102.53**	**$ 170.75**		
270	Gemini #2260		2	$ 50.00	$ 25.00	$ 16.38	$ -	H	
270	Needle Huber Gripper 22gx1		1	$ 21.00	$ 21.00	$ 6.88	$ -	H	
270	Needle Huber Gripper 22x3		1	$ 21.00	$ 21.00	$ 6.88	$ -	H	
270	Set Prim Pump 20DR w/2 SS		2	$ 30.00	$ 15.00	$ 9.83	$ -	H	
270	Tray Vasc Access Biopatch		2	$ 170.00	$ 85.00	$ 55.69	$ -	H	
		Total		**$ 292.00**		**$ 95.66**	**$ -**		
335	Chemo iv infus each addl seq	96417	2	$ 656.00	$ 328.00	$ 203.81	$ 176.66	H	
335	Chemo iv infusion 1 hr	96413	1	$ 650.00	$ 650.00	$ 201.95	$ 272.58	H	
335	Chemo iv infusion 1 hr	96413	1	$ 650.00	$ 650.00	$ 201.95	$ 272.58	H	
335	Chemo iv infusion addl hr	96415	2	$ 456.00	$ 228.00	$ 141.67	$ 92.54	H	
		Total		**$ 2,412.00**		**$ 749.38**	**$ 814.36**		
	Grand Total			**$ 43,191.38**		**$ 1,037.67**	**$ 985.11**		
				43,191.38		1,037.67	985.11		

HOW COST-PLUS WORKS FOR YOUR EMPLOYEES



THE SAVINGS ARE REAL

ELAP's commitment to reducing the cost of healthcare for our clients' has led to:

Significantly Lower Claim and Stop Loss Costs

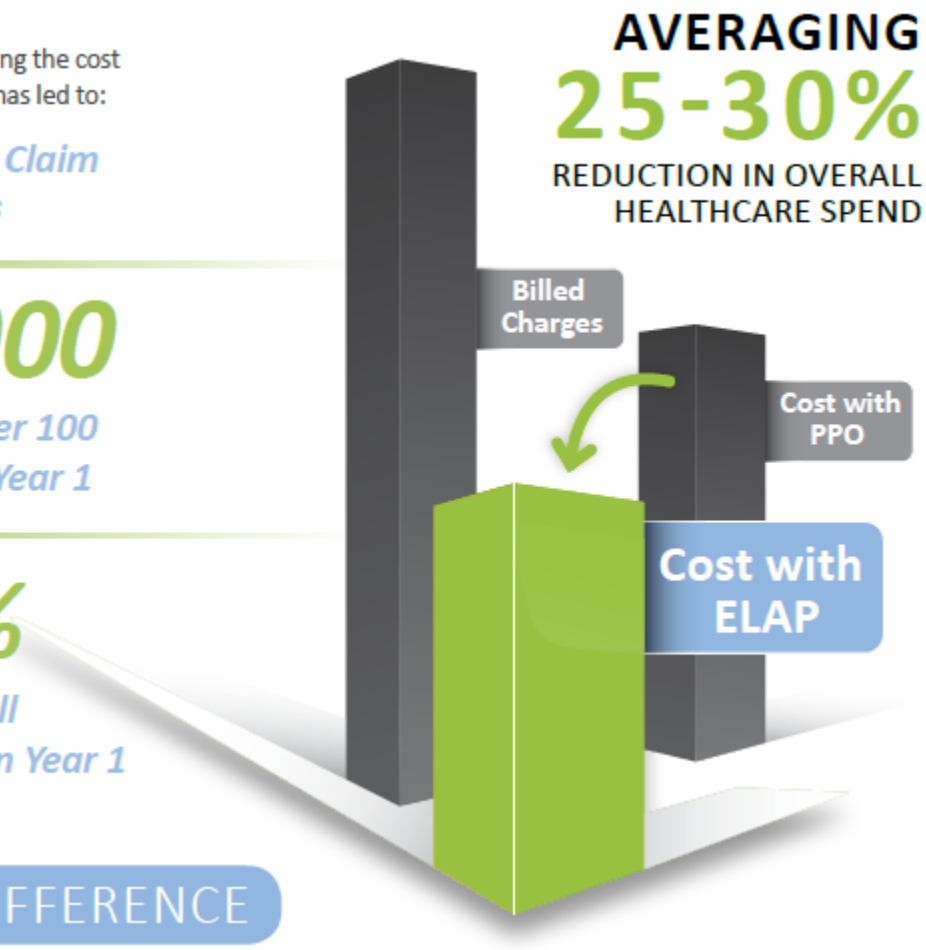
$150,000

Average Savings Per 100 Employee Lives in Year 1

25-30%

Reduction in Overall Healthcare Spend in Year 1

THE ELAP DIFFERENCE



WRAP-UP

Employers are leaning in to the benefit programs they are offering to their employees to engage members and manage cost

Fully-Insured:

- Make sure you understand the high volume of program changes that are forced upon you
- Consider alternatively funding your program

Self-Funded:

- Engage and actively manage your claims and your population
- Consider the broad spectrum of self-funded options available

REACH OUT WITH QUESTIONS

STEVE PASDIORA

Employee Benefits, C&B

spasdiora@cottinghambutler.com

312-789-5273

Employee Benefits Seminar
Prescription Drug Strategies

Presented By | Nancy Daas

Cottingham & Butler

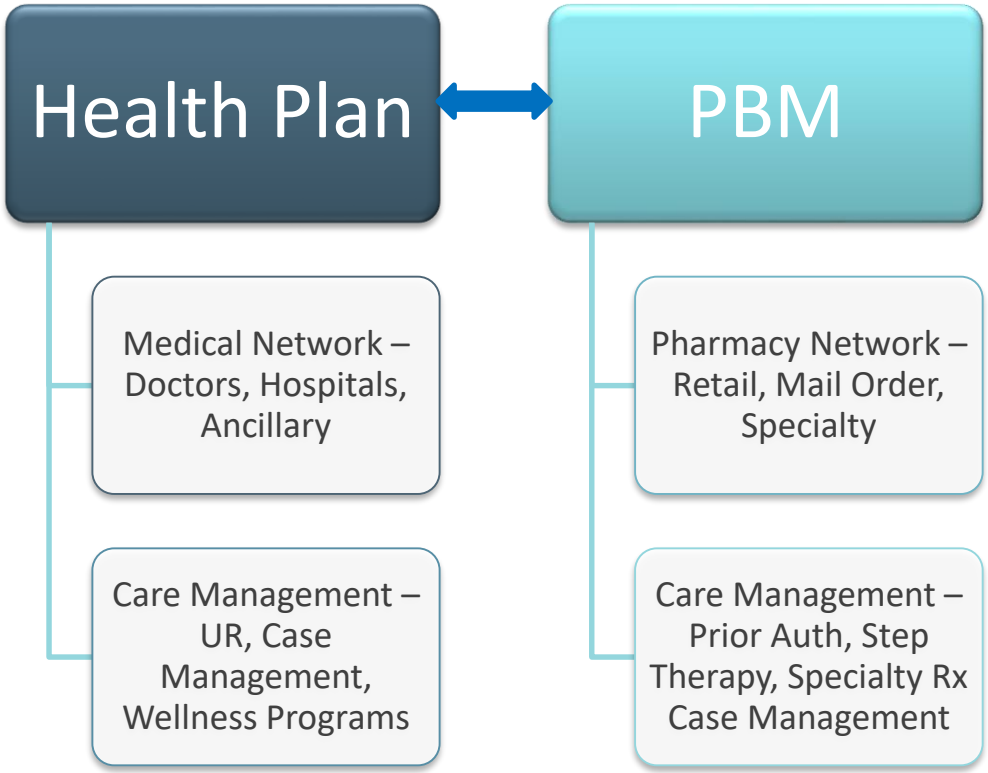
Agenda

AGENDA

- Context: Health Plan – PBM Dynamic, Pharmacy Supply Chain & the Components of PBM Pricing
- Current Rx Trends
- Strategies for Managing Drug Spend

Context

CONTEXT: HEALTH PLAN – PBM DYNAMIC



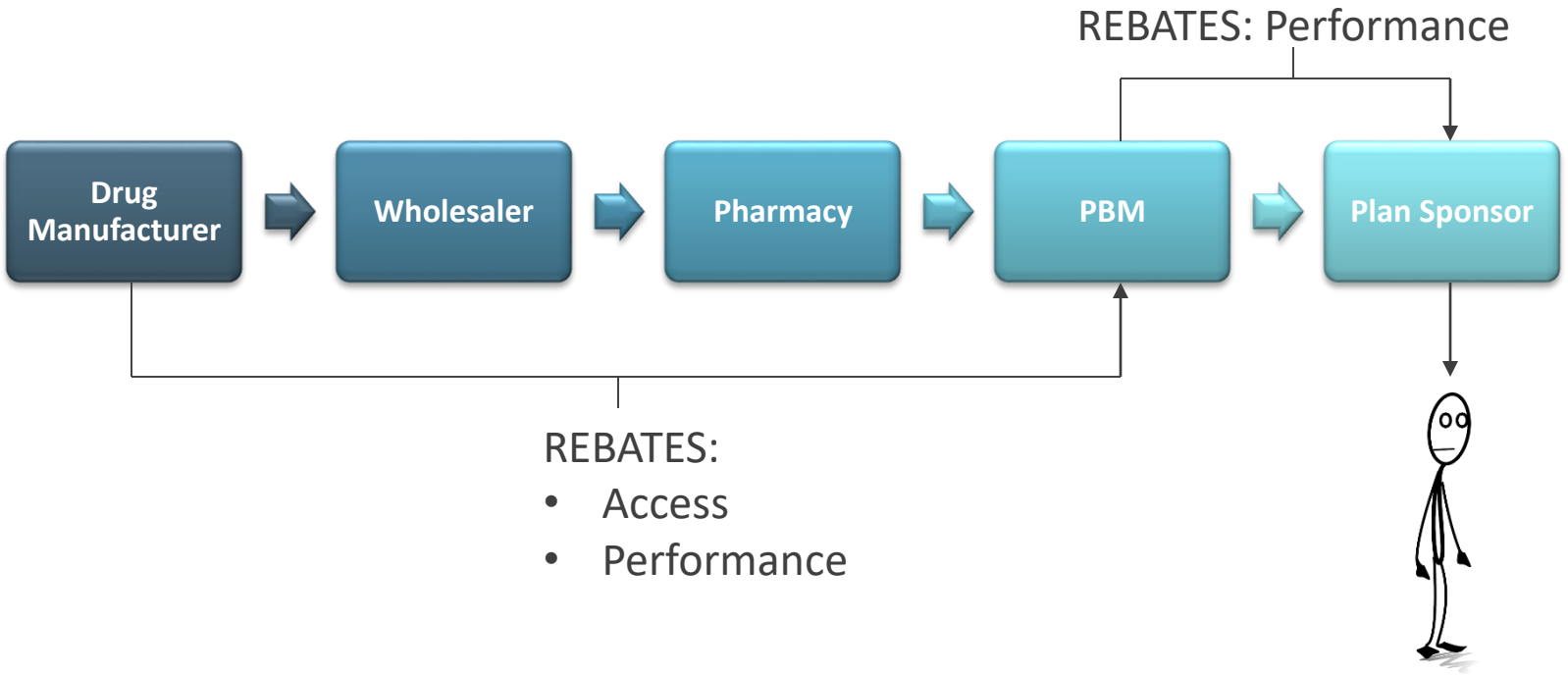
Fully Insured

- Health plan / carrier directly integrates with PBM
- Rebates retained by the health plan

Self Insured

- Plan sponsor may utilize PBM partnered with health plan/TPA or may carve out and select own PBM
- If carved in, pharmacy contracts vary, and health plan may or may not pass through rebates to plan sponsor
- If Rx is carved out, PBM and health plan will have varying levels of integration; rebates to plan sponsor

CONTEXT: PHARMACY SUPPLY CHAIN



- Understanding the pharmacy supply chain is key to understanding what drives plan sponsors' pharmaceutical spend
- For Rx manufacturers, market share is the holy grail – multifaceted strategies utilized by drug companies to drive utilization and market share
- The plan sponsor's view of the Rx supply chain is seen through the prism of the PBM, and can, therefore, be distorted

CONTEXT: COMPONENTS OF PBM PRICING FOR PLAN SPONSORS

Dispensing Fees

- Fee paid to the pharmacy for dispensing the prescription
- Usually $2.50/script or less

Ingredient Cost

- Brand cost – typically AWP-X%
- Generic cost – AWP or MAC
- PBM cost does not always = plan sponsor cost

→ PBM earns $ on the spread between the price paid to pharmacy and the price charged to the plan sponsor

Rebates

- Paid by manufacturers to PBMs to drive market share
- Two kinds – Access & Performance
- Only Performance rebates shared with plan sponsor

→ PBM earns $ by retaining a portion of the performance rebates & by retaining 100% of access rebates

Administration Fees

- Claim processing fee charged by PBM – range from $0 to $4/claim – If $0, contract is not transparent
- Added fees may result from prior authorizations, step therapy or rejected claims

- Additional PBM revenue sources include fees for data sold, therapeutic switching fees, upcharging (using alternative NDC number to charge plan sponsor higher ingredient cost than the PBM paid)

Rx Trends

RX TRENDS – PBM CONSOLIDATION

The PBM marketplace has witnessed significant consolidation in recent years:

- CVS buys Caremark in 2007
- Express Scripts (ESI) acquires MedCo in 2012
- Catamaran buys ReStat in 2013; UHC buys Catamaran in 2015
- RiteAid bought EnvisionRx in 2015
- CVS/Caremark bought Omnicare (largest provider of drugs to nursing homes) and Target pharmacies & medical clinics – both in 2015

- Big three PBMs – ESI, CVS and UHC/Optum estimated to control two-thirds to three-quarters of the market

RX TRENDS – PBM CONSOLIDATION

Why is consolidation a problem? Big three have negotiating clout, but…

- PBMs are not taking risk; their primary responsibility is administrative – to adjudicate pharmacy claims
- The plan sponsor ultimately retains the financial risk for pharmacy costs
- Profit motive is first priority for PBM; best outcomes and lowest cost for plan sponsor is secondary

Results:

- Lack of transparency related to ingredient cost & rebates - PBM profiting off the spread
- Unilateral control of PBMs over formularies and tiering – driving greater profits for PBMs through rebates, but are these the best decisions for the plan sponsor?
- Best in class PBM contract allows plan sponsor to consider both financial and clinical outcomes

RX TRENDS – SPECIALTY DRUGS

Specialty Rx spending rising rapidly – expected to increase to 50% of total drug spend by 2020

- Currently specialty spend is ~25 - 30% of total Rx spend for most employers
- Specialty drug prices expected to increase 10 – 20% per year over next few years
- Greater utilization of specialty meds through both introduction of new drugs and expanded approved uses of given medications

New drugs in pipeline mostly specialty drugs

- Expansion in types of conditions treated with specialty meds and overall number of medications - specialty meds for the treatment of relatively small populations – rare diseases
- PCSK9 Inhibitors – an alternative for statins, for those whose cholesterol is not lowered to goal levels with the use of statins – annual cost of $14,000 vs. $150 for generic statins
- Hepatitis-C treatments – provide a cure, which means likely lower overall spend during a lifetime, better outcomes and quality of life.
  - The CDC estimates ~ 3.5 Million individuals are living with the Hepatitis C (HCV) infection in the US; cost of Rx cure for Hepatitis C is $75,000 - $100,000

Specialty drug programs expand beyond cost-effective procurement to provide comprehensive care management support for specialty drug users

- Specialty medications are not a silver bullet; compliance and adherence are necessary to achieve results
- Specialty medications should be subject to clinically-based prior authorization review
- Effective specialty pharmacy programs provide condition-specific case management and member support to drive adherence and to assist with adverse reactions/side effects

RX TRENDS – PLAN DESIGN

Current plan design trends:

- Increased number of tiers – up to 6 different copay tiers
  - Preferred and non-preferred generic
  - Preferred and non-preferred brand
  - Preferred and non-preferred specialty
- Key considerations for copay amounts and tiering in plan design
  - Spread between tiers does drive rebate amounts – e.g. greater spread between preferred and non-preferred brand will drive higher rebates
  - Raising copays = cost shifting to the member, not necessarily removing unnecessary costs from the system
  - Avoid making member cost share unaffordable – medication adherence is critical to drive best clinical outcomes
- Focus on Rx efficacy
  - Exclude compound medications and non-FDA approved drugs
  - Address manufacturers' direct to consumer copay coupons – Jublia at $500 per script vs. Lamisil at $14 OTC to treat toenail fungus

RX TRENDS – PLAN DESIGN

Current plan design trends:

- Prior authorization & step therapy very common strategies today
  - Fully insured plans mandate
  - Effective utilization management strategy? What is incentive for PBM to employ strict PA protocols if these limit PBM's rebate volume?
  - PBM may review one time and set prior approval with no end date – manufacturer rebates incent this behavior
  - Outsourcing prior authorization review to clinical UR firm shifts focus to achieving best clinical outcomes
- Exclusionary formularies – exclude certain drugs from the formulary altogether
  - Should drive lower ingredient cost and higher rebates for plan sponsor
  - May result in higher profits for PBM – access rebates & other incentives
  - Key question: is the exclusionary formulary aligned with best outcomes for members or the greatest financial gain for PBM?

RX TRENDS – NETWORKS

Most PBMs now offer multiple networks to choose from:

- **Open Pharmacy Network** – A broad national network providing open access – typically 65,000+ pharmacy locations
- **Open Pharmacy Network Excluding One** - Broad national network excluding one of the major chains – e.g. exclude either CVS or Walgreens - ~55,000 pharmacy locations
  - BCBS IL / Prime Therapeutics excluded CVS starting 1/1/2017 for all insured PPO plans; option for self-insured
- **Preferred Pharmacy Network** – Member can access any network pharmacy in the broad national network, but has a financial incentive – e.g. $10 copay differential – to use a pharmacy that is in the preferred network
  - Very common network strategy with Medicare Part D plans
  - BCBS IL / Prime Therapeutics introduced this strategy with some insured plans for 2017 – includes Walgreen's, Walmart, Albertson's/Osco & a select group of independent pharmacies
- **Limited Pharmacy Network** – Significantly more limited network of pharmacies for members to access – 20,000 – 30,000 pharmacies nationwide

RX TRENDS – NETWORKS

- 90-days at retail – No longer limited to mail order, ability to fill a 90-day supply for a maintenance drug at retail drives use of preferred pharmacies
- Specialty drugs – Exclusive use of a mandated specialty pharmacy
  - PBM-owned or aligned specialty pharmacy
  - Unbundled specialty pharmacy – separate from the PBM
- Tradeoff: Driving greater use of certain pharmacies through incentives or limits will drive down costs at the expense of consumer choice/convenience

Cost Management Strategies

COST MANAGEMENT STRATEGIES

Vendor selection & contract negotiation – Self Insured Plans

- If plan is currently self-funded with PBM carved in, consider any marketing should evaluate both carve-in and carve-out contracts
  - Introduce competition to drive best in class pricing
  - Consider value of carve-in national health plans estimate full integration through carve-in reduces medical costs by 3 – 5%
  - Carve-out deal may improve overall costs enough to make it financially worthwhile
- Evaluate the market & solicit competitive bids at least every three years – pharmacy pricing is dynamic and constantly evolving
- Benchmark and negotiate to achieve market competitive pricing
  - Dispensing fees
  - Ingredient cost & discounts
  - Rebates
  - Administrative fees
- Adopt a transparent or full pass-through deal
  - PBM passes through full rebates to plan sponsor
- Evaluate and implement clear definitions in your PBM contract:
  - Definitions of brand, generic and specialty drugs
  - Source of AWP should be limited to Medispan
  - PBM contract should allow plan sponsor audit rights with a reasonable definition of acceptable audit firms

Execute a contract that aligns financial incentives with achieving the possible best clinical outcomes.

COST MANAGEMENT STRATEGIES

Plan design

- Evaluate copays, tiering and cost sharing
  - Design a plan that balances the member's cost share with the need to drive medication adherence
  - Consider additional drug tiers to drive utilization of most cost-effective medications
- Mandatory generic / mandatory mail order
  - only if financial incentives for plan sponsor align with those of the PBM
- Implement step therapy & prior authorization protocols that drive better clinical outcomes
  - May need to outsource to clinical UR specialist in order to achieve best clinical outcomes
- Limit specialty medications to 30 day fills only – do not allow 90-days for specialty
- Avoid exclusionary formularies – utilized by some PBMs to maximize their rebates, these formularies prioritize rebates over clinical efficacy

COST MANAGEMENT STRATEGIES

Plan design

- Implement medication adherence and clinical management programs to drive better outcomes
  - Clinical support to maximize adherence with medications to treat chronic conditions such as diabetes, high cholesterol and asthma
  - Specialty condition management – oncology, transplant, rheumatoid arthritis, Hepatitis C, multiple sclerosis and HIV
- Exclude compound medications, non-FDA approved drugs

COST MANAGEMENT STRATEGIES

Network Management

- Evaluate financial impact of preferred or limited network options
  - Weigh against member disruption
- Options range from elimination of one major pharmacy chain to direct contracting with one pharmacy chain (e.g. Walgreen's or Walmart only)
- Implement 90 days at retail through a limited number of preferred pharmacies
- Mandatory sourcing of specialty meds through a specialty pharmacy
  - Consider carving this function out from PBM to a direct contract with a specialty pharmacy (or multiple pharmacies)

COST MANAGEMENT STRATEGIES

- For fully insured plans, many of these plan design and network strategies have already been introduced or mandated by the carriers
  - Definitely evaluate these plan design changes if offered as options to reduce premium costs
- Whether fully insured or self-insured, always review and discuss all plan design, network and formulary changes with your health plan or PBM
  - Understand what is mandated and what is optional
  - Ask your health plan/PBM to price out the estimated impact of any plan design or formulary change – they have the data to do this with precision
  - Any network or formulary changes should have a disruption analysis included, as well
  - Ask health plans to differentiate between multiple your plan options as not all plan, network and formulary changes consistently apply to all plan options offered by an employer group

Q & A

ACA Update

Presented By | Adam Jensen, Vice President

Cottingham & Butler

PRESENTERS

Adam Jensen

Vice President
Compliance and Human Resource Consulting

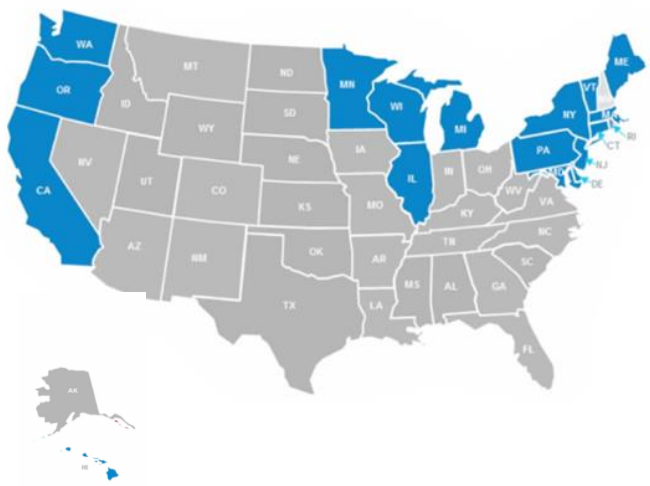
ajensen@cottinghambutler.com
608-467-5030

AGENDA

- Election Results and Potential Future Impacts on the ACA
- Potential Strategies
- Key Players and Potential Roadmap to Replace ACA
- What Stays, What Goes, What Changes?
- Executive Order
- Next Steps

ELECTION RESULTS AND POTENTIAL FUTURE IMPACTS ON THE ACA

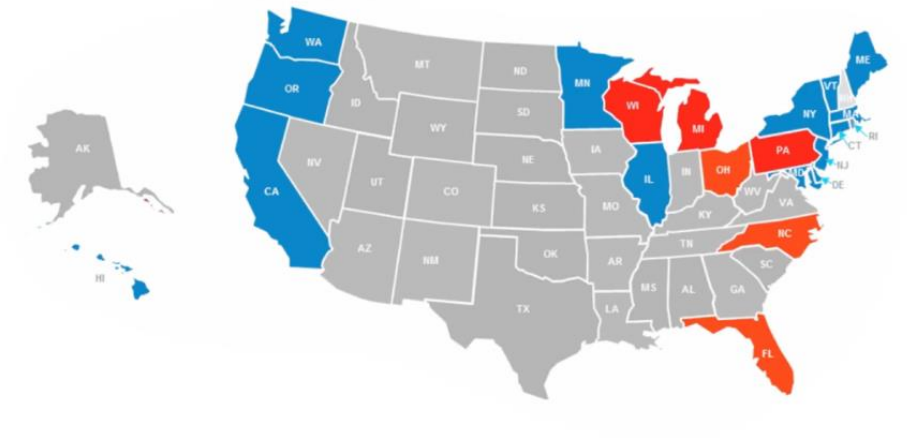
1992-2012



1992-2012 these 18 states and the District of Columbia have voted in the same pattern. This represents 242 electoral votes, also known as the "Blue Wall." 270 electoral votes to win the election.

- Source New York Times 270towin.com

2016



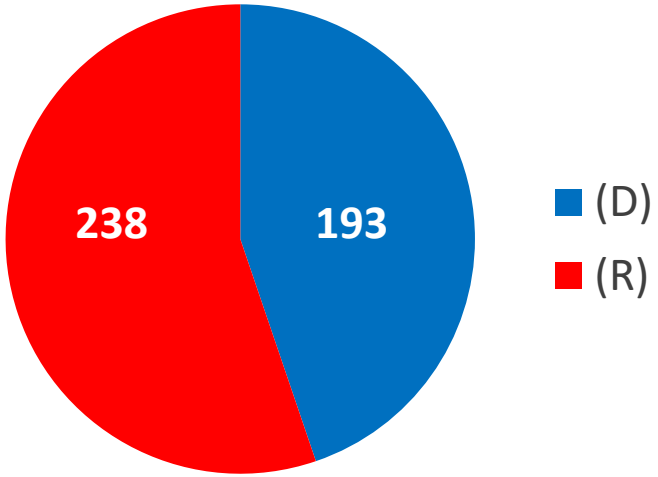
Traditional swing states like Ohio, Florida and North Carolina all voted for Trump in 2016. Pennsylvania, Michigan and Wisconsin, states that were a part of the "Blue Wall" Trump carried in 2016.

Wisconsin – George W. Bush lost twice by less than 1%.
Pennsylvania – 1988
Michigan - 1988

Source – New York Times 270towin.com

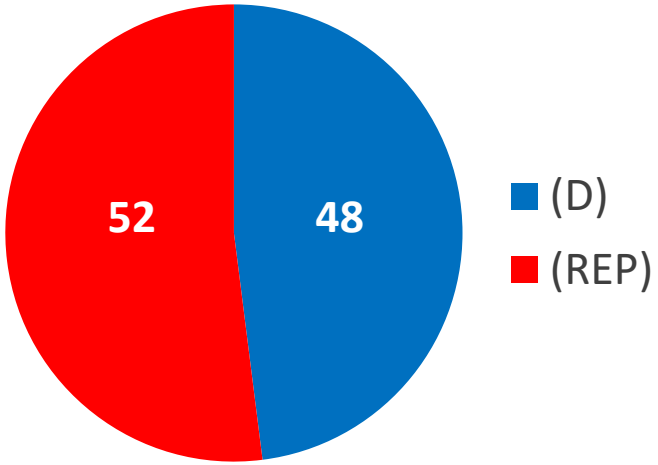
ELECTION RESULTS AND POTENTIAL FUTURE IMPACTS ON THE ACA

Post Election House of Representatives



Post Election Senate

** Two Independent Senate Seats. Both (I) candidates caucus with Democrats*



- GOP has a majority in Congress, but not a "super majority" of 60 seats needed to be "filibuster-proof".
- Republicans are in much the same position as the Democrats were in 2010.
- Strategy and actions likely to be driven by Republican desire to win 60 seats in 2018 midterm elections.

POTENTIAL STRATEGIES

- Due to lack of super majority (60 votes) in the Senate and the threat of a potential filibuster, Republicans may try to use the “Reconciliation” strategy that the Obama administration used to pass the ACA originally.
- Reconciliation only needs a simple majority of 50, fewer than the 52 seats Republicans currently hold.
- Very specific requirements to use Reconciliation.
- According to the “Byrd Rule”, Reconciliation is limited to provisions that affect federal revenues and spending and requires only a simple majority to pass.

POTENTIAL STRATEGIES

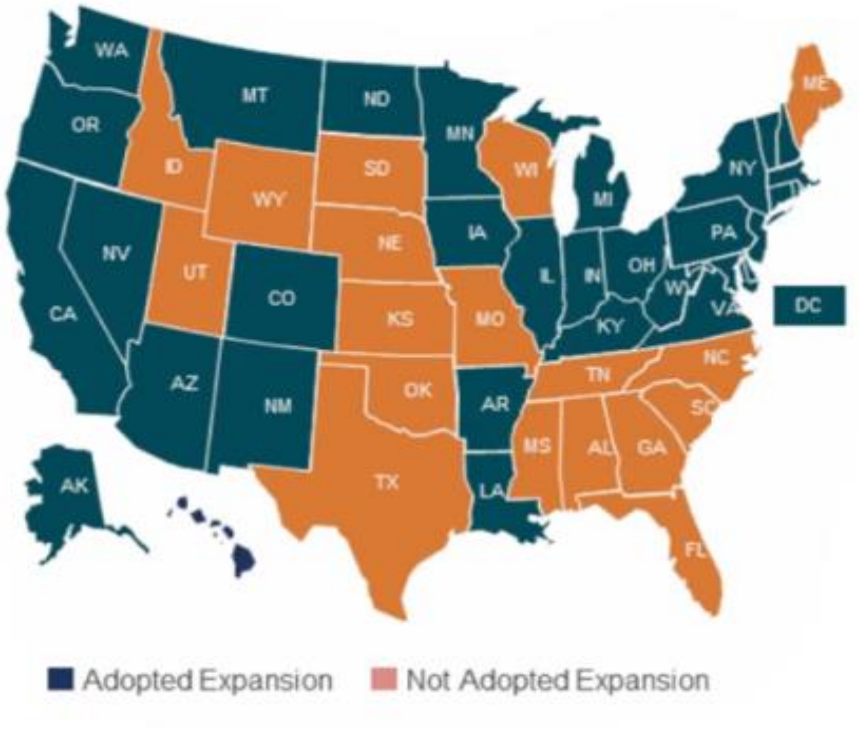
- This means the Republicans can repeal Obamacare, but with only 52 seats they cannot pass its replacement without cooperation from the Democrats who can filibuster.
- This effectively gives Republicans two options:

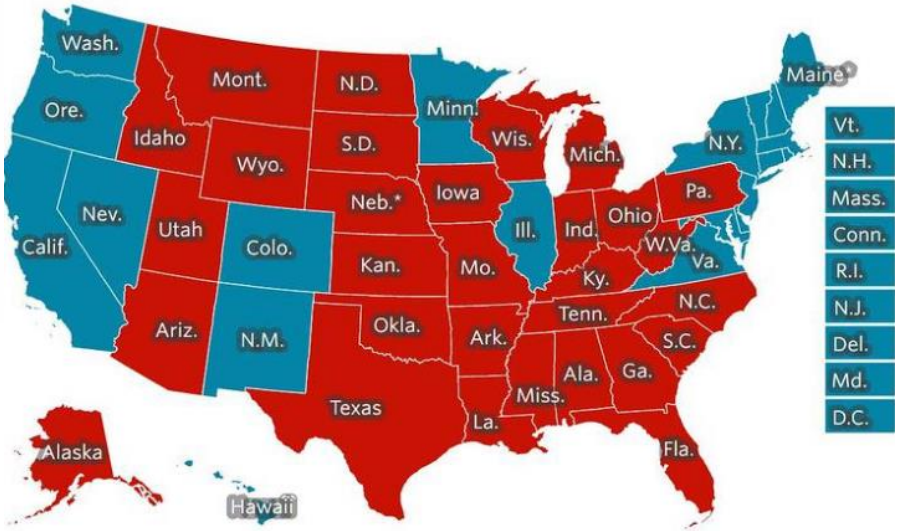
1. Repeal and Replace
2. Repeal and Delay

- Both strategies have dangers for the Republicans.

POTENTIAL STRATEGIES

Immediate repeal of the funding of Obamacare would create massive insurance market issues. It also would immediately take away the Medicaid expansion 31 states picked up. This would leave roughly 19-22 million people potentially without coverage with the potential loss of Medicaid expansion and exchanges. This would also create significant political blow back before the 2018 Mid-Term Elections.





POTENTIAL STRATEGIES

Step 1: Legislation **Repeals** the ACA
How: Through Reconciliation
Benefit: Only need 50 votes to pass, (R) have 52 current seats.
Issue: Potential political set backs, large spike in uninsured rates.
Solution: The most likely scenario would be to delay reduction of funds for Medicaid and exchange subsidies for 12-24 months. Provides time to plan for a replacement plan. This would also make sense because the Republican party is currently divided on how this should work.

Step 2: Legislation **Replaces** ACA
How: Timing will play a role here with the Mid-term elections. If super majority isn't established bi-partisan coalition would be required.
Benefit: Democrats may be willing to make compromises to avoid individuals losing coverage. However, there are only a few items the sides have historically agreed on.
Issue: Democrats may not be willing to make compromises and individuals lose coverage when no immediate replacement plan is implemented.

KEY PLAYERS AND POTENTIAL ROADMAP TO REPLACE ACA

Key Players in the Repeal Process

- Tom Price - President Trump's selection for Secretary of Health and Human Services. (HHS)
- Price will oversee the $1 Trillion dollar budget department.
- A six time Republican congressman from Georgia, and a former orthopedic surgeon.
- Rep. Price has introduced bills offering a detailed, comprehensive replacement plan in every year since 2009.
- Favors widely available affordable coverage.
- Many of his offerings mirror those of Paul Ryan's "A Better Way".

KEY PLAYERS AND POTENTIAL ROADMAP TO REPLACE ACA

Tom Price is the architect of the "Empowering Patients First Act"

The Act would:

- Repeal the Affordable Care Act and offer age-adjusted tax credits for the purchase of individual and family health insurance policies.
- Tax credits would create refunds for those who don't normally get refunds as a way to reimburse people for coverage rather than advanced tax credits up front.
- Create incentives for people to contribute to health savings accounts; offer grants to states to subsidize insurance for "high-risk populations"
- Allow insurers licensed in one state to sell policies to residents of others.
- Authorize business and professional groups to provide coverage to members through "association health plans."

KEY PLAYERS AND POTENTIAL ROADMAP TO REPLACE ACA

Key Players in the Repeal Process

- Paul Ryan – House Speaker.
- March of 2016 he introduced "A Better Way" aiming to replace the ACA and make changes to 5 other areas (national security, taxes, poverty, economy and the Constitution).

KEY PLAYERS AND POTENTIAL ROADMAP TO REPLACE ACA

Paul Ryan's "A Better Way" proposal is expected to be a guide for the administration.

- For people without access to employer coverage, Medicare, or Medicaid, offers a refundable tax credit to help buy health insurance in the individual market.
- Expand the use of health savings accounts.
- Preserve employer-based insurance, but caps the open-ended tax break on employer-based premiums.
- Allow sales across state lines.
- Allow small businesses and individuals to band together through new pooling mechanisms.
- Back wellness programs.
- Medical liability reform.

ACA

What stays, what goes?

ACA feature likely to remain:

- Elimination of Pre-Existing Conditions
- Potential for 2-tiered system:

1. Continuous coverage, no Pre-Ex
2. Break in coverage, subject to Pre-Ex

- Supported by insurance industry to combat adverse selection/death spiral

WHAT STAYS, WHAT GOES, WHAT CHANGES?

What stays, what goes?

ACA feature likely to remain:

- Ban on Rescissions
- Guaranteed Issue
- Guaranteed Renewal

WHAT STAYS, WHAT GOES, WHAT CHANGES?

What stays, what goes?

ACA feature likely to remain:

- Elimination of Lifetime Dollar Limits (Annual Dollar Limits might return)
- Coverage to Age 26
- Coverage of Clinical Trials
- Elimination of Prior Auth for OB/GYN, Pediatric Svcs, Out-of-Network ER Care
- Increased Wellness Incentives

WHAT STAYS, WHAT GOES, WHAT CHANGES?

What stays, what goes?

ACA features likely to go/change:

- Employer Mandate (“Play or Pay”)
- Reporting (possibly not right away)
  - Needed for MarketPlace subsidies
- Individual Mandate
- Cadillac Tax

WHAT STAYS, WHAT GOES, WHAT CHANGES?

What stays, what goes?

ACA features likely to go/change:

- Federal Operation of Exchanges/MarketPlaces (reinstate state high risk pools?)
- Medicaid Expansion (replace with block grants?)
- Advanced Premium Tax Credits
- Other ACA Taxes (Medicare Surtax, Medical Device Tax, Health Insurer Tax)
- OTC Ban, Dollar Cap for FSAs
- Effect on IRS Guidance (Cash in lieu of benefits, etc.)

WHAT STAYS, WHAT GOES, WHAT CHANGES?

ACA Items on the fence:

- Medical Loss Ratio/Limits on Carrier Profits (trade off for MarketPlace?)
- Annual Dollar Limits
- Preventive Care without Cost Sharing (Staying but changing?)
- Section 1557 non-discrimination rules

WHAT STAYS, WHAT GOES, WHAT CHANGES?

How quickly might this happen?

- Don't expect to see the suspension of ACA reporting for this cycle
- IRS announced in Notice 2016-70 the extension of "good faith reporting" for 2016 filings and also extended the individual statement deadline from January 31, 2017 to March 2, 2017
- Conservative position is to carry through with 2016 1095-C filings
- Executive Order arguably waives Play or Pay penalties for 2016
- The ACA "is the law until is isn't"; it's in effect until repealed/replaced

EXECUTIVE ORDER

On January 20th, President Trump signed an Executive Order "Minimizing The Economic Burden Of The Patient Protection And Affordable Care Act Pending Repeal".

Section 2 of the Executive Order states:

> "Sec. 2. To the maximum extent permitted by law, the Secretary of Health and Human Services (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."

EXECUTIVE ORDER

- The Executive Order essentially instructs the regulatory agencies (DOL, IRS, HHS) to do what they can to unwind the law, but any changes to the actual agency-made regulatory law must comply with the Administrative Procedures Act (APA).
- Formally changing existing regulations takes time, due to notice-and-comment periods for proposed regulations.
- Agencies can extend compliance and enforcement delays or be more lenient in enforcement, but the law is still the law (until it isn't).
- In the short run, employers will need to continue to offer coverage and comply with the reporting requirements for the 1094-C/1095-C.
- Do not anticipate any waiver of the reporting requirement for the current cycle.
- If the Trump administration retains an of income-based MarketPlace subsidy, some type of employer reporting will be needed.

NEXT STEPS

What should employers do next?

- All ACA provisions remain in effect.
- In the near term, employers should continue to comply with the ACA.
- Employers should complete their 2016 plan year 1094-C/1095-C reporting obligations.
  - Employee 1095-C statements must be provided to employees by March 2, 2017.
  - Employers must complete electronic filing with the IRS by March 31, 2017.
- Employers must continue to offer coverage to full time employees and their dependents.
- Employer coverage must continue to meet the affordability and 60% minimum value requirements.
- Employers should continue to monitor the situation.

QUESTIONS?

Adam Jensen

Vice President
Compliance and Human Resource Consulting

ajensen@cottinghambutler.com
608-467-5030