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INTEGRATION IN HEALTH CARE DELIVERY

Several corporations have announced mergers and acquisitions recently that may affect the future of health care delivery. These mergers are not just two prominent health insurance carriers joining forces; instead, they represent a vertical integration of specific health care service vendors.

Regulators and shareholders still need to approve a $69 billion CVS and Aetna deal. CVS will take over Aetna, the third largest insurance carrier in the country. Aetna will become a standalone unit inside CVS. CVS businesses currently include the retail pharmacy chain, Minute Clinics and CVS Caremark, one of the largest pharmacy benefit managers in the country.

The combined organization intends to redefine how we access healthcare by making retail clinics a key part of health care services. Employers struggling with cost have historically tried to steer members to the lowest cost venue that would meet their care needs. The general plan is to use the retail clinics along with other Aetna health care providers. These clinics, already part of the community, can help manage chronic conditions. According to the Centers for Disease Control and Prevention (CDC) 86 percent of the $2.7 trillion spent on health care involves either chronic or mental health conditions.

Once the dust from the merger settles, the organization hopes to expand the range of services its retail clinics offer. It may even add biometric services and nutritional counseling. The aim will be to coordinate care with Aetna physicians and hospitals. If the nurse practitioner at the clinic notices a patient has a medical issue, the nurse could contact the physician or even the hospital directly to help guide the patient to appropriate care immediately.

United HealthCare is taking a similar approach. Its business unit, Optum, recently purchased DaVita Medical Group. This medical group includes 300 clinics that offer primary and

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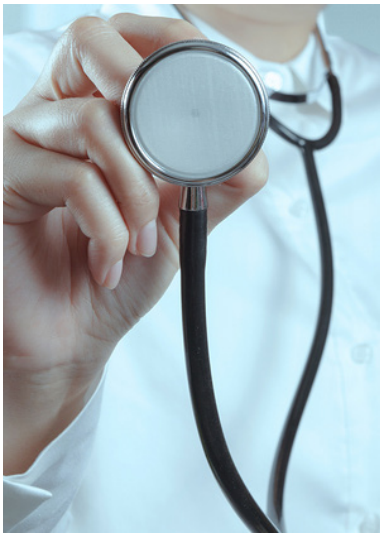

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specialist care, urgent care centers and also a few surgical care centers. United Healthcare intends to actually own the entry points to the health care system. The benefit of owning primary care is that United Healthcare will steer and manage patient care early in the treatment process. United Healthcare will also try to direct members to the lowest cost venue.

The hope is that these vertical integrations may help rein in some health care spending. A conveniently located, neighborhood walk-in clinic rather than a physician's office, urgent care center or even the emergency room could reduce costs. For certain conditions or for routine checks on chronic conditions, patients can receive effectively delivered care at a retail walk-in clinic. In some cases these walk-in clinics can be enhanced to help patients coordinate their care and eliminate unnecessary office visits. The idea is to reduce hospitalization through better access to primary care for chronic conditions. It is also a hope that as patients form relationships with nurse practitioners at retail clinics, patients will seek care from them for routine or non-emergency care. These practitioners will effectively guide patients through the health care system.

It is not a given. Some contend that having easy, affordable access to primary care will increase utilization. People may choose to seek care when they might otherwise wait it out when care is so readily available.

DID YOU KNOW

- 32% of health plans cover genetic testing
- 29% of health plans cover genetic counseling
- 68% of health plans cover online medical visits
- 43% of health plans cover online behavioral health visits
- 53% of employer's health plan administrators or vendors promote mobile technology tools
- 19% of employers believe the majority of their employees use the mobile technology for health needs

Source: International Foundation of Employee Benefit Plans and Horizon Actuarial Services LLC, 63rd Annual Employee Benefits Conference, 2017

The other interesting development in health care innovation is the new company being formed by Amazon, Berkshire, and JPMorgan. These three organizations plan to create a company whose goal will be to reduce their employees' health plan costs. While the new company is focused on the health care cost for Amazon, Berkshire and JPMorgan, they may develop innovations that can be adopted by other organizations.

It is good to see insurance carriers, health care providers and employers trying new ways to help reduce costs. Many employers are struggling to afford their group health plans. Historically, to meet budget targets, employers shifted cost to employees. Cost-shifts take two forms:

- Increased cost-sharing when members use the plan
- Increased contributions to elect coverage

Many employers are concerned that health care is becoming unaffordable for many employees. Yet, health plan costs continue to rise and employers are struggling. They are trying to focus on cost control measures that do not shift cost to employees but use health plan funds more efficiently instead. If health plan vendors can offer more cost effective plans, some employers may be able to control cost without shifting more and more cost to employees. This may be an opportunity to create health plan options that employees can more readily afford.

More vertical integrations may be on the horizon. Owning the entry point to the health care system can help control cost. Guiding a patient to appropriate care at the right time would go a long way to reducing unnecessary care. If easily accessible

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walk-in clinics could help patients better manage chronic conditions, patients may not suffer costly complications.

Many are at a breaking point when it comes to health care costs. Employers can't continue to absorb increases 2 to 3 times the rate of inflation. Employees covered by high deductible plans simply don't seek needed care because they know they can't afford a hospital stay or an emergency room visit. The cost of health care is the problem. Innovative efforts to lower the cost of care, or deliver care more efficiently may help better control these costs for employers and employees. MMA

PHARMACY BENEFITS WILL TAKE THE SPOTLIGHT IN 2018

As health plan costs continue to increase, pharmacy benefits will continue to be a key part of the discussion. Health plans are spending more and more on these benefits. PriceWaterhouseCoopers projects pharmacy benefits will account for approximately 17 percent of employer-sponsored health plan spending in 2017. Employers find it difficult to determine whether they are effectively managing their pharmacy benefit program. Increases in drug prices over the last few years have created many problems in paying for prescriptions. It helps to understand all the entities that contribute to managing complex pharmacy benefits.

Following are the key entities in the process:

- Pharmaceutical manufacturers – make the drug.
- Wholesalers – connect the manufacturer with the pharmacy. They purchase medication from manufacturers for an amount called the Wholesale Acquisition Cost (WAC). However, this amount is the list price for a medication and not always what the wholesaler spends. The WAC is often discounted based on bulk-purchasing, prompt payment or other discounts and rebates.
- Retail or mail order pharmacies – where a patient buys prescribed medications.
- Pharmacy benefit managers (whether separate or part of an insurance carrier's pharmacy department) – typically administer prescription drug claims for a self-funded employer or for an insurance carrier's block of business. They negotiate pricing, rebates and other provisions usually with participating pharmacies. When an insured member buys a medication, the PBM processes the claim and employees pay their share. PBMs also offer a range of administrative and clinical tools to reduce the amount the health plan spends on medications.

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YOUR QUESTIONS

Q: Our organization is working on calculating the cost of health care coverage to include in Box 12 of the W-2. Last year, we launched a wellness perks program for our employees through our insurance carrier. The cost of the program is embedded in our insurance premium. Should we include this cost in our Box 12 calculations or should we ask the insurance carrier to provide us premiums without the wellness perks program?

A: Good question. The fact the cost of the perks is embedded in your premium means you should include it in the cost reported in box 12. The IRS guidance states that if you charge a COBRA premium for the wellness program, then it should be included in the reporting for Box 12. If you do not charge a COBRA premium to continue the wellness program, then including the cost in the Box 12 is optional. In your case, since the program cost is embedded in the insured premium, it would be part of the COBRA cost and should be include in Box 12.

TREND TIDBITS

$ Health plan cost increased at 2.6% in 2017 after plan changes.

$ A fourth of employers reported no increase or a decrease in 2017.

$ A third of employers reported an increase of 10% or more in 2017.

$ In the last five years, health plan cost increases averaged just over 3%, compared with 6% averaged over the prior five-year period.

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2017

- Employers/Health plan sponsors – Ultimately they pay for the prescription drugs their members purchase. They typically pay for utilization, unless fully insured.

At every stage, except the employer payment stage, every entity will make some money for the service it provides. Some of the payments are transparent like an administrative fee per script. Other payments are less transparent, such as when a pharmacy charges the negotiated cost, rather than a lower cash price offered to those without insurance.

Employers need to understand how all these entities are paid and how transparent the pharmacy arrangement is.

Most PBMs focus on savings they offer when they try to obtain your business. Expected rebates are a large part of the discussion. The PBM or health plan sponsor receives rebates based on the specific mix of covered brand name drugs.

Evaluating a pharmacy arrangement has gotten more complicated over the last decade. While most employers look at savings before they change vendors, they miss part of the picture if they don't also look at how much they will spend under a new contract. It is best to use a consultant that understands pharmacy benefit management and can explain the provisions.

Health plans are very concerned with pharmacy prices because these prices are becoming an increasing percentage of their costs. Health plan members are also very concerned with pharmacy prices because they are paying a greater share of the cost in many cases. In some ways, employees may be able to spend less on medications by paying cash at specific pharmacies or taking advantage of manufacturer coupons.

For example, in some situations, members may pay less if they pay cash for their prescriptions rather than making a claim through the health insurance plan. Employees are aware of the retail generic programs. All the programs are different but many stores, such as Walmart and Costco, sell generics at a deep discount. In many case, generic medications can cost just $4 for a thirty day fill. Meijer actually has a list of medications that are available with no copay at all.

Employees can also check cash prices on GoodRx. GoodRx is an app you can download on your smart phone. It compares drug prices at local pharmacies (including discount stores like Walmart). It also offers coupons valid at participating pharmacies.

If employees have a prescription for a very expensive medication with no generic option, encourage them to check the manufacturer's website. Some companies offer discounts (often called copay coupon cards) to help cover insured patients' out-of-pocket costs, at least for the first few months. Depending on their income, employees may also qualify for patient-assistance programs, which are run either by the drug maker or a charity that the drug maker finances. These coupon programs, however, can have a flip side that encourages your employees to use more expensive drugs. In these instances, the name-brand drug manufacturer offers a coupon to offset an employee's copay. The employee can, in some cases, fill the brand name drug for a lower cost with the coupon, while the employer's plan pays a higher cost for the brand name drug. Employers can make generics mandatory to avoid these potential costs.

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Managing pharmacy benefits is a struggle for employers and employees.

For employers, analyzing pharmacy costs and contract provisions is always a challenge. Understanding how the contract terms translate into what the employer pays, what the employee pays and how the pharmacy and pharmacy benefit manager are paid is difficult. For employees, understanding how to get an affordable price or the most cost-effective medication is a challenge.

Pharmacy costs will continue to increase, challenging both employers and employees. The cost challenges will remain a media focus. Employers need to understand how pharmacy benefit managers operate and take action to manage pharmacy cost carefully. MMA

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Technical Corner

BENEFIT ADMINISTRATION SYSTEMS

Most employers just finished open enrollment. Now is the time to evaluate that process to determine whether to make changes for 2018. Whether you conduct open enrollment electronically or collect information on paper, reviewing the process will help you identify areas to improve.

First, if you are still collecting open enrollment information on paper and manually entering changes with carriers, consider a benefit administration system. These systems collect information electronically and most will transmit data electronically to carriers and even your payroll system. This process tends to cause fewer errors than multiple manual entries (into carrier systems, payroll system and possibly even Human Resources Information Systems).

When you use a benefit administration system, you will still be an integral part of the process. You will need to verify the system has the correct rates and options loaded. In addition, you must reconcile all carrier bills and employee elections once you load open enrollment data in carrier systems and your payroll system. If you offer voluntary benefits that require evidence of insurability, make sure you finalize election amounts in the system once the evidence of insurability has been approved.

Even though you must reconcile and check all data included in the system, electronic enrollment is more efficient and more accurate than a manual process. You need to review and test the system before open enrollment to make sure all the information is correct and enrollment rules are applied correctly.

If you have considered a benefit administration system in the past and decided it was too expensive, check again. The costs have become more competitive over the last five years.

Even if your enrollment process is electronic, it always makes sense to do a post-open enrollment debrief. What went wrong? What processes added to the time it took to manage enrollment? What areas were difficult for employees? By reviewing the process now, you can correct or improve the system for next year. Improvements may involve different parts of the process. Improvement steps could focus on improving instructions or describing benefit plans in a more direct and pared down way.

Every employer who manages open enrollment should schedule a debrief session to analyze what worked and what needs to work better. Even if your organization plans appropriately and makes decisions on time, problems inevitably occur. If you take time to review and improve every year, the process will not be as daunting. MMA

LIABILITY LESSONS

WHAT CAN WE EXPECT WITH INSURANCE RATES IN 2018?

From the wildfires in California, the earthquakes hitting Mexico and other areas, and the six substantial hurricanes that we have experienced in 2017, insurance rates are expected to continue to rise in 2018.

WHEN WILL WE SEE THE RISE IN PREMIUMS?

With the auto market becoming tighter each month, we will see a gradual increase in auto premiums of 7%-12% over the next two years.

Unfortunately property premium increases are also on the way as well, and should expect to see the changes by late first quarter in 2018. We are predicting rates to go up each quarter by 3%-4%. Because of the increase in current litigation trends, the cost of General Liability insurance keeps rising and expected to increase 5%-7% in each of the next two years.

Workers' Compensation will continue to stay soft with a possible small decrease of 5%-8% due to the medical cost inflation that was overstated in prior years.

Following the same pattern of the General Liability and auto increases, Umbrella /Excess pricing will start to show an increase but on a smaller level. Management liability rates will also see small increases due to litigation and cyber losses. Economic and political change will also put pressure on corporate boards and leadership.

WHAT CAN YOU DO TO ANTICIPATE AND PLAN FOR THESE CHANGES?

Group Captives and Alternative Risk options should be discussed proactively. Planning, preventing, reducing, and managing risk needs to be a top priority in 2018. Turning your focus to your hiring procedures, facility safety, and cyber security tactics will help you mitigate and reduce your risks. After all, insurance can only support 35%-40% of your risk. Developing a plan and putting it in place is crucial. Meet with your insurance representative and see if they offer benchmarking and analytics technology to expose the biggest areas of concern in your organization. MMA

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