

Financial Executives International - Central PA Chapter

Avoiding Costly Mistakes in your Health Plan Offerings

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Agenda

- Financial Healthcare Risks
 - Healthcare Cost Trends
 - Health Plan Offering Options
 - Special focus on Prescription Drug Costs
- Compliance Risks
 - Long-Standing Compliance Tasks
 - New Emerging Health Legislation Risks
- Employee Recruitment/Retention Risks
 - Health Plan Communication and Education
- Questions and Discussion

Financial Healthcare Risks

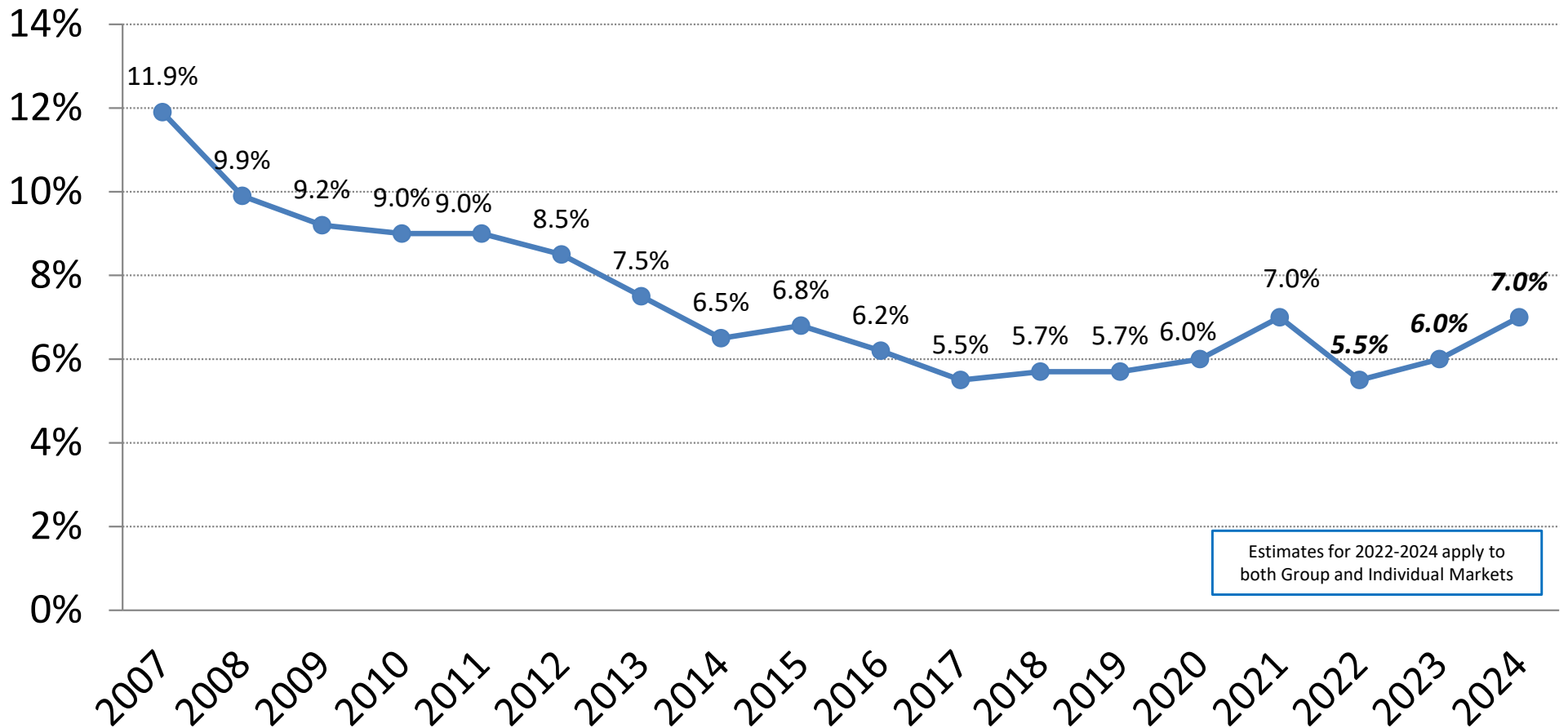
Financial Risks in Healthcare

- **The rising rate of health cost trends**
- **Changes in healthcare funding arrangements and plan offerings**
- **Significant cost drivers in the prescription drug space**
 - **GLP-1 drugs**
 - **Gene/Cell Therapy Treatments**
- **Increasing costs for an “unmanaged” health plan**

What Impacts Healthcare Trend?

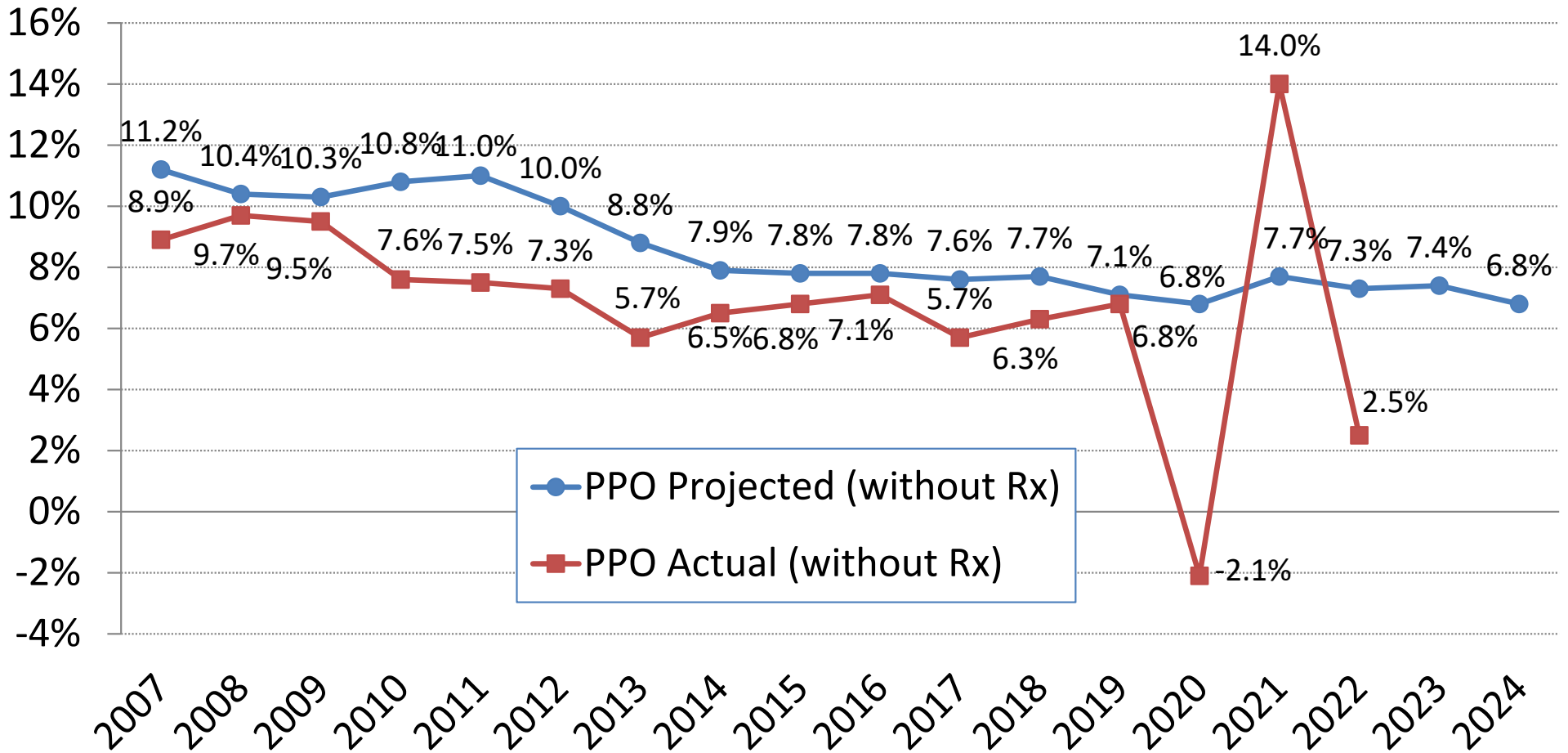
General Inflators	General Deflators
<ul style="list-style-type: none">• Post-COVID and General Inflationary Impacts on Providers	<ul style="list-style-type: none">• Shifts in Utilization to Lower Cost Site of Care
<ul style="list-style-type: none">• Rising Pharmacy Costs (including for rare disease specialty drugs)	<ul style="list-style-type: none">• Increasing Introduction of Biosimilars to the Market
<ul style="list-style-type: none">• Increase in Demand for Mental Health Services	<ul style="list-style-type: none">• Alternative Provider Contracting Arrangements
<ul style="list-style-type: none">• New Treatments and Technologies	
<ul style="list-style-type: none">• Healthcare Staffing Shortages	
<ul style="list-style-type: none">• Provider Consolidation	

Medical & Rx Cost Trends, 2009-2024



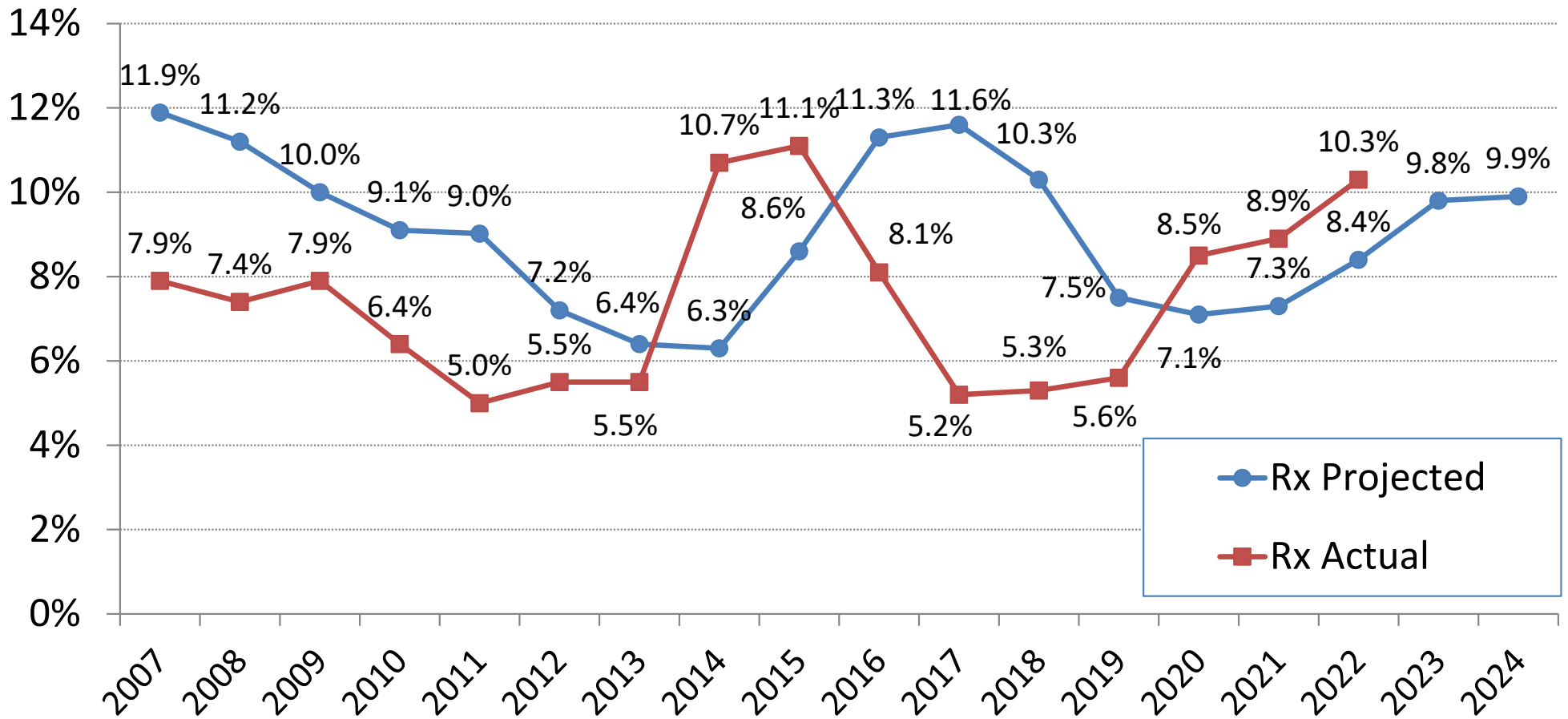
Source: PwC Health Research Institute Medical Cost Trends, 2009-2024

Medical Trends – Actual vs. Projected



Sources: Segal Health Plan Cost Trend Surveys

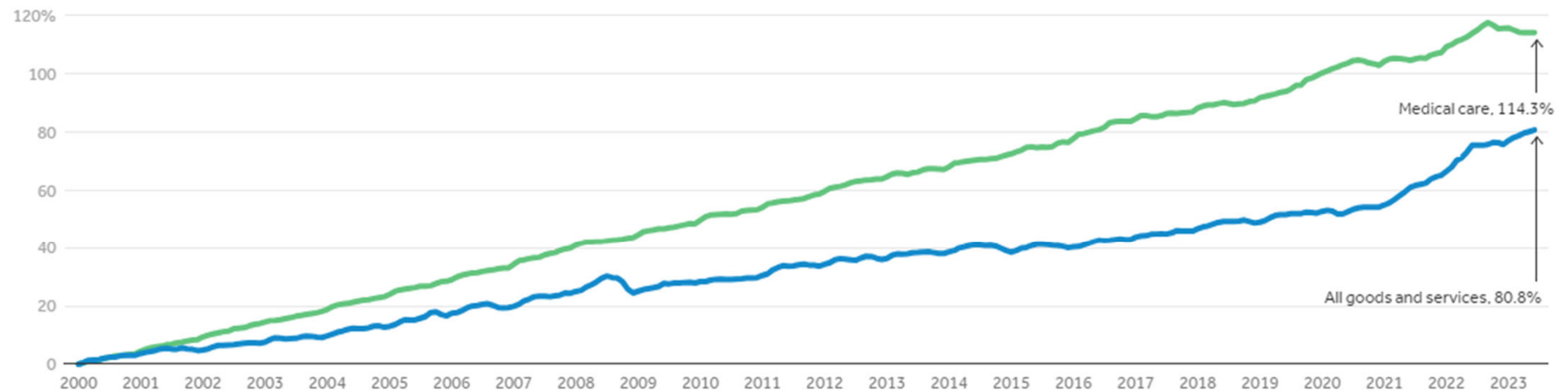
Prescription Drug Trends – Actual vs. Projected



Sources: Segal Health Plan Cost Trend Surveys

Healthcare Inflation vs. General Inflation

Cumulative percent change in Consumer Price Index for All Urban Consumers (CPI-U) for medical care and for all goods and services, January 2000 - June 2023



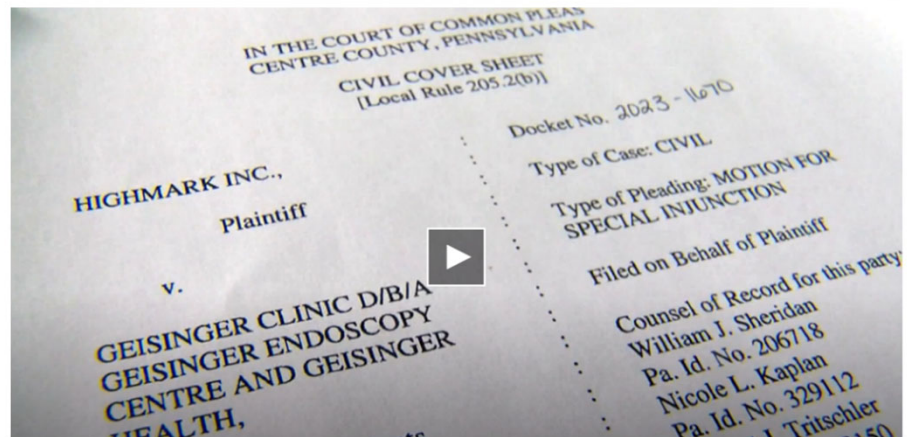
Note: Medical care includes medical services as well as commodities such as equipment and drugs.

- For many years, general inflation trends lagged notably behind medical trend. However, the gap significantly narrowed between 2021 and 2023 due to notable increases in general inflation, without corresponding bumps to health costs.

Will Healthcare Trend See a Delayed Increase?

Emergency order issued in ongoing legal dispute between Geisinger & Highmark

by Gary Sinderson | Wed, August 2nd 2023, 5:19 PM EDT



METRO

Some Ohio Medicare Advantage patients may need new doctors if dispute between Mercy Health, Anthem Blue Cross isn't settled

Updated: Aug. 17, 2023, 6:14 p.m. | Published: Aug. 17, 2023, 5:53 p.m.

HEALTH

WellNow, Excellus BlueCross BlueShield still at odds over urgent care coverage

BY JUSTIN VELAZQUEZ | SYRACUSE
PUBLISHED 8:02 PM ET JAN. 03, 2024

Johns Hopkins Medicine Termination Notice

Posted on 2022-09-08 | Updated on 2023-01-12 15:46:01

As a not-for-profit healthcare company, CareFirst BlueCross BlueShield (CareFirst) recognizes that rising costs are a significant concern for everyone, especially for the people and communities we serve. CareFirst works with all network providers to review arrangements and set compensation that is fair, reasonable and in the interest of our members and employers.

CareFirst and Johns Hopkins Medicine (Johns Hopkins) have been negotiating new contract terms for the physician rates that will apply to CareFirst members (primary care and specialty services) and surgery centers. On September 6, 2022, Johns Hopkins issued a notice to CareFirst terminating our existing network contract.

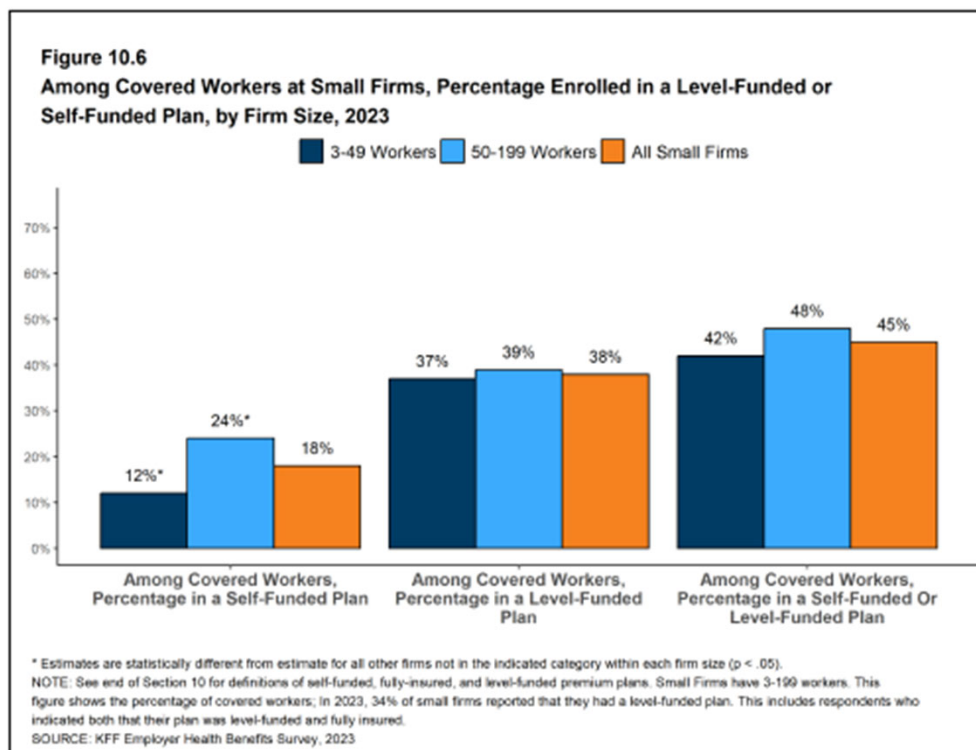
CareFirst members should be reassured this will not immediately impact anyone's access to healthcare services offered through Johns Hopkins. Members with scheduled physician visits or procedures through December 4, 2022, do not need to make alternative care arrangements.

Tiered/Narrow Networks and the Evolution of Plans

- 1980's – 2000's: HMO and "Indemnity" Style Health Plan Arrangements
 - Plans generally accepted by most providers (local/national) – uniform benefits
- 2000's – Current: PPO and Q-Plan Arrangements
 - Differentiation between "in-network" and "out-of-network" providers/benefits
- Late 2010's – Current: Narrow or Tiered Networks
 - Driving health plan utilizers to lower cost or preferred network providers via plan design

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.)			
Individual	\$2,000	\$4,000	\$5,000
Family	\$4,000	\$8,000	\$10,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits.)			
Individual	None	None	\$10,000
Family	None	None	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$8,550		Not Applicable
Family	\$17,100		Not Applicable

Plan Funding – Trends and Opportunities



- Medium and smaller employers have more recently looked to take advantage of self-funding or level-funding opportunities when available
- Recent trends mean a much more enhanced focus on cost containment through contracting and plan design, especially for prescription drug

How can employers respond to the risk in healthcare cost increases?

- Insured plans should continue to review the plans and options available in the marketplace, leveraging costs by taking plans out to market and considering tiered or narrow network plans for their employees.
- Insured plans should also consider self-funded or level-funded plan options based on their risk tolerance and their ability to review and project claims information, while minimizing any fixed costs.
- Self-funded plans must be diligent in reviewing and negotiating prescription drug contracts every few years to ensure that drug pricing is minimized while drug rebates are transparent and passed through to maximize savings (additional discussion in following section).
- All plans should monitor the marketplace to look for signs of provider/insurer contract negotiation that could notably impact costs.

GLP-1 Prescription Drug Background

- Many GLP-1 medications have recently hit the market and had effective results in helping reduce weight for diabetes patients.
- In the recent past, GLP-1 drugs have been brought to market for both diabetes and weight loss indications, including (but not limited to):

Diabetes Indication	Weight Loss Indication
Ozempic	Wegovy
Trulicity	Saxenda
Rybelsus	Zepbound
Mounjaro	
Victoza	

- Based on a June 2021 from US Health and Human Services, it is estimated that approximately 42% of adults are defined as having obesity (defined as BMI greater than or equal to 30), with another 30% being “overweight” (defined as BMI between 25 and 30).
- Average plan costs for an annual treatment of a GLP-1 can run from **\$12,000 - \$15,000** per year.

Prescription Drug: GLP-1 Analysis

Case Study: Year-Over-Year GLP-1 Analysis

Prescription	Primary Indication	2021-22 Rx Data		2022-23 Rx Data		Proj. 2023-24 Data		Cost Increase % for 2023-24
		Costs	Scripts	Costs	Scripts	Costs	Scripts	
Trulicity	Diabetes	\$532,167	415	\$605,602	478	\$556,700	430	-8.07%
Ozempic	Diabetes	\$441,377	324	\$592,571	410	\$874,500	640	47.58%
Rybelsus	Diabetes	\$94,573	95	\$171,809	130	\$178,900	140	4.13%
Victoza	Diabetes	\$93,809	52	\$43,017	23	\$21,500	20	-50.02%
Mounjaro	Diabetes	\$0	0	\$129,679	109	\$508,600	460	292.20%
Wegovy	Weight Loss	\$502,366	352	\$1,588,929	1,062	\$3,552,800	2,410	123.60%
Saxenda	Weight Loss	\$280,946	212	\$483,816	366	\$111,100	90	-77.04%
Zepbound	Weight Loss	\$0	0	\$0	0	\$531,800	530	n/a
Total GLP-1 Scripts / Costs:		\$1,945,238	1,450	\$3,615,422	2,578	\$6,335,900	4,720	75.25%
Diabetes Indication		\$1,161,926	886	\$1,542,678	1,150	\$2,140,200	1,690	38.73%
Weight Loss Indication		\$783,312	564	\$2,072,744	1,428	\$4,195,700	3,030	102.42%
Total Prescription Utilization:		\$24,400,180	134,451	\$28,027,594	145,999	\$31,099,800	142,827	10.96%
GLP-1 % of Total:		7.97%	1.08%	12.90%	1.77%	20.37%	3.30%	

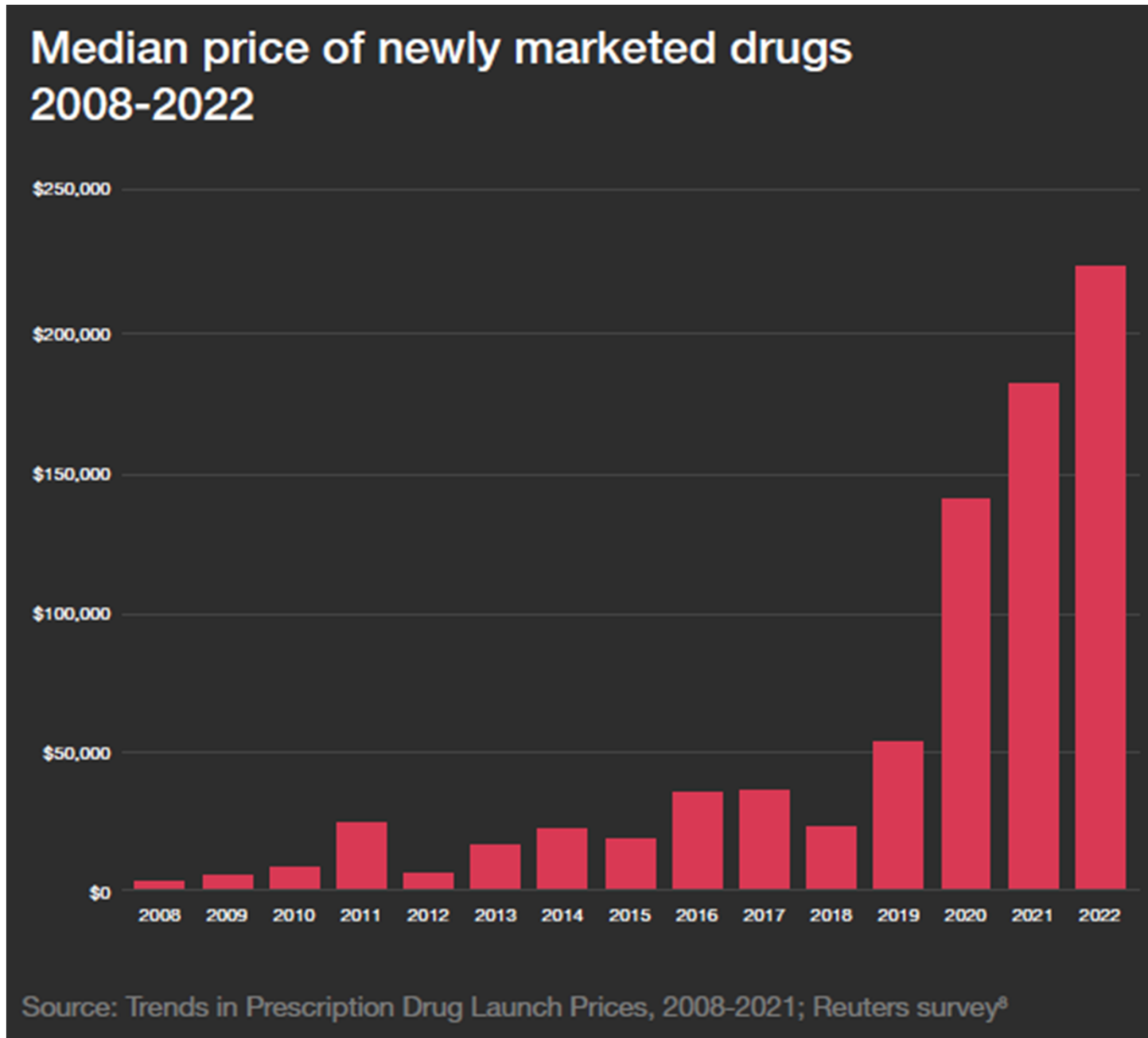
- 2023-24 YTD information shows claims filled in July-Mar., paid through 04/07/2024. Projected 2023-24 data shows Jul.-Mar. data completed through EOY based on March 2024 claims.
- Overall claim impact does not show prescription drug rebate payments, which apply for the scripts shown above.
- Data above is representative of one School Trust with more than 13,000 total covered lives.

Additional Weight Loss Drug Considerations

- Comparison of GLP-1 utilization for a few public sector Conrad Siegel clients in 2023:

Group	PBM/Insurer	2023 Weight Loss PMPM	2023 Diabetes PMPM	2023 Total GLP-1 PMPM
School Trust	PBM A	\$20.75	\$12.23	\$32.98
School Trust (does not allow weight loss drugs but no off-label prescribing controls)	PBM B	N/A	\$32.31	\$32.31
Gov't Employer	Insurer A	\$13.15	\$25.12	\$38.27
School Entity 1	Insurer B	\$8.36	\$13.26	\$21.62
School Entity 2	Insurer B	\$8.61	\$8.86	\$17.47

- PMPM – Per member per month claim costs (including dependents)
- Data above does not adjust for differences in plan design, demographics, population health or PBM management.



What are Cell and Gene Therapies?

- **Gene Therapy** is a technique that modifies a person's genes to treat or cure disease; they can replace a disease-causing gene with a healthy copy, or inactivate a disease-causing gene that is not functioning properly.
- **Cell Therapy** refers to placing new, healthy cells into the body to replace diseased or damaged cells, or the removal of disease causing or dysfunctional cells using immune cells.
- These therapies are life altering and often life-saving therapies.
- Challenge for health plans and payers is they also come with significant costs.

Emerging Cell & Gene Therapies

<u>Drug Name</u>	<u>Estimated Cost</u>	<u>Treated Condition</u>	<u>FDA Approved</u>
Hemgenix™	\$3,500,000	Hemophilia B	11/22/2022
Elevidys™	\$3,200,000	Duchenne Muscular Dystrophy	6/22/2023
Skysona™	\$3,000,000	Cerebral <u>Adrenoleukodystrophy</u>	9/16/2022
Roctavian™	\$2,900,000	Hemophilia A	6/29/2023
Zynteglo™	\$2,800,000	Beta Thalassemia	8/17/2022
Rethymic™	\$2,700,000	Congenital Athymia	10/8/2021
Zolgensma™	\$2,250,000	Spinal Muscular Atrophy	5/24/2019
Carvykti™	\$500,000	Multiple Myeloma	4/1/2022
Breyanzi™	\$471,000	Large B-cell Lymphoma	6/24/2022
Omisrige™	\$338,000	Stem Cell Transplant	4/17/2023
Abecma™	\$482,000-\$545,000	Multiple Myeloma	3/27/2021
Vyjuvek™	\$300,000/year	Dystropic Epidermolysis Bullosa	5/19/2023
Adstiladrin™	\$160,000-\$260,000	Bladder Cancer	12/16/2022

GLP-1 Drugs, Gene/Cell Therapy treatments, and other Rx Trends: How can health plans and employers respond?

- Reviewing prescription drug contracts to negotiate favorable rebates, pricing, and exclusions
- Consideration of alternate or more narrow formularies to control prescription drug costs
- Implementing different utilization management controls (e.g. prior authorization or quantity management) to control costs, especially around emerging weight loss drugs
- Considering stop-loss or pooled coverage arrangements to prevent catastrophic cost impacts for gene therapy drugs
- Utilizing data analytics to monitor utilization and look for irregular prescribing habits that drive costs
- Continuing to review/monitor prescription plan to understand cost risks

Compliance Risks in Healthcare

Examples of Financial Risks in Healthcare

- **Ongoing compliance items**
 - **5500 filings**
 - **Annual notices and disclosures / nondiscrimination testing**
 - **Affordable Care Act**
 - **Employer mandate and 1095 Reporting**
- **New compliance risks**
 - **Prescription Drug Data Collection (RxDC) Reporting**
 - **Gag Clause Attestations for Health Plans**
 - **Mental Health Parity**

Ongoing Compliance Items

- Form 5500 Filing
 - Required automatically for all health and welfare plans with greater than 100 participants
 - Also required for small “funded” welfare plans, which are recently more common with small group level-funded / self-funded options
 - 5500 filing required for each “plan” (benefit) unless a Wrap Document is in place
 - DOL late filing penalty up to \$2,529 per day
- Annual Notices/Disclosures and Nondiscrimination Testing
 - Several notices/disclosures are required to be distributed annually, including SBCs, CHIP Notice, WHCRA Notice, and HIPAA enrollment rights.
 - Per day penalties of hundreds of dollars for compliance violations
 - Nondiscrimination testing for health benefits is required for all Section 125 (tax-free) benefits and self-funded health plans
 - Plans that do not satisfy nondiscrimination testing for Section 125 plans could potentially lose tax-favored treatments for employees and the employer

Affordable Care Act Compliance Items

- Employer Mandate / Employer Reporting
 - 2023 and 2024 have seen a significant increase in the IRS's enforcement of the requirement of offering 30+ hour employees health coverage and its accompanying 1095 reporting.

GOVERNMENT POSITION:

Since there was no response from the Employer to the inquiry letters showing that the returns were either filed or the employer was not required to file the information returns, penalties under IRC 6721 and 6722 are being proposed for 2020:

IRC 6721 - Failure to File: \$78,400.00

IRC 6722 - Failure to Furnish: \$78,120.00

The Service determined the employer filed 279 Form(s) W-2 for 2020.

- IRS Penalty Letters
 - Sent to applicable large employers (employers with 50 or more full time equivalent employees) with coding errors in their 1095 forms or missing filings
 - Mailed to a general address and feature a short 30-day response window
 - Feature limited contact information/assistance from the IRS
 - Sometimes feature "penalties" for incorrect codes: situations where an employer is not at fault
- Employers should ensure that 1095 reporting is completed accurately and timely, and that support is available in the event of IRS inquiries or letters.

New Legislative Items Impacting Plans

- Prescription Drug Data Collection (RxDC) Reporting
 - As a result of the Transparency Rules, RxDC is required reporting that each employer must submit (or have submitted on their behalf) each year by June 1.
 - Self-funded plan sponsors have responsibility for submitting own reporting, which means creating a HIOS account and obtaining plan cost/enrollment data.
 - Insured plans still must provide information to the insurer to assist with filing.
- Gag Clause Attestation
 - By December 31 each year, all health plans must attest to the fact that there are no health plan cost “gag” clauses in their agreements. The original filing was due to be submitted by all self-funded plan sponsors by 12/31/2023, with annual updates to follow.
- Mental Health Parity (MHP)
 - While the original MHP law has been in place for more than a decade, recent updates and feedback from the Pennsylvania Department of Insurance has required notable changes for health plans in 2023 and 2024 to ensure mental health and substance abuse benefits are in parity with medical/surgical benefits.

Employee Retention and Recruitment Risks in Health Offerings

Employee Benefits and Recruitment/Retention Risks

- With the current state of the workforce market, the “total rewards” package has become more important for recruiting and retaining quality employees.
- Many employers make critical mistakes or oversights with respect to their health plan offering that impact their workforce, even after ensuring that their benefit plans have been designed in a cost-efficient manner.
- As consumer-driven plans become more common, employers must do more to communicate and educate certain benefit aspects / topics of their plans.
 - Health Savings Accounts (HSA) education should be heavily rolled out in the initial year that an employer offers a qualified high deductible plan and should be revisited annually at open enrollment.
 - Plans featuring tiered/narrow networks or different formularies must provide the proper training to guide employees to the carrier information that is relevant to their plan.
 - Employers should consider additional benefits or resources that may be relatively low cost but very valuable to employees

Employee Benefits and Recruitment/Retention Risks

- Employee HSA Education
 - Through review of Q-Plan differences and HSA rules at implementation
 - Annual/ongoing HSA education for “trickier” topics or more nuanced rules
 - Training or resources to assist with HSA vendor portal/tools
- Insurance Carrier / Third Party Administrator Information
 - Carrier website/portal training should be provided, especially for plans with narrow networks or different formularies
 - Employees should be aware of provider arrangements/relationships that could help minimize their out-of-pocket costs (e.g. independent labs)
 - Work with vendors who can assist with employee claim/insurance questions
- Additional Benefits/Resources
 - Insurer resources like discount gym programs, gift card rewards for provider usage, and other wellness tools
 - Consideration of additional benefits/tools such as those for mental health, virtual care, infertility services, and EAP programs

Questions?

Thank you for your time!

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