MARCH 2017

Volume #2

What's Inside

Our Office will be closed on Monday, April 17, 2017

IBSI

INNOVATIVE BENEFIT SOLUTIONS, INC.

FOREFRONT

How You Can Help

We all want the cost of health care to be reduced today, and continue to into the future. We all know the Trump administration desires to do away with Obamacare, but what will it be replaced with?

Two researchers have proposed a new way to design health insurance plans that could win bipartisan support and has already started to do so. The University of Michigan's Mark Fendrick, MD, and Harvard University's Michael Chernew, PhD, laid out the framework for what they call a "High-Value Health Plan" (HVHP). The idea also has appeared in a bipartisan U.S. House bill introduced in the last Congress and has received multi-stakeholder support.

The proposal combines the consumer-driven, market-based concepts of High-Deductible Health Plans (HDHP's) linked to Health Saving Accounts (HSA's), with exceptions that enhance coverage for clinical services that have been proved to benefit patients the most. Current IRS regulations permit Safe Harbor that allows coverage of specified preventive services prior to satisfaction of an HSA-HDHP plan deductible. However, existing IRS regulations designate that clinical service meant to treat an existing illness, injury, or condition are excluded from pre-deductible coverage.

As a result, HSA-HDHP patients with chronic illness such as diabetes, depression, or heart disease must pay the entire amount of their tests, appointments, and services until they meet their plan deductible. Many of these services are proven to keep their condition from getting worse, and in some cases have been found to lower total health care spending.

The concern is that consumers may forgo care due to the size of the deductible. To enable the continued growth of HSA-HDHP's insurers need flexibility to provide pre-deductible coverage for high-quality services across the spectrum of clinical care.

I urge you to contact your representatives in support of this initiative. This approach is good legislation as it provides broader coverage and plan flexibility, while preserving the spirit of consumer engagement, accountability, and transparency in Consumer-Directed Health Plans.

Let your voice be heard!

Randall B. Marking
President

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Healthy Living

Some Movement on the ACA

***Breaking News**: The Trump administration has released its first health care related rule which seems to ease the concerns of the insurance industry looking for ways to curb the number of sicker people who sign up for coverage on the insurance Exchanges.*

The rule, meant to stabilize the insurance market and even out the risk pool would shorten the enrollment period for next year. Instead of lasting three months, it will start on November 1 and end on December 15.

The Trump administration appears to be offering insurers a reprieve while Congress attempts to unite around a plan to replace the Affordable Care Act (ACA).

Anyone who signs up during this period will be subject to strict proof of eligibility. To that end, the agency is expanding a pilot announced each year that tests the impact of stricter verification. The agency had planned to have only fifty percent of new applications with special enrollment periods to submit documents before their coverage begins. The agency now proposes to expand that to one hundred percent.

Insurers say both issues are crucial to discouraging people from signing up when they realize they need costly medical services and then drop their coverage after receiving care.

The rule also allows insurers to refuse to cover a person who has not paid their premiums. The issuer would have to apply this policy to all employers or individuals regardless of health status.

Health plans will also get more flexibility in creating products, meaning they will no longer be tied to levels of coverage mandated by the ACA.

During a previous Senate Finance Committee hearing, Marilyn Tavenner *(former Administrator of the Centers for Medicare & Medicaid Services)* wanted subsidies to be paid in their entirety for the next two to three years and also wanted full federal reinsurance payments for 2016.

The pool of money was supposed to be paid to insurers that covered higher risk patients. Tavenner said it is imperative the individual mandate continue to be enforced as long as current market rules prohibit the exclusion of pre-existing conditions, require guarantee issue of insurance policies, and impose community-rating requirements.

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A Costly Future

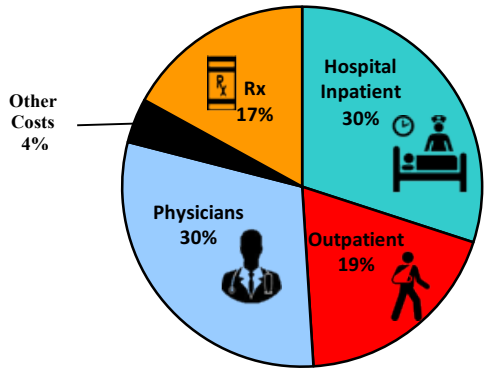
PricewaterhouseCoopers (PwC) recently looked at 2016 realities and 2017 projections for the future of health care. They project the 2017 medical cost trend to be the same as the current year with a 6.5% growth rate.

Among the key findings:

- *Medical costs will continue to rise 6.5% in 2017*
- *The decades slowing medical cost growth rate could move back up as a new health access points increase utilization*
- *Drug spending is still a relatively small portion of overall spend*
- *Price, not utilization, is the force behind historical medical cost trends*
- *Cost-saving strategies deployed over the last few years have seen their course and may not be able to bend the cost curve with new inflators on the horizon.*
- *A close focus on both prices and health care delivery are needed to contain costs.*
- *The proliferation of convenient ways to get care is expected to lead to higher utilization.*

2017 SHARE OF EMPLOYER HEALTH BENEFITS
PRICE WATERHOUSE COOPERS PROJECTIONS

About half of employer costs are from Inpatient & outpatient spending, but prescription drugs are increasing.



$13,500 - MEDICAL IDENTITY THEFT

$13,500 represents the average cost victims pay to resolve medical identity theft; that is when they can resolve it. The impact of medical identity theft can be measured in both financial terms and how it hurts the patient-provider relationship. A common complaint is that a provider or insurer does not inform the patient about the theft. Instead, victims learn about it on their own from an error in their bill or collection letter.

Clearly, this is not a patient issue. The cost to providers and facilities can range from lost revenue to a costly and litigious review of all entries in a medical record. Just think about how time consuming and complicated it is to unravel a single medical record blended with encounters from two or more different patients.

We can all help reduce incidents of medical identity theft. As patients, we need to control our medical information to prevent anyone else from having access. When we receive an explanation of benefits (EOB), we need to be sure we received all the services being billed to our insurance plan. We need to keep track of our insurance cards and destroy old cards when receiving new ones to prevent someone else from using your insurance.

Raising awareness and taking steps to reduce medical identity theft will help keep health care costs down for all of us in addition to helping protect the patient-provider relationship.

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Tax Phishing Scheme

The IRS recently alerted payroll and human resources professionals to beware of a continuing phishing email scheme that purports to be from company executives and requests W-2 forms and personal information on employers.

IRS Commissioner, John Koskinen said, *"this is one of the most dangerous email phishing scams we've seen in a long time. It can result in the large-scale theft of sensitive data that criminals can use to commit various crimes, including filing fraudulent tax returns."* The scheme, which surfaced last year, has spread to include not just businesses, but school districts and nonprofits.

Where there is a will, there is a way

Across the country the trend of having to do more with less grows, and no one understands the painful ramifications of that more than cash strapped public sector. With thousands of students to educate and hundreds of thousands of residents to care for, how does a public sector function when faced with mounting budget pressures, including escalating insurance premiums and moderate to zero budget increase allocation?

That is the kind of reality that causes real angst about the ability to provide employees with things like salary increases and comprehensive benefits packages. In the face of all that, one Wisconsin County is doing more than waving the white flag in surrender.

It was time to get creative with plan design that would help the County, but no one could have imagined to what extent. Thanks to the focus on consumer engagement that **IBSI** brings to the table and in this case, the determination by the County Supervisor and his team, the County ultimately flipped the solemn message of "no raises this year" to a very different one. Here are the results of our efforts:

- 400 Current plan participants
- $7,000,000 Current Annual Premium
- $7,420,000 Renewal (6%) Annual Premium
- $6,307,000 Carrier Change Annual Premium *(same benefit design – Two Year Rate Guarantee)*
- Created a Command and Control Data Center *(Claim Transparency)*
- Aligned Employee Behavior to better Fiscal & Physical Health through $83,000 of Grants *($200 Per Employee Per Year)*
- Employer Grant Funding of $350,000
- "At Risk" Employees are given the opportunity to voluntarily leave the employer plan for a better plan of benefits at no cost to them. This is a win-win situation.
- Local Employer/Hospital Direct Partnership

This effort was greater than saving money; It was about improving morale and showing employees that the County has their quality of life and their best interest in mind. Caring for people and helping them is what it is all about and that is why we do what we do!

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More Work Ahead

Obamacare was a massive transfer of wealth from the better off to those with low incomes, and because of that, it was very unpopular among the middle class. The House Republican plan is just shifting much of that from the Democratic base back to the Republican base. If it becomes law, we will just have different group of people upset.

The House Republican plan does a much better job than Obamacare in providing health insurance to the working middle class

It does a much worse job in affording access to affordable health insurance to those with low incomes.

It would be nice if we could have a health insurance reform plan that a consensus of the people could appreciate. According to the CBO, it sounds like the Republicans will have $227 billion to make things better, and they should.

Hospitals under *Pressure*

An example of what is going on at the hospital level.

In a Kingston, New York hospital two gleaming operating rooms still look brand new seven years after being built for five million dollars. Interestingly, they have never seen one patient, and never will.

With an occupancy rate of just over fifty percent, the 150-bed hospital, its surgery center, and emergency department which were renovated in 2011 for six million dollars will be closed and retrofitted into what its new owner calls a "medical village" of outpatient services such as physical therapy and behavioral health services.

This story of a 123-year old facility, located in a small town about one hundred miles north of New York City is repeating itself nationwide. Hospitals are disappearing in the U.S. as government pressure to drive down costs moved care to stand-alone units, doctors' offices, and even patient's homes.

With a redo of the ACA on the horizon, and regardless of what Trumpcare looks like, hospitals will have to dramatically change how they do business. They will have to support direct contracting with key local employers, get into other areas and businesses to free up cash and generate better margins than inpatient care, which has been a slow-growth business.

All kinds of services are moving outside hospitals, such as hip and knee replacements, heart valve repairs, and even childbirth. Mt. Sinai Health System in New York City, which is closing an 856 bed hospital to re-open at the same site as a 70-bed facility, has a program that provides hospital level care in patient's homes for conditions such as congestive heart failure and cellulitis infections.

At IBSI we feel now is the time for employers to consider how they can work directly with area providers to improve the quality of care while lowering the cost of care. IBSI will be working this year and beyond to create employer/hospital partnerships for our clients.

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We are a privately owned insurance benefits firm specializing in the development, delivery, and implementation of employee benefits. Our primary focus is tailoring health care solutions for active and retiree populations. These solutions include our proprietary programs wrapped within a complete package of employee benefits and administration. We are a one-stop shop.

IBSI is on the cutting edge of providing benefits to active employees as well as both pre- and post-65 retirees for major employers nationwide. We offer Medicare Supplement, Major Medical, Life, Dental, Vision, and Prescription Drug Benefits on both a fully insured and self-funded basis. We integrate HMO Risk contracts and PPO's with our core solutions for the retiree segment.

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