Innovative Benefit Solutions, Inc.

FOREFRONT

May 2017

Volume #3

What's Inside

Health Care Claims 2017

HSA's Revisited

2018 Increased HSA Indexed Figures

The Latest on Health Savings Accounts

Let's Talk Pharmacy

Latest on Rx

Consumer Tips Managing HDHP

HR 1628

The Night of the Walking Dead

PCORI Reminder

Our office will be closed on Monday, May 29, 2017

IBSI

Obamacare

As Republicans prepare to repeal and replace Obamacare, several major health insurers have scaled back their involvement on the Exchanges.

Things are so bad, that rather than raising rates insurers are just dropping out. Humana is withdrawing from Obamacare's individual market entirely. Aetna has left Virginia and Iowa, experiencing large pullouts.

Here is what three states can expect when it comes to Obamacare:

Connecticut:	2 Insurance Carriers	24% premium increase
Maryland:	4 Insurance Carriers	45% premium increase
Virginia:	6 Insurance Carriers	31% premium increase

Other states will release their Exchange activity over the next several months, but the trend is clear to me.

The above information clearly states we are in a health insurance crisis. Many Americans may only have one single choice of an insurer in 2018. There is no reason to assign blame, but there is a reason to say enough is enough. The American people deserve much better.

Randall B. Marking
President

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FOREFRONT
Volume 3 - 2017

Healthy Living

Health Care Claims 2017

We now know that 2017 will be a year of uncertainty. While it is difficult to predict what will happen to ACA regulations in the future, employers are sure to face another year of rising health care costs. Emerging forces are shaping health care for employers and HR professionals. Here are some of the top trends for 2017:

Behavioral health care will increase in cost and utilization

Some factors driving this include:

- Current opioid crisis
- Increased mainstream recognition and decreased stigma among patients seeking care
- Inclusion of essential benefits by ACA
- Federal parity laws for mental health and substance use treatments
- Increased direct-to-consumer advertising

Pharmaceutical companies will continue current pricing practices

The cost for older, well-established prescriptions will continue to skyrocket, despite public outcry over price gouging. Drug companies will continue to deflect criticism by:

1. Offering more coupons to consumers to cover copays/deductibles;
2. Supporting grassroots efforts to have more of these treatments covered by insurance; and
3. Continuing to tout their charitable donation efforts and rebates/discounts to insurers.

Specialty Rx drugs will come to market faster

New specialty drugs will be coming to market faster, using orphan drug approvals or the breakthrough therapy process. Unfortunately, even in areas where there is competition, expect to see prices remain the same or even higher. There will continue to be a lot of discussion on specialty drug pricing, but do not expect to see any resolution in 2017.

Biosimilar drugs will get more attention

Expect to see more biosimilar drugs, or highly similar versions approved and authorized biological medicines. Two biosimilar drugs are approved right now, with more on the way.

- Zarxio, which is a biosimilar for Neupogen *(Cancer Infection)*
- Inflectra, a biosimilar from Remicade *(Crohn's Disease, Arthritis, & Psoriasis)*

Policymakers will push federal negotiation of drug pricing

Will 2017 be the year that Medicare gets the right to negotiate prescription costs? Several proposals have been put forward, but prospects are unclear.

Telemedicine on the Rise

Telemedicine will become a regular benefit for most employers. The telemedicine industry is predicted to surpass thirty billion dollars by 2020. It is viewed favorably by most workers and saves money for employees, including travel time and much lower copays *($50 for virtual visits vs. $170 for primary care visits).* Expect to see more states require coverage for telehealth services.

Medical Inflation stays at 6.5 Percent - Employers must remain vigilant

PricewaterhouseCoopers projects the 2017 medical cost trend to be the same as 2016 which is a 6.5 percent increase. Although hospital spending *(both inpatient and outpatient)* makes up roughly half of all costs, spending on prescription drugs is growing. Employers should carefully analyze and continue to manage the top cost drivers in their health plan aggressively.

Health Savings Accounts (HSA's) Revisited

It looks as though Health Savings Accounts (HSA's) are in the spotlight which may be a good thing for your employees. Not only will HSA's help your workers with their health care expenses, the savings vehicle also will put them on a better track for retirement planning.

According to the Kaiser Family Foundation, by 2018, there will be twenty-seven million HSA accounts and more than fifty billion dollars in HSA assets. Currently, there are eighteen million accounts and $34.7 billion in assets. Given what is going on in the marketplace and Washington, one might be able to say these accounts have the potential to become more compelling than a 401K due to the tax deductible and tax deferred incentives.

Current Washington proposals are positioning HSA's as the hybrid of medical and retirement savings. It is not just a health account; it is a savings account. Health care expenses are a major concern for retirees and often cause employees to push back plans for retirement. If HSA funds are not needed for medical expenses, the money can be withdrawn after age 65 and taxed as ordinary income.

The HSA is the nexus between health care and retirement and I believe will be the most effective way for many to save and invest for one's biggest expense in retirement. Plan sponsors should encourage employees first to max out their HSA's and then match their 401K's.

2018 Increased HSA Indexed Figures

On May 4, 2017, the IRS released the new Health Savings Account (HSA) index figures for 2018.

	2017	2018
Minimum deductible amounts for qualifying High-Deductible Health Plan (HDHP)		
Individual Coverage:	$1,300	$1,350
Family Coverage:	$2,600	$2,700
Maximum Contribution Levels		
Individual Coverage:	$3,400	$3,450
Family Coverage:	$6,750	$6,900
Catch-up Contribution for those 55 & Over:	$1,000	$1,000
Maximums for HDHP Out-Of-Pocket Expenses		
Individual Coverage:	$6,550	$6,650
Family Coverage:	$13,100	$13,300

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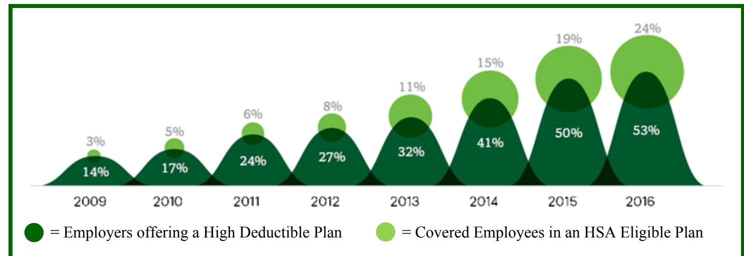
FOREFRONT
Volume 3 - 2017

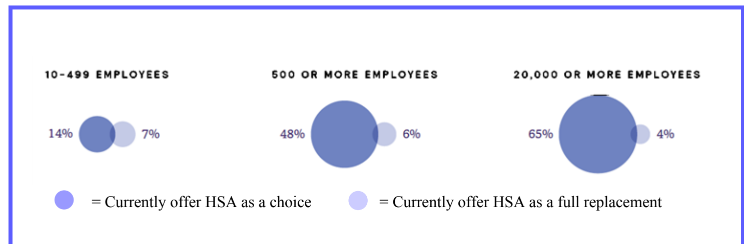
The Latest on Health Savings Accounts

The past decade has seen rapid growth in high-deductible health plans coupled with health savings accounts. Employers use High Deductible Health Plans to advance many goals: (1) to promote consumerism, (2) provide more affordable coverage, (3) permit tax-advantaged savings, and (4) control benefits costs growth. These goals are especially important under the threat of the ACA's Cadillac tax and will remain a priority regardless of what happens in Washington. The average per-employee cost of HSA-eligible plans is thirteen percent less than that of a traditional PPO.

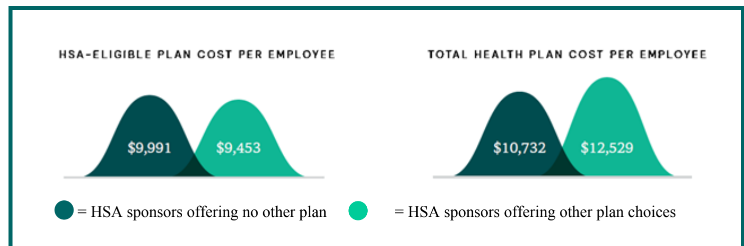
Employers keep adding HSA plans, but enrollment remains a challenge: More than half (53%) of all large employers offer an HSA-eligible plan, but under a fourth (24%) of covered employees are enrolled in one.



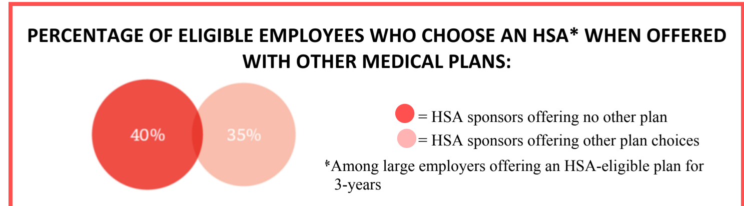
What is holding up HSA adoption?
Despite the cost savings, for the most part, large employers still offer these plans as a choice, rather than as the only medical plan. Just six percent of all large employers offered an HSA-eligible plan as a full replacement of their traditional plan. HSA enrollment grows relatively slowly when these plans are offered as a choice, suggesting that many employees remain uncomfortable with the higher deductible.



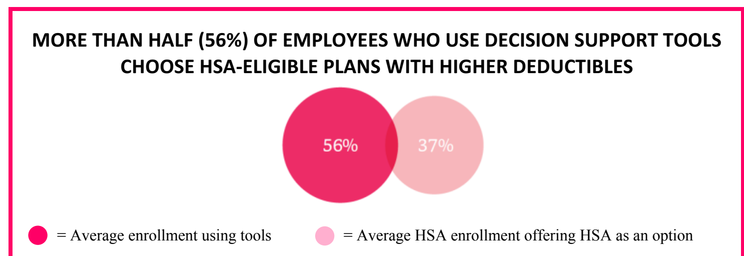
The skinny behind full replacement strategies: What is at stake in offering an HSA-based plan as an option rather than as a complete replacement? Although full replacement HSA plans cost more than those offered as a choice, when you compare total health plan cost per employee, across all medical plans offered, employers offering full replacement HSA-eligible plans spend much less. This translates to lower paycheck deduction.



Do employer contributions change the game/outcome? Even when employers make a contribution to their employee's HSA accounts, average enrollment is only slightly higher than when they do not.



With the right support, employees are more likely to choose HSA's: Some employees clearly value the opportunity to pay lower monthly premiums and take advantage of the tax savings available through the HSA's while others are reluctant to make that trade-off. When you want to build enrollment over time or move to a full replacement, some tools make the transition easier for employees.



Ref: Mercer.com https://www.mercer.com/content/dam/mercer/attachments/private/gl-2017-health-national-survey-infographic-series-mercer.pdf

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FOREFRONT
Volume 3 - 2017

Let's Talk Pharmacy

According to a new analysis from Amundsen Consulting that in spite of robust negotiations between biopharmaceutical companies and payers, health plans do not pass along the savings achieved via rebates and discounts on the price of medications, but instead still require patients with high deductibles or coinsurance to pay up to the drugs' full list price.

We all know that biopharmaceutical companies set the list price for their medicines, but it is the health plan that ultimately determines how much a patient pays out-of-pocket. More than one-third of the list price is rebated back to payers and the supply chain; health plans do not pass along these discounts to patients with high deductibles and coinsurance.

This often results in patients with high deductibles or coinsurance being more likely to stop taking medications as prescribed or even abandoning their prescriptions at the pharmacy. This, in turn, can expose them to higher risk for trips to the emergency room, and otherwise avoidable hospitalizations resulting in poorer health.

The American Prospect magazine reports that the problem is Pharmacy Benefit Managers (PBM), who act as middlemen in managing prescription drug benefits for health plans. A PBM's primary role is to negotiate discounts from drug companies and pharmacies, which agree to discounts to gain access to the patient networks the PBM's have aggregated. Pharmacy Benefit Managers control which drugs are listed on the formulary *(the list of reimbursable drugs)* for the networks they serve. According to the report, PBMs get rebates from drug companies in exchange for the formulary listing, rather than disclosing the rebates to health plans or passing them along to pharmacies or consumers, they retain them!

IBSI only uses Pharmacy Benefit Managers that do pass along industry rebates!

Latest on Rx

Prescription drug spending has increased annually for Blue Cross and Blue Shield members since 2010. Branded drugs with no generic alternatives or single source drugs are the main culprit, which are rising at an average annual rate of twenty-five percent, or a total of 185 percent since 2010. These patent-produced drugs now make up sixty-three percent of total drug spending, up from twenty-nine percent of total spending in 2010, despite the fact that they make up less than ten percent of total prescriptions filled.

PHARMACEUTICAL COMPANIES PAY MANUFACTURERS TO NOT DEVELOP GENERIC ALTERNATIVES.

This rapid rise in drug costs is likely to continue in future years. This is because there are not enough manufacturers making alternatives. Specialty drugs such as Enbrel, Gilenya, Harvoni, and Humira will not have generics enter the market anytime soon. Main reasons include complex and complicated approval processes and patents that translate to challenging and expensive development as well as existing patents that are valid for five years or longer. It also must be noted that pharmaceutical companies pay manufacturers not to develop generic alternatives.

A bit of good news is that generic utilization is up nine percent since 2010. Thus, it is important that the benefit plan design is developed to move your people to embrace the use of generic alternatives.

Several bills are moving through Congress that aim to reduce drug costs, but history tells us the chance of Congress passing any of these bills is small in my estimation. The pharmaceutical industry heavily lobbies Congress to secure their profit margins.

Consumer Tips for Managing Spending in an HDHP

Typically, paycheck deductions are lower for HDHP participation, but the question is how to keep from falling behind financially when one needs care. Here are some suggestions:

1. **Preventive Care Services** - Take advantage of these services covered at 100%.
2. **In Network Provider** - use online resources to find which doctors are in-network for your plan.
3. **Nurse Line** - Consult with a nurse for free; call the nurse line for a consultation before scheduling an appointment with a physician – this could save an office visit.
4. **TeleMedicine -** If you have a telemedicine benefit, use it. This is a potentially huge cost saver.
5. **Convenience Care -** Investigate convenience care clinics in your area. These services offer a limited number of services at a lower cost than urgent care or a physician office visit and are located in stores like Target, CVS, and Walgreens.
6. **Prescription Price** – When your physician gives you a prescription ask how much it costs and if there are over-the-counter or generic alternatives available. Check a few pharmacies for the best price. There are free apps and online services that will do this for you.
7. **Prescription Quantity –** If a prescribed drug is very expensive, and you have not used it before, ask whether you could have a smaller number of pills at first to be sure it works. Check with the manufacturer if there are patient assistance programs to help defray the cost.
8. **Saving –** If you moved to the high-deductible plan from a more expensive plan, take the savings from lower paycheck deductions and deposit them *(tax-free)* in a health savings account. That way you will have some money set aside to help pay for care before you meet the deductible.
9. **HSA** – Take advantage of any opportunities to earn dollars from your Health Savings Account (HSA) by participating in healthy activities like biometric screenings.

These **are good suggestions to communicate to employees and their families.** Even if you have provided similar guidance in the past, everyone can always use a refresher.

HR 1628

By a razor-thin margin in the House of Representatives, Republicans secured enough votes to send AHCA to the Senate. In the Senate, anything can happen. For the time being, the ACA is still in effect. Top points of HR 1628:

- ✓Subject to certain requirements, states could opt out of essential health benefits, aspects of community rating and age banding requirements are removed;
- ✓Employer's ACA reporting not repealed;
- ✓Medicaid funding significantly changed with per enrollee capped payments, option for block grants;
- ✓HSA enhancements – increased limits to roughly $6,650 single/$13,300 families for 2018 under High Deductible Health Plans;
- ✓Cadillac Tax remains, though delayed from 2020 to 2026;
- ✓Individual and employer mandate penalties eliminated;
- ✓Age-based tax credit starting in 2020 - credits phase out for those making more than $75,000 per year *($150,000 joint filers)*. No credit for individuals offered employer coverage.

We will continue to track this topic and provide updates.

From the President

The Night of the Walking Dead

In this newsletter, I mentioned just a couple of instances where states are beginning to see massive premium increases in their health care Exchanges. Health Insurers are losing millions of dollars in these Exchanges. The pool of beneficiaries is becoming sicker, in part because healthier people are not coming in at the level hoped.

The significant premium increases assume the Trump administration will continue to make the cost sharing subsidy payments. If they do not, the rates would be ten percent to fifteen percent higher. Experts suggest that about fifty percent of Exchange participants are unsubsidized and they will feel the full brunt of these increases. This unsubsidized group will begin to melt away causing the early stage of a classic death spiral.

The Trump administration has not helped the situation. President Trump has threatened to withhold seven billion dollars in annual out-of-pocket subsidies and has effectively directed the IRS not to enforce the individual mandate.

Here is where we are right now

The lowest income people who get the best premium subsidies, also have their deductibles and co-pays reduced, are not feeling these increases, we, the taxpayer are paying those costs.

The unsubsidized will get hurt badly and forced out of the pools. Premiums will only accelerate going forward. Ironically, the people most likely to be hurt are the working class and the middle-class Trump supporters.

The health plans can no longer tolerate these losses. Their board of directors will mandate no more Obamacare losses ever again.

As a result, the health insurance companies' defensive strategy is simple. Limit the plan offerings available to those plans that bring in the most premium and then drive the rates as high as necessary to protect the insurance company's solvency. Health plan executives realize this will push the unsubsidized and partially subsidized people off the rolls, but leave a core enrollment of taxpayer-subsidized people insulated against the costs and ultimately profitable for the insurers. This is what the latest big increases are all about.

Then there is political stability for Obamacare. As long as the middle class is getting the short end of the stick, Obamacare can never be stable. Thus, when President Trump says that things will only get worse, he is correct.

Who knew solving this massive issue would take more than a couple of weeks?

PCORI Reminder

The Patient-Centered Outcomes Research Institute (PCORI) fee helps fund research that evaluates and compares health outcomes, clinical effectiveness, and the risks and benefits of medical treatments and services. Under the ACA, health insurers and plan sponsors are responsible for paying the PCORI fee.

Self-funded plan sponsors must file a Form 720 and pay the PCORI fee directly to the IRS by July 31 of the calendar year following the last day of the plan year. Employer groups will determine which counting method they wish to use, complete and file the IRS Form 720. The Federal Excise Tax Return Form 720 can be found on the IRS website.

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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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