November 2018

VOLUME 5

Happy Thanksgiving!

Our Office will be Closed:

Thursday November 22 & Friday November 23

INNOVATIVE BENEFIT SOLUTIONS, INC.

FOREFRONT

SINGLE PAYER Health Insurance

I must comment on a topic that hits too close to home. "BernieCare" is the latest attempt to move health care under the government tent. I have written on these pages before that health insurance will never cost more than when it is free and that sentiment holds true today.

This is what "BernieCare" means:

- Estimated cost is $32.6 trillion over 10 years;
- In 2022 *(date of inception)*, $32.6 trillion represents 10.7% of GDP;
- National defense represents 3% of GDP;
- Doubling all currently projected federal individual and corporate income tax would be insufficient to finance the cost of "BernieCare";
- Since we cannot finance the $32.6 trillion, we are left with rationing of care with dramatic price controls. This means that if you suffer from minor ailments, you are welcome now. If you need joint surgery or breast reconstruction, get in line;
- Medicare programs will be completely destroyed by "BernieCare"; Young and old will have to join this new program.

Let's take a look at whose mini-version of "BernieCare" has been tried:

1. Senator Bernie Sanders' home state of Vermont – Democratic governor abandoned the idea in 2014 as he was looking at an 11.5% payroll tax, plus a 9.5% income tax, with more increases to come.
2. Colorado – In 2016 this state toyed with the single payer model and nearly 80% of Colorado's residents voted down such an idea.

Every voting eligible American has a right to speak their mind on this topic and to vote accordingly. My rule of thumb, reform should not cause greater harm. There can be no doubt that health insurance needs reform, but "BernieCare" is not it.

Randall B. Marking
President

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Healthy Living

Are You Being Billed for Preventive Services?

Historically, insurers did not pay for preventive services and providers were trained to always add a condition based diagnosis code to every medical claim. Providers felt they were helping their patients by linking condition codes to these procedures.

The U.S. Preventive Care Guidelines presents an outline of what services are considered preventive and what frequency is recommended. These services generally include vaccinations, cardiovascular screenings, lifestyle counseling, mental health counseling, and screening for some chronic infections.

These guidelines, however, are unclear to most providers because they do not include common procedural terminology *(CPT codes)* to clearly state what services are recommended as preventive. This has left administrators to establish clinical and administrative policies, resulting in inconsistencies between commercial insurers and commercial payers.

One example is the CMS billing requirements that state providers must include a diagnostic code for each service line on a claim submission. Administrative policy enacted by the carriers will pay the service based on the diagnostic code provided. Unfortunately, if a diagnostic test is listed as a preventive service and is submitted with an illness diagnostic code, it will be paid as medical instead of preventive.

To address this issue, many employers and payers have developed policies to simplify the process. For example,

- Some payers will pay for the first colonoscopy of the year for members over the age of 50 as a preventive service, regardless of whether a biopsy is performed or not;
- Many payers will pay for a service that is a preventive service regardless of the age of the patient;
- Many employers have asked their health plans to share a resource guide with providers defining what services are preventive and how the health plan requests that these be coded.

Health plans could improve the member service experience by establishing a rapid appeal process, as these issues are rarely complex and can be easily settled. It is worth a conversation with your health plan to determine how you can simplify the process.

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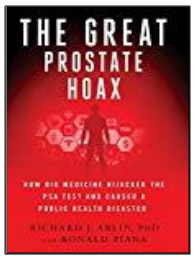
PSA TESTS

The PSA test was FDA-approved in 1994 and it is designed to help detect cancer. In fact, for the last 25 years, it has been the first line of defense against prostate cancer. However, the problem with the PSA test is it does not actually detect cancer! What is worse is the PSA test can lead to false positives and these false positives can result in unnecessary surgeries that can leave men incontinent and impotent!



Unfortunately, there is discussion going on in the medical community today that the PSA test does NOT detect prostate cancer. Dr. Richard Ablin, a research professor of immunobiology and pathology at the University of Arizona College of Medicine and the president of the Robert Benjamin Ablin Foundation for Cancer Research, is the physician who developed the PSA test in 1970. He now concedes the PSA test is a profit-driven disaster pushed by the pharmaceutical companies and even wrote a book about it, titled The Great Prostate Hoax: How Big Medicine Hijacked the PSA Test and Caused a Public Health Disaster.

In a *New York Times* article, Dr. Ablin wrote, *"PSA testing can't detect prostate cancer and, more important, it can't distinguish between the two types of prostate cancer – the one that will kill you and the one that won't."*

Men are desperate for an accurate prostate test. In fact, in the U.S. alone, over 50 million men are over the age of 50 have been diagnosed with Benign prostatic hyperplasia (BPH) which is not cancerous but it can still cause symptoms that require medical or surgical treatment.

The U.S. Preventive Services Task Force, a nationwide panel of experts in medicine, says bluntly, *"Do not use PSA-screening for prostate cancer!"* Dr. Steven Salzberg, Professor of biomedical engineering, computer science, and biostatistics at Johns Hopkins University affirms the PSA fail rate can be as high as 80%!

We may be on the verge of a breakthrough regarding this dreaded disease and we will be watching this matter closely.

RETIREMENT PLANS

What do you think? If it were easier for small businesses to band together and offer sponsored plans, would more workers begin to save?

It appears the White House thinks so by signing an executive order on the eve of Labor Day that is aimed at lowering the barriers for small companies to participate in multi-employer plans.

A recent Pew survey found that nearly three quarters of small businesses that do not offer a retirement plan cited high costs as their primary deterrent.

President Trump is directing Labor and Treasury to propose revisions to current rules that could produce a more employer-friendly retirement environment. Part of this review will certainly be a consideration that prevents businesses from disparate industries from banding together to offer a retirement plan.

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H E A L T H Reimbursement A C C O U N T S

On October 23rd, the Trump administration proposed to substantially expand the use of tax-advantaged Health Reimbursement Accounts (HRAs) by allowing employers to pay for their workers' health plans in the individual market.

HRAs are employer-sponsored accounts by allowing employers to pay for employee premiums and other qualified medical expenses on a tax-free basis. Guidance issued under the previous administration, however, prevents the use of HRAs, cafeteria plans, or other employer arrangements to buy such coverage.

The proposed rule includes safeguards meant to ease those concerns. Employers could, for example, offer different types of employee coverage through either an HRA or a traditional group health plan, but all employees within the same class *(e.g., full-time, part-time, collectively bargained employees, and employees working at the same site)* would generally receive the same amount of money and have to be offered the same type of plan.

Under the proposal, all employers could use an HRA to help employees buy individual plans sold either on or off the federal and state Exchanges created by the Affordable Care Act (ACA). Under a special rule, employees could pay the portion of the premiums not covered by the HRA for off-Exchange policies with pre-tax cafeteria plan salary reductions. Employers could provide an HRA contribution as significant as they would have made for the premiums of the employer-sponsored plan.

This will likely spur some smaller employers to consider moving to a pure defined contribution health benefit approach. Whether these employers, and ultimately larger firms as well, adopt this approach will depend on the terms of the final rule and whether the individual market will have affordable coverage available. If the coverage is competitively priced, these potential reforms could offer opportunities to employers with part-time workers.

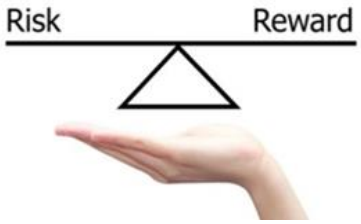
Another option under the proposal would permit an employer that offers a group health plan to offer as an additional benefit, up to $1,800 per year *(indexed for inflation)* to cover out-of-pocket costs and premiums for excepted benefit coverage such as dental or vision, COBRA, or short term limited duration insurance.

An employer could only offer an excepted-benefit HRA if traditional group health plan coverage is also made available to employees eligible to participate in the excepted-benefit HRA. An employer could not offer both an HRA integrated with individual health insurance coverage and an excepted-benefit HRA to the same employees.

We will be watching for the final rules and regulations to be firmed up and will report back to you.

REFERENCE-BASED PRICING

Reference-based pricing has created quite a buzz over the last several years. Much of the fanfare has centered on the potential cost savings to plan sponsors, but also the potential for significant balance billing of employees.



Basically, reference-based designs are a pre-determined maximum reimbursement level for health services. Participants and providers may not be aware at the time of service that this maximum reimbursement is in place. This has led to lawsuits currently working their way through courts and centered on ERISA violations, breach of contract, misrepresentation, and fraud.

While these reference-based pricing designs are new and intriguing for the way they change payment for care, employers will need to get comfortable with some uncertainties, particularly relating to legal challenges. Working with qualified legal counsel to understand risks related to these compliance issues is a must.

BYE-BYE GAG CLAUSE

President Donald Trump has signed a pair of bills aimed at increasing drug-pricing transparency; the first such legislation to become law since his administration rolled out its strategy to tackle the cost of prescription medications in May.

The bills prohibit so called gag-clauses in health plan contracts that prevent pharmacists from telling customers they could save money on drugs by paying out-of-pocket rather than using their insurance benefit. One of the bills, S2553, would apply to Medicare's prescription drug plans, and the other, S2554, would apply to private group and individual plans.

Why is this important?

Earlier this year, *The Journal of the American Medical Association* study, used 2013 data and found prescription drug claims for 12 of the 20 most commonly prescribed drugs in the U.S. often had copayments that exceeded the average retail price.

The "Patient Right to Know Drug Prices Act" (S2554), also includes new reporting requirements for makers of biopharmaceuticals intended to prevent "pay for delay" deals in which brand-name biologic companies pay the makers of generic versions to stay off the market for some period of time. Companies that make brand name and generic versions of other types of drugs already file such disclosures.

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From the President, Randall B. Marking

A Crack in the Wall

Most employers cede control of health care costs to their health insurers, the hospitals that treat their employees, and the companies they pay to manage their benefits. This is the way health care works in America; however, this is not the way it works in Montana or North Carolina.

Montana asked its administrator, Cigna, for its pricing terms with the hospitals and Cigna refused to provide the information. Cigna allowed the state to get individual claims and other limited information, but the data was aggregated and is useless. Therefore, Montana settled on a radical solution: the plan would set its own prices for the hospital using the prices set by Medicare as a reference point.

Medicare is a good benchmark because it makes it prices public and adjusts them for hospitals based on geography and other factors. Montana's plan would pay hospitals a set percentage above the Medicare amount, a method known as reference-based pricing (RBP), making it impossible for the hospitals to arbitrarily raise their prices. If a hospital wants to treat state employees, the hospital would have to accept the state set rates. If not, state employees will move to other hospitals for care. The result is that all Montana hospitals have agreed to this new reimbursement approach.

North Carolina is also moving to reference-based pricing. For decades, the state has used Blue Cross and Blue Shield of North Carolina's commercial network of providers. Ironically, North Carolina requires by law, demand price transparency; however, Blue Cross Blue Shield is standing on its confidentiality in pricing with no transparency. Expectations are that North Carolina will save $300 million *(10% overall savings)* and plan members will save over $60 million.

From an article in *The Moore County Pilot*, State Treasurer Dale R. Folwell announced the state health plan will launch a new medical reimbursement strategy for North Carolina providers, he stated, *"We're going to be asking a little from a lot of people, and a lot from a few. I'm asking health care providers in the state to help us sustain this benefit for teachers, public safety officers and other public servants."* He also declared, *"For years, the plan has paid medical claims after the fact without knowing the contracted fee. It is unacceptable, unsustainable, and indefensible. We aim to change that. This new pricing model will help us ensure the delivery of quality care to our members and better control health care costs, preserve the sustainability of the Plan, and promote transparency for plan members and state taxpayers like them."*

I believe we are seeing a crack in the wall of high cost health care!

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SHORT-TERM HEALTH INSURANCE

On August 1, 2018 the Department of Health and Human Services (HHS), Department of Labor (DOL), and the Treasury issued a final rule that allows for the sale and renewal of short-term, limited duration health insurance plans that cover longer periods than previously permitted.

Originally, short-term insurance covered less than three months in duration. The plan also had to contain an expiration date specified in the contract that was less than three months after the effective date. These final rules amended the definition of short-term, limited-duration insurance while continuing to maintain its non-compliance with the insurance mandates contained in the Affordable Care Act (ACA).

Short-term health insurance may have an initial maximum coverage period of less than 12-months after the original effective date of the contract, taking into account any extensions that may be elected by the policyholder without the issuer's consent. The limited duration time period allows renewal or extensions for up to a total of 36 months.

There are no rules concerning the purchase of more than one policy as long as each policy is separate and does not extend the maximum short-term or limited duration extension periods.

HEALTH PLAN STRATEGIES FOR LOW WAGE EARNERS

Many employers struggle with the problem of how to offer affordable health care coverage to those on the low end of the totem pole. If you are one of these employers, below are several strategies that may be helpful. Health care is expensive, but all concerned parties must be active participants in reining in health care costs.

Tie Benefits to Salary: The most obvious plan design strategy to drive lower out-of-pocket costs for low-paid workers is through salary-based plan features, contributions, deductibles, and out-of-pocket maximums. If you offer a plan that is eligible for a Health Savings Account (HSA), you can make matching contributions based on salary. For example, 3:1 for employees earning less than $50K; 2:1 for $50K-$100K; and 1:1 for those over $100K.

Fill Coverage Gaps: Low-paid employees tend to avoid high-deductible health plans even if the premium contribution is lower than their other options. To make this plan an easier choice, consider providing an accident or hospital indemnity coverage at zero cost to the employee. These plans are allowed under the HSA rules.

Narrow Provider Network: Look to add a limited provider network as a plan option. This option may be attractive to employees looking to minimize their payroll deduction.

Communicate: Make sure your employees understand their options, including how they can save money. Several money savings options are telehealth *(if available)*, retail convenience care clinics, urgent care, generic drugs, MRI options, etc.

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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.

FOREFRONT is a publication produced by Innovative Benefit Solutions, Inc.

Layout & design by Sandy

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