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FOREFRONT

MARCH 2019

Is Health Care a Beast?

Health care has gone up three times faster than inflation in the past 40 years. Currently, about $0.20 of every dollar made in the U.S. is spent on health care and it is getting worse.

Kristin Downey, a *Washington Post* Staff Writer, reported, *"for each mid-size car DaimlerChrysler AG builds at one of its U.S. plants, the company pays about $1,300 to cover employee health care costs — more than twice the cost of the sheet metal in the vehicle. When it builds an identical car across the border in Canada, the health care cost is negligible."*

Clearly increasing health care costs, if unabated, stand to make American products and services less competitive. The 2019 changes address this matter. Starting in January of 2019, a new federal regulation requires hospitals to publish price lists online for all the services they provide. Separately, the government is also proposing a new rule that would require pharmaceutical companies to publish the price of their drugs in television advertisements.

As consumers, both of these changes are undoubtedly good things because part of the problem with our health care system is the lack of price transparency.

It certainly is a start!

Randall B. Marking

President

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Healthy Living

NEXT on the HEALTH CARE FRONT

As 2019 brings us a new Congress where Democrats control the House of Representatives, what affect will this limited power change bring regarding health care's future?

First of all, we know that no important legislation will come out of this Congress. We will probably hear more and more about the single payer concept, but nothing meaningful will happen over the next two years. However, the House will focus on improving Obamacare in the following areas:

- Currently, 40% of people in the individual market make too much money for any subsidies. The middle class is struggling to cover the astronomical costs, so the insurance Exchange subsidies will need to improve.
- Protect the pre-existing condition reforms.

These two points of focus will likely be a political win for Democrats. They will stay away from single-payer health care. The focus will be on the middle class voters that Obamacare's huge premiums have hurt while protecting the universally popular medical underwriting reforms.

Regardless of what the House Democrats do, when it comes to health care, it will go nowhere in the Republican Senate.

Up & Up

On January 17, 2019, the Trump administration proposed changes that could raise health insurance costs for millions of Americans who get coverage on an employer sponsored health plan.

The proposal released by the Centers for Medicare and Medicaid Services would raise the out-of-pocket maximum that people with employer-sponsored coverage pay in 2020.

The maximum out-of-pocket limit would increase by $200 for an individual and $400 for a family. *(The individual out-of-pocket limit in 2020 would be $8,200, instead of $8,000, while the family limit would be $16,400, instead of $16,000).*

The plan would also change a calculation that determines how much people pay if they buy insurance from the ACA Exchange with credits to reduce their monthly premiums.

Further details are expected, but roughly nine million Americans who get the credit could expect to pay more in premiums.

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HEALTH REIMBURSEMENT ARRANGEMENT Guidance

A recent IRS notice provides a future path for employers to avoid ACA employer mandate penalties by reimbursing employees for a portion of the cost of individual insurance coverage through an employer-sponsored Health Reimbursement Arrangement.

While the notice is not binding and at this stage is essentially a discussion of relevant issues, it does represent a significant departure from the IRS's current position that an employer can only avoid ACA employer mandate penalties by offering a major medical plan.

Nothing is finalized yet. Employers are not permitted to rely on the proposed regulations or the notice at this time. The proposed regulations are aimed to take effect on January 1, 2020; stay tuned.

Eliminate the Resume?

Do resumes work for your organization? We are seeing that more employers have decided to do away with the document and here are a few example of what employers are doing instead:

- Ask a series of job related questions, such as why does the candidate think they might be a fit for the job, or what experience can they share regarding their value proposition;
- Look to more innovated recruiting strategies;
    - Create an appropriate test for the job;
    - Pre-interview via video;
    - Submit their social media profile;
    - Use a mechanism to evaluate candidate before they are in the door to find out where they are in their career;
    - Create a company website where candidates fill out contact information and answer a series of questions to showcase what they are great at before submitting an application.

An employer's number one goal is to find a well-qualified candidate and all of the above examples help reveal the truth about applicants, which we all want in a new hire.

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CIGNA & Express Scripts Merger

The deal is done; CIGNA and Express Scripts have now merged as one company. We have officially swung into the future where medical and pharmacy benefits are managed by one entity. This type of vertical integration makes business sense because of the opportunity to manage the total cost of care. The proof of concept will be in the bottom line for the consumer and employer-sponsored plans.

The big question is whether the alliance between a medical plan and a pharmacy benefit management (PBM) will bring greater cost efficiencies or whether they will limit competition choice and employers leverage in the marketplace. From a consumer perspective, the integration could be a good thing. Today, provider relationships are key to an insurance company's success.

When pharmacy is carved out of the medical plan, there is little the insurance company oversight for medications prescribed and administered by physicians versus the PBM. For example, many large self-funded employers have often found opportunities to secure specialty drugs at a lower cost and at a site of care that might be better for the patient. All of this will only matter if the employers ensure there is accountability and transparency.

Generic Drug Costs Up

Drug makers have sharply boosted prices of some older, low-cost prescription medicines due to shortages. The increases are leading to higher costs for hospitals, pharmacies, and patients on generic drugs. Price increases are based on list prices and drug makers contend the ultimate price is often lower because of discounts and rebates negotiated by pharmacy benefit managers and insurance carriers.

Virtus Pharmaceuticals recently raised the U.S. price of a bottle of muscle relaxant, Methocarbamol, to $105 from $8.48 which is a 1,137% increase due to short supply! When shortages arise, health regulators such as the FDA sometimes ask other suppliers to boost production and when a company incurs costs to boost production, it sometimes chooses to pass the price increase on to consumers.

Many patients with high deductibles pay full list price or part of the cost as a consequence of the list price. One patient reports paying $13 out-of-pocket for a 90-day supply of high blood pressure medicine, but then because of drug recalls, he had to switch to a different medication and the price jumped to $108.

As always, we will follow this closely and keep you informed. .

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Drug Rebates

United Healthcare will require new employer clients to pass drug rebates onto the people who take the medications. The move will apply to employers that sign new contracts after January 1, 2020, but United Healthcare will grandfather in existing clients that choose a different set up. The new shift will involve employers that begin using United Healthcare's pharmacy benefits manager, Optum Rx, including those that are self-funded. This year, United Healthcare switched to passing along rebates directly to consumers under certain employer plans that are fully insured. United Healthcare said this existing program to pass through rebates has lowered costs for affected consumers by $130 per prescription on coverage and increased adherence to medication regimens.

Not Good News

Insurance carriers are not maximizing their leverage to increase rates on employers at a time when carriers cope with rising claims cost, as analyzed in Guy Carpenter's recent employer stop-loss study. According to the study, the persistency rate stood at 70%-80% on renewals in 2017, which signals that insurers enjoyed pricing power.

For carriers, raising rates is a necessity as large claims grow and increase frequency shows no sign of slowing down. The growth in claims is partly due to the passage of the ACA which removed the cap on claims, as well as increased the cost of health care.

Here Comes Apple

Apple's latest venture is a partnership with Aetna, part of CVS health, to launch a new app called "*Attain*" that harnesses the Apple watch technology, and helps users measure and track their progress against their personal health goals.

Employers offering Aetna coverage will be able to purchase access to the app for plan members who can earn rewards for meeting their goals. This partnership gets even more interesting when you consider that CVS Health is a disruptor, with ambitious plans to create a new front door to health care.

The *Attain app* and Apple's other plays into health care are a harbinger for bigger disruptions to come.

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From the President, Randall B. Marking

Surprise, Surprise, Surprise!

I may be dating myself with the above famous line from Gomer Pile, but it does describe the shock patients feel when getting out-of-network medical bills.

Groups representing employers, health insurers, and consumers issued a set of principles to guide Congress in developing legislation to protect patients from surprise medical bills from out-of-network providers. Here are the four principals:

1. Patients should be protected from surprise medical bills;
2. Patients should be informed when care is out-of-network;
3. Federal policy should protect consumers from surprise medical bills while restraining costs and ensuring quality networks;
4. Payments to out-of-network facilities and doctors regarding surprise billing should be based on a federal standard.

Large and unexpected balance billing by out-of-network providers is a growing concern for patients as well as plan sponsors. These surprise medical bills frequently arise from emergency care or treatment provided by an out-of-network hospital or facility or an out-of-network provider to an in-network facility. In such cases, the health plan will pay benefits under the terms of the plan with a balance bill sent to the patient.

Legislation can be properly crafted to address this issue and it would be most appreciated by all of us.

Canadian Style Single Payer Plan

The 2018 elections resulted in a number of Democrats calling for a Canadian–style single-payer plan. Two-thirds of incoming House Democratic freshman *(26 new members)* supported single-payer health care in the November elections.

Single-payer health care will get major play in the 2020 presidential election. If we take a look back at the Bernie Sanders program for self-payer health care, this is what it may mean to our treasury.

In 2016, the left-leaning Urban Institute evaluated Senator Sanders "Medicare-for-All" proposal and here is what they found:

- It will increase national health expenditures by $6.6 trillion between 2016 and 2026.
- It will increase Federal expenditures by $32 trillion between 2017 and 2026.
- It will fall short of paying for itself; Sanders' proposal would raise taxes by $15.3 trillion from 2017 to 2026 compared to the estimated Federal price tag of $32 trillion during the same period, thus the proposed taxes are much too low to fully finance his plan.

I have no idea what the Republicans will run on concerning health care, and apparently at this point neither do they.

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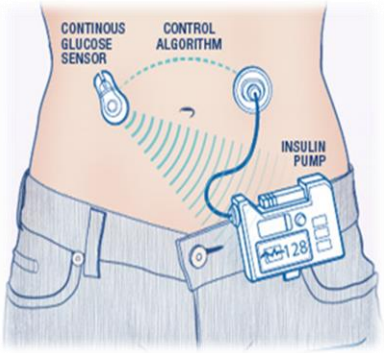
A Diabetic Breakthrough!

On September 28th, the U.S. FDA approved the first hybrid Closed Loop System. This Closed Loop Device is known to many as the Artificial Pancreas and has been approved for people with Type-1 Diabetes ages 14 years and older. In addition, clinical studies are being performed to evaluate the safety and effectiveness of the device in diabetic children 7-13 years old and due to risks associated with use of the system, this device is unsafe for use in children 6 years old or younger, or in patients who require less than eight units of insulin per day.

The cost is estimated to be about $25,000 and the benefits last 10 years with no more monitoring blood-sugar levels or insulin injections. While $25,000 does not seem that costly, consider the potential volume. According to the CDC, 30.3 million Americans have diabetes and another 84 million are pre-diabetic, so there is a large potential target market for this procedure.

What is a Closed-Loop Artificial Pancreas System?



Taking insulin or other diabetes medicines is often part of treating diabetes, along with healthy food choices and physical activity. The Artificial Pancreas Closed-Loop System monitors blood sugar levels and automatically dispenses insulin so a patient no longer has to manage their diabetes on a daily basis. It is a device, or series of devices that can work in concert with one another to automatically give the correct amount of insulin in response to food intake and rising blood glucose. It requires no action on the patient's part and everything is done automatically by the device.

You certainly can put this on the list of great things for diabetes! Patients who have an artificial pancreas will have more freedom and less stress about having to test, monitor, and administer medications for their Type-1 Diabetes. Families have reported better sleep quality from use of the new system, as they do not have to worry about manually checking blood glucose levels during the night. This is almost the best scientific discovery since insulin itself. Patients report that it is making their lives easier and who doesn't want that?

This is simply one example of many emerging therapies and technologies that have long-lasting or lifetime value for a patient. While all positive therapies and technologies make sense for the patient and our society, how will your health program handle the costs?

I expect the insurance market will begin to offer new insurance alternative products in response to these trends.

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