Ideas & Strategies to Reduce Health Care Costs for Self-Insured Employers

Dr. Francis Wong, MBBS, MBA, MPH

www.franciswong.com

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First Draft

“Healthcare is a tapeworm on the economic system”

- Warren Buffett, 2018

- Healthcare expenditures were 17.9% of US GDP in 2016 and are forecast to reach 19.7% by 2026[1].
- Employer-based health insurance covered 49% of the total US population in 2017[2].
- Average employer-based premiums were $19,616 for families and $6,896 for single coverage in 2018[3].
- Rising healthcare costs are a drag on company performance and global competitiveness. They have held back wage growth and led to increased employee cost-sharing.
- Most believe we are late in the current economic cycle. Good times have enabled firms to absorb growing healthcare costs with record high employment and modest wage growth. How will they respond in the inevitable downturn if we don’t treat the tapeworm?

1 https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html 2 KFF: Health Insurance Coverage of the Total Population
3 Premiums for Employer-sponsored Family Health Coverage rise 5% to average $19,616

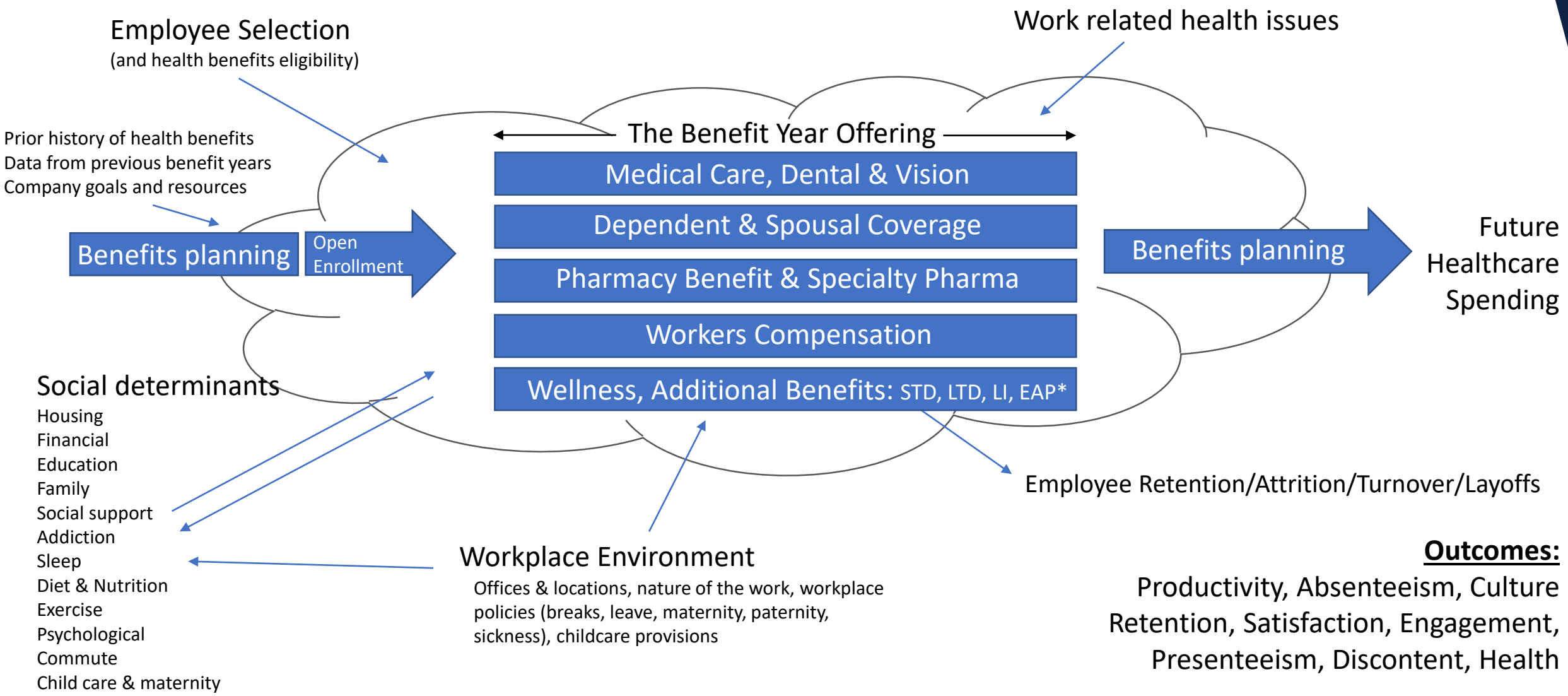
About the author

- UK physician & surgeon, UC Berkeley MBA & MPH. Trained and practiced for 5 years in a wide range of specialties, worked in product management at Castlight Health (pre-IPO) and cofounded Outcomes.com. Incoming Stanford Biodesign Innovation Fellow starting August 2019.
- No conflicts of interest, only an active interest in how we can dramatically improve US health care to achieve a better future for our society.
- My most recent work has been in the field of patient-reported outcomes, building and implementing modern patient and provider-facing software.
- Since moving to the US in 2012, and with a learner's mindset I have immersed myself in the Bay Area health technology ecosystem and have developed a special interest in the potential for employers to drive meaningful change in the US healthcare system.

Goals

- Identify and list strategies that self-insured employers have used or could use to ***reduce health care costs*** (cost is the focus of this deck, although outcomes and satisfaction are arguably more important and almost always intertwined).
- Summarize those strategies with a balanced selection of evidence and consider their potential future applications.
- Discuss options without prejudice, even those I do not agree with and may seem controversial or punitive. Doing so will help build a more complete understanding of how we got here, potential pitfalls and the limitations of the current system.
- Share some draft frameworks to help clarify thinking around the benefits cycle, categories of medical claims and the options to address them.

The Benefits Model



*Short-term disability benefit (STD), Long-term disability benefit (LTD), Life Insurance (LI), Employee Assistance Program (EAP)

Framework for Categorizing Medical Claims

Low Acuity, Episodic

Flu, colds, gastroenteritis
Urinary tract infections
Reflux esophagitis
Ear infections
Cellulitis and skin infections
Dental & Vision

Low Acuity, Chronic

Eczema, psoriasis, gout
Allergic rhinitis
Migraines
Dental
Vision

Emergency, One-time

Fractures
Sports injuries
Pneumonia
Caesarian Section
Complicated or pre-term delivery
Appendicitis

Preventative

Birth control
Screening tests
Annual physical
Vaccinations
Dietary counselling

Emergency, Chronic Implications

Major RTA
Stroke
Sports injuries
Complicated pregnancy
Complicated and/or pre-term delivery
Cancer
Heart Attack
GI bleeding
Pulmonary Embolism
Traumatic Brain Injury

Chronic Conditions

Diabetes
Hypertension
Hyperlipidemia
Osteoarthritis, Rheumatoid Arthritis
Cancer
Mental Health
Ischemic heart disease
Sickle Cell Disease
HIV
Asthma
COPD
Multiple Sclerosis
Epilepsy
Congestive Heart Failure
Migraines
Chronic Kidney Disease

Chronic, Curable

Hepatitis C
Cancer
Mental Health
Gallstones
Obesity
Smoking-related
Arrhythmias
Deep vein thrombosis

Discretionary

IVF & some Fertility Treatment
PrEP
Autism care
Orthotics
Off guideline screening tests
Genetic testing

Planned, One-time

Many elective surgeries
Child Birth
Sterilization
Vasectomy
Abortion

Acute on Chronic

Asthma, COPD
Sickle Cell Disease
Congestive Heart Failure
Inflammatory Bowel Disease

Of course, many of these categories are debatable and nor are they mutually exclusive but my goal is to think of broad categories of claims in order to create more effective strategies to address them.

Strategies to Address Categories

Low Acuity, Episodic

Flu, colds, gastroenteritis
Uri
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Cellulitis and skin infections
Dental & Vision

Telemedicine, On-site Clinics, Direct Contracting: Primary Care

Low Acuity, Chronic

Eczema, psoriasis, gout
Alle
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Vision

Telemedicine, On-site Clinics, Direct Contracting: Primary Care

Emergency, One-time

Fractures
Spo
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Caesarian Section
Complicated or pre-term delivery
Appendicitis

Urgent Care, Narrow Networks, Care Navigation

Preventative

Birth control
Scre
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Vaccinations
Dietary counselling

On-site Clinics, Telemedicine

Emergency, Chronic Implications

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Cancer
Heart Attack
GI bleeding
Pulmonary Embolism
Traumatic Brain Injury

Care Navigation, Chronic Disease Management, Hotspotting, Narrow Networks

Chronic Conditions

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Sickle Cell Disease
HIV
Asthma
COPD
Multiple Sclerosis
Epilepsy
Congestive Heart Failure
Migraines
Chronic Kidney Disease

Chronic Disease Management, Wellness programs, Telemedicine Hotspotting, HRAs, Centers of Excellence, Second Opinion Services

Chronic, Curable

H
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Smoking-related
Arrhythmias
Deep vein thrombosis

Outcomes-based Contracting, Centers of Excellence, Prior Authorization

Discretionary

IVF
PrE
Aut
Ort
Off guideline screening tests
Genetic testing

Prior Authorization, Reference Pricing, HSA/HRA/FSA

Planned, One-time

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Abortion

Care Navigation, Prior Authorization, Centers of Excellence, Reference Pricing

Acute on Chronic

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Chronic Disease Management, Care Navigation, Hotspotting

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Contents

Plan Design

High Deductibles

- The rationale behind high deductibles was not only to shift cost to employees in the face of rising premiums, but to encourage more conscious consumerism of care, where employees with ”skin in the game” would shop based on cost and quality. In many cases price and quality transparency tools to “shop” for care were rolled out simultaneously. HSAs, HRAs & FSAs helped soften the initial cost burden on employees and provided an added incentive to use funds more cautiously.
- Enthusiasm for such plans seems to have peaked due to several factors:
    1. There is increasing evidence that higher out-of-pocket costs are leading many to avoid necessary care[4,5] and use their coverage only in cases of catastrophe
    2. High utilizers of care quickly exceed their deductible and OOPM at which point they lose the incentive to shop based on cost
    3. Members may not be willing nor able to shop for care in a moment of need
    4. The healthcare delivery system is not set up to enable patient choice based on cost, which puts the member at odds with their provider’s recommendation
    5. Accurate cost and quality data has proven difficult to obtain, interpret and communicate to members
    6. Some of the perceived cost savings with HDHPs may be due to favorable selection in attracting healthier enrollees[2]
- All of this is to say that while there may have been initial cost savings, there is a genuine concern that the modest amounts saved may simply have been deferred and we have failed to enable a functioning consumer marketplace while worsening the member experience.
- Maximum and minimum allowable deductibles for high deductible health plans are governed by the IRS who annually adjust for inflation. For 2018 the deductible range for self-only coverage was $1,350 - $3,450 and for family coverage, $2,700 - $6,900. They also control out-of-pocket maximums which were $6,650 and $13,300 respectively[3].

1 Employers curb high-deductible plans even as insurance costs rise 2 RAND: Analysis of High Deductible Health Plans 3 IRS: Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans 4 Diabetes Outpatient Care and Acute Complications Before and After High-Deductible Insurance Enrollment 5 Commonwealth Fund: The Problem of Underinsurance and How Rising Deductibles Will Make It Worse

Higher Out-Of-Pocket Maximums

- HHS sets limits for out-of-pocket maximums (OOPM): in 2018 it was $7,350 for self-only coverage and $14,700 for family coverage. These limits, however, do not necessarily apply to out-of-network care.
- KFF reported that in 2018 the average OOPM for single coverage at small firms was $4,517 and $3,608 at large firms (≥200 employees)[1].
- PPOs have historically covered out-of-network claims with the same out-of-pocket limits as for in-network care. Recently, many PPO plans have increased the OOPM for out-of-network claims and in some cases removed it altogether leaving members entirely liable for out-of-network costs[2].
- EPO and HMO plans typically have no out-of-network coverage except in cases of emergency are rarely count out-of-network care toward the OOPM.
- As with the deductible, the OOPM is an effective mechanism to increase cost sharing to a limit. Recent trends to exclude out-of-network care from counting toward the OOPM strengthen the importance of staying within network, however out-of-network claims are not always intentional[4] and could put members at greater financial risk.

1 KFF: Among covered workers with an OOPM for Single Coverage, Average OOPM by Firm Size 2 KHN: 2016 PPO plans remove out-of-network cost limits, a costly trap for consumers 3 An analysis of out-of-network claims in large employers health plans

Employee Selection & Classification

- Several important laws protect employees from discrimination in the workplace and during the hiring process including:
  - ***Age Discrimination in Employment Act***: protects individuals aged 40 or over, making it unlawful to discriminate against a person in employment or hiring because of his/her age with respect to any term, condition or privilege of employment
  - ***The Americans with Disabilities Act***: prohibits discrimination against employees and job applicants who have physical or mental impairments that substantially limit "major life activities". Many medical conditions including diabetes have been accepted in to this loose definition.
  - ***Family and Medical Leave Act***: allows employees to take up to 12 weeks unpaid leave within a 12-month period if they had a serious illness, injury or medical impairment as further defined by the act.
  - ***Civil Rights Act***: prohibits discrimination based on race, color, religion, sex or national origin.
  - ***Black Lung Benefits Act***: prohibits discrimination by mine operators against miners who suffer "black lung disease" (pneumoconiosis)
- State laws provide additional protections, yet there are still many gaps (for example, LGBT discrimination is still legal in 31 states[1]) with many grey areas, e.g. what constitutes "substantial limitation to major life activities" and thus defines the medical conditions that cannot be discriminated against. Where the law applies, discrimination still regularly occurs and employers must be aware of their responsibilities.
- Some employers do discriminate on based on legally permissible factors that can be associated with higher healthcare costs, for example Geisinger does not employ smokers[2]. Citizens Medical Center in Victoria, Texas rolled out a policy not to hire people with a BMI >35 although subsequently rescinded the policy after a backlash[3].
- Many employers through their structure, nature of work or age of business skew toward employee demographics and characteristics with lower healthcare costs. Previous studies have found a positive correlation between high job status and lower risk of mortality, hypertension and heart attacks[4]. Similarly many health harming exposures at work have been identified, such as exposure to chemicals and dust, repetitive strain and job insecurity[4] that have links to costly medical conditions.
- Many employers make heavy use of part-time workers (<30hrs/wk), who are excluded from the ACA's employer mandate. In 2014, Walmart and several other large employers decided to drop health coverage for part-time workers[5]. A labor group report claims that part-time workers now make up half of Walmart's workforce, up from 20% in 2004.
- Companies in the "gig economy" such as Uber do not employ drivers. Instead drivers are classified as 1099 contractors who are not entitled to receive health benefits. Instacart also contracted with drivers and pickers. After increasing legal pressure, Instacart decided to offer the contractors the opportunity to become part-time employees with some additional benefits but hours capped at 30hrs/wk, again avoiding the employer mandate.

1 New Campaign Puts Spotlight on 31 States Where LGBT Discrimination Remains the Law 2 KHN: Geisinger System: We Won't Hire Smokers 3 Citizens Medical Center in Texas Rescinds Employment BMI requirement 4 Bad Jobs Bad Health? How Work and Working Conditions Contribute to Health Disparities 5 Walmart to End Health Coverage for 30,000 Part-Time Workers 6 Half of Walmart's workforce are part-time workers: labor group 6 Instacart contractors turned part-time employees still won't get health insurance

Plan Selection

- Health plan selection during open enrollment is a critical time to educate employees and their dependents on their plan options, the details of those plans and any ancillary benefits. By doing so, members can hope to make better decisions and make the most of their benefits while employers can maximize their return on investment on the time-consuming and crucially important work put in to plan design.
- Plan selection is also an opportunity to nudge employees toward new plan options and/or those that fit with a longer-term benefits strategy. In doing so:
  - ***The plan details matter – and not just the cost-sharing aspects:*** PBGH found that for 26%, the main reason they chose their plan was the employee premium contribution and for 25% it was the doctors in the plan. The Urban Institute found that in their target survey population 43% were willing to accept limits in covered services, 42% limited drug coverage, 39% restrictions on accessing specialist care and 34% a limited choice of providers.
  - ***The way plans are presented makes a big difference:*** As the result above illustrates, the doctors in the plan can be an important deciding factor so it is crucial that information is made available during open enrollment. If an employee has existing doctors they would like to continue seeing and can't easily verify whether they are included in the EPO, they're likely to go with the PPO. As a study of Healthcare.gov's choice architecture illustrated[4], comprehension of options can affect choices as can many other factors in the realm of behavioral economics such as the order in which plans are presented[5].
- Employers can be mindful of these factors as they plan their open enrollment process. Companies such as Picwell offer plan selection tools that can make personalized recommendations to employees and Jellyvision's Alex (used by Harvard & Walmart) offers an interactive online tool to help educate employees about their options and health insurance basics and come to a more informed decision.

1 Urban Policy Institute: Factors Influencing Health Plan Choice among the Marketplace Target Population on the Eve of Health Reform 2 PBGH: Helping Consumers Choose the Right Health Plan for their Needs 3 Can Plan Recommendations Improve the Coverage Decisions of Vulnerable Populations in Health Insurance Marketplaces 4 Poor Consumer Comprehension and Plan Selection Inconsistencies Under the 2016 Healthcare.gov Choice Architecture 5 Behavioral Economics and the Affordable Care Act Marketplaces: Utilizing Choice Architecture to Optimize Consumer Decisions for Health Insurance

Fewer Plan Designs

- In 2018, KFF reports that 42% of large firms only have one health plan type (HMO/PPO/HDHP/POS), 45% have two plan types and 13% have three or more. From previous KFF survey years, it appears the trend has been for large firms to offer more plan options.
- While having more plan options gives employees and their families greater choice especially where there may be concerns about keeping certain providers within network, there is a strong case to be made for consolidating plan options (networks and/or plan types).
- With fewer plan options, fewer networks or just a single network to manage, employers could:
  - Have a greater focus in their cost saving and quality improvement efforts
  - Gain greater bargaining power with higher concentration of members
  - Simplify communication of health plan design
  - Streamline TPA, prior authorization, care navigation processes
  - Encourage greater collaboration, coordination and data-sharing between their in-network providers
  - Reduce cost-sharing in return for reduced choice
- There are also risks and challenges of this approach:
  - Disruption for members whose doctors fall out of network
  - Consolidating plans across diverse geographies may not be feasible
  - Less diversity of plans may create less competition between providers in the long run

1 KFF 2018 Employer Health Benefits Survey: Types of Plans Offered

90-day Maximum Waiting Period

- The ACA mandates a maximum of a 90-day waiting period before activating health benefits for new employees.
- Many employers waive this period entirely, opting to activate benefits from day 1. However, other employers particularly those with lower paying and higher turnover jobs opt to use this waiting period as a hurdle and in doing so end up paying for less months of coverage. In the case employment is ended during the waiting period, the employer avoids COBRA administration costs and subsequent liability (where coverage can be retroactively purchased for up to 60 days, and cost of COBRA coverage - studies suggest COBRA recipients incur 45% more claim costs versus active employees[1]).

1 Spencer's COBRA Survey Finds More Eligible Employees Elect COBRA Coverage, Companies Paying Significantly Higher Costs

Increased Coinsurance or Copays

- Copays are set dollar fees typically used for discrete, lower cost visits. Coinsurance is the percentage of costs the member pays, typically reserved for more expensive specialist and complex care. Although fine-print may vary, co-pays rarely count toward a deductible, but do usually count toward the out-of-pocket maximum (OOPM). Coinsured services will generally be paid entirely out-of-pocket until the deductible is met, at the co-insured rate between the deductible and OOPM and entirely by the insurance after the OOPM is met. Plans vary on their out-of-network coverage and often carry higher co-insurance for out-of-network care with a different or unlimited OOPM.
- Employees and their dependents are increasingly gaining coverage through High-Deductible Health Plans with rapid growth from 4% of large employer plans in 2004 to 29% in 2018. Under such plans, coinsurance is much more common than copays, as they are designed to make members highly price sensitive and more active shoppers for care from the moment their insurance starts. Data shows that between 2006-2016, member spending on deductibles has risen 176%, coinsurance spending has risen 67% and spending on copays has decreased 38%[1].
- Coinsurance and copays are also an important mechanism in value-based insurance design. Increasing coinsurance or copay requirements can disincentivize lower value services while reducing them for select services can encourage use or preference of designated high-value services.
- Copays and coinsurance are another variable that employers and plan designers can use to change the profile of cost-sharing for members and shape health care use. They hold a close relationship with deductibles, out-of-pocket maximums and network coverage mentioned elsewhere in this document.

1 Increases in cost-sharing payments continue to outpace wage growth 2 KFF Percentage of Covered Workers Enrolled in a HDHP/HRA or HSA Qualified HDHP

Cash-in-lieu of Benefits

- Some employers are offering cash payments to employees if they do not take up health insurance. Some require proof that the employee has gained coverage elsewhere (though their spouse, parents or the market), others offer cash unconditionally. There are important tax and ACA compliance considerations for employers implementing such a program[1].
- In another example, Netflix currently offers employees a health budget that can be used to purchase from a range of plan options. They are not required to purchase health insurance and anything unspent is returned in the employee's taxable monthly paycheck.
- The Netflix example helps make the total cost of health benefits more transparent to employees. These mechanisms are also likely to shift health care costs to other employers who do not offer similar incentives.

1 Opting out of health insurance: Employee compensation in Lieu of Benefits

Spousal, Dependent and Unitized Coverage

- The ACA mandates coverage for dependent children until the age of 26 but coverage for spouses is not required by law. However, KFF reports that 95% of small firms and 99% of large firms offered spousal coverage in 2018[1] with 63% extending that coverage to same-sex partners[2].
- The ACA affordability safe harbor still applies to spouses, setting a ceiling for the employee contribution for spousal coverage, however many employers that started from a low or zero base are beginning to increase the contribution required for spouse coverage. In some cases, employers are withdrawing coverage or levying a surcharge if the employee's spouse has the option to get coverage through their own employer.
- Many predicted that many companies would drop spousal coverage altogether, but it has not yet happened. As employers compete to attract talent and reinforce family-friendly cultures[3], some are going in the opposite direction, extending coverage to domestic partners and even parents.
- Another strategy being used is to "unitize" family plans. Instead of charging the same employee contribution for a family plan that could include 1, 5 or sometimes an unlimited number of dependents, employers might charge an additional contribution for each additional dependent. It could be viewed as fairer and more reflective of true costs, but also shifts costs towards those with larger families.

1 KFF: 2018 Employer Health Benefits Survey 2 KFF: Access to Employer-Sponsored Health Coverage for Same-Sex Spouses: 2018 Update 3 'Carving Out' Spousal Benefits: Cost-Cutting with Repercussions

Coverage Inclusions & Exclusions

- The ACA created a universal floor of coverage called Essential Health Benefits (EHBs). Additional benefits may be mandated at a state level and conversely, some states have chosen to outlaw certain benefits, for example insurance coverage for abortions. ERISA often means EHBs do not apply[1], although many employers have chosen to follow the ACA's lead. It is no surprise that there are many health benefits that employers are not required to offer that could be beneficial to their employees and dependents, or perhaps less likely, benefits that employers offer that increase your costs, offer low-value and are not legally required.
- Just some of the treatments and services that can be discretionary include:
  - Laparoscopic Gastric Banding and Bariatric Surgery
  - IVF and other fertility services
  - Autism screening and autism services[3]
  - Off-guideline cancer screenings (eg. early PSA tests, genetic screening based on DTC tests)
  - Pre-exposure Prophylaxis (PrEP) for those at high risk of HIV contact
  - Hearing aids, orthotics and prosthetics
- Employers may wish to regularly review their coverage inclusions and exclusions to both meet member needs and control costs.

1 Health Affairs: ERISA: a Bipartisan problem for the ACA and AHCA 2 Does your insurance cover abortions? 3 Autism Speaks: Self-Funded Health Benefit Plans

Savings Accounts & HRAs

- As cost-sharing rose rapidly in the 90s through higher deductibles, copays, coinsurance and employee premium contributions, employers looked to reimbursement arrangements and savings accounts to soften the impact and increase adoption of high deductible health plans.
- There are three saving and reimbursement account options for employers:
  - ***HRA (Health Reimbursement Arrangements):*** Funded solely by employer with no maximum contribution, tax deductible, covers qualified medical and dental expenditures and can be used to pay employee premium contributions. Does not require a HDHP. Employer can choose whether it rolls over, is portable and how it is paid out. Can be used in conjunction with an FSA.
  - ***HSA (Health Savings Account):*** First introduced in 2003. Fully vested means it rolls over to subsequent years. Employer and/or employee contributes up to IRS defined maximum. Employee contributions are tax deductible until age 65. HSA funds can earn interests and be invested. Tax free if spent on qualified medical expenses, otherwise non-qualified expenditures incur 20% penalty (applied until age 65) and tax.
  - ***FSA (Flexible Savings Account):*** Most frequently funded by employee but the employer may also contribute up to an IRS defined maximum. Typically does not roll over and not portable. Does not require a HDHP.
- There are pros and cons for each of these options and there are no mandates requiring employers to offer them. Use it or lose it designs incentivize members to spend allocated funds on necessary care but do not allow saving for high cost events. HSAs may encourage members to save their money for retirement and employer contributions are more likely to be considered as part of an employee's compensation. Employers could choose to increase the burden of cost sharing by reducing HSA/FSA/HRA contributions or shift contributions to use it or lose it designs where unused contributions are returned to the employer.

Health Maintenance Organizations

- With the emergence of narrow networks, accountable care organizations, widespread utilization management, exclusive provider organizations and point-of-service plans, the lines that distinguish Health Maintenance Organizations (HMOs) have become increasingly blurry[3]. Many of these developments can be better understood through the history of managed care, its rise from traditional indemnity plans in the 90s and the subsequent backlash[4].
- Ultimately, Federal[1] and State legislation govern the requirements and certification of HMOs. While there are a broad spectrum of HMOs, most feature:
  - Narrow networks with little or no out-of-network coverage except in the case of emergency
  - Members who are typically required to designate a primary care physician who acts as a gatekeeper to specialists
  - An HMO as a medical insurance group that provides health services for a fixed annual fee and often uses capitation in contracting, in contrast to ACOs that are provider-led.
  - Managed care - performing utilization review and management to shape practice, referrals and prescribing to control both short-term and long-term costs.
- HMOs operate under many different and sometimes overlapping models that bring pros and cons, especially with respect to the ability to shape practice:
  - Staffed: The physicians and medical staff are directly employed and salaried by the HMO, seeing only members of the HMO. Very few operate using this model now
  - Group: The physicians and medical staff belong to medical groups that are directly contracted, often on a capitated basis, to exclusively provide care for HMO members
  - Open-panel: The HMO contracts with Independent Physician Associations (IPAs) to on a non-exclusive basis to provide care for HMO members
  - Network: Often used by new HMOs, these HMOs may combine the above models to form a network that is adequate to provide services for HMO members
  - Carrier HMO: Accounting for most HMOs, run by commercial insurance carriers and rely on contracting with medical groups without owning any medical infrastructure
  - Delivery System HMO: Prime example is Kaiser Permanente, that controls the insurance group (KFHP), the medical group (TPMG) and the Kaiser Foundation Hospitals
- Some HMOs offer self-funded or experience-rated products where premiums include an administration fee, profit and reflect actual utilization. KFF reports that in 2018 the average HMO premium for single coverage was $6,869, almost exactly the average across all plan types and $410 more than the HDHP/SO alternative. While HMOs typically come with lower cost-sharing and potentially higher quality care, these figures do not suggest significant cost savings to employers. Some employers complain that HMOs offer little transparency in to real utilization and use this to retain greater profits.
- Ambitious employer(s) may be able to build and operate their own HMOs by directly contracting with providers through a combination of ACOs, IPAs, Hospitals, Primary Care Practices, Centers of Excellence, exclusively contracted medical groups and staff to provide adequate network coverage. Without profit-making incentives, such HMOs would increase employer visibility in to care delivery and could significantly lower costs. Employers may also be able to push for greater visibility and control over existing HMO plan options offered through carriers and delivery system HMOs.

1 The Public Health and Welfare Act: Section 300e: Requirements of Health Maintenance Organizations 2 Health Affairs: HMOs and Managed Care 3 NYTimes: Accountable Care Organizations: Like HMOs but Different
4 Managed Care: What Went Wrong? Can It Be Fixed? 5 Essentials of Managed Care by Peter R Kongstvetd

Exclusive Provider Organizations

- Exclusive Provider Organization (EPO) plans usually offer a narrow high-performance network with little or no out-of-network coverage[1,2] and do not typically require a primary care referral to access specialists.
- In the case where the EPO uses primary care gatekeeping to specialists, the main difference between HMOs and EPOs is that the latter are regulated under ERISA, not more restrictive HMO laws and regulations[3].
- Health plans have touted double-digit percentage cost savings with EPO plan designs[1]. While their networks often involve contracts with large health systems, there have also been concerns about the network adequacy of EPOs due to their relative lack of regulation under ERISA[4].
- While KFF do not break down plan type enrollment in to EPOs, a Milliman survey suggests that EPOs are rapidly gaining popularity in Texas, both in the individual and employer markets, rising from 1.1% of enrollment at large employers in 2013 to 6% in 2015[5].
- Employees may be increasingly willing to accept the narrow networks and and limited out-of-network coverage in return for lower cost-sharing. EPOs with primary care gatekeeping offer, perhaps, a more flexible way for employers to build something that looks like an HMO and can deliver cost savings without the administrative burden and restrictions of HMO regulation.

1 Price sensitive? Health plans with no out-of-network benefits heat up in employer market 2 Are EPOs the new Narrow Networks? 3 Essentials of Managed Care by Peter R Kongstvetd 4 What consumers need to know about EPO plans 5 Texas Association of Health: Trends in the Commercial Insurance Market

Point-of-Service Plans

- Point-of-Service (POS) plans emerged in the 80s from the managed care movement. They require referral from in-network primary care to access most specialists and typically offer a broader network of specialists than EPO plans with varying levels of out-of-network coverage. Some POS plans emerged directly from HMOs who wanted to broaden their appeal by including access to care outside of the HMO for highly specialized services, often subject to utilization review[2].
- Some POS plans allow self-referral to specialists for a fee, however studies have shown that this option is rarely exercised when offered[1].
- KFF report that POS plans have continued to decline in popularity among employers, from their rapid rise from the ashes of conventional indemnity plans in the late 90s, reaching 24% of plans, consistently declining a 6% share in 2018.
- KFF report that average premiums for POS plans in 2018 were $7,048 for single coverage and $19,216 for families, coming in cheaper than PPOs, close to HMOs and more expensive than HDHPs.
- While POS plans in their current form, based on KFF average statistics, are not delivering significant comparative cost savings, their design holds much promise for future plans: with the cost control and narrow network features of an HMO and the flexibility that could make nudging a majority of employees to this plan type easier.

1 Majority of Patient in Point-of-Service Health Plans Never Use Self-Referral Option for Specialty Care (2002) 2 Essentials of Managed Care by Peter R Kongstvetd 3 KFF: Distribution of Health Plan Enrollment for Covered Workers by Plan Type 1988-2018 4 KFF 2018 Employer Health Benefits Survey: Cost of Health Insurance

Increased Employee Contributions

- The IRS imposes an upper limit on employee contribution for single employee coverage: The least expensive health insurance plan option must be "affordable", costing less than 9.5% of household income[1], although employees can voluntarily choose higher cost options with higher levels of coverage. Since employers rarely know household income, they have a few other alternatives, including the 9.5% of W-2 wages or the single Federal Poverty Level, currently $12,140 * 9 .5% / 12 = $96.10 per month.
- KFF reports that average employee contribution for single coverage in 2018 was $99 per month[2] (18% of total premium), suggesting that most employers charge close to this FPL-based upper limit or employees tend to opt for more expensive plans with higher levels of coverage. In the same year, average employee contribution toward family plans were $462 per month (29% of total premiums). With no imposed limit on employee contribution for spouse and dependent coverage there is significant room to increase such employee contributions.
- While most employers have set dollar contributions for given plans across all employees, some employers are turning to what may be viewed as a more equitable structure: ***contributions based on salary***. This can be as a fixed percentage of salary or based on salary tiers with dollar or percentage of salary contributions[5]. One example of such a design can be seen in Harvard's tiered rates for staff[3]. This can help reduce cost sharing for the lowest paid employees while maintaining or potentially increasing employee contributions to overall company healthcare costs.
- Some employers also apply tobacco rating to their employee contributions. While this practice is outlawed in the individual insurance market in some states, it remains permissible under ERISA. Walmart, for example, charges $63.05 per month for tobacco free associates or $126.10 per month for tobacco users under their 2018 high-deductible plan[5]. There may also be latitude for employers to alter contributions based on employee location and age, should these reflect underlying cost differences, although employers must be mindful of Age Discrimination Employment Act, the Health Insurance Portability and Accountability Act.
- Employee contribution amounts can also be used to steer employees toward certain plan designs that are expected to lead to reduced overall costs. This can be particularly useful when introducing new plan types.

1 Don't Overlook 2018 Change in 'Affordability' Safe Harbor Percentage 2 KFF 2018 Employer Health Benefits Survey: Worker and Employer Contributions for Premiums 3 Harvard Staff Benefits at a Glance 2019 4 Tying Health Plan Premiums to Salary can Aid Lower-Paid Earners 5 Walmart 2018 Annual Enrollment

Evidence-Based Guidelines

- Variation in care and adherence to evidence-based guidelines is widely documented[1] and while some degree of variation is to be expected and perhaps encouraged, excessive variation costs employers billions of dollars through ineffective and unnecessary care and iatrogenic harm to members.
- Employers can both encourage the production and dissemination of authoritative guidelines and can encourage the adherence to existing guidelines through a few mechanisms:
  - ***Prior authorization (PA):*** PA can be applied across a wide range of treatments and care pathways, requiring providers to obtain authorization from the administrator in order to be reimbursed. While generating additional administrative burden on all sides it can enforce guidelines and over time shape practice as providers move from a reactive to a more proactive approach, especially if PA requirements become standardized across payers. As practice patterns shift PA requirements can be relaxed and refocused on problem areas.
  - ***Evidence-based coverage:*** It is important that health plans remain proactive as new evidence emerges both in withdrawing and adding coverage that may ultimately improve outcomes and reduce costs. Many plans have both in-house and external consultants who help assess new technologies and change coverage policies, while also following the lead of Medicare and committees such as MEDCAC[4]. Prime coverage examples include the reduction in coverage for arthroscopic debridement and lavage for osteoarthritis of the knee[6] and addition of coverage for highly effective antiviral treatments for Hepatitis C[5] and the absence of a value-driven framework for coverage.
  - ***Advocacy of guidelines:*** Employers can start by advocating evidence-based approaches with their own members. Perhaps the most prominent example is Choosing Wisely[2], an initiative from the ABIM Foundation that promotes evidence-based conversations around treatment. Second opinion services can also help guide members along a more evidence-based path. The USPSTF[4] states that its recommendations and reviews be used to foster communication between employers, providers and research organizations to develop quality improvement strategies[8].
  - ***Quality measures:*** As employers develop direct contracts with providers, they can require reporting of quality measures that reflect the practice of evidence-based medicine.

1 The Dartmouth Atlas of Health Care: Variation in Health Care Delivery 2 Choosing Wisely: Promoting conversations between patients and clinicians 3 US Preventative Services Task Force 4 Medicare Evidence Development & Coverage Advisory Committee 5 Health Insurance and Coverage of Evidence-based Care 6 Evidence of No benefit from Knee Surgery for Osteoarthritis Led to Coverage Changes and is Linked to Decline in Procedures 7 Choosing Wisely Employer Toolkit 8 USPTF: Refining evidence-based recommendation development

Incentives Beyond the OOPM

- While many argue that cost sharing helps develop activated consumers of healthcare, the teeth of co-payments and co-insurance are entirely lost once the out-of-pocket maximum (OOPM) is exceeded (with the exception of out-of-network claims, that plans may or may not cover). For members who know with certainty at the start of the benefit year that they or their family will exceed the OOPM, out of pocket payments become merely a formality.
- Other levers such as networks, navigators and prior authorization are increasingly being pulled to further incentivize and in some cases force members to choose high-value providers for necessary care beyond the OOPM.
- Consumer driven reference-based pricing (RBP) as previously discussed has the potential to incentivize beyond the OOPM by only covering given treatments and services up to a pre-determined reference price. If the member chooses a more expensive option, they pay the difference even past the OOPM. Experts agree that RBP cannot be applied across all types of health care[2] and previously discussed limitations apply.
- Another option that has yet to be fully explored is paying patients to choose the lower cost, higher value option. I worked on a product called Castlight Rewards that would credit points (which could be redeemed for financial/non-monetary rewards) to members choosing lower cost labs or imaging providers. In the absence of robust quality data there is a risk this approach could lead to patients going to lower cost, lower quality providers and it also has the potential to incentivize over-utilization of care, but it may be worth exploring.
- There are controversial examples in the UK of private insurers paying members cash incentives to use the NHS for major procedures instead of private care[1].

1 Insurers offer cash to patients using NHS 2 How Safeway cut lab test spending by $2.6m with reference pricing

Value-based Insurance Design

- Value-based Insurance Design (VBID) is the concept of structuring cost-sharing and other health plan design elements to incentive use of high-value services and disincentivize use of low-value services[1]. Two broad approaches exist[6] – 1) reducing cost-sharing for specific drugs or treatments that do not discriminate based on patient, for example lowering copays for aspirin that may be used for a wide range of conditions 2) reducing cost-sharing based on patient characteristics, for example if they have a specific condition.
- The ACA Requirements for Coverage of Preventive Services, that removed cost-sharing for patients receiving selected services such as evidence-based screenings and routine immunizations[2] is, at its core a VBID. Many of the other strategies in this document, such as tiered formularies, Centers of Excellence and Care Management programs (with lower cost-sharing) are also examples of VBID.
- Much of the early work around VBID started at self-insured employers in the 90s: Pitney Bowes significantly reduced cost-sharing for diabetes, hypertension and asthma drugs. For diabetes, they achieved this by shifting all diabetes drugs and devices to the lowest formulary tier (10% coinsurance, vs 25% for tier 2 and 50% for tier 3). In the subsequent 2-3 years they found greater medication possession rates among diabetics, a 7% reduction in total pharmacy costs and a 26% reduction in ER visits. Overall direct healthcare costs in members with diabetes decreased by 6%[3].
- Many experiments with VBID are currently underway in Medicare populations, with self-funded employers and commercial insurers[5]. Some of the largest efforts include efforts from BCBS, the Oregon Educators Benefit Board and TRICARE[6].
- Michael Chernew and colleagues succinctly lay out many of the barriers to implementing VBID, including concerns over increased used, cost of implementation, data issues, insufficient research, fraud, privacy concerns, adverse employee selection and other unintended consequences[6].
- For employers looking to ramp up VBID initiatives, a good place to start is with data – to identify high-cost conditions, analyze the underlying use of services to treat those conditions and investigate whether there are higher value treatment options that could be used to treat those conditions.

1 Medicare Advantage Value-Based Insurance Design Model 2 Preventive Services Covered by Private Health Plans under the Affordable Care Act 3 Reducing patient drug acquisition costs can lower diabetes health claims
4 Value-Based Insurance Design 5 Containing Employee Benefit Costs Through Value-Based Insurance Design 6 Health Affairs: Value-Based Insurance Design

Coverage Withdrawal

- KFF reports that in 2017 96.6% of firms with ≥50 employees and 30.2% of firms with <50 employees offered health insurance [1]
- With the introduction of the employer mandate many predicted that employers would drop coverage, pushing employees to exchanges – that didn't happen. Political change, uncertainty around exchanges, a competitive jobs market, a highly valued status quo, tax benefits to both employees and employers offering insurance, wanting to do right by employees and many other reasons have been cited as to why. Furthermore anti-discrimination laws strengthened by the ACA largely prevent offering insurance only to certain groups of full-time employees making it an all or nothing proposition.
- **If an employer with 50,000 FT US based employees decided not to offer health insurance, what would the total cost of coverage be?**
- Under the employer mandate, a $2,320 penalty per employee (less the first 30 employees) would be assessed = $116M. Employees would then have to choose to get coverage in the market with their post-tax dollars and a federal subsidy depending on their income level and family size. Let's assume 5% decided not to insure, 25% took out family plans and 70% took out individual policies at average 2018 marketplace prices[3]. 2,500 x $0 (no cover) + 12,500 x $14,016 (family) + 35,000 x $5,280 (individual) = $360MM. Let's deduct $100M of federal subsidies and add in the $116M penalty, we get a total cost of penalties + coverage: **$371M**.
- **Let's compare that to the average cost for employer-sponsored coverage** with 5% choosing to take coverage elsewhere, 25% family plans and 70% individual plans again at average 2018 group plan prices[4] (interestingly these are higher than group plan costs). 2,500 x $0 (no cover) + 12,500 x $13,469 (family) + 35,000 * $4,953 (individual) = $341M employer contribution + 2,500 x $0 + 12,500 x $5,218 + 35,000 x $1,415 = $115M. The total cost $456M, but if we consider the tax breaks[2] that employer-sponsored insurance receives and apply an assumed blended effective tax rate of 25% we reach $456M x 0.75 = **$342M**.
- While these calculations are incredibly rough, it appears that the cost of the employer penalty + individual coverage vs group coverage is in the same ballpark and larger employers may be able to achieve greater cost savings through economies of scale. Add in the positive externalities employer sponsored health insurance brings and there is a strong rationale for maintaining it. In the first scenario, if the employer passed on the cost savings of not having to pay for coverage to employees, employees themselves would see little difference in their disposable income. If however employers decided to keep the savings, employees would see their total compensation decrease.

1 KFF: Percent of private sector establishments that offer health insurance to employees by size 2 Tax Policy Center: How does the tax exclusions for employer-sponsored health insurance work? 3 eHealth Insurance: How much does health insurance cost without a subsidy?

Plan Administration

Claims Adjudication & Bill Review

- Traditionally TPAs had few incentives to scrutinize incoming claims. With little oversight from the employer, it may have been in their interest to have a low bar for approving claims to strengthen provider relationships for their fully insured offerings, especially if their fees are based on percentage of settled claims.
- Studies of claims have estimated between 30% to 80% of medical bills contain errors[1].
- As employers look to control costs, they can pressure TPAs to exercise more scrutiny over claims or bring in specialists to work with their TPA to review claims.
- Such specialists typically use a data-driven approach to identify unusual individual claims, patterns of claims or simply prioritize claims for review over a certain dollar amount. Their process starts with looking for obvious errors followed by more detailed review, cross-checking against negotiated rates and in some cases even repricing charges. The claim is then negotiated to a settlement, however if a settlement is not easily reached there is a chance that the member could receive a balance bill or the claim could end in litigation[2].

1 WSJ: How to Fight a Bogus Bill: Many Medical Bills Contain Errors That Could End Up Wrecking Your Credit Score: Here's what you need to know 2 Reconstructing Healthcare Podcast – Merrit Quarum MD of WellRithms Inc.

Fraud Detection

- It is estimated that fraud accounts for 3-10% of US healthcare spending[1]. Private insurers and CMS dedicate significant resources to tackle fraud while employers rely largely on their TPA for this function. Some employers are beginning to take a more active role in tackling healthcare fraud.

Types of most common fraud relevant to employers

- ***Provider side:*** Upcoding (charging for more expensive service than was rendered), phantom billing (charging for things that did not happen), unnecessary care, misrepresentation of services (performing services not covered but billing as a covered service), unbundling (charging separately for procedures that were part of a single procedure), masquerading as health professionals (delivering services without a proper license).
- ***Member side:*** Doctor shopping (bouncing from one doctor to another to obtain multiple prescriptions for controlled substances), identify theft (impersonation of member to utilize health benefits), dependent and spouse benefit ineligibility (claiming to be eligible for benefits, eg. Enrolling a family member's child or claiming a spouse was not offered health insurance by their employer).
- ***How can employers act?*** While employers may not have the expertise to directly tackle fraud, they can work with their TPA to exercise greater oversight or partner with third parties to administer anti-fraud initiatives. Employers can implement up-front verification of dependent eligibility or retrospective audits, although both of these approaches may be met with some hostility from employees[2].

1 BCBS Michigan: Fraud Statistics 2 More companies require employees to verify status of spouses and dependents 3

Health Risk Assessment

- Health Risk Assessments (HRAs) are typically annual surveys that ask a wide range of questions about a member's health, health-related behaviors and other social determinants. They often include aspects of patient-reported outcome measures such as the PHQ-9 or the VR-12 to assess mental health and general quality of life. Their results can be used by plans to design benefits, predict health costs, identify members for disease management programs and evaluate year-over-year outcomes from health initiatives.
- While HRAs are not new, they are increasingly being delivered electronically creating opportunities for more interactive experiences, more frequent data collection, fluid risk modeling, seamless integration with other programs and data sources (for example, making HRA information available to care management programs or drawing in information from interactions with care navigators in to a risk assessment profile) and real-time analytic capabilities.
- HRAs still come with some challenges:
  - ***Getting employees to complete HRAs:*** HRAs are typically voluntary, otherwise they may fall foul of the American Disability Act[2]. Given the private nature of the questions asked in HRAs, employees are often reluctant to complete them. Financial incentives can boost engagement significantly.
  - ***Asking the right questions:*** HRAs probe on sensitive topics and gather extremely valuable data, but at the same time cannot be excessively burdensome. As employees go through multiple annual cycles of HRAs there may be opportunities to build on previous answers instead of asking the same questions.
  - ***Engaging spouses and dependents:*** Spouses and dependents are equally as important when it comes to controlling healthcare costs, but may be more difficult to engage in an HRA program. As with employees, under many circumstances, financial incentives can be offered for engagement[3]. It is unclear whether gathering health risk assessment data on dependents under the age of 18 is even permissible.

1 Example Health Risk Assessment for Cigna Arizona Medicare Advantage Plan 2019 2 "Mandatory" or "Required" HRAs or biometric screens are problematic under the law 3 EEOC: Incentives for Health Assessments of Spouses Permitted

Benefits Awareness & Education

- If members are not aware of the benefits available to them and do not understand the design of their health plan, they are unlikely to maximize the value of their benefits at their moment of need, they are more likely to fall foul to the many traps of insurance-based coverage (eg. unintentionally going out-of-network or failing to use an FSA) and are more likely to be dissatisfied.
- Benefits such as Employee Assistance Programs (EAP) are notoriously underused[1], studies report that only 19% of employees have a high level of understanding of their benefits[2] and few Americans understand basic health insurance terms[3]. These represent opportunities to boost the impact and ROI of a carefully designed benefits package.
- Strategies to boost awareness and educate employees include:
  - Attention to Insurance ID card design to ensure members know where to learn more
  - Benefits portal that is easy to navigate, includes all programs and is mobile ready
  - Simplified benefits materials available in multiple languages
  - Video educational content that can be specific to member plan or about general health insurance
  - Benefits fairs, benefits educators, benefits champions within your organization
  - Incentives for viewing benefits content, completing quizzes or training
  - Care navigators or “member advocates” who are experts on member plan details

1 Workforce: EAPs are Valuable but Underused 2 International Foundation of Employee Benefit Plans Survey Results 3 PolicyGenuis: 4 basic health insurance terms 96% of Americans don’t understand

Plan Analytics

- One key advantage of self-funded employer health plans is access to data. Access to employee claims brings huge responsibility but also significant opportunities to better understand and better serve a member population while using resources more effectively.
- Technology is also making it easier to integrate other forms of data, from health risk assessments and Rx claims to data from third party vendors and electronic health records in to a unified data warehouse. With the right tools, plan administrators can gain a more complete and real-time view in to member health and health plan performance.
- Here are just a few examples of how plan data could be used to reduce plan costs:
    - Identify costly and avoidable patterns of healthcare usage and implement benefit changes to shift use. For example identifying avoidable ER usage and act by commissioning a new telemedicine program for lower acuity emergent conditions.
    - Close the feedback loop by monitoring the impact of that same telemedicine program to see whether members are engaging with the new program and whether avoidable ER usage decreased.
    - Identify that relatively few members with a hypertension diagnosis actively fill anti-hypertension medications. Act by reducing cost-sharing for first line anti-hypertensive medications and monitor uptake.
    - Implement an outcomes-based contract with the manufacturer of a high-cost drug to control asthma based on a measurable reduction in readmissions. Redeem a rebate when the drug fails to deliver the expected benefit based on your claims data at the year end.
    - Identify the top 5% of members based on healthcare spending and find common threads in causes for high spending. In collaboration with a clinical team or perhaps the contracted ACO the members are part of, craft a tailored outreach strategy aimed at improving care for this population and reducing long-term spending.
    - Assess return-on-investment of benefit add-ons such as care management programs at the end of a plan year and decide whether to renew or reallocate resources.
- Employers should consider health plan data a strategic advantage and ask more from their TPAs and partners both in the breadth and frequency of their data feeds. While data security and privacy will be of utmost concern, investing early in a data warehouse strategy that pools linked and structured data across a wide variety of sources in a single place that can be easily queried is likely to pay dividends in the long-run and provide a great deal of flexibility to implement more innovative plan designs.

COBRA Costs

- COBRA continuation of coverage is a temporary continuation of group health coverage that would otherwise be lost due to life events such as termination of employment, reduction of hours, death of an employee and divorce. Mandated under ERISA, most self-funded employers are required to offer COBRA coverage to their employees after a qualifying event, provided they have had at least 1 day of health plan enrollment.
- COBRA coverage can last 18 or 36 months and can be retroactively applied up to 60 days after a qualifying event[1]. Unlike subsidized employee premiums, employers can charge up to the full premium[2] for COBRA coverage plus a 2% administration fee or 150% of the full premium in the case of a disability extension.
- With a fluid and low-unemployment jobs market COBRA-eligibles are likely to switch to a new employer's plan. For those not finding re-employment, COBRA may be expensive compared with subsidized policies obtained through the exchange. However, members who are already receiving medical care and wish to keep their network and level of coverage, older members who face age-rated plans in the exchange, or those with large families who might see higher relative premiums on the exchange may wish to active COBRA coverage. The 60-day grace also creates a free option of catastrophic coverage during the period.
- While most benefit design strategies that apply to employees will also apply to COBRA enrollees, employers may also look to remove any subsidies from COBRA premiums, reassess how they calculate their COBRA premiums (as the rules allow much room for interpretation[4]) and consider increasing their waiting period for benefits eligibility to reduce COBRA liability.

1 Department of Labor: An employer's guide to group health continuation coverage under COBRA 2 How is the COBRA rate for self-insured plans calculated? 3 Spencer's COBRA survey finds more eligible employees elect COBRA coverage, companies paying significantly higher claim costs 4 Bouchey & Clarke Compliance Overview: COBRA Premiums

Benefits Portals

- A critical aspect of successfully implementing and changing benefit designs over time is being able to communicate those benefits and make them readily accessible at a time of need. As health plan designs have become increasingly complicated and employers have added new programs, many of which I have talked about in this document, the need for a more cohesive one-stop member experience has never been greater.
- Traditionally benefits are communicated as part of on-boarding and open enrollment and the details of those benefits contained within thick paper binders or static company intranet sites. As employees now expect to learn about and access those benefits online and through their phone there is an opportunity to create a ”one stop shop” for benefits that is personalized, integrated (through technologies such as single sign-on) and simplified for the member accessing it.
- Several approaches have emerged: Companies such as Castlight Health and Amino started with provider search but have expanded to become full-service benefits platforms. Collective Health, who started as a modern TPA and now deliver a cohesive experience that includes “Member Advocates” who function as navigators. Care navigation companies themselves can be seen as the voice-enabled benefit portal. Insurers are working to modernize their member experience with collaborations such as Anthem Engage[1]. Companies like Workday who have consolidated the HR stack also have a significant opportunity to extend their reach to benefits portals.

1 Anthem Blue Cross to Launch Integrated Digital Benefits and Health Engagement Platform

Third-Party Administrators

- Employers are beginning to expect more from their TPA to enable cost containment and deliver a more integrated and modern member experience. Here are just some of those of the features we are beginning to see in TPA offerings:
  - Easy and mobile access to ID cards, EOB, deductible status and HSA/FSA/HRA
  - Accessible support services for members to help navigate benefits
  - Integration with other vendors (eg. care management, telemedicine, smoking cessation, health risk assessment, wellness programs, care navigation)
  - A more rigorous adjudication of claims including bill review
  - Real-time analytics enabling more responsive benefit design
  - Easy to use and current provider directories contextualized to plan network with cost and quality information. Uniting network design, direct contracting arrangements including CoEs and on-site clinics.
  - Price transparency and cost comparison tools
  - Electronic and mobile document sharing, eg. scanning of bills

Engaging spouses and dependents

- Spouses and dependents enrolled in group health plans are equally responsible for employer healthcare costs as employees, yet most awareness, education and outreach programs focus on the employee.
- While employees may be invited to benefits fairs, access benefits information on the company intranet and meet with benefits vendors, spouses and dependents rarely have access. Their main experience is receiving their punch-out ID card in the mail.
- To unlock the ROI of benefit design employers can:
  - Create benefits portals that are accessible to spouses and dependents from the open enrollment period through the plan year
  - Send welcome packs explaining benefits in the mail and/or email, if appropriate with translations[1]
  - Invite spouses and dependents in for benefits events and fairs

1 NEJM Catalyst: Facilitating Health Insurance Enrollment in an Uncertain Environment

PBM Strategies

Prior Authorization

- Prior authorization (PA) is a form of utilization management that can be applied to a wide variety of medical procedures, diagnostics, treatments and drugs. As the name implies, authorization must be granted by the plan administrator for associated claims to be paid. Ideally the prior authorization requirement is identified before prescribing or initiating the procedure or treatment, so it can be proactively sought. If it is identified after prescribing, at the pharmacy, the patient can choose to self-pay for the drug to be dispensed or the pharmacist can request the prescribing provider initiate the PA process. If a procedure or treatment is performed without prior authorization where it is required, claims will be denied, the member cannot typically be billed and the provider loses revenue.
- PA is usually applied to certain high cost procedures, treatments, high doses or where there may be cheaper or higher value alternatives. It adds significant administrative burden for the provider, patient and health plan that can add delays to care delivery, however it is used as a tool to verify that claims are medically necessary and ensure adherence to plan defined guidelines. Appeals can be lodged, and exceptions granted at the discretion of the plan.
- There is a surprisingly lack of studies demonstrating the cost-controlling impact of prior authorization. However, in one recent series of Medicare demonstrations spread over 6 years across just 5 services/items saved between $1.1-1.9bn[1] and most agree that prior authorization controls costs, at least in the short term, by adding hurdles to expensive claims and encouraging appropriate utilization. Others argue that PA policies are guided by cost not outcomes and shape practice along the path of least resistance that may not be in the patient's best interest. There is a significant body of evidence that PA negatively impacts both the patient experience and the provider's practice with the AMA[2] finding 92% physicians report delays associated with PA, 78% reporting PA can sometimes lead to treatment abandonment, 84% of physicians reporting PA has a high or extremely high burden on their practice and 34% employing staff who work exclusively on PA. It has been estimated that a physician or their staff spend up to 20 hours per week on PA requests, costing $69bn per year nationwide, much of which is passed on to payers[6].
- How can employers improve the effectiveness and reduce the negative consequences associated with PA?
  - Provide easy to access details of prior authorization requirements for patients and providers and encourage streamlined electronic prior authorization processes
  - Develop value-based relationships that remove prior authorization requirements, allow freedom of practice but with spending goals and shared risk
  - Direct contracting relationships that are trust based, removing prior authorization but with retrospective oversight
  - Implement quality measures that serve as proxies for appropriate care utilization, allowing removal of PA policies
  - Integrate prior authorization processes in to EHR and payer systems to allow real-time adjudication (this work is underway with projects like HL7 FHIR Da Vinci[7])
  - Harmonization of PA policies among payers and collaboration with providers to agree upon common standards of PA

1 GAO: CMS Should Take Actions To Continue Prior Authorization Efforts To Reduce Spending 2 2017 AMA Prior Authorization Physician Survey 3 Modifying prescribing behavior of angiotensin receptor blockers by selectively rescinding managerial prior authorization requirements for losartan 4 Practice characteristics and prior authorization costs: secondary analysis of data collected by SALT-Net in 9 central New York Primary Care Practices 5 Uncompensated Medical Provider Costs Associated with Prior Authorization for Prescription Medications in an HIV clinic 6 The prior authorization predicament 7 HL7 Da Vinci Project Use Cases

Step Therapy

STEP 1 MEDICATIONS	STEP 2 MEDICATIONS	STEP 3 MEDICATIONS
Cholesterol Lowering		
atorvastatin (generic Lipitor®) lovastatin (generic Mevacor®) pravastatin (generic Pravachol®) simvastatin (generic Zocor®)	Crestor® 5mg, 10mg	Altoprev® Lipitor® (brand only) LiptruzetTM Livalo® Mevacor® (brand only) Pravachol® (brand only) Vytorin® Zocor® (brand only)

Example of Step Therapy in Treatment of Hypercholesterolemia

- Step therapy is a form of prior authorization utilization management, sometimes referred to as “fail first”, that requires progression through different lines of therapy to reach more expensive branded drugs or options that come with greater side effects.
- On failing a Step 1 option, authorization can be gained for a Step 2 medication and so on. Exceptions can be made at the PBM’s discretion on clinical grounds or in the case of a member who is already on a step 2/3 medication when entering a new plan design.
- As with most forms of utilization management the literature is crowded out with patient and provider centric studies on the negative consequences of step therapy[6,7] and 18 states have moved to impose restrictions on step therapy for commercial plans[8] and some are pushing for changes to ERISA to make step therapy more patient friendly[9]. There is some evidence of cost savings[5] and Medicare recently gave it a cautious endorsement for Part B drugs[2]. A commercial insurer publicly lists over 100 drugs in their commercial plan that are subject to step therapy[4].
- It is reported that 75% of large employers already offer plans that use step therapy[8]. How could employers gain the benefits of step therapy without the negative impacts? With a very similar approach as to prior authorization:
  - Provide easy to access details of step therapy requirements for patients and providers and encourage streamlined electronic authorization processes
  - Develop value-based relationships that remove step therapy requirements, allow freedom of practice but with spending goals and shared risk
  - Direct contracting relationships that are trust based, removing step therapy but with retrospective oversight
  - Implement quality measures that serve as proxies for appropriate care utilization, allowing removal of step therapy policies
  - Integrate step therapy processes in to EHR and payer systems to allow real-time adjudication (this work is underway with projects like HL7 FHIR Da Vinci[7])
  - Harmonization of step therapy policies among payers and collaborate with providers to agree upon common standards of step therapy

1 “Step Therapy” Approach To Lowering Health Care Costs Raises Concerns 2 Medicare Advantage Prior Authorization and Step Therapy for Part B Drugs 3 The Ethics of ‘Fail First’: Guidelines and Practical Scenarios for Step Therapy Coverage Policies 4 UnitedHealthcare: Clinical Program Drug Step Therapy – Commercial 5 Plan-sponsor savings and member experience with point-of-service step therapy 6 Is Step Therapy a Move In the Wrong Direction? 7 FailFirstHurts.org 8 AAD: Step Therapy Legislation 9 There’s a Better Way To Do Step Therapy

Quantity Limitation

- Limits can be set for select medications on the quantity and time period for which the medication is covered. Quantity limitation is typically used where there might be potential for abuse, addiction, resale or where the medication is only approved for short term use. It may also be limited based on clinically accepted guidelines that advise against long courses of medications or exceeding a given dose.
- Quantity limitations on opioid based medications are becoming increasingly common in response to the opioid crisis[1].
- A thorough review by KFF[3] of the evidence behind cost control strategies for prescription drugs cites studies that found quantity limits could reduce Toradol (for acute severe pain) claims by 45% and similarly when quantities of triptans dispensed for migraines costs decreased by $12.25 per month.
- Clearly there can be negative impact to the patient if quantity limits are unreasonable or are applied without understanding the nuance of the clinical need. In another study in the the review[3], they compared fills of 15-days, 30-days and 90-days of a number of medications. They found that despite wasted supplies, 90-day fills were more cost effective due to the increased cost of having to write more prescriptions.

The drug classes listed in the below chart are subject to quantity limits.

Quantity Limit Classes	**Drug Name Examples** – *Includes generics, where available; Also may be subject to formulary prior authorization coverage*	**Prior Authorization Available** (To Exceed Quantity)
All Respiratory Inhalers (for asthma, COPD, allergies and other respiratory disorders)	Long and Short Acting Beta2 Agonists (examples: Advair, Proair products) Intranasal Steroids and Antihistamines (example: Nasonex) Anticholinergic, Combination and Mast Cell Stabilizer (example: Spiriva) Corticosteroid Inhalers (example: Flovent)	No
Pain	Nucynta, Nucynta ER (tapentadol products)	No
	Xartemis XR (oxycodone/APAP ER)	No
	Extended Release Morphine Products (Avinza, Kadian, MorphaBond, Embeda, MS Contin)	Yes
	Oxycontin (oxycodone ER)	Yes
	Hydrocodone ER (Hysingla ER, Zohydro ER)	Yes
	Opana ER (oxymorphone ER)	Yes
	Hydromorphone (Exalgo)	Yes
	Tramadol products (Ultram, Ultracet)	No
	Stadol NS (butorphanol)	Yes
Migraine Therapies	Amerge, Axert, Frova, Alsuma, Imitrex, Maxalt, Relpax, Sumavel Dosepro, Treximet, Zomig, Migranal	Yes (except Migranal)
Influenza	Tamiflu, Relenza	Yes
Erectile Dysfunction	Cialis, Levitra, Staxyn, Stendra, Viagra, Caverject, Edex, Muse	No (except Cialis 5 mg)

Example CVS Caremark list of Quantity Limited Drugs[2]

1 Avalere: Limits on Opioid Prescriptions Are Becoming More Widespread 2 CVS Caremark Quantity Limits 3 KFF: Cost Containment Strategies for Prescription Drugs: Assessing the Evidence in the Literature

Narrow Pharmacy Networks

- As with provider networks, plans are increasingly using narrow pharmacy networks to control costs, build networks based on quality and increase data sharing capabilities. As almost all PBMs become vertically integrated in to plans and pharmacy chains it is not surprising that we are seeing a trend toward networks defined around those same vertical lines.
- According to surveys, the use of narrow pharmacy networks in employer-sponsored plans is growing – in 2016 an estimated 50% of plans had narrow networks of which 36% had a preferred network and 14% had a limited network, which they defined as <20,000 pharmacies for traditional medications and 1-5 pharmacies for specialty drugs[3].
- While there is little published around the cost savings narrow pharmacy networks can achieve, CVS Health report that people in narrow pharmacy networks were more adherent, citing that fewer people use multiple pharmacies which results in easier refills and better clinical oversight[2].

1 Preferred Pharmacy Network will dominate 2018 Medicare Part D plans 2 CVS Health: Could having fewer pharmacies in a network improve adherence? 3 Yes, Commercial Payers are Adopting Narrow Retail Pharmacy Networks

Formulary Design

- One of the primary duties of a PBM is to maintain a formulary. At its core is the on-going management of a list of medications that for given indications, are covered under the benefits plan. There has been a shift away from open formularies toward closed formularies that exclude many drugs often based on cost and only cover off-formulary drugs for medical necessity.
- At most PBMs the the formulary design is guided by three key steps that are performed for new medications and on an on-going basis:
    1. Therapeutic assessment: investigating the therapeutic evidence base for, and efficacy of a given medication.
    2. Pharmacy & Therapeutics Committee: assessing indications and where that medication fits in with existing medications within a formulary.
    3. Value assessment: considering price, efficacy and outcomes and deciding whether the medication offers enough value for inclusion.
- Several factors may also influence the assessment process including negotiated discounts from stakeholders in the supply chain, regulatory requirements, precedents for coverage, patient & provider feedback, the pressure to reduce costs payers and profit-making incentives to preserve or improve PBM margins.
- The formulary is an important tool in reducing prescription drug spending that can also have both positive and negative impacts on providers, patient access & affordability and the care they ultimately receive.
- Formularies have a wide range of mechanisms[1] to exercise cost control, including:
    - Utilization management such as tiering, prior authorization and differential cost-sharing as mentioned in other slides
    - Exclusions: excluding new medications from the formulary or removing existing medications from the formulary entirely
    - Indication restrictions both on-label and off-label
    - Generic switching and formulary preference toward lower cost medications
- As with many other complex benefit designs, there is often a disconnect between design and use – in this case between the formulary and actual prescribing. While employers can influence formulary design to help control costs, they should also look for ways to change practice, for example, through integration of formularies with clinical systems[3], through standardization of formularies across employers, streamlining and integration of utilization management and better patient/provider access to the specific details of their formulary.

1 P&T Community: PBM P&T Practices 2 Mercy Health saves $42m by tying list of approved medications to EHR 3 Together is better: Standardizing a health system formulary

Tiered Formulary

- In tiered formularies drugs are segmented in to tiers, primarily based on cost. Those with the highest cost are in higher tiers that can come with higher co-pays or co-insurance. Lower tiers typically include generic medications whereas higher tiers tend to include branded and specialty drugs often requiring prior authorization.
- KFF report that in 2019, 92% of workers were in tiered formulary plans with 88% in plans with three or more tiers and 48% at large firms in plans with four or more tiers[1]. Where there is a tier exclusively for specialty drugs, 59% of those tiers were subject to co-insurance.
- The evidence is mixed for tiered formularies[2] and NY, MA and VT have moved to limit insurers to three tiers while NY prohibits the use of specialty tiers. There is evidence that tiered formularies reduce overall spending and encourage generic switching[3,6] however it is likely to come at the expense of increased member cost-sharing[3], particularly for those who require specialty drugs. Increased cost-sharing in the context of tiered formularies has also been shown to decrease adherence[5].

1 KFF 2018 Employer Health Benefits Survey: Prescription Drug Benefits 2 University of Wisconsin: What works for Health? Tiered Formularies 3 The effect of a three-tier formulary on antidepressant utilization and expenditures. 4 Economic impact of ambulatory care formulary restrictions at a large county health system 5 Bad Tiered Formulary Designs Yield Poor Outcomes, High Cost 6 How Do Incentive-Based Formularies Influence Drug Selection and Spending For Hypertension?

Non-Medical Switching

- Non-medical switching is a PBM utilization management practice that encourages switching of a patient's medications typically to lower cost alternatives for non-medical reasons through formulary changes (adjusting tiers, dropping coverage), rejecting patient coupons (eg. through copay adjusters) and financial incentives given to providers for switching.
- A strong argument can be made that, for medications where a cheaper equivalent generic alternative exists, switching to that generic at the time of their repeat refill may have a negligible or positive impact on the patient, reducing costs for the plan, and potentially reducing patient cost-sharing.
- Conversely there is a growing backlash led by patient advocacy groups, providers and pharmaceutical companies against non-medical switching, especially when changes are made midway through a plan year[1]. Non-medical switching may lead to switching to different medications within the same therapeutic class, from costly biologics to biosimilars and to medications that have different formulations or release mechanisms.
- Such switches can have negative consequences for a patient's care, with the potential to disrupt treatment and destabilize a chronic condition. Studies (although beware vested interests) have shown higher downstream health care costs due to non-medical switching, risk of treatment abandonment and worsened outcomes[2,3,4].
- How can employers retain the benefits of a nimble pharmacy that is responsive to manufacturer prices while avoiding the negative consequences of switching? Here are a few ideas:
    - Foster more accountability, (through accountable care, bundled payments or otherwise) for pharmacy costs among providers at the time of prescribing and on periodically reviewing active repeat prescriptions.
    - Grandfather coverage during the plan year and offer upside-only incentives to the patient for switching to avoid risk of treatment abandonment
    - Encourage greater standardization of formularies and invest in clinical guidelines that can be broadly adopted to drive evidence-based switching

1 50-State Network: Patients seeking stability must be protected from insurers constantly changing which drugs are covered 2 Non-medical switching from Originator Tumor Necrosis Factor Inhibitors to their Biosimilars: A Systematic Review 3 Short-term costs associated with non-medical switching in autoimmune conditions 4 The impact of non-medical switch on type 2 diabetes patients treated with canagliflozin in the commercially insured US population 5

Transform the PBM Model

- PBMs arose from the Medicare Modernization Act of 2003 to implement tighter cost controls and utilization management for burgeoning drug costs and negotiate discounts with pharmaceutical companies. Since their creation there has been significant consolidation such that in 2017 three companies controlled 72% of market share (Aetna-CVS Health 25%, Cigna-Express Scripts 24%, UHC-OptumRx 22%) with all three now vertically integrated with commercial insurers.
- What does it take to be a successful PBM?
  - ***Scale of membership:*** Through employers, commercial insurers, Medicare Part D plans and Medicare Advantage. The CVS-Aetna mega-merger, for example, further cements CVS Health's captive membership.
  - ***Negotiated discounts:*** With scale of membership, PBMs can use their purchasing power to negotiate steep discounts from pharmaceutical companies in the form of lower list prices and rebates, extracting a fee through spread pricing. This purchasing power also helps keep new market entrants out.
  - ***Clinical & administrative capability***: PBMs maintain a formulary, manage utilization through mechanisms such as prior authorization & step therapy that also provide leverage in negotiating discounts. Tailoring benefit design, handling and paying claims.
  - ***A network of pharmacies:*** Due to the market dominance of PBMs, most pharmacies work with all the major PBMs.
- Critics claim that PBMs are intermediaries who use their market dominance, lack of transparency and formulary control (that may be driven as much by profit making incentives as clinical evidence) to extract large rebates that they get to keep, while inflating prices for patients[1] and payers.
- What can employers do?
  - ***Start their own PBM:*** For the reasons above, this is no mean feat and is likely to be met with retaliation from the incumbents. Walmart has tried: in 2008 it formed a close partnership with WellPoint Next Rx[2] with a potential view to acquisition, however Express Scripts swept in the following year to acquire the PBM for $4.7bn. Walmart may well get a second shot as rumors swirl around their acquisition talked with Humana, the 4th largest PBM. TRICARE anticipated savings of $1.67bn by negotiating its own discounts[5].
  - ***Lobby for more transparency:*** Employers can apply pressure to PBMs to make concessions. Point-of-sale discounts are one such concession where PBMs will start applying a portion of their rebates to point-of-sale prices thus lowering out-of-pocket costs for patients. Some next generation PBMs are offering "pass-through" models where negotiated discounts are transparent and only a fixed administration fee is charged.
  - ***Form a coalition and partner with or acquire PBM:*** The Health Transformation Alliance, with 38 of America's largest companies on-board announced a partnership with CVS Health and OptumRx to change how companies provide pharmacy benefits with more transparency, lower prices and unified formularies[3]. Serving as a potential blueprint for employers, Prime Therapeutics was formed when ProPar, a TPA merged with BCBS MN's in-house formulary management company, Pharmacy Gold. Prime Therapeutics now has 18 Blue Cross owner-customers and recently formed an alliance with Walgreens[4].

1 Patients Overpay for Prescriptions 23% of the Time, Analysis Shows 2 Could a Wal-Mart PBM succeed? 3 Health Transformation Alliance 3 One Year Later a Group of Leading Private Sector Companies Is Working To Fix a Broken Health System 4 Prime Therapeutics History 5 PBM P&T Practices Appendix: PBMs, alliances and vertical integrations

Outcomes-Based Contracting

- Prescription drug costs account for 9.5% of total US healthcare spending in 2017 and continue to grow at a rapid rate – 11.5% in 2014 and 8.1% in 2015[1]. Spending is mainly driven by high-price brand name drugs that account for about 12% of prescriptions but 72% of costs[2].
- Outcomes-Based contracting, sometimes referred to as value-based pricing, has been proposed as a way taper growing drug spending by tying the price paid for high-cost drugs to measurable outcomes in the patient populations they treat.
- Many newly approved high-cost drugs have only been demonstrated to be effective in small targeted populations and lack the real-world evidence that comes with many years if not decades of use. Outcomes-based contracting also offers the potential to broaden access to new therapies by ensuring payers get value for their money in return for inclusion on a formulary[2].
- Most outcomes-based contract thus far have been based on manufacturer rebates that can be claimed if outcome targets are not met. For a robust contract, outcomes must be easily attributed and measured, and currently are largely obtained through claims data.
- KPMG reports there are 25 branded therapies under value-based contracts, that include Luxturna (a one-time gene therapy that costs $425,000 per eye) with Harvard Pilgrim tied to measurable improvements in sight[3] and Ernesto (sacubitril/valsartan), a combination drug to treat heart failure from Pfizer and Aetna tied to the reduction in readmissions it achieved in its earlier trials[2].
- As the authors of the Commonwealth study point out, we are still early in testing this new model of payment and currently many limitations exist including a focus on short-term and surrogate outcome measures that may not be truly reflective of meaningful outcomes. Furthermore, this pricing model is only likely to be applied to a small subset of drugs and it is unclear whether manufacturers will simply increased prices to negate the impact of outcome-based rebates.
- The core concept of Outcomes-Based Contracting is one that is propagating through healthcare in the form models like bundled payments and ACOs, which also share the same challenges of outcome measurement. Employers can consider using this same model as they approach their benefits and vendors they engage with.

1 What are the recent and forecasted trends in prescription drug spending? 2 Outcomes-Based Pharmaceutical Contracts: An Answer To High US Drug Spending? 3 The Naked Truth About Outcome-Based Pricing

Copay Accumulators/Maximizers/Adjusters

- In order to increase access and help counter increasing out-of-pocket costs, pharmaceutical companies have been offering patients coupons that help cover the expense.
- **Example:** Let's say a member is on a long-term $3000 per month biologic and they have a HDHP with a deductible of $6000. The pharmaceutical company might give them a coupon that offers the drug for only a $10 co-pay with the pharma company picking up the balance ($2990 per month). Historically that balance would be counted toward the member's deductible, thus after two months of treatment the member would have almost met their deductible and only be $20 out-of-pocket. The employer would then be on the hook cost-sharing until the OOPM and the full price thereafter.
- Proponents argue that coupons increase access and affordability of much needed therapies but it also removes weakens cost-sharing incentives and might encourage misuse or inappropriate use of these high cost therapies by members to reduce their overall out-of-pocket expenses.
- Copay accumulators (also known as copay maximizers or adjusters) prevent these coupons from counting toward the deductible or OOPM. Thus in our example above, if the coupon were still active, the member would pay $20 out of pocket for the first two months, then $3000 in month 3 and $2960 in month 4 before co-insurance kicks in. For consumer sensitive to reaching their OOPM, the $3000 biologic now looks rather expensive. The pharmaceutical company has lost a lever to reduce patient cost-sharing and might consider reducing the price of the biologic, although the difference between $3000 and $10 is vast.
- Copay adjusters are currently used by around 25% of employers but expected to grow rapidly over the coming years[1]

1 Walmart, Home Depot adopt health insurer tactic in drug copay battle

Mail-order Pharmacy

- As consumers grow accustomed to having almost everything delivered to their doorstep, medications seem the next logical step. Mail-order pharmacies have operated for many decades[5] and there is a good body of evidence that the medications delivered to the doorstep can be safe[4], lead to greater adherence[3] and better outcomes[2].
- New technologies make mail order pharmacy at scale a more compelling proposition, not only for refills but also first-time and time-limited prescriptions, thanks to real-time logistics and supply-chains, robotic dispensing, integrated electronic systems for managing and transferring prescriptions and telemedicine to provide support and guidance to patients.
- While improved adherence and outcomes alone may bring cost benefits, there is also mixed evidence[6,7] that mail order pharmacy can be cheaper than its retail alternative, polarized by the strong views on either side.
- Some of the challenges that persist with the mail-order pharmacy model at scale include:
  - While home delivery may be feasible and more convenient for many members, it is not ideal for everyone, thus a retail pharmacy network is still required. Furthermore, same day delivery will be required to make mail-order a realistic option for new/time-limited scripts.
  - Mail-order pharmacies can centralize operations without the high overheads of retail locations, however large retail chains have national scale that gives them a purchasing power advantage. What mail-order pharmacies gain in reduced overhead may be offset by delivery costs.
  - Major PBMs have built (eg. OptumRx) or acquired (eg. Express Scripts acq. Medco) their own mail-order pharmacies. PBMs tend to preferentially encourage members to use their own mail-order pharmacy. Integrated systems also give them an advantage in having access to their members' active prescriptions. PBMs may use this advantage to retain an outsized share of cost-savings.
  - Communication that facilitates verification of medications, education and on-going support is a highly valuable aspect of what retail pharmacies currently provide. It remains to be seen whether mail-order pharmacies can provide the same level of service.
  - Dispensing preferences are likely to take a long time to change. Studies have shown that preferential cost-sharing can shift use patterns[9] but also that there are socio-economic disparities that exist between non vs mail-order pharmacy users[8] that may be widened[9].
  - Collecting a repeat prescription from a physical location is a strong indication the member wishes to continue and is adhering to treatment. How can mail-order pharmacies capture the same intent?

1 PCMA: The 21st Century Pharmacy 2 The comparative effectiveness of Mail Order Pharmacy Use vs Local Pharmacy Use on LDL-C Control in New Statin Users 3 Mail order pharmacy use and adherence to Diabetes-Related Medications 4 The Safety and Effectiveness of Mail Order Pharmacy Use in Diabetes Patients 5 1973: The Mail-Order Prescription Drug Industry 6 A Comparison of The Costs of Dispensing Prescriptions Through Retail and Mail Order Pharmacies 7 Mail-service and Specialty Pharmacies to Save $1.8bn for California Consumers, Employers and other Payers in 2015 8 Characteristics of Mail-order Pharmacy Users: Results from the Medical Expenditures Panel Survey 9 Impact of Pharmacy Benefit Change on New Users of Mail Order Pharmacy among Diabetic Patients: The Diabetes Study of Northern California (DISTANCE)

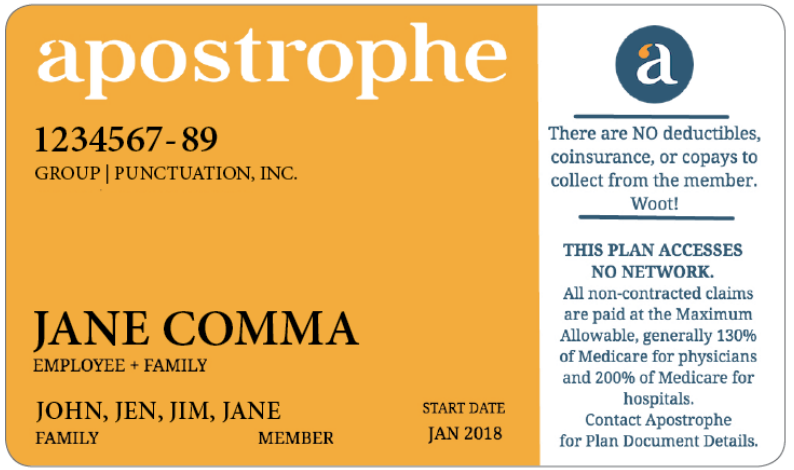
Consumer-driven Reference Pricing

- This form of reference-based pricing (RBP) involves prospectively setting a reference price for chosen treatments or services (eg. A knee replacement, MRI studies, a colonoscopy, classes of medications) – the employer covers costs up to the reference price, the member covers the rest if they choose an option that costs more than the reference price (even beyond the OOPM).
- The reference price should be set high enough to include access to a sufficient number of high-quality providers or recommended treatment options with modest out-of-pocket payments[1].
- Examples of RBP in action:
  - ***Safeway***[2]: Implemented RBP for laboratory pricing over 3 years and compared to policy holders of a large national insurer over the same period. 31.9% reduction in average price paid per test by year 3 and total lab test spending declined by $2.57m. Out-of-pocket costs for patients declined $1m.
  - ***CalPERS***: Implemented RBP for Colonoscopy[3] in 2012 with 21.6k members. Utilization of low-priced facilities increased from 68% to 90%. In the two years after implementation CalPERS saved $7.0m. RBP was implemented in 2011 for hip and knee replacement surgery[4]. They found that with RBP, surgical volumes increased 21% at low-price and decreased by 34% at high-price facilities realizing savings of $2.1m in 2011. Prices charged to members at initially high-price facilities declined 18% after the first year.
- RBP in its current form is best used for services that exhibit a high degree of variability in price but little variability in quality. It also comes with several challenges as to its implementation[5]: It can be difficult to explain in simple terms, setting an equitable reference price especially across geographically diverse areas, adjusting that reference price over time, members and providers not being aware of reference pricing, requires a degree of price transparency to work.

1 Payers test reference pricing and centers of excellence to steer patients to low-price and high quality providers 2 JAMA 2016: Association of Reference Pricing for Diagnostic Laboratory Testing With Changes in Patient Choices, Prices and Total Spending for Diagnostic Tests 3 JAMA 2015: Association of Reference Payment for Colonoscopy with consumer choices, insurer spending and procedural complications 4 Increases in consumer cost sharing redirect patient volumes and reduce hospital prices for orthopedic surgery 5 FamiliesUSA: How to make reference pricing work for consumers

Claims-based Reference Pricing

- Unlike consumer-driven RBP, this largely retrospective claims-based approach applies reference prices to a wide range of services, usually based on a multiple of Medicare prices (e.g. 1.5x). These reference prices are the amount the plan aims to pay for services rendered and this is the maximum price that the member will be held liable for under the plan.
- While some providers may be known to accept such reference-based prices and members may be steered toward these providers, the approach sometimes involves operating without a network (echoing back to conventional or indemnity health insurance plans) or simply including any provider that accepts RBP in-network[1].
- Members seek care where they choose, the TPA/RBP vendor receives and reviews the bill, making a pricing adjustment to their chosen reference price. Ideally the payment is then accepted, perhaps after a period of negotiation. Reportedly, it is rare that cases involve litigation (where a reasonable reference price can be supported by existing case law) or balance billing, in which case the employee is encouraged to turn the bill over to the TPA/RBP vendor immediately.
- RBP vendors advocating this approach claim significant cost savings, however they are likely to come with a significant burden to the member. Not having a formal network may be discomforting and members may be met with push back, even denial of care from providers. Although RBP vendors report that only 2% of RBP members ever receive balance bills and those balance bills should be the responsibility of the employer, they may still cause considerable anxiety if the plan design is not adequately communicated.



Apostrophe Health's website: Example Member ID Card

1 SHRM: Reference-based pricing: Another option for self-insured employers Graphic: Apostrophe Health website

Network Design

Narrow Networks

- Narrow networks, sometimes referred to as “high performance networks” or “value-based networks” restrict choice of providers typically in return for lower premiums. For payers they bring the promise of lower cost and higher quality through careful composition of the network and imposing quality requirements for inclusion. Depending on plan design and whether the OOPM applies, members going outside of the narrow network may find themselves responsible for the full cost of care.
- In 2018, narrow networks accounted for 72% of all plans purchased on health exchanges including HMO plans that comprised 53% and Exclusive Provider Organization plans that comprised 19%. However as Drew Altman of KFF points out[2], in group plans only 7% of firms offered narrow networks and fewer (2%) eliminated hospitals from networks. Those figures are higher for the largest of employers (>5000 employees) yet remain low at 18% and 6% respectively. He posits that it has been hard for employers to satisfy diverse workforces with a network of limited doctors and hospitals and particularly difficult to exclude the most prominent and often most expensive providers in a market.
- There is emerging evidence that narrow networks can significantly reduce healthcare costs. In a study of Massachusetts state employees, investigators found that 10% of members switched to a narrow network when given a 3-month premium holiday[3]. They subsequently found medical care spending fell by 40% as a result of both the quantity and price of specialist and emergency care. They also found primary care spending went up in the narrow network group.
- As with tiered networks, narrow networks can also be used to steer patients toward providers who are directly contracted by the employer for example in ACOs, bundled payment arrangements or centers of excellence. To avoid the missteps and backlash of the narrow networks of the 90’s it will be crucial to ensure quality of care and access is maintained[5], if not improved from the outset.
- Some of the challenges that are important to address with narrow networks include:
  - Ensuring the network provides adequate, timely access to service all health needs across employee geographies and meets requirements of emerging regulatory requirements[6,7]
  - Dealing with members who find their regular providers are no longer in network
  - Maintaining an easily accessed and accurate provider directory to identify in-network providers both for members and referrers
  - Avoiding balance billing issues for emergencies and unexpected out-of-network providers or facilities[4]
  - Ensuring that facility and provider network alignment

1 Narrow network health plans continue to dominate ACA exchanges 2 Narrow health care networks aren’t actually that common 3 Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees 4 An analysis of out-of-network claims in large employer health plans 5 NYT: Savings? Yes. But Narrow Health Networks Also Show Troubling Signs 6 National Association of Insurance Commissioners: Network Adequacy 7 Regulation of Health Plan Provider Networks

Tiered Networks

- Tiered network design is a way to maintain a degree of in-network choice (where OOPM limits still apply) while steering members toward preferred providers (usually based on cost, quality and/or relationships) through differential cost-sharing[1].
- Employers are increasingly playing a more active role in defining their networks. This might include placing providers who they have directly contracted with in the higher priority tiers or using claims data alongside quality data to identify high-value providers and place them in higher tiers accordingly. Tiered designs can also signal to members the relative value of providers.
- Examples of tiered design include Stanford's Aetna-administered Choice POS II available for post-docs which has a three-tier design. The first tier is Stanford Health Alliance providers where there is no deductible and lower co-pays. Tier 2 providers come under a small deductible and higher co-pays and co-insurance levels. Tier 3 comes with a larger deductible, a 2x out-of-pocket maximum and co-pays replaced with co-insurance[2].
- As with narrowed networks, there is evidence to suggest that tiered networks can reduce healthcare costs. A study comparing healthcare costs for over 180,000 non-elderly members in tiered-network BCBS Massachusetts small & large-group health plans over 4 years found a 5% total health care spending decrease per member per quarter[3].

1 Narrow Networks May Contain Costs, But Are Tiered Networks a Better Option? 2 Stanford Aetna Choice POS II: Summary of Benefits and Coverage 3 Enrollment in a Health Plan with a Tiered Provider Network Decreased Medical Spending by 5 Percent 3 Avalere: Trends in Tiered and Narrow Insurance Networks

Direct Contracting

- As employers seek to gain greater control of their healthcare costs through disintermediation of the baggage that often comes with TPAs/carriers, many are forming their own contracts with provider groups where they leverage their volume to negotiate favorable pricing, share risk, gain quality assurances and work under new value-based payment models such as bundled payment.
- Centers of Excellence (link to slide) are gaining popularity as employers like Walmart expand their programs to cover a broader range of "big ticket" treatments (cancer, cardiovascular, orthopedic, bariatric, maternity, fertility, etc). In many cases Walmart now requires that employees use their CoEs to remain in-network.
- Bundled payment programs (link to slide) involve negotiating a bundle price for a given treatment that includes the full-cycle of care that might include pre-treatment workup and follow-on care with a readmission warranty. The terms of the bundle should address issues such as inclusion/exclusion criteria, bundle period, readmission criteria, quality measures and quality reporting.
- As Accountable Care Organizations mature and grow in their ability to take on risk, they provide another option for direct contracting. If there is sufficient scale and appetite, the employer may even consider developing an ACO to meet their needs in conjunction with their health plan[1].
- There are also opportunities to directly contract with primary care providers, whether it is a group providing on-site care, running specific disease management programs, leading initiatives such as vaccination campaigns or screening programs or offering access to a group such as One Medical as a benefit.
- The following slides go in to greater detail on some direct contracting models.

1 CPR and PBGH: How-To Guide: Accountable Care Organizations 2 AAFP: Direct Contracting with Businesses by Family Physicians (Discussion Paper)

Incentives for Quality

- As employers take a more active role in building their networks through direct contracting with small practices through to health systems and ACOs, they also have an opportunity encourage data-sharing and become more involved in quality measurement, quality transparency and value-based designs that incentivize quality through partnership, payment and volume.
- Existing programs that have been implemented by private insurers may serve as a blueprint to such initiatives and may even provide opportunities to piggy-back and/or collaborate with other purchasers:
  - ***Alternative Quality Contract[1]:*** A commercial ACO model that invited participation from providers within the Blue Cross MA HMO network in 2009 and by 2010 had recruited over 1,600 PCPs and over 3,200 specialists[2]. It combines a global budget, shared 2-sided risk and significant quality incentives over a 5-year contract with a commitment to investment and improvement. Medical groups can earn up to an additional 10% of their global budget for absolute performance on 64 pre-defined, nationally accepted and annually updated quality metrics. Now covering over 680,000 members and beginning to expand to PPO members the AQC has seen success in cost control, quality improvement and narrowing disparities in quality of care. As the contract looks to further its quality measures it is increasingly tracking patient-reported outcomes in key disease areas[4,7].
  - ***Highmark True Performance:*** Launched in January 2017, True Performance is a value-based reimbursement program for primary care providers focused on cost control and quality of care. The program includes 30 quality measures, largely process based with two clinical outcome measures[5]. Dependent on these quality measures, cost measures and utilization measures, PCPs may earn a monthly care coordination fee and a quarterly or annual lump sum payment. Highmark reports members who see True Performance PCPs had 11% fewer ER visits, 16% fewer inpatient admissions and avoided costs of $38m[6].

1 Blue Cross Blue Shield Massachusetts: Alternative Quality Contract 2 Health Affairs: The 'Alternative Quality Contract', Based on a Global Budget, Lowered Medical Spending and Improved Quality 3 Lessons from a Decade of Commercial ACO Contracting 4 The Alternative Quality Contract (AQC): Improving Quality While Slowing Spending Growth 5 Highmark True Value Provider Manual 6 Highmark's True Performance program avoided health care costs by more than $260m in 2017 7 Getting To The Next Generation Of Performance Measures For Value-Based Payment

Centers of Excellence

- Centers of Excellence (CoE) programs are a form of direct contracting where an employer selects a preferred provider for specific treatments, often at pre-negotiated bundled rates (e.g. For hip or knee replacement surgeries). NBGH reports that in 12% of employers had CoE programs in 2018 and 18% planned to have one in 2019[4].
- The rationale behind programs is that for high-cost treatments, centers with high volume and high quality (with some evidence linking the two[3]) are likely to deliver better outcomes for members, with greater efficiency and lower total costs. Higher quality may also mean not performing unnecessary surgeries and it is reported that around 40% of members referred to Walmart CoEs end up avoiding surgery altogether[6].Furthermore by developing preferential relationships, employers can drive volume and obtain discounts while having some oversight in to quality.
- Centers are chosen on a wide range of factors that can include quality of care, cost, breadth of services and proximity. Employers have implemented CoE programs for a wide range of treatment including: orthopedic joint replacement & spine surgery, treatment of cancer, bariatric surgery, congenital heart conditions and transplant surgery
- Member awareness is critically important when implementing a CoE program to ensure an uptick in usage and return on investment. In most cases, members are incentivized to preferentially use CoEs through lower or waived cost-sharing, covered travel expenses and designs where failing to use the CoE for covered conditions results in the claim falling out-of-network.
- While there is little peer reviewed literature on the cost reductions that can be achieved with CoE programs, vendors report savings of between 30-50% per average episode across a range of specialties[7,8,9].

1 The Right Care at the Right Time: Expanding Our Centers of Excellence Network 2 Health Design Plus: Centers of Excellence FAQ 3 Relationship between surgeon volume and outcomes: a review of systematic reviews
4 NBGH: Large US employers eye changes to healthcare delivery system as cost to provide health benefits nears $15,000 per employee 5 Catalyst for Payment Reform & Urban Institute Research Report: Centers of Excellence 6 Walmart steps up and into healthcare fray 7 Cost savings of Centers of Excellence 8 EDHC 9 Carrum Health

Bundled Payments

- At their core, bundled payments are fixed payments for all services delivered within full cycle of care. Unlike fee-for-service payments, bundled models give providers a financial incentive to deliver a cycle of care as cost efficiently as possible to increase their profit margin. Providers also take on the downside risk of the episode of care costing more than the bundle price, although models may include reconciliation payments and/or mechanisms for reimbursement in extenuating circumstances.
- If designed correctly, bundles also give the purchaser the opportunity to negotiate a fair bundle price with robust patient inclusion and exclusion criteria, while reducing unnecessary care, encouraging a more integrated patient experience and implementing quality controls[1].
- Bundled payments have seen most traction with well characterized elective episodes of care that are typically high volume, high cost with a high variability in cost, with measurable outcomes and unambiguous inclusion and exclusion criteria. Examples include orthopedic joint replacement surgery and heart surgery. Medicare's latest Bundled Payments for Care Improvement (BPCI) Advanced[2] is pushing the boundaries to includes 29 different conditions from urinary tract infections to stroke.
- As Medicare and private payers accelerate adoption of bundled payment models, employers also have an opportunity to partner with providers to create their own programs. To establish such programs requires tightly written and agreed upon contracts, claims and health plan integration, data sharing and oversight. Companies like Remedy Partners have recently announced collaborations[3,4] with purchaser groups to enable adoption by employers while companies such as Carrum Health provide off-the-shelf bundled programs[5].

1 RAND: Analysis of Bundled Payment 2 CMS BPCI Advanced 3 Remedy Partners and the Florida Health Care Coalition Join Forces to Succeed with Bundled Payment Programs 4 National Alliance of Healthcare Purchaser Coalitions and Remedy Partners Collaborate to Accelerate Healthcare Payment Reform 5: Carrum Health

Accountable Care Organizations

- ACOs are groups of providers who are held collectively accountable for the quality of care and total health spending for their assigned patients[1]. Patients are assigned to the ACO based on a trigger, typically by receiving care from a primary care provider in the ACO. Patients are usually unaware that they are in an ACO and are free to use providers outside of the ACO. The most common payment mechanism is a shared-savings model which compares actual spending versus a risk-adjusted spending benchmark and, contingent on meeting quality standards, pays the ACO a share of the savings (upside) or claws back a portion of the overspend (downside).
- As providers gain more experience operating ACOs, there will be opportunities for employers to partner with existing ACOs (directly or through carrier networks) or encourage the formation of new ACOs to deliver care for their members. While ACO results have been mixed, many of the early Medicare ACOs and private ACO such as the AQC are beginning to show significant cost savings. These results along with ACO initiates from employers[6,7] emerging approaches like the Blue Premier commercial ACO (spearheaded by Patrick Conway, formerly of CMS)[8] and guidance from organizations like PBGH[5] can help identify best practices for ACO formation, contracting and operations.
- There are multiple challenges in implementing a successful ACO strategy:
  - ***Encouraging and incentivizing*** providers to ditch the status quo to participate in ACOs and take on risk, especially in to two-sided models.
  - ***Contracting & administration*** – defining the terms of the risk-sharing contract with inclusion criteria and reporting requirements.
  - ***Setting benchmark prices*** **-** risk-adjustment and adjust the benchmark price over time to retain enough upside potential but also contain costs.
  - ***Choosing*** a selection of ***quality measures*** that are meaningful and can be realistically captured with plans to adjust and elevate these over time. Opportunity to piggyback on Medicare measures[3].
  - ***Overload and overspill*** – layering too many ACOs with too little support over the same providers may lead to confusion however existing ACOs may also have positive spillover effects[4] to new ACOs and even FFS care.
  - ***Clinical systems and integration*** – part of the rationale behind ACOs is to encourage greater cross-collaboration and integration between currently disparate providers of care. Technology can and must play a role, but significant investments and commitments will need to be made on the provider side to make it happen.
  - ***Patient "leakage"*** – if assigned patients frequently venture outside of the ACO for care it will be hard for the ACO to deliver on its goals. ACOs that have high geographic market share may be less prone but come with greater pricing power over purchasers. Models like the AQC initially operated within HMO plans where patient referrals can be more tightly predicted and controlled. Putting primary care at the center of ACOs seems a logical choice and Medicare has announced plans to offer patients up to a $20 incentive for qualifying primary care visits and potential for patients to opt-in to ACOs[1].
  - ***Spanning geographies*** may mean managing multiple different ACO contracts and gaps in ACO coverage. Since starting in 2012, Medicare now has 28% (10.5m) of their FFS beneficiaries in Medicare Shared Savings ACOs.

1 Pathways to Success: A New Start for Medicare's Accountable Care Organizations 2 Becker's Hospital Review: 144 ACOs to know in 2018 3 CMS: MSSP 2018 ACO Quality Measures 4 ACO Spillover Effects: An opportunity not to be missed 5 PBGH: Accountable Care Organizations 6 The Benefits of Direct-to-Employer ACO Arrangements 7 Emory Healthcare Launches ACO with Walmart 8 Engineering a rapid shift to Value-Based Payment in North Carolina: Goals and Challenges for a Commercial ACO

Mental Health

- Data suggest nearly 1 in 5 people experience mental illness in any given year and 60% of those people do not receive any form of care[1]. Studies have found significant costs of mental illness among workers, with losses from productivity, absenteeism, presenteeism and increased health care costs. It has been estimated that mental health issues cost businesses $225bn every year[2].
- Coverage and reimbursement for mental health services has been historically poor, and parity with other physical health coverage was only established in 2008 with the passage of the Mental Health Parity Law. Consequently there has been a chronic underinvestment in mental health services and training with the field continuing to struggle with recruitment[3].
- For those mental health professionals and psychiatrists in service, many have chosen not to participate in provider networks – a 2009 survey found only 55% accepted any form of insurance[4]. Many reasons have been cited for this including low reimbursement rates that do not reflect how mental health care should be practiced (eg. with longer visits and more continuity of care), high administrative burden for what are typically small practices and high demand meaning they can choose to practice on their own terms.
- Members seeking mental health care are often met with a limited selection of in-network providers, many of whom have full patient panels and are not accepting new patients. A study[6] found that 26% of outpatient mental claims in employer plans were from out-of-network providers vs 7.7% for overall claims. Emergency situations can often end up in the ER and the same study found 33% of admissions for psychological or substance abuse reasons included an out-of-network provider claim, saddling members with high out-of-network costs at a moment of need.
- What options do employers have to tackle the estimated $225bn lost to mental health issues?
  - Improve EAP programs, make them more accessible and visible: Most employers have an Employee Assistance Program however they are notoriously underutilized.
  - Implement mental health and substance abuse programs on top of existing benefits that provide greater access to affordable in-person/tele-care, eg. Lyra Health, Quartet or Pear Therapeutics.
  - Directly contract with mental health providers to provide accessible services to members or consider commissioning on-site or near-site mental health practices (Facebook has a staff psychiatrist through Crossover Health). Work with carrier to increase reimbursement for mental health providers to encourage greater participation in network.
  - Increase awareness of mental health and resources available issues through benefits portals, educational materials and programs like Mental Health First Aid.

1 Access and cost barriers to Mental Health Care by Insurance, 1999 to 2010 2 How Mental Health Can Save Businesses $225bn Each Year 3 Psychiatry Workforce and Psychiatry Recruitment: Two Intertwined Challenges 4 Acceptance of Insurance by Psychiatrists and Implications for Access to Mental Health Care 5 Declining psychiatrist participation in health insurance networks: where do we go from here? 6 An analysis of out-of-network claims in large employer health plans 7

Primary Care

- Data suggest that primary care accounts for just 5.8-7.7% of US healthcare spending[1] despite evidence that greater use of primary care results in fewer hospitalizations, lower spending and better patient satisfaction. States such as Oregon have passed legislature setting a minimum threshold for all payers of at least 12% of total medical expenditures on primary care[2].
- The HMO model is based on the premise that primary care is best placed to act as a front door to the broader health system; building long-term relationships with patients, coordinating complex care, managing chronic conditions and appropriately referring to specialists. Technologies such as telemedicine, population management and referral systems coupled greater use of upskilled NPs, PAs and MAs can make primary care efficient and effective.
- How can employers encourage a more primary care first approach for members?
  - ***Plan Type:*** Employers could nudge employees toward the two plan types that require primary care designation and gatekeeping: HMO and POS plans. For the first time since the 90s, HMO plans are rising in popularity in the employer-based market (16% in 2018), perhaps as employees look for ways to reduce increasingly burdensome cost-sharing. Point-of-sale plans that require primary care referrals have declined in popularity accounting for only 6% of plans in 2018.
  - ***Financial Incentives:*** Employees could be offered lower cost sharing with HMO and POS options to nudge them toward those plan selections. Within all plan types, lower co-pays for primary care or potentially no cost-sharing at all for primary care could be offered. Some plan designs allow members to see specialists without a referral but charge a self-referral fee.
  - ***Convenience and access:*** On-site primary care may provide the ultimate convenience and reason for visiting primary care first. Access to concierge or tech-enabled primary care practices such as One Medical may also provide the convenience that makes it a first choice, with online scheduling and often same-day appointments and video visits all part of the service.
  - ***Primary care centric ACOs:*** Contracting with ACOs that have emphasis and incentives for primary care management.

1 Patient-Centered Primary Care Collaborative: Spending for Primary Care 2 Patient-Centered Primary. Care Collaborative: Primary Care Investment 3 Gatekeeping and patterns of outpatient care post healthcare reform
4 Outcomes in Older Adults with Multimorbidity Associated with Predominant Provider Care Specialty

On-site or Near-site Clinics

- Employers are deploying primary care services at or near the workplace and it is reported that around 10% of American workers have access to an on-site clinic[1]. Not only is this a convenient and valuable benefit to employees but it can help boost productivity, reduce absenteeism and provide useful mechanism to control healthcare costs.
- While some employers opt to club together to provide near-site clinics shared with neighboring firms, others are establishing dedicated clinics solely for their own employees.
- The most ambitious employers are creating their own clinics from the ground up (eg. Apple), while others are opting to contract directly with local primary care providers or companies who establish and run practices on the employer's behalf (eg. Google with One Medical, Facebook with Crossover Health). Some employers have experimented with on-site pharmacies to help bring down costs[2].
- Employees and their dependents can be further incentivized to use on-site services through reduced co-pays and easy scheduling of appointments. With primary care as the front door to the broader healthcare ecosystem, this model provides the opportunity to deliver efficient and high-quality primary care while steering members toward high-value secondary and tertiary care when needed.
- On-site clinics however require a significant upfront investment, require geographic concentration of employees, may be met with some skepticism by employees over worker privacy and may not prove as convenient for spouses or covered dependents.

1 The Commonwealth Fund: Is an on-site clinic right for your firm? 2 How Premise Health onsite pharmacy decreased medical and prescription costs by $13.8m

Plan Add-ons

Second Opinion Services

- Complex medical conditions are often met with diagnostic uncertainty, a plethora of expensive tests, a vast selection of treatment approaches with uncertain outcomes.
- Patients who find themselves in the middle of such a quagmire usually follow the recommendations of their doctor(s) but it is reported that around 20% choose to seek a second opinion.
- Second opinions can bring clarity to a situation, correcting a diagnosis, providing more acceptable and efficacious treatment alternatives or confirming an existing diagnosis and approach. Equally they have the potential to increase confusion, run up additional costs in duplicated tests while arriving at a different but still incorrect diagnosis or suboptimal treatment path.
- In 2017, 66% of employers in a NBGH survey[1] reported they would include a second opinion service as part of their health benefits in 2018. Such services typically include a streamlined process for collecting existing records and test results, matching the member with a specialist for the given condition and coordinating the consultation process. These services are often delivered by highly regarded academic institutions that might already serve as a company's center of excellence, or technology platforms who develop and partner with a network of specialists.
- Second opinion services may serve as a useful adjunct to narrow networks (for example in EPOs) where where the most specialized of providers or renowned experts may not be readily accessible, helping allay members' concerns regarding reduced choice.

1 NBGH Press Release 2017: Employer Healthcare Costs

Member Navigation & Advocacy

- From an employer perspective, member navigators and advocates (while technically distinct, the two terms are often used interchangeably) aim to be the single point of entry for healthcare needs, advising and guiding members through the complexity of the health care system and health benefit plans.
- While employers and plans have broadly adopted self-service tools for navigating care such provider directories, online formularies, price transparency tools, the growth of navigation solutions is perhaps a recognition that an experienced human voice may be the best current interface to demystify complex benefit designs that change frequently and a hard to navigate health system that members should not have to invest significant time in to understand.
- There are several different approaches to member navigation. TPAs such as Collective Health embed non-clinician "member advocates" as part of their platform. Accolade integrates with your existing benefits ecosystem to provide a range of services that include both non-clinical health assistants and a clinical team who can interface directly with providers. Navigators should have access to the member's full plan details and ideally past claims, health risk assessments and any other relevant data. While telephone is the most common method of communication, with the navigation service number usually featured on member ID cards, many navigation platforms are expanding to include live chat, SMS, video-based, chatbot and in-person interactions.
- How can Member Navigation Solutions help employers?
  - Help members navigate health plan intricacies, avoiding pitfalls of out-of-network providers, utilization management features, anticipate costs, build comprehensive care plans and deal with ad-hoc issues
  - Steer members toward higher value providers and complimentary benefits such as telemedicine & EAP, increasing ROI on network design and plan add-ons
  - Increase member satisfaction by reducing complexity, improving convenience and helping members make more timely and effective choices
  - Collect valuable data on members, including emerging health issues and preferences. Use the data to serve members more proactively
  - Increase the flexibility of benefit design and member responsiveness through navigators who are experts on your latest changes
- What impact do navigator programs have on health care costs?
  - Accolade report that for the 14,000 members of Temple University Health System they achieved 50% engagement and $2m in savings in year 1, with $9.8m savings in year 2, with a 7% reduction in hospital admissions and 11% reduction in hospital days[1]. In a study by Aon they found an Accolade customer experienced cumulative cost growth over two years of 2.7% vs 7.8% for a matched control.

1 Accolade Case Study: Temple University Health System 2 AON: Accolade: The effect of personalized advocacy on claims cost

Telemedicine

- Consumer telemedicine has reached maturity in recent years with the ubiquity of smartphones and the development of new technology platforms and staffing models that have combined to deliver a compelling on-demand experience for patients with a wide range of minor conditions.
- Telemedicine is also being used for asynchronous applications and by health systems for a wide variety of use cases including patient follow-up, although the relative lack of reimbursement has curtailed investment and adoption in fee-for-service settings.
- Employers are increasingly layering telemedicine programs on top of existing benefits to offer low-cost and convenient care for low acuity conditions, avoiding costly and time-consuming visits to brick-and-mortar providers while also boosting productivity and lowering absenteeism. Some telemedicine vendors report to offer a provider network that matches your population's needs including managing chronic conditions such as diabetes, hypertension and mental health issues. Similarly modern disease management programs are also often incorporate tele-care.
- NBGH reports that in 2018, 96% of large employers intended to offer telemedicine services and 56%, tele-behavioral health services[1]. Utilization, however, remains low with studies finding that in 2016 only 0.5% of members who had access and at least one recent outpatient episode used tele-medicine[2]. Modern benefits portals, favorable co-pays (McKinsey for example, offers Doctor on Demand visits free of charge to all employees) and increasing awareness may change the tide over time.
- So far evidence for cost saving is mixed. A 2017 RAND study[3] of 300,000 CalPERS members enrolled in a Blue Shield CA HMO plan who were offered Teladoc access estimated that 12% of tele-medicine visits for acute respiratory illness replaced in-person and 88% constituted new utilization. They found that net annual spending on acute respiratory illness increased by $45 per telehealth user.

1 2018 NBGH Press Release 2 Health System Tracker: More employers are paying for telemedicine, but enrollee take-up has been relatively low 3 Direct-To-Consumer May Increase Access But Does Not Decrease Spending

Price Transparency

- Price transparency is the concept of having up-front pricing information for various types of consultations, diagnostics, procedures and treatments across a network of providers based on a member's coverage. Such information, if readily accessible and provided with an indication of quality, could enable members to be more informed health care consumers. Paired with cost-sharing incentives that drive members to lower cost providers, price transparency could also significantly reduce overall costs for employers.
- The emergence and growth of high deductible health plans (HDHP) +/- saving option in 2006[1] created greater need for price transparency and the opportunity to build functioning consumer-driven marketplaces.
- With no visibility in to proprietary rates negotiated by carriers, self-funded employers relied on companies like Castlight Health to analyze years of historic claims data and tease out past prices and thus, predictions of future prices. The more claims, the more accurate the predictions, making this method most effective with the largest of employers. Carrier contracts typically prohibit pooling of data between employers.
- Castlight Health productized the pricing predictions in to an online platform where members can search for care and compare predicted costs for given services. Healthcare Bluebook offers a similar service and report that employers save an average of $1,500 every time a member uses their platform to shop for care. Many commercial insurers and TPAs have also implemented rudimentary price transparency tools.
- Such services do come with limitations: historic claims data can only offer estimates of cost and meaningful quality information remains elusive and challenging for consumers to understand. Furthermore, in order to prospectively shop based on cost, consumers must know the services they require and must be willing and able to shop at the time of need.
- Other promising although early price transparency efforts are afoot. On January 1, the hospital price transparency rule took effect and required hospitals to post their chargemasters online, although a lack of standardization makes it hard to use[3]. Maryland implemented all-payer rate setting in the 1970s, meaning all third parties pay the same price for services at a given hospital. This has necessitated transparency and there has been continued interest in spreading this approach. Medicare have been experimenting with price transparency and very recently launched a new app called "What's covered"[4].

1 KFF: Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2017 2 Aspen Valley Hospital Charge Master Example 3 Hospital Price Lists can be Extremely Confusing to Patients 4 Get Medicare's new "What's Covered" app

Wellness Programs

- Wellness programs have been broadly adopted by large US employers with SHRM finding that 75% offered wellness resources and/or a general wellness program in 2018[4].
- Wellness programs exist across a vast spectrum of design and function that spans initiatives to encourage healthy lifestyles through to targeted disease management and population health initiatives[5] with larger employers more likely to have complex multifaceted programs[1].
- The largest study of wellness programs to date performed by RAND in 2013[1] found that most employers characterize wellness programs as a combination of screening for health risks (including health risk assessments) and interventions to reduce those risks and promote healthy lifestyles.
- The study found that while around 50% of employees participated in screening activities only 7% of identified smokers participated in smoking cessation programs and 16% in disease management. They also found that financial incentives can be effective in boosting participation. Of those who did engage in programs, they found statistically significant and clinically meaningful improvements in exercise frequency, smoking behavior and weight control. While they were unable to demonstrate a statistically significant difference in health care costs in participants vs non-participants, they note that the two groups do diverge, and they estimate the annual difference to be $157 per participant. With limited data on the investment costs for the wellness programs studied, they estimated that it would take 5 years to reach break even, which has led to some skepticism around vendors more optimistic ROI estimates.
- Employers seem to be embracing wellness programs[4] despite limited evidence and what may be a long pay back period. Of course, the benefits of a wellness program are likely to extend to improved productivity, reduced absenteeism and presenteeism. In the 6 years since the RAND study (which looked at programs implemented in the years prior to that) technology has dramatically improved in ways that are likely to boost the effectiveness and increase the ease of participation in wellness programs and their constituent initiatives.

1 RAND: Workplace wellness study 2 An evaluation of the Well at Dell health management program: health risk change and return on investment 3 Long-term impact of Johnson & Johnson's Health and Wellness program on health care utilization and expenditures 4 SHRM: 2018 Employee Benefits Research Report 5 The Advisory Board: Understand the wellness spectrum

Care Management

- Chronic care management is an old concept but the emergence of technology that enables more personalized, connected and scalable programs has led to renewed enthusiasm and encouraged many new entrants with what some have termed point-solutions.
- Most of these programs target conditions with the greatest employer spending. Some companies that started out with point-solutions are now shifting toward a platform approach to address a wide variety of high-cost health issues.
- The impact of such programs is difficult to quantify, with cost savings of improved disease management often taking years to materialize , other benefits changes thrown in to the mix and little peer-reviewed research evaluation programs. A recent study found that much of the evidence that has been published on these modern platforms focuses on relatively healthy patients with few data on outcomes, cost or access[3].
- From just a few vendors, here are some of the cost savings they report to have achieved:
  - ***Livongo*** (T2DM management with connected glucometer): Applying a correlation between lower HbA1c and healthcare costs found in other studies, they estimate a $73-$99pm cost saving excluding the cost of the program[4]. In another report, they analyze claims data comparing diabetics enrolled vs non-enrolled. They found a $83pppm, although the methodology is unclear as are the underlying differences between the two groups.
  - ***Propeller Health*** (asthma & COPD management): With results showing that 50% of patients with uncontrolled asthma achieve controlled status within 1 year, they draw links to existing studies comparing healthcare costs in those with controlled vs uncontrolled asthma. They estimate a cost saving of $930 per participant per year in direct asthma cost savings and $2,101 less in total costs.
- New payment models for programs are emerging including PMPM (total/enrolled/engaged with specific target metrics), fixed fee, outcome based (percentage of savings/on meeting certain outcome metrics +/- risk adjustment) and billing through claims. They bring the potential to align incentives to encourage enrollment and engagement and drive outcomes in even the most complex patients and avoid costly, poorly utilized programs. Furthermore, the use of financial incentives for participants both on engagement and outcomes can help boost the ROI of such programs[5].
- Primary care, the traditional venue for chronic disease management can also be incentivized and empowered to better manage chronic disease through value-based and capitated models of payment (such as with the AQC and the ambulatory quality measures). Inspiration can be drawn from Medicare programs such as Comprehensive Primary Care Plus and Chronic Care Management that provide funds for chronic care management and encourage practices to strengthen their capabilities.

1 IFEPB's Workplace Wellness Trends 2017 Survey 2 Why Consider Point Solutions? (And What Are They, Anyhow?) 3 Top-funded Digital Health Companies And Their Impact on High-Burden, High-Cost Conditions
4 Livongo Clinical and Financial Outcomes Report 5 Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act

Smoking Cessation

- Cigarette smoking rates have continued to fall from 42.4% of US adults in 1965 to an estimated 14% in 2017 (↓ 1.5% from 2016)[1].
- Recent surveys have estimated that employees who smoke cigarettes cost employers an additional $6,000 each year in lost productivity and health costs[2].
- Employers have long targeted tobacco use through smoking cessation programs, tobacco free workplaces and even refusing to hire tobacco users (as at Geisginer). In 2004, Kevin Volpp started a study at GE[3] that identified tobacco users compared offering incentives for smoking cessation vs providing smoking cessation resources without incentives. The incentives were $100 for completing a smoking cessation program, $250 for demonstrating they were cigarette free via a biochemical test at 6 months and a further $400 for the same test after another 6 months. They found the odds of quitting in the incentivized group was 15%, 3.28 times higher than in the control group.
- The ACA increased the incentive ceiling for "programs of health promotion and disease prevention" to 30% of coverage costs or up to 50% if at least 20% is targeted at tobacco use. This means that tobacco users could face surcharges of up to 50% of the cost of coverage if employers so wished. Employers could also use such incentives, either in the form of carrots or sticks, for reductions in BMI, for engagement in a disease management program or for completion of a Health Risk Assessment, although employers must also be mindful of the ADA and GINA[8].
- There has also been an increasing amount of innovation in the vendor space, with new digital platforms that help employees tackle smoking while being easily accessible and highly scalable. Pivot, for example, combines a mobile application that can provide coaching, educational content and smoking insights based on data collected from a personal CO breath sensor.
- Employers have a growing range of options to tackle smoking in their members and despite decreasing rates of smoking, it still represents a significant opportunity to reduce long-term health care spending. Financial incentives, which can be applied in a wide range of care management programs beyond smoking cessation, can help boost engagement and reward participant outcomes.

1 CDC says smoking rates fall to record low in US 2 OSU Study: Companies pay almost $6,000 extra per year for each employee that smokes 3 Commonwealth Fund: What happened when GE paid employees to quit smoking? 4 Smoking, Obesity, Health Insurance, and Health Incentives in the Affordable Care Act 5 A pragmatic trial of E-Cigarettes, Incentives, and Drugs for Smoking Cessation 6 45 CFR §146.121(f). 7 Evidence Suggests That ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation 8 Wellness Program Incentive Amounts for 2019: What to do?

Hotspotting

- Hotspotting is the concept of using data to identify super-utilizers of care, understand their individual needs and allocate resources to those individuals through the design and delivery of effective interventions. It rose to prominence through the Camden Coalition[1]. Their work with Medicaid patients also drew further attention to the social determinants of health that were often intricately intertwined with the health issues of the individuals they identified.
- While there have been many hotspotting initiatives in public payer populations, there has been much less activity in self-funded employer populations beyond chronic care management. No doubt this is partly due to privacy concerns that knowing identities of high spending members could lead to or be attributed to workplace decisions, the understandable privacy concerns of employees, identifying the trusted party that can reach out to the member, and the potential implications of HIPAA.
- Perhaps the most prominent initiative has been the Intensive Outpatient Care Program (IOCP) initially implemented by PBGH and Boeing, reducing costs by up to 20% for medically complex patients[2]. Centered around primary care and dedicated care coordinators, the program identifies members based on a combination of analytics and referrals from PCPs/in-hospital providers or existing disease management programs through a warm hand-off approach[1]. Care coordinators work to understand the individual needs of the member with in-home visits, regular check-ins and use of patient-reported outcomes. The coordinator serves as an always available first point of contact to organize holistic services around the member[3].

1 Healthcare Hotspotting: A Project of the Camden Coalition of Healthcare Partners 2 Intensive Outpatient Care Program: A Care Model for the Medically Complex Piloted by Employers 3 Intensive Outpatient Care Program: PBGH Toolkit 4 Consistently high turnover in the group of top healthcare spenders

The Opioid Crisis

- A 2016 study by Castlight Health found that opioid use disorder could be costing US employers around $18bn in lost productivity and medical expenses.
- Opioid use (as measured through claims) has declined from 17.3% of large employer plan enrollees in 2009 to 13.6% in 2016. However, a KFF analysis found that large employers paid $2.6bn for opioid-addiction diagnoses in 2016, up 8-fold from 2004, with 53% of spending attributed to dependent children.
- NBGH reported that 30% of large employers have altered plans to restrict use of prescription opioids and 21% have added programs to manage opioid prescription use[4]. Limiting legitimate supply of opioids without, at the same time offering support, treatment and alternatives may bring its own negative consequences.
- Tackling opioid abuse, dependence and misuse head on now may bring cost saving benefits for many years to come. While there is no silver bullet there are several approaches that can work[5,6] including:
  - PBM-based[7]: Quantity limitation, application of strict guidelines for dispensing, patient risk scoring, prior authorization, physician messaging & alerts, patient education, increased data sharing, formulary policies for naltrexone, methadone, buprenorphine & naloxone
  - Medication Assisted Treatment[8], biometric screening, advocating tighter provider controls, EAP awareness with inclusive and supportive programs, mental health programs, access to programs such as reSET-O[9]

1 MBGH: The opiod epidemic and how it is impacting the workplace 2 Castlight Health: The opioid crisis in America's workforce 3 KFF: Cost of treating opioid addiction rose rapidly for large employers as the number of prescriptions has declined 4 NBGH Large Employers' Health Care Strategy and Plan Design Survey 2018 5 UnitedHealthcare: The opioid crisis – 6 ways your clients can fight back 6 Strategies for stemming the opioid epidemic 7 Four PBM programs poised to rein in the opioid epidemic 8 Substance abuse and Mental Health Services Administration 9 Pear Therapeutics reSET-o program

Miscellaneous

Healthy Workplace Design

- With employees spending most of their waking hours in the work environment, a healthy workplace design has the potential to significantly impact employee health and reinforce a culture of wellness.
- While there is a paucity of evidence studying the effects of workplace design on health care costs, a recent study that looked at the relationship between Corporate Health Assessment Scores (CHAS) completed by employees and healthcare spending across several large employers. They found that higher CHAS scores generally correlated with lower health care cost trend[2].
- Workplaces vary considerably depending on the nature of the work, however there are a few common themes[4] that employers can consider:
  - Ensure a safe workplace and minimize occupational hazards
  - Promote physical activity throughout the day
  - Encourage healthy eating, good hydration and avoid junk foods
  - Invest in workplace ergonomics, lighting and air quality
  - Encourage regular social interactions and collaboration

1 Does a healthy workplace improve the bottom line? 2 The Correlation of a Corporate Culture of Health Assessment Score and Health Care Cost Trend 3 Examining the relationship between the food environment and adult diabetes prevalence by county economic and racial composition: an ecological study 4 How employers can design workplaces to promote wellness

Coalitions & Lobbying

- Self-funded employers have a long history of collaborating and using their collective purchasing power to advocate for policy, lobby and push forward initiatives that improve the quality of care for their members and reduce costs. On a backdrop of increasing provider consolidation and mega-mergers such as Aetna-CVS, it is my view that these coalitions will become increasingly important.
- The most prominent coalitions and organizations out there include the National Business Group on Health, the Pacific Business Group on Health, the Catalyst for Payment Reform, the National Alliance of Healthcare Purchaser Coalitions (which includes many regional coalitions), the Healthcare Transformation Task Force and The Alliance.
- Just a small selection of the initiatives from these groups include:
  - Funding and supporting clinical registries such as the California Joint Replacement Registry
  - eValue8 and the PBM Assessment tool to help employers assess health plan performance and identify results-oriented vendors
  - Advocating for 75% of business in value-based payment arrangements by 2020[1]
  - Coalition with private vendor, Remedy Partners, to accelerate development and adoption of bundled payment models[2]
  - Dossia, founded by a consortium of employers in 2006, developing a personally controlled personal health records platform[3]

1 Healthcare Transformation Taskforce: What is value? 2 National Alliance of Healthcare Purchaser Coalitions and Remedy Partners Collaborate to Accelerate Payment Reform 3 Dossia Consortium: About Us

Medicare Advantage as a blueprint Part 1/2

- Medicare Advantage plans are paid by CMS on a capitated per member basis, based on average costs for FFS Medicare beneficiaries and risk-adjustment. Similarly employers have a budget for healthcare expenditures in a given year to cover all enrollees that is based on prior years.
- In 2019 the Medicare Advantage monthly capitation rate with a 0% bonus ranged from $322 in American Samoa to $706 in Presidio TX to $1453 in Nome AK[1]. The average cost of employer-based coverage in 2018 was $574 (including employee contributions)[2]. Consider that the MA population is over 65 years old and likely to incur higher medical costs.
- Medicare Advantage plans have been rapidly growing in popularity, with many citing their lower premiums as the primary reason, with 20.4M enrollees accounting for 34% of Medicare beneficiaries in 2018[3]. In 2019 the majority of MA plans are HMOs (68%) and 92% include Prescription Drug Part-D coverage[5].
- Most Medicare Advantage enrollees are in plans operated by UnitedHealthcare, Humana and BCBS affiliates (55% combined in 2018) however there have been many new entrants to the market including 14 new firms for 2019[6]. Despite entrenched competition, new entrants see an opportunity to use novel technology-enabled approaches to win market share and manage patient populations at lower cost than Medicare reimbursement.

1 CMS: 2019 MA Rate Book 2 KFF: 2018 Employer Health Benefits Survey 3 KFF: A dozen facts about Medicare Advantage 4 More 2019 Medicare Advantage Plan Options 5 KFF: New MA Entrants for 2019 Table 6 Medicare Advantage Plan Directory, sorted by Contract Start Date

Medicare Advantage as a blueprint Part 2/2

- Medicare Advantage plans have many similarities with self-funded employer plans and some key differences:
  - Both have an imperative to work within a defined budget and reduce costs to improve the bottom line, to offer efficient and high-quality care to their members, and ultimately to improve the health of their members with the added flexibility to use unconventional means.
  - MA plans cover an older population, with (in general) more complex health needs. MA plans compete as one of many options in a MA marketplace or as an alternative to FFS Medicare (which generally reimburses providers at much lower rates than employer-based coverage), whereas employees and their dependents are captive to the options presented by their employer on a backdrop of a benefits previously offered by the company.
- How could a Medicare Advantage mindset be applied to employer-based coverage?
  - A shift toward HMO plans with narrow high-performance networks and a primary-care first approach
  - Directly contract with health systems, who through consolidation, are increasingly able to offer a wide range of services across broad geographies with greater data-sharing and reporting capability
  - Build a network of directly contracted primary care practices that serve as the front door to your members. Work closely with them to share data, enable more proactive and coordinated care, track outcomes, ensure standards of care are met and look for cost & efficiency saving opportunities (eg. reducing polypharmacy)
  - Use additional funds to help address social determinants of health, or the symptoms thereof.
  - With knowledge of your member population, incorporate programs to address high cost chronic conditions
  - Use modern CRM to develop stronger ties with members and to be there at the time of need

Conclusion

- This is just a small selection of the potential strategies available.
- It is easy to see how US healthcare is an economist's dream and a patient's nightmare with a vast web of often conflicting incentives and terminology with so many exceptions that even the most common of terms mean nothing without reading the fine print.
- While my focus here has been cost, any strategy must be considered in the context of the ***companies***, their ***benefits structure*** and on the three dimensions of the Triple Aim: ***cost***, ***health outcomes*** and ***experience.***
- No single strategy is likely to have the kind of step change impact that is required but many strategies are overlapping and synergistic and together have the potential to bring about meaningful change.

Appendix

Benefit Design Examples

Walmart

2018 Medical Plan Options		HSA Plan Walmart matches your contributions when you put money in a tax-free health savings account (HSA) for this year's expenses – or for future needs.	HRA Plan Let Walmart help pay for your medical care, with a special health reimbursement account (HRA) that helps cover eligible expenses before your deductible kicks in.	HRA High Plan Get more Walmart dollars and lower deductibles, plus all the benefits of the HRA Plan, at a higher cost per paycheck.
In-network coverage	**Walmart's annual max contribution** Associate only Associate + dependents	Match up to $350 in your HSA Match up to $700 in your HSA	$300 credited to your HRA $600 credited to your HRA	$500 credited to your HRA $1,000 credited to your HRA
	Annual deductible (except preventive care) Associate only Associate + dependents	$3,000 $6,000	$2,750 $5,500	$1,750 $3,500
	Annual out-of-pocket maximum Per person Entire family	$6,650 $13,300	$6,850 $13,700	$6,850 $13,700
	Care and services Including doctor visits, diagnostic tests, hospitalization, behavioral health	75% covered after deductible	75% covered after deductible	75% covered after deductible
	Doctor On Demand Video doctor visit for medical, behavioral health needs	75% covered after deductible	75% covered after deductible	75% covered after deductible
Walmart/Sam's Club pharmacy	**Generic drugs**	$4 after deductible	$4	$4
	Brand-name drugs	$50 or 25% of allowed cost* after deductible	$50 or 25% of allowed cost*	$50 or 25% of allowed cost*
	Specialty drugs Available only at Walmart Specialty Pharmacy or ESI/Accredo specialty pharmacies	$50 or 20% of allowed cost* after deductible	$50 or 20% of allowed cost*	$50 or 20% of allowed cost*
Your cost per biweekly pay period**	Associate only *(tobacco free/one tobacco user)*	**$29.10 / $58.20**	**$26.10 / $52.20**	**$78.50 / $157.00**
	Associate + spouse/partner *(tobacco free/one tobacco user/two tobacco users)*	**$130.50 / $159.60 / $188.70**	**$124.80 / $150.90 / $177.00**	**$265.90 / $344.40 / $422.90**
	Associate + child(ren) *(tobacco free/one tobacco user)*	**$45.70 / $74.80**	**$41.90 / $68.00**	**$110.80 / $189.30**
	Associate + family *(tobacco free/one tobacco user/two tobacco users)*	**$150.70 / $179.80 / $208.90**	**$146.40 / $172.50 / $198.60**	**$284.60 / $363.10 / $441.60**

HDHP options only

High cost sharing

Telemedicine covered

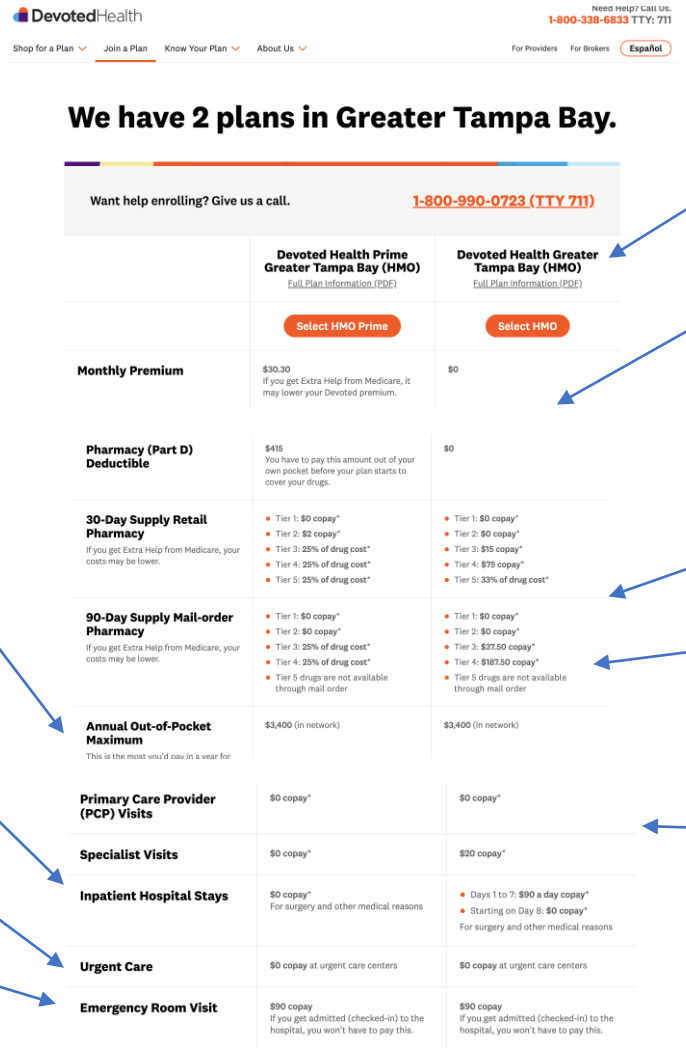
Big savings for generics

Narrow pharmacy & Specialty pharma network

Partly unitized coverage

Smoking premium rating

Medicare Advantage: Devoted Health



DevotedHealth

Need Help? Call Us. 1-800-338-6833 TTY: 711

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Want help enrolling? Give us a call. 1-800-990-0723 (TTY 711)

	Devoted Health Prime Greater Tampa Bay (HMO) Full Plan Information (PDF)	Devoted Health Greater Tampa Bay (HMO) Full Plan Information (PDF)
	Select HMO Prime	Select HMO
Monthly Premium	$30.30 If you get Extra Help from Medicare, it may lower your Devoted premium.	$0
Pharmacy (Part D) Deductible	$415 You have to pay this amount out of your own pocket before your plan starts to cover your drugs.	$0
30-Day Supply Retail Pharmacy If you get Extra Help from Medicare, your costs may be lower.	• Tier 1: $0 copay* • Tier 2: $2 copay* • Tier 3: 25% of drug cost* • Tier 4: 25% of drug cost* • Tier 5: 25% of drug cost*	• Tier 1: $0 copay* • Tier 2: $0 copay* • Tier 3: $15 copay* • Tier 4: $75 copay* • Tier 5: 33% of drug cost*
90-Day Supply Mail-order Pharmacy If you get Extra Help from Medicare, your costs may be lower.	• Tier 1: $0 copay* • Tier 2: $0 copay* • Tier 3: 25% of drug cost* • Tier 4: 25% of drug cost* • Tier 5 drugs are not available through mail order	• Tier 1: $0 copay* • Tier 2: $0 copay* • Tier 3: $37.50 copay* • Tier 4: $187.50 copay* • Tier 5 drugs are not available through mail order
Annual Out-of-Pocket Maximum This is the most you'd pay in a year for	$3,400 (in network)	$3,400 (in network)
Primary Care Provider (PCP) Visits	$0 copay*	$0 copay*
Specialist Visits	$0 copay*	$20 copay*
Inpatient Hospital Stays	$0 copay* For surgery and other medical reasons	• Days 1 to 7: $90 a day copay* • Starting on Day 8: $0 copay* For surgery and other medical reasons
Urgent Care	$0 copay at urgent care centers	$0 copay at urgent care centers
Emergency Room Visit	$90 copay If you get admitted (checked-in) to the hospital, you won't have to pay this.	$90 copay If you get admitted (checked-in) to the hospital, you won't have to pay this.

No out-of-network coverage

We trust our primary care network to refer appropriately

Try primary care and Urgent care before ER

ER encouraged for appropriate visits

HMO model plans only

Low monthly premiums and Part-D coverage to attract new members

5-tier pharmacy benefit design

Incentivizing mail order for long-term supply

$0 co-pays demonstrating high level of trust for provider network

Benefit Design Examples

FACULTY, ADMINISTRATIVE AND PROFESSIONAL STAFF, AND OTHER NONUNION STAFF

TIERED RATES FOR 2019

Harvard offers four salary tiers for premiums based on your full-time equivalent (FTE) salary. If you work part time, your salary tier and premiums are based on your FTE salary.

MONTHLY COST BY SALARY TIER	TIER 1 LESS THAN $55,000		TIER 2 $55,000–$74,999		TIER 3 $75,000–$99,999		TIER 4 $100,000 AND ABOVE	
	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY
HMO								
Harvard University Group Health Plan (HUGHP)	$80	$215	$92	$249	$141	$382	$181	$489
Harvard Pilgrim Health Care (HPHC)	$99	$266	$111	$300	$160	$433	$200	$540
POS								
HUGHP	$115	$309	$127	$343	$176	$476	$216	$583
HPHC	$134	$360	$146	$394	$195	$527	$235	$634
POS Plus								
HUGHP	$129	$347	$141	$381	$190	$514	$230	$621
HPHC	$148	$398	$160	$432	$209	$565	$249	$672
HDHP								
HUGHP	$46	$124	$58	$158	$107	$291	$147	$398
HPHC	$46	$124	$58	$158	$107	$291	$147	$398

HARVARD UNIVERSITY

Contributions based on salary

No traditional PPO option

¾ options have PCP gatekeeping

Benefit Design Example: Stanford University

Stanford
HEALTH CARE ALLIANCE

Plan Benefits

- No cost when you cover yourself only
- No deductible
- No claims to file
- Fixed copay for office visits, emergency room visits and hospital stays
- Must use SHCA network doctors and facilities - **Sutter Health providers, including Palo Alto Medical Foundation ARE NOT in the SHCA network.**
- Must live within the service area (based on your home zip code)
- Must get pre-authorizations for elective and radiology imaging services
- Prescription drug coverage
- Out of network care available for **urgent and emergency care when traveling outside the service area**, including outside the United States

Please Note: If you recieve services from an out-of-network provider, i.e. Palo Alto Medical Foundation, you will be responsible for 100% of the bill. No coverage for out-of-network providers for routine, preventative, or follow-up care.

Low cost sharing

Narrow network for specific geographic area

Prior authorization for high cost, overutilized services

Out-of-network coverage only in emergencies

Network explicitly excludes the major geographic competitor

Benefit Design Example: Indiana University

Medical Benefits - IU Health Plans Network		
IU Health Plans Network includes most Indiana counties. Visit **iuhealthplans.org** for a provider directory.		
Service	**In-Network Provider – Member Pays[1]**	**Out-of-Network Provider – Member Pays[1]**
Annual Deductible Applies to all medical and prescription services except wellness/preventive.	$2,500 for employee-only coverage $5,000 all other coverage levels	
Covered Charges	Up to the Maximum Allowable Amount that In-Network providers accept as payment in full.	
Medical Out-of-Pocket Maximum (All co-insurances and deductibles apply toward this maximum)	$3,000 for employee-only coverage $6,000 all other coverage levels	
Physician Office Services • Primary care (PCP) visits/consultations • Specialist visits/consultations/therapy • High cost diagnostics, pharmaceuticals, durable medical equipment/ prosthetics, allergy testing	20% coinsurance after deductible	
Preventive Services • Office Services (e.g. routine exams, well child visits, immunizations, labs, hearing screenings) • Hospital/Alternative Facility[2] Surgical Procedures (e.g. screening colonoscopy) • Non-surgical Hospital/Alternative Facility[2] services (pap tests, mammograms, PSA, and other lab services) • Women's contraceptive services such as IUDs, implanted and injectable hormones, and sterilization	No coinsurance or deductible	No coverage except in an emergency[3]
Hospital/Alternative Facility[2] Outpatient Surgical Procedure	20% coinsurance after deductible	
Hospital Inpatient Services	20% coinsurance after deductible	
Professional Services Provided during a Hospital Inpatient Stay or during an Outpatient/Alternative Facility[2] Surgical Procedure	20% coinsurance after deductible	
Maternity Services	Covered as any other illness. Subject to same deductibles, coinsurance, and maximums.	
Emergency Room for Emergency Care No coverage unless an emergency	20% coinsurance after deductible	Paid as In-Network when emergency[3]
Urgent Care Facility • Facility Visit • High cost diagnostics, pharmaceuticals, durable medical equipment/ prosthetics, allergy testing	20% coinsurance after deductible	Paid as In-Network when more than 50 miles from home
Other Outpatient Services • Non-surgical outpatient services (examples: MRIs, C-Scans, Chemotherapy, Ultrasounds, X-Rays, and other diagnostics) • Durable Medical Equipment (DME) • Home Care (Out-of-Network limited to 30 visits) • Outpatient Laboratory Services	20% coinsurance after deductible	No coverage except in an emergency[3]

[1] In-Network and Out-of-Network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.
[2] Alternative Facilities include facilities (free standing/attached to a hospital) that are designated primarily for outpatient services like surgery, diagnostic testing (e.g. MRIs), or therapy/rehabilitation.
[3] Primary and Urgent Care paid as In-Network for Out-of-State dependents.

High deductible plans

No out-of-network coverage

Preventive services fully covered as per ACA

No ER coverage unless “emergency”

Source: [Indiana University High Deductible Health Plans Overview]