

Health & Group Benefits

AN EMPLOYER BENEFITS UPDATE

MARCH 2019

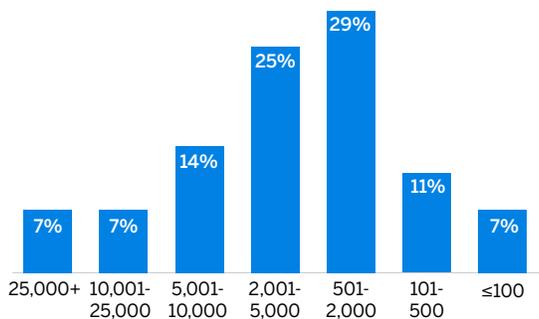
Milliman Rx survey results: Employer-sponsored prescription drug strategies

Ryan Hart

Rising prescription drug costs is old news, and costs are only expected to climb higher, particularly due to the increased presence of specialty drugs. Prescription drug costs will continue to be the fastest-growing health category and are expected to consistently outpace other health spending.¹ Milliman recently conducted an employer-based survey focused specifically on pharmacy spend and what strategies are in place to manage prescription drug spend. The results of this survey have been summarized below.

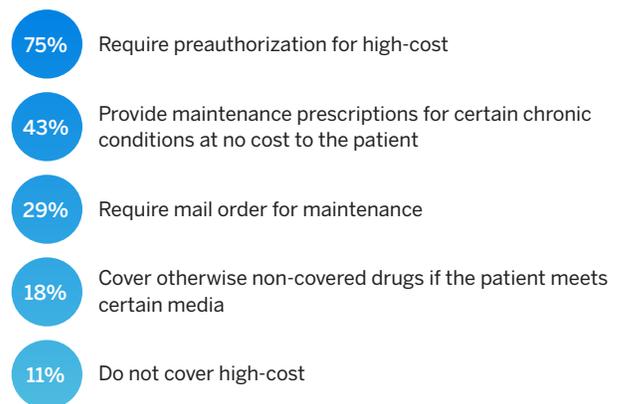
Figure 1 highlights the survey responders by employee size. The majority of responders were within the range of 500 to 5,000 employees.

FIGURE 1: SURVEY RESPONDENTS BY EMPLOYEE COUNT



The survey results indicate employer-sponsored plans are currently using a number of methods to control their pharmacy spend (see Figure 2). With an overwhelming 75% of respondents indicating that they require prior authorization for high-cost drugs, clearly this is the most popular method currently in use. Other popular methods surround maintenance drugs, including offering them at no cost and requiring the use of mail order.

FIGURE 2: MOST SURVEY RESPONDENTS HAVE CONTROLS IN PLACE TO MANAGE PRESCRIPTION DRUG COSTS



The results in Figure 2 seem to demonstrate a disconnect between the strategies that organizations currently employ versus what they believe is the more effective solution. Reasons for it could include cost and lack of access to resources. According to Figure 3, many respondents believe working with a pharmacy benefit manager (PBM) is the most cost-effective way to manage long-term drug costs even though most are still contracting with a health carrier or third-party administrator (TPA).

FIGURE 3: CARVE IN OR CARVE OUT

How do you manage long-term drug costs?	Current Approach	Most Effective Approach
Contract directly with PBM (carve out)	36%	46%
Contract through a third-party PBM Purchasing Coalition (carve out)	24%	42%
Contract through a Health Carrier to TPA	56%	27%
On-site Clinic	16%	11%
Direct Contract with a pharmacy chain	4%	15%

¹ Centers for Medicare and Medicaid Services (2018). CMS Office of the Actuary Releases 2017-2026 Projections of National Health Expenditures, 2018.

When asked about discounts and rebates, 39% of respondents did not know whether they are receiving the best deal from their pharmacy arrangements, as shown in Figure 4. Beyond the majority of respondents not necessarily knowing they are getting the best deal with their pharmacy spend, there is a relatively even distribution between reliance on third-party expertise, be it consultant or PBM, and conducting regular maintenance with pharmacy benefits including audits, requests for proposal (RFPs), and examining contracts.

Finally, the perception of these resources seems to differ between those who are the most equipped versus those who are most effective or responsible in managing cost. There doesn't seem to be one clear choice as to who can be effective, responsible, and objective when it comes to managing pharmacy cost. It is evident from the results in Figure 5 that the PBM is in the best position to be effective. On the other hand, the specialized consultant seems to be the best equipped to provide advice.

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FIGURE 4: VALUE OF CURRENT PROGRAM

Do you know if you're getting the best deal on discounts or rebates?	Response
I don't	39%
I trust the Pharmacy Benefit Manager	11%
I have periodic independent audits conducted	18%
I use a consultant	18%
I frequently review our contract	7%
Other	7%

FIGURE 5: WHICH VENDOR CAN BE EFFECTIVE, RESPONSIBLE, AND OBJECTIVE?

Do you know if you're getting the best deal on discounts or rebates?	Currently Responsible	Best Equipped to Provide Advice	Most Effective
Pharmacy Benefit Manager	46%	25%	40%
Carrier / TPA	29%	7%	12%
Benefit Broker / Consulting Firm	18%	18%	8%
Specialized Consultant	7%	32%	16%
Actuarial Consultant	0%	11%	4%
Independent Medical Management Firm	0%	7%	20%

Employer considerations for addressing opioid use disorder

Stoddard Davenport | Alexandra Weaver, ASA, MAAA | Matt Caverly

According to a 2017 survey conducted by the National Safety Council, 71% of employers in the United States reported having been affected in some way by employee use of prescription drugs, primarily through absenteeism or impaired work performance.¹ Understanding the prevalence of opioid use disorder in the workforce is an important first step in addressing its negative impacts.

In 2018, a Milliman study found that an estimated 1.5 million privately and publicly insured individuals in the United States were diagnosed with opioid use disorder in 2015, and about 622,000 (40%) of them had commercial insurance coverage, predominantly through employer-sponsored

group insurance plans.² As a follow-up, we also compared opioid use patterns between individuals with *diagnosed* opioid use disorder versus those *undiagnosed* who filled similarly high volumes of opioid prescriptions in a year (coined “super-users”).³ Studying administrative claims data for 3.9 million commercially insured members in 2015, we found that *undiagnosed* opioid super-users outnumbered those with *diagnosed* opioid use disorder by factors of 6 to 9, depending on the chosen opioid use threshold.

1 B2B International (January 2017). National Employer Survey: Prescription Drugs and the U.S. Workforce. National Safety Council. Retrieved February 27, 2019, from <https://www.nsc.org/Portals/O/Documents/NewsDocuments/2017/National-Employer-Addiction-Survey-Methodology.pdf?ver=2018-07-05-105114-883>.

2 Davenport, Stoddard & Matthews, Katie (March 2018). Opioid Use Disorder in the United States: Diagnosed Prevalence by Payer, Age, Sex, and State. Milliman White Paper. Retrieved November 15, 2018, from http://us.milliman.com/uploadedFiles/insight/2018/Opioid_Use_Disorder_Prevalence.pdf.

3 Davenport, S., Weaver, A., & Caverly, M. (August 2018). Opioid Prescription Drug Patterns in Diagnosed and Non-Diagnosed Opioid Use Disorder populations. Milliman White Paper. Retrieved February 27, 2019, from <http://us.milliman.com/uploadedFiles/insight/2018/opioid-prescription-patterns.pdf>.

Figure 1 shows our national estimates for the number of commercially insured patients that exceeded key opioid use thresholds in 2015. This figure shows:

- The number of patients prescribed high quantities of opioids (at least 360 days’ supply, equivalent to twelve 30-day prescriptions in a year)
- Patients treated with high-potency opioids, an average of over 200 morphine milligram equivalents (MME) per day, well in excess of the Centers for Disease Control and Prevention (CDC) guideline to avoid prescribing more than 90 MME per day without careful consideration
- Patients with high opioid coverage over the course of a year (over 75% of their eligibility covered by an opioid prescription in 2015)

As illustrated in Figure 1, a significant number of *undiagnosed* patients consume the same elevated level of opioids as those with a *diagnosed* opioid use disorder. These levels of opioid use may be clinically justified in some circumstances, but the CDC recommends carefully assessing the evidence of individual benefits and risks when prescribing opioids.

Employer considerations

Employers looking to understand the prevalence of opioid use issues in their populations should analyze prescription drug claims for elevated opioid levels in addition to medical claims data. Employers have been using claims analysis to target prescriptions that fall outside of CDC guidelines and identify individuals who may be at risk of developing a use disorder.⁴

Additionally, many employers are partnering with their pharmacy benefit managers and health plans to address problematic use of prescription opioids. A few strategies

recommended by the National Business Group on Health include:

1. Encourage use of employee assistance programs for treatment and help returning to work.
2. Educate employees about how to seek alternative pain management strategies, properly dispose of unused pills, and identify signs of drug addiction.
3. Implement CDC guidelines for opioid prescriptions.
4. Limit the number and potency of opioid prescriptions that can be prescribed.
5. Establish prescription drug formularies that encourage use of non-opioid pain medication.
6. Create benefit designs that encourage employees to use providers with opioid-reduction strategies.

It is important to note that opioid prescribing practices are a sensitive topic, as pressures to reduce prescriptions challenge the needs of chronic pain patients. Overprescribing opioids can lead to abuse and addiction, but limiting the prescriptions available to chronic pain patients can leave those patients feeling abandoned by the healthcare system, and in some cases may exacerbate a shift toward illicit opioid use, which can be far more dangerous. Reducing the number of opioid prescriptions may be one component of the national strategy in addressing the opioid epidemic, but access to comprehensive treatment options for both chronic pain and substance use disorders will be critical to ensure that patient needs are not left out of the discussion.

CONTACT

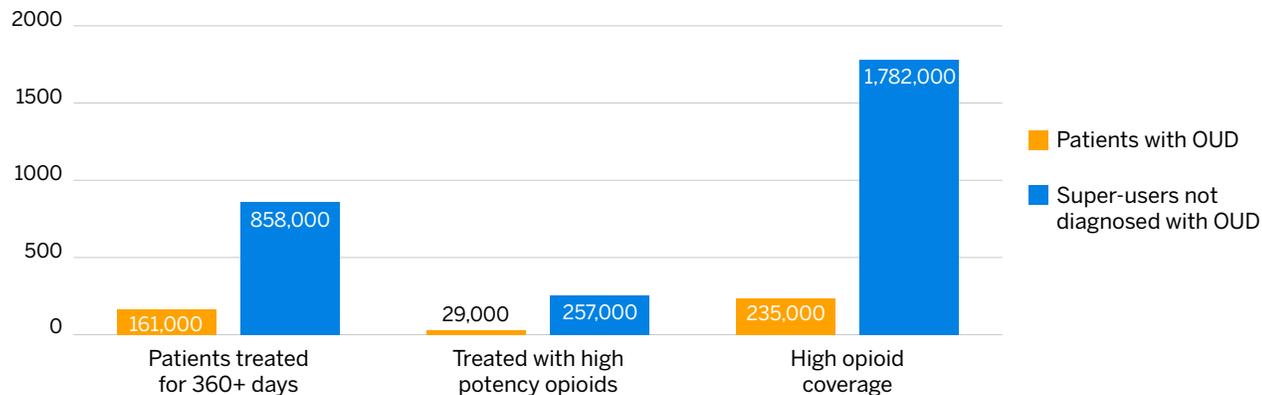
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4 National Business Group on Health (2018). Infographic: The Employer Response to Opioids. Retrieved February 27, 2019, from <https://www.cigna.com/static/docs/painplan/the-employer-response-to-opioids-infographic.pdf>.

FIGURE 1: NATIONAL ESTIMATES FOR THE NUMBER OF OPIOID USE DISORDER PATIENTS AND SUPER-USERS EXCEEDING KEY OPIOID USE THRESHOLDS, 2015



Effective drug benefit management strategies for employer plans

Considering plan design to make informed decisions

Deana Bell, FSA, MAAA | Tracy Margiott, FSA, MAAA

The employer-sponsored drug benefit landscape includes a wide range of plan designs; high-deductible health plans (HDHPs) as well as copay and/or coinsurance plans are among available benefit options. While a creative array of plan designs offers flexibility to members, it creates new challenges for plan sponsors.

Pharmacy benefit manager (PBM)¹ contracts are often complex and include several terms and conditions. Point-of-sale (POS) discounts, post-POS price concessions (often referred to as “rebates”), and formulary design are key drivers of savings for drug plans. Plan sponsors should periodically review their PBM contracts in an effort to mitigate rising drug costs. However, simply comparing contract terms without considering plan design may not be enough for a plan sponsor to make informed decisions. In this article, we illustrate how different benefit designs can affect the realized value of discounts and rebates.

Rebates include drug manufacturer rebates, pharmacy performance-based price concessions, and any other price concessions used to decrease a plan sponsor’s costs after prescriptions have been dispensed (post-POS).

Discounts are cost reductions from a reference price, such as the average wholesale price (AWP), that are negotiated with pharmacies to lower drug costs at the point of sale.

Realized value varies with plan design

Plan sponsors typically share negotiated drug cost reductions with members through reduced monthly plan premium contributions and cost sharing (e.g., deductibles, copayments, and coinsurance). PBMs may present their proposals by focusing on the total savings to members and plan sponsors combined. This total savings view may not account for how much of the savings is captured by the plan.

The “realized value” to the plan sponsor is the portion of the total drug cost² savings that is used to reduce the plan’s

costs prior to member premium contributions.³ The amount of savings that the plan sponsor realizes varies with the underlying plan design. Figure 1 illustrates the potential realized value of a 1% improvement in overall discounts⁴ by representative plan design. Actual realized value may be higher or lower than illustrated in this example based on a group’s claims experience and other factors.

FIGURE 1: ILLUSTRATIVE PLAN SPONSOR REALIZED VALUE OF DISCOUNT IMPROVEMENT

Plan Design	Potential Realized Value Captured
\$20 Copay Plan	90%
20% Coinsurance Plan	80%
\$1,000 HDHP	70%

All three scenarios above, for simplification, reflect the same total cost savings and assume no out-of-pocket maximums. In this example, the plan sponsor captures 90% of the savings with the \$20 copay plan (i.e., for every dollar in total drug cost savings, the plan sponsor’s costs are reduced by \$0.90). However, the plan sponsor only captures 70% of the savings with the HDHP.

COPAY PLAN

What drives the differences in realized value in Figure 1?

For drugs that have discounted costs below the \$20 copay, the members typically pay the lower drug cost and thus benefit directly from the reduced drug cost.

If the drug costs more than \$20, the member continues to pay \$20 for prescriptions regardless of the reduction in costs from the discount improvement. The plan sponsor therefore retains 100% of discount improvements for these drugs.

In this example, this results in the 90% plan sponsor realized value illustrated in Figure 1.

1 PBMs are third-party administrators (TPAs) of pharmacy benefits. Some plan sponsors or groups of plan sponsors contract directly with drug manufacturers and administer their plans without PBMs.

2 Total drug cost (sometimes referred to as discounted allowed cost) is the amount charged at the point of sale for a drug, and is typically the discounted ingredient cost plus applicable dispensing fees.

3 Put another way, this is the portion of drug costs covered by plan premium and/or member premium contributions, excluding member cost sharing. Any reduction in plan sponsor costs may be passed to members through reduced premium contributions or benefit enhancements.

4 Generic and some multisource brand drugs may be subject to maximum allowable cost (MAC) pricing. “Discounts” in this paper refer to effective AWP discount equivalents.

COINSURANCE PLAN

For the 20% coinsurance plan, discount improvements reduce both the plan cost and the members' per script cost sharing proportionally. Therefore, the plan realizes 80% (= 1 - 20% member cost sharing) of reductions in drug cost.

HIGH-DEDUCTIBLE HEALTH PLAN

Consider a drug benefit with a \$1,000 deductible after which 20% coinsurance applies. This benefit design results in the lowest realized value to the plan because, for scripts below the deductible, the member would realize the entire discount improvement through reduced out-of-pocket costs. In this example, that leads to an estimated 70% realized value.

Members taking a few generic medications throughout the year may incur most of their costs below the deductible, while members taking primarily higher-cost brand medications may incur more costs above the deductible. Therefore, plan sponsors may realize minimal cost savings from improved generic discounts but higher cost savings from improved brand or specialty discounts. Brand and specialty drugs are more likely to have costs above the deductible, where the plan sponsor realizes 80% of discount improvements, as opposed to realizing 0% of the discount improvement below the deductible.

A new direction with rebates

Rebates are another key driver of savings for plan sponsors. They are usually used to directly reduce the cost to the plan (i.e., 100% realized value), which is often passed to the member through lower monthly premiums. Due to the heightened scrutiny of rebates in government and commercial markets, some PBMs have started to offer plan administration options that allow for a portion of rebates to be applied at the point of sale to reduce member cost sharing. Recent communications and proposed regulations from the federal government have focused on banning post-POS rebates and moving the savings to the point of sale.⁵ These recent and potential market changes will affect the realized value of rebates.

Who benefits from realized value savings?

Plan sponsors must decide how to utilize potential reductions in plan cost due to PBM contract changes. Options include using savings to reduce member premium contributions, improve member benefits, mitigate recent large increases in drug costs, and build up surplus to guard the financial health and longevity of the plan. This can be a combination of sharing savings across all members, reducing cost sharing for certain members with claims, or reducing plan costs.

PBM contracting can be complicated and can affect both members and plan sponsors. Striking a balance between the long-term financial soundness of the plan and providing important healthcare benefits and support to employees is the ultimate duty of plan sponsors. Understanding the impact to key stakeholders allows plan sponsors to align contracting decisions with their employee benefit philosophy and financial goals.

Optimizing plan contracting value

Plan design plays a key role in determining the realized value of changes in PBM contracts, including discounts, rebates, utilization management, and other price concessions. Drug benefit designs can be complex, especially when taking into account utilization management tools like formularies, prior authorization, and step therapy.

Plan sponsors should devote significant resources toward PBM contract negotiation in an effort to manage rising drug costs. Estimating the realized value of potential contract terms for a plan sponsor's specific benefit structure and claims experience can help with making decisions that benefit the plan and the member holistically.

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⁵ See Milliman's white paper, "Changing the Rebate Game: A Primer on the HHS Proposed Rule to Shift Drug Rebates to POS," at <http://us.milliman.com/insight/2019/Changing-the-rebate-game-A-primer-on-HHSs-proposed-rule-to-shift-drug-rebates-to-POS/>.

Regulatory Roundup

Recent legislative impact on employer-sponsored insurance

[Milliman Employee Benefits Research Group](#)

DHHS issued final report, “Changes in Individual and Small Group Behavioral Health Coverage under Parity Requirements”

The Office of the Assistant Secretary for Planning and Evaluation and the Office of Disability, Aging, and Long-Term Policy of the U.S. Department of Health and Human Services (DHHS) released [Changes in Individual and Small Group Behavioral Health Coverage under Parity Requirements](#). The 90-page report assessed the degree to which behavioral health coverage and medical/surgical coverage in individual and small group plans changed after federal parity requirements took effect in 2014. The results focus on changes in scope of coverage (what conditions and services are covered) and level of coverage (quantitative restrictions, such as the copayment and limits on visits).

CMS released public use files on health information

The Centers for Medicare and Medicaid Services (CMS) released its [public use files](#) on health plan information (e.g., benefits, copayments, premiums, and geographic coverage), providing data on 2019 health insurance exchanges and rate review data for researchers and other stakeholders.

CMS issued 2019 cost-of-living adjustments for Medicare benefits (see [CAB: 18-3](#))

DHHS’s CMS [announced](#) cost-of-living adjustment figures for Medicare Part A and Part B for 2019. Some of the increases are in the chart below:

ITEM	2018	2019
Part A Deductible for up to 60 days	\$1,340.00	\$1,364.00
Part B Deductible	\$183.00	\$185.00
Part B Standard Monthly Premium	\$134.00	\$135.50
Part D National Monthly Average Premium	\$35.02	\$33.19

IRS’s Notice 18-85 contains the new PCORI fee

The IRS released a [notice](#) containing the Patient Centered Outcomes Research Institute (PCORI) fee of \$2.45 for plan years ending on or after October 1, 2018, and before October 1, 2019. The amount represents an increase from \$2.39 in the prior year.

Agencies published final rules on exemptions from the ACA’s contraceptive coverage requirement

The U.S. Departments of Treasury, Labor, and Health and Human Services published two final rules, addressing the [religious objection](#) exemption and the [moral objection](#) exemption under the contraceptive coverage mandate of the Patient Protection and Affordable Care Act (ACA).

IRS released 2019 inflation-adjusted limits for employee benefits

The Internal Revenue Service issued [Revenue Procedure 2018-57](#), which among other cost-of-living adjustments includes the 2019 limits for health flexible spending arrangements (FSAs) and employer-sponsored transportation benefits, shown in the chart below:

ITEM	2018	2019
Health Flexible Spending Arrangements (FSAs)	\$2,650	\$2,700
Qualified Parking	\$260	\$265

CMS provided guidance to help states with Section 1332 waivers

CMS issued [guidance](#), “Section 1332 State Relief and Empowerment Waiver Concepts,” which announces four relief waiver concepts designed to illustrate how states can waive certain ACA provisions under Section 1332 and develop alternatives. Under this new guidance, states may explore new healthcare programs aimed at reaching important goals, including strengthening their health insurance markets, expanding choices of coverage, and targeting public resources to those most in need. The four waiver concepts are: account-based subsidies, state-specific premium assistance, adjusted plan options, and risk stabilization strategies.

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HEALTH & WELFARE KEY DATES FOR APRIL 2019-JANUARY 2020**APRIL 1**

- 2018 Forms 1094-B, 1095-B, 1094-C, or 1095-C to IRS (electronically)
- Applicability of DoL's final rule for newly formed self-insured association health plans

JULY 31

- Send Form 720 to IRS for payment of the Patient-Centered Outcomes Research Institute (PCORI) fee (plan year ending before 10/1/2018)
- 2018 Form 5500 Annual/Return Report, unless extension applies

SEPTEMBER 30

- Summary Annual Report (SAR) to employees, unless extension applies

OCTOBER 14

- Rx Drug Creditable Coverage Notice to Medicare Part D-eligible individuals

NOVEMBER 1

- Open enrollment begins for ACA insurance coverage in 2020

DECEMBER 1

- Summary of Benefits and Coverage (plans without open enrollment) to employees

DECEMBER 15

- Open enrollment ends for ACA insurance coverage in 2020
- SAR to employees if Form 5500 filing date was extended

DECEMBER 31

- Notice of election to opt out of certain HIPAA portability requirements to CMS and to enrollees
- Deadline to make discretionary plan amendments for changes implemented during 2019
- Expiration of tax credit for qualifying health insurance costs purchased by eligible individuals, including Trade Adjustment Assistance recipients, PBGC pension recipients, workers with certain COBRA coverage, and spousal group health plan coverage

JANUARY 31, 2020

- 2019 Form W-2 to employees and to the Social Security Administration
- 2019 Form 1095-C/1095-B to full-time employees of "applicable large employers"/not full-time employees enrolled in self-funded group health plan (Note: Form 1095-C for 2019 has not been released)



IT TAKES VISION