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# A Transformative Year for Health Care

By Bruce Davis

The proposed acquisition of Aetna by CVS Health has been called transformative. So too has the rumor that Amazon will soon provide medications by working directly with drug manufacturers and bypassing Pharmacy Benefit Managers (PBMs).

A proposed rule by the Department of Labor (DOL), once finalized, may also prove to be transformative. Issued January 4, 2018, the proposed rule is intended to implement, at President Trump's direction, expanded access to small business health plans (a.k.a. association health plans or AHP) by disengaging AHPs from the separate states' small group requirements and ACA mandated essential health benefits. The news release posted on the DOL website promotes the proposed rules stating, ". . . employers may reduce administrative costs through economies of scale, strengthen their bargaining position to obtain more favorable deals, enhance their ability to self-insure, and offer a wider array of insurance options."

## Markets and cost structure

One of the biggest changes under the proposed rules is the ability of employers of any size, including sole proprietors, to band together for the express purpose of buying health coverage in the large-group market—regardless of where those employers are located.

A second important change is that employers would no longer have to demonstrate they are in the same business or belong to an organization that provides benefits or resources other than a group health insurance buying arrangement. Under the proposed rules, AHPs appear to offer great flexibility in form; they do, however, need to be a formal organization with a Board, bylaws, etc. Since the proposed rules indicate AHPs will be treated as MEWAs (multiple employer welfare arrangements) and the states currently have the ability to regulate MEWAs, will the final rules enable AHPs to also avoid state mandated benefits, similar to the ERISA preemption enjoyed by self-funded plans? And if AHPs are able to avoid both ACA and state-mandated benefits and thus, are less expensive, will they encourage termination of individual plans and destabilize Marketplace plans (i.e., healthcare.gov) and the small group insurance market?

The cost of buying health coverage through the AHP cannot be based on the health status of individual employees. Although the AHP could vary its rates between full-time and part-time employees or add a surcharge for employers in certain industries, presumably the claims experience of a new employer group could not be used to set the rates for that group. Employer comments on these proposed rules will drive their final form and determine to what extent rates for prospective groups can vary and whether merit rating structures (where renewal rates are derived from incurred loss ratio tiers) are permissible.

President Trump also directed the DOL, HHS, and Treasury in October to draft rules within 120 days to permit employers of any size—not just those with fewer than 50 employees—to contribute to an employee's health care reimbursement arrangement (HRA) and enable the employee to use this money to pay health insurance premiums. The HRA-related directive means an employee would have access to tax-free cash to pay for health insurance.

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This fosters a defined contribution approach that is attractive to many CFOs, as it enables them to extricate their organizations from health care trend rates that are several times higher than average wage/salary increases. As such, would this reenergize the use of private health insurance

exchanges and erode the number of employer-sponsored plans? Could the combination of the AHP and HRA rules lead AHPs to replace existing association plans and consortia sponsored by K–12 school districts, chambers of commerce, professional employer organizations, or other employer organizations?

Clearly, the health care market will change under the proposed rules. Undoubtedly, brokers, carriers, and TPAs with relevant experience in the association plan market are excited about the prospect of forming and selling the next generation of AHPs. The time has come to think beyond using a carrier-administered narrow network or having a health system and its TPA partner market directly to the employers using the system's Accountable Care Organizations (ACO) platform. Rather than replicate old models with broad-based PPOs (and their primary focus on discounts), or imposing higher, HDHP-style employee cost sharing (believing the covered members will magically become better health care consumers) a new approach is necessary for these AHPs (or any employer-sponsored health plan for that matter) to succeed and be self-sustaining.

## Forming a successful AHP

Hopefully, entities that underwrite, sell, and administer AHP plans have learned some valuable lessons about creating and maintaining successful plans. A key to success and long-term financial integrity is building strong ties that bind members to the AHP and discourage them from easily or quickly exiting the AHP for the promise of a better deal (i.e., lower rates). Sound underwriting procedures and discipline are necessary to keep AHP members together. Experience in the association or consortia plan space demonstrates that often employers that leave an AHP do not find greener pastures elsewhere. If a group does leave the AHP, it should be required to sit out for one or more years before it is readmitted.

To ensure a high level of member satisfaction and plan success, the AHP should provide highly trained care coordinators to explain coverage details and help participants navigate the health care system. This includes various aspects of "concierge" services, such as:

- Helping participants without a family physician select one who is taking new patients (and arranging for the first visit)
- Educating participants on how and when to use telehealth services and/or e-visits
- Encouraging participants to engage in biometric screenings and understand their numbers
- Linking participants to health coaches and case managers when appropriate
- Advising participants who are prescribed an MRI, CAT-scan, or PET-scan where they can have those tests performed less expensively (and calling to make the appointment)
- Arranging pharmacogenetics testing for participants with complex or chronic conditions to ensure newly prescribed specialty drugs will be tolerated
- Delivering Rx benefits to members using new low-cost and convenient channels, such as a health system's wholesale acquisition cost arrangements (or an Amazon-type solution if it comes to fruition).
- Promoting participant adherence to recommended treatment regimens

On-site health center are another beneficial design feature, especially when employees are not geographically dispersed. Employers may partner with other local employers to share in the cost to operate the center. AHP members will need to determine the scope of services to be offered, whether the employees will pay to use those services, and importantly, how to ensure employee privacy and confidentiality.

## Managing high cost claims

Knowing that a high percentage of health care spending is concentrated among a small portion of a group's population, focusing on high-cost participants can be beneficial for participants and the employer.

Insured employers with high cost claimants see the impact at renewal. It is essential that when they try to search for insured alternatives after receiving an onerous rate increase, employers see other carriers building the cost for ongoing large claims into their prospective rates. Self-funded employers cannot avoid the impact of large claims, either. Their stop-loss carriers will either laser those claims with higher deductibles or exclude them altogether. And

even though captive managers may admit the plan sponsor and agree to cover a lasered claim, the captive will likely require the employer to remain in the captive until the cost of covering that high cost claim is recouped.

To spread this risk, states could establish high-risk pools and require funding from all employers, consortia, and Taft-Hartley Health and Welfare Trusts. Each state could then promulgate rules on how large claimants are adjudicated. For example, a self-funded employer may choose to be responsible for the first $50,000 to $100,000 of eligible expenses; purchase reinsurance or stop-loss insurance for the next $50,000 to $400,000; and then the fiscal intermediary for the state-established high-risk pool would administer the remainder of expenses for the balance of the year.

For those participants whose annual medical and Rx claims exceed $25,000 (or some similar threshold), the plan could assign a Health Care Supply Chain Manager to facilitate and coordinate a personalized care plan using centers of excellence where possible. IDC Manufacturing published A Path to a Thinking Supply Chain, which discusses new, customer-centric supply chain models with direct selling to individual customers as “a real near-term possibility.” Health insurers and providers can turn to leading supply chain managers for guidance on using information and technology to deliver customized care in the most efficient manner.

## In perspective

If employers believe a health benefits offering (even if it is a defined contribution structure) helps them attract and retain qualified talent, then employers must demand more of the insurers and health care providers to deliver care solutions employees really want and need. By working together, all stakeholders in the healthcare continuum have the opportunity to find solutions to age-old problems and create effective plans that meet the needs of employers and their employees.

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