total control HEALTH PLANS®

THE RISK REPORT

March 2024 | **Volume 6** | Issue 3

Employee Benefits

Three Trends Driving Employers' Health Care Costs

PHARMACY SPENDING, high-cost claimants and newly developed anti-obesity drugs are expected to shape health benefits and affect the cost of care and health insurance for employers, according to a new report.

The "2024 Employee Health Trends" report by Springbuk, an online health intelligence platform, reflects concerns among employers and insurers about runaway drug costs due to increasingly expensive medications and new diabetes and anti-obesity drugs.

Also, the report looks at the effects of high-cost health plan enrollees, those who are high health care users either due to a chronic condition, cancer or an accident or illness that requires ongoing care.

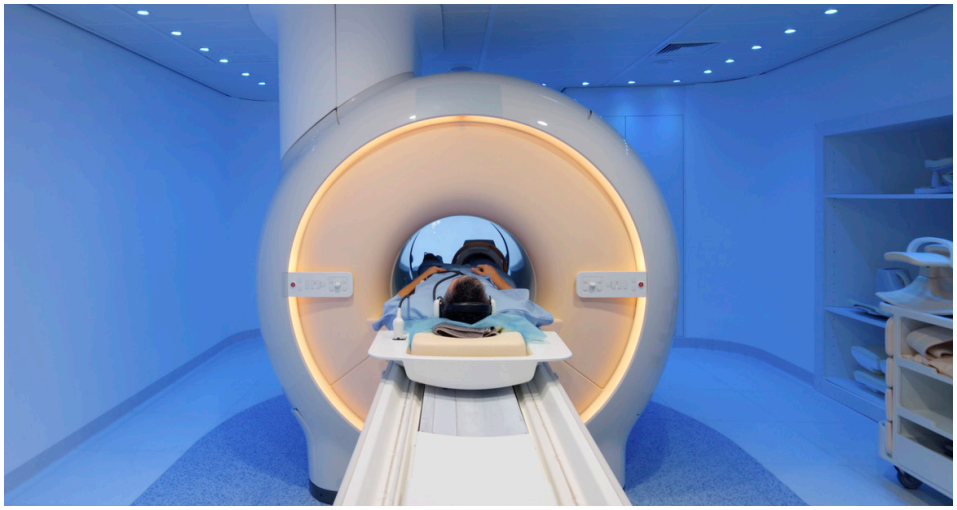
One such employee enrolled in one of your group health insurance plans can result in massive costs that overshadow those of the rest of your workforce if you are a small or mid-sized employer.

High-cost claimants

According to Springbuk's research:

- One out of every 1,000 health plan enrollees is likely to account for total paid claims of $340,000.
- Five out of every 1,000 members are likely to have total paid claims of over $140,000.
- About one in five members in each high-cost category was in the same category in the previous year.

Common high-cost claim conditions include cancers, multiple sclerosis, heart disease, sepsis, renal failure, psoriasis and diabetes, among others.



REPORT TIPS

- Understand the population at greatest risk of becoming high-cost claimants based on conditions and those with a history of being a high-cost claimant.
- To reduce surgical costs, the health plan can push for expert/second opinions, partner with a center of excellence, engage in payment-bundling arrangements, and more.
- Use risk-reduction programs (weight-loss, diabetes management).
- Use price transparency tools to determine which facilities are less costly, but make sure to consider the quality of care.

Pharmacy spending

Between 2020 and 2023, the average per member per month pharmacy spend increased 38% from $86 to $119. Two main contributors to higher spending are specialty drugs and brand-name medications for treating chronic conditions.

See 'Average' on page 2

total control HEALTH PLANS®

Total Control Health Plans

Phone: (616) 301-6757

E-mail: Info@/totalcontrolhealthplans.com

www.**totalcontrolhealthplans**.com

Tax Burden

Spread the Word About Additional HSA Contributions

IF YOU have staff with health savings accounts, they still have until April 15 to make additional contributions to their accounts if they want to reduce their tax bills for last year.

HSAs allow your employees to put away funds to pay for future medical expenses. Usually, these accounts are funded with pre-tax deductions from your employees' paychecks, but if they didn't max out their contributions last year, they still can do so up until the tax-filing deadline.

Under IRS rules, for 2023 employers and employees can contribute a combined $3,850 for single employees and $7,750 for families. (For 2024, the limits are $4,150 for single coverage and $8,300 for family coverage.) Since funds workers contribute to their HSA are made before their salaries are taxed, they reduce their overall taxable income.

Employees 55 and older can contribute an additional $1,000 every year as a catch-up contribution on both single and family plans.

One of the key features of these plans is that the funds in them can be carried over from year to year and can be invested like a 401(k) plan. Funds in HSAs can be used to pay for a myriad of out-of-pocket medical-related expenses, pharmaceuticals and medical devices. Withdrawals to reimburse for these expenses are also not taxed.

Not everyone is eligible to participate in an HSA. They are only available to employees enrolled in a high-deductible health plan. HDHPs feature lower premiums in exchange for a higher deductible, meaning the employees have to pay more out of pocket before coverage kicks in.

Remind your staff

Consider sending out a memo to your staff reminding them that if they didn't max out their HSA contributions last year, they can still do so until April 15.

Under IRS rules, even staff who didn't have an HSA last year are eligible to open one for 2023 and contribute funds to the account up until April 15. The only catch is that any funds they contribute can only be used for future medical bills after the account is set up.

The HSA administrator will generate the required tax forms that your employees will need to include when filing their taxes. There are two forms:

- IRS Form 5498-SA, which reports contributions, and
- IRS Form 1099-SA, which reports distributions taken out of the HSA.

Individual filers must also report the figures on those two forms on IRS Form 8889. ❖

Continued from page 1

Average Plan Spending to Treat Obesity Jumped 40% in 2023

Since the majority of drug spending is related to chronic conditions, strategies focused on their main causes can help rein in spending. These include offering programs that focus on weight loss, smoking cessation, diabetes management, etc. Other options include free gym memberships.

Other recommendations:

- Target brand-name drugs and specialty drugs in your cost-containment strategies.
- Ensure members taking specialty and high-cost brand-name drugs are using generic formulations and biosimilars where available, provided the net cost is lower.
- Understand the pharmacy benefit manager contract.
- Consider engaging with a clinical program partner that focuses on pharmacy savings opportunities.

One thing to consider about these medications is that they are helping your employees control their conditions and preventing complications or progression of the illness, thereby reducing other health care costs.

Obesity

More than 41% of Americans are considered clinically obese, defined as having a body mass index of 30 or more. Obesity is linked to a number of health conditions, which are all costly to treat, including diabetes, gastrointestinal disorders, heart disease, cancer and musculoskeletal disorders.

Enter highly expensive GLP-1 drugs, originally designed to treat diabetes, with one of their main side effects being that those who take them eat less and shed weight. As a result, demand for these pharmaceuticals has boomed, but not all health plans cover them.

Overall plan outlays for treating obesity jumped 40% in 2023 from the year prior, driven largely by an eye-popping 138% explosion in drug spending thanks to GLP-1 drugs.

You can take steps to reduce these outlays for treating obesity by using step therapy, which entails first starting a program that is focused on diet, exercise and behavioral modifications. If those efforts fail, traditional weight-loss medications may be considered before moving to GLP-1 drugs or bariatric surgery.

Consider partnering with a clinical program that addresses obesity .❖

New Legal Threat

Workers Sue Employer Over PBM Contract That 'Overcharged'

A NEW AREA of potential liability for employers was recently opened when a class-action suit was filed against Johnson & Johnson, accusing it of mismanaging its pharmacy benefit manager plan, resulting in the health plan and its enrollees overspending millions of dollars on medications.

Health plans contract with PBMs to tamp down pharmaceutical costs, but reports have shown that they often send enrollees to pharmacies they own and which overcharge for medications sometimes by thousands of percent.

PBMs have been drawing increasing flak from states' attorneys general as well as Congress and state houses, where multiple measures that would rein them in are in play.

If the lawsuit is successful, it could leave both self-insured and insured employers exposed to lawsuits by disgruntled employees who are forking out significantly more than they should.

The case

The class action, filed Feb. 5 in the US District Court for the District of New Jersey, accuses J&J of breaching its fiduciary duty under ERISA when it allegedly mismanaged its employee health plan by paying its PBM, Express Scripts Inc., inflated prices for generic specialty drugs that are widely available at a much lower cost.

The employees suing J&J cite a number of examples of how the company's plan overpaid for prescription drugs. One of the most egregious examples cited in the lawsuit was an instance when the plan paid more than $10,000 for a 90-pill generic drug to treat multiple sclerosis, which can be purchased without insurance on different retail and online pharmacies for $28 and $77.

"The burden for that massive overpayment falls on Johnson and Johnson's ERISA plans, which pay most of the agreed amount from plan assets, and on beneficiaries of the plans, who generally pay out-of-pocket for a portion of that inflated price," the plaintiffs wrote.

"No prudent fiduciary would agree to make its plan and beneficiaries pay a price that is two-hundred-and-fifty times higher than the price available to any individual who just walks into a pharmacy and pays out-of-pocket," they added.

It further accuses J&J of agreeing to terms under which plan beneficiaries were financially incentivized to obtain their prescriptions from the PBM's own mail-order pharmacy, even though that pharmacy's prices are routinely higher than the prices at other pharmacies.

THE ACCUSATIONS

The case accuses the company of:

- Failing to regularly put PBM services out to bid.
- Failing to negotiate favorable terms with PBMs and continually supervise PBMs' actions to ensure that the plan is reducing costs and maximizing outcomes for beneficiaries.
- Failing to periodically attempt to renegotiate PBM contracts.
- Failure to independently assess the PBM's formulary placement of each prescription drug and closely supervise the PBM's formulary management to ensure the plan is paying only reasonable amounts for each prescription drug.
- Improperly steering enrollees towards the PBM's own mail-order pharmacy, even though that pharmacy's prices were routinely higher than what retail pharmacies charge for the same drugs.

The fallout

Legal observers say that employers who purchase group health plans for their workers — that offer their employees insurance that includes one of the nation's large PBMs — could be targeted.

The driving argument would be that employers have been warned through news reports of how PBMs have been accused of not being transparent about their negotiated prices, and how they often pocket rebates that could be used to lower the plan's and enrollees' outlays.

Most at risk are employers that are in self-insured or level-funded plans. It's not clear yet how much liability insured employers may have, but they too could be accused of choosing health plans for their employees that contracted with PBMs that allegedly overcharge for medications. ❖

Administrative Lapses

Errors That Can Make Businesses Overpay for Coverage

ONE OFTEN overlooked cost driver to your employee benefits plans is administrative errors and oversights that are the result of sloppy record-keeping and a lack of checks and balances among your account and human resources teams.

If you are not diligent in keeping up with outgoing employees, are not paying enough attention to admin details and checking billing for errors, and are not reviewing accounts regularly, you could be leaving money on the table unnecessarily and overpaying for your group health insurance and other employee benefits you offer.

The following are some of the most common administrative mistakes that could lead to overspending on your group health plan.

Failing to keep up with staffing numbers

If your human resources and accounting are not talking to each other, you risk failing to account for personnel that leaves and continuing to include them in the health insurance roster and paying their premium.

Obviously, this is typically not an issue in a small organization of, say 10 to 15 employees, but the more workers you have, the easier it is for one to slip through the cracks after they leave.

Consider having HR review personnel numbers monthly and updating your files to avoid this happening.

Failing to check for 'age-outs'

Workers who have turned age 65 may not require your company health plan anymore, since they are eligible for Medicare. You can reduce health care administration and benefits costs substantially by keeping an eye out for age-outs each year.

Missing changes to plans

Before and during open enrollment it's important to review all of the benefits plans that you offer — health, dental and vision coverage — to make sure there aren't any changes that will increase the cost of the plans.

Sometimes a plan will introduce additional coverage that your employees may not need and, if you are not staying on top of changes, you may miss the opportunity to move them to another plan.

Insurance company errors

Administrative mistakes made by the insurers you contract with can be overlooked, forcing you to overpay for your employees' coverage.

Your accounting and HR teams should regularly audit your insurers' billings to check for errors and ask the companies to correct any that are found. One of the most common mistakes is for an insurer to have an incorrect employee count. But the carriers can make other mistakes in billing, too.

If you notice an increase in your monthly bill with no new staff additions, you may want to delve deeper.

The takeaway

By putting in place administrative controls and a regime for regular billing and personnel-count auditing, you can avoid mistakes that add to your employee benefits costs.

Keep an open line of communication with your insurers in case you need to work with them to address any issues that arise. ❖