Health Care Overview

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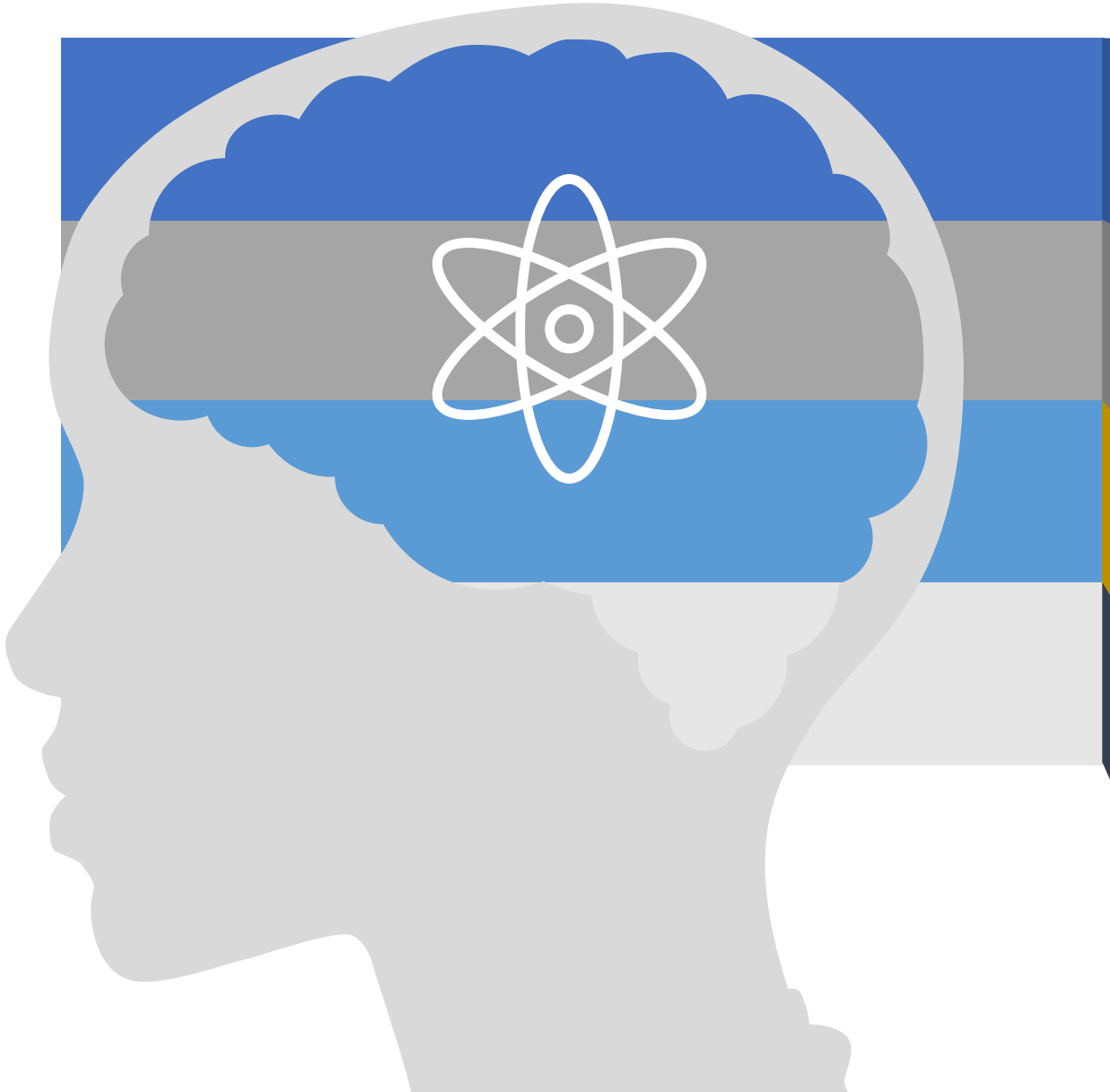
Agenda



01 Insight

- What are the key Issues with Healthcare in the US
- Where the health costs lie?
- Employer Health Care Cost increases

02 Models

- Self-Insured vs. Fully-insured Model
- Pharmacy Broker Model

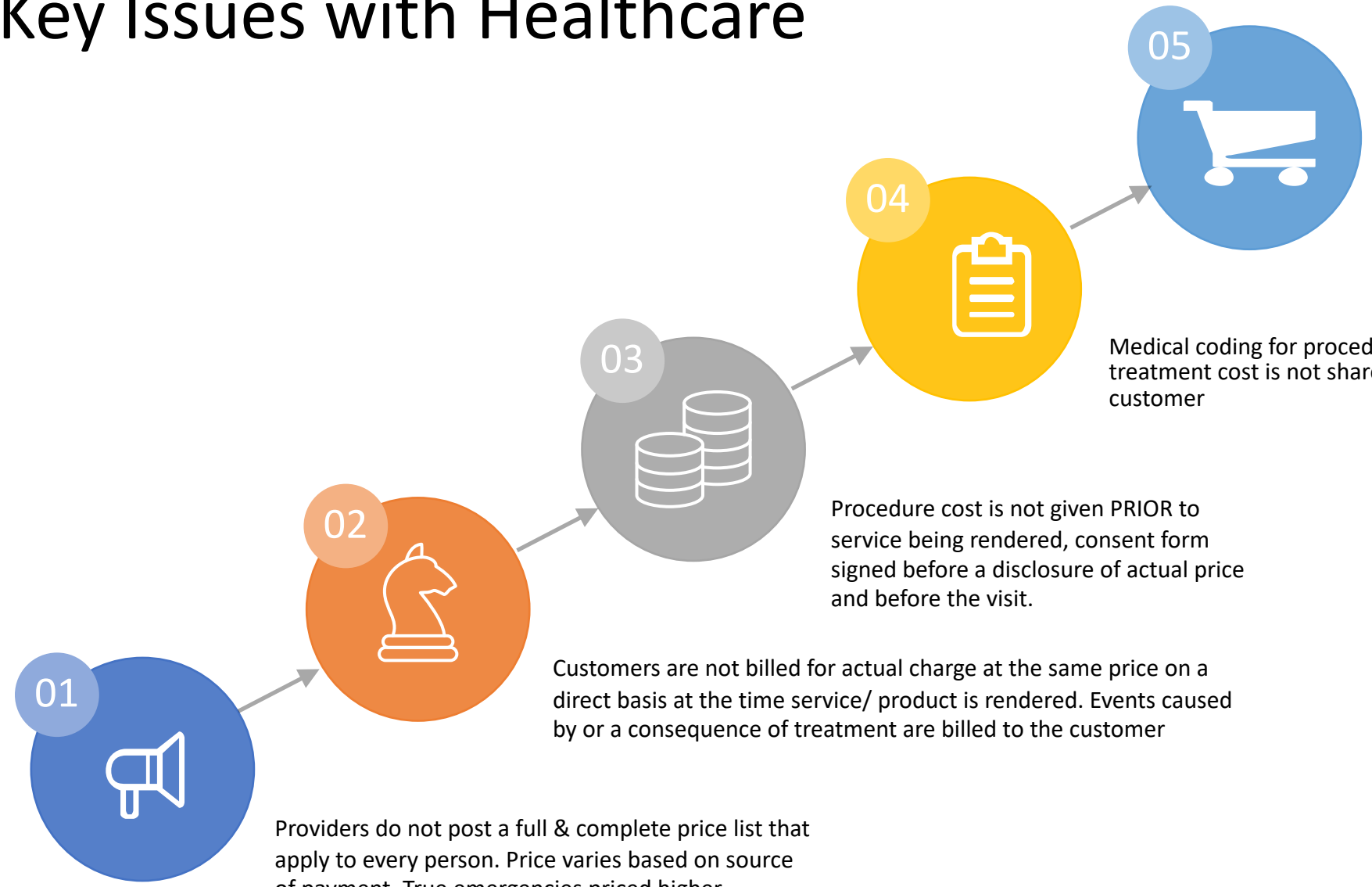
03 Innovation

- What are the alternatives?
- Recommendations for PBM

04 Back up slide

Insight

Key Issues with Healthcare



Providers do not post a full & complete price list that apply to every person. Price varies based on source of payment. True emergencies priced higher.

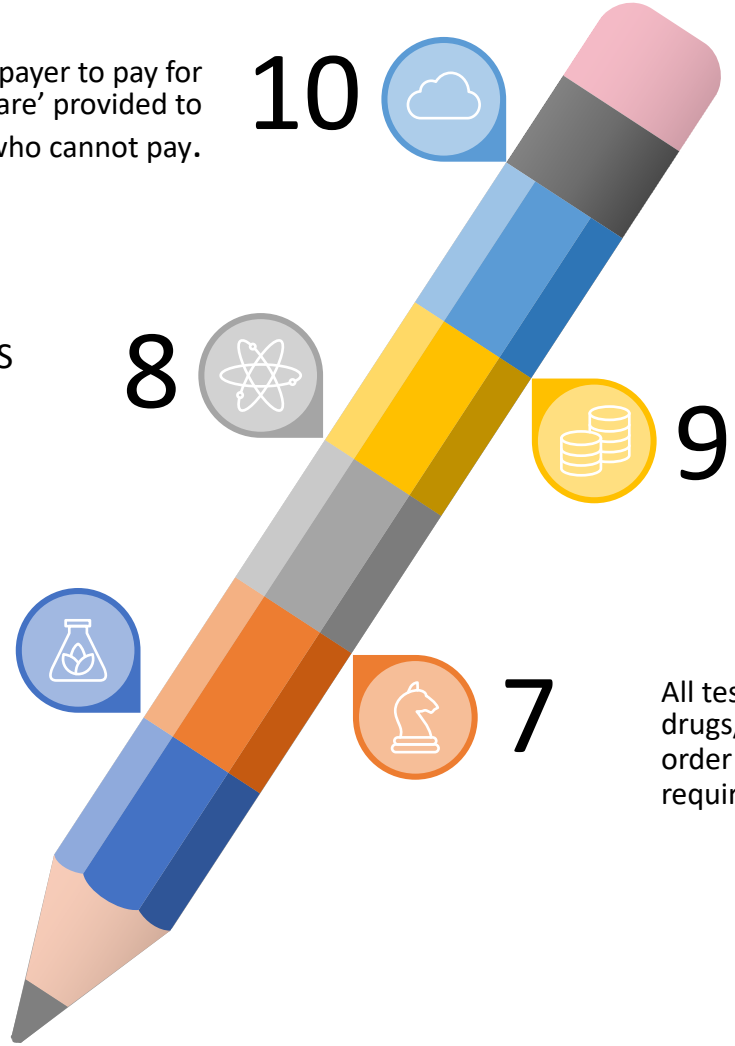
Customers are not billed for actual charge at the same price on a direct basis at the time service/ product is rendered. Events caused by or a consequence of treatment are billed to the customer

Procedure cost is not given PRIOR to service being rendered, consent form signed before a disclosure of actual price and before the visit.

Medical coding for procedure and treatment cost is not shared with the customer

Consumers cannot shop for price, outcome or quality as procedure counts, complications and outcomes are not published

Key Issues with Healthcare



10 EMTALA forces the tax payer to pay for 'uncompensated care' provided to illegals and people who cannot pay.

8 Whole sale drug pricing in the US is substantially higher than elsewhere in the world (50-90% higher)

9 Government funding for treatment of Lifestyle choices like obesity, type 2 diabetes cost 25% of Medicare/ Medicaid dollars ($350-400 billion a year of federal spending). Medicare and Medicaid cost is subsidized by employee paid or private paid cost

6 Anti-trust and consumer protection laws are NOT enforced

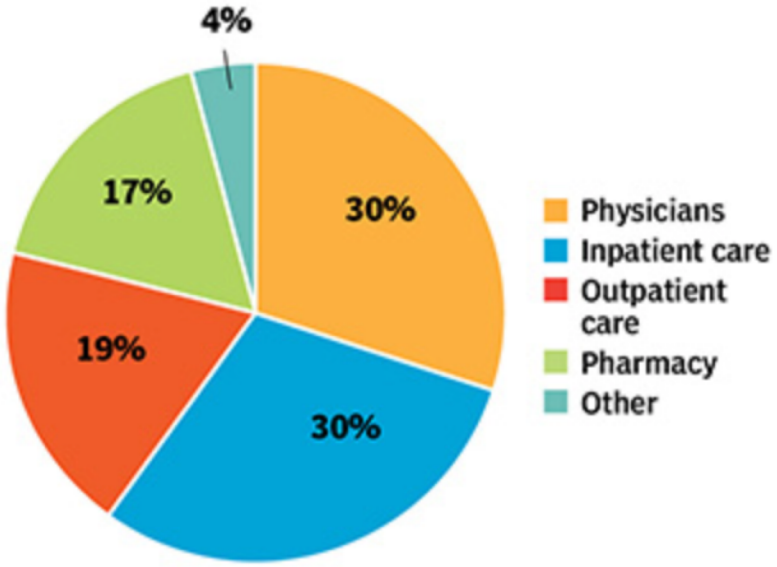
7 All test and diagnostic that carries no exposure to drugs/ radiations, are non invasive require doctor order or prescription and many times aux services are required to be purchased at the point of use

Where the health costs lie?

Top Cost Management Priorities

Where the Health Costs Lie

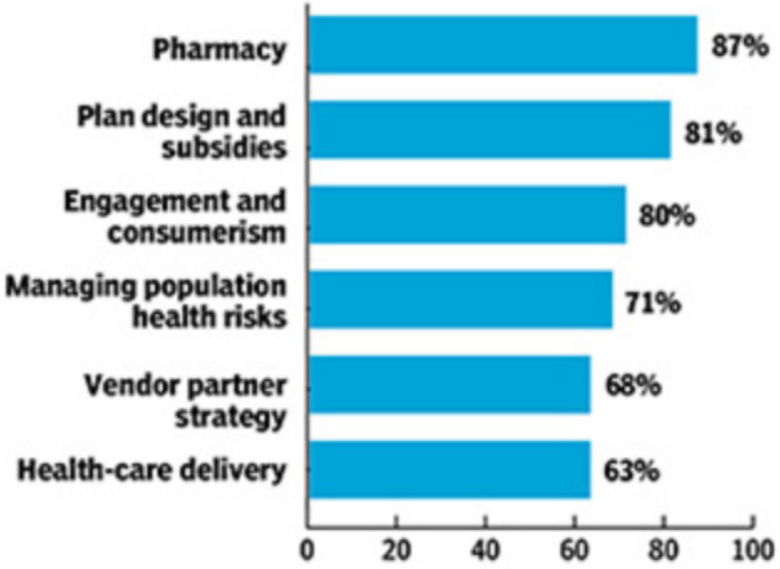
Roughly half of all medical costs are projected to come from hospital spending: 30% from inpatient and 19% from outpatient care.*



*Projections for 2017
Source: PricewaterhouseCoopers Health Research Institute

Top Cost-Management Priorities

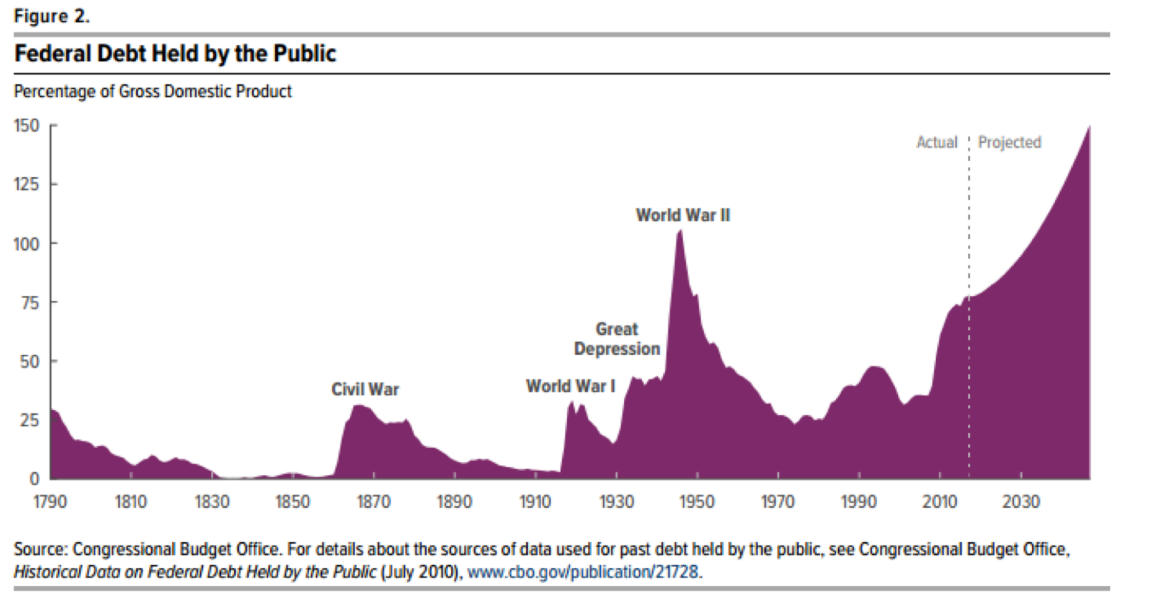
Controlling rising pharmacy costs over the next two years is of greatest importance to organizations.*



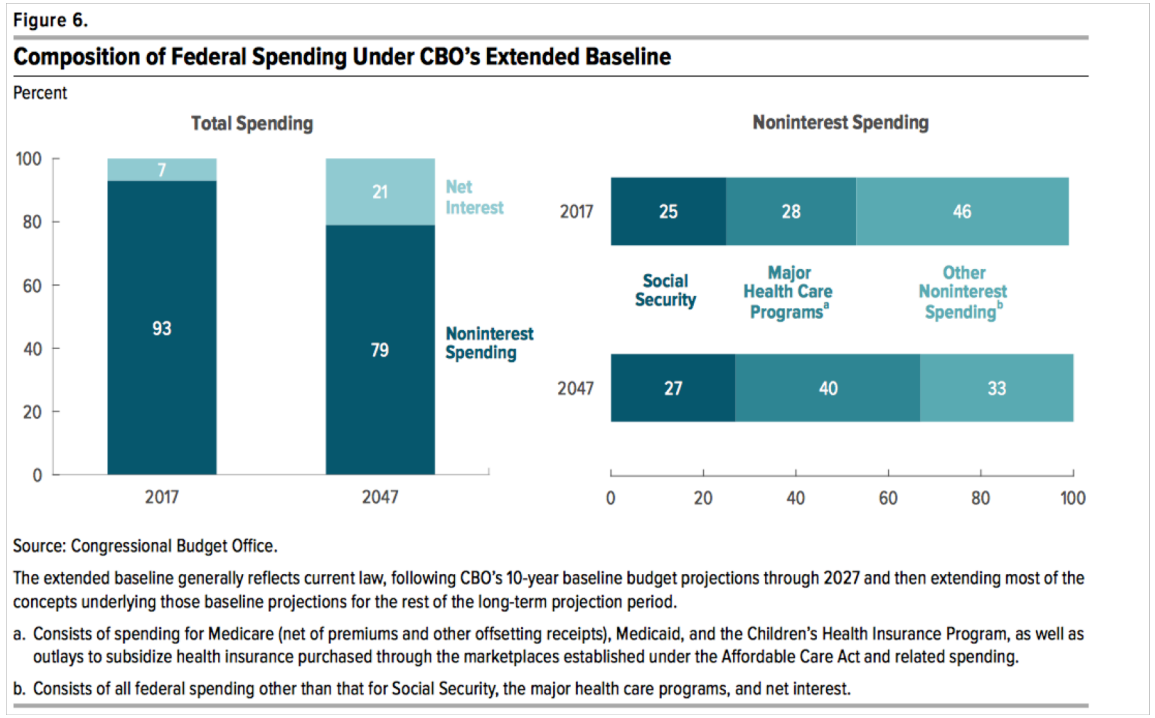
*Percentage rating management of a given health-care cost at 4 or 5 on a 5-point scale (5=highest priority)
Source: Willis Towers Watson

How big is the problem?

National Healthcare cost increases will break the Nation! CBO Link (click here)



- Federal Debt is already at 75% of GDP in 2017.
- By 2047, Fed debt will be at 150% of GDP
- By 2047, Major health care program would have grown from 28% to 40% of the Non interest spending!!!
- By 2047, Non interest spending will 79% of total spending
- The biggest white elephant in the room is HEALTHCARE!



How big is the problem?

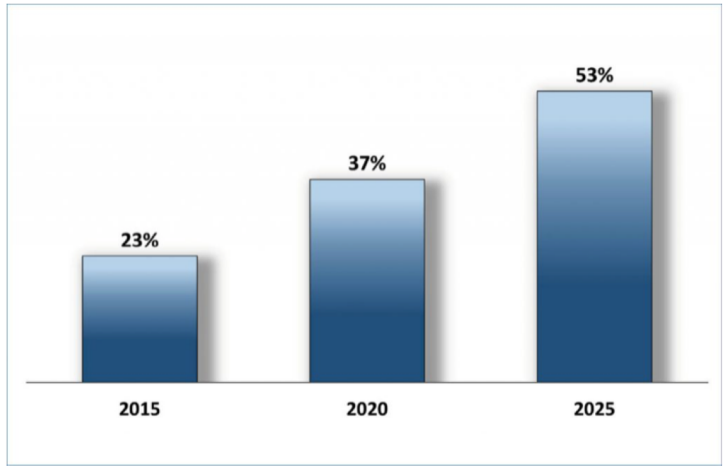
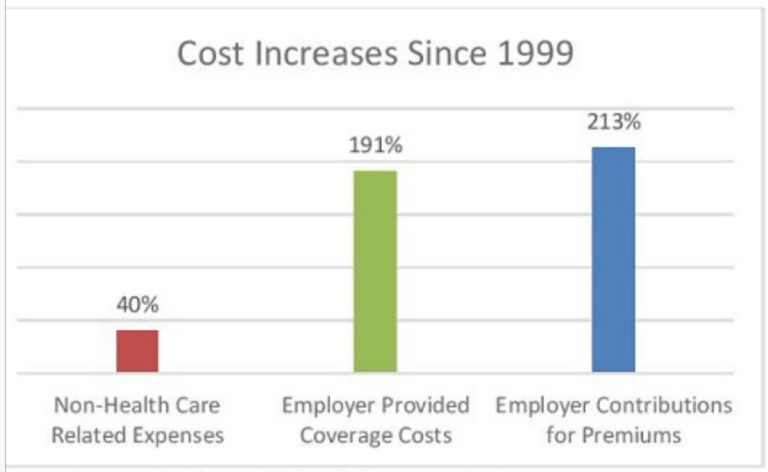
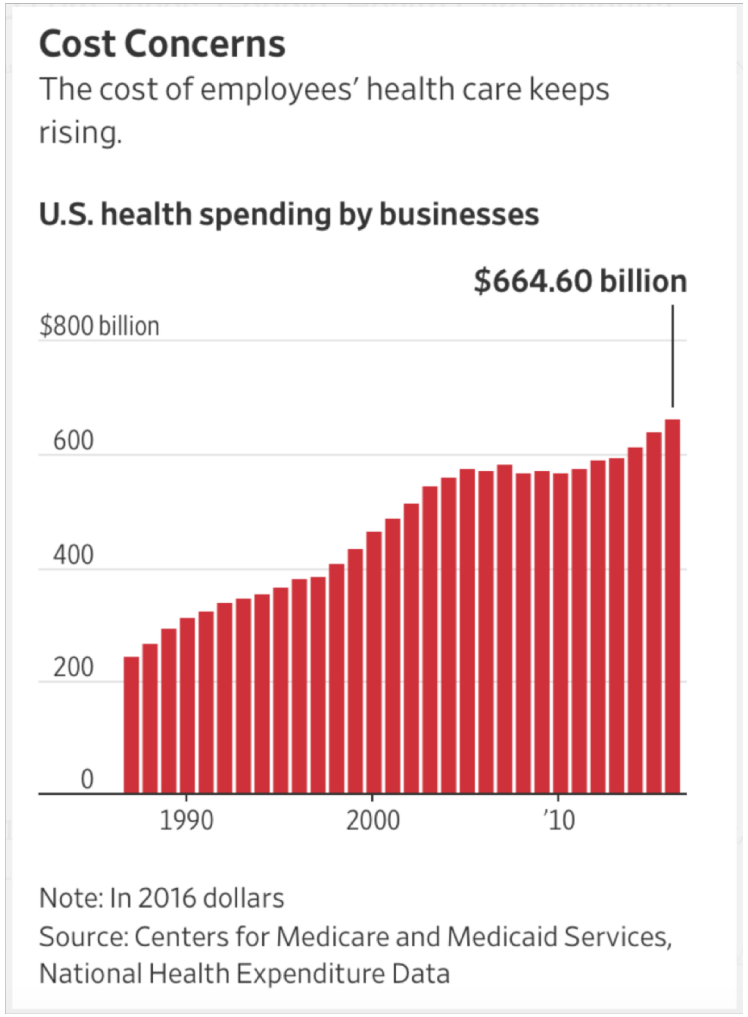


Fig. 2. Percentage of family heads whose employer-sponsored healthcare may exceed 9.5% of their income. Source: American Health Policy Institute



ource: Bureau of Labor Statistics; Kaiser Annual Employer Survey

Fig. 1. HTA is focused on the cost rise in healthcare under employer benefit plans



- Shifting costs to employees, offering wellness programs, and adding consumer-directed health plans (CDHPs) to the benefits mix — may be nearing the end of their useful life.
- Employer related Health Care Cost increases 4% avg YOY
- U.S. health-care sector, which represents 17.9% of the gross domestic product

Existing Models

How do the different models work?

Self-Insured vs. Fully-insured Model

- **Self-insured model**
- Employer pays a PEPM fee to Insurer
- Employer is billed separately for all insurance claims. Monthly amount is estimated based on previous years claims and is trued up monthly
- Estimate budget, will pay more/less based on actual claims

- Aetna Medical PPO, HDHP, HSA, Stop Loss, Telemedicine
- Delta Dental
- VSP Vision
- Sedgwick STD & LOA

- **Fully-insured model**
- Insurer quotes a flat fee per employee – based on past claims experience
- Annual premiums may go up/down based on previous year claims experience
- Know the actual budget, pay the flat fee for that entire year regardless of claim amounts

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- Kaiser HMO California & Hawaii
- Cigna Life, AD&D, LTD
- Most policies outside US

Overview of PBM (Pharmacy Broker Model)

1. Prescription-drug spending is of particular concern as cost is increasing 6-8% on an average.
2. Companies hire middlemen called pharmacy-benefit managers, or PBMs, to negotiate discounts and rebates on drug prices from pharmaceutical companies and retail pharmacies.
3. PBMs also try to keep costs down by steering patients to lower-cost treatments, such as generics or brand-name drugs with the largest rebates.
4. But PBMs often keep a portion of the discounts they negotiate with drug makers, without always divulging how much they're keeping. The contract terms PBMs cut with employers can vary widely.

Innovation

Alternative Models

- Health Transformation Alliance (HTA)
- Accountable Care organizations (ACO)
- Hub of Support
- Direct Care
- PBM Best practices

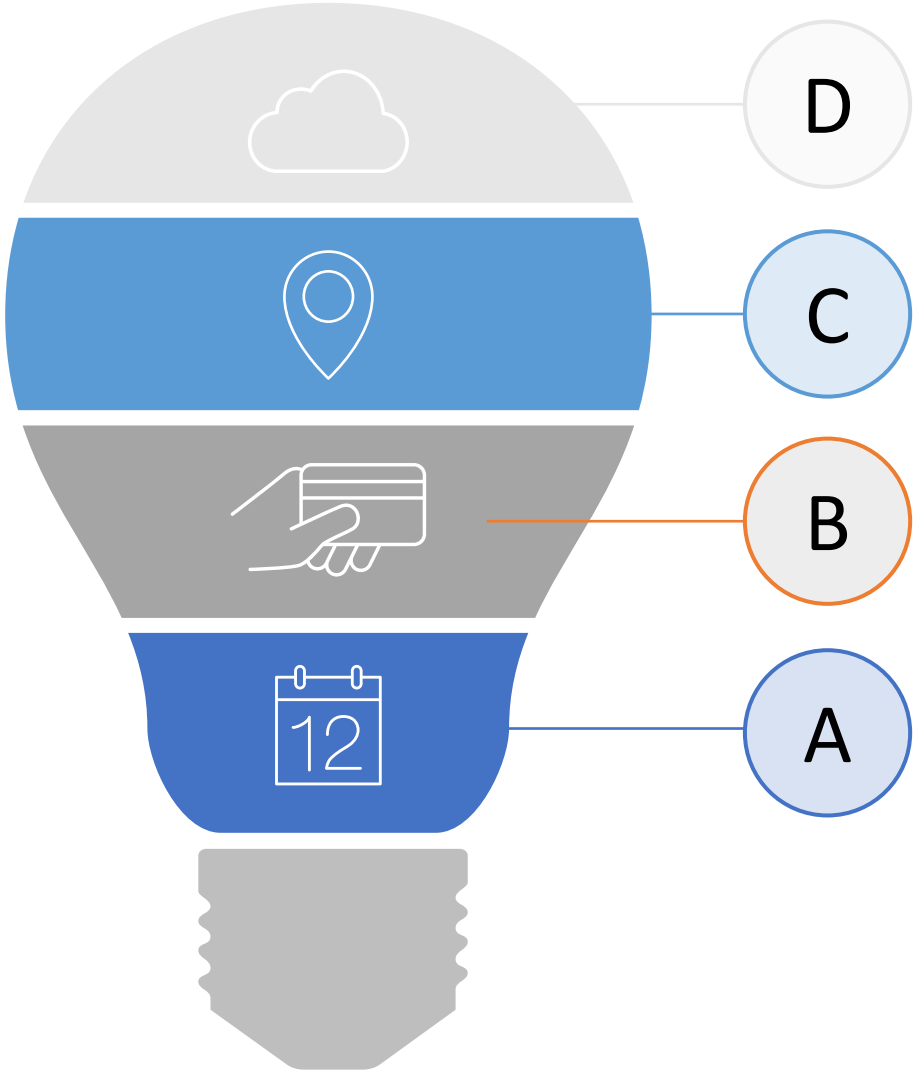
Health Transformation Alliance

An alternative Model

Objective

To achieve transformation through transparency, better quality, lower costs, and by being focused on outcomes rather than revenue.

Healthcare providers, both medical and pharmaceutical, compete on the basis of above objective to qualify for the right to serve its members



D — **Member/Owners**
40 companies + 6M emp

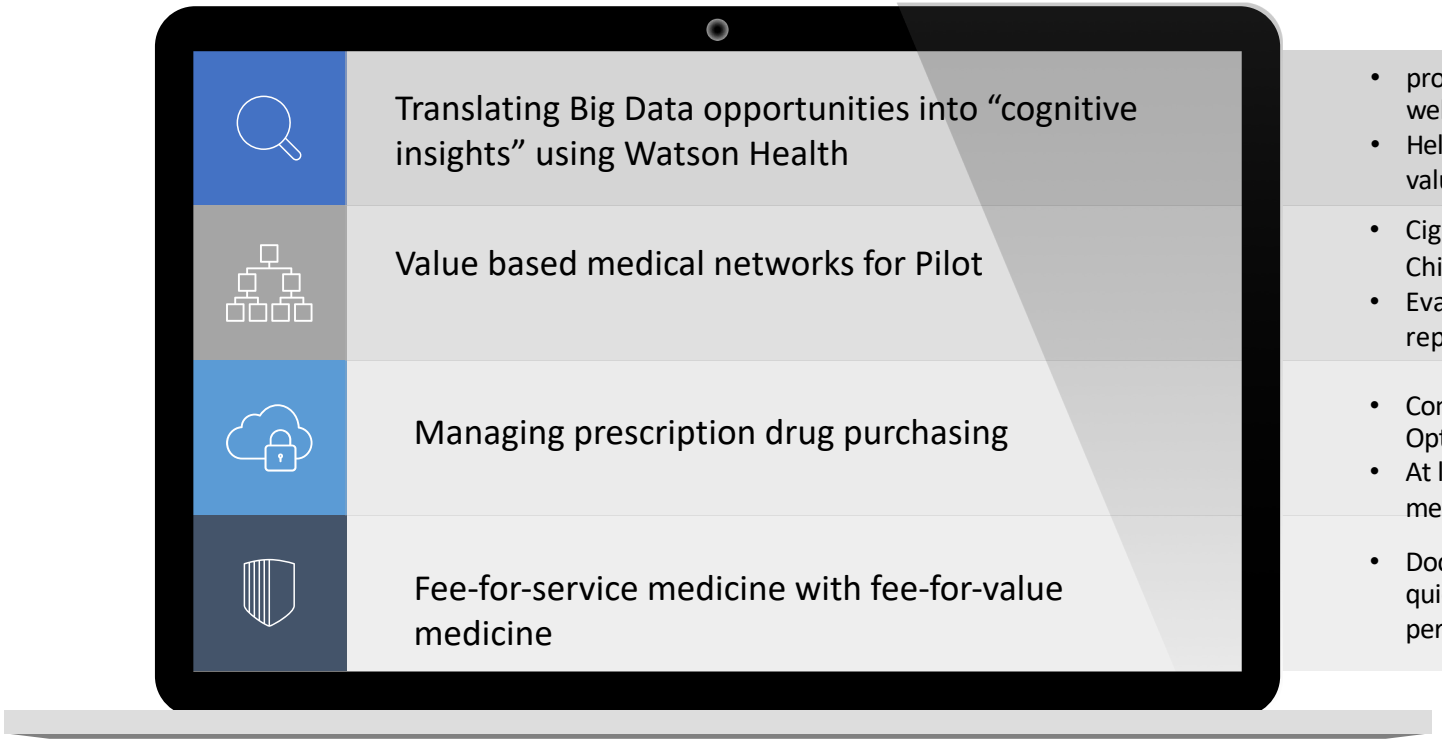
C — **Network**
US Based + US Pilot

B — **Better healthcare**
Low cost + Better quality

A — **Timeline**
Started 2 year back

Overall Goal of HTA

Specific steps in reaching the goal



Translating Big Data opportunities into “cognitive insights” using Watson Health

- provides insights both into outcomes of medical interventions, as well as wellness initiatives to improve employees’ health.
- Help member companies choose the drugs and doctors that provide the best value

Value based medical networks for Pilot

- Cigna and UnitedHealthcare, and the Dallas/Ft. Worth, Phoenix and Chicago markets
- Eval four common healthcare therapies: Type 2 diabetes, hip and knee replacement, and back pain, (40% cost)

Managing prescription drug purchasing

- Contracting with two pharmacy-benefit managers, or PBMs (CVS Health and OptumRx, to provide lower prices and more transparency on fees and rebates.
- At least $600 million over three years (14%–15% of total drug spending, on median, for the employers)

Fee-for-service medicine with fee-for-value medicine

- Doctors are paid based on how well they meet certain targets, such as quick recovery times, rather than for each procedure and test they perform.

ACO (Accountable Care organizations)

Are regional or local groups of medical providers — doctors, hospitals, clinics — intended to provide coordinated health care with higher quality and lower costs

Employer-ACO arrangements differ in the details, but the following elements are fairly common:

- The ACO and employer negotiate pricing, as well as quality and cost targets. The provider network gets a share of savings if results are on the positive side of the targets, and bears the risk for poor results. Less of the ACO's total compensation is derived from fees for service. The lion's share of pay is by reducing cost and improving quality
- Plan participants and employers benefit from coordinated care provided through a narrower network than those offered by big insurers like Aetna or United Healthcare. One effect of that is fewer duplicative or otherwise unnecessary diagnostic tests.
- Patients with chronic, costly diseases like diabetes and asthma receive individual attention from an ACO care manager.
- Employees can choose a more traditional health plan but get discounts when they use the narrow network — on the pricing of services, co-payments or deductibles, or some combination of those.
- Network providers share patients' electronic medical records, a feature that's often missing from traditional health plans even though it can improve the quality and cost of care.
- For ACOs, a direct contract makes sense only if an employer has enough workers in a location to drive meaningful market share.

Hub of Support

Can results in an average of 8.6% lower medical cost inflation than the market trend

- “Interpersonal hubs,” in which an employee calls a single number for any health care-related issue. The first time an employee calls, even if it’s for something simple like ordering a new insurance card, he or she is assigned to a specific health coordinator. That person will remain the employee’s advocate for all future inquiries and can help him or her navigate through all the health options the company offers.

- These individuals build enough trust and 4 times higher engagement with employees that they get to know the issues in their lives. The advocate also steers plan members to value-based providers and otherwise looks to hold costs in check for both employee and employer.

- The service is often provided by a third party under a contract with a health insurer. The best-known third parties are Accolade and Quantum Health.

- Among the employers that recently began offering such a hub is pharmacy chain Walgreens Boots Alliance.

Direct Care

The subscription fee covers almost all primary care services including clinical, laboratory, consultative services, care coordination and comprehensive care management.

- Retail health-care service providers that market themselves to patients as convenient and typically low-cost are also helping companies control expenses.

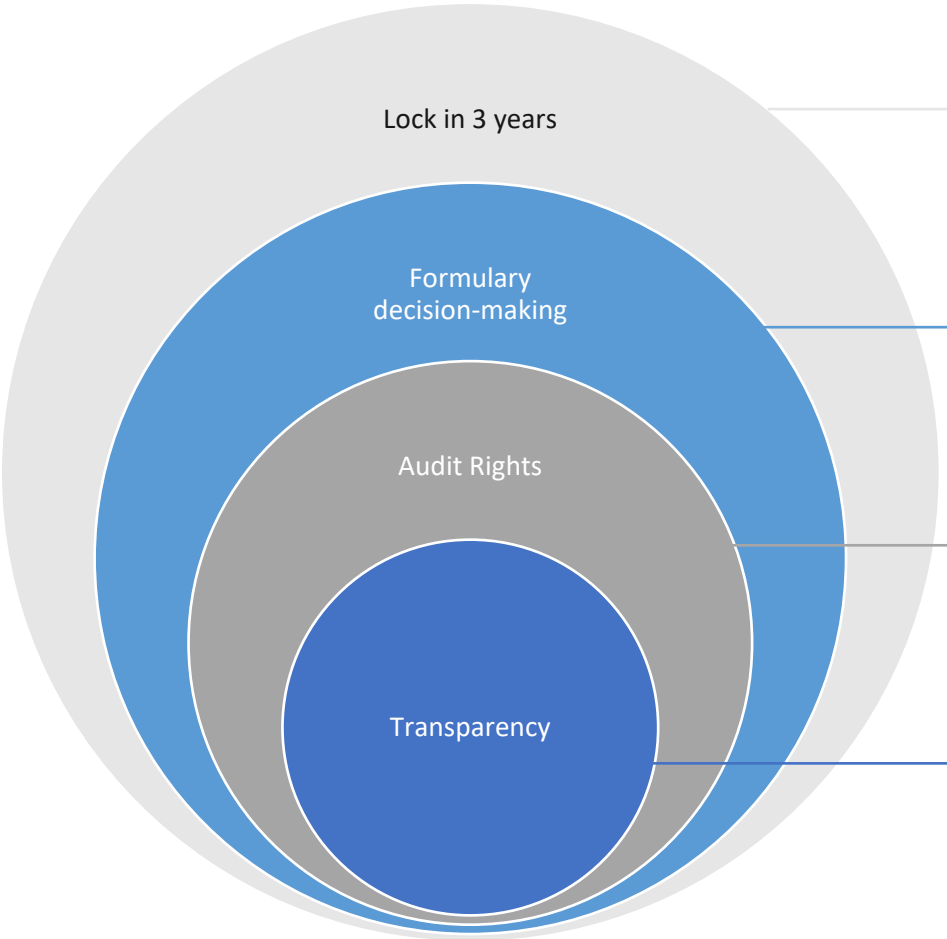
- The providers in this “direct care” model can make it worthwhile for employees to pay out of pocket and bypass insurance. Single episodes of care might be priced at $79 or $99.

- Contract for low prices with providers of other services employers know they’ll need in abundance, such as physical therapy and chiropractic care.

- Direct care enables companies & TPA to avoid specialty costs by creating an earlier pathway to nurses, physical therapists, and chiropractors.

PBM Takeaways/ Recommendations

Key things to consider in the contract with PBM



Aggregate Demand
Lock in rates for 3 years.

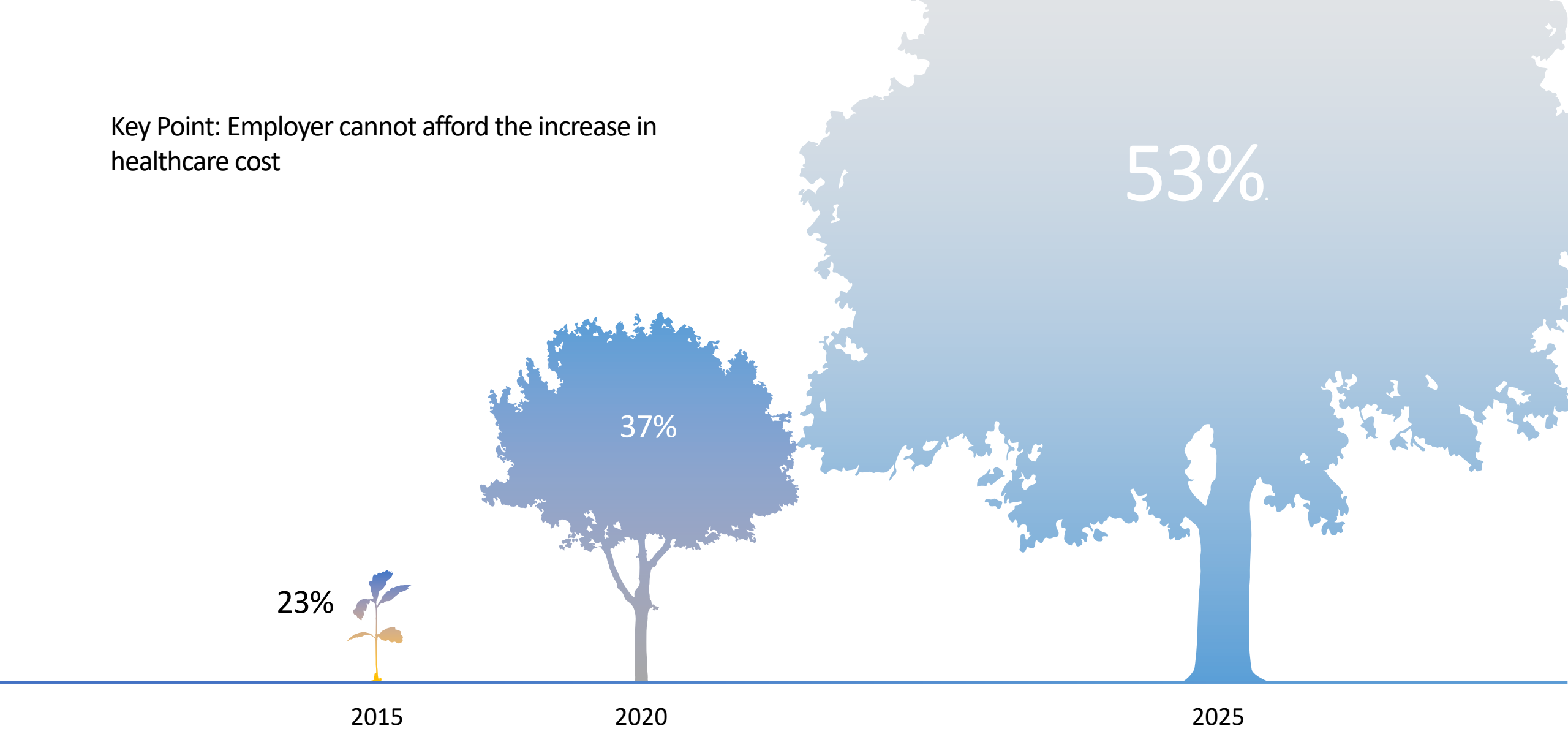
Have a Seat on the table:
Company + committees deliberate formulary placement

Insist on Detailed Audit Right
Tie it with their fee, not just ‘white glove’

On Rebates and Discounts
True transparency on what the client paid

End

Key Point: Employer cannot afford the increase in healthcare cost



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