Custom Design Benefits

Innovative Cost Containment Solutions for Employee Benefits

+Inside

NEWSLETTER

Q4 | 2021

Executive Spotlight

They say fall is a time for new beginnings – a time to recharge and renew the mind, body and spirit.

The same could be said of our 14th Annual Customer Conference, which was held in September at the Hard Rock Casino in Cincinnati, OH.

At this year's conference, we reconnected and provided helpful information employers and their brokers could use when considering benefit plan changes for the upcoming year. We talked about what's working, what isn't and discussed ways we can continue to improve the quality and affordability of care.

We hope you were able to join us for this great event. But if you happened to miss it, you're in luck. In this issue, we have included recaps from our speaker sessions so you can stay up to date on the latest trends and issues. This year's topics ran the gamut from specialty pharmacy costs and mental health, to balance billing and the No-Surprises Act.

We also provided data on the impact of COVID-19 on medical claims, new COBRA legislation and an update on proposed changes to the Family and Medical Leave Act.

On October 1st, Custom Design Benefits celebrated a 30-year milestone of providing self-funded health insurance solutions and consumer driven services for the Tri-State Area. It was a great opportunity to take stock of how far we've come while discussing the need to explore larger office space for our expanding staff and operations.

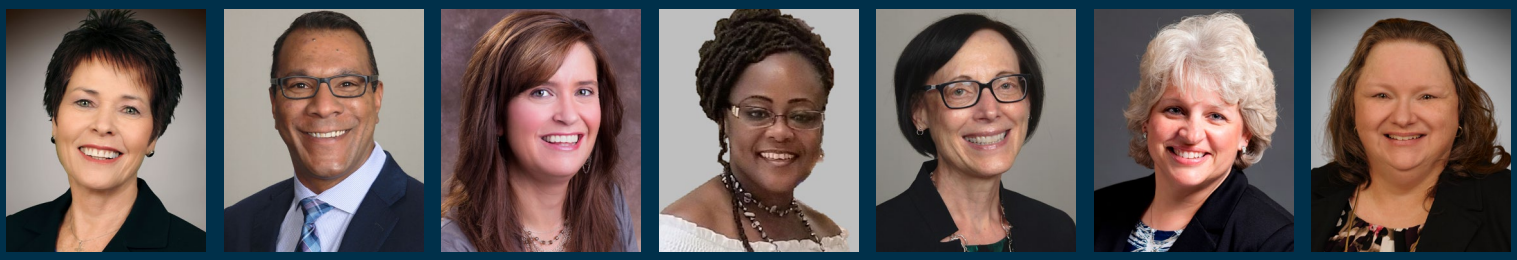
Thank you for your continued partnership. Together, we can take on these exciting new challenges and do what is needed to "take charge" of future health care costs.

Yours truly,

Julie

Custom Design Benefits Marks 30-Years of Service

CDB leadership team



Julie Mueller | Steve Fiorino | Amanda Guinan | Alberta Manga | Terri Martin | Karen Murphy | Deb Williams

On October 1, we celebrated 30-years in service to the greater Ohio, Indiana and Northern Kentucky markets as the area's largest independent third party administrator of self-funded health benefit plans.

Much has changed since our founding in 1991. Starting out as a small boutique firm, we quickly developed a reputation for helping employers and their brokers navigate the costly and difficult process of providing health care benefits to their employees. To keep up with the changing times, we offered more services, added new clients to our portfolio and expanded staffing levels.

Over the years we've been fortunate to be recognized several times as a "Top Workplace in Cincinnati," by the Cincinnati Enquirer and a "Top 10 Benefits Administration/Consulting Service Company" by Manage HR Magazine.

While we're a little wiser at 30 than we were at year one, one thing is certain – we haven't stopped growing and focusing on providing excellent customer service and innovative solutions. As such, we are currently discussing the need to expand into a larger office location. "It's a good problem to have because it means more employers than ever are looking for outside-of-the-box alternatives to their current health care plans," said Julie Mueller, President and CEO of Custom Design Benefits.

"For 30 years, CDB has been pioneering a new direction through self-funding, strategic cost containment and benefit plans designed to meet the needs of today's workforce," said Mueller. "Our vision is to continue to be an employer of choice while serving our clients, brokers and community for years to come."

Congratulations to Our Portal Contest Winners!

To encourage portal usage, self-service and customer satisfaction, we asked employers to raise their percentage of enrolled portal members throughout the month of October.

For every 10% increase* in enrollees, employers were given 1 entry into a drawing to win gift cards for the employer's HR team (or to be shared as desired). Gift cards were awarded to the following sets of winners for two portal categories – the CDB Web Member Portal and CDB Custom Flex Member Portal.

CDB Web Member Portal

$250 Gift Card
Kemba Credit Union

$150 Gift Card
Jefferson County

$100 Gift Card
Towne Properties

Custom Flex Member Portal

$250 Gift Card
Kenton County Fiscal Court

$150 Gift Card
Alexander Mann Solutions Group

$100 Gift Card
United Wheels/Huffy

**Using number of members enrolled as of 9/23/2021 as a baseline*

The 14th Annual Customer Conference

Thank You to our Customer Conference guest speakers:

- Dr. David Galardi, Paydhealth
- Dr. Marc Whitsett, The Ridge
- Darsey Stump, The Ridge
- Mary Piecuch, Payer Compass
- Ron Peck, The Phia Group

Thank You to our Customer Conference panelists:

Beefing Up Patient Care: How Near-Site Clinics are Driving Better Patient Outcomes

- Frank Birkenhauer, Township Administrator, Green Township
- Joe Shriver, County Administrator, Kenton County Fiscal Court
- JeNelle Gouvas, Director of Business Development, Premise Health
- Dr. Ed Schwartz, National Medical Director, Premise Health

Stop Loss – Today and Tomorrow

- Horace Garfield, D.W. Van Dyke & Co. (Moderator)
- Tom Gage, National Underwriting Services
- Mike Meloch, TPAC Underwriters
- Brian Miller, Partners MGU

Customer Satisfaction Survey

Winner of $250 Gift Card

Jim Stahl, Maple Knoll Communities, Inc.







Q&A: *Near-site Clinic*

There were so many great questions that were submitted for our near-site clinic panel discussion. Unfortunately, due to time constraints, we weren't able to address all of them at the conference. Here are some of those questions and our answers:

1. **Can the clinic be used for walk-in situations instead of urgent care?**

   Yes, but it depends on the goals of the client. If a client wants individuals to get back to work as soon as possible, then it is vital to manage on-time patient care. Walk-in appointments can be difficult to accommodate. At many sites, we block off a limited number of same-day appointments that can only be scheduled that day.

2. **For a company with employees in different cities, is it possible to set up a multi-city arrangement with Premise Health?**

   This would be a great case for Virtual Primary Care (digital health) to be included in the offering. As for near site clinics, this would need to be investigated further based on the particular location and footprint.

3. **Does Premise Health have a position on whether patients with HDHP's should be charged some sort of Copay?**

   Members under HDHP's aren't typically getting "free" care. We follow the federal laws in this area based on client needs. Most do charge a fair market value for non-wellness and non-included chronic care conditions (in accordance with Executive Orders). We generally see charges from $25-$75, but it is up to the client to determine the case rate charge based on guidance from their attorneys.

Speaker Highlights:

Grabbing Specialty Pharmacy Costs by the Horns with Patient Assistance Programs

Dr. David Galardi, Paydhealth

Paying for high-cost specialty drugs has long been a challenge for employers.

But according to David Galardi, Pharm.D., there's a strategy that can be used to improve access and better manage costs through what's known as alternative funding. Alternative funding is now found in two main forms: copay assistance programs (CAP) and patient assistance programs (PAP).

The alternative funding market is currently valued at $20 billion, with more than 10,000 programs covering almost all specialty drugs. The market is growing at 17% year-over-year and gets funding from some of the largest pharma and tech companies in the country: Pfizer, Merck, Gilead, Google and Microsoft, just to name a few.

A main difference between CAPs and PAPs concerns a drug manufacturer's ability to influence a patients' choice of a specific drug. Manufacturers cannot provide CAPs to beneficiaries of government programs such as Medicare and Medicaid. However, the same beneficiaries can be eligible for some PAPs.

Q&A: *Grabbing Specialty Pharmacy Costs by the Horns with Patient Assistance Programs*

1. **What are some criteria for the plan member to qualify?**

   Generally, fully funded benefactor programs will have more complex eligibility criteria than price concession programs such as coupons/co-payment care programs. Some areas that may be of interest within those criteria include: 1) Citizenship, 2) Residency, 3) Indication/Drug, 4) Household socio-economic profile related to health including household size, income and economic burden on the household of health.

2. **Any chance the government will address cost?**

   None from our perspective

3. **What are the best prospects for alternate funding?**

   Generally, all individuals qualify for some form of alternate funding. Those with more significant disease and higher economic burden as related to the household will be offered more alternate funding.

4. **Can you speak to excluding of drugs under your program vs similar.**

   Paydhealth does not require any drug to be excluded. Other organizations do.

5. **As you get more groups/members participating, will you run into a situation where all of the funding sources are maxed out?**

   Doubtful, the alternate funding market is growing along with the pharmaceutical industry (which is currently at about $450B in top line sales).

6. **Would a member on an ongoing drug need to reapply every year?**

   Not necessarily, Paydhealth manages this process on behalf of the member in a proactive manner.

7. **If member has reached their Max OOP, they may not be cooperative in providing info**

because they don't have financial skin in the game at that point. What can employers do at that point? Are they stuck with the bill? Are you seeing Plans providing cash rewards to patients to cooperate?

   If the member does not cooperate, they are in non-compliance with the plan. Therefore, the Plan has no obligation to pay. Some Plans have incorporated a rewards model for participation, but most have not seen a need to do so.

8. **So do orphan drugs and J codes fall into the definition of specialty drugs? Is there any distinction?**

   The Centers for Medicare and Medicaid Services use a specific definition for specialty drugs. Paydhealth uses the same. An orphan drug is usually considered a subset of the specialty drug group. A J-Code is a form of a HCPCS code, and along with some Q-Codes may have a subset that are included in that same definition.

9. **How many specialty medications have alternative funding available?**

   All branded specialty medications have some form of funding available.

10. **If we only get a partial payment does 100% of savings go to employee first? Or split between employee and employer?**

    Alternate funding must be applied to the member pay portion of a claim. Always. The member portion of the claim may fluctuate based on the amount of alternate funding available.

Speaker Highlights:

Addressing Mental Health and Substance Abuse with More Optimism, Options and Support

Dr. Mark Whitsett, The Ridge

Mental health and drug addiction has long affected millions, but the ongoing COVID-19 pandemic continues to make the problem worse for an even larger segment of today's workforce, according to Dr. Mark Whitsett.

Dr. Whitsett is the Medical Director of The Ridge, an inpatient residential addiction treatment center outside of Cincinnati. According to Whitsett, there are five challenges employers may not know they have when it comes to substance abuse and mental health. These challenges include the stigma that addiction is still viewed as a character flaw and not a disease, that the problem doesn't exist within one's own company or when a decision is made to ignore the problem entirely when an employee is diagnosed. Having a zero-tolerance policy for substance-using employees and overlooking the relationship between substance use and mental illness can also have serious consequences, he said.

Mental Health/Substance Abuse in the Workplace Facts & Figures:

- Between 38-50% of all workers' compensation claims are related to the abuse of alcohol or drugs in the workplace (U.S. Department of Labor)
- On average, each substance using employee costs his or her employer $7,000 per year (Small Business Administration).
- Untreated mental illness costs the United States up to $193 billion every year in lost productivity (National Alliance on Mental Health).
- Workplace stress costs employers $500 billion annually in decreased work performance or absenteeism (Mental Health America)

Solutions to the Problem

What can employers do to better manage mental health and substance abuse?

Whitsett recommends employers re-examine current policies and practices to ensure parity between mental and physical health insurance coverage, and to improve employee assistance programs to provide greater access to quality care. Implementing last-chance agreements that avoid termination in exchange for substance abuse treatment can also have a positive impact, he said.

Other initiatives that can lead to better results include training leaders to recognize the signs of substance abuse and working toward fostering a culture of wellness by encouraging mental health days and other initiatives to strike a better work/life balance.

Speaker Highlights

Coming Soon: TrueCost Connect

Mary Piecuch, Payer Compass

Mary Piecuch, a Senior Vice President at Payer Compass, provided a sneak peak of the new TrueCost Connect tool and its ability to provide greater price transparency and healthier patient outcomes.

With this custom-built digital application, employers will be able to:

- Plan benefits and utilization to support plan participation
- Keep your finger on the pulse of high-value, high-performance providers to support direct contracting and overall plan strategy
- Navigate optimal plan design by reviewing post-care data through back-end reporting

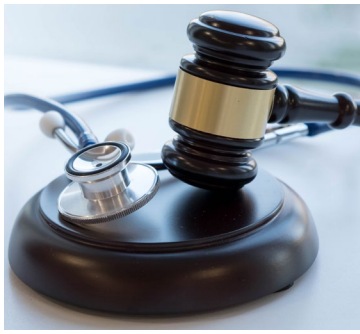
TRUECOST CONNECT USER EXPERIENCE

Once fully launched, members will be able to search and compare healthcare providers, receive and rate care, and view their data.

Stay Tuned: A video demo showing members how to use the tool will be available soon.

Speaker Highlights

Transparency, Balance Bills, and Drugs – Oh My!



Ron Peck, the Phia Group

Ron Peck, Chief Legal Officer of the Phia Group, gave an overview of new legislative rules on the horizon that are already impacting insurers and health providers.

The Department of Health and Human Services, Treasury and Labor's "Transparency in Coverage" final rule requires most non-grandfathered group health plans, health insurance and providers to disclose price and cost-sharing information to participants, beneficiaries and enrollees.

To comply, providers need to make the information publicly available and update it on an annual basis using an easily accessible web-based self-service tool or via digital files. However, many hospitals (83% according to a Harvard Study) have not complied with the rule. Of those hospitals who have participated, the information revealed that wide variances in pricing still remains.

In regard to the "No Surprises Act," there are many misconceptions that still need to be cleared up, Peck said. Primarily, the act does not outlaw balance billing. Rather, it is a comprehensive approach to protecting consumers against "surprise" medical bills. However, what can qualify as a "surprise" medical bill is still largely open to interpretation.

Peck also addressed several questions regarding COVID-19 claims and the Biden Administration's mandate for large employers to ensure workers get vaccinated or tested weekly.

A follow-up webinar was conducted by Ron Peck for CDB clients on November 17. A recording is available at https://attendee.gotowebinar.com/recording/4633350115145491725

Compliance Corner:

When is an Emergency Not Really an Emergency?

With implementation of the No Surprises Act (NSA) right around the corner, administrators and plans are working diligently to make sure they are ready for the changes. One piece of the NSA deals specifically with billing for emergency services. Under the rule, beginning January 1, 2022 out-of-network providers of emergency services will no longer be allowed to balance bill a patient for amounts above the corresponding in-network cost-sharing responsibility. The Interim Final Rule implementing certain provisions on the NSA also addresses the practice of plans denying claims for emergency services or treating the claims as non-emergency, based on the patient's final diagnosis. The Interim Final Rules make it clear that relying on the final diagnosis to determine what is an emergency is not an acceptable practice. Instead, a "prudent layperson" standard must be used to determine whether there is an emergency, as defined below:

The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that includes:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Essentially, if a patient reasonably believes their symptoms warranted a trip to the emergency department, the claim should be treated as an emergency, regardless of the final diagnosis. For plans that currently treat emergency and non-emergency visits to the emergency department in the same way, no change will be necessary. However, plans that currently differentiate between emergency and non-emergency will need to ensure that the final diagnosis is not being used to make this determination.

Silent Auction Exceeds Expectations!

A huge “Thank You” to everyone who supported our silent auction. We’re proud to announce that **we were able to raise $13,000** this year for the American Heart Association. We’d also like to thank the following partners for their donations:

American Heart Association

bardon insurance

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Paydhealth

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