Custom Design Benefits

Innovative Cost Containment Solutions for Employee Benefits

+Inside

NEWSLETTER

#2|2022

Executive Spotlight

Things are heating up this summer at Custom Design Benefits.

At the end of June, we relaunched our website to give it a fresh, modern look to better communicate our services as the region's expert in personalized employee benefit solutions and self-funded plans. We've also been busy planning for our upcoming Customer Conference.

This year's theme, "Stop the Panda-monium of Rising Health Care Costs," and lineup of expert speakers will be something C-suite executives, human resource professionals, brokers and others won't want to miss.

In this edition of our client newsletter, we'll cover a topic that we deal with daily: markups for medications at the hospital and doctor's office and explain how you can avoid paying these hidden fees. Then, we'll close with important compliance updates and regulatory guidance that employers need to be aware of.

If you haven't already, please visit customdesignbenefits.com/conferencersvp to let us know you plan to attend the Customer Conference by the August 5th deadline. We are looking forward to seeing everyone August 25th at a new event location: Manor House in Mason, Ohio!

Until then, we hope you can kick back a little and enjoy the summer!

Best regards,

Julie D. Mueller
President & CEO

Avoiding the High Cost of Prescription Drug Markups

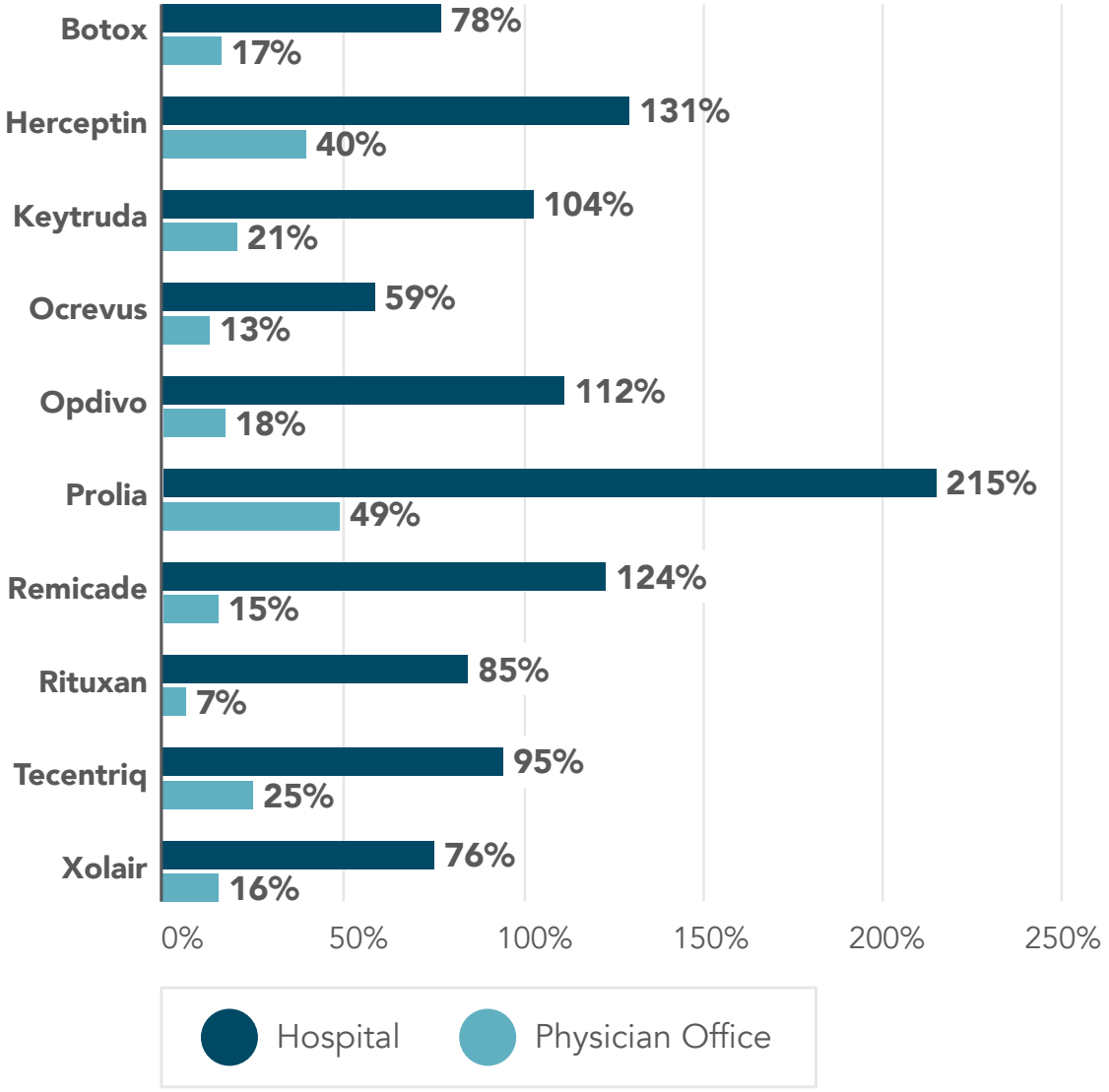
Everyone knows prescription drug costs are out-of-control. But what's not often discussed is how much costs for the same medications can fluctuate based on where and how they are taken.

Since 2014, drug prices have increased by 35% – 16 percentage points higher than the cost of all goods and services, according to a recent GoodRx report. It's to the point now where medications account for more than 20% of an employer's total health benefits spend.

To earn a profit, all goods and services in the U.S. are sold at a marked-up price. Medications are no different. But there's a noticeable disparity when you compare the costs at the pharmacy, doctor's office, or hospital.

According to America's Health Insurance Plans (AHIP), a national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans, costs for a single treatment of drugs administered in hospitals are $7,000 higher than those purchased through pharmacies. The AHIP also reported that hospitals, on average, charge double (108%) for the same drugs, compared to pharmacies. Physician offices were found to charge on average 22% higher for the same drugs.

Figure 1. Average Markups for Drugs in Hospitals and Physician Offices Over Pharmacies (2018-2020)



Source: AHIP "Hospital Price Hikes: Markups for Drugs Cost Patients Thousands of Dollars" February 2022.

Prices for the same medications can vary widely depending on where and who administers them. On average, hospitals charge 108% more for the same drugs sold at a pharmacy. Physicians were found to charge 22% more.

What recourse do employers have to make sure they don't get taken advantage of?

The answer starts with selecting a benefits plan administrator that is equipped to do the heavy lifting when it comes to pharmacy risk management.

Identifying Inflated Drugs

In today's world of health care billing, automation is a great tool.

It can help ensure accurate tracking and posting of claim payments, verify insurance coverage to ensure bills are assigned appropriately and more.

But for several reasons, identifying marked-up medications is still a practice that needs to be adjudicated by hand. Without humans scrutinizing bills and comparing costs, there's a high likelihood that the employer will be unaware they are paying an inflated cost.

Specialty medications are one area of particular concern where markups are known to run rampant. According to the American Pharmacist Association, specialty medications include all or some of the following characteristics:

- Treatment of complex, chronic, and/or rare conditions.
- High cost, often exceeding $10,000, with some costing more than $100,000 annually.
- Availability through exclusive, restricted, or limited distribution.
- Special storage, handling, and/or administration requirements.
- Ongoing monitoring for safety and/or efficacy.
- Risk evaluation mitigation strategy.

Did You Know?

Today, specialty drugs make up 1-2% of claims, but account for more than 50-60% of total prescription spending. It's no wonder why many employers say managing specialty drug spend is their highest priority.

The CDB Approach

Custom Design Benefits (CDB) partners with RxResults, an industry leader in evidence-based pharmacy risk management, to ensure access to medications that are proven safe and effective, while providing cost control. RxResults partners with the University of Arkansas College of Pharmacy's Evidence-Based Prescription Drug Program, which provides independent and unbiased analyses of peer-reviewed clinical studies of medications and classes of medications, and develops clinical and evidence-based prior authorization criteria. RxResults receives no revenue from pharmaceutical manufacturers, PBMs, or pharmacies so there is no conflict of interest.

CDB contracts directly with RxResults to administer prior authorizations on all pharmacy claims and injections given at the hospital or doctor's office.

All injectable drugs that appear on outpatient and inpatient billing invoices are immediately flagged and then reviewed to determine if the treatment meets guidelines for medical necessity.

With direct contracting through the pharmacy benefit manager (PBM), CDB can access the average wholesale price (AWP) discount – the price distributors charge retail pharmacies – to use as a benchmark. This allows CDB to identify and eliminate excessive markups that might have snuck by otherwise.

"We're going to take it a step further," said Donna Singer, a CDB Account Manager and Certified Pharmacy Benefit Specialist. "We're going to take that claim that came in through the doctor's office or hospital and we're going to go to the PBM and ask them what the discount was and then reimburse the provider at that rate."

One recent example includes an invoice from a doctor's office for one dose of RUXIENCE®, which is an injection that is used to treat adults with non-Hodgkin's lymphoma and other auto-immune diseases.

According to the AWP, a single dosage should cost $6,277.45. However, the total that appeared on the bill was $21,141.55.

"We have to really look at those bills with a fine-tooth comb and hold providers accountable for the price they charge," Singer said.

This is only one example of how CDB has been able to control spending for employers and plan members.

By working closely with their fully integrated pharmacy benefit manager, Custom Design Benefits can catch inflated drug costs and assign an "allowed amount" based on the Average Wholesale Price for medications.

Billed Amount	CDB Allowed Amount	Place of Service Description	Procedure Description	Paid Amount
$21,141.55	$6,277.45	Outpatient Hospital	Ruxience, 10 MgOutpatient	$5,021.96
$21,141.55	$6,277.45	Outpatient Hospital	Ruxience, 10 MgOffice	$5,021.96
$3,760.00	$2,689.58	Office	Renflexis	$2,689.58
$3,680.00	$1,231.81	Outpatient Hospital	Onabotulinumtoxina	$985.45

Billed Amount	Allowed Amount	Paid Amount	Place of Service Description	Primary Diagnosis Description	Procedure	Proc Desc
$24,219.54	$14,235.65	$14,235.65	Outpatient Hospital	Crohn's Disease of Small Intestine With Fistula	J3380	Injection, Vedolizumab
$18,219.00	$8,396.11	$8,396.11	Outpatient Hospital	Crohn's Disease, Unspecified, Without Complications	J3380	Injection, Vedolizumab

Conclusion

Because the higher prices of specialty drugs can pose serious financial risks, it's imperative employers with self-funded plans work with an advocate who can use direct PBM contracting and reference-based pricing to their advantage.

In addition, it is important that employers make sure their plans require pre-authorization for high-cost medications. This ensures that the prescription is necessary before it is dispensed, helps plan members avoid paying the marked-up price and provides opportunities to explore other cost-saving strategies.

Custom Design Benefits
2022 Customer Conference

Please mark your calendars for our 15th Annual Customer Conference on **August 25, 2022**. We'll reflect on key learnings from 2021, share the latest regulatory updates, and provide insights to help you calm the un*bear*able uproar of rising benefit costs in 2023.

RSVP Deadline: Friday, August 5
Scan the QR code with your mobile device to RSVP today!

Thursday
August 25, 2022
8:30 am to 4 pm

New Location:
Manor House
7440 Mason Montgomery Road
Mason, Ohio 45040

Note: This program has been approved for 5 general HR recertification credit hours toward aPHR™, aPHRi™, PHR®, PHRca®, SPHR®, GPHR®, PHRi™, and SPHRi™ recertification through HR Certification Institute® (HRCI®).

New CDB Website Refresh

We've given our website a makeover! To see the new look, visit:customdesignbenefits.com

Industry News & Insights

Julie Mueller, President and CEO of Custom Design Benefits, was one of five speakers invited by the Cincinnati Business Courier to speak about how CDB is handling labor shortages and other pandemic-related workplace challenges.

For the full article visit:

https://www.bizjournals.com/cincinnati/news/2022/06/03/hr-forum-2022.html

FTC to Examine Business Practices of Several Large PBMs

CVS caremark® EXPRESS SCRIPTS® Optum Rx®
Humana PRIME THERAPEUTICS® MedImpact

The Federal Trade Commission has launched an inquiry intended to shed light on questionable practices of CVS Caremark, Express Scripts, OptumRx, Humana, Prime Therapeutics and MedImpact Healthcare Systems. The inquiry is expected to focus on methods to steer patients to PBM-owned pharmacies, methods of determining reimbursement, the impact of rebates and fees on formulary design, and more.

For the full story, visit:

https://www.benefitspro.com/2022/06/15/ftc-to-examine-business-practices-of-several-large-pbms/

Insider Insights: My Blood (Sugar) is Boiling

Will a bill intended to cap the price of insulin to $35 actually help lower costs or is it just cost-shifting in disguise? Ron E. Peck, Esq., chief legal officer with The Phia Group, LLC, provides his two cents on a topic that hits close to home.

To read the article, visit:

https://www.benefitspro.com/2022/06/16/my-blood-sugar-is-boiling/

Compliance Corner

Reminder: Patient-Centered Outcomes Research Institute Trust Fund Fees Are Due

Fees for the Patient-Centered Outcomes Research Institute (PCORI) trust fund are due July 31 from issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans.

What is the PCORI trust fund fee?

The PCORI trust fund fee is a fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans. The fee helps fund the Patient-Centered Outcomes Research Institute which helps patients, clinicians, purchasers, and policymakers make better-informed healthcare choices by advancing clinical effectiveness research. If you are a CDB group medical client, you can find the average number of covered lives on your monthly report on the CedarGate portal, titled “Monthly Summary.”

When did the PCORI fee go into effect?

The PCORI fee applies to specified health insurance policies with policy years ending after September 30, 2012, and before October 1, 2029. It also includes applicable self-insured health plans with plan years ending after September 30, 2012, and before October 1, 2029.

How much is the PCORI fee? (updated March 4, 2022)

The amount of the PCORI fee is equal to the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. If you are are a CDB group medical client, you can find the average number of covered lives on your monthly report on the CedarGate portal, titled Monthly Summary.

The applicable dollar amount is adjusted yearly to reflect inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services. For policy and plan years ending:

• After September 20, 2021, and before October 1, 2022, the applicable dollar amount is $2.79

• Fees are reported on IRS Form 720

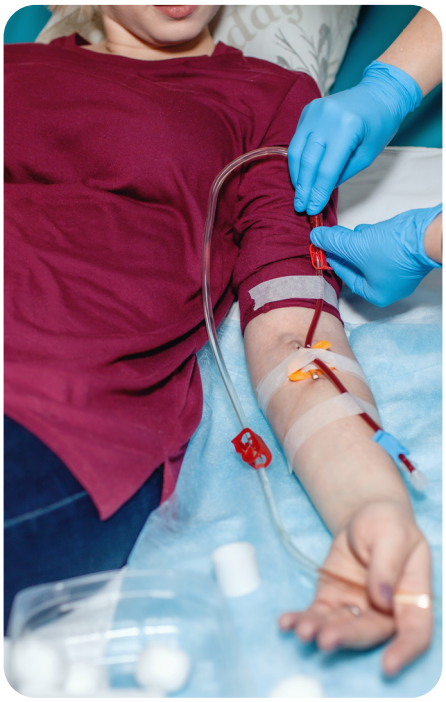
For additional information and guidance, visit: Patient Centered Outcomes Research Trust Fund Fee: Questions and Answer

Internal Revenue Service (irs.gov)

U.S. Supreme Court Rules on Dialysis Carve-outs

The following article was provided by the Phia Group

This is an update on an important case that affirms self-funded health plans participants' rights to use cost-containment strategies to reduce ever-increasing dialysis costs.



On June 21, 2022, the U.S. Supreme Court published its decision in Marietta Memorial Hospital, et al. v. DaVita, et al. In this decision, the Supreme Court ruled that self-funded health plans have the authority under the Medicare Secondary Payor Act (MSPA) to carve out dialysis benefits and set rates for such benefits at appropriate levels for plans and their members. In reaching its decision, the Supreme Court relied on the reasoning in the Amy's Kitchen case, cementing Renalogic's ImpactProtect cost containment program as the market-leading, most legally sound methodology for dialysis cost containment.

Background

The kidney dialysis market is dominated by two large, multi-national companies: DaVita and Fresenius. Because of their dominance and lack of viable competition, dialysis rates billed to commercial health plans have ballooned by roughly 400% since 2008.

Marietta was one of five federal cases launched by DaVita in late 2018 – early 2019 against commercial health plans and other organizations. In this lawsuit, DaVita argued that a commercial health plan does not have the legal authority to carve out dialysis benefits and pay dialysis claims differently from other types of claims under the MSPA. In contrast, Marietta Hospital and the U.S. Department of Justice argued that the MSPA was designed to coordinate benefits between insurance plans and Medicare for individuals covered by both, and not to provide preferential status to dialysis claims or individuals needing dialysis.

Marietta Hospital won in the trial court, while the Sixth Circuit Court of Appeals reversed the trial court's decision, holding for DaVita. The Supreme Court agreed to hear the case to settle the issue because of its importance and because the Ninth Circuit Court of Appeals reached an opposite decision than that of the Sixth Circuit in the landmark Amy's Kitchen case. In the Amy's Kitchen case, the Ninth Circuit categorically supported health plans' authority to carve out dialysis benefits and approved Renalogic's claims repricing methodology, ImpactProtect.

DOL Issues New Guidance on FMLA Leave for Mental Health

The DOL has issued new guidance and frequently asked questions (FAQs) for extending leave through the Family and Medical Leave Act to employees who need time off from work to care for their own mental health or those of a covered family member.

For more information, visit: https://www.dol.gov/agencies/whd/fact-sheets/28o-mental-health or contact your CDB account manager.

Update on Machine-Readable Files & Transparency in Coverage

We're pleased to update our clients and brokers on our progress on a federally mandated initiative that requires group health plans and health insurance issuers to publicly disclose price and cost-sharing information by way of machine-readable files (MRFs).

Under the Department of Labor's Transparency in Coverage requirements, employers with traditional insurance plans can receive MRFs from their insurance carriers and third-party administrators (TPAs). Self-funded employers can satisfy requirements through a written agreement designating their TPA (or other service provider) to provide MRFs.

For our TrueCost clients, CDB has entered into an agreement with Payer Compass to display both contracted hospital rates and non-contracted rates (Medicare Plus) via a link on our website. Within the agreement with Payer Compass, there are costs associated with programming and hosting the data. CDB is assessing any related fees that will be passed onto our clients along with any potential amended administrative agreements.

On July 1, CDB updated its company website, customdesignbenefits.com, with the MRF links to MMO, TrueCost, FrontPath and Cigna. These links can be found by clicking on the “Resources” tab on the website or by visiting: https://www.customdesignbenefits.com/resources

Note that the functionality behind some of the links is still being finalized. As this new requirement is being implemented, employers are protected from any final technical issues or delays by the following legislation:

Good Faith Compliance – Safe Harbor

A plan or carrier will not fail to comply with these requirements when, acting in good faith and with reasonable diligence:

• An error or omission in the required disclosure is made, provided the information is corrected as soon as practicable.

• The internet website hosting the MRF files is temporarily inaccessible, provided that the plan or carrier makes the information available as soon as practicable.

Further, when information must be obtained from a third party, the plan or carrier will not fail to comply with this requirement because it relied in good faith on the information provided by the third party, unless it is known (or reasonably should have known) the information is incomplete or inaccurate.

We continue to monitor the GitHub site daily and the DOL for any updated FAQs and/or required adjustments to the data.

For more information, you can visit the following links below or contact your CDB account manager.

Price Transparency Guide

FAQS About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49

Technical Clarifications

At CDB, we are always staying up to date on the latest regulatory requirements so that we can help you better understand what these changes could mean for you and your employees.

Client Spotlight: Harmony Systems & Service

Harmony Systems & Service, based in Piqua, Ohio, recently received the Vilfredo Award at the ParetoHealth Convention in Coronado, California. The Vilfredo award recognizes initiatives in health care that contain costs while maximizing care.

The initiatives taken by Harmony Systems included the negotiation of a strong stop-loss insurance policy, cost-containment contracts with providers, a direct partnership with Wilson Health Network and the addition of an on-site employee clinic.

More than 600 companies were eligible for the award, but only six (including Harmony Systems) were deemed award-winners.