# Employee Benefits Report

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# Why Prescription Drugs Cost so Much and What You Can Do About it

**Prescription drug costs rose by 12.6 percent in 2014 and by 10 percent in 2015 — well beyond the U.S. inflation rate. And in some extreme cases, specialty drug costs increased more than 5,000 percent. What can employers do to control these soaring costs?**

In 2015, Martin Shkreli, chief executive officer of Turing Pharmaceuticals, was asked to explain why his company raised the cost of Daraprim by 5,556 percent from $18 a pill to $750. The drug, used to treat AIDS, was not a new medication. Shkreli explained he raised the price of Daraprim so researchers would have incentive to develop new drugs for the disease. The public was outraged and Turing was pressured to lower costs, which they did by 50 percent…but only for hospitals.

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## This Just In

Does your health plan offer no-cost, unlimited primary care visits, mental health visits…and yoga? A new health plan available only in Chicago and Atlanta offers members these services, along with 24/7 access to doctors, a "personal care" team to help members meet their health goals, and free classes on a variety of health-related topics.

According to HealthInsuranceCrisis.net, "This individual and small group health plan offering appears primarily aimed at boosting health literacy and appreciation for healthy lifestyles among those new to health insurance…This cohort can be frequent users of care because they lack pre-existing provider relationships and tend to rack up costly emergency room visits for nonemergency care." The plan aims to reach them — and reduce ER visits — by offering unlimited primary care visits without out-of-pocket costs.

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And while the increase for Daraprimby was extreme, the cost of specialty drugs overall did increase by as much as 30 percent in 2014. In addition, the Consumer Reports Health Rating Center says that the price for drugs that are within five years of coming off a patent rises 88 percent before they lose their exclusivity.

Nationally, employers' pharmacy costs also are being affected, rising about 9.5 percent in 2015 and expected to climb 10 percent this year, according to Aon Hewitt, a benefits consultant. The firm expects employers' other medical costs to rise far less, at 4.5 percent in 2015 and 5 percent in 2016.

The result of these escalating prices is that many patients can't afford the medications and the healthcare they need.

## The Reasons

There is plenty of finger pointing as to where the blame lies for soaring drug prices. Here are some of the theories.

The Affordable Care Act's (ACA) rules and regulations are focused on reining in the insurance industry. Insurers now have to cover a wider array of benefits and are prohibited from denying coverage based on preexisting conditions. The ACA also instituted new rules for insurers, including how premiums are set, how benefit plans are designed, a tiered system of cost-sharing and caps on insurance company profits. The new law extended drug coverage, making prescription drugs one of 10 "essential benefits" that insurers must cover — insurers were not required to cover prescription drugs prior to the ACA. It also closed the coverage gap in Medicare Part D plans, requiring drug companies to offer seniors a discount on their drugs.

Insurers had to adapt and find new ways to be profitable, such as shifting some costs to consumers via increased drug costs. For instance, 46 percent of plans on exchanges now combine medical and pharmaceutical deductibles, while only 12 percent of employer plans do so, according to a Milliman analysis.

While the pharmaceutical industry was required to pay for some of the law's increased drug coverage, it was mostly left unregulated. As a result drug companies can set their own prices, with no restrictions on profit margins and little pricing transparency. This created an added cost for insurers, while allowing pharmaceutical companies to expand their market for new drugs.

Long patent lengths also allow drug companies to capitalize on lack of competition by raising prices unchecked.

## Ways to Save

Fortunately, there are steps that consumers, employers and government payers can take to rein in drug costs.

Consumers

- Ask your doctor whether a generic drug is a viable option instead of a brand name drug. According to ClearPoint Credit Counseling Solutions, generic medications can cost up to 90 percent less. It helps that three-quarters of medications are available as a generic.
- If a generic drug isn't available, ask your doctor if there is a lower cost brand-name that will work.
- Check into discount generic drug programs offered by retailers such as Wal-Mart, Target, CVS and Walgreens. These retailers offer discount generic drug programs for as little as $4 a month or $10 for a 90-day supply.
- Ask your doctor or pharmacist to review all of your medications at least every six months. This can eliminate duplicate or unnecessary drugs or adjust dosages that are higher than necessary.
- You may be able to split a tablet if you need a lower dose, but are only able to purchase a higher dose. Check with your doctor to see if this would be a safe option. To make the practice safe, only divide tablets, not time-release pills, and use a pill-splitting device.
- It can pay to compare drug costs between drug stores or online pharmacies. To make sure you're getting the best quality medications, stick with pharmacies that carry the VIPPS (Verified Internet Pharmacy Practice Site) seal, which is awarded by the National Association of Boards of Pharmacy.
- You may be able to save up to 40 percent by purchasing a 90-day supply. However, to ensure the medicine doesn't expire before you've taken it all, don't buy more than a 90-day supply..
- Free samples from your doctor are not always a good deal if the drug is an expensive brand name that you will need to take — and purchase — regularly.

Healthinsurancecrisis.net concludes that the plan is aiming to build long-term relationships with its members by instilling in them an appreciation for maintaining healthy lifestyles that will help avoid high-cost care. New directions like this one are redefining today's health maintenance organizations. Source: http://healthinsurancecrisis.net/

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- Be wary of TV ads, that promote the newest drugs. They are often are more expensive and not necessarily better than older versions.
- The right drug plan can save you a lot of money, so be sure you choose the insurance that is best for you. If your employer chooses your coverage, then make sure you read and understand what your coverage entails.
- When the option is available, purchase your prescriptions through mail order to save money.
- Pharmaceutical companies offer free or low-cost medication through their patient assistance programs.

Employers

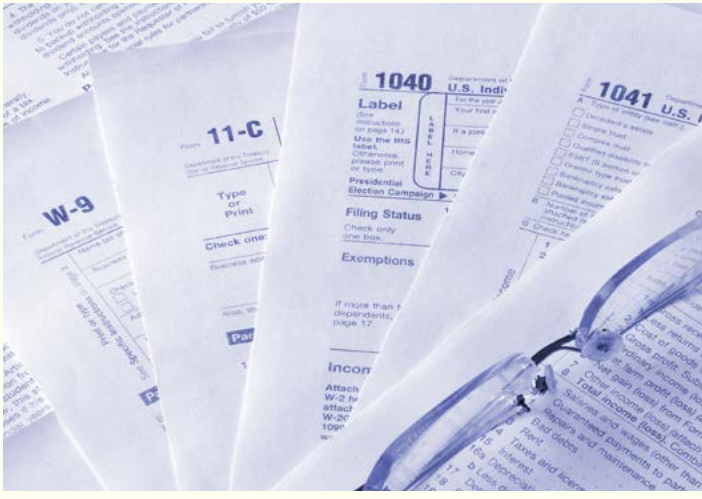
- Compare potential insurance plans to find the one that has the lowest out-of-pocket prescription costs for your employees.
- Encourage employees to use generic drugs, which could result in a savings to your company.
- Encourage employees to use mail order — a less expensive option than buying them from the neighborhood drugstore.
- Consider requiring doctors to obtain prior authorization from health-plan administrators for certain costly drugs, such as anti-inflammatory drugs for rheumatoid arthritis.
- Institute a "step therapy" strategy, which requires doctors to treat employees with lower-cost drugs before the health plan will pay for more expensive drugs.

Government

- There is increased interest in changing the law to allow Medicare, the largest purchaser of health care services in the country, to negotiate prices with pharmaceutical companies.
- Shorter patents would allow new generic medications to be developed sooner, offering consumers more options and bringing down costs through competition.
- The government could make it easier for consumers to purchase prescription drugs in other countries. In addition to consumers having access to lower cost medications, the increased competition could encourage American companies to lower their prices.
- More transparency about the costs and prices of all pharmaceutical products would help reduce prices. If you don't know what a drug should cost, it's difficult to know if you're overpaying. ■

# Implementation of Cadillac Tax Delayed for Two Years

**Implementation of the "Cadillac Tax," a tax on expensive employer health plans, has been pushed back from 2018 until 2020. Many, though, would like to see the tax go away completely.**




More formally known as Section 9001 of the Affordable Care Act (ACA), the 40 percent excise tax will be levied against "excess" benefits and will be paid by the employer of a self-funded plan or an insurance company — although it's assumed the cost will be passed on to consumers.

The amount to be taxed will vary annually. For instance, in 2018, it's estimated that the base dollar threshold would have been $10,200 for self-only coverage, and $27,500 for other cov-

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erage — although these base limits would have been subject to adjustment based upon a variety of factors.

The intent of the tax was to rein in high-priced insurance policies offered by employers by imposing a tax on an amount considered to be an excess benefit. The hope was that the tax would produce these results:

- Employers would have a strong incentive to seek lower-price plans.
- Employers and employees would rely on more efficient hospitals, doctors and other care providers.
- Employees, who would have to pay for more of their healthcare costs with less generous plans (instead of getting a plan that covers almost everything), would use health services more judiciously.

It also was hoped that the tax would slow the growth of healthcare spending and raise money to cover the cost of the ACA. The congressional Joint Committee on Taxation estimated the tax would have brought in $2.2 billion in 2018 and $7.2 billion in 2019. Delaying the Cadillac Tax for two years is expected to add $91 billion to the deficit over a decade, according to the Committee for a Responsible Federal Budget.

While the nickname for the tax implies that it only applies to expensive health plans, over time it will increasingly apply to average plans. This is because even though premium thresholds are adjusted annually for the Consumer Price Index, the Medical Consumer Price Index is projected to rise faster. Studies indicate that 30 percent of employers will be affected by the tax by 2023 and 42 percent five years after that. This assumes their health plans remain unchanged and health costs continue rising at the same pace.

Proponents of the two-year delay say will give Congress more time to make adjustments to the regulation. Others worry that the delay will become a permanent deferral. Either way, it's expected that companies would still cut benefits now to be in compliance by 2020.

For more information on the Cadillac Tax and other laws and regulations that affect your benefits programs, please contact us.

# The Pros and Cons of Paid Sick Leave

**Five states, 22 cities, and one county in the United States mandate paid sick leave benefits, making the United States the only country among 22 developed nations that doesn't guarantee paid leave if someone falls ill or has to care for a sick family member.**

President Obama in 2015 signed an executive order requiring federal contractors to allow their employees to earn up to seven days of paid sick time annually. He also wants businesses with 15 or more employees to offer seven paid sick days each year. Some Democrats have even proposed a massive government paid-leave entitlement program.

Vermont legislators in February approved a bill that supports paid sick days. It's the fifth state to legislate the benefit, joining Connecticut, California, Massachusetts and Oregon. The legislation requires employers to provide employees with three paid sick days each year in 2017 and 2018. The number rises to five paid sick days beginning in 2019. The requirement does not apply to employees who work fewer than 18 hours per week or 21 weeks a year, employees under the age of 18; or seasonal workers.

And while a 2013 survey by a HuffPost/YouGov_poll found that 74 percent of Americans support government action, there are some who say that legislating paid sick leave will cause more problems than it fixes.

## The Case for Paid Sick Leave

One of the biggest arguments in favor of paid sick leave is that sick employees should not come to work. When someone who is ill stays at home, the chances of that illness being shared at work diminishes. Plus, workers recover faster from illness when they have the time to rest or seek medical attention.

The *Journal of Occupational and Environmental Medicine* reports that nearly two-thirds of servers and cooks say they have served or cooked while ill. This increases the likelihood that illnesses will be spread to customers, causing potential public health issues.

Many workers choose to come to

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work ill because they fear they will lose pay or their job if they stay home to recover. Some also call in sick to stay with a sick child who cannot stay home alone.

While some employees do come to work when they are ill, it can lead to what is known as "presenteeism," which means employees are not working up to their potential.


According to the United States Department of Labor, workers without paid sick time are more likely than their counterparts with paid sick time to be injured on the job, especially those employed in health care support occupations, construction and production.

Paid sick leave is thought to build loyalty and reduce turnover, which is particularly important in the lower wage industries where turnover is highest. Replacing workers can be expensive. According to the Society for Human Resource Management, it costs about 38 percent of an employee's annual earnings to replace them, including recruitment, training, the separation process and losses in productivity.

There also are concerns about how the lack of paid leave affects health care costs. Many emergency centers report that workers without paid sick leave are more than twice as likely to seek emergency room care because they can't take time off during normal work hours.

## The Case Against Paid Sick Leave

On the opposing side, employers argue that mandatory paid sick leave may force price increases on goods and services and/or reduce employees' hours or other benefits.

Following passage of San Francisco's paid leave mandate, for instance, an Institute for Women's Policy Research study showed that nearly 30 percent of the lowest-wage employees reported layoffs or reduced hours at their workplace. An Urban Institute study found that to comply with the law's requirements some employers had scaled back on employee bonuses, vacation time, and part-time help.

In addition, studies have shown that even with mandatory paid sick leave, workers still come to work sick just as often. A report by the Freedom Foundation indicated that of five studies that examined the effect of mandatory paid sick leave laws on presenteeism, four found no reduction.

The reason given for mandating paid leave in Seattle was that employees were being forced to work while they were ill. However, survey results suggest such claims were overstated and not a serious problem, according to 83 percent of the businesses surveyed.

Another reason employers resisted mandated paid sick leave was its "one size fits all" approach. The Bureau of Labor Statistics reports that 30 percent of a worker's total compensation goes to provide benefits. Some opponents of mandated benefits think some workers might prefer more take-home pay and fewer benefits.

Opponents also argue that it's wrong to think that workers will only be treated fairly if paid sick leave is legislated by the government. Many employers already provide paid sick leave.

# AHIP Starts Pilot Program to Improve Provider Directory Information

If knowledge is power, most Americans lack power when it comes to choosing healthcare providers because the quality of resources and number available is poor.

America's Health Insurance Plans (AHIP), a national political advocacy and trade association, has commissioned a pilot program to improve the way information is gathered for provider directories. These directories are used by consumers to choose health plans and providers. AHIP representatives said the quality of information provided to directories can be made more accurate and timely by providing better coordination between providers and health plans.

Ari Tulla, co-founder and CEO of BetterDoctor, a company that provides data and platforms for managing provider directories, pointed out that about 20 percent of doctors move or change practices, making information unreliable. Current procedures rely on health plans making calls, sending faxes and emails, and in-person visits to providers to get information. Paul Markovich, who is leading AHIP's task force on the AHIP pilot project, said it takes both providers and health plans to make the directories work and there needs to be a "single stop" for updating this information.

The pilot program started in April 2016 in Indiana, California and Florida. The pilot program incorporates recent regulatory changes related to network directories, including:

- Medicare Advantage regulations requiring quarterly outreach to providers to verify key directory data in 2016
- California legislation — SB 137 — requiring bi-annual validation of providers' data for individual and institutional providers
- California Department of Insurance network adequacy regulations
- Federal standards for qualified health plans participating in the federal marketplace.

Twelve health plans representing more than 100,000 providers are participating in the pilot. The plans represent commercial, Medicaid and Medicare Advantage markets and include:

- Anthem
- AvMed
- Blue Shield of California
- Cigna
- Florida Blue
- Health Net
- Humana
- L.A. Care Health Plan
- Molina Healthcare of California
- SCAN Health Plan
- WellCare
- Western Health Advantage.

The results of the pilot programs will be released in fall 2016. ■

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