



THE POWER OF PROGNOSTICATION

WRITTEN BY BRUCE SHUTAN

SIIA KEYNOTERS PREDICT POLITICS AND THE FUTURE OF BUSINESS

Crystal balls were on full display at SIIA's National Educational Conference & Expo at the JW Marriott in Austin, Texas. Two captivating keynoters shared their expert insight into the future of business and politics with a record-breaking 1,900 attendees of the world's largest event focused exclusively on the self-insurance and captive insurance marketplace.

Although most conference attendees identified themselves as Republicans in a Slido.com straw poll, they feared the GOP would lose their House majority in the mid-term election and that President Donald Trump would face a primary challenge in 2020.

Those results appeared to be "largely on target" based on historical patterns involving the fate of political parties in power, according to Guy Benson, political editor for Townhall.com. Top-ranking GOP strategists and senior officials have told him they worry about voter complacency and deem Trump's red-wave prediction on Twitter harmful.

He predicted that Democrats will win the House, while Republicans will hold onto the Senate, which could benefit Trump given the inertia associated with a GOP majority across Congress. "Trump likes having something to play off of and a foil," opined Benson, a Fox News contributor sometimes referred to as the "the Millennial Conservative."



Guy Benson

As many as 40 House seats hang in the balance, according to a Cook Political Report analysis. In the Senate, 24 Democrats and nine Republicans are up for re-election, but he said that based on the previous election it's doubtful that the GOP will lose their 51-49 majority. At the state level, Benson noted that 33 governors are in power compared with just 16 Democrats and one independent in Alaska.

Regardless of which party runs Congress after Election Day, Corporate America is at a crossroad where adapting to a changing marketplace spells the difference between success and failure. Futurist Mike Walsh wowed the crowd with a fast-moving and self-deprecating presentation on megatrends he believes will shape the future of business and consumer behavior. The CEO of Tomorrow examined how companies can leverage disruptive innovation, adopt a data-driven mindset and embrace digital transformation.

He sought to determine what algorithms, artificial intelligence (AI) and data analytics that are reshaping daily activities will mean for business – sometimes referencing Brave New World applications. For example, he said footwear can be fitted with technology that guides consumers to store shelves with products that might interest them most based on their buying patterns.

Walsh also noted that facial recognition is becoming the primary way to authorize transactions in China whose stores are fully automated.

There's also a device that detects worker fatigue, he said, while data can be leveraged in real time to assess consumer behavior and adjust insurance risk. Walsh referenced John Hancock, which recently announced that it won't sell life insurance to people who aren't part of a wellness program called Vitality.



Mike Walsh



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Disruptive innovators include Hitachi, which he said is using AI to identify the causes of poor health and have identified 150 data points for 45,000 unhealthy employees. Another is MassMutual, whose Haven Life spinoff leveraged 15 years of life insurance data to offer more affordable products online.

Quipping that Millennials will be passé by 2030, Walsh suggested that companies court a new generation that has grown up with gadgets. As such, he suggested that it's more valuable to have performance-driven people who are agile thinkers and make good decisions in ambiguous situations than a specific skill set when it comes to recruiting and retaining top talent.

Young people now expect businesses to anticipate their needs and make interactions more personal as big data and customer obsessions continue to meld, according to Walsh. He suggested that attendees ask this segment of their workforce for their feedback on how the technology shaping their lives can be applied to customers.

There's a fear that automation will end jobs, he said, but the reality is that they'll simply change (i.e., someone will need to maintain machines). For example, he noted that ATMs enabled bank tellers to transition into a new strategic role of cross-selling financial products.

Walsh described the future as an invitation for everyone to think in new ways, noting that the best thinkers in history had the courage to embrace dangerous ideas that drive disruptive innovation.

HOW AND WHY MILLENNIALS SHOULD ENROLL IN HEALTH PLANS

Millennials may not think there's any need to enroll in their company's health plan between a repeal of the individual mandate under the Affordable Care Act and ability to stay on a parent's plan until age 26. But their participation can be valuable to both young employees as well as the self-insured group health plan's risk pool, explained Erin Weenum, employee benefit strategist for Leavitt Group in the session "Keeping Millennials on Your Self-Insured Health Plan."

Millennials, who were born after 1980, average just \$2,647 a year in health care spending vs. \$8,670 for Baby Boomers, according to the Petersen-Kaiser Health System Tracker. As many as 46% of the U.S. workforce will be comprised of Millennials by 2020, Weenum noted, believing recruitment and retention of this segment is crucial, especially if the labor market remains tight.

However, they find benefits difficult to understand. A 2016 TransUnion Healthcare Millennial Report noting that 74% of them do not pay their medical bills in full, while 46% would be more apt to do so if they understood their out-of-pocket costs upfront.

She cited other notable statistics suggesting that 16% do not have any health insurance and 80% do not have a health savings account. Since many Millennials are not in a high tax bracket and won't care about their triple-tax benefits, she said HSAs need to be communicated as simply a mechanism to self-fund their health care.



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A first critical step is to identify the employee benefits most important to Millennials, she urged attendees. This segment of the workforce is well educated and energetic, she said, but they're also financially fragile and unprepared for the future with higher levels of stress and depression and a more difficult path to homeownership.

Among the benefits that may resonate most with younger employees: student loan repayment and employer-assisted home purchase programs, as well as medical tourism and holistic employee assistance programs that accommodate chiropractic, massage therapy or acupuncture services. These programs can be wrapped around self-insured medical plans to help recruit and retain Millennials, she added.

Careful communication is critical to the success of Millennials signing up for coverage, according to Weenum, who said they struggle to identify with a benefits brand that doesn't fit their conception of social media's personalized messaging. So rather than brand plan documents with standard insurance descriptions, she suggested self-insured employers simplify the description of plan offerings and emphasize that they care about them.

Millennials also want online open enrollment to work more like the Amazon shopping experience, she said. Many TPAs and ASOs have mobile apps, which can help self-insured employers court this segment of the workforce. Some platforms include text messages with prescription refill reminders or information about health care

advocates who can help them find the right specialty provider.

But Weenum explained that there's a need to integrate into these apps decision-support tools and resources to help navigate their way through the benefits selection process, as well as telemedicine, and include a mental health component.

INCENTIVES, QUALITY SCORES BLAZE PATH TO ENGAGEMENT

Employee buy-in is critical for all benefit plans, but by elevating their level of engagement, self-insured employers can actually burnish cost-containment strategies, several industry experts noted in a panel discussion session "Getting Employees on the Health Plan Cost Containment Team."

Member engagement is "an unbelievably important component" of health care, especially in the bundled surgery space or dealing with specialty drugs, noted Mark Davenport, SVP of sales for PriceMDs.com, whose proprietary search engine helps patients locate affordable prices for quality health care procedures worldwide.

He suggested offering health plan members financial incentives to interact with high-quality clinicians, which could ultimately save hundreds of thousands of dollars. His firm was able to save a not-for-profit employer client more than \$2 million on an orphan drug to treat hemophilia called NovoSeven, whose annual claims were \$3.2 million. The employee who was prescribed this drug was paid a whopping \$100,000 to follow cost-savings protocols.





Jeff Bernhard, president of Continental Benefits, said it's imperative to provide employees with provider quality scores. More than 90% of the workforces that his TPA serves are clueless when it comes to deciphering quality.

What's needed is an independent third party with risk-adjusted data on numerous physicians and hospitals, according to Bernhard, who recommended contracting with Quantros, a leading provider of enterprise SaaS-based solutions and information services that advance health care quality and safety performance. "I'm not sure that there's a huge trust factor with TPAs and insurance companies," he added.

Contracting with direct primary care services on a fixed monthly fee is an excellent alternative to capitated fees that can vary widely, observed Bill Hennessey, M.D., CEO of Pratter. He lauded Amazon and Priceline for their real-pricing model, which his firm applies to health care with "a cost concierge staffed by medical billers."

Pratter's proprietary platform identifies by ZIP code known charges and claim allowables before services are actually rendered. He said independent physicians who "didn't have to sell out to the hospital" tend to offer the best quality care. Other important cost-saving elements include wise plan design with narrow networks, benefit tiers and reference-based pricing.

Mandatory second opinions should be built into all self-funded health plans for specialty procedures, which will help ensure 95% compliance, Bernhard opined, citing Grand Rounds' service as an example.

It's also important to personalize health care for employees who are inundated with information and use targeted messaging alongside behavioral economics to explain that certain decisions will save money and improve their safety, said Jeff Rice, M.D., J.D., CEO of Healthcare Bluebook.

His firm uses an algorithm to help large self-insured employers identify fair market prices for various hospital services. Rice has seen an eleven-fold increase in patient engagement among those who are offered the right education and resources, including health care advocates.

Bernhard suggested that employers focus on the 1% segment of the workforce that drives most of the self-funded plan's health care spending and connect them with a direct primary care physician and health care coach. Patients with multiple chronic conditions that can be very costly need a health care advocate to guide them through the system 24/7, he noted.

After hospital discharges, Bernhard recommended that nurse practitioners follow up with patients in their homes for a set amount of time to coordinate their aftercare and ensure adherence to prescription drug regimens.

Requiring genetic testing for those who are prescribed specialty drugs agree will ensure that treatment is appropriate, he said. *"There's no sense in prescribing a biological drug to somebody that won't benefit from it,"* he added.

SYNERGY OF MEDICAL STOP-LOSS AND P&C CAPTIVES TOUTED

The power of a stop-loss captive program for reining in rising health care cost is undeniable and gaining traction among many small and midsize employers. The same is true for group captives on the property and casualty side for controlling workers' comp, auto and general liability insurance costs. Imagine the results when these separate solutions work in tandem, suggested an enthusiastic panel of industry experts during the session "Stop-Loss Captives Programs and P&C Group Captives – A Powerful Risk Management Combination."

Although Amanda Klimaski works only on the P&C side as captive director at Artex Risk Solutions, Inc., she has noticed more of her employer clients have shown interest in a medical stop-loss captive over the past five to seven years.

Despite a general reluctance to take on risk in this area and realization they have no control over what employees do outside of work to prevent illness and injury, she said the thinking is that if they can get employees to be healthier, then they can reap dividends on the work comp side and realize synergies in bridging these two silos.

The lure of captive insurance for both areas is trickling down to middle-market companies, Klimaski observed, noting that captive members have more control over pushing back on potentially fraudulent claims. There's

also realization that every claim dollar that can be reduced puts money back in the pockets of employees in the form of bonuses, she added.

The potential cost savings associated with captive insurance immediately piqued the interest of the Fall River Group, Inc., a family owned manufacturer founded in 1954 with 235 employees in two locations in southeast Wisconsin that specialize in foundering nonferrous alloys.

Kevin Lamp, the company's treasurer and chief financial officer, noted that after joining a stop-loss captive in 2014, a group captive was added the following year for work comp and general liability, which immediately saved 40% on premium. The number of members expanded from 42 to 58, capping annual growth to 10%.

"Experience modification for our foundry is 0.65, and that goes to the partners that we've had along the years to help us with our loss-control programs," he reported. With that in mind, his firm sought to pursue a heterogeneous model – taking into account what the experiences might be in his volatile foundry business.

A two-fisted strategy dovetailed nicely into the culture of health, wellness and safety that was created around loss control and employee engagement with their health plan. It also helped preserve a \$250 annual deductible that's antiquated in an age of high-deductible health plans, but deemed important in the eyes of family ownership.





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"We don't want to create a situation where we have to increase premiums and take more money out of employee pockets," Lamp said, noting that a first dividend distribution was shared with the workforce that's well aware of the arrangements' rewards. Prescription drug trend, especially in the specialty Rx arena, is a critical part of the manufacturer's medical stop-loss program.

Another panelist shared about the synergy of captive solutions for benefits and comp.

"Our premiums have trended down," reported Keith Coleman, EVP for Beard Construction Group, Inc., whose roughly 300 employees have been in a group health captive for about six years that has nearly 40 members and P&C captive for nearly 13 years. The P&C captive supports a safety culture with loss-control partners, meeting twice a year to share best practices, as well as learn from other members in terms of successes and failures.

There hasn't been a lost-time accident for Beard Construction Group in almost a decade. Fewer people are getting injured and everyone is doing a better job of loss control, according to Coleman. However, he sees auto liability with employees in company vehicles trending up.

On the health side, cost-control is still an ongoing challenge given the pool of people employed, particularly in

Louisiana where he quipped that gumbo, jambalaya and Bud Light are so popular. It also hasn't been easy implementing a wellness program for skeptical workers who suspect they're being dinged for an additional premium.

Coleman reported loss ratios of 20% on the P&C side and 90% on the health side, remarking that the latter is still a victory when factoring in an aging workforce and stable rate increase the following year. Indeed, Klimaski noted that on the medical stop-loss side the goal is to simply mitigate increases from one year to the next.

EYEING BLOCKCHAIN TECHNOLOGY APPS FOR SELF-INSURANCE

While blockchain applications for self-insured health claims administration and related stop-loss insurance are still in their infancy, the technology is expected to set a new course for core transactions across the benefits landscape as well as a variety of industries. This was explored in the session "Exploring Blockchain Technology Applications for Self-Insurance – One Block at a Time."

"I think there's a real opportunity within reinsurance specifically, and health care overall, for blockchain to, reinvent the market from a technology perspective of taking us to another level of interaction and integration," observed Jeremy Martin, a technology consultant who has specialized in blockchain over the past three years.

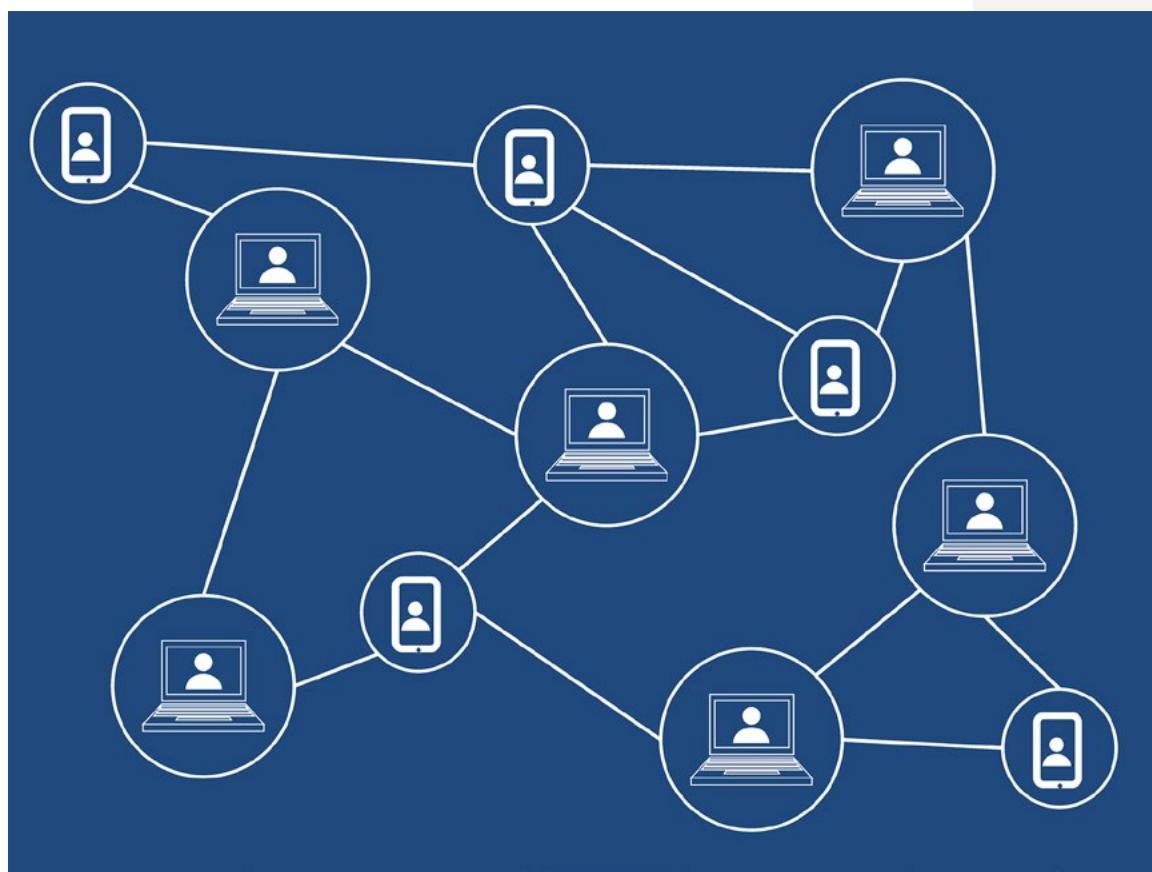


In the case of prescribing patterns, for example, he said everyone participating in the blockchain, including the manufacturer, distributor, doctor and pharmacist, can review an immutable audit trail and history of a particular prescription drug "from cradle to grave."

There's also a sense of immediacy that can vastly improve clinical, administrative or operational processes. There's no need to wait weeks for a pharmacy benefits management (PBM) download or guessing whether health plan members picked up their prescription or made it to a doctor's appointment, according to Martin. "All that happens at the point of transaction in real time, and I would see it right then and there," he said.

Moreover, different capabilities involving contract renewals or meeting certain criteria before transactions are made (i.e., fulfilling annual deductibles) can be embedded into a private encrypted blockchain chain for all participating parties to view. "It allows for greater automation vs. having to touch and handle every step through the process," Martin explained.

Whatever parameters are required for a quote, including several years of census data or medical history, get loaded into the blockchain and transmitted to a carrier or managing general underwriter "without a whole lot of work and interaction," he pointed out.



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Data from winning bidders can be incorporated into a so-called smart contract to stipulate renewal dates, deductible accumulation and other terms, he said, while revisions can be easily made and finalized with digital signatures.

Spending on blockchain technology is expected to reach \$2 billion in 2018 from \$945 million last year,

noted Todd Roberti, CEO of Ringmaster Technologies, Inc., who moderated the blockchain panel discussion. Global revenue from an enterprise blockchain application is expected to reach \$42 billion by 2025 from \$19 billion today, he added.

In the face of this explosive growth, there's still a need to educate the self-insurance community about the basics of blockchain. When people think about this emerging technology,

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Bitcoin often comes to mind, but Martin explained that it's merely based on blockchain, which is a peer-to-peer network that replicates data across all the nodes that participate in a computer network. "There's a lot more to it than the cryptocurrency," he said.

With blockchain, there's no central point where information is stored and potentially more vulnerable to hackers or natural disasters, according to Martin. Rather, he said, it involves decentralized data that's written into an encrypted chain of communication that all participating parties easily can modify or flag as suspicious. The result is a greater sense of transparency with real-time verification of information that's stored inside the chain forever.

As the central point where data is either pushed or pulled, third-party administrators stand to benefit from claim transactions being made in a more real-time environment, noted Wanda Owen, VP of operations for MedCost, LLC, a TPA.

As formats become less important, she said blockchain participants "become trusted in the data that gets exchanged, whether it be for accumulators with a pharmacy vendor, 834s or stop-loss reimbursement claims." The ability to recognize a coupon at the point of service for a pharmacy transaction can help revolutionize at least the member experience in that space, she added.

It also can have a huge impact on PBM contracts.

Roberti, a co-founder of Zelis Healthcare whose new technology company is focused on blockchain, wondered whether self-insured payers in the future would simply enter formularies into a blockchain, agree on pricing with drug manufacturers and directly reimburse them as part of a smart contract instead of having PBMs handle the negotiations and legwork.

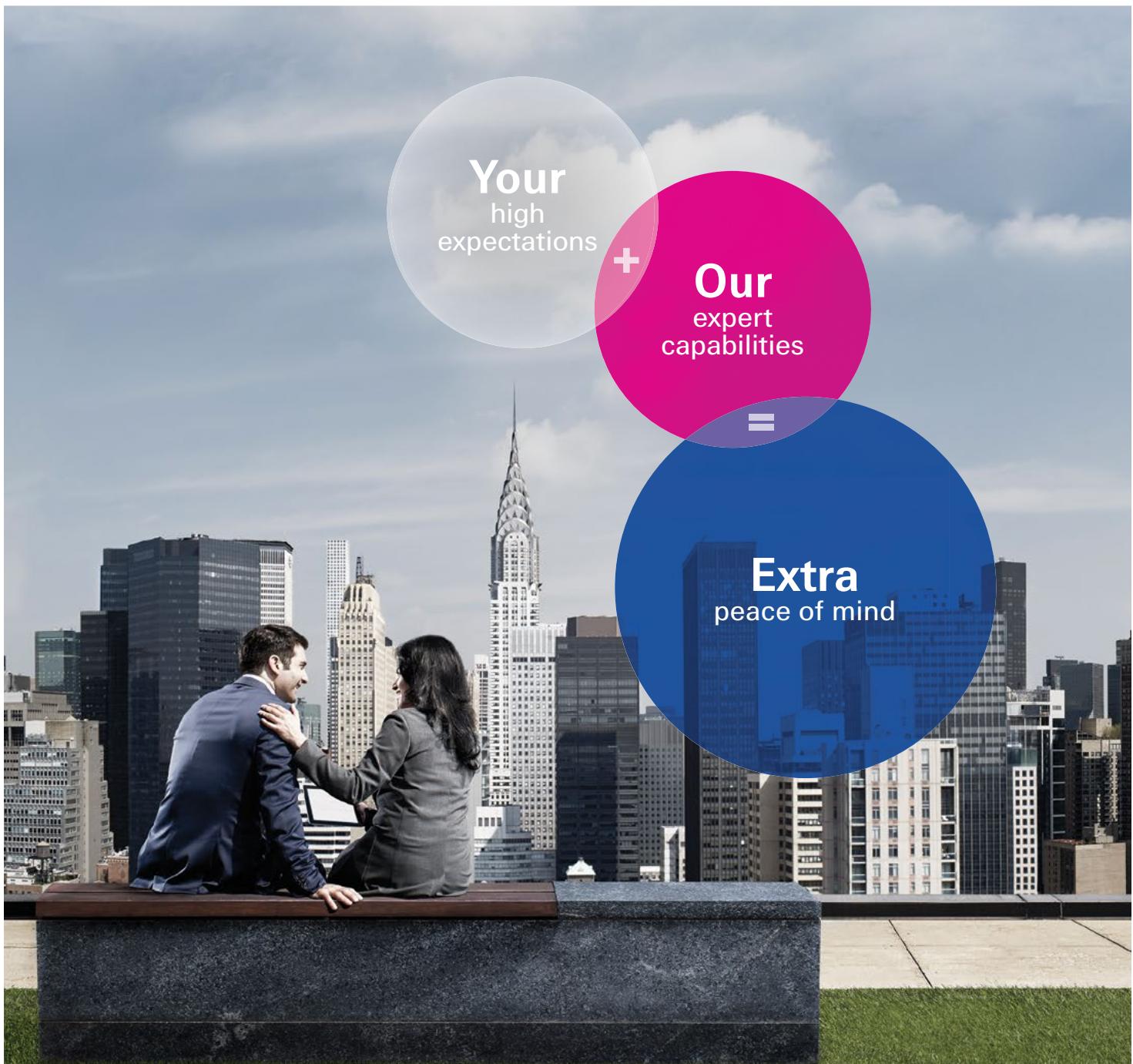
"I don't think that blockchain is really a threat to the PBM space," opined Ryan Kelly, CTO of Capital Rx, a startup PBM. "The expertise that PBMs have in negotiating rebate contracts, working to develop a formulary and contracting with employers is still a necessary and very valuable activity."

Moving his company's revenue cycle onto the blockchain could conceivably result in "same-day immediate settlement" in a real-time environment that would be beneficial for everyone, he surmised. In stark contrast, Kelly said PBMs typically are paid within two days followed by a two-week float back to pharmacies and rebates that are managed, on a six-month lag.

For all its potential, blockchain isn't expected to completely replace existing underwriting or adjudication platform. "This will be an ancillary add-on for real-time visibility," Martin explained, noting minimal cost barriers in the "hundreds of dollars range" vs. millions.

While blockchain technology in health care involves business-to-business applications, he foresees business-to-consumer uses such as electronic medical records that allow patients to control that information and become more engaged. He cited as an example an Amazon app that requires consumers to enter their data at every doctor visit.





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PANEL ASSESSES ALL THE MOVING PARTS OF SPECIALTY RX

Specialty drug costs continue to be a thorn in the side of self-insurance with astounding price increases, but a panel of experts from various industry segments cautioned that there are multiple moving parts that must be assessed and no easy way to contain rising expenses.

Christine Vago, who moderated the session "Taking 360-Degree View of Specialty Drug Issues and Trends Affecting Self-Insured Plans" and leads the national distribution of specialty health products as SVP of OneBeacon Health, noted that a 2018 drug trend report by the Pharmaceutical Strategies Group pegged the average treatment for a specialty drug at about \$52,000, which exceeds the nation's average median wage of \$48,000.

She cited other troubling statistics from the report, noting that specialty drug costs have soared 55% under the medical benefit since 2011 with double-digit annual specialty drug trend under the pharmacy benefit now the norm. In addition, she said specialty drugs are expected to account for half of the total U.S. drug spend by 2020, even though just 1% to 2% of Americans use them.

The panel addressed several key culprits. Jakki Lynch, director of cost containment for Sequoia Reinsurance Services, LLC, identified "automatic fills, considering partial fills or split-fill programs for allowing for a less-than-30-day fill option for some drugs" as top cost drivers in the specialty drug distribution channel.

Other considerations include the medical vs. pharmacy benefit, as well as site of care. "Because the costs and usage of specialty drugs are growing so quickly, this determination becomes more important," she explained, "and the determination of medical benefit or pharmacy benefit usually now requires a drug-by-drug analysis."

The high cost of R&D, marketing and a broken health care system are driving up specialty drug prices, said Steven T. Boyd, PharmD, BCPS, EVP of business development for Southern Scripts.

To defray these expenses, he noted that drug companies inflate the cost of drugs that win Food and Drug Administration (FDA) approval (just one in 10 do), while rebate dollars are used as a pawn for investing in expensive direct-to-consumer marketing and advertising campaigns on television. He said the average cost of bringing a drug to market last year was \$2.6 billion, according to the Tufts Center of Study and Drug Development.

In some cases, Boyd said R&D may involve simply purchasing an ingredient for \$10 billion and selling it at that amount annually over the next six years until the patent wears off. "Is that research and development?" he asked rhetorically. "No."



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Marc A. Sweeney, PharmD, SVP of clinical consulting for ARMSRx Pharmacy Benefit Consulting and founding dean of the School of Pharmacy at Cedarville University, noted that the cost of drugs have been siloed off from medical costs. When Hepatitis C drugs came to market, for example, he said the value of those costly scripts was emphasized relative to "the overall medical management of those patients."

In assessing the cost and value equation, it helps to examine market complexities that lurk behind the scenes. The fact is that pharmaceutical companies are taking on risk and exposing themselves to malpractice lawsuits, Sweeney explained. They're also putting a substantial amount of time and money into R&D with some drugs that are envisioned never getting out of the product pipeline. "So we have to, in some ways, subsidize those unsuccessful research efforts with successful ones," he suggested.

A 2016 analysis Sweeney did with a major chain pharmacy found a \$40,000 variation in how much was invoiced back to the plan between the medical and pharmacy sides. One noteworthy finding was that physicians were earning "a significant amount of money off of billing for those drugs," he reported. "And even though historically we've done a lot of intravenous and injection-types of therapies in the physician office, the real question is, is that causing an inflation of the drug prices?"

While there's plenty of waste in the health care system, Boyd believes the root of the problem is a lack of data transparency and communication among

clinicians and between the TPA, stop-loss carrier, PBM and employer in a collective manner. Also, with profits based on a percentage of specialty drug costs, he cautioned that there's no incentive to lower price tags and the pursuit of profit isn't aligned with the mission to support patients. As long as that approach continues, he lamented that "the cost of the drugs are going to continue to rise."

But there's a very real solution within reach that hasn't been realized, Boyd suggested. "If we had real-time adjudication of medical claims right in the provider's office," he said, "that all of a sudden now expedites the cost of that drug right then and there and allows us to communicate better... The idea of real-time medical adjudication claims would change the industry."

With clinical trial data for common specialty drugs showing efficacies of less than 25%, Vago wondered whether they're worth their high price tags. Slowing the pipeline for approval to raise the level efficacy will dash the hope of patients who are suffering from various conditions that could be treated, according to Boyd, though stressing the importance of having appropriate and efficacious drugs.

It's no surprise that the high cost of specialty drugs can lead to financial ruin. Sweeney pointed out that 40% of U.S. families who have a loved one with a terminal disease become impoverished. Society is wrestling with the question of who should pick up the tab, he said, citing the family, insurer, plan sponsor or government.

One bold approach to ending this cycle of misery is that self-insured employers can actually exclude specialty drugs. But it has to be done right, according to Brady Bizarro, a health care attorney and director for The Phia Group, LLC. To wit: "As long as the plan has a caveat about preventive drugs" and doesn't discriminate against people with particular diseases or conditions, he explained.

Self-funded ERISA plans do not have to cover all essential health benefits, but if they do, he said "they can't impose annual or lifetime dollar limitations on it. Most states do have Rx drugs listed as an EHP, but a plan does not have to cover them." And if that's the case, they must be mindful about multiple categories of discrimination under the Health Insurance Portability and Accountability Act.

"You have to make a distinction between excluding drugs as a treatment vs. excluding the disease," Bizarro said. "If you're excluding all categories of drugs that treat that particular disease, that's a problem. That is discrimination under HIPAA."

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CVS was still reviewing a program for compliance purposes that would exclude specialty drugs over a certain dollar amount, he noted. The trouble with such programs, however, is a tendency to discriminate against classes of drugs that are for particular diseases, Bizarro reiterated.

Another issue is that the health plan would have to notify its members of any such change and follow notice requirements under both ERISA and the Affordable Care Act, he suggested, as well as review and terminate PBM contracts. At the end of the day, he said most self-funded plans decide not to exclude specialty drugs because of the risks involved with such a drastic step.

The panel also addressed the legality and safety of international drug sourcing and medical tourism. Bizarro said "it's technically illegal to import drugs overseas, even people who do so for

personal use. But the risk to the individual who's doing this is very small because the FDA has a policy of non-enforcement in certain situations." While someone who is importing or carrying into the country small amounts of drugs for personal use more than likely wouldn't be prosecuted, he cautioned that "it could be a problem is the plan is importing drugs."

Provider liability also factors into the mix, according to Bizarro, referencing laws in other countries that govern medical malpractice over counterfeit or unsafe drugs routed through tier-one countries such as Canada. "You can never really trust a drug that you're importing that's not FDA approved," he said.

Asked about patient co-pay assistance programs that manufacturers use to reduce the impact of high-cost drugs, Bizarro said there hasn't been a legal challenge to this industry practice, which he hastened to add, can be confusing.

"If you assume that you have a \$3,000 list price of a specialty drug and the plan imposes a \$500 co-pay, if the patient goes to the register and picks up the drug, and they have with them a \$490 manufacturer co-pay card, what are they actually paying out-of-pocket?" he asked. "They're paying \$10, or are they paying \$500? Which amount are they paying? That's the question that we're asking here." ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for 30 years.

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