Health Coverage Options

Janell Williams – CSI Attorney
Lesley Von Eschen – CostCare
Carol Bridges – CostCare
Types of Coverage

- QHP Marketplace Coverage
- Off-Exchange Major Medical Coverage
- Catastrophic Coverage (High Deductible Health Plans)
- Self-Funded Employer Sponsored Coverage
- Association Health Plans (AHPs) / Multiple Employer Welfare Arrangements (MEWAs)
- Medicare Supplemental
- Short Term Limited Duration Health Insurance
- Health Sharing Ministries
- Direct Primary Care (DPC)
<table>
<thead>
<tr>
<th>Essential Health Benefits</th>
<th>No Annual/Lifetime Maximums</th>
<th>Preventive Care</th>
<th>Guaranteed Renewability</th>
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</thead>
<tbody>
<tr>
<td>Health Sharing Ministries</td>
<td>Short Term Limited Duration Insurance</td>
<td>Excepted Benefit Plans</td>
<td>Direct Primary Care</td>
</tr>
</tbody>
</table>
Recent Changes

- NY v. DOL (AHP Suit)

- Association for Community Affiliated Plans, et al. v. US Dept. of Treasury (STLDP Suit)

- Cadillac Tax Repeal Imminent (H.R. 748 – July 2019)

- $0 Individual Mandate Penalty (January 2019)

- DPC Membership Fees - Qualified Health Expense for HSAs (June Executive Order)
NY v. DOL (AHP Suit)

- DOL/EBSA Final Rule modified ERISA Section 3(5) definition of “employer”.
- Rule “intended to expand access to affordable, high-quality healthcare options, particularly for employees of small employers”.
- Establishes criteria for a “bona fide group or association of employers” that may establish a single-employer AHP under ERISA.
- NY and 11 other states sued the DOL.
- District Court ruled in States’ favor - DOL failed to establish a “meaningful limit”
- DOL currently appealing decision.
Final Rule extended the duration of STLDI from 3 months to 12 months.

ACAP filed suit – claimed new definition of STLDI “contrary to HIPAA and ACA and/or arbitrary and capricious”.

“Sought to circumvent” the ACA to “create an alternative health insurance regime”.

Court found that the Rule was not arbitrary or capricious, and that Congress meant to keep STLDI’s separate from ACA reforms.

ACAP is appealing... stay tuned.
• Cadillac Tax: a 40% excise tax on certain plan premiums/contributions exceeding an inflation-adjusted ceiling.
• Tax would be used to help finance the expansion of health coverage under the ACA.
• Originally effective in 2018, pushed to 2020, then to 2022.
• HR 748 – “Middle Class Health Benefits Tax Repeal Act of 2019” 419-6.
• Working through Senate now.
$0 Individual Mandate Penalty

- Effective January 1, 2019, the penalty for failure to maintain coverage reduced to $0.
- Individual Mandate (§5000A) still law, but no penalty assessed.
- Approximately 5% drop in enrollment - total individual market - in Q1 2019 (Kaiser Family Foundation Analysis).
- Unsubsidized enrollment dropped, Subsidized enrollment up.
DPC Membership Fees/HSM Costs

- Requires Dept. of Treasury to propose regulations within 180 days.
- Treat Direct Primary Care Membership Fees and Health Sharing Ministry Costs as eligible expenses under section 213(d) of the Internal Revenue Code.
- This means dollars from your account-based plans (for example, HSAs) can be used to pay for DPC and HSM costs.
- Executive Order also included price and quality transparency initiatives.
Protecting Your Clients

- **Education is Key**
  - Attend Your Agent Trainings/Continuing Education
  - Industry is Changing – Pay attention

- **Listen, Linda!**
  - Stay Attentive/Be Responsive to Clients

- **Appropriateness**
  - Does this product/plan fit your Client’s needs?

- **Document**
  - Details
  - Record Retention
DIRECT PRIMARY CARE

OLD FASHIONED MEDICINE WITH NEW TECHNOLOGY
WHAT IS DPC?

- DPC is a low cost membership model for primary care
- Fixed cost of routine care
- Clearly defined package of services
- Personalized relationship with your provider - panel of patients typically 600 patients per provider
- Separates cost of catastrophic from routine care
- Not Concierge medicine
1138 DPC practices in the US
Montana DPC Practices

- Missoula - CostCare Direct
- Polson - Pure Health Care
- Kalispell - Glacier DPC
- Billings - Flex Family Health
- Bozeman - Bozeman Primary Care
- Whitefish - coming 2020
- Helena - coming 2020
WHY DPC?

- Primary care should be affordable
- 80% Healthcare needs can be met with a primary care provider
- Outside factors that drive up cost:
  - Hospital Facility cost
  - Hospital Administration
  - Labs
  - Imaging
  - Pharmacy
  - Specialty Care
  - Physical Therapy
DPC care is not comprehensive and is best partnered with an affordable wrap around plan
Reduction in Downstream Cost

- ER Visits
- Hospitalizations
- Surgeries
- Specialist Visits

Keep people out of the expensive parts of the healthcare system!
DPC is virtually the opposite of the “see more, do more, bill more” model that is bankrupting our country
DPC Practices Bring Value by Partnering with Multiple Different Plan types

- Equally invested in obtaining services at a lower price to pass these savings
- Motivated to keep patients within the clinic with less referrals to specialists
- Cognizant of patient/employee schedules to help increase productivity and decrease absenteeism both by keeping patients healthy and not requiring in clinic visits for provider interaction.
WHAT’S INCLUDED?

- All office visits
- In office tests
- 24/7 access to your provider via phone, text, email, telemedicine, FaceTime, in office visits
- Pap + HPV screening
- One set of wellness labs yearly
- Flu Shots
- DOT
- Labs, vaccines and in clinic medications at cost +10%
IN-OFFICE TESTS INCLUDED

• RAPID STREP TEST MONOSPOT
• RAPID FLU TEST URINE DIP
• URINE PREGNANCY RSV SCREEN
• CAPILLARY GLUCOSE PAP + HPV
• INR (PROTIME) SPIROMETRY
• EKG AUDIOMETRY
$20 SERVICES

- MOLE REMOVAL
- LACERATIONS
- CYST REMOVAL
- PELLETS
- JOINT INJECTIONS
- IUD/NEXPLANON INSERTIONS
Common Lab Prices

- CMP $4 ($40)
- CBC $2 ($30-60)
- TSH $4 ($35-50)
- HGA1C $3 ($40)
- LIPID PANEL $4 ($30)
- PSA $3 ($30)
- CRP $4 ($25-40)
- IRON PANEL $11 ($70)
- URINALYSIS $3 ($25)
- VITAMIN D LEVEL $3 ($60)
- URIC ACID $3 ($30)
X-RAYS

- $60 X-rays
- Mobile - can come to our office, work or home
- With radiology over-read
MRI

- Orthopedic MRI without contrast $500
- Orthopedic MRI with contrast $700
- both include radiology over-read
# Inquiry to Local UC About Cost to Treat UTI

<table>
<thead>
<tr>
<th></th>
<th>Quote from UC</th>
<th>CostCare Direct</th>
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<tr>
<td>Office Visit</td>
<td>$190-$350</td>
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<tr>
<td>Labs</td>
<td>Average $147</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$397</strong></td>
<td><strong>0</strong></td>
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</table>
# SUTURES

<table>
<thead>
<tr>
<th></th>
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<tr>
<td>VISIT</td>
<td>$1127</td>
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<tr>
<td>PROCEDURE</td>
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<td>TOTAL</td>
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<tr>
<td></td>
<td>ER</td>
<td>COSTCARE</td>
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<td>----------</td>
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<tr>
<td>EVALUATION</td>
<td>$2300</td>
<td>$127</td>
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<td>EKG</td>
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<td>$30</td>
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<tr>
<td>LABS</td>
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<tr>
<td>TOTAL</td>
<td>$3531</td>
<td>$377</td>
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</tbody>
</table>
Medications
Some at cost to pharmacist
or
Generic: Cost + $5
Name Brand: Cost + $12
Case Study

- Digital Globe provides satellite images

- 2015 offered DPC + catastrophic care plan to employees in addition to the traditional PPO plan

- 205 employees enrolled for the DPC plan, 7 mo, Colorado
FINDINGS

- **Risk Reduction:** In the first 7 months, the average risk score decreased from 9.17 to 8.74 (4.9% reduction)

- **Diverted Costs:** $221,442 of cost diverted from the plan. Also early intervention including pre-diabetes and pre-cancerous conditions
Union County, NC

- John Locke Foundation Article (johnlocke.org)
- 1000 employees, savings of $1.28 million in year 1
- 59% had 1 chronic illness
- 35% had 2+ chronic conditions
- 46% decrease in out of pocket expenses reported by employees
- Redirected $750 from HRA to DPC
DPC is....The Answer

Accessible
Bi-partisan
Transparent
Cost
Effective
Questions?
Lesley VonEschen, PA-C
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Dr. Carol Bridges, MD
406-546-2446
ajannie1@yahoo.com
CSI Initiatives, Actions and Leadership

Kristin Hansen, Deputy State Auditor
Marilyn Bartlett, Special Projects Coordinator
Office of the Montana State Auditor, Commissioner of Securities and Insurance
CSI Authority

• 33-1-311(2) The commissioner has the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of the laws of this state.

• 33-1-311(3) ... [T]he commissioner shall administer the department to ENSURE THAT THE INTERESTS OF INSURANCE CONSUMERS ARE PROTECTED.

• 33-1-311 (4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of the laws of this state or to secure information useful in the lawful administration of any provision.
Here's How Much Soaring Health Care Prices Have Cost American Workers

Montana hospital prices among highest in national study
BY MIKE DENNISON/MTN NEWS

1 in 4 Americans have to refuse medical care because they can’t afford it
Published: June 6, 2017 4:40 p.m. ET

Health insurance deductibles soar, leaving Americans with unaffordable bills
Medical Bill Bankruptcy

Medical Bills Are the Biggest Cause of US Bankruptcies: Study

CNBC

Matt M. Rosendale
Commissioner of Securities & Insurance
Americans paying too much for healthcare

In 2017, Private Insurance paid $900 billion in hospital, physician and clinic, and prescription drug spend

Costs have tripled in 20 years.

Source: Kaiser Family Foundation, Peterson-Kaiser Health System Tracker
STATE AUDITOR EMPLOYEE LISTED AS ONE OF FORTUNE MAGAZINE’S “WORLD’S GREATEST LEADERS”

APRIL 18, 2019 2019, LEGISLATURE, PRESS RELEASE
Marilyn Bartlett recognized for her inspiring leadership
CSI taking leadership role to lower healthcare costs

<table>
<thead>
<tr>
<th><strong>Research</strong></th>
<th><strong>Engagement</strong></th>
<th><strong>Action</strong></th>
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<tbody>
<tr>
<td>Johns Hopkins</td>
<td>N Carolina Clear Pricing Project</td>
<td>Regulatory</td>
</tr>
<tr>
<td>Brookings Institute</td>
<td>Colorado Hospital Value Project</td>
<td>Legislation</td>
</tr>
<tr>
<td>UC Hasting</td>
<td>Maine Legislature</td>
<td>Federal Trade Commission</td>
</tr>
<tr>
<td>RAND</td>
<td>Washington Health Benefit Exchange</td>
<td>Senate HELP Committee</td>
</tr>
<tr>
<td>NCOIL</td>
<td>Employer Forums (Indiana, California, Texas, Pennsylvania, Wisconsin)</td>
<td>Senate Finance Committee</td>
</tr>
<tr>
<td>NAIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NAAG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A Health Check on COPAs - Assessing the Impact of COPAs in...

On June 18, 2019, the Federal Trade Commission hosted a public workshop...
Taking Action - Pharmaceutical costs

• CSI Research lead to Legislative action

• Senate Bill 71, “Regulate health insurers' administration of pharmacy benefits for consumers”
  ✓ Health Insurer accountable for providing transparent, pass-through RX benefit for individual products
  ✓ 100% Rebates to Insurer; No Spread Pricing. Savings to benefit of consumer.
  ✓ Formularies – No Conflict of Interest
  ✓ Expand consumer access – mail order cannot replace retail

• And what happened?
  Feb 27: Passed Senate 37-3
  Apr 4: Passed House 71-27
  May 9: Vetoed by Governor

• CSI action continues
  • Maine Legislature – LD 1504
  • US Senate – Lower Health Care Cost Act – Section 306
  • National Academy of State Health Policy (NASHP)
  • NCOIL and NAIC
340B Program

• Program inception in 1992
  ✓ Designed to correct an unintended consequence of 1990 Medicaid drug rebate program that resulted in higher drug prices for the VA and safety-net providers.

• Manufacturer. To participate in Medicaid, VA, and US Department of Defense prescription drug contracting programs, must participate in 340B program. Manufacturer must sell listed drugs at deeply discounted prices to Covered Entities.

• Covered Entity. “Serve the nation’s most vulnerable patient populations.” Initially included only qualified DSH Hospitals and limited safety-net providers (about 2700 entities).

• Patient. Must be a patient of the Covered Entity.

• Contracted Pharmacy. Covered Entity may contract with outside pharmacy to dispense drug.
340B Basics

Covered Entity pays 340B Price to Manufacturer

Manufacturer distributes Outpatient Drug to Covered Entity

If insured, Patient pays Cost Sharing

Covered Entity Dispenses Outpatient Drug

Plan (or PBM) pays their contracted rate

Drug Manufacturer

Patient’s Plan (if insured)

Original Intent:
• Uninsured Patient receives deep discount
• Insured Patient – Plan benefit paid. Covered Entity uses spread benefit low income, indigent patients
340B More Players Enter the Game

Covered Entity pays 340B Price to Manufacturer

Covered Entities

Drug Manufacturer

Money transfers both ways: Plan payment to Covered Entity offset by Dispensing Fees

Patient pays Cost Sharing

Contracted or Covered Entity Pharmacy Dispenses Drug

Patient

Specialty Pharmacies

Retail Pharmacies

Covered Entity Pharmacies

PBM

Manufacturer distributes Drug to Pharmacy

Plan payment passes through PBM

Patient’s Plan
Research into 340B Program

• 149 Covered Entities in Montana; 208 Contracted Pharmacies serving Montana Covered Entities

• No transparency into contracted pharmacy fees, investment in outpatient programs for low income patients, patient eligibility or expansion into hospital owned clinics in affluent areas.

• GAO’s latest findings showed 2 out of 3 hospitals did not offer the 340B discounted drug price to low-income, uninsured patient.

• Nationally, 340B discounted drug purchases now total $24.3 billion (up 26% from the prior year)

• 340B unintended consequences leading to anti-competitive practices:
  • NFP Hospitals buying physician practices and building stand alone infusion centers with 340B profits.
  • 340B covered entities offering low drug prices to insurance companies and employer health plans in return for patients using the entity’s other services
  • Providers incentivized to prescribe 340B eligible drugs that may lead to higher costs for insurer, taxpayer (Medicare/Medicaid) and Patient (Coinsurance)
  • Cost shifting to Commercial Market
Initiative: 340B Program

- 340B is a Federal program
- 340B is a sacred cow - Who will rein in the 340B program when many parties are profiting?
- CSI Initiatives
  - CSI Research
    - Is the program raising costs for consumers?
    - Are profits earned on 340B used to assist low-income, uninsured patients?
    - Does the 340B program create anti-competitive practices?
  - Federal and National Level
    - Working with FTC – do anti-trust issues exist within the current program?
    - Congressional bills introduced
Hospital Prices

Average Hospital Prices for Privately Insured vs. Medicare, 2015-17 (%)

Rand Corporation, 2019
The problem with Charge Master pricing

- Charge Master is produced by the hospital and lists the “charges” for services and supplies.
- Charges have little, if any, relationship to costs; insurer, Medicaid or Medicare reimbursements; or competitor charges.
- Ratio of cost to charges is most commonly used by a hospital to “estimate” the cost of a procedure.

- Cost to charge ratios ranged from 26% to 52% for the 10 large acute care facilities in Montana
- Charge master rates have been used by not-for-profit hospitals in reporting the value of community benefit.
Community Benefit Reporting – NFP Hospitals

2014 Report – Prepared for Montana Attorney General by School of Public and Community Health Sciences (University of Montana)

- 41% Subsidized Services
- 37% Charity Care
- 17% Unreimbursed Medicaid
- 5% Community Benefit

Total Community Benefit = $169 Million
Charity Care = $59 million
Calculated tax benefit = $56 million
# New Reporting Standards - FASB

<table>
<thead>
<tr>
<th>2014 Report</th>
<th>Uncompensated Care Category</th>
<th>2019 Accounting Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsidized Services</td>
<td>Explicit Discounts</td>
<td>Report only contracted amount as revenue, with no expense for discounts</td>
</tr>
<tr>
<td>Subsidized Services</td>
<td>Implicit Discounts</td>
<td>Report only revenue based on historical or expected collection, not charge master rates. No expense for discounts. If actual collections vary significantly in a grouping, reduce revenue.</td>
</tr>
<tr>
<td>Charity Care</td>
<td>Bad Debt Expense</td>
<td>Report only uncollected contracted amounts (explicit and implicit)</td>
</tr>
<tr>
<td>Charity Care</td>
<td>Charity Care</td>
<td>Report COST of charity care provided under hospital documented charity care program</td>
</tr>
</tbody>
</table>
Fact Checking

Subsidies for 10 Montana Large Acute Care Hospitals:

• Medicare Reimbursements covered average of 91% of the hospital’s Medicare Costs

• Medicaid Reimbursements with CMS Supplemental Payments covered average of 104.5% of the hospital’s Medicaid Costs

• Additional Medicare HVBP payments totaled $1.2 million. Applied to MS-DRG reimbursements on per claim basis under PPS payments

• Hospitals receiving additional profits from 340B Program
Taking Action - Lower hospital prices

- **Rep Tom Woods brought forth HB 747**

- **HAPPI Bill (Hospital and Provider Payment Initiative)**
  - ✓ 250% Medicare, Approval required by Commissioner for price to exceed allowed price
  - ✓ Appeals Process, Monitoring and Reporting
  - ✓ Penalty = $5,000 per violation

- **And what happened?**
  - March 27: Passed House Business and Labor Committee 13-6
  - March 28: MHA activates Voter Voice portal; Insurance Carriers, Hospitals, MHA lobbyists work overtime
  - March 29: House Floor – Amendment passed 80-19 (Facilities pay costs of initiative)
  - March 29: House Floor – Amended bill failed 38-62
  - March 30: House Floor – Reconsideration – failed 34-66

- **CSI Action continues**
  - ✓ Washington Health Benefit Exchange
  - ✓ Colorado Hospital Value Project
  - ✓ N Carolina Clear Pricing Project
CSI asking the questions

• Does Not for Profit Status contribute to hospital cost increases?
• Can Community Needs reporting be improved for accuracy and relevance?
• Does Provider Network contracting prohibit insurer or employer from implementing Centers of Excellence, Medical Tourism, or Telemedicine?
• How do the various facets/issues in the healthcare distribution/payment process impact Critical Access Hospitals?
• Do network access requirements give an advantage to Acute Care Hospitals in network negotiations?
• Do Government policies discourage new entrants into the hospital marketplace?
• What is preventing transparency into hospital prices and anticompetitive contracts?
Minimum Loss Ratio (MLR)

- Affordable Care Act
- Requires health insurance companies to report proportion of premium dollars spent on claims and quality improvement
- CFR 45 158.210
- Required to issue rebates to enrollees if percentages not met.

<table>
<thead>
<tr>
<th></th>
<th>Individual and Small Group</th>
<th>Large Group</th>
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<tbody>
<tr>
<td>Premiums</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Claims and Quality Improvement Expenses (at least)</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Administrative Expenses and Profits</td>
<td>20%</td>
<td>15%</td>
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</table>
Initiative: MLR reporting

- Minimum Loss Ratio (MLR)
  - 45 CFR 158.140(b)(3)(ii)
  - PBM Retained Rebates = Administrative Expense?
  - Actuarial Memorandum

- Research
  - MLR Reporting Practices
  - Contracting Practices
  - Opaque system
  - Potential underpayment of subscriber rebates by the insurer if MLR incorrectly calculated

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
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<tbody>
<tr>
<td>Premiums</td>
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<tr>
<td>Claims</td>
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<td>Medical</td>
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<td>RX</td>
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<tr>
<td>Less RX Rebates</td>
<td>$(500,000)</td>
<td>$(900,000)</td>
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<tr>
<td>Net Claims</td>
<td>$ 8,000,000</td>
<td>$ 7,100,000</td>
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<tr>
<td>MLR</td>
<td>80%</td>
<td>71%</td>
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Spread Pricing = $500,000
Rebate Retention = $400,000
WRAP UP