IT'S NOT THE "WHAT" IT'S THE "HOW"

HDHP BENEFIT DESIGN CONSIDERATIONS FOR MEMBERS ON SPECIALTY MEDICATIONS

FOR EMPLOYER HEALTH CARE BENEFITS SPECIALISTS ONLY

HDHP=high deductible health plan.

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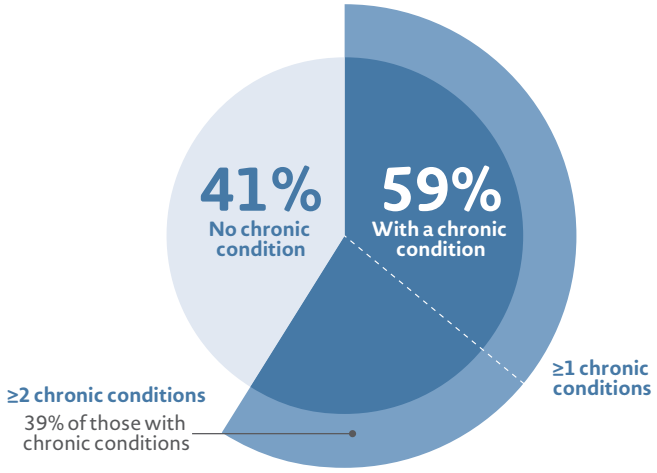
CHRONIC DISEASES MAY AFFECT MANY MEMBERS, AND THESE CONDITIONS CAN BE COSTLY TO EMPLOYERS

Chronic diseases affect nearly 200 million Americans and may cost more than $2 trillion annually[1]*

US population with chronic conditions in 2015[1,2]



- In 2015, **191 million people in the United States had at least one chronic disease**; 75 million had 2 or more chronic diseases[1]
- Chronic diseases are projected to cost the United States **$2 trillion in medical costs** on average annually through 2030[1]

ALTHOUGH THE PREVALENCE OF COMPLEX, CHRONIC DISEASES SUCH AS RHEUMATOID ARTHRITIS IS LOW, **THESE CONDITIONS CAN BE COSTLY**[3,4†]

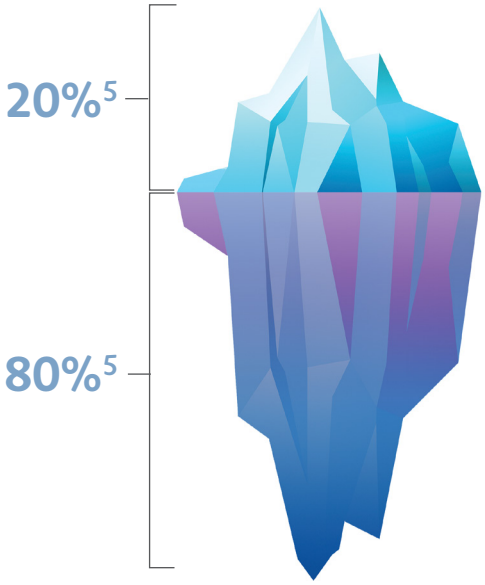
The total cost of chronic diseases such as RA is primarily driven by indirect costs, not just pharmacy and medical costs

Direct health costs[5]

- Medical care
- Pharmacy costs

Indirect costs[5]

- Presenteeism and absenteeism, for example:
  - Overtime pay
  - Turnover
  - Hiring of temps
  - Training replacement workers
- Business impact, for example:
  - Delayed work/deliveries
  - Customer complaints
  - Variable quality



INDIRECT COSTS RESULTING FROM EMPLOYEES WITH RA MAY BE AS HIGH AS **$22,000 ANNUALLY PER EMPLOYEE**[6]

RA=rheumatoid arthritis, a systemic autoimmune disease which attacks synovial tissues within joints. RA causes chronic pain and swelling and can cause permanent disability.

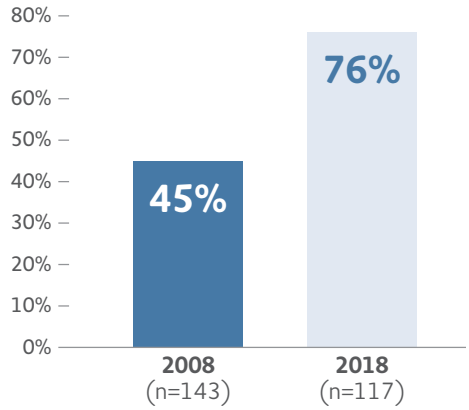
*Projected average of $2 trillion in medical costs annually (2016-2030).

†The overall age-adjusted prevalence of RA among individuals aged 18 years or older on January 1, 2014, ranged from 0.53% to 0.55%, according to an observational, retrospective, cross-sectional study of two US administrative health insurance claims databases.[3]

THE BENEFITS TO MANAGE THESE COSTS POSE CHALLENGES DUE TO LOW HEALTH LITERACY

In an attempt to manage direct health care costs, many employers have turned to HDHPs with HSAs[7]

Percentage of Employers offering HDHPs



Potential reasons for offering HDHPs

- Help keep overall health care spend down
- Remain below Cadillac Tax thresholds
- Members need to have more "**skin in the game**"
- Members need to be "**smarter health care consumers**"

Unfortunately, members may lack the health literacy to fully understand their health care benefits

In a 2017 survey of >1000 US adults:

61% Knew the correct meaning of the term **health plan premium**

62% Recognized the correct definition of the term **health plan deductible**

39% Knew the meaning of the term **out-of-pocket maximum**

31% Had a good understanding of the term **coinsurance**

Only 9% could correctly define all 4 common insurance terms[8]

MEMBERS MAY NOT FULLY UNDERSTAND THE OUT-OF-POCKET **FINANCIAL RESPONSIBILITY** ASSOCIATED WITH THEIR BENEFIT CHOICES IF THEY DON'T UNDERSTAND THESE BASIC TERMS

HSA=health savings account.
Source: Telephone survey of 1006 US adults, 2017.

IN ADDITION, THEY MAY LACK THE NECESSARY FUNDS IN THEIR HSAs TO COVER THEIR DEDUCTIBLE

Less than 50% of employees with HSAs contribute to their accounts—and those who contribute still fall short of their deductibles[9,10]

In a database of 5.5 million HSA accounts in 2016, average contributions among those who contributed[9]:

Employees: $1987

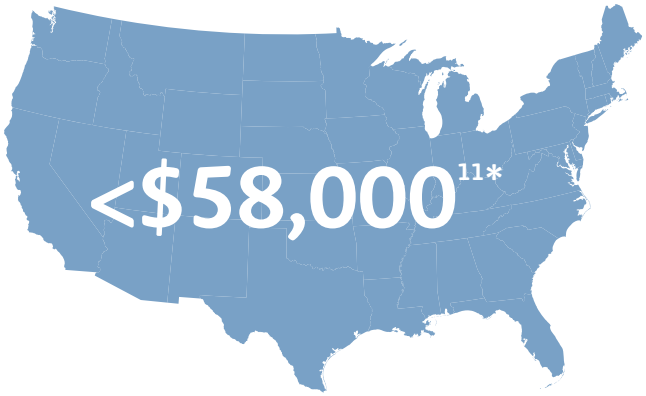
Average deductibles for HSA-qualified HDHPs in 2017[10]

Single: $2433

Family: $4647

Many members may lack sufficient income to significantly contribute to their HSAs

National median household income in the US



More than **3 in 4** US workers live paycheck-to-paycheck[12]

1 in 10 US workers making $100,000 live paycheck-to-paycheck[12]

*2016 inflation-adjusted dollars.

AS A RESULT, HDHP MEMBERS MAY NOT BE GETTING THE CARE THEY NEED[13]

HDHP members are delaying needed care or avoiding it altogether[13]

In a 2016 national online survey of covered employees

1 in 3 HDHP members reported that they had:

- **Skipped a doctor visit**
- **Avoided x-rays**
- **Avoided a blood test**
- **Delayed a recommended procedure/surgery**
- **Did not fill a prescription**

Only 44% of HDHP members **believe they are keeping up** with routine doctors' appointments and checkups*

Avoidance of needed care may lead to more ED visits

In a 2015 poll, **7 in 10** emergency physicians reported having seen insured patients who had **delayed seeking medical care because of high deductibles and other OOP expenses.**[14,†]

In a recent study that examined the **impact of a full-replacement HDHP** on health services utilization over 5 years (2006-2010), employees who switched from a PPO to an HDHP[15,‡]:

- **Reduced** their outpatient **physician visits** and **prescription drug** fills in each of the 4 years post-HDHP enrollment[§]
- **Increased** their **ED visits** in the fourth year post–HDHP enrollment[‖]

WHAT HAPPENS TO MEMBERS NEEDING **SPECIALTY MEDICATIONS?**

ED=emergency department.

Source: Guardian Workplace Benefits Survey of 1439 employees, 2016.

*Compared with 50% of employees with a traditional health plan.

†Patients with health insurance through private and exchange plans only.

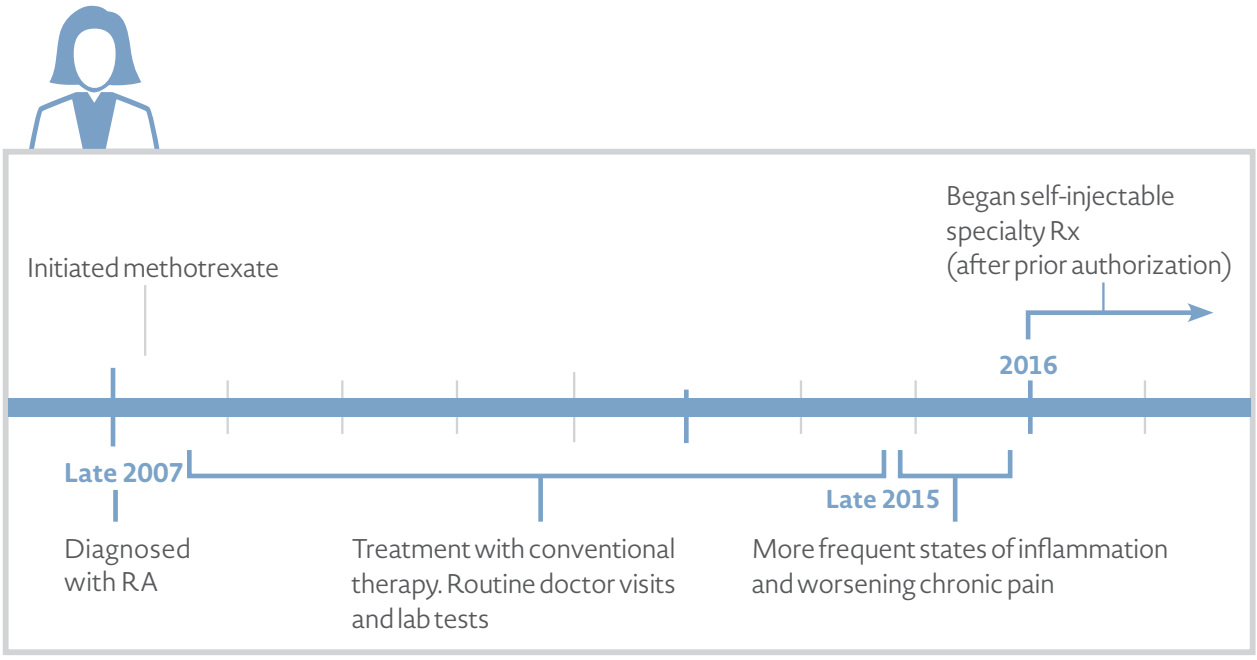
‡Effects of a full-replacement HDHP on health services use relative to the level of use before 2006, when the HDHP was implemented.

§For 2007, 2008, 2009, and 2010, the marginal effects of a full-replacement HDHP were reduced as follows: physician visits by 0.4749, 0.2321, 0.2170, and 0.2591, respectively ($P<0.01$), and prescription drug fills by 1.3681, 0.9162, 0.8038, and 0.8469, respectively ($P<0.01$). It is unknown whether people reduced unnecessary prescriptions or reduced necessary pharmaceutical services.

‖For 2010, ED visits increased by 0.0179 ($P<0.05$). More research is needed to understand the increase in ED use.

CONSIDER JANE
A LABORATORY TECHNICIAN, MARRIED WITH 2 KIDS, $48K SALARY

FICTIONAL. FOR ILLUSTRATIVE PURPOSES ONLY.



With her medication cost as part of her deductible, **her HSA contribution** in January **won't cover her prescription cost, leaving her with a large OOP responsibility**

	Monthly Premium	Rx Cost	
PPO	$434	$100 (co-pay)	**Total OOPs January.....$534**

In 2018, Jane switched from a PPO to an HDHP with an HSA; however, she doesn't have the money she needs for her specialty medication in January

HDHP	$200	$4000 (deductible)	**Total OOPs January .....$4200** Jane's contribution .....($250) Employer HSA contribution.....($1000) **Jane's net expense in January $2950**

EVEN THOUGH JANE IS CONTRIBUTING TO HER HSA EACH MONTH,
HOW WILL SHE AFFORD HER MEDICATION AT THE BEGINNING OF THE YEAR?

OOP=out-of-pocket; PPO=preferred provider organization. Rx=prescription.

JANE MAY OBTAIN MANUFACTURER CO-PAY ASSISTANCE—WHAT HAPPENS THEN?

Jane's coverage and manufacturer program*:

Benefit design:
$4000 deductible, **20%** co-insurance, **$100** monthly cap (after deductible is met)
Drug cost:
$4000 per Rx
Co-pay assistance program:
$12,000 annual limit; member responsible for monthly **$5** OOP until limit is reached

Month	Deductible Balance at Beginning of Month	Medication Cost	Jane OOP	Manufacturer Support
January	$4000	$4000	$5	$3995
February	$0	$4000	$5	$95
March	$0	$4000	$5	$95
April through December	$0 (per month)	$4000 (per month)	$5 (per month)	$95 (per month)
Annual Totals	**$4000**	**$48,000**	**$60**	**$5040**

Some employers have concerns about the use of manufacturer co-pay assistance by members in HDHPs

Examples of concerns expressed by employers and benefits consultants

"...These co-pay cards are circumventing our plan design."

"These members have signed up for these plans, paid lower premiums... they SHOULD pay their deductible themselves."

"It's not fair that a woman who has a baby has to pay her deductible, yet a woman on a biologic for RA does not."

*This fictional scenario is for illustrative purposes only. It represents a worst-case scenario and assumes NO other health care expenses that may apply toward the deductible.

PBMs ARE OFFERING CO-PAY ACCUMULATOR ADJUSTMENT PROGRAMS— BUT WHAT COULD HAPPEN TO JANE?

- **Co-pay Accumulator Adjustment Programs** ensure co-pay assistance does not count against member deductibles and/or annual OOP max[16]
- Such programs can lead to a "**co-pay surprise**" for members like Jane

Month	Deductible Balance at Beginning of Month	Medication Cost	Jane OOP	Manufacturer Support
January	$4000	$4000	$5	$3995
February	$3995	$4000	$5	$3990
March	$3990	$4000	$5	$3985
April	$3985 (per month)	$4000 (per month)	$5 (per month)	$95 (per month)

What could happen to Jane when she faces "co-pay surprise?" Will she stop taking her RA medication?

- Will Jane's condition potentially worsen?
- How will she perform at work?
- Could she end up in the hospital?
- Who will take over her work while she is out?
- Does she have good disability benefits?
- How will she care for her family?

HOW WOULD THIS IMPACT HER **EMPLOYER'S HEALTH CARE** AND OTHER ORGANIZATIONAL **COSTS**?

PBM=pharmacy benefits manager.

*This fictional scenario is for illustrative purposes only. It represents a worst-case scenario and assumes NO other health care expenses that may apply toward the deductible.

NOTE: These are not inclusive of all potential reactions to a patient facing high medication OOP costs.

HOW CAN YOU HELP MEMBERS LIKE JANE WITHOUT SACRIFICING YOUR BENEFIT DESIGN GOALS?

Augment Jane's Plan Options

Offer HDHPs with HRAs or PPOs in addition to HSA plans

- Implement a $0 or low-cost pharmacy deductible in those other plan options
- Work with your carrier to reach out to members on specialty medications and offer them the opportunity to switch to an HRA or PPO option

Modify How Deductibles Are Implemented

Examine ways to adjust deductibles or the medications that are subject to the deductible

- Consider ways to modify which specialty drugs are subject to the deductible
- Evaluate opportunities to keep deductibles as low as possible (and adjust premiums as necessary)

WHAT WOULD **PHARMACY AND MEDICAL COSTS** BE AS A RESULT OF CHANGES LIKE THESE?

Members like Jane have considerable pharmacy costs due to their Rx benefit specialty medications, but they also incur high medical costs during the year

Prime Therapeutics conducted a study on the 2016 prevalence, drug treatment, and total medical and pharmacy claims expense in a 15-million-member commercially insured population[17]

Benefit Category	Total Average Annual Costs
PHARMACY BENEFIT HEALTH CARE:	
Self-injectable specialty Rx for RA	**$30,990**
Other pharmacy benefit health care	
MEDICAL BENEFIT HEALTH CARE:	
Outpatient care (eg, office visits, imaging)	**$12,362**
Inpatient care	
Total Average Annual Cost	**$43,352**

CAN BENEFITS BE ADJUSTED, YET STILL ENSURE **MEMBERS PAY THEIR DEDUCTIBLE**?

HRA=health reimbursement arrangement; PPO=preferred provider organization.

*This fictional scenario is for illustrative purposes only. It represents a worst-case scenario and assumes NO other health care expenses that may apply toward the deductible.

IF JANE'S PHARMACY BENEFIT RA SPECIALTY MEDICATION **IS** SUBJECT TO HER DEDUCTIBLE, SHE WILL COVER HER ENTIRE DEDUCTIBLE WITHIN THE FIRST QUARTER[17]

Jane's coverage

Deductible: $4000

Rx: 20% coinsurance ($100/month cap) after deductible is met

Medical: $25 office co-pay, $200 hospital co-pay, 20% lab fees after deductible is met

- If Jane's pharmacy benefit RA medications are subject to the deductible, she will satisfy her deductible in the first quarter of the year with her first prescriptions
- After Jane spends $4000 on her pharmacy care, her health care would cost her the post-deductible cost-share

	Q1	Q2	Q3	Q4
PHARMACY BENEFIT HEALTH CARE	Jane meets her deductible on pharmacy costs	← Post-deductible cost-share →		
MEDICAL BENEFIT HEALTH CARE	← Post-deductible cost-share →			

Employer

- Jane's employer cost will be $0 until Jane spends $4000
- Her employer pays nothing for the first 1-2 pharmacy fills, depending on the cost of the medication
- However, her employer would pay the post-deductible cost-share for medical care starting in Q1

	Q1	Q2	Q3	Q4
PHARMACY BENEFIT HEALTH CARE	$0 until $4000 in Rx expense	← Post-deductible cost-share →		
MEDICAL BENEFIT HEALTH CARE	← Post-deductible cost-share →			

DOES THIS HELP ENSURE JANE IS A "SMARTER HEALTH CARE CONSUMER"?

IF JANE'S PHARMACY BENEFIT RA SPECIALTY MEDICATION IS **NOT** SUBJECT TO A DEDUCTIBLE, SHE WILL STILL HAVE TO PAY HER ENTIRE DEDUCTIBLE, LIKELY BY Q3[17]

Jane's coverage

Deductible: $4000

Rx: 20% coinsurance ($100/month cap) after deductible is met

Medical: $25 office co-pay, $200 hospital co-pay, 20% lab fees after deductible is met

- Jane has a $4000 deductible for her medical care, so she will pay the full cost of her medical care until she meets her deductible
- If she meets her deductible in the 3rd quarter, her post-deductible coverage begins
- Jane WILL need to pay her full $4000 deductible, but she will be able to do it over the course of the year

	Q1	Q2	Q3	Q4
PHARMACY BENEFIT HEALTH CARE	← No Deductible – regular cost-share (i.e., $100 / month) →			
MEDICAL BENEFIT HEALTH CARE	Pre-deductible: Jane pays full cost		Jane meets her deductible	Post-deductible cost-share

Employer

- Jane's employer pays $0 for her medical care until she meets her $4000 medical deductible
- Assuming she meets her deductible in the third quarter, at that point, her employer will begin paying for a portion of her medical care

	Q1	Q2	Q3	Q4
PHARMACY BENEFIT HEALTH CARE	← No Deductible – regular cost-share →			
MEDICAL BENEFIT HEALTH CARE	$0	$0	$0 or some post-deductible cost-share	Post-deductible cost-share

EMPLOYERS WOULD SPEND MORE ON PHARMACY BENEFITS IN THIS SCENARIO, BUT WOULD PAY LESS IN MEDICAL BENEFITS, WHICH COULD BALANCE OUT

"HOW" YOU DESIGN YOUR HDHPs CAN HELP YOU ACHIEVE YOUR GOALS WITHOUT CREATING UNINTENDED CONSEQUENCES FOR YOUR MEMBERS

HOW TO
Design Your HDHP Options:

- Provide an HDHP with a HRA with a $0 or low Rx deductible
- Add HDHP options with lowest possible deductibles
- Work with your benefits partners to contact members who have chosen plans with the highest deductibles and who have a history of high health care costs and educate them on their options

HOW TO
Revise Your HSA Funding Options:

- Frontload your company's contributions
- Encourage employees to take premiums savings and put them into their HSAs
- Consider strategies that allow members to tap into HSAs before the account is fully funded

HOW TO
Determine Medications Subject to the Deductible:

- Evaluate modifications to your Preventive Drug List (PDL)
- Talk to your PBM about its PDL and carefully consider implementing modifications

HOW YOU DESIGN YOUR BENEFITS CAN ELIMINATE THE NEED FOR PROGRAMS LIKE ACCUMULATOR ADJUSTORS

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