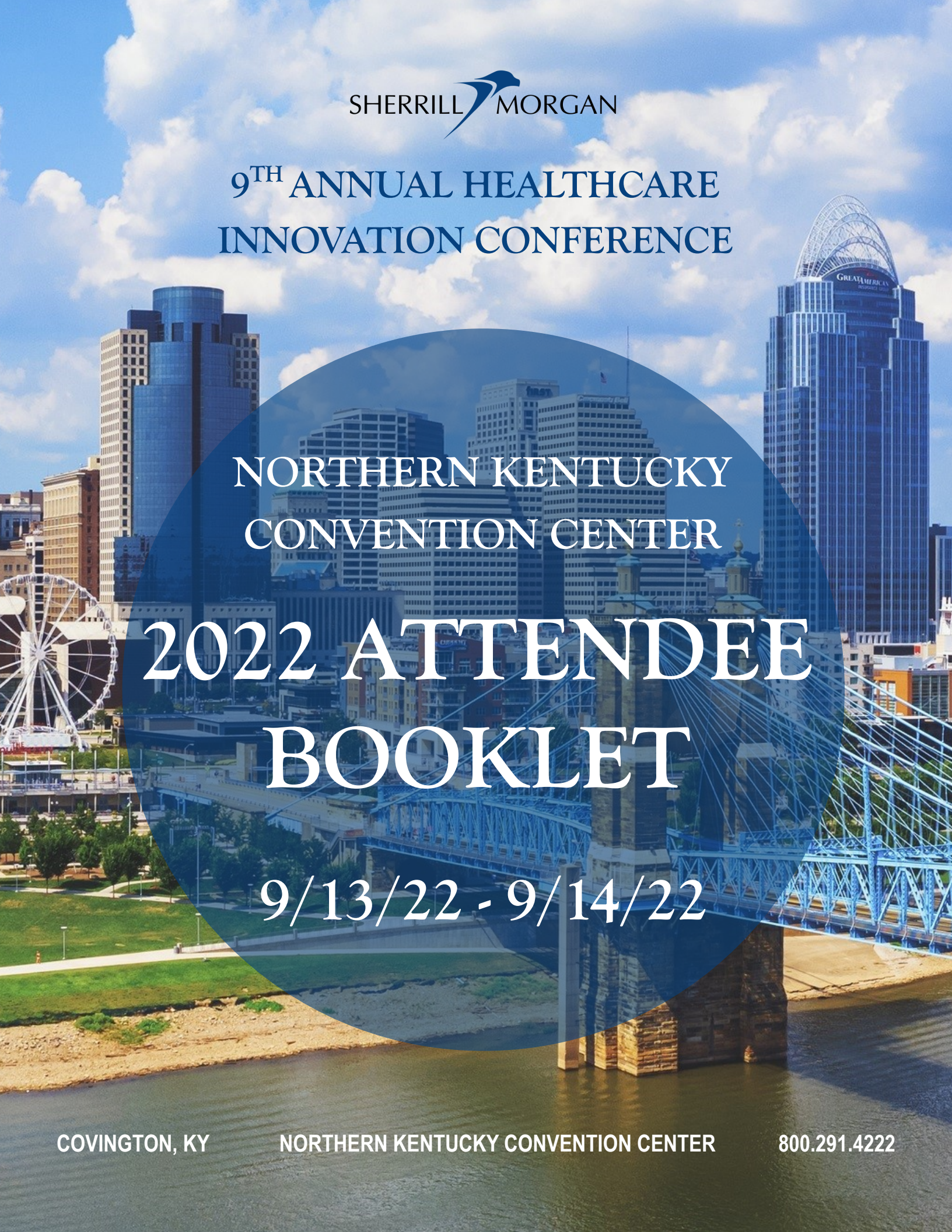
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DAY 1 INNOVATOR BIOGRAPHIES

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Mike Williams, *C.E.O.* - SHERRILL MORGAN

Mike has been with SHERRILL MORGAN for more than 20 years and has been instrumental in developing the company's fully insured and small group divisions. He has been a driving force for groups to implement new cost cutting solutions such as pooling and small group self-funding. As a licensed Agent and Consultant, Mike has extensive health insurance knowledge of claims issues, state laws and guidelines, and customer service. Mike is regularly sought to be a speaker on topics such as community rating, collaborative health plans, and innovative plan design options.

Mike is also an active member in the health care industry having served on several insurance company advisory boards and on several state advisory panels including the Insurance Coverage Affordability and Relief program in Kentucky. He has also been an advocate for transparency with pricing of drugs and services in the industry and practices that transparency as one of SHERRILL MORGAN's core values.

Frank N. Stockdale Carney, *Shareholder* - Evans Petree

Mr. Carney's practice is grounded in federal, state, and local tax codes and regulations. He works directly with clients in employee benefits, tax planning, and estate planning. He understands the need to navigate these complex laws while providing options for each unique situation. His practice areas include but are not limited to the following:

- Employee and welfare benefit plans of private, tax-exempt, and governmental employers
- Other post-employment benefit trusts
- Executive compensation
- Corporate and individual tax planning
- Estate planning
- State and local sales and corporate franchise/excise taxes
- Health law

Mr. Carney is a member of the American, Tennessee, Memphis and Shelby County Bar Associations, American Society of Pension Professionals and Actuaries, National Association of Public Pension Attorneys, National Association of Bond Lawyers, and the NHLA/AAHA American Health Lawyers Association. He is AV-rated by Martindale-Hubbell. Mr. Carney was recently selected by his peers for inclusion in *The Best Lawyers in America* 2022 in the fields of Employee Benefits (ERISA) Law, ERISA Litigation, Trusts and Estates, and Tax Law for the thirteenth year. He was named the *Best Lawyers* 2022 Employee Benefits (ERISA) Law "Lawyer of the Year" in Memphis, the *Best Lawyers* 2021 Litigation-ERISA "Lawyer of the Year" in Memphis, and the *Best Lawyers* 2020 Employee Benefits (ERISA) Law "Lawyer of the Year" in Memphis. Mr. Carney was selected as a fellow of the American Bar Association in 2020.

Catalina Gorla, *Chief Executive Officer*– TruDataRx

Catalina serves as the Chief Executive Officer for TruDataRx. In this role, Catalina works closely with the clinical team and clients of TruDataRx to ensure an exceptional customer experience that results in meaningful savings in pharmacy benefits driven by rigorous evidence-based analytics. Catalina also works with the TruDataRx development team to build the analytical tools and software that drive the value for clients.

Catalina has spent the past 10 years working in healthcare in a range of roles involving research commercialization, enterprise formation, and operations development. Prior to founding TruDataRx, Catalina worked at Dartmouth College as the Program Manager of innovations in translation and new initiatives at the Dartmouth Center for Healthcare Delivery Science. Through this role, Catalina worked with researchers and business professionals to create self-sustaining entities that address needs in the health care delivery system. Prior to Dartmouth, she worked as an economist for a large investment management firm, focusing on international financial markets. In this role, she developed new tools and analytical reports on investible foreign markets. Prior to her work in economic research, Catalina completed a financial leadership rotation program in the insurance industry. Catalina graduated cum laude from Dartmouth College.

DAY 1 INNOVATOR BIOGRAPHIES

Annual Innovation Conference

Ed McNamara, *Executive VP., Business Development Strategy* - Premise Health

Ed McNamara serves as Executive Vice President and currently oversees all growth and strategy initiatives for the organization. With more than 19 years as a strategic growth executive, Ed is responsible for working across multiple business areas including operations, clinical, information technology, and finance to develop growth initiatives and brand strategies that fit within the needs and future of our industry.

Prior to his time at Premise, Ed was a securities trader for Freddie Mac, a financial services company that provides mortgage capital to lenders, where he managed multi-billion-dollar portfolios and managed interest rate risks. Ed holds a Bachelor of Business Administration from James Madison University, where he was named GTE Scholar Athlete of the Year during his time on the men's basketball team.

Kurt Harden, *President and Chief Executive Officer* - MedBen

Kurt Harden is President and Chief Executive Officer for MedBen, a Newark, Ohio-based group third party administrator and data analytics company with clients throughout the United States. Harden started with MedBen in 1991 and held numerous positions with the company before being named President in 2012 and CEO in 2018. He has overseen the development of innovative cost saving solutions for clients in the areas of pharmacy benefit coverage, clinical claim review, wellness, and plan language solutions. In 2015 MedBen launched MedBen Analytics, LLC., a Medicare bundled payment analytics company that turns clients' claim data into actionable insights.

Harden speaks to national audiences on leveraging data to transform behavior. He has been active in his community serving in a variety of volunteer and elected positions with local business, governmental, and educational organizations. He lives in Newark with his wife Kate and has five children.

Karen Naccarato, *Vice President, Business Development* - SHERRILL MORGAN

Karen Naccarato currently is Vice President of Business Development for Sherrill Morgan. Before joining Sherrill Morgan in April of 2022, she was the Employee Benefits Supervisor for Bartlett City Schools (2014-2022), Benefits Manager for Memphis Shelby County Schools (2013-2014) and Director of Employee Benefits for Shelby County Schools (1995-2013). She has an MBA from Keller Institute of Management and welcomes the opportunity to communicate her passion for benefits to others.

During 2013-2014 she saw the merger of Shelby County Schools and Memphis City Schools, which formed one of the largest school districts in the US. Her 27 years' experience in the Employee Benefits field were key in the planning and communication of the benefits package for the joint district of twenty-six thousand active and retired employees. The following year when four municipal school districts were formed from the merged district, she, along with Sherrill Morgan, were instrumental in the planning of the benefits package. In addition to her duties with Sherrill Morgan, she is the Plan Administrator of the 40M Health Trust which supplies health benefits to the four municipal school districts and three municipalities that joined to create the Municipal School Districts of Shelby County.

DAY 1 INNOVATOR BIOGRAPHIES

Annual Innovation Conference

Lisa Boone, *Account Development Executive* - American Fidelity

Lisa has 31 years of experience working with the public sector and their benefit needs. She has vast knowledge regarding building a benefit plan that is meaningful to employees while streamlining processes for the employer with customized solutions. She spends the majority of her time in the field with customers elevating benefits and processes. She also has experience managing field agents, managing internal staff, policy management, product development, association partnerships, consortium partners and managing a successful open enrollment process that is relevant to employees. She has been involved in public speaking for over 35 years. Lisa has been married for 29 years and they have four children.

Blair Pickerill, *Senior Benefits Advisor* - SHERRILL MORGAN

Blair Pickerill has been in the insurance/employee benefits field for 30 years. He started out at a third-party administrator, Consultants and Administrators, where he held many positions from claims to underwriting. He was asked to join a joint venture, Managing Underwriters, where he was mentored in marketing and sales by the President and Vice President of Sales. He moved to Louisville where he was Director of Operations at RCH Administrators. He not only oversaw the day to day functions, but he also managed the customer experience.

Blair then joined MedBen as a sales representative and was then appointed as a Regional Vice President. He engaged agencies and employers alike in the advantages of self-funding their employee benefits programs. With that experience, he consulted with Toyota Tsusho as they explored the possibility of opening up an employee benefits firm. He is now a Senior Benefits Advisor at SHERRILL MORGAN. Due to his experience, he thinks strategically and conceptually and brings savings opportunities to the table.

Rob Hudson, *Attorney at Law* - Frost Brown Todd

Robert D. Hudson, a member of Frost Brown Todd LLC's labor and employment law practice group, has been representing employers for more than twenty- five years. He currently represents healthcare employers nationwide in proceedings before the National Labor Relations Board. Rob is a former Chair of the Northern Kentucky Chamber, a former Chair of the Covington Business Council, a past President of the Northern Kentucky Society for Human Resources. He is a bestselling author of several business books which have received more than a dozen regional and national awards. Having appeared on Fox News, Fox Business News, and the Blaze to address business education issues, Rob's 2014 pro-business newspaper columns were submitted for a Pulitzer Prize.

Mark Morgan, *President*– SHERRILL MORGAN

In his 30 years at SHERRILL MORGAN, Mark has accumulated a wealth of experience in establishing and managing employee benefit plans. As the founder of SHERRILL MORGAN's group health division, he paved the way in developing a systematic approach to healthcare benefits for governmental clients and has personally managed over 150 of them. He is a licensed Agent and Consultant and per SHERRILL MORGAN policy, is up to date on the latest healthcare rules and regulations. Understanding that an innovative approach is necessary to stay ahead in the healthcare industry, Mark has helped SHERRILL MORGAN to develop its partial self-funding division which allows employers (especially government agencies) to have a measure of control over their healthcare costs.

Mark is a leading proponent for transparency in healthcare costs and is regularly invited to speak at human resource conventions on health benefits and health care reform. Mark is also an active community supporter having served on the Boards of numerous organizations including Kids Helping Kids, the Steinford Toy Foundation, and Kentucky Health Purchasing.

DAY 2 INNOVATOR BIOGRAPHIES

Annual Innovation Conference

Lisa Stamm, Esq., *VP, Consulting Services* - SHERRILL MORGAN

Lisa is a graduate of Northern Kentucky University and the University of Cincinnati College of Law. As a licensed attorney, she is able to consult with clients regarding applicable state and federal laws that are applicable to their health plans. She is also knowledgeable about compliance with applicable laws, including federal health care reform, COBRA, ERISA, and HIPAA.

Lisa leads the self-funded division at SHERRILL MORGAN. Her team employs innovative new tools and plan designs to save clients money and allow them more control over their health plans. She is an expert at contract review and negotiation and strives to provide clients with the best possible service.

Lisa is also an expert and featured speaker on regulatory issues, particularly as they relate to health care reform. She is a regular speaker at local, regional, and national conferences. She has been a member of the Kentucky Bar Association since 1992.

Brian Fargus, *Vice President of Sales & Marketing* - MedBen

Brian Fargus directs the sales efforts for MedBen, a Midwest leader in benefits management. He also oversees MedBen Analytics as well as marketing for a variety of self-funded services, including MedBen Rx, MedBen WellLiving, consumer-driven products, and stop-loss policies, as he has sat on multiple stop loss carrier advisory boards. Brian is a graduate of West Liberty University and has been in the insurance industry since 1992. He is enjoying his 21st year with MedBen.

Walter Hoff, *Physician* - A-S Medication Solutions

Walter Hoff is Chief Executive Officer and Managing Member in A-S Medication Solutions LLC ("ASM"). ASM is the leading provider of electronic prescribing and dispensing solutions in the United States. ASM has over 17,000 doctors using its solutions to dispense medicine and vaccines at the point of care. ASM is a FDA/DEA Licensed Drug Wholesaler and Manufacturer throughout the United States. ASM also maintains VAWD accreditation, the gold standard for wholesale distributors nationally.

Mr. Hoff was Chairman and Chief Executive Officer of NDCHealth Corporation (NYSE: NDC). NDCHealth was acquired by McKesson Corporation. Under Mr. Hoff's leadership NDCHealth grew to become a leading provider of healthcare claims processing, point of sale application systems and information solutions. NDCHealth processed approximately 50% of all healthcare claims in the United States; including over 80% of retail pharmacy claims and 40% of the largest hospital claims. Further, NDCHealth provided retail point of sale systems to 20% of all retail pharmacies, numerous pharmacy mail order operations as well as over 100,000 physicians. NDCHealth's information solutions were used by over 100 pharmaceutical manufacturers. Through Mr. Hoff's efforts, NDCHealth was awarded by the Center of Medicare and Medicaid Services, an exclusive contract to provide the Eligibility and TROOP Services needed for the new Medicare Modernization Act which began January 1, 2006. Mr. Hoff's activity in healthcare has included the Chairmanship of the Leadership Committee of the National Association of Drug Chains, membership on the Board of MedUnite, participation in Health Insight, as well as numerous speaking engagements and committee activity. Prior to NDCHealth, Mr. Hoff was Executive Vice President of First Data Corporation based in Omaha. His responsibilities at First Data included oversight of the Card Services Group, which processed the majority of credit card transactions in the United States and United Kingdom. He was also the Chief Financial Officer of First Data, when the Company successfully undertook one of the largest initial public offerings from the time of its spin off from American Express Corporation in 1991.

DAY 2 INNOVATOR BIOGRAPHIES

Annual Innovation Conference

Brendan Nugent, *Chief Marketing Officer* - The Jefferson Health Plan

Brendan has been with the Jefferson Health Plan since 2016 and became the group's Chief Marketing Officer this past April. He received his BA in management from Hiram College.

The Jefferson Health Plan was established in 1985 and provides health care and related employee benefit programs to over 180 public employer member organizations throughout the States of Ohio, Michigan and Tennessee covering over 22,000 employees. The group provides a variety of benefits to participating member organizations including medical care, prescription drug, dental, vision, life insurance, accidental death and dismemberment insurance, and voluntary life insurance.

Julie Mueller., *President and C.E.O* - Custom Design Benefits

Ms. Julie D. Mueller is President and CEO of Custom Design Benefits, a Third Party Administrator (TPA) of health care benefits based in Cincinnati, Ohio. Established in 1991, CDB is the only privately held and independent TPA in the Tri-State area and is known for offering creative cost containment solutions to employers while providing their members with high-touch customer service.

Ms. Mueller has served in the health care field throughout her career. Her early days began with MEDCO Peer Review, a corporation launched by physicians in the 1970s to manage Medicare cost, in one of the early forays into managed care. Then she was a team of four individuals who launched a TPA using similar cost
containment strategies to help self-funded employers manage their health care costs. She spent twenty years as a senior executive growing this TPA to one of the nation's largest.

Since 2003, after joining Custom Design Benefits, Ms. Mueller and her team have created a dynamic, service-oriented organization specializing in the administration of self-funded health benefits, compliance services such as FMLA, COBRA and Consumer Driven Services.

In 2012, Custom Design Benefits unveiled TrueCost, an innovative solution for self-funded employers who need to stabilize and reduce out-of-control health costs. TrueCost eliminates PPO networks, deductibles and co-insurance and reimburses all providers based on Medicare plus a bonus, with direct hospital contracts.

Ms. Mueller and her husband, Rick, live in Northern Kentucky. They have one son, Zak, who recently joined Custom Design Benefits.

Alberta Manga, *Director of Medical & Risk Management* - Custom Design Benefits

Alberta joined Custom Design Benefits (CDB) in 2021 as Manager, Medical & Risk Management. Alberta, a Registered Nurse for 29 years, brings a wealth of experience from her career working in various clinic settings, worker's compensation, and self-funded benefit plans. She has 17 years of experience managing self-funded accounts of over a million lives in ASO plans where her work ranged from managing inquiries from union employees to responding to audits conducted by accreditation bodies. Alberta was promoted to Director, Medical & Risk Management in May 2022.

Alberta demonstrates her passion for medical management through her focus on timeliness and quality of care. She advocates for both the member and the client to ensure the right level of care is provided by the appropriate provider at the right time, thereby eliminating any claims-related issues.

Albert volunteers in her community and loves spending time with family, especially when she fills the role of "Uber Aunt" for her nieces and nephews.

DAY 2 INNOVATOR BIOGRAPHIES

Annual Innovation Conference

Terri Evans, *Vice President* - Employer Advisory Services

Terri spent the majority of her career with the City of Kingsport, starting in 1984 and joining the Risk Management department in 1986. While with the City, Terri performed all risk functions within the department including benefits, self-funded health insurance, on-site wellness center installation / management, self-funded workers' compensation, pooled liability with a large self-insured retention, and safety programs and training. Terri was promoted to Risk Manager in January 2001.

An accomplished trainer and communicator, Terri has worked with public risk and benefits professionals from all over the US, and all departments in the city, including the K-12 school system, assisting to incorporate risk management principles and practices into daily activities. Terri wrote and evaluated requests for proposals for all programs, evaluated insurance policies and contracts, wrote policies and procedures, and created an internal risk financing allocation system. This system set funding annually for the various governmental funds that utilize the risk fund, including general government, water, sewer, solid waste, mass transit, MPO, fleet, and schools.

Terri proudly served as the 2016-17 President of Public Risk Management Association (PRIMA) and served as the national conference planning chairperson for PRIMA-Houston 2015. Terri served as co-chair of PRIMA Institute in 2018 and 2019. She has also been involved in the leadership of the Tennessee Chapter of PRIMA, serving as Vice-President, President, Director, and conference planning committee member since 2006. Terri received the TN-PRIMA Risk Manager of the Year award in 2012 and the Abbie Hudgens Distinguished Service Award in 2016.

DAY 1 AGENDA & PRESENTATIONS

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SHERRILL MORGAN

NORTHERN KENTUCKY CONVENTION CENTER

DAY 1 AGENDA	TUESDAY, SEPTEMBER 13TH
8:30am - 9:00am	**Breakfast and Conference Registration**
9:00am - 9:20am	**Opening Remarks** Mark Morgan | SHERRILL MORGAN
9:20am - 9:40am	**On the Cutting Edge: Direct Pay to Provider Plans** Mike Williams | SHERRILL MORGAN
9:40am - 10:20am	**Innovative Health Plan Management Panel** Frank N. Stockdale Carney | Evans Petree Mark Morgan | SHERRILL MORGAN Karen Naccarato | SHERRILL MORGAN
10:20am - 11:00am	**Does Comparative Effectiveness Research Have a Role to Play in Rx Management?** Catalina Gorla | TruDataRx
11:00am - 11:20am	**Opportunities for Employers to Improve Access to Care for their Workforce** Ed McNamara | Premise Health
11:20am - 12:00pm	**Plan Language Matters – Presentation Around DaVita v. Marietta Memorial** Kurt Harden | MedBen
12:00pm - 1:00pm	**Lunch and Exhibitor Meet & Greet**
1:00pm - 1:20pm	**The Upside of Sharing Services** Karen Naccarato | SHERRILL MORGAN
1:20pm - 2:05pm	**Leading Questions: Keeping Your Finger on the Pulse in These Challenging Days** Lisa Boone | American Fidelity
2:05pm - 2:15pm	**Break and Exhibitor Meet & Greet**
2:15pm - 2:45pm	**Large Claims 101: What to Watch For & What to Do About It** Blair Pickerill | SHERRILL MORGAN
2:45pm - 3:25pm	**Diving into Dobbs & Its Impact on Employers and Personnel Policies** Rob Hudson | Frost Brown Todd
3:25pm - 4:10pm	**Transforming our Wellness Programs in the Wake of COVID-19** Mark Morgan | SHERRILL MORGAN
4:10pm - 4:30pm	**Closing**
6:00pm	**1920's Themed Social Event at Ghost Baby**

Direct pay to Provider plans

Mike Williams, C.E.O.
SHERRILL MORGAN

In the beginning…

Direct Pay to Providers

Direct payment to providers

“Rural settlers often had nothing to pay with except the fruits of their labor. Doctors would commonly be paid in cord wood, produce, meat, eggs, blankets or other items of value.” (Oregon Health and Science University)

Payment methodology evolved

- Indemnity- Go to any provider, plans indemnified covered people
- PPO- Contracting to get better deals, like any other “supplier”
- HMO- PPO on steroids, eliminating non providers.
  - Lots of models of HMO’s

Current Sources of Payment for providers

- Medicare
- Medicaid
- Private insurers
- Cash payors

Next phase

- Reference Based Pricing
- Direct payment to provider plans

Things got a little out of whack

- Cash Price is often significantly less than what the managed care price is

Direct Payment to Providers, How it works

- Members request a “pre-bill”
- Members use the App to determine the “benefit amount” available to the for the type of service they need.
- App allows members to see what providers accept as payment based on historical cash payments, which allows patients, a.k.a. consumers, to actually shop providers.
- Members encouraged to call provider to verify cash price

Direct Payment to Providers, How it works

- If provider charges more than the benefit amount, the member pays the difference, if they charge less, the member keeps the difference.
- Members provided with a Visa debit card to be used at time of service
- Members upload a copy of the Medical Invoice to the App
- Members receive their benefit amount

Examples

Specialist office visit with a benefit amount of $145

Doctor's Price	Member Pays/or Keeps the difference
$130	Member keeps $15difference
$150	Member pays $5 difference

Examples

Emergency Room Visit, Covered under No Surprises Act

Provider Charge	Benefit amount
$2800	$2800
$1500	$1500

Network Question

- There is no network, members can see any provider

Questions?

Mike Williams

Mike@sherrillmorgan.com

Innovative Health Plan Management Pool

Frank N. Stockdale Carney
Evans Petree PC
1715 Aaron Brenner, Suite 800
Memphis. TN 38120

Creation of the Interlocal Health Benefits Committee and the Interlocal Health Benefits Plan Assets Trust

Legal Sources Governing Plans

- Employee Retirement Income Security Act (ERISA) for ERISA entities
- State Law for Governmental Plans Under IRC 414(d)

Tennessee Authorizing Legislation (Governing State Law)

Tenn. Code Ann. 12-9-104 “Interlocal Cooperation Act”

(a)(1) Any power or powers, privileges or authority exercised or capable of exercise by a public agency of this state . . . may be exercised and enjoyed jointly with any other public agency of this state . . . and jointly with any public agency of any other state or the United States.

This statute sets forth what a joint agreement shall contain including the manner of financing the joint undertaking

Tenn. Code Ann. 12-9-104:

(c) Any such agreement shall specify the following

(1) Its duration;

(2) The precise organization, composition and nature of any separate legal or administrative entity or entities created thereby, which may include, but is not limited to, a corporation not-for-profit, together with the powers delegated to such a corporation;

(3) Its purpose or purposes;

(4) The manner of financing the joint or cooperative undertaking and of establishing and maintaining a budget for such undertaking;

(5) The permissible method or methods to be employed in accomplishing the partial or complete termination of the agreement and for disposing of property upon such partial or complete termination; and

(6) Any other necessary and proper matters.

Tenn. Code Ann. 29-20-401 “Creation of reserve or special fund – Pooling arrangements with other governmental entities – Election to self-insure”

> *(b)(1) Any two(2) or more governmental entities are hereby granted the power, any provision of law to the contrary notwithstanding, to enter into an agreement or agreements with one another for joint or cooperative action to pool their financial and administrative resources for the purpose of providing to the participating governmental entities risk management, insurance, reinsurance . . . or any combination thereof for any and all of the areas of liability or insurability, or both . . .*

Tenn. Code Ann. 29-20-401 “Election to Self Insure”

(c)(1) Any governmental entity choosing to create and maintain a special fund, or to enter into an agreement, as authorized in this section for the purpose of insuring against the liabilities created by this chapter, shall be deemed to be electing to self-insure against the liabilities . . .

Counsel of each of the nine (9) entities got together to put together the Interlocal Administration Agreement to outline the rights, duties, responsibilities, and powers of each of its entities.

Items to Resolve Among Entities

- *Committee Members*
- *Committee Officers*
- *Designation of Joint Employee for Administering Day-to-Day*
- *Meeting Requirements*
- *Voting Powers*
- *Requirements for Admission of New Members*
- *Procedure for Withdrawal of and Liability of Withdrawing Member*
- *Mandatory Contribution Requirements and Mandatory Contribution Call Procedures*
- *Dispute Procedures*
- *Breach Consequences*
- *Duration*

Once that document was completed the nine (9) member's counsel got together to designate employee benefits counsel for the Interlocal Entity, Plan, and Trust

Two Tasks for Employee Benefit Counsel

- Formalize the legal entity to effectuate the provisions of the Interlocal Administration Agreement
- Establish the funding vehicle for procedures and paying the self-insured claims (i.e. the Interlocal Health Benefits Plan Asset Trust)

Statute governing legal entity and granting corporate powers of the entity

Tenn. Code Ann. 12-9-111

Authorizes creation of a “local governmental joint venture entity” filed with the Comptroller of the Treasury, with the requirement of the filing of an annual audit with the Comptroller

Interlocal Health Benefits Committee purpose:

to jointly establish and administer a health insurance program through individually adopted health plans utilizing the Trust as pooled trust for (1) payment of claims under the Plans, (ii) payment of stop loss insurance premiums, (iii) payment of certain premiums) and (iv) payment of certain administrative expenses of the Trust.

Statute governing the Trust

State Statutes Governing Investment of Governmental Assets

- Tennessee Uniform Trust Code
- Uniform Prudent Management of Institutional Funds Act
- Tennessee Public Finances Act
- Tennessee Uniform Fiduciaries Act

Innovative Health Plan Management Pool

SHERRILL MORGAN

THE CREATION OF MSSC

In 2008 the City of Memphis cut funding to Memphis City Schools

2 years later, Memphis City Schools surrendered its charter, which began the process of merging Memphis City Schools and Shelby County Schools.

March 9, 2011, the citizens of Memphis voted to disband the Memphis City School District

Memphis City Schools had 103,000 students, 8,000 employees and almost 100 schools. It served the children living in the incorporated City of Memphis

Shelby County Schools had 48,000 students, 5,000 employees and 51 schools. It served the children living in unincorporated Shelby County, and children in the incorporated cities of Millington, Bartlett, Lakeland, Arlington, Collierville and Germantown

For one year, on July 1, 2013, the “merged” Shelby County Schools became the nation's 14 largest district

150,000 children/ 13,000 employees/12,000 retirees

The Process of Demerging the School District

- 2013 - Norris-Todd bill became law
- July 2013 – MSC and SCS merged
- August 2013 – School Boards elected
- October 2013 - Interviewed Superintendent candidates
- January 2014 - Superintendents hired
- February 2014 – CFO/HR hired
- April 2014 – Benefits Supervisor (Shared Services) hired
- April 2014 – Review RFPs with consultant (Sherrill Morgan)
- May 2014 – Choose vendors for benefit package
- June 2014 – Obtain benefit approval from municipal boards
- July 2014 – Teachers and other school-based employees hired / benefits for school administration became effective
- August 4, 2014 – First day of school
- September 2014 – Benefits for all school-based employees became effective

MSSC was formed to provide a comparable benefit package specifically for “Teachers” of the “New” Municipal School Districts in order to comply with Tennessee law

Pooled Assets/Members

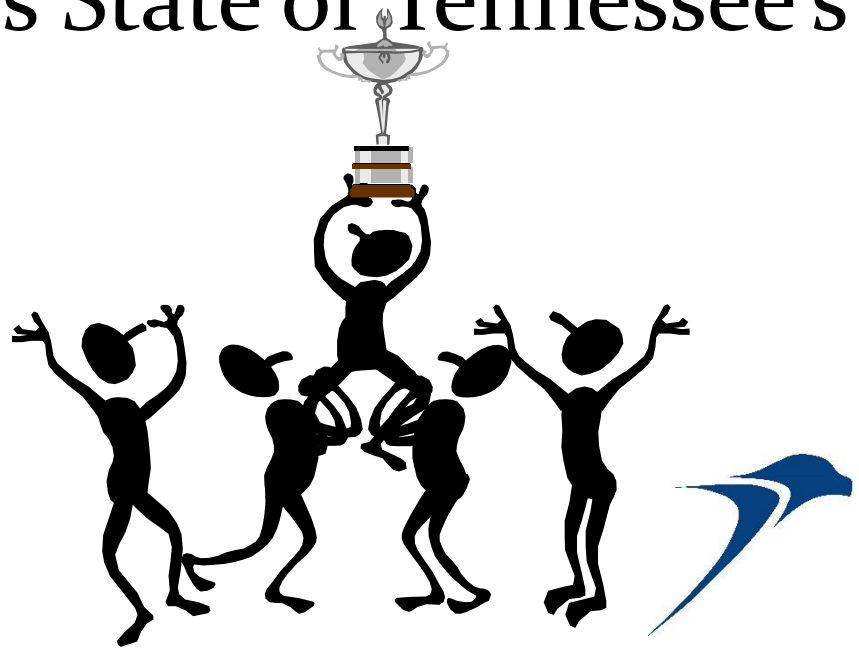
- Attorneys representing each entity worked on the “Interlocal Agreement” to work out details on how the “group” could function

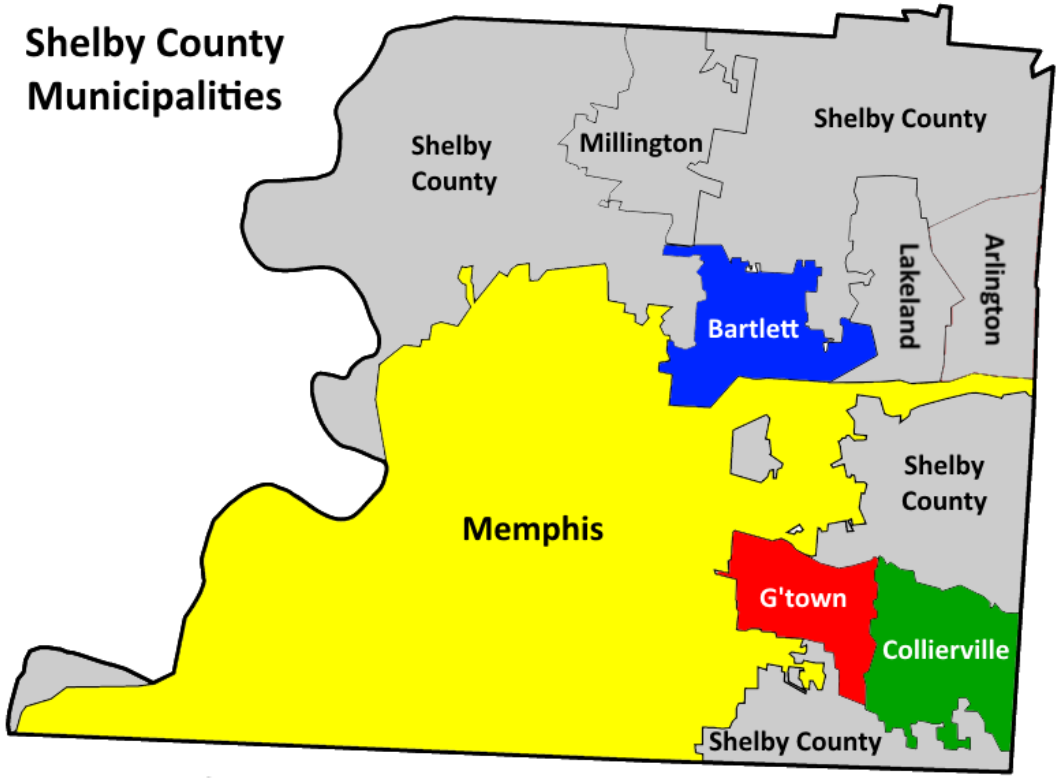
- A “Trust” was setup through a bank that would receive contributions and pay claims

- Employees reaped the benefits that a larger population would provide - 3114 employees approximately 7000 total lives

SUCCESS – 9 Years Later

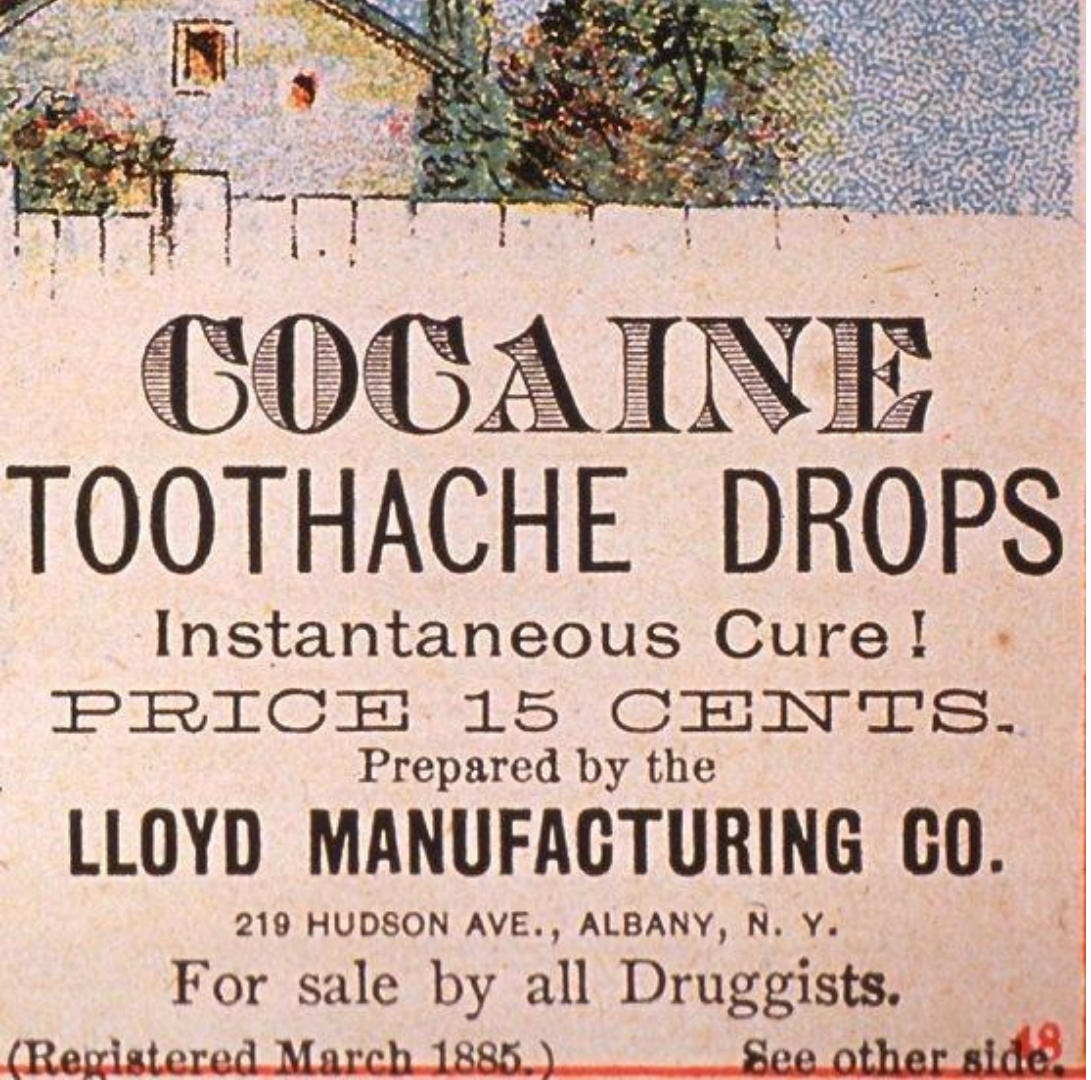
- Met and exceeded all goals established
- All school districts have grown
- Educational excellence achieved
- MSSC benefits package exceeds State of Tennessee's benefits
- Sizable reserve is on account





MSSC Current Members

- Arlington Community Schools (342)
- Bartlett City Schools (752)
- City of Bartlett (604)
- Collierville Schools (760)
- Town of Collierville (474)
- Lakeland School System (146)
- City of Lakeland (36)



Does Comparative Effectiveness Research have a role to play in Rx Management?

Catalina Gorla
co-founder & CEO, TruDataRx
September 13, 2022

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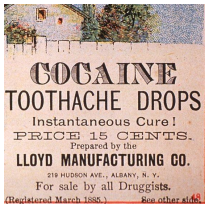
Modern drug era begins with the Kefauver-Harris Amendments to the 1938 Act

1800

US Pharmacopeia 1820



1900

Pure Food & Drugs Act 1906
Labeling

FDA 1930

Federal Food, Drug, and Cosmetic Act 1938
Safety

Kefauver-Harris 1962
Safety + Efficacy

Hatch-Waxman 1984
Patent ext
Generics

2000

ACA 2010

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The 1962 Kefauver-Harris Amendment proposed…

- **Reduce patent life** from 17 years to 3, require licensing thereafter at no more than 8% royalties
- **Require clinical studies** prove safety in animals reporting of side effects, ability for FDA to stop trials, establishes the IND and NDA process.
- Drugs must demonstrate **safety and efficacy**

AMA

Pharmaceutical Manufacturers' Association

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The 1962 Kefauver-Harris Amendment passed…

✖ **Reduce patent life** from 17 years to 3, require licensing thereafter at no more than 8% royalties

- **Require clinical studies** prove safety in animals reporting of side effects, ability for FDA to stop trials, establishes the IND and NDA process.

✓ Drugs must demonstrate **safety and efficacy**

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“FDA-approved”

A drug must show **statistically significant** difference on a **primary outcome** compared to **placebo**

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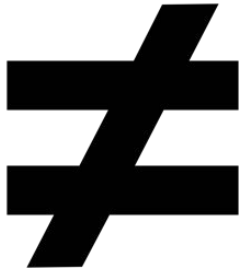
“New and approved”



“New and *improved*”

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73%

of physicians

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As newly approved drugs flood the market, how can we assess the **comparative value** of different treatment options?

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Comparative effectiveness research is the highest quality clinical research available

	Basis of Clinical Efficacy	Strength
Regulatory Approval	"Is the drug better than **placebo**?"	Weak
? Comparative Effectiveness Research	"Is the drug **better than other drugs?"**	**Strong**

Most OECD countries include comparative effectiveness in their formulary decision-making. Specialized skills are required to be able to access this valuable information.

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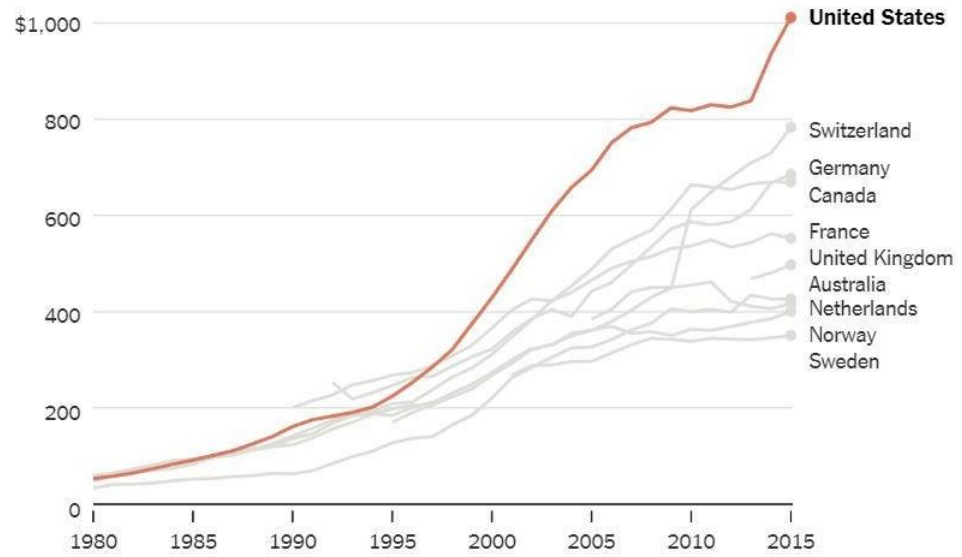
Note when these lines diverge

International Comparison of Drug Spending

American pharmaceutical spending started taking off in the late 1990s compared with other advanced nations.

Annual retail prescription drug spending per person



Adjusted for the relative purchasing power of different currencies. The Netherlands and U.K. figures include prescribed medicines, over-the-counter medications and other medical nondurable goods.

Source: The Commonwealth Fund

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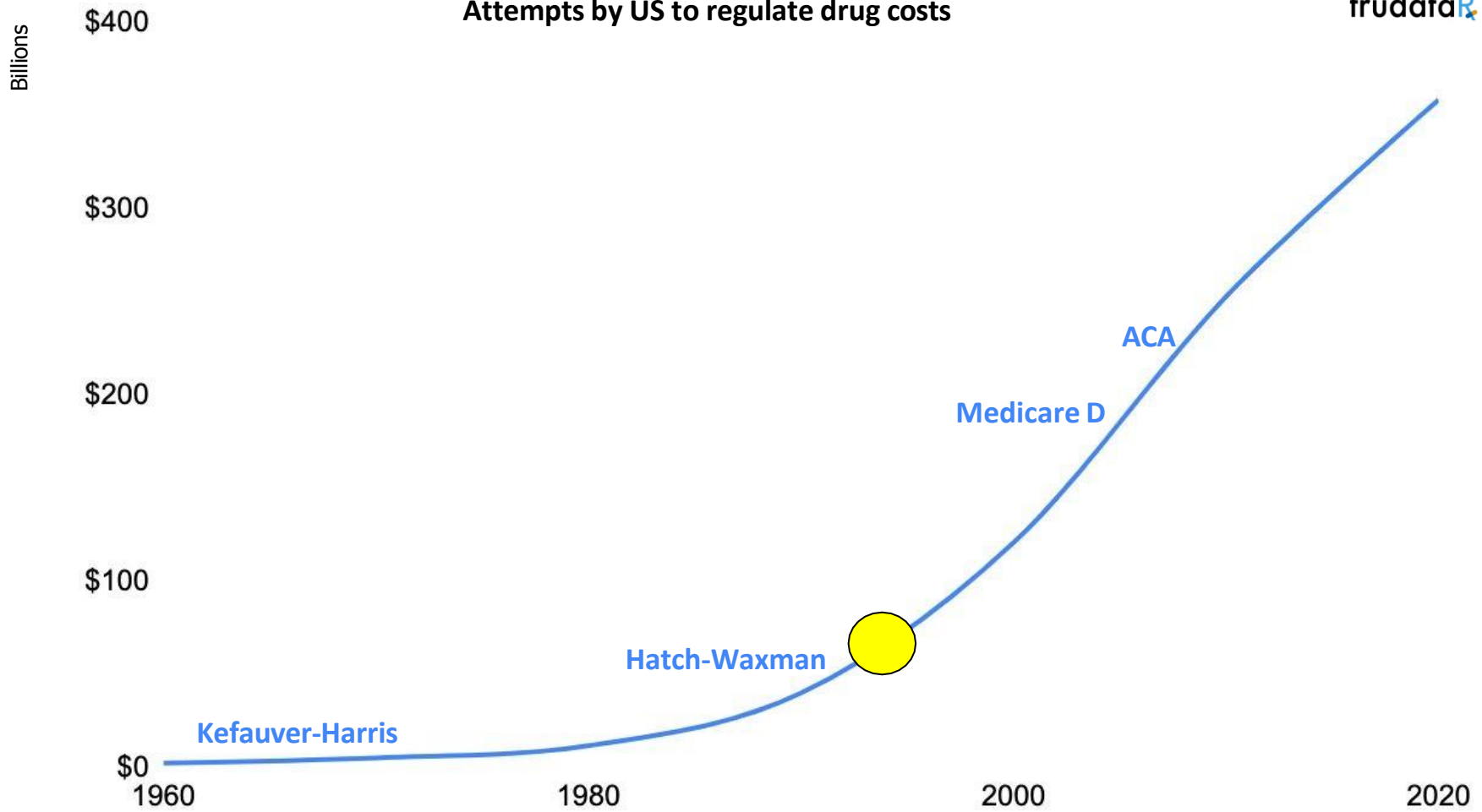
Attempts by US to regulate drug costs



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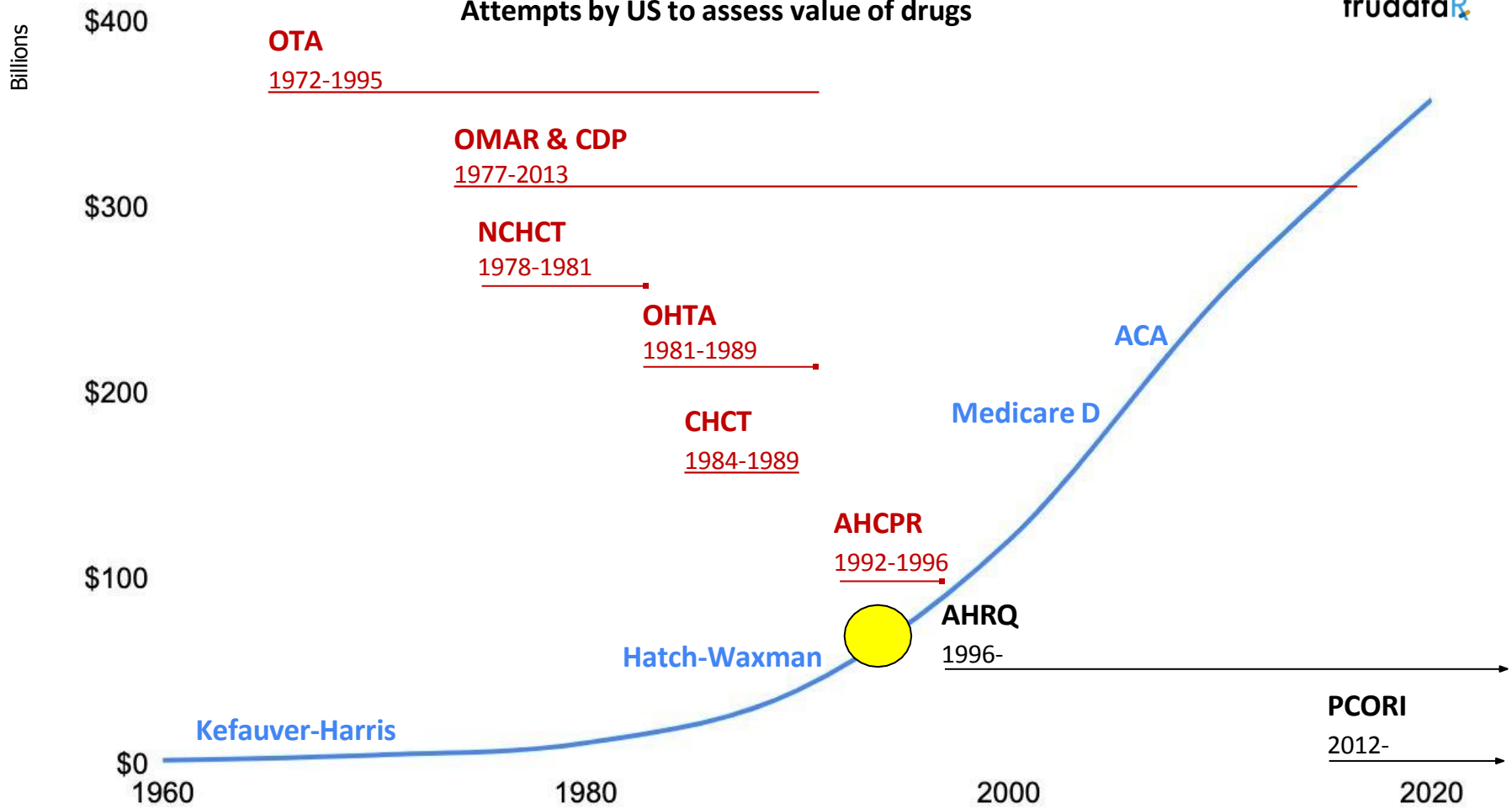
Attempts by US to assess value of drugs



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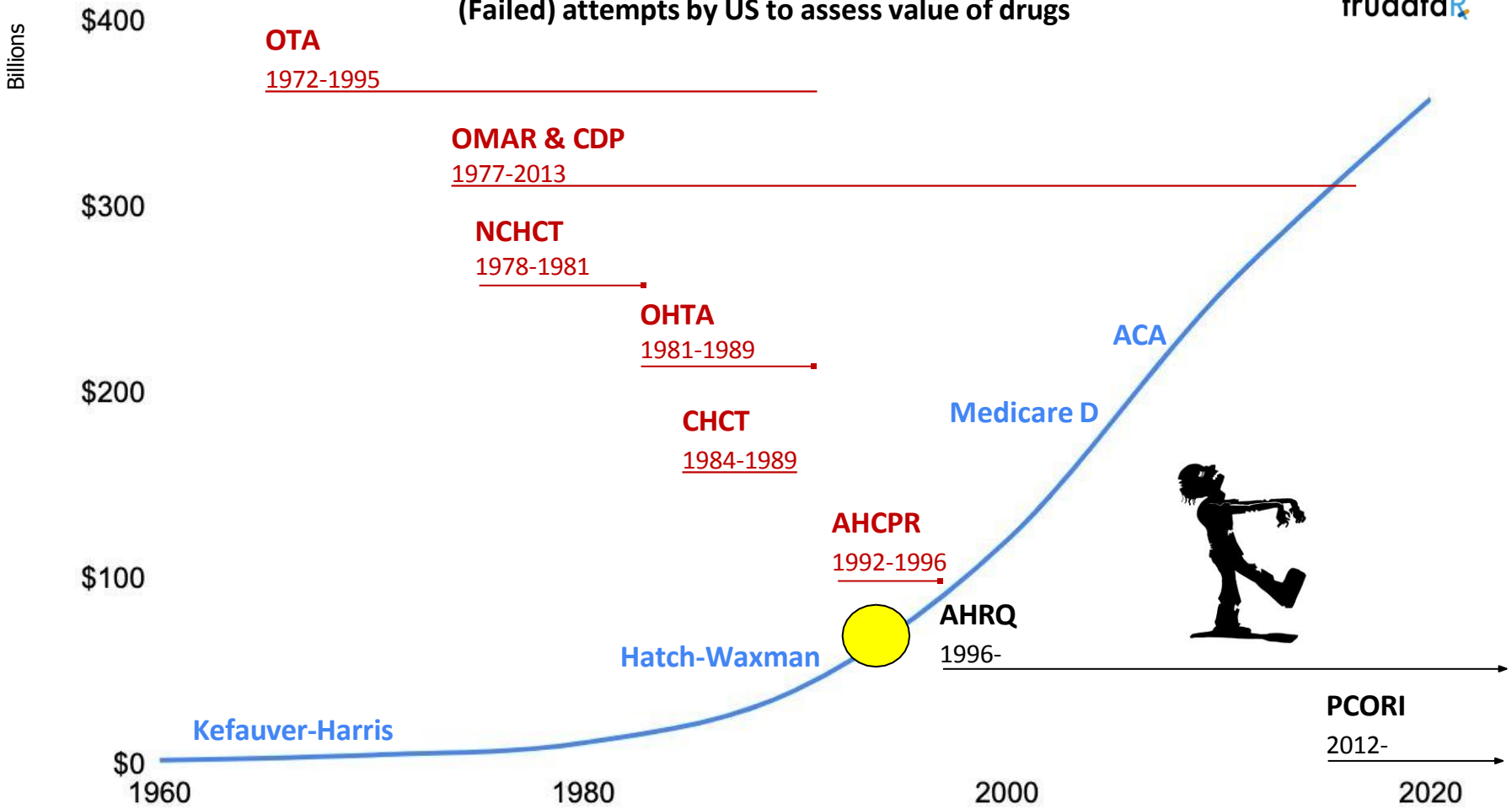
(Failed) attempts by US to assess value of drugs

trudataR



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There are two main ways for employers to manage Rx

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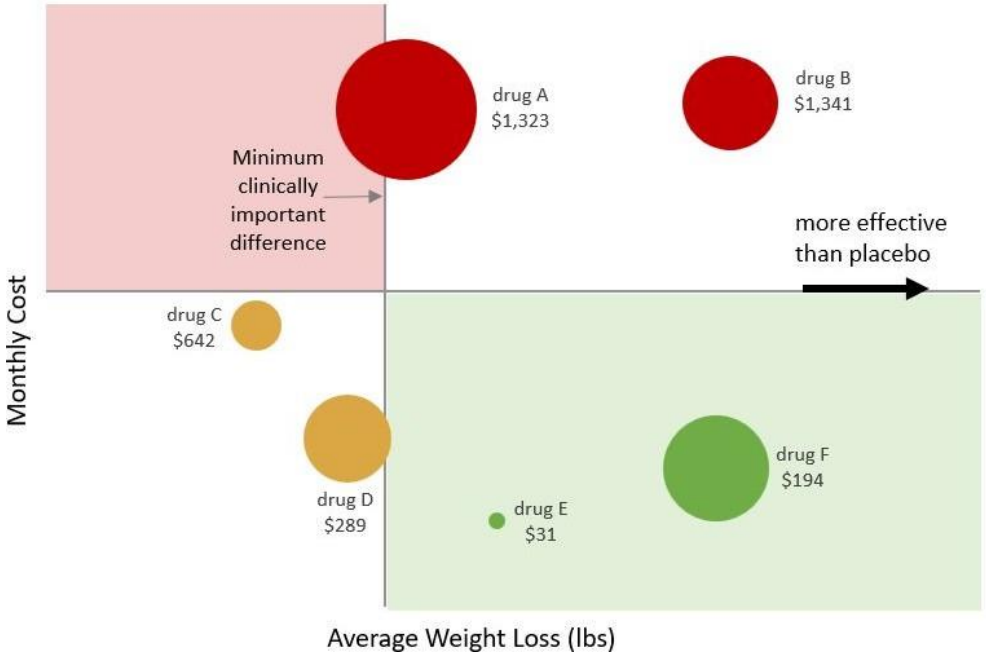
CER allows employers to balance best price and value

CER for Weight Loss drugs



Review of clinical evidence

The comparative efficacy and safety of drugs and non-drug treatments for obesity were examined in 12 meta-analyses and 9 clinical trials assessing 121,639 patients.

TruDataRx Analysis

Opportunity to double clinical effectiveness and reduce cost by **85%** with a lower cost and higher value medication in weight loss.

Graph Legend

- Size of bubble represents relative number of utilizing members
- Red: Low value drugs with spend (high savings possible)
- Green: High value drugs with spend
- Yellow: Other drugs with spend

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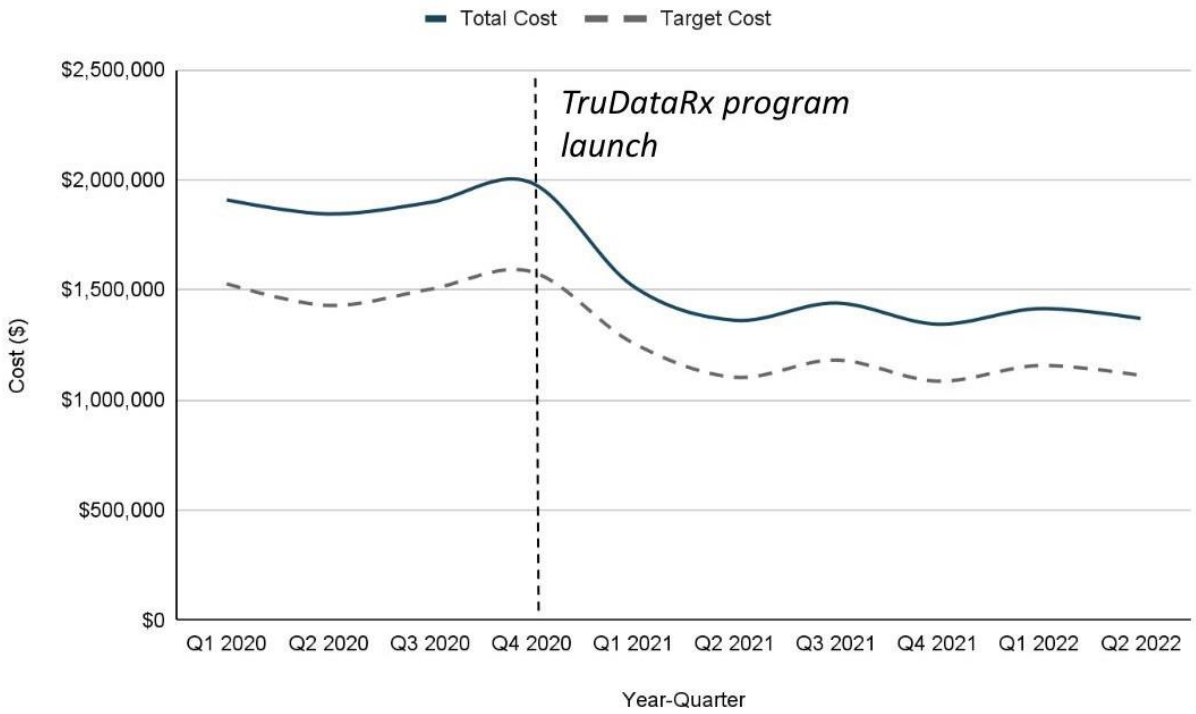
Win win: CER reduces costs overall and allows plan to share savings with members



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$6bn

$24bn

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$6bn

$24bn

$200bn

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Premise Health®

Opportunities for Employers to Improve Access to Care

Ed McNamara, Executive Vice President, Premise Health

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Our Vision

To be the premier direct healthcare company in the world

Dedicated – Proactive – Primary – Comprehensive – Aligned

Our Mission

To help people get, stay and be well

Our Values

Providing high-quality, tech-enabled, personal care that is focused on health improvement and an exceptional member and client experience

Courageous – Engaged – Innovative – Accountable – Quality-Focused – Respectful – Ethical

SIZE AND SCALE

11M+ eligible members

800+ wellness centers

45 states and Guam

EXPERIENCE AND VALUE

94 net promoter score

95th percentile HEDIS

29% claims-based savings

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Over 30 Healthcare Products and Growing

More integrated care than any other direct healthcare company

Primary Care

Condition Management
Dental
Pandemic Readiness
Vision
Women's Health

Pharmacy

Clinical Pharmacy
Provider Dispensing

Connected Care+

Care Management
Care Navigation
Care Consult
Care Excellence

Behavioral Health

Occupational Health

Case Management
Ergonomics
Injury and Illness Care
Medical Surveillance

Musculoskeletal

Acupuncture
Chiropractic
Massage
Occupational Therapy
Physical Therapy

Fitness

Medical Fitness Management
Fitness Center Management
Fitness Center Design

Wellness

Biometric Screenings
Nutrition
Wellness Coaching
Wellness Program Management

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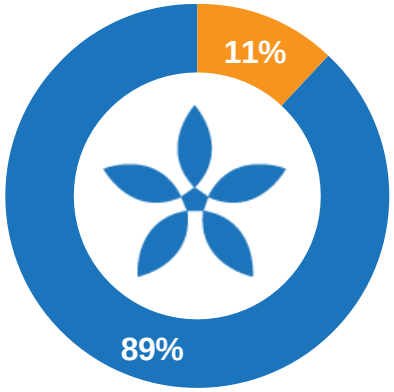
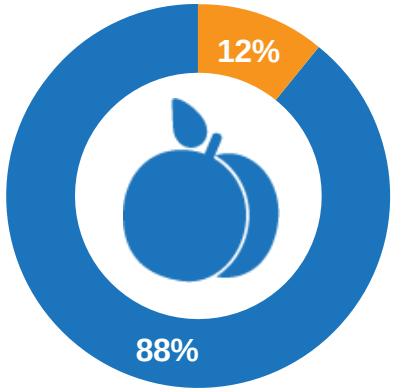
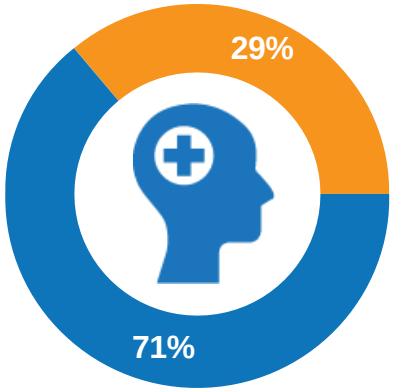
Premise data from 2021 shows that **there is a lot of variability in how patients choose to access care digitally and in-person**



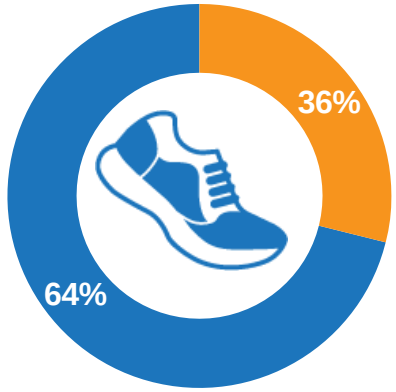
Wellness Coaching



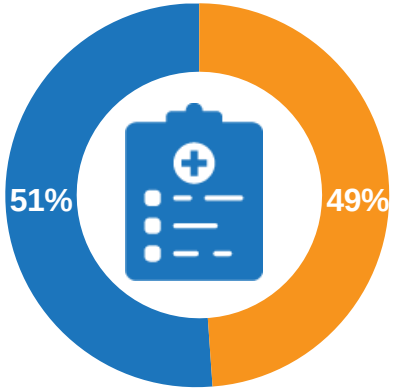
Nutrition



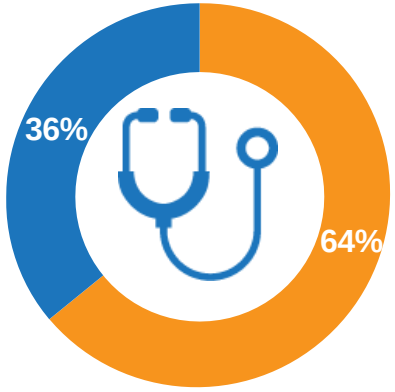
Behavioral Health



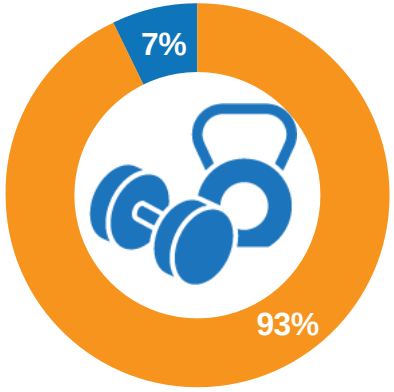
Fitness



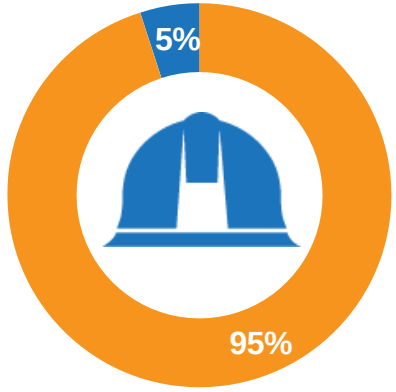
Condition Management



Primary Care



Physical Therapy



Occupational Health

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Care in Action

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A Spotlight on the Northern Kentucky Coalition

The Northern Kentucky Coalition is made up of 12 employers across Kentucky and Ohio who partnered together to build a nearsite network and increase access for their member populations.

- City of Erlanger
- City of Covington
- City of Edgewood
- City of Florence
- City of Independence
- City of Newport Group
- Kenton County
- Meyer Tool Group
- Rosedale Green Group
- Sanitation District 1
- Toyota Tsusho Group
- Transit Authority of Northern Kentucky

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Bending the Cost Curve

The Kentucky Coalition serves 4,900+ members from 12 employers, helping them achieve the scale needed to impact healthcare cost and quality.

Marketplace Savings

In 2021, the Northern Kentucky Coalition saw marketplace savings of **more than $700k**.

Costs Avoided

Through early detection of health risk conditions, the Northern Kentucky Coalition avoided **more than $3.9 million** of healthcare costs.

Member Satisfaction

More than 9 out of 10 Northern Kentucky Coalition members would recommend the onsite clinic to a family member or co-worker.

"All of the doctors and nurses are great! The convenience of the appointments and having the pharmacy in the same location makes it the best place to go!" - Member, City of Florence, Kentucky

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Compelling Financial Value Proposition for Clients

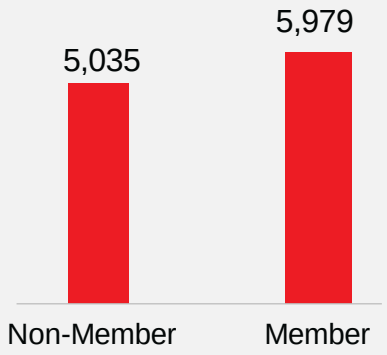
Direct healthcare improves productivity and serves as a valuable talent recruiting and retention tool

Significant Financial Benefits Delivered[1]

29% Savings
Risk-Adjusted PMPM

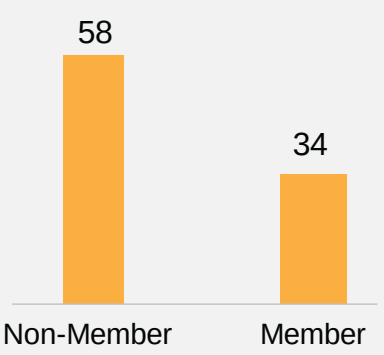
Primary Care Visits

19% Increase



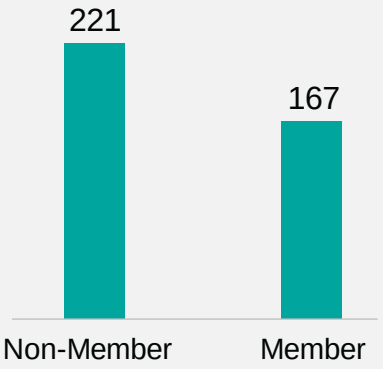
Inpatient Admissions

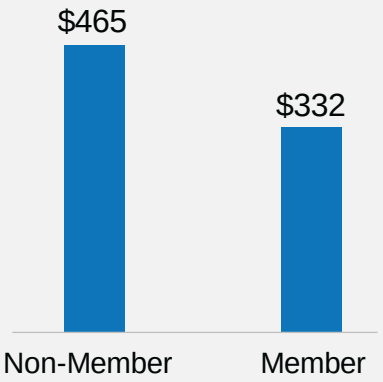
41% Reduction



Outpatient Services

24% Reduction





Representative book of business analysis on approx. 67,000 eligible lives shown in rates per 1,000 members

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Questions?

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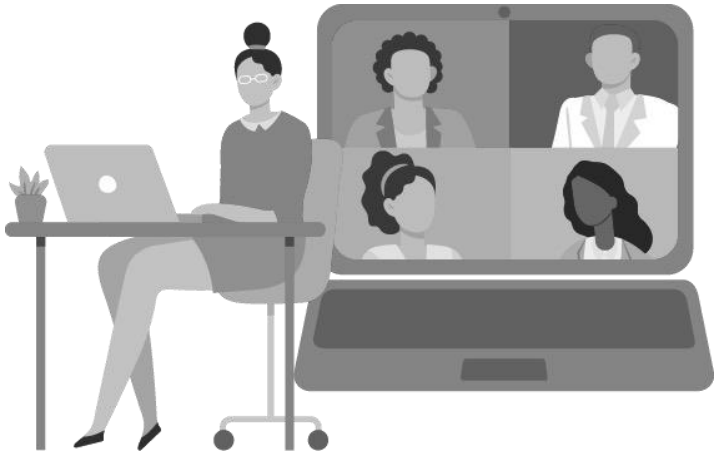
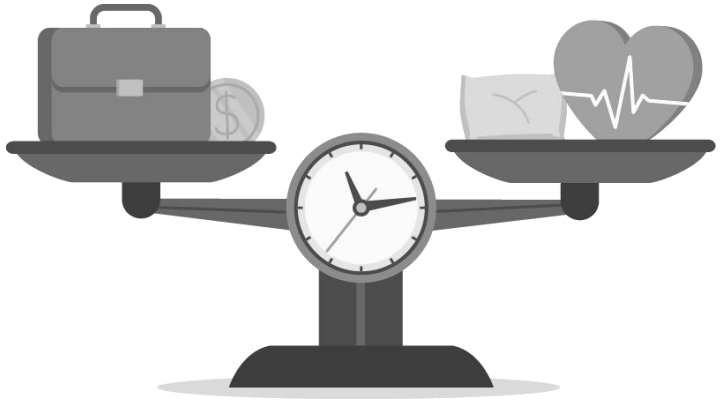
The More Things Change…



Where we work
From work, from home, from anywhere in the world



How we see the world
Culture, values, purpose – Today, they matter more than ever

What we expect
Tech-enabled experiences and personalized attention? Table stakes

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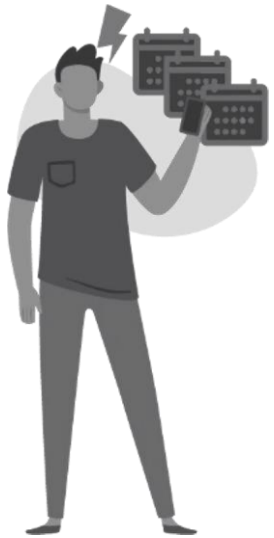
The More Things Stay the Same

Inaccessible
Access is getting worse in rural areas and already underserved communities



Confusing
No matter who you are, the healthcare system is hard to understand and navigate

Fee-for-Service
Hospitals are paid based on how many patients they see and procedures they do, not the outcomes they deliver

Expensive
Every year, increases in company healthcare costs outpace increases in worker wages

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An Opportunity for Different

DIGITAL WELLNESS CENTER

24/7 centralized virtual care

MOBILE EVENT ONSITE NEARSITE

In-person care

Virtual and in-person care

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Digital Wellness Center

One of the largest digital providers in the country

National, Premise-employed care team

Available in all 50 states

24/7, on-demand access to an exclusive network of providers

Unparalleled convenience and quality

Holistic, high-quality virtual primary care, virtual behavioral health, virtual occupational health, and virtual pharmacy

Concierge member experience

Powered by a single, cloud-based technology platform

Added reliability and security

Artificial intelligence and learning

Ease of administration

Integrated Connected Care+ suite

Predictive analytics and population health insights

Proactive care management and care navigation

Seamless care consults with and referrals to Mayo Clinic

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Onsite and Nearsite Wellness Centers

Onsite or nearsite in-person care

- Convenient, high-quality onsite and nearsite care
- Access to 30+ care products
- Delivered by your local Premise Health care team

Virtual care from local providers

- Ideal for members who travel, live, or work remotely
- High-quality care delivered during normal business hours
- Delivered by your local Premise Health care team

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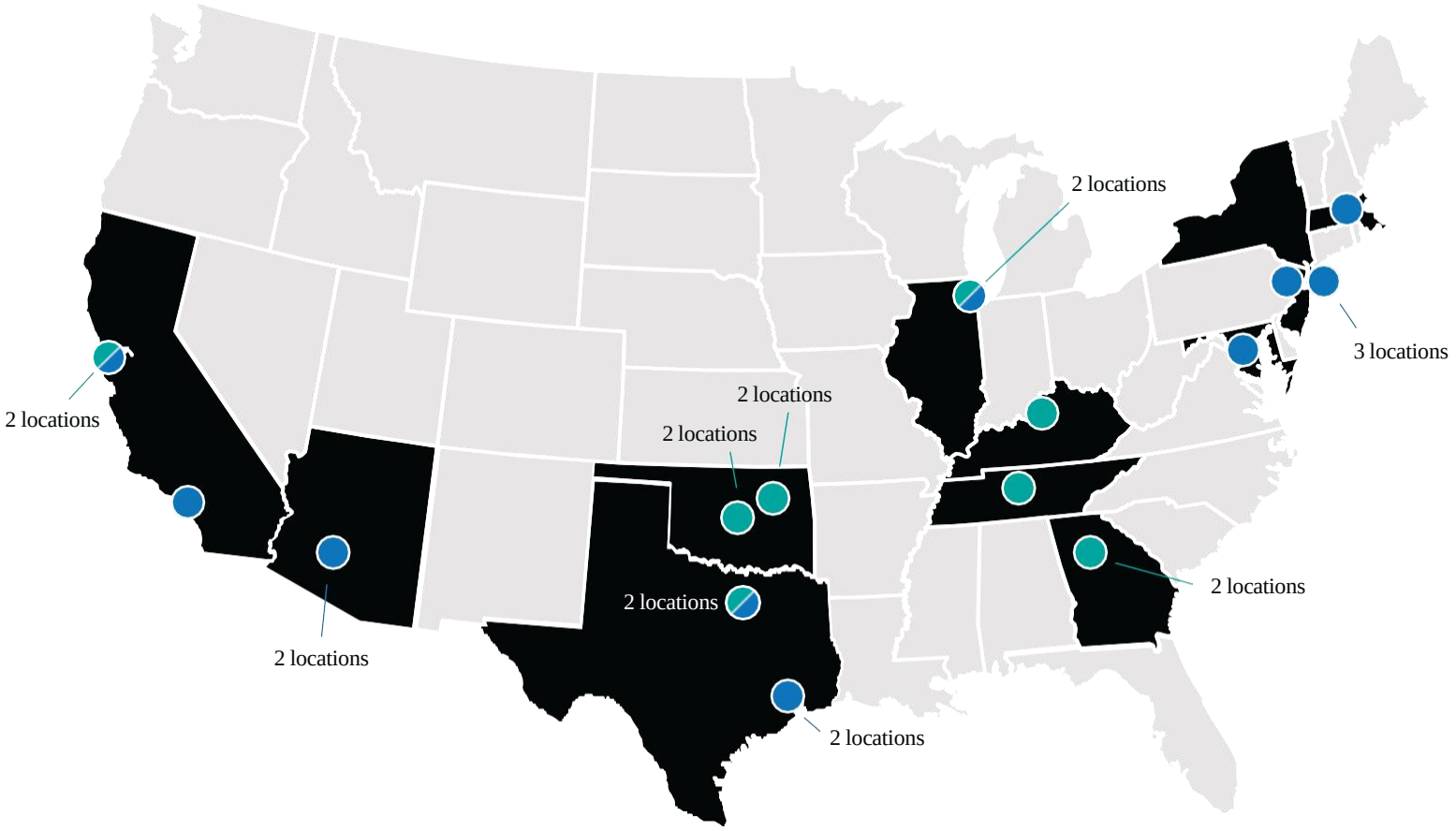
National Shared Nearsite Network

We're expanding our local footprint to better serve hybrid work environments and enhance care for dependent populations



Open in 2022

- Atlanta, GA
- Brentwood, TN
- Louisville, KY
- Northbrook, IL
- Oakland, CA
- Oklahoma City, OK
- Plano, TX
- Tulsa, OK

Coming in 2023

- Boston, MA
- Chicago, IL
- Houston, TX
- Dallas, TX
- Jersey City, NJ
- Los Angeles, CA
- New York, NY
- Phoenix, AZ
- San Francisco, CA
- Washington D.C.

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Benefits of a Shared Nearsite

Exclusive provider access

- Dedicated provider team
- Same day visits, in-person or virtually
- No crowded waiting rooms

Located in the community

- No security barriers to entry
- Easily accessible to dependents
- Ideal for remote workforces

Focus on value, not volume

- More time to spend with members
- Outcome-driven care

Comprehensive Primary Care That's Simple:

No Upfront Costs

No Hidden Fees

PMPM Pricing

Premise Health.

Plan Language Matters

Marietta Memorial Hospital Employee Health Plan et al. v. DaVita Inc. et al.

The Problem - 2014

Billed Charges = $62k in monthly charges

Discounts = $9,300 per month

Covered Expense = $52,700 per month ($632,400 per year)

MedBen health. benefits.

The Solution - 2014

New Plan Language

Billed Charges = $62k in monthly charges

Discounts = $60,320 per month

Covered Expense = $6,940 per month ($90,237 per year)

MedBen health. benefits.

Average Charge per Dialysis Treatment	$9,113.18
Average Medicare Reimbursement Per Treatment	$211.67

MedBen health. benefits.

What Does Dialysis Cost?

"JUSTICE ALITO: Well, the statistic I have is that your average cost per treatment is $269 and you charge on average $1,041. Is that right?

MR. WAXMAN: Well, it is $290, as -as we explain in our brief, and the average price that we charge is $1,000."

MedBen health. benefits.

Avg. Billed Charges as Percent of Medicare

By Provider Type

Provider Type	Avg. Billed Charge
Physicians	196%
Hospital Outpatient	497%
Hospital Inpatient	286%
Dialysis	2,300%

MedBen health. benefits.

Why?

FIGURE 3 – DIALYSIS CLINICS MARKET SHARE[3]

OPERATOR	NUMBER OF U.S. CLINICS	U.S. MARKET SHARE
DAVITA KIDNEY CARE	2,821	37%
FRESENIUS MEDICAL CARE	2,634	35%
U.S. RENAL CARE, INC.	252	3%
DIALYSIS CLINIC, INC.	252	3%
AMERICAN RENAL ASSOCIATES	240	3%
INDEPENDENTLY OWNED CLINICS	830	11%
ALL OTHER	537	7%
TOTAL	7,566	100%

MedBen health. benefits.

Allegations – December 19, 2018

- Marietta Memorial Hospital violated the “take into account” provision of Medicare Secondary Payer Act
- Marietta Memorial Hospital discriminated against patients suffering from End Stage Renal Disease by providing inferior benefits to those patients.

September 20, 2019

U.S. District Judge determined that Marietta Memorial treated individuals with ESRD the same as other health plan participants and dismisses case.

"This argument ignores one of the statute's corresponding regulations, which specifically says that 'a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.'"

Ruling was consistent with other similar lawsuits filed throughout the country by DaVita – Amy's Kitchen, Winco Foods.

December 2, 2019

DaVita Appealed the U.S. District Court's Decision to the 6th Circuit Appeals Court

DaVita Appealed the Amy's Kitchen Case to the 9th Circuit Appeals Court

MedBen health. benefits.

October 2020

- October 14, 2020 – Sixth Circuit Appeals Court found that DaVita's case merited a hearing.
- October 28, 2020 – MedBen filed motion to have the 6th Circuit rehear the case *en banc*

  "The majority's decision to recognize disparate impact as a basis for violation of the MSPA directly conflicts with Supreme Court precedent and the text and purpose of the Act"
- *En banc* request denied

MedBen health. benefits.

February 23, 2021

DaVita files First Amended Complaint adding a disparate impact (disparate treatment) element to the allegation of violations of the MSPA.

Disparate impact argument supported by Sixth Circuit Court of Appeals Opinion

MedBen health. benefits.

Ninth Circuit Finds for Amy's Kitchen

- Very similar facts
- Ninth Circuit cited minority opinion in Marietta 6th Circuit case.
- Split Circuits

MedBen
health. benefits.

U.S. Supreme Court

- File Writ of Certiorari filed on May 21, 2021
- November 5, 2021 – Supreme Court Grants Writ
- March 1, 2021 – Oral Arguments (1:20)
- June 21, 2022 – Decision – 7-2 (Kavanaugh) – Dissent on discrimination against ESRD

DaVita Legislation

House – 1859 (Yvette Clark) - *Restore Protections for Dialysis Patients Act*

Senate – 4750 (Robert Menendez)

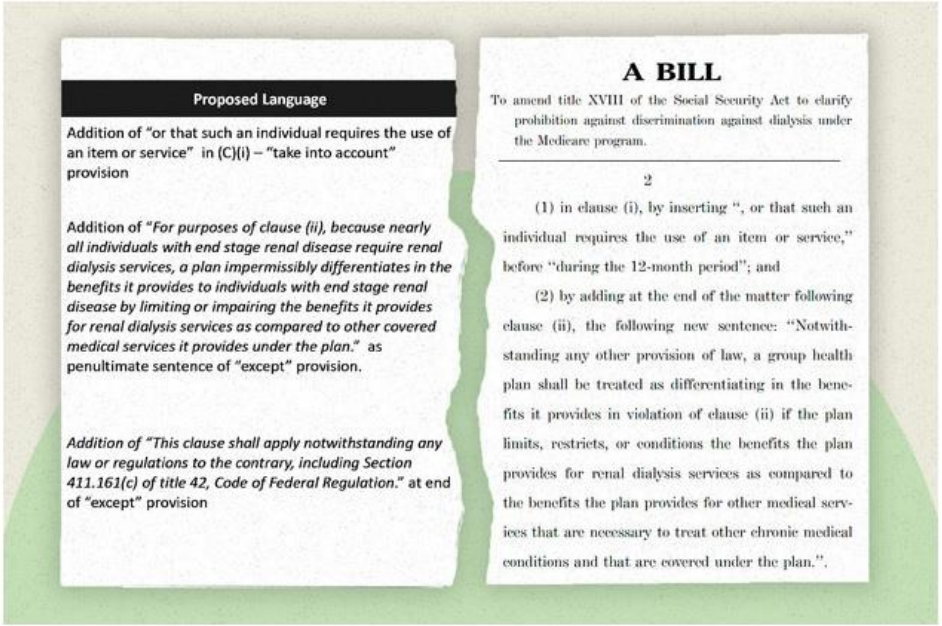
"Notwithstanding any other provision of law, a group health plan shall be treated as differentiating in the benefits it provides in violation of clause (ii) if the plan limits, restricts, or conditions the benefits the plan provides for renal dialysis services as compared to the benefits the plan provides for other medical services that are necessary to treat other chronic medical conditions and that are covered under the plan."

MedBen health. benefits.

HEALTH CARE

DaVita helped craft new bill to fix "loophole" left by Supreme Court ruling, documents show

Lawmakers introduced a measure mirroring a proposal written by one of the nation's largest dialysis providers.



Proposed Language

Addition of "or that such an individual requires the use of an item or service" in (C)(i) – "take into account" provision

Addition of *"For purposes of clause (ii), because nearly all individuals with end stage renal disease require renal dialysis services, a plan impermissibly differentiates in the benefits it provides to individuals with end stage renal disease by limiting or impairing the benefits it provides for renal dialysis services as compared to other covered medical services it provides under the plan."* as penultimate sentence of "except" provision.

Addition of "This clause shall apply notwithstanding any law or regulations to the contrary, including Section 411.161(c) of title 42, Code of Federal Regulation." at end of "except" provision

A BILL

To amend title XVIII of the Social Security Act to clarify prohibition against discrimination against dialysis under the Medicare program.

2

(1) in clause (i), by inserting ", or that such an individual requires the use of an item or service," before "during the 12-month period"; and

(2) by adding at the end of the matter following clause (ii), the following new sentence: "Notwithstanding any other provision of law, a group health plan shall be treated as differentiating in the benefits it provides in violation of clause (ii) if the plan limits, restricts, or conditions the benefits the plan provides for renal dialysis services as compared to the benefits the plan provides for other medical services that are necessary to treat other chronic medical conditions and that are covered under the plan.".

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Lessons

Plan Language Matters

- The Plan Language Should Match Payment Practice
- Uniform Treatment Is Important
  Capture Your Intent
- Compliance is A Valuable Investment

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The Media Won't Get It Right. . .

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Supreme Court rules in favor of insurance plan that pushed kidney failure patient to Medicare

But The Media Doesn't Issue Decisions

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Not Over

Member's Out of Pocket Would Have Been Higher

Not "Pushed" Off Plan

Wasn't Paid As Out-Of-Network

Charges Will Almost Certainly Continue to Rise if Unchecked By Market Solutions

Let Your Representatives Know

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SHERRILL MORGAN

The Upside of Sharing Services

Types of Sharing

DEPARTMENTS

- HR/Benefits
- Payroll
- Information Technology
- Transportation
- Purchasing
- Maintenance

Types of Sharing- Continued

SERVICES

- Benefit Packages (Consortiums)
- Clinics
- Pharmacies

Benefits of Sharing Services

- Saves Money
- Improve Service
- Reduces Redundancy
- Qualified Workforce Shortage

Benefits of Sharing Services- continued

- Creates Opportunity
- Central Point of Contact
- Flexibility
- Improves Productivity

What to Do?

AGREEMENT

- Define the Scope of Work
- Determine Responsibilities
- Create an Implementation Plan?

Success Stories

ARLINGTON COMMUNITY SCHOOLS
BARTLETT CITY SCHOOLS
COLLIERVILLE SCHOOLS
LAKELAND SCHOOL SYSTEM
MILLINGTON MUNICIPAL SCHOOLS
Excellence in Education

ARLINGTON COMMUNITY SCHOOLS
BARTLETT CITY SCHOOLS
COLLIERVILLE SCHOOLS
LAKELAND SCHOOL SYSTEM

CITY OF LAKELAND TENNESSEE

Look for your opportunities to Share Services!

Large Claims 101: What to Watch For & What to Do About It

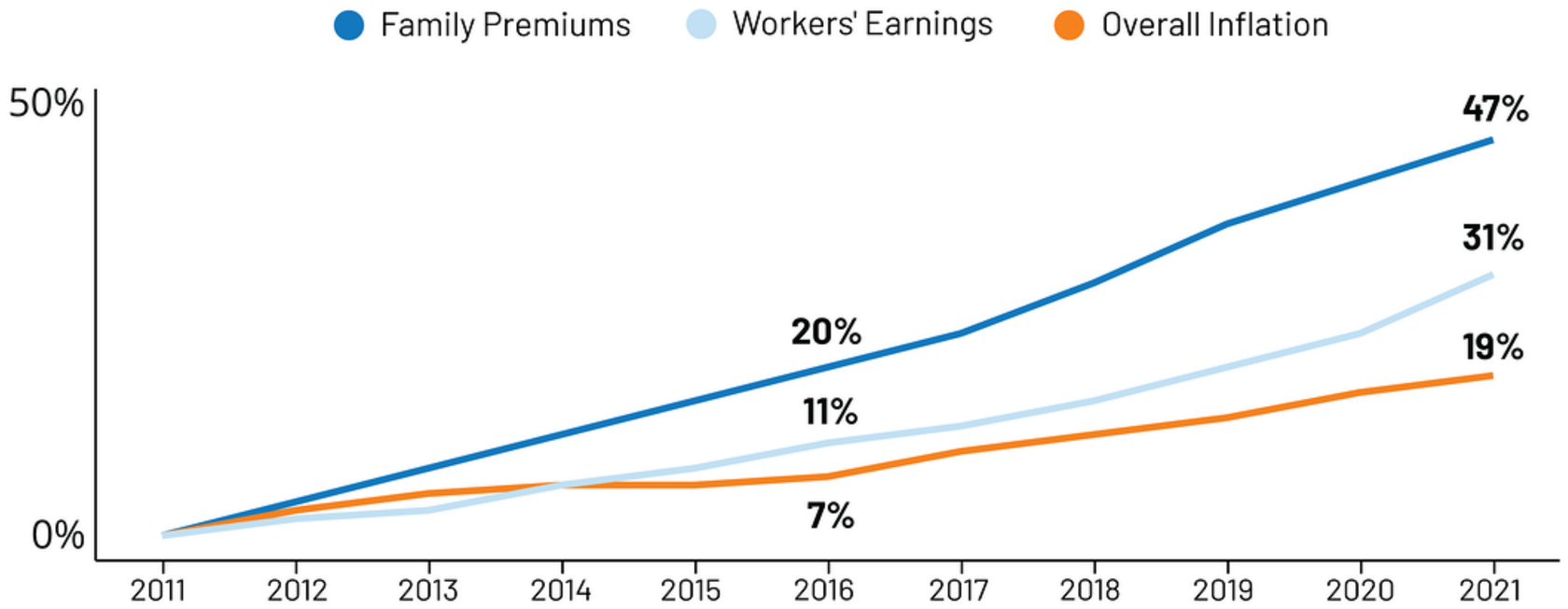
Presented by: SHERRILL MORGAN

“Medical costs are the tapeworm of American economic competitiveness”

Warren Buffett

2nd or 3rd Largest Expense

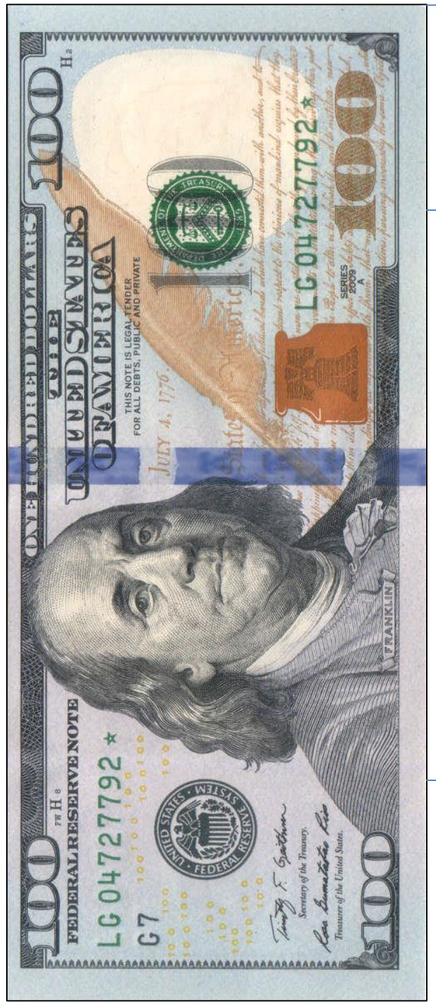
Over Time, Family Premiums Have Risen Faster than Wages and Inflation



SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2011-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2011-2021.

KFF

Fully Insured vs Self-Funded



Maximum Cost -

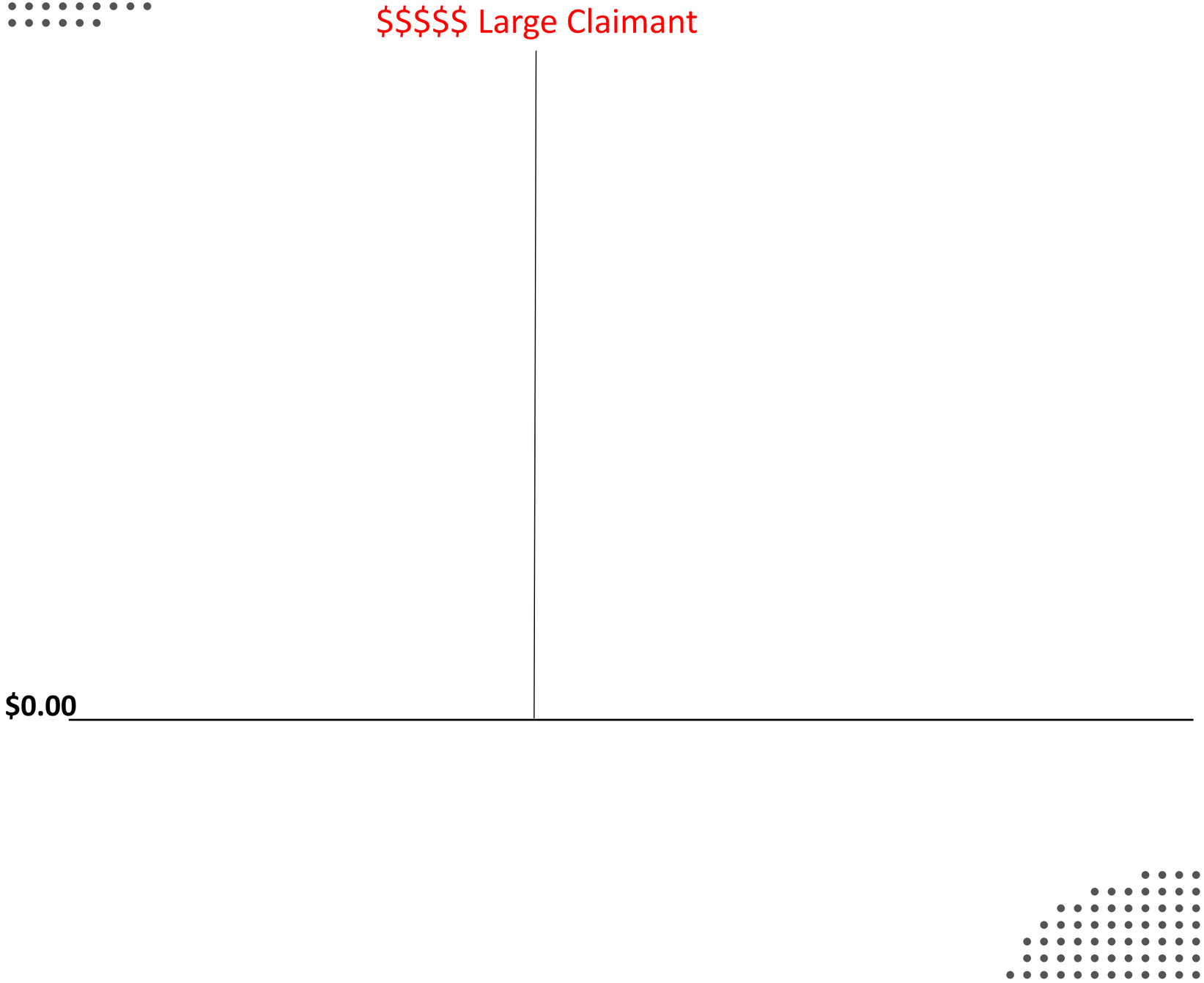
Difference Between Exp & Max Carrier Profit or Client Retention

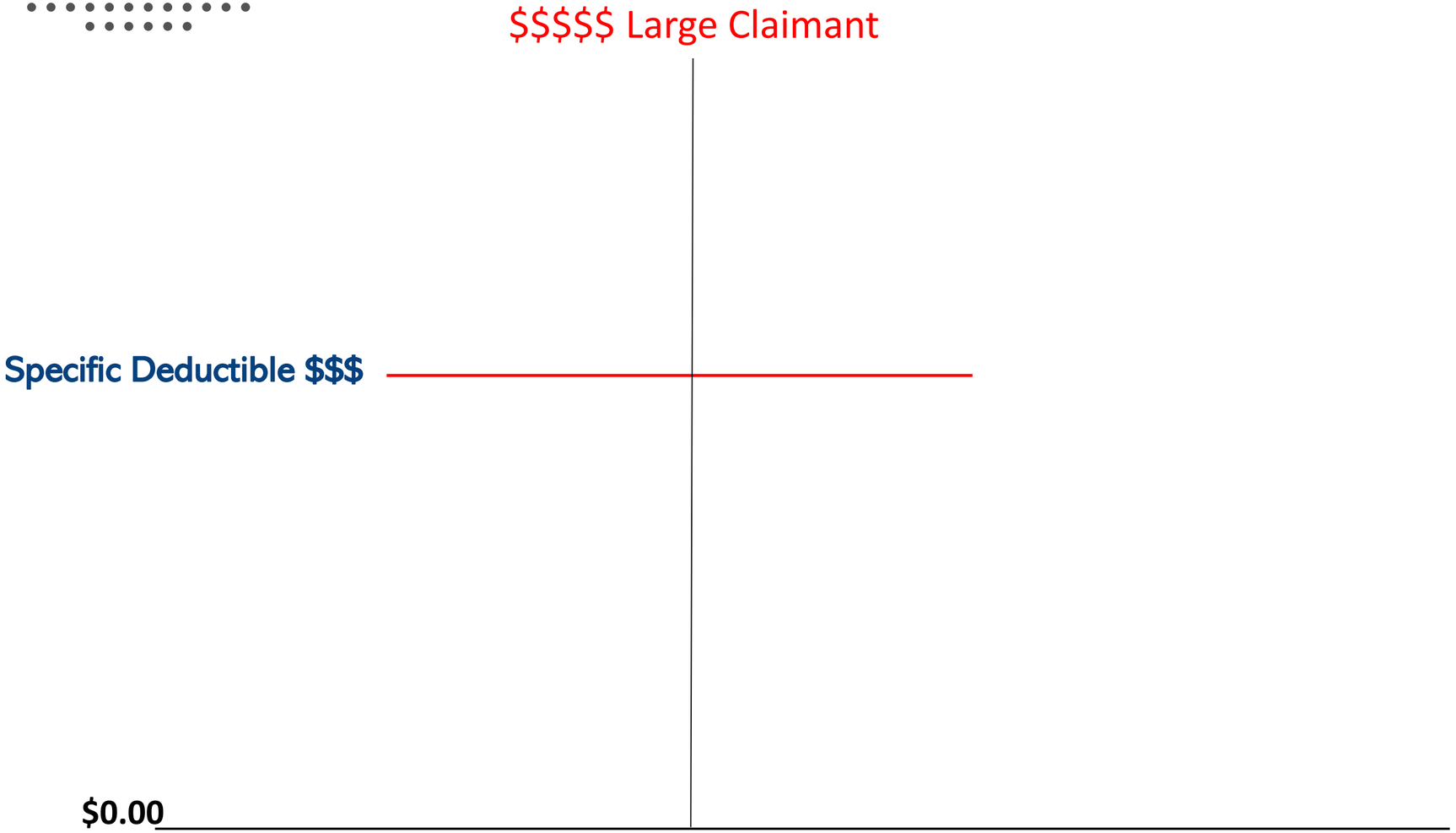
Expected Claims

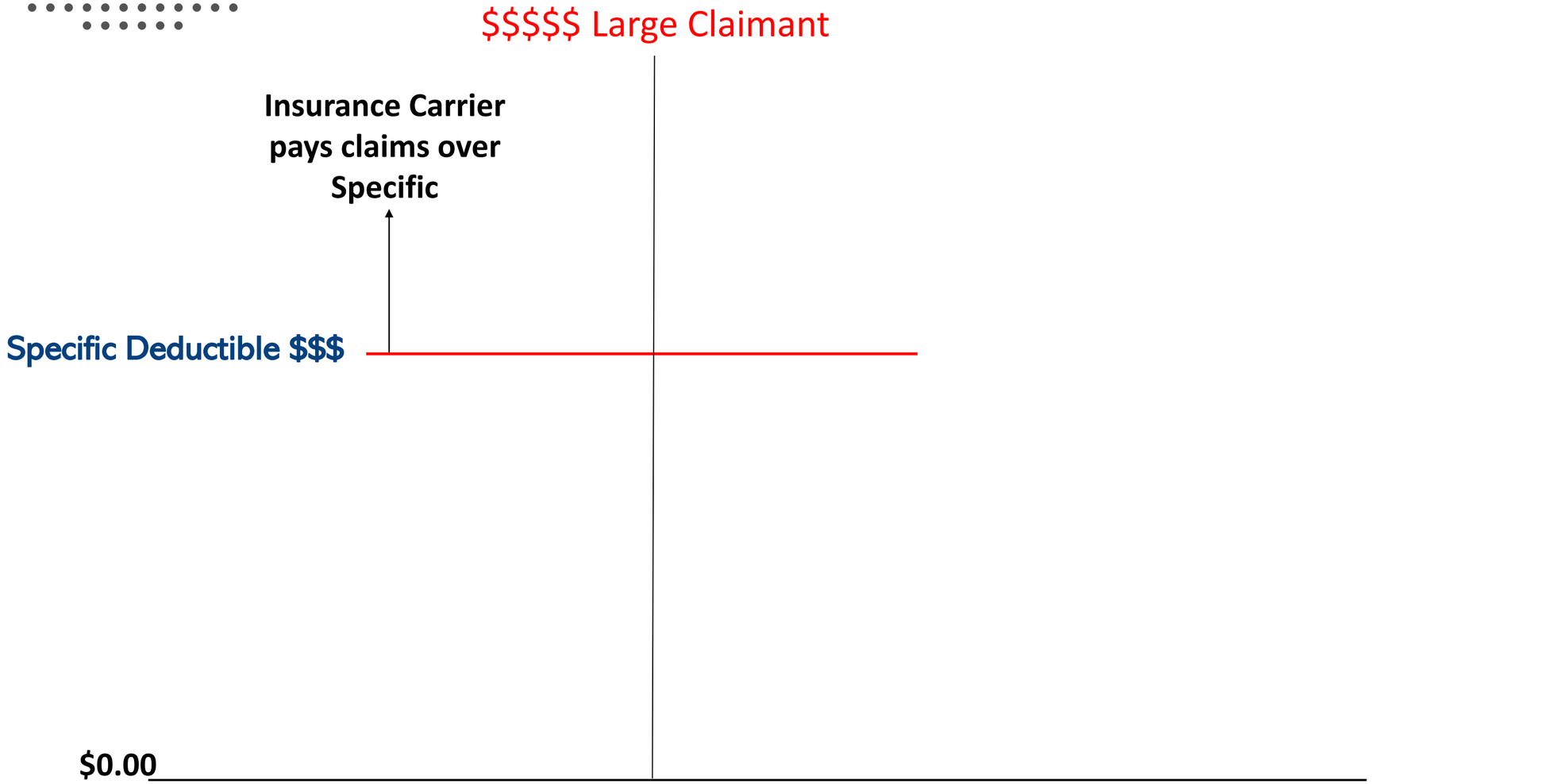
Fixed Cost

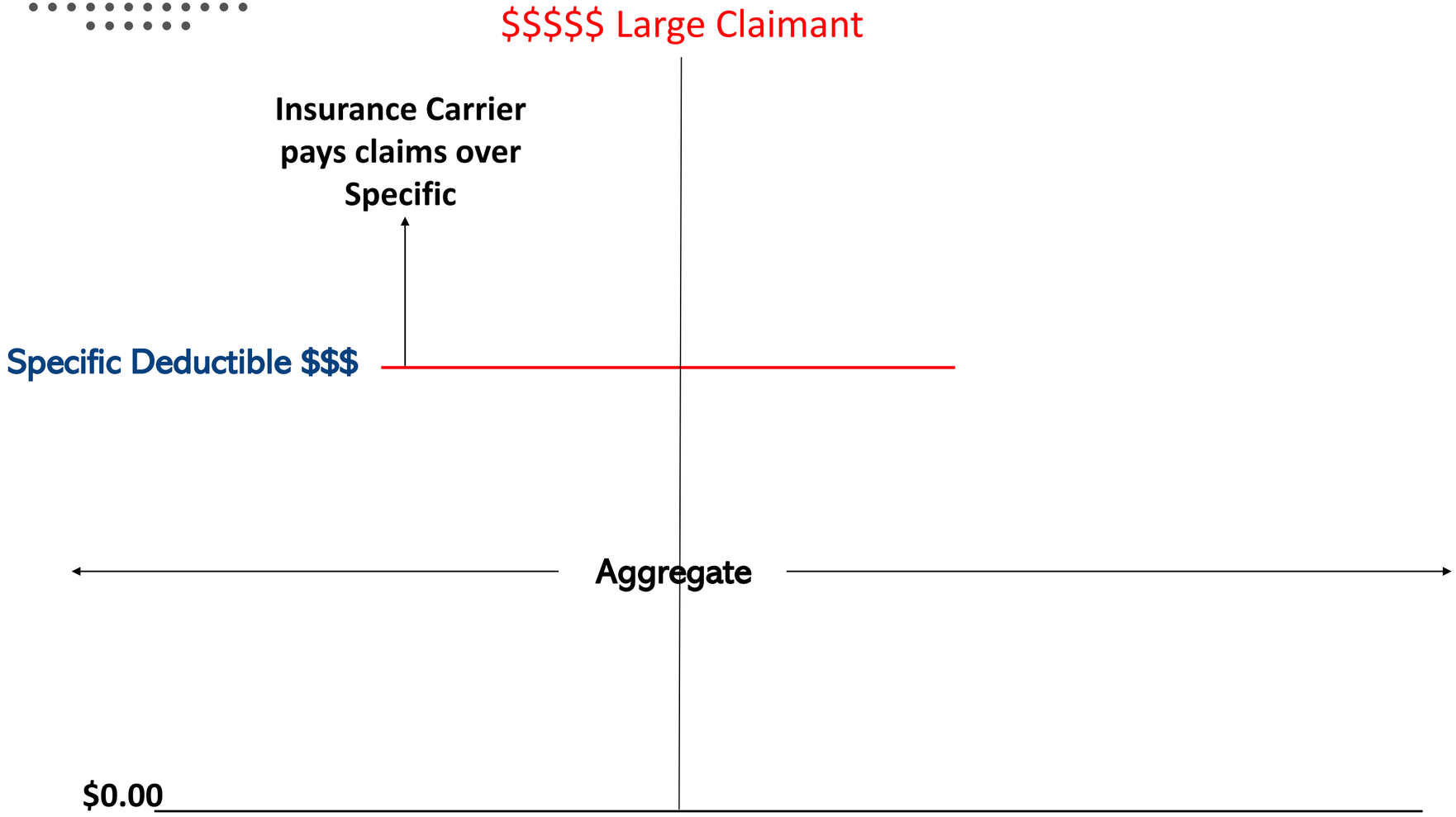
Insurance Components

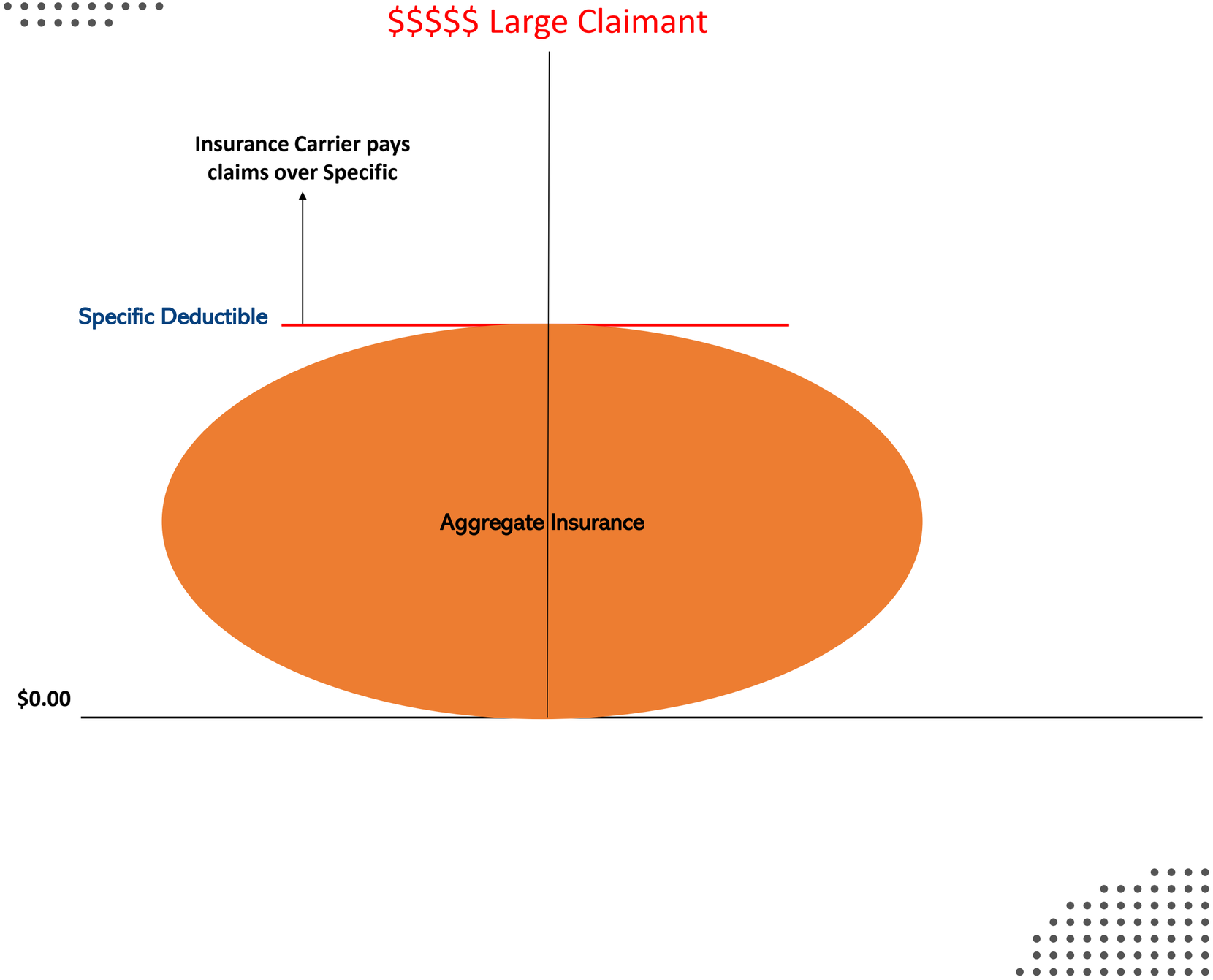
- Specific Insurance (Specific Deductible)
- Aggregate Insurance


$$$$$ Large Claimant
$0.00

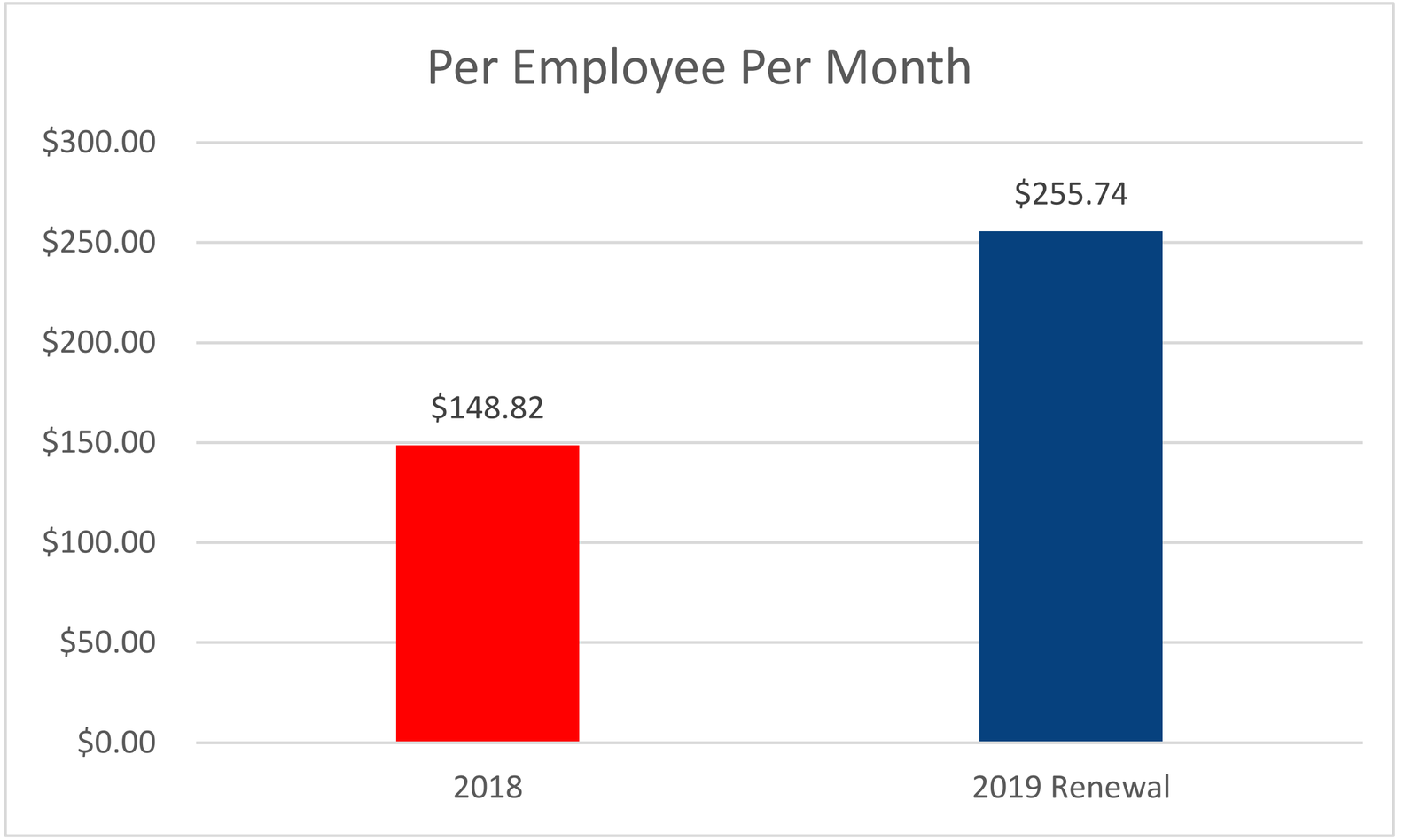

$$$$$ Large Claimant
Specific Deductible $$$
$0.00


$$$$$ Large Claimant
Insurance Carrier pays claims over Specific
Specific Deductible $$$
$0.00

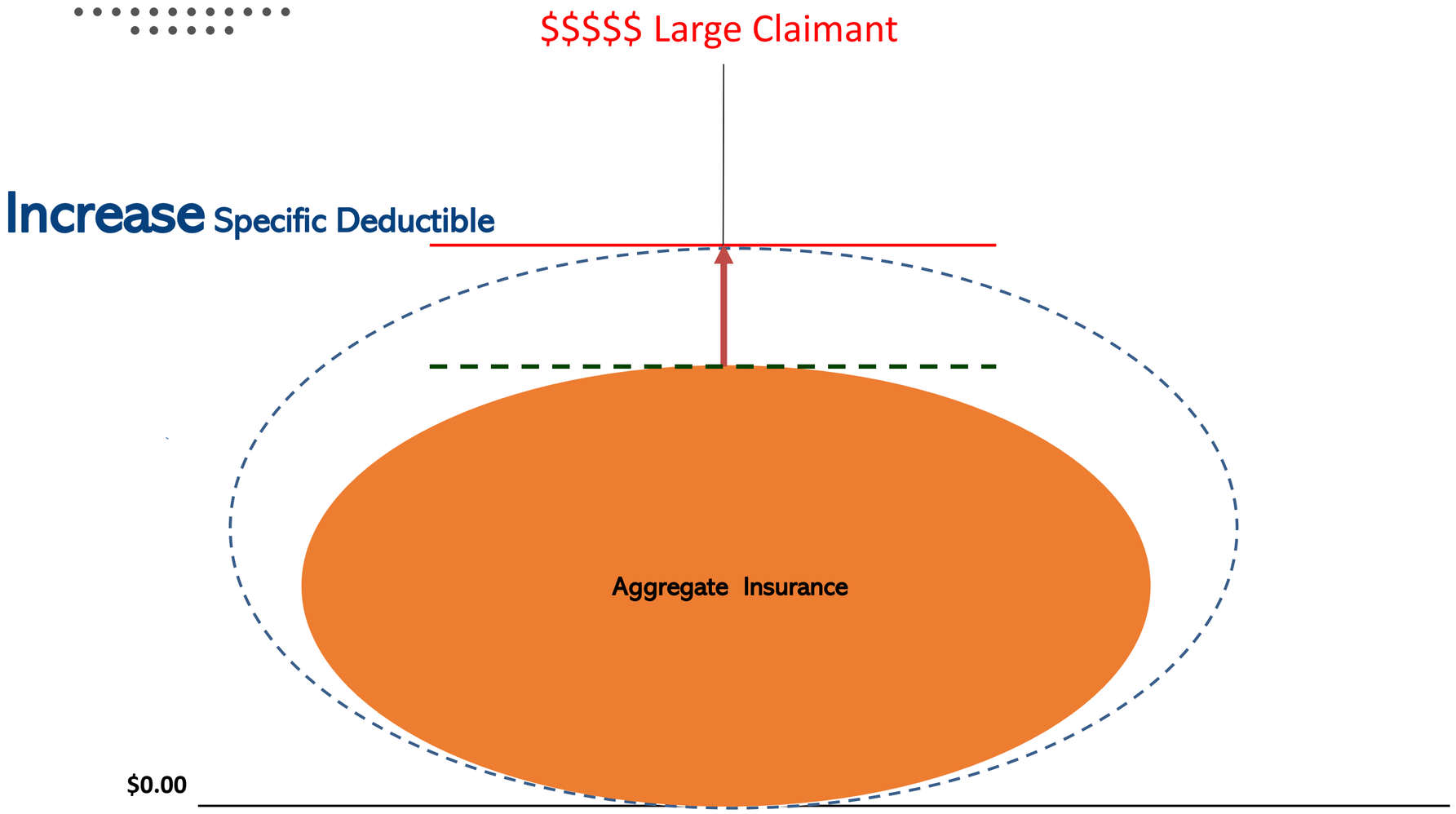

$$$$$ Large Claimant
Insurance Carrier pays claims over Specific
Specific Deductible $$$
Aggregate
$0.00


$$$$$ Large Claimant
Insurance Carrier pays
claims over Specific
Specific Deductible
Aggregate Insurance
$0.00

Stop Loss Increase

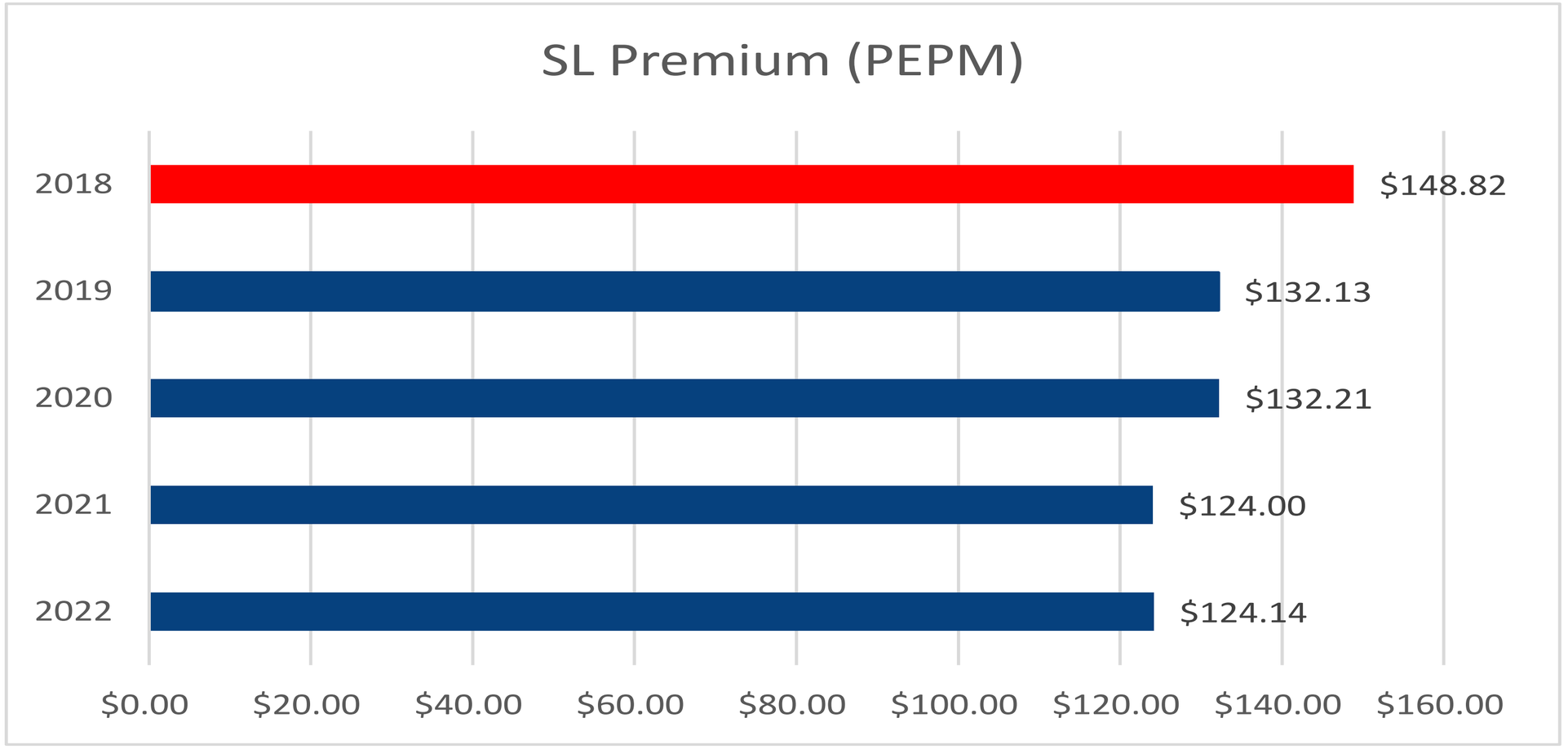


***70% + / $600,000 Premium Increase**


$$$$$ Large Claimant
Increase Specific Deductible
Aggregate Insurance
$0.00

Contributing Factors

- Plan Design
- Inflation
- Healthcare Providers
- ACA
- Specialty Drugs – Injectables
- COVID



$338,000 in savings since 2018

Focus…

- Lower cost while maintaining attractive benefits

Winning Solution: *Biggest Carrier + Best Discount*

We are told…

Keep your eye on the ball

Biggest Carrier + Best Discount = ??Savings??

Contributing Factors

- Plan Design
- Inflation
- Healthcare Providers
- ACA
- Specialty Drugs – Injectables
- COVID

Contributing Factors

- Plan Design
  - Increased Deductibles have led to barriers to care
  - Employees Hear – Deductible and Coinsurance are increasing

Contributing Factors

- Inflation

Contributing Factors

- Healthcare Providers – Hospitals
  - WSJ – 15% increase in prices

Contributing Factors

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  - WSJ – 15% increase in prices
  - Study - Robert Woods Johnson Foundation

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- Healthcare Providers – Hospitals
  - WSJ – 15% increase in prices
  - Study - Robert Woods Johnson Foundation
    - Hospital consolidation results in higher prices,

Contributing Factors

- Healthcare Providers – Hospitals
  - WSJ – 15% increase in prices
  - Study - Robert Woods Johnson Foundation
    - Hospital consolidation results in higher prices,
    - Physician-hospital consolidation has not led to either improved quality or reduced costs

Contributing Factors

- ACA
  - OLD NEWS!!!

Contributing Factors

- ACA
  - OLD NEWS!!!
  - September 23, 2010

Contributing Factors

- Increasing Large Claims – Medical
  - “2022 Sun Life Stop-Loss & Health Research Report – High-cost claims and injectable drug trends analysis.”
    - 22%
    - 2017-2022 – 31% increase in Million Dollar Claims
    - 2022 – $6.2

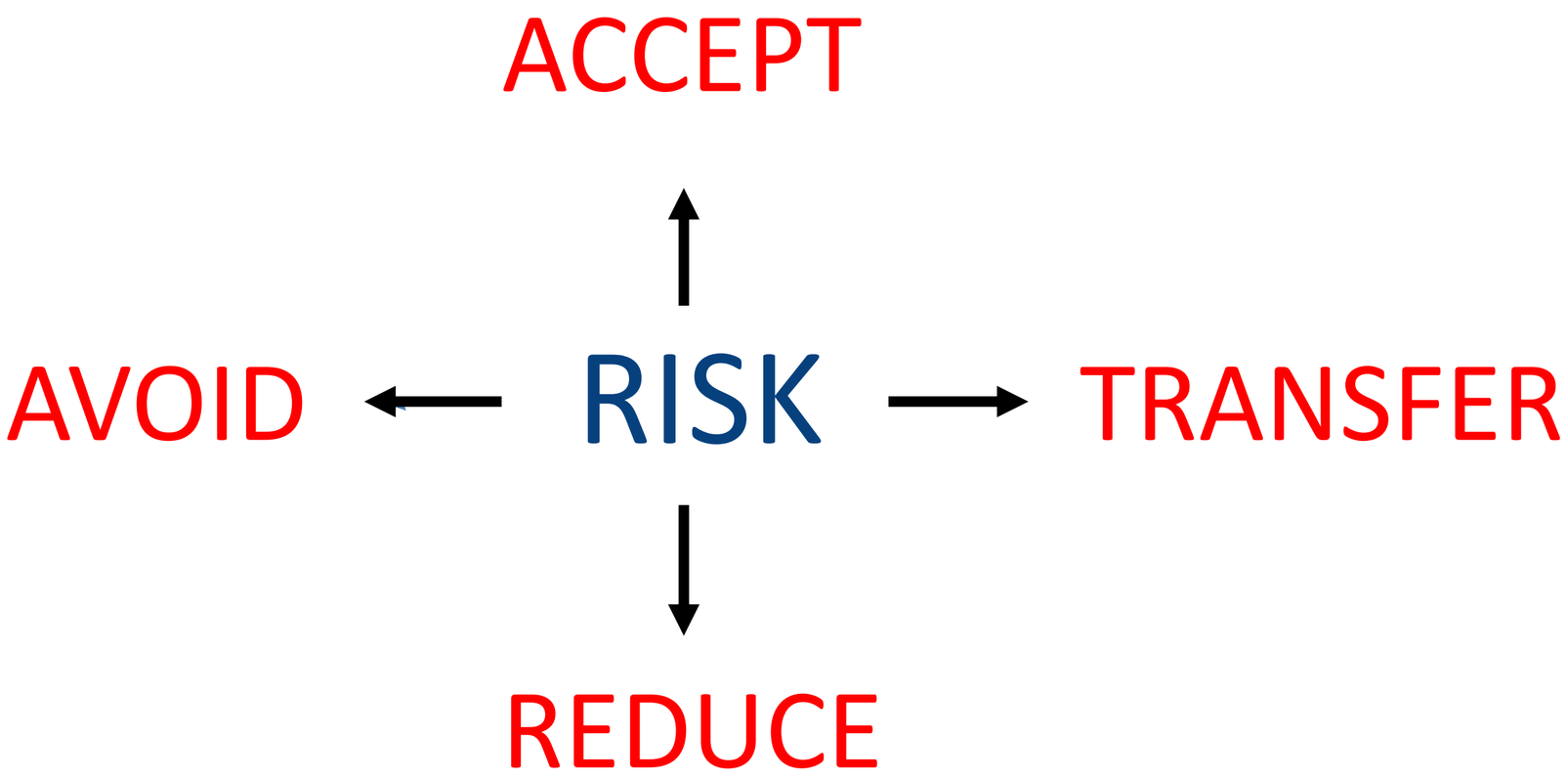
Contributing Factors

- Specialty Drugs – Injectables
  - Keytruda
  - *2021 - $148.3K, 6% increase over 2020
  - *25% of total cost to fight cancer
  - **Cell & Gene Therapy 2023 will be 4X $$$$$ 2022

*Sun Life & **Tokio Marine reports

Contributing Factors

- COVID
  - Positive - New Treatments through mRNA Technology
  - Negative – Cancer Screenings were Down over 9M


ACCEPT
AVOID
RISK
TRANSFER
REDUCE

What works?

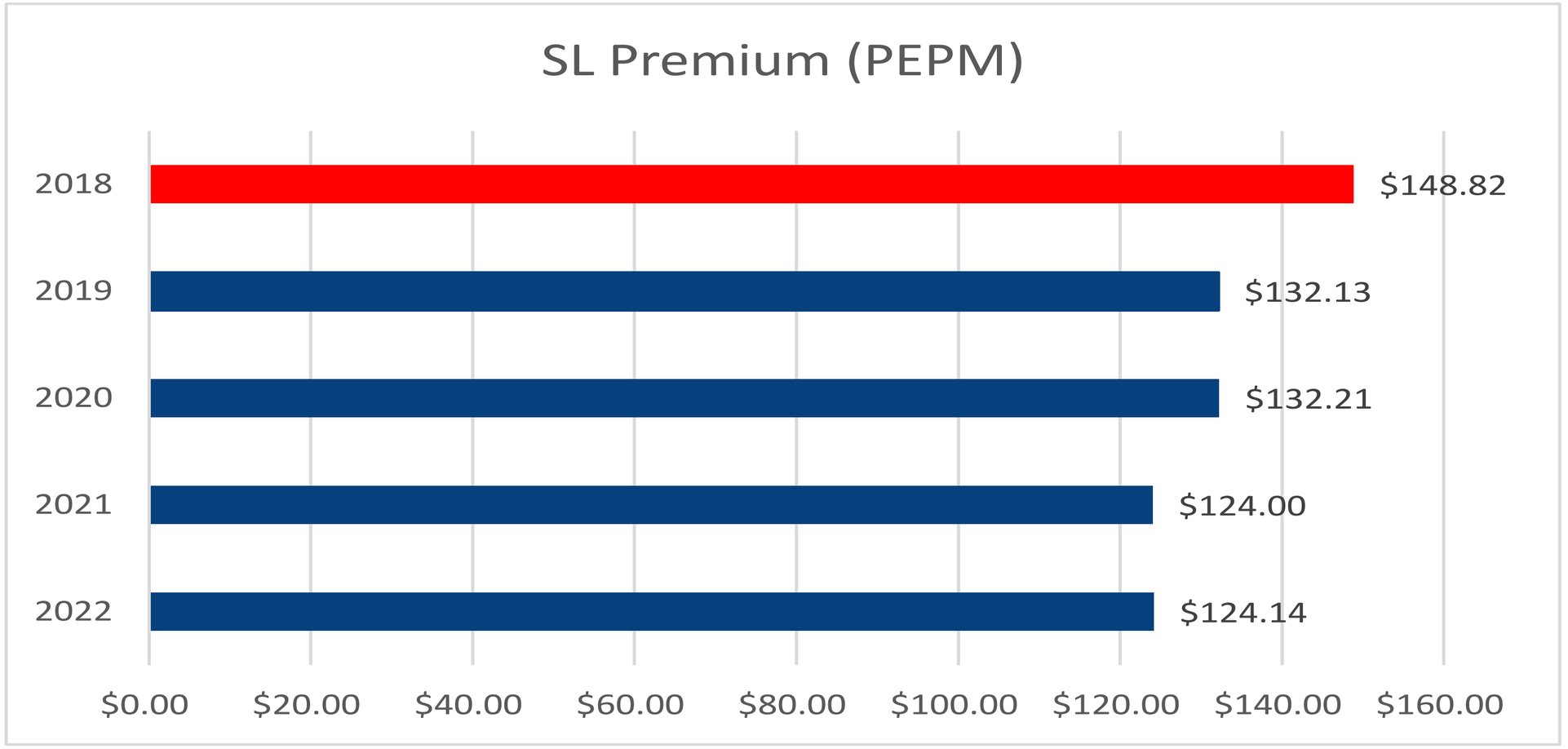
- What gets to the cost?

This works?

- RBP/VBP – Reference Based Payments or Value Based Payments

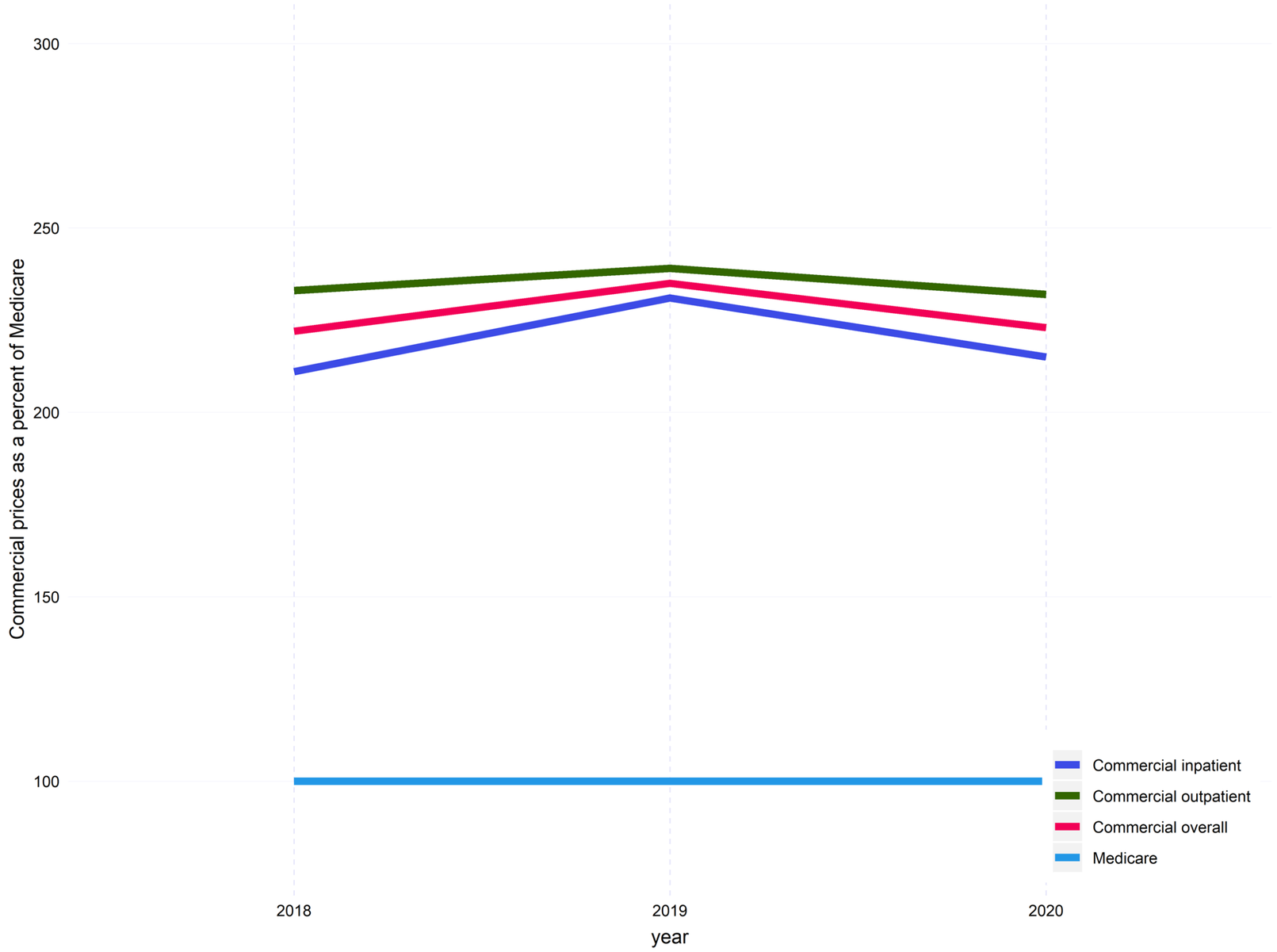
How well?

- RBP/VBP – Reference Based Payments, Value Based Payments, Direct Contracts
  - **20+% Savings**
  - Full or Partial
  - Lower SL Premiums and Claims



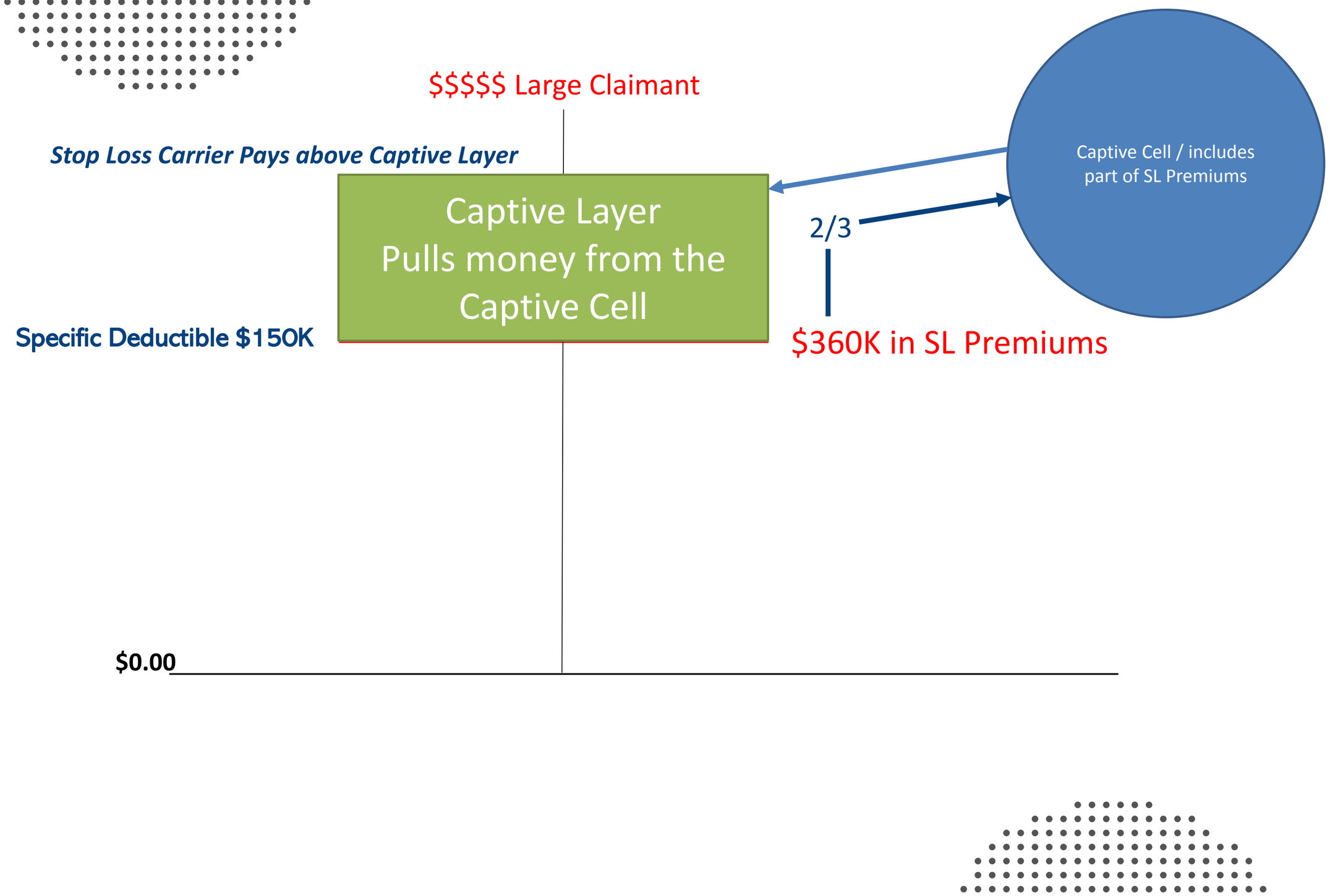
$338,000 in savings since 2018

Why it works


300
250
200
150
100
Commercial prices as a percent of Medicare
2018
2019
2020
year
Commercial inpatient
Commercial outpatient
Commercial overall
Medicare

What else works?

- Captives
  - SL Premium Retention


$$$$$ Large Claimant
Stop Loss Carrier Pays above Captive Layer
Captive Layer
Pulls money from the
Captive Cell
Captive Cell / includes
part of SL Premiums
2/3
Specific Deductible $150K
$360K in SL Premiums
$0.00

What works?

- Rx – Specialty Carve-Out

How It works?

- Rx – Specialty Carve-Out
  - Everyone gets their prescriptions
  - Members have a prescription advocate
  - Many Members pay nothing little to nothing for their medications

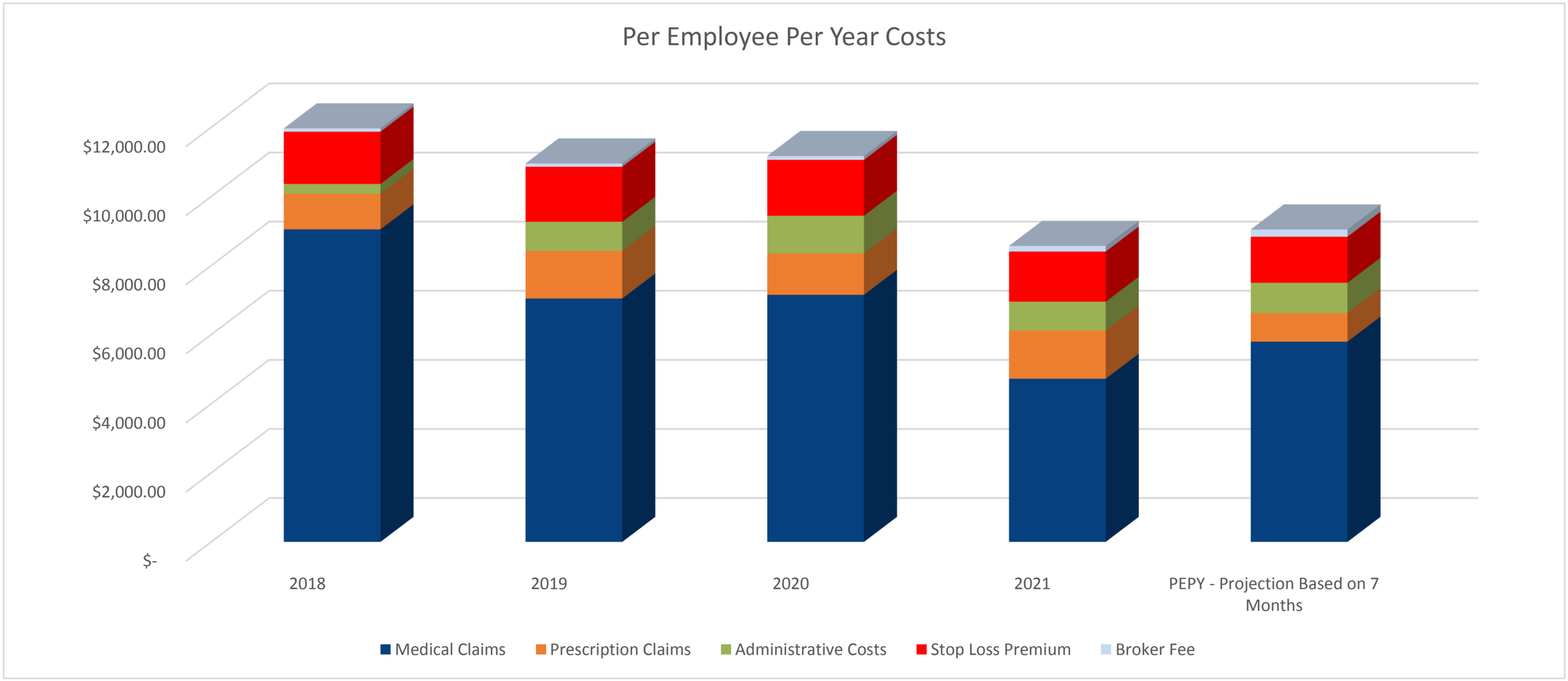
Results?

- Rx – Specialty Carve-Out
  - Ex. 1 - 270 ee client $280K savings
    - Or over $1,000 PEPY Decrease

Results?

- Rx – Specialty Carve-Out
  - Ex. 2 - 460 ee client $779K savings
    - Or over $1,600 PEPY Decrease
    - Initial overrides $249K

It Does Work


Per Employee Per Year Costs
$12,000.00
$10,000.00
$8,000.00
$6,000.00
$4,000.00
$2,000.00
$-
2018
2019
2020
2021
PEPY - Projection Based on 7 Months
Medical Claims
Prescription Claims
Administrative Costs
Stop Loss Premium
Broker Fee

Don’t Lose Focus

- *If nothing else a great benefit program can maintain your work force.*

In-Review

- *We can see why this statement was made*

“Medical costs are the tapeworm of American economic competitiveness”

“Greater volatility and uncertainty in costs is expected going forward. Not taking action is not a good option…”

In-Review

There are solutions that work

It allows you to maintain an attractive benefit program to retain your staff

SHERRILL MORGAN

Questions?

Dobbs and Its Impact on Employment/Benefits Laws

Frost Brown Todd LLC
ATTORNEYS

September 13, 2022

Robert D. Hudson
(859) 817-5909
rhudson@fbtlaw.com

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IMMEDIATE DOBBS IMPACT

- Abortion restrictions are now a matter of state law.
- About 24 states criminalize abortion on some level.
- At least 20 states protect abortion.
- Dobbs generates a series of potential conflicts with existing laws relating to employment and benefits.

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PREGNANCY DISCRIMINATION LAWS

- Many states, such as Kentucky, elevate pregnancy-related medical conditions to special protected status.
- In the event of a medically difficult pregnancy, but for Kentucky's abortion prohibition, its pregnancy law would likely provide for protected time off.
- Can the statutes be reconciled?

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FMLA

- Would the FMLA protect time away from work for a trip out of state for an abortion?
- What about a medically required abortion that places the mother's life in danger?
- What if the abortion need results from a reproductive system impairment?
- More than 3 days of incapacity?
- What if state law prohibits aiding and abetting?

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ADA

- Again, what about a medically required abortion that places the mother's life in danger?
- Again, what if the abortion need results from a reproductive system impairment?
- Would unpaid time off be a reasonable accommodation? Probably.
- Would the ADA preempt a state criminal law?

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EMPLOYEE MEDICAL TRAVEL BENEFITS

- What about funding the trip out of state for an abortion?
- Does this serve a business purpose? Pro's and con's?
- How should a company go about doing this?

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EMPLOYEE MEDICAL TRAVEL BENEFITS

- What about a general travel reimbursement?
- This can be okay, but it's rare, and it will result in taxable income.
- It would need to be neutral as to medical-related travel.
- Amending a business travel policy to tack on a specific healthcare-related reimbursement won't work. That raises ACA issues.

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EMPLOYEE MEDICAL TRAVEL BENEFITS

- Fully insured plans are governed by state law.
- This will limit traditional insured plan offerings for abortion-related costs.
- States banning abortion will not approve the plans.

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EMPLOYEE MEDICAL TRAVEL BENEFITS

- What about a self-insured medical plan?
- You don’t have to deal with state insurance issuance laws.
- But plans typically indicate that state laws must be followed.
- State criminal laws are not pre-empted by ERISA.

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EMPLOYEE MEDICAL TRAVEL BENEFITS

- What about aiding and abetting?
- Criminal exposure?
- Texas already sent a cease and desist letter to one company.
- Can Texas affect activities in another state?
- Or is it really only affecting what happens as far as payments in its state?
- What about the constitutional right to travel? Justice Kavanaugh recognized it.

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EMPLOYEE MEDICAL TRAVEL BENEFITS

- What if the government requests information about an employee's abortion?
- It's PHI.
- What if it's a subpoena?
- HIPAA exception.
- And finally, what about rich benefits?
- The IRS has limits on reimbursements.

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CONCLUSION

- ADA, FMLA, and pregnancy-related medical condition statute conflicts will be rare in practice, but potentially problematic.
- Reimbursement programs that provide travel funding for banned abortion states will be very difficult, if not impossible.
- Multi-state employers beware.
- Programs of general applicability, like PTO, will be available.
- Stay tuned….

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Transforming Our Wellness Programs in the Wake of COVID-19

Mark Morgan
President, SHERRILL MORGAN

What is Wellness?

Our Current Evaluative Status

- BMI
- Cholesterol
- A1C
- BP
- Regular Exercise
- Diet
- Annual Exam

The goal is to live a healthier, longer life

During COVID-19, we all had the apparent time to address these issues, though no major improvement was made

The Impact of Isolation

- The prolonged confinement is evidently related to psychological damage, considering that individuals would be subjected to stressors for a longer period of time. In some cases, these psychic losses lasted for many months after the end of this confinement.

- It is necessary to develop and implement actions to minimize the population psychological distress in meeting the needs of the communities affected by COVID-19.

"Effects of quarantine on mental health of populations affected by Covid-19". *Journal of Affective Disorders*

The Self-Reported Problem: An Increase from 21% to 37%

- The percentage of Americans who reported feeling hopeless more than half of the time has increased from 21% in 2019 to 37% in 2020.
- According to the Substance Abuse and Mental Health Services Administration:
  - Adults reporting any kind of mental illness has lingered between 17% and 21% for the past 10 years.
  - 1 in 5 adults reported having mental illness in 2019
  - Young women are the most impacted, with over 1 in 3 people ages 18-29 reporting mental illness
  - 16.1% of adults received mental health treatment at some point in 2019

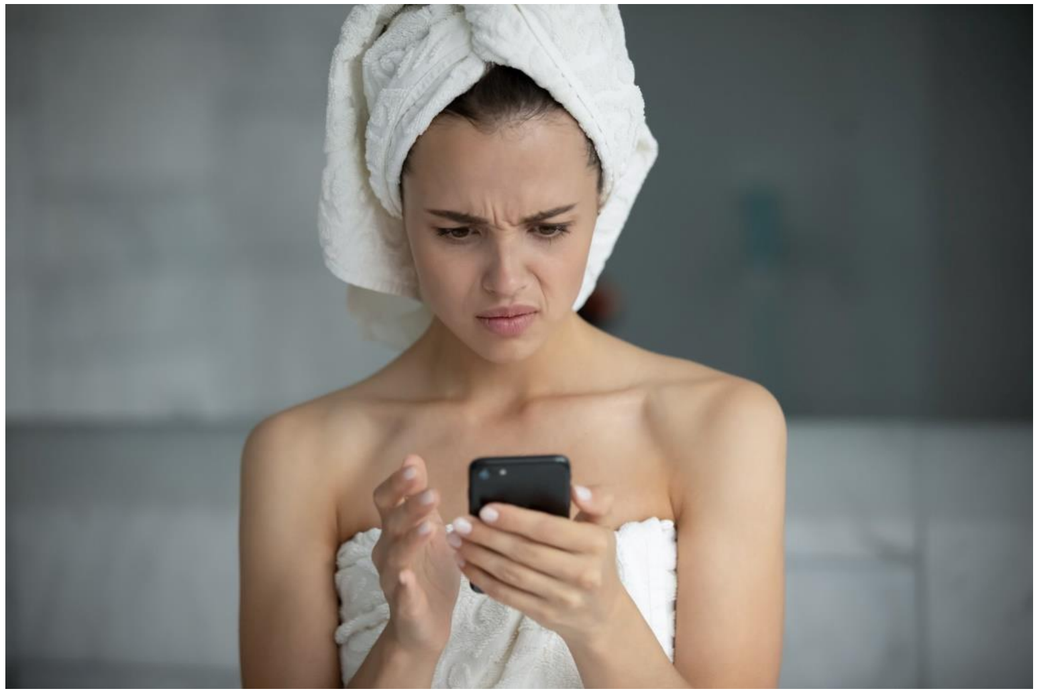
"As Covid-19 cases rise, 37% of adults are reporting a significant symptom of depression". *USA Facts*

Screen Time is NOT a Social Substitute

- 32% of teen girls said that when they felt bad about their bodies, Instagram made them feel worse

- For the past 3 years, Facebook has been conducting studies into how Instagram affects its millions of young users. Repeatedly, the company's researchers found that Instagram is harmful for a sizable percentage of them, most notably teenage girls.

- "We make body image issues worse for one in three girls," said one slide from 2019, summarizing research about teen girls who experience the issues.



"Facebook knows Instagram is toxic for teen girls, company documents show".
Georgia Wells, Jeff Horwiitz, and Deepa Seetharaman. *Wall Street Journal*

Screen Time is NOT a Social Substitute

Drug Overdoses Have Jumped 30%…

- Deaths from drug overdoses hit a record 93,000 in 2020, a nearly 30% jump from the prior year, according to a report from the CDC's National Center for Health Statistics

- The estimated number of overdose deaths reached 93,331 in 2020, according to the new data. More than 900,000 people have died of overdoses since the U.S. drug epidemic began about 1999, according to the CDC.

- Amid the COVID-19 pandemic, "we took our eye off the opioid epidemic," said Tami Mark, PhD, health economist and senior fellow at think tank RTI International. "When we weren't looking, it got horribly worse."

"'Terrifying': 2020 drug overdoses jump 30%, hit record 93,000 deaths". Gabrielle Masson. *Beckers Hospital Review*

...And Continue to Climb

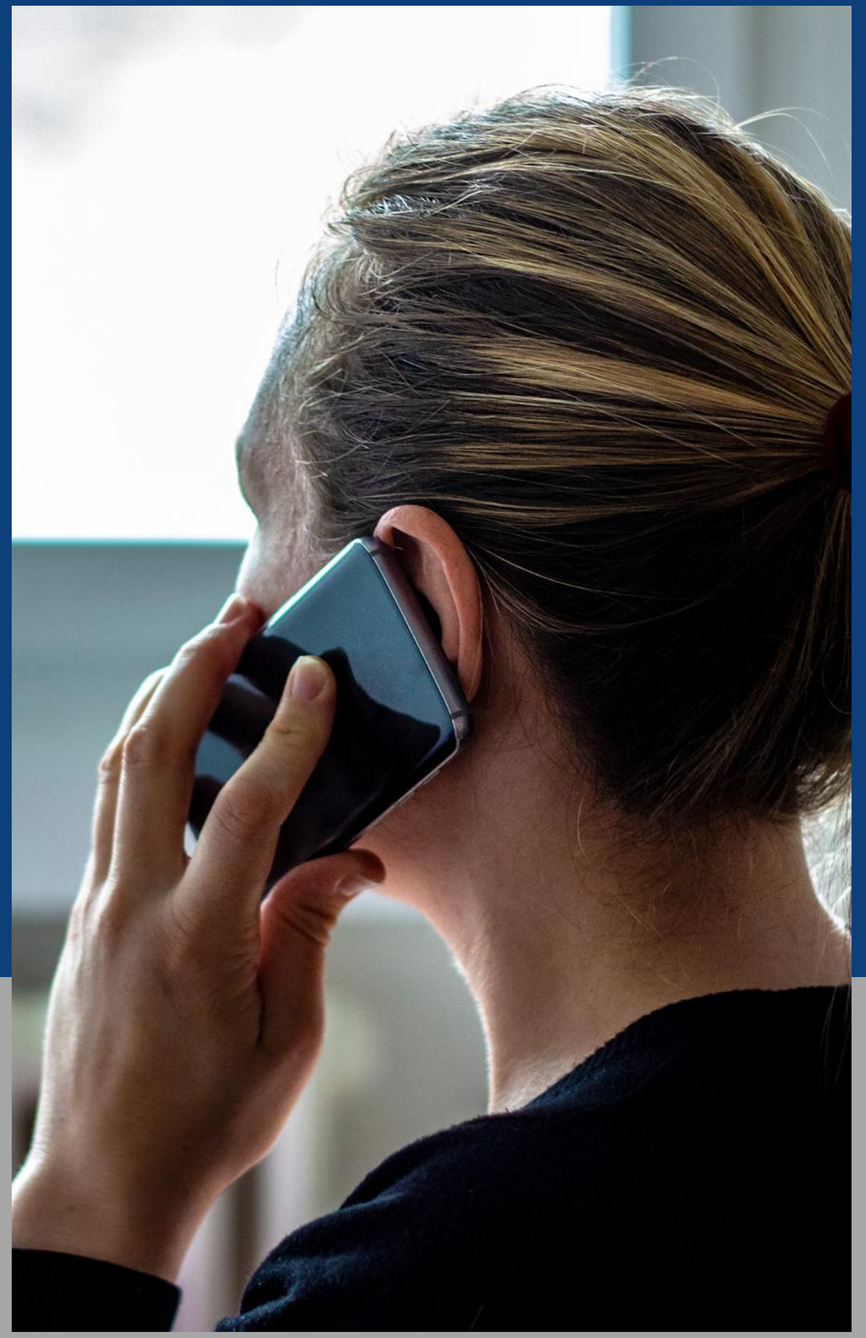
- In Kentucky alone, there were 1,964 overdose deaths in 2020. This was a **49%** increase from 2019
- Then in 2021, there were 2,250 overdose deaths, another substantial increase of **14.5%**

"2021 Overdose Fatality Report". Kerry Harvey and Van Ingram. *Kentucky Office of Drug Control Policy*

You Aren’t Alone

As of July 16, 2022, the U.S. has transitioned from a 10-digit National Suicide Prevention Lifeline to a 3-digit one: ***988***. The lifeline, which also links to the Veterans Crisis Line, follows a three-year joint effort by the U.S. Department of Health and Human Services (HHS), Federal Communications Commission (FCC), and the U.S. Department of Veterans Affairs (VA) to put crisis care more in reach for people in need.

SAMHSA.GOV



New Age of Awareness of an Existing Problem

- The frequency of telehealth claims for behavioral and mental health disorders far exceeded all other clinical issues. Claims for behavioral and mental health disorders were 4-5 times more frequent than those for other common categories of disease, including circulatory and endocrine disorders.

“A Covid-19 telehealth impact study: exploring one year of telehealth experimentation”. *Telehealth and Medicine Today*

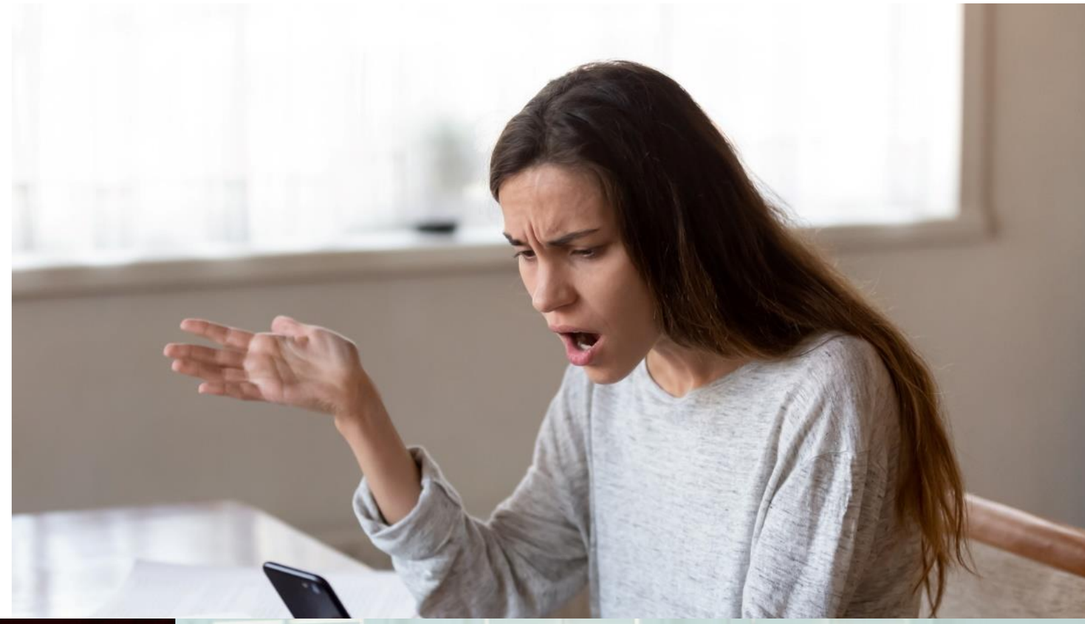
In My Own Experience

- Training from Hazelton/Betty Ford Clinic, Minnesota

- Characteristics and symptoms of mental illness:
  - Desire to separate/be apart
  - Blaming others for events in our lives
  - Inability to control certain behaviors such as drinking or eating
  - Destruction of personal and community support systems

- Some of these characteristics were forced unnaturally upon us due to the isolation of the COVID-19 response

Limited Access to Care



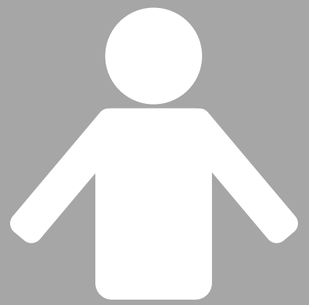
Through COVID-19, Our Wellness Programs Couldn't Make US Well

PERHAPS WE WERE ONLY MEASURING HALF OF THE CRITERIA NEEDED FOR WELLNESS

IF WELLNESS IS OUR GOAL, TO LIVE LONGER, HEALTHIER, AND HAPPIER LIVES, THEN ADDITIONAL MEASURES SHOULD BE USED TO ACHIEVE THIS

WHAT IS WELLNESS?

HEALTHY LIVING = LONGEVITY = HAPPINESS



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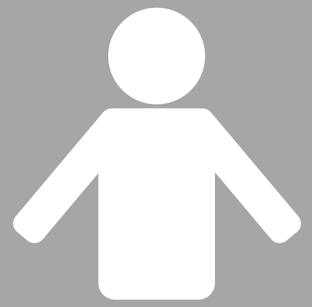
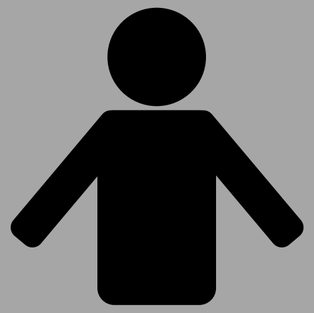
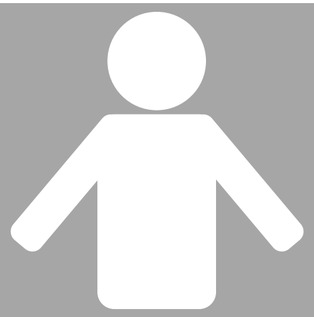




OR

HAPPINESS = HEALTHY LIVING = LONGEVITY



Happiness Today

"We are promised happiness with the next pay raise, the next new gadget – even the next sip of soda.

The Swedish business professor Carl Cederström argues persuasively in his book "The Happiness Fantasy" that corporations and advertisers have promised satisfaction but have led people instead into a rat race of joyless production and consumption.

"Though the material comforts of life in the U.S. have increased for many of its citizens, those things don't give life meaning."

The Atlantic 2020, "Are We Trading Our Happiness for Modern Comforts?"


EST. 1949
ANDERSON FAMILY
IS THIS HEAVEN?
THE NORTH FACE

Longevity


BLUE ZONES PROJECT
by HEALTHWAYS
LOMA LINDA
CALIFORNIA
SARDINIA
ITALY
IKARIA
GREECE
OKINAWA
JAPAN
NICOYA
COSTA RICA
The Five Original Blue Zones

Longevity

"Socializing and maintaining tight-knit communities also plays a significant role in longevity. The healthiest people in the world don't eat in front of the TV. They eat with their family and friends. They linger over shared meals because they are enjoyable. They don't grab a quick bite simply to eat."

The Longevity Solution: Rediscovering Centuries-Old Secrets to a Healthy, Long Life
Dr. James DiNicolantonio & Dr. Jason Fung

Longevity

"Although these people live throughout the world, with seemingly widely divergent diets and lifestyles, they all share certain characteristics that might help them live longer, fuller lives. These people often smoke less, move more (and at a moderate level), and prioritize family and socializing above all else."

The Longevity Solution: Rediscovering Centuries-Old Secrets to a Healthy, Long Life
Dr. James DiNicolantonio & Dr. Jason Fung


DX3
Healthy Life

Going Forward, Should We Be Measuring These In Our Wellness Programs?

Should these be incentivized wellness activities?

- Weekly friends/family activities
- Reduction in screen time
- Weekly participation in religious/community organizations
- Regular physical exercise with friends/family
- Number of meals shared with friends/family

Communicating the availability of access to care

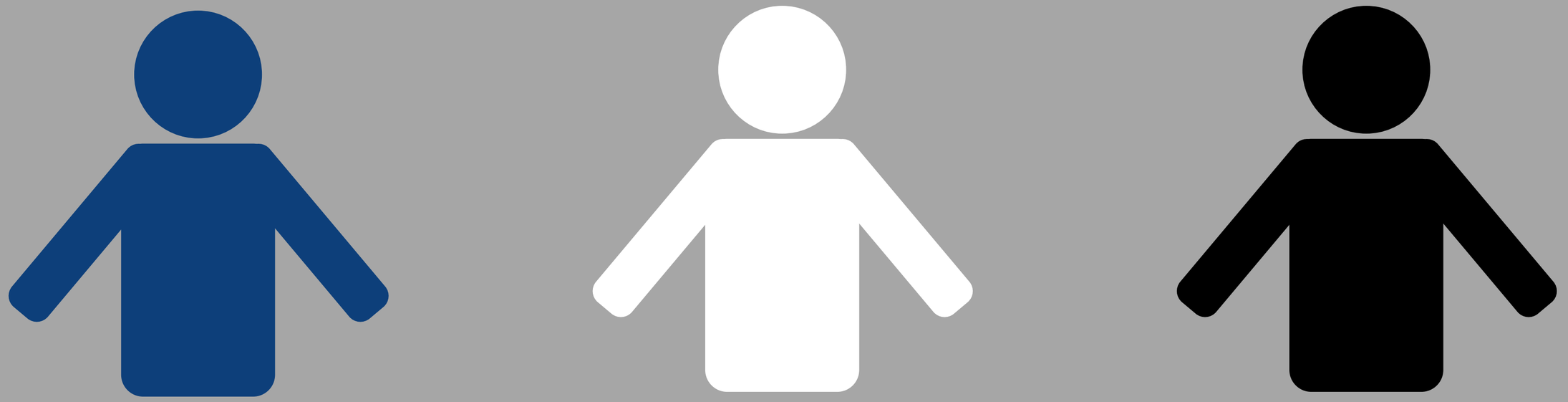
BEHIND THE SCENES OF WELLNESS PROGRAMS

- The design is up to the employer
- ACA and EEOC requirements don't apply to incentives based upon activities like going to dinner, spending time with friends, or being social

- **Issues**
  - How to get reports / how employees can prove they are meeting the requirements
  - If money / valuables (i.e., gift cards) are offered as benefits, they will be taxable income because the value of the incentive will be considered imputed income for tax purposes

WHAT IS HAPPINESS?

HAPPINESS = HEALTHY LIVING = LONGEVITY



QUESTIONS?

MARK MORGAN

President

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DAY 2 AGENDA & PRESENTATIONS

SHERRILL MORGAN

ASM
A-S Medication Solutions

Premise Health.

9TH ANNUAL HEALTHCARE INNOVATION CONFERENCE

SHERRILL MORGAN

NORTHERN KENTUCKY CONVENTION CENTER

DAY 2 AGENDA

WEDNESDAY, SEPTEMBER 14TH

8:30am - 9:00am	**Breakfast, Registration, and Exhibitor Meet & Greet**
9:00am - 9:10am	**Opening Remarks** Mark Morgan | SHERRILL MORGAN
9:10am - 9:20am	**2nd Day Welcome** Brent Cooper | NKY Chamber of Commerce
9:20am - 9:50am	**The Legal Rundown: Updates on Regulatory Issues** Lisa Stamm | SHERRILL MORGAN
9:50am - 10:10am	**Trends in Claim Surveillance** Brian Fargus | MedBen
10:10am - 10:40am	**Medication Solutions** Walter Hoff | A-S Medication Solutions
10:40am - 11:00am	**Jefferson Health Plan** Brendan Nugent | The Jefferson Health Plan
11:00am - 11:40am	**Using AI to Help Predict and Prevent the Shock Claims of Tomorrow** Julie Mueller & Alberta Manga | Custom Design Benefits
11:40am - 12:00pm	**What is Cost Avoidance?** Terri Evans | Employer Advisory Services
12:00pm - 1:00pm	**Lunch & Closing Remarks**

2022 Compliance Update

Lisa A. Stamm, Esq.
SHERRILL MORGAN

Topics We'll Cover

- ACA Developments
- *Dobbs'* Impact on Group Health Plans
- Inflation Reduction Act
- Other Developments

ACA Developments

Indexed Adjustments for 2023

- Out-of-Pocket Maximums
  - $9,100 single/$18,200 family
- Affordability
  - Self-only coverage cannot exceed 9.12% of total household income
  - This is LOWER than in 2021's 9.61% and second year in a row it has decreased
- Employer Shared Responsibility Penalties
  - 4980H(a): $2,880
  - 4980H(b): $4,320

PCORI Fees

- ACA tax self-funded plans must pay (fully insured too, but carriers pay; note that fully insured employers with HRAs must pay the fee for HRA)
- Plan years ending in month of October, November, or December: fee due by July 31, 2023; amount TBD
- Plan years ending in other months: will owe $2.79 per covered life by July 31, 2023
- Fee remitted on Form 720

Section 1557

- Prohibits discrimination on basis of race, color, national origin, sex, age, or disability by "covered entities"
- Definition of covered entities has been interpreted to include insurers and employers who sponsor group health plans who also receive funding from HHS
- Section 1557 does not specifically require coverage of gender transition surgery/related services, but new proposed regulations would clarify that sex discrimination includes discrimination based on sex stereotypes and characteristics
- Regardless of Section 1557's scope, EEOC is still a concern for plans who exclude gender transition; subject of much litigation

Transparency in Coverage Rules

- Designed to introduce price transparency to the health care arena so consumers can make informed decisions about care
- Hospital Price Transparency rule went into effect in 2020; required hospitals to publish negotiated rates for 300 common services; compliance has been poor
- Transparency in Coverage rule for health insurers and non-grandfathered health plans now being implemented in three phases

Transparency in Coverage Rules

- 7/1/22: must post machine-readable files on public website;
  - Must contain in-network rate file for all covered items and services and billed and allowed amounts for out-of-network providers*
  - New guidance provides that plan can contract in writing with service provider to put the link on the service provider's public website
- Plan or policy years on or after 1/1/23: self-service pricing tool for 500 shoppable services
- Plan or policy years on or after 1/1/24: self-service pricing tool for all services

*Requirement to publish historical prescription drug costs has been indefinitely delayed, partly because of disclosure requirements under the Consolidated Appropriations Act of 2021

Contraceptives

- Following Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization* (overturning Roe v. Wade), tri-agencies (DOL, HHS, and IRS) issued guidance reminding non-grandfathered health plans about some of ACA's preventive care provisions, which require coverage with no cost-sharing for certain birth control methods
- Examples:
  - One form of contraception in each category in the FDA's birth control guide
  - FDA-approved emergency contraceptive when prescribed by a provider
  - Contraceptive counseling
- Will likely be increased enforcement

Other Possible ACA Developments

- Commonsense Reporting Act of 2022
  - Bipartisan legislation introduced in Congress
  - Designed to simplify the reporting requirements of the ACA's employer mandate
  - Act would allow employers to voluntarily report general information about their health plans (e.g., affordability, minimum value, etc.) for the current plan year prior to the beginning of open enrollment; that would satisfy reporting obligation
  - Earlier version of the bill was introduced in 2019
- Some of the 12 Medicaid expansion holdout states may finally participate in expansion
- Proposed rule to fix the "family glitch" (in which only cost of single coverage on employer plan is considered for purpose of marketplace subsidies); note this would not change the employer mandate rules (single premium would still be key to affordability)

Dobbs v. Jackson Women's Health Organization

The *Dobbs* Decision

- On June 24, 2022, U.S. Supreme Court overturned the earlier cases of *Roe v. Wade* (1973) and *Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992)
- Held that the Constitution does not confer a right to privacy (in *Roe,* the Court had found this right in the 14th Amendment)
- States may now regulate abortion; state laws regarding abortion must be analyzed like any other state statute governing health and welfare (whether a rational basis exists)

Dobbs' Implications for Employers

- Can your group health plan cover abortions?
  - **Fully insured plans:** subject to state laws regulating employee benefit plans
  - **Self-funded non-ERISA plans:** subject to state laws regulating employee benefit plans
  - **Self-funded ERISA plans:** not subject to state laws regulating employee benefit plans because of ERISA preemption

HOWEVER, it's not that simple!

Dobbs' Implications for Employers

- Non-ERISA plans with employee in multiple states: which law applies? Where the employer is? Where the employee lives? Where the member lives?
- Potential conflicts between state and federal laws
  - ACA's contraceptive mandate
  - Pregnancy Discrimination Act: requires plans to cover pregnancy-related expenses the same as other conditions, including abortion when the life of the mother is at risk or for complications of abortion

Dobbs' Implications for Employers

- ERISA preemption does not apply to generally applicable criminal laws
- Some states have laws making aiding and abetting an abortion a criminal offense; some even tie that to paying for an abortion
- Could be an issue for plan sponsors who cover abortions or employers who pay travel expenses
- Some high-profile employers (Netflix, Microsoft, Walt Disney, and others) have announced plans to cover travel and legal expenses; some states expected to aggressively enforce aiding and abetting statutes

Inflation Reduction Act

Inflation Reduction Act (2022)

- Federal spending and tax legislation signed into law on August 16, 2022; contains healthcare provisions
- Passed Senate through Reconciliation process, with Vice President Harris casting tie-breaking vote
- Reconciliation allows legislation to pass Senate on simple majority vote, without possibility of filibuster, but must be limited to legislation affecting federal budget
- Senate Parliamentarian said provisions relating to private health insurance did not affect federal budget and couldn't pass through Reconciliation

Inflation Reduction Act (2022)

- Prescription drug provisions mostly affect Medicare
- Key Medicare provisions:
  - Allows CMS to negotiate the price top brand drugs, starting in 2026
  - Limits cost-share for insulin to $35 per month*
  - Limits overall cost-sharing to $2,000 per year starting in 2025
  - Limits amount certain drugs can inflate*

* Would have applied to private plans also, before Parliamentarian's ruling

Inflation Reduction Act (2022)

- Private Insurance:
  - Allows high-deductible health plans to cover selected insulin products before deductible even with no diagnosis of diabetes
  - Effect of Medicare provisions: cost-shifting?

Inflation Reduction Act (2022)

- Marketplace Subsidy Extension
  - American Rescue Plan Act (2021) expanded access to Marketplace subsidies by eliminating cutoff for earners over 400% of FPL
  - Took marketplace enrollment to record highs
  - Inflation Reduction Act expands these until 2025
  - Without the expansion, premiums would have gone up an average of **53%**
  - Could increase the likelihood of employer mandate penalties; subsidized coverage required before a penalty is assessed

Other Developments

Prescription Drug Data Collection (RxDC)

- As part of Consolidated Appropriations Act of 2021, insurance companies and employer health plans are required to provide information on prescription drug spending to CMS
- Data for calendar years 2020 and 2021 due by 12/27/22
- Subsequent calendar year data due by June 1 of following year

Prescription Drug Data Collection (RxDC)

- Fully insured: your carrier will do this
- Self-funded: your TPA should be assisting; they'll need some information from you
- Information being collected:
  - Amount spent on prescription drugs
  - Drugs prescribed most frequently
  - Manufacturer rebates
  - Premiums and cost-sharing

Prescription Drug Data Collection (RxDC)

- Why is CMS collecting this data?
  - To determine why prescription drugs are inflating faster than overall healthcare services
  - To understand the effect of rebates
  - To promote transparency in pricing

Pharmacy Benefit Manager Scrutiny

- PBMs are “middlemen” between drug manufacturers and insurers/health plans
- In June 2022, FTC launched an investigation into 6 largest PBMs (CVS Caremark, Express Scripts, OptumRx, Humana, Prime Therapeutics, and MedImpact Healthcare Systems)
- PBMs are required to turn over information about their business practices going back 5 years
- Some of the practices being scrutinized:
  - Vertical consolidation with insurance companies (e.g., CVS owns Aetna; United HealthGroup owns Optum)
  - Rebate contracts
  - Steering prescriptions to PBM-owned pharmacies
- “Big 3” (CVS Caremark, Express Scripts, and Optum Rx) have all recently set up “group purchasing organizations;” Express Scripts’ is in Switzerland and Optum’s is in Ireland

“No Surprises” Act

- NSA prevents balance billing on certain types of out-of-network claims
- When plan and provider can’t agree on payment amount, plan can use “Qualified Payment Amount,” which is median contracted rate for item or services in geographical region
- Final Regulations on NSA issued in August 2022 clarify that when provider triggers Independent Dispute Resolution, QPA is not presumptive rate, but just one factor that IDR entity should consider

Dialysis Carveouts

- Dialysis industry historically controlled by two providers, making dialysis claims extraordinarily expensive
- In *Marietta Memorial Hospital Employee Benefits Plan v. Davita*, the U.S. Supreme Court held that the Marietta plan could limit the amount of reimbursement for outpatient dialysis
- Court rejected Davita's argument that this practice violated Medicare Secondary Payer laws because it disparately impacted end-stage renal patients, who are often on Medicare

Questions?

Lisa Stamm

lisa@sherrillmorgan.com

Trends in Claim Surveillance


Bill

Case Study: “i-STATing”

The Client

200-life municipality

The Problem

- ICU patient required regular **automated potassium tests** over 4 days
- i-Stat machine ran that test as well as **7 other unnecessary ones** (544 tests total)

MedBen health. benefits.

Case Study: “i-STATing”

The Solution

- Claims surveillance system **flagged $191,500 claim**
- Claim **reviewed and negotiated** by physician specialists

The Outcome

Negotiations with provider **saved $21,600**

MedBen health. benefits.

Cutting Corners

Case Study: Open Heart Surgery

The Patient

- 19-year-old with congenital valve disease, admitted for open heart surgery
- Total Charges: $162,572.38
- Length of Stay: 8 days

08/15/1287081	BACT CULTURE SURVEILANCE	QUANTITY	1	120.00
08/15/1287015	ACID-FAST CONCENTRATION	QUANTITY	2	100.00
08/15/1287116	AFB CULTURE AND ISOLATION	QUANTITY	2	154.00
08/15/1287206	AFB FLUOROCHROME DIRECT SMEAR	QUANTITY	2	120.00
08/15/1287206	FUNGAL ACID FAST STAIN	QUANTITY	1	60.00
08/15/1287102	FUNGAL CULTURE OTHER SOURCE	QUANTITY	3	390.00
08/15/1288305	SURGICAL PATH LEVEL IV	QUANTITY	1	220.00
08/15/1271010	CHEST 1 VIEW	QUANTITY	1	230.00
08/15/12	OR HOURS 6.25	QUANTITY	1	19,700.00
08/15/12	CARDIAC SURGERY SERVICE			.00
08/15/12	OR BASE 4			.00
08/15/12	PERFUSION TIME UPTO HR 7.00	QUANTITY	1	12,730.00
08/15/12	PTU EVAL MAIN OR INPATIENT	QUANTITY	1	560.00
08/15/12	ANESTHESIA TIME HOURS 6.25	QUANTITY	1	3,250.00
08/15/12P9047	ALBUMIN HUMAN INJ 25% 50ML 44206025105	QUANTITY	4	856.00
08/15/12P9045	ALBUMIN HUMAN INJ 5% 250ML 44206031025	QUANTITY	3	642.00

MedBen health. benefits.

Case Study: Open Heart Surgery

The Patient

- 19-year-old with congenital valve disease, admitted for open heart surgery
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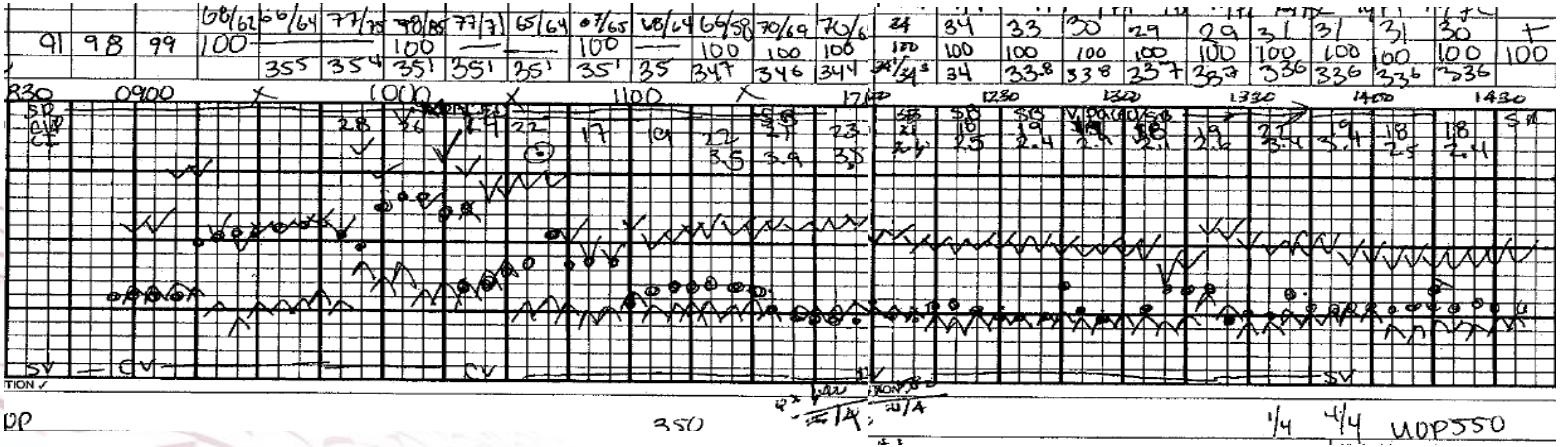
Anesthesia Record



MedBen health. benefits.

Case Study: Open Heart Surgery

The Patient

- 19-year-old with congenital valve disease, admitted for open heart surgery
- Total Charges: $162,572.38
- Length of Stay: 8 days

The Problem

- Unforeseen infected pacemaker aborted valve replacement surgery
- Infected pacemaker treated with Betadine and re-implanted, chest closed
- Attending surgeon in another operating room

MedBen health. benefits.

Case Study: Open Heart Surgery

The Patient

- 19-year-old with congenital valve disease, admitted for open heart surgery
- Total Charges: $162,572.38
- Length of Stay: 8 days

The Solution

Review and a few phone calls caused immediate refund of all payments by facility for both admissions

MedBen health. benefits.

Do More with Less

Case Study: Amyloidosis

The Patient

- 59-year-old male with medical history of asthma, hypercholesterolemia, shortness of breath for 6 months
- No heart failure evaluation by primary care provider
- Admitted through Emergency Department

The Problem

- Diagnosis – Amyloidosis, heart failure, acute renal failure
- Developed non-sustained ventricular tachycardia

MedBen health. benefits.

Case Study: Amyloidosis

The Patient

- 59-year-old male with medical history of asthma, hypercholesterolemia, shortness of breath for 6 months
- No heart failure evaluation by primary care provider
- Admitted through Emergency Department

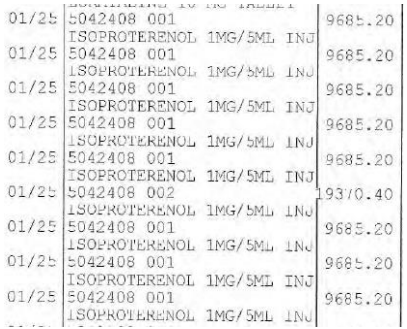
The Solution

- Treated with Isoproterenol to ventricular tachycardia recurrence
- ICD pacemaker implanted

MedBen health. benefits.

Case Study: Amyloidosis

Isoproterenol Charges for 8 days



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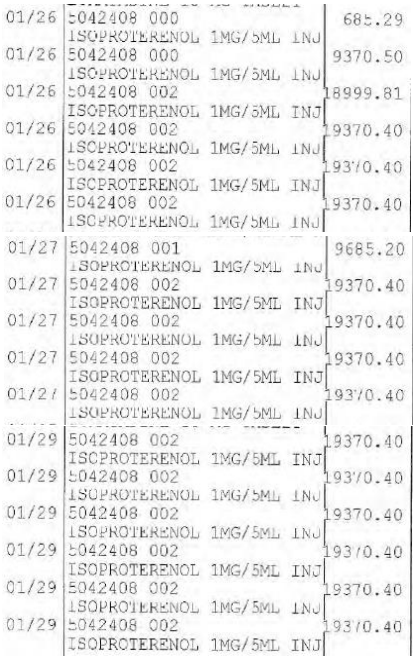

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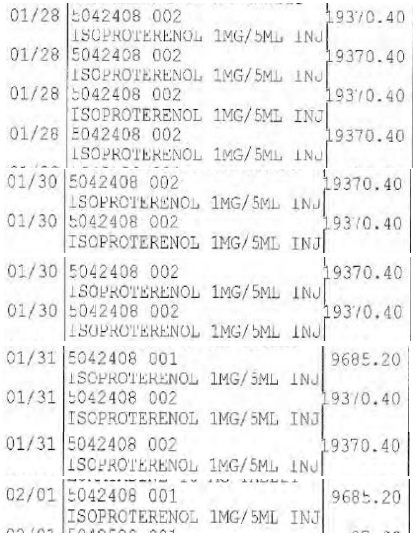

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01/30	5042408 002 ISOPROTERENOL 1MG/5ML INJ	19370.40
01/30	5042408 002 ISOPROTERENOL 1MG/5ML INJ	19370.40
01/30	5042408 002 ISOPROTERENOL 1MG/5ML INJ	19370.40
01/31	5042408 001 ISOPROTERENOL 1MG/5ML INJ	9685.20
01/31	5042408 002 ISOPROTERENOL 1MG/5ML INJ	19370.40
01/31	5042408 002 ISOPROTERENOL 1MG/5ML INJ	19370.40
02/01	5042408 001 ISOPROTERENOL 1MG/5ML INJ	9685.20

- $19,370.40 per 6 hours
- $77,481.40 per day
- $ 599,797.11 for 8 days

MedBen health. benefits.

Case Study: Amyloidosis

Valeant acquired **Isuprel** and **Nitropress** (and other drugs) in February 2015 for $350 million.

	The price on day of acquisition was….	*On that same day, Valient raised price to…*	*Valient has since raised price to…*
Isuprel *(ten 5 milliliter vials)*	$2,183.00	$13,097.10 *(500% increase)*	$17,901.12 *(720% cumulative increase)*
Nitropress *(ten 2 milliliter vials)*	$2,148.30	$6,444.90 *(200% increase)*	$8,808.80 *(310% cumulative increase)*

MedBen health. benefits.

Case Study: Amyloidosis

Alternatives to Isuprel (Isoproterenol)

1. Dopamine or Dobutamine
2. Temporary Pacing Wire
3. Temporary Transcutaneous Pacemaker

Case Study: Amyloidosis

The Patient

59-year-old male with amyloidosis

The Outcome

- Total Charges: $823,094
- Length of Stay: 34 Days
- Denied Charges: $676,893 (82%)
  - Isoproterenol: $599,797
  - ICD Pacemaker: $77,096
- 11 days - Not Medically Necessary
- Died 5 days after ICD Pacemaker implantation

MedBen health. benefits.

Claims Management Studies

Case Study: Robotic Hernia Repair

The Client

425-life food production employer

The Problem

- Plan member with ventral hernia underwent **robotic hernia repair**
- $**310,000** robotic bill charge (for 15-minute usage of robotics)

MedBen health. benefits.

Case Study: Robotic Hernia Repair

The Solution

As part of claims surveillance process, **excess fee was caught**

The Outcome

Employer saved $230,000 with no “balance billing”

MedBen health. benefits.

Case Study: Shoulder Surgery

The Client

150-life health care employer

The Problem

- **Shoulder tear surgery** performed at hospital – billed **$26,000**, plan paid **$13,500**
- Same surgery **with same surgeon** at outpatient center two months later cost **$45,600**

MedBen health. benefits.

Case Study: Shoulder Surgery

The Solution

MedBen negotiated **new contract with outpatient center**

The Outcome

Plan paid **just $12,700** for second surgery

MedBen health. benefits.

Case Study: Mast Cell Activation Disease

The Client

350-life municipality

The Problem

- Patient with severe allergic symptoms diagnosed with Mast Cell Activation Disease (MCAD) and admitted to hospital
- Two claims for MSAD totaled **$2,630,872** (allowable charges $1,157,584)

MedBen health. benefits.

Case Study: Mast Cell Activation Disease

The Solution

- Claims surveillance found occurrences of unbundling
- Physician review determined length of hospital stay exceeded medical necessity standards

The Outcome

- Recommended payment following review was **just $38,559** – a **97% savings**
- Provider wrote off difference with **no balance billing**

MedBen health. benefits.

Case Study: Infusion

The Client

3,100-life municipality

The Problem

- Patient diagnosed with iron deficiency received IV infusion
- Client billed **$48,400** and PPO discount reduced bill to **$33,750**; *however*…

MedBen health. benefits.

Case Study: Infusion

The Solution

MedBen saw an opportunity to further reduce cost and conducted negotiations with provider

The Outcome

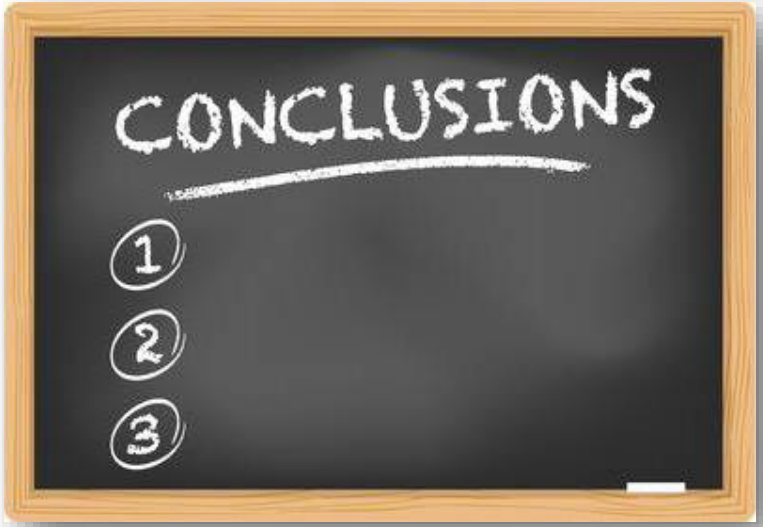
Provider agreed to final payment of **$18,600** following discount and negotiations… a **62%** overall savings

MedBen health. benefits.

Conclusions

1. Solid Plan Language – Prior Authorizations
2. Case Management
3. Forensic Review

   PPO & Direct Contracts allowing claims audit and review



MedBen health. benefits.

1975 Tamarack Rd. Newark, OH 43055

MedBen
health. benefits.

A-S Medication Solutions

Innovative pharmaceutical solutions to improve patient outcomes and increase savings

Prescription drugs can be expensive

BUT

Employees who do not take their medications are more costly in the long run

ASM
A-S Medication Solutions

Ask how Sherrill Morgan and Premise Health partner with ASM to improve patient compliance and lower drug costs

Benefits of Onsite Dispensing

Closed Formulary of the Right Medications

ASM works with clients to determine the most utilized, high-powered, and cost-effective medications for the targeted population.

Improved Compliance

Onsite dispensing eliminates barriers (cost, travel, pharmacy wait times, etc.) to medication compliance and adherence.

Point of Care Consultations

Prescribers speak directly to patients about the medications to improve their understanding of the therapy.

Comprehensive Coordination of Care

Onsite dispensing completes the cycle of coordination of care by linking patients, providers, and pharmacists.

Savings to Reduce Copays

The client can pass on savings to the patient population to reduce patients' out-of-pocket costs.

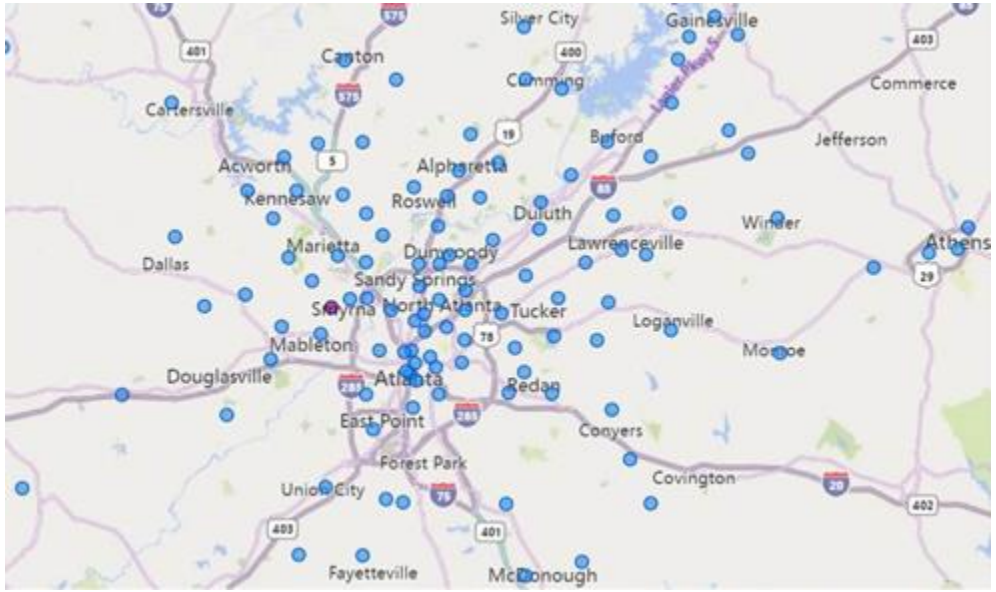
Care Everywhere

The natural combination of ASM and Sav-Rx means that programs can be enhanced in the clinic, in telehealth, and retail pharmacy settings.

ASM
A-S Medication Solutions

Integrated Onsite Solutions for a Diverse Patient Population

How ASM Can Support Company Strategies



Local Fills for a Single Employer in Georgia

Nationwide Fills for the Same Employer

ASM
A-S Medication Solutions

A Multichannel Solution

eRx Retail Card Program

- Access to limited formulary at 70,000 retail locations
- Ideal for emergency supplies or access in states with dispensing limitations
- No inventory carrying costs and competitive dispensing fees
- Covers 80% of prescribed drugs
- Seamless patient experience helps drive adherence
- Supports telehealth prescribing and access

Onsite Dispensing

- Best patient compliance results
- Highest patient satisfaction
- Best solution for most practices
- Allows practice to bring in greater revenue stream
- Covers more than 90% of prescribed drugs

Mail Order

- Delivery to patients' homes
- 24/7/365 customer service, website, and patient portal
- Integration with specialty programs
- No inventory holding costs or program fees
- Available in all 50 states
- Covers 100% of prescribed drugs
- Bridges the 'treatment gap' in telehealth

Providing the Right Medication, to the Right Patient, Safely

ASM
A-S Medication Solutions

The ASM Savings Process

Day One

Competitive and honest rates

Deeply discounted dispensing fees

No hidden fees

100% of pharmaceutical manufacturer revenue in rebate passthrough

All-inclusive pricing

Focus on net lowest cost

Long Term

Improving population health

Highly-tailored clinical programs

Increased utilization of lower-cost drugs

Reduced waste

Clinical analyses and reporting

Honest contracting

Dedicated management

ASM
A-S Medication Solutions

The ASM Client Advantage

- Lowest Net Cost of Medications and Highest Compliance
- Industry-Best Account Management and Customer Service
- Innovative and Flexible Dispensing Programs
- Competitive Transparent Prices and Cost-Saving Solutions
- Highly Effective Coupon Programs
- Long-Term Trend Management
- ASM will work with you to develop and grow pilot programs
- True Partnership with Plan, Vendors, and Medical Professionals

Presented by:

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CEO
A-S Medication Solutions
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ASM
A-S Medication Solutions


Jefferson
HEALTH PLAN

The Jefferson Health Plan

Our Strategic Plan

Identity

JHP is a market leader committed to providing flexible solutions and services to our members.

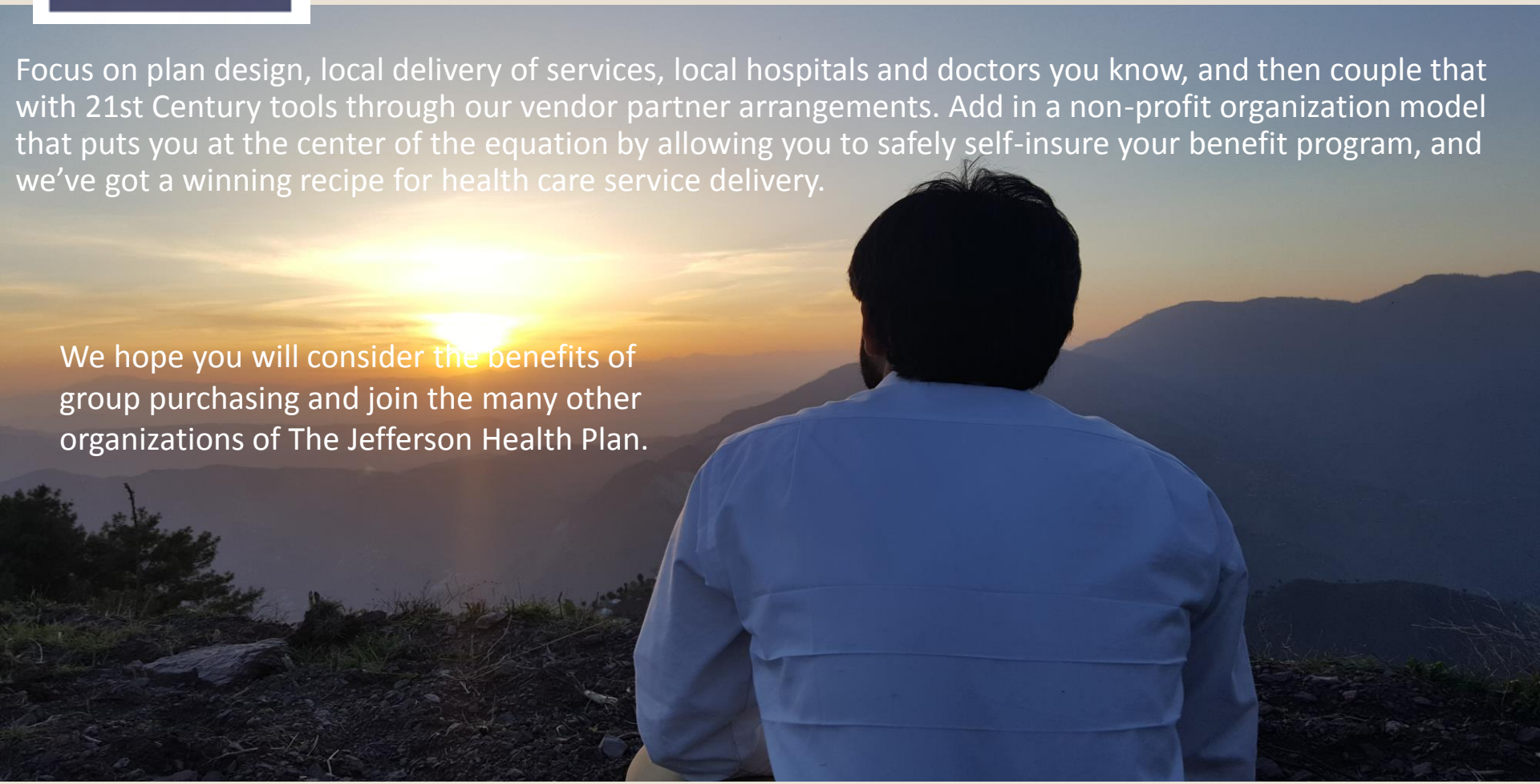
Vision

JHP will be recognized in the development and delivery of long-term innovative solutions and services.

Mission

Provide innovative market leading financial and management products and services to our members.

A New Way of Thinking About Health Care



Focus on plan design, local delivery of services, local hospitals and doctors you know, and then couple that with 21st Century tools through our vendor partner arrangements. Add in a non-profit organization model that puts you at the center of the equation by allowing you to safely self-insure your benefit program, and we've got a winning recipe for health care service delivery.

We hope you will consider the benefits of group purchasing and join the many other organizations of The Jefferson Health Plan.

Your organization and employees deserve the BEST!

JHP by the Numbers

Established 1985

200+ Governments

$50+ Million LCRP

$200+ Million Reserves

25,000+ Covered EE's

9 Sub Pools

Michigan 2020

Tennessee 2016

Indiana 2021

Ohio 1985

Your organization and employees deserve the BEST!

JHP by the Numbers

Current Expansion:

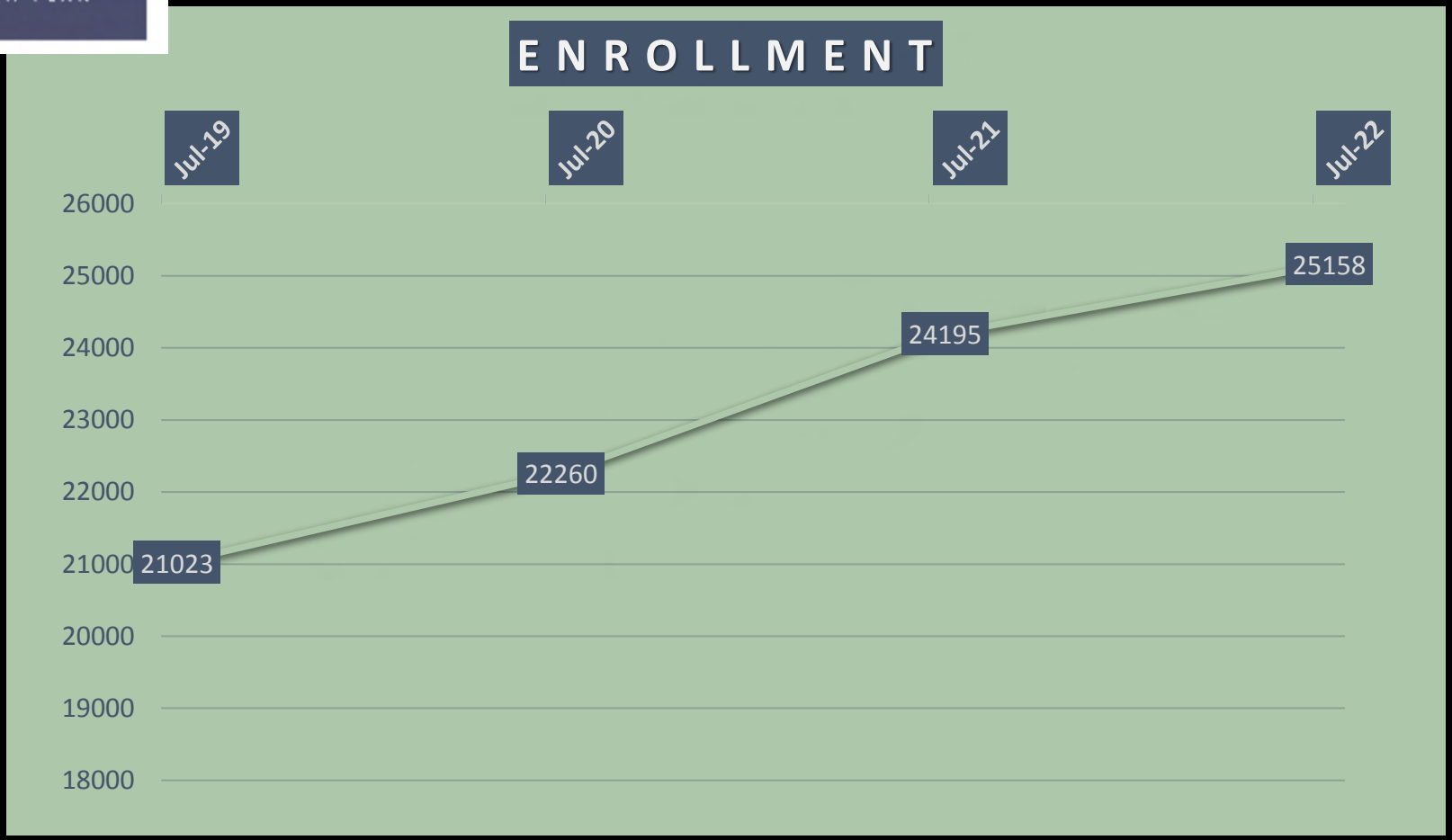
- Tennessee launched January 2016
- Michigan launched January 2020
- West Virginia approved April 2021
- Virginia launched July 2021
- Indiana approved January 2022
- Kentucky approved June 2022
- Others - TBD

JHP Strength

Successful fiscal management and underwriting continues to build strong reserves, helping member organizations control healthcare budgets

Your organization and employees deserve the BEST!

JHP Strength



Steady membership growth benefits all member organizations

Your organization and employees deserve the BEST!

Value Proposition

Self-Insured employers pay less for their benefits!

- ✓ Save State and ACA Taxes
- ✓ Retain Surpluses in Good Years
- ✓ Maintain Reserve for Poor Experience Years
- ✓ Reduced Administrative Costs
- ✓ Full Transparency
- ✓ Minimize Risk, Profit & Insurance Charges

Your organization and employees deserve the BEST!

Value Proposition

Less able to self insure their benefit programs because of size

Risk in self insurance is the risk of having to pay for **large claims** when they occur

Public employers can band together to share risk of large claims through participation in statutory consortium programs

Your organization and employees deserve the BEST!

Value Proposition

Insurance Agency/Benefits Advisor

- **Work with your preferred benefits representative**
- **Representative manages member expectation, provides guidance and education**

Jefferson Health Plan

- **Underwriting**
- **Vendor Management**
- **Health Plan Compliance**
- **Administrative Support**

Claims Administrator

- **Administers the negotiated plan of benefits**
- **Provides customer service for plan participants**

Your organization and employees deserve the BEST!

Allocated Balance Model

PLAN DESIGN	*Member Decides*
NETWORK/TPA	*Member Decides*
RISK DEDUCTIBLE	*Member Choice*
COSTS BLEND	*Experience/Pool*
RESERVES	*Owned by Member*
INTEREST INCOME	*Retained by Member*
MORATORIA	*Member Decides*
REBATES	*Member & Risk Pool*
REPORTING	*Full Transparency*
ABILITY TO IMPACT COSTS	*Member Controls*

JHP Risk Model

Accrual Factors

- Monthly accruals include expected claims + fixed program costs
- Monthly accrual factors do not fluctuate

LCRP

- Choose the LCRP amount (individual stop loss) and pay a fixed fee
- Receive protection against unexpected large claims

Reserve Balance

- Unused accrual funds are held in member's reserve balance
- Moratoria (premium holiday) can be taken to access excess reserves

JHP

- Level monthly funding
- Non-profit
- Group purchasing power
- Employer shares risk w/other Gov’ts
- Total transparency
- Plan control
- Protection against bad experience
- Administrative assistance

EMPLOYER RETAINS FUNDING SURPLUS, SPREADS DEFICITS OVER TIME

FULLY INSURED

- Fixed premium
- Employer transfers risk
- No flexibility
- No transparency
- No control

ALL PROFITS TO CARRIER

INDEPENDENTLY SELF-FUNDED

- Employer takes claim risk
- Funding fluctuations
- Volatile stop loss
- Administrative responsibilities/ burdens
- Contract limitations
- Size matters for underwriting

EMPLOYER IMMEDIATELY KEEPS ANY SAVINGS, PAYS ANY DEFICITS

Your organization and employees deserve the BEST!

Large Claim Reimbursement Program (LCRP) Risk Model

LCRP risk levels are determined by each JHP member. Fees are based on deductible chosen from $50,000 to $250,000 in $25,000 increments. In this example, a $75,000 risk level was chosen:

Each Plan Participant Claims < $75,000

- Paid in full by the member group

Each Plan Participant Claims > $75,000

- Member group pays a fee based on the deductible level chosen
- Claims paid by the LCRP program

Each Plan Participant Claims > $1,500,000

- Covered by insurance carrier stop loss protection
- Members share greatly reduced insurance cost

Your organization and employees deserve the BEST!

Why LCRP Works?

The Large Claim Reimbursement Program works because The Jefferson Health Plan (JHP)

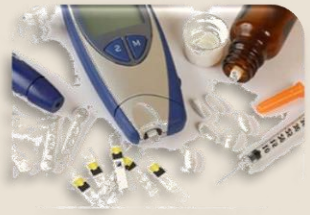
- is a member driven organization
- designs programs in members' best interest
- has no profit agenda
- uses its size to provide purchasing power
- uses its reserve strength to offer flexible and innovative large claim protection
- avoids premium taxes
- eliminates commissions, bonuses and overrides in the underwriting process
- uses consistently lower trends than for-profit underwriters
- does not use selective underwriting (lasering) to avoid risk
- greatly reduces cost volatility of large claim protection

Your organization and employees deserve the BEST!

JHP Value-Added Programs

Care Management Program

Diabetes Management Program



Employee Assistance Program (EAP)

Wellness Website Portal

Your organization and employees deserve the BEST!

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

Using A.I. to Predict and Prevent Shock Claims

Julie Mueller
President & CEO
Custom Design Benefits

Alberta Manga RN, BSN, MSA, CRRN, LSSBB
Director, Medical & Risk Management
Custom Design Benefits

Who We Are

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

The Region's Largest Independent, Full-Service Third Party Administrator

Experts in Self-Funded Employee Benefits

Innovative Partner for Cost Containment Solutions for Custom Employee Benefits

National Leader in Reference-Based Pricing Plans

One of Ohio's Best Workplaces

Founded in 1991 – Serving our clients and broker partners for over 30 years

Certified WBENC Women's Business Enterprise

Ohio Business 2022 BEST WORKPLACES IN OHIO

Best in CINCY BUSINESS 2022 by Cincy Magazine

OHIO SUCCESS AWARDS

Full Service & Fully Customizable

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

Administration of Self-Funded Plans

Full services and fully customizable

- Medical with PBM integration
- Dental
- Vision
- Hybrid Insurance Plan (HIP) - Advanced HRA

Compliance Administration & Support Solutions

- Compliance Support
- COBRA administration
- SPD & Plan Documents
- Claim fiduciary services

FMLA & Leave Management

Medical and Pharmacy Risk Management

- TrueCost Rx – Reference-Based Pricing on Pharmacy
- Independent Specialty Drug Prior Authorizations
- Custom Care Population Health Management
- In-House Utilization & Case Management

Administration of Custom Flex

- Flexible Spending Accounts
- Health Savings Accounts
- Health Reimbursement Arrangements

Advanced Data Analytics

- Executive Dashboard
- Integrated medical & prescription data
- Monthly & on-demand reporting

Cost Containment Solutions

- TrueCost Reference-Based Pricing
- Bundled payments and Centers of Excellence
- Telemedicine with behavioral health & EAP
- Innovate 360 – Integrated Find a Provider
- Direct Primary Care

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

Using A.I. to Predict and Prevent Shock Claims

Alberta Manga RN, BSN, MSA, CRRN, LSSBB

Objectives

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- Claims and risk assessment awareness
- The impact of claims on a self-insured plan
- Managing identified risks
- Collaborating with clients to promote member engagement

Definitions

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Shock Claims:

- Unexpected claims that can drain the self-funding reserves which was meant to cover the entire employee pool for the year

- These claims are a result of illness or injury which can incur a significant medical expense in the next 24 months

The Fund:

- Contributions by employer and employees

- If claims paid are less than the contributions, the surplus stays with the client and can be used to reduce contribution rates or add coverage

- Claims are paid as they occur and varies month to month based on care utilized

Care Prediction

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- Artificial intelligence enables us to identify members at risk
- Data is obtained through medical and pharmacy claims
- Social Determinant scores are utilized in the risk assessment
- It provides concurrent and prospective risks and cost
- Our target is >/= 25% probability of hospital admission or Emergency room visit

Care Prevention

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- Care Alerts are reviewed per identified member
- Resources are then identified to positively influence the health outcomes
  - Community resources
  - Educational materials by MCG
  - Medication assistance programs
- Collaboration with the member's treating team to ensure successful management of the chronic condition in the community
- A Care plan is established per engaged member and monitored until all gaps are closed

Our Approach

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- Dedicated Case Managers are assigned per client
- Verification of contact numbers with HR personnel prior to an outreach
- Outreach to member is via telephone, generic text message, private email if known, via the member portal and then a letter
- Case closure on unsuccessful outreach and a follow up communication to HR when unable to reach a member
- UR nurse collaboration allows immediate CM notification if member is inpatient or set to receive a scheduled procedure.

Client Collaboration

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Innovative Cost Containment Solutions for Employee Benefits

- Program elaboration by Account Managers during open enrollment and each client meeting
- Flyers at client site regarding the program and assigned Case Manager
- Mid-year reviews per client on member participation rate
- Open interaction between Case Manager and identified HR personnel to get accurate contact information

Outcome

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Inpatient Admissions

2020: 2359
2021: 2011
2022: 965

Medical Claims $

A prospective 20% reduction over actual paid claims overall

Use of Emergency Rooms

2020: 23 members had 6 or more ER visits
2021: 33 members had 6 or more ER visits
2022: 11 members had 6 or more ER visits

Custom Care Update

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

2020 through August 2022

886
Qualifying Members

552
Engaged Members

70%
Overall % Engaged

The Software

Custom Design Benefits
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- Plan Analytics by CedarGate
- Cohorts were created to capture medical and claims data
  - IP Probability Admission probability
  - ER visit probability
- Predictions are made 6 months ahead based on the diagnosis and claims feeds
- Care alerts and gaps are auto generated into the Care Management system for the Case Managers to address with the members

Case Study 1

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

A 42yo female with endometrial cancer.

Initial assessment identified the fact that she did not want to seek treatment. Case Management encouraged her to do so and checked on her bi-weekly including talking to her mother.

Upon one such call, it was found out that she had missed a series of her radiation appointments as there was no one to take her to the treatment center. Further communications enabled the Case Manager to understand that the family support was inadequate, and her pain affected her ability to ambulate.

This was communicated to the treating physician by the Case Manager at which point, home health care was ordered, and a determination made that the member was better placed in inpatient Hospice.

Her end of life was prolonged for 2 weeks with adequate pain management and care. Her mother was indeed grateful for the support received from Case Management.

Case Study 2

Custom Design Benefits
Innovative Cost Containment Solutions for Employee Benefits

57yo was identified through our Utilization Nurse referral. He was recently discharged from inpatient psych unit following the loss of his spouse. The expectation was to enroll in an Outpatient Intensive program.

When CDB's Case Manager called him, he had not followed up with the plan. She educated him on the importance of compliance to the plan. She partnered with the facilitator at the Intensive program center to ensure member's adherence to the program.

The Case Manager scheduled routine calls with the member to maintain the support and as of Aug 23rd, he successfully completed the intensive outpatient program. He is to follow up with the Outpatient Therapist every 2 weeks.

In addition, he has community support and a Life coach provided by the Case Manager which has also been very helpful to him and he is doing a whole lot better than when we first talked to him.

Questions?

COST AVOIDANCE

TERRI EVANS, VICE PRESIDENT, EAS HEALTH

What is Cost Avoidance

Cost avoidance is **the preservation of existing spending to prevent or limit price increases due to inflation, economics or the rising costs of products or services**.

A measure that lowers the potential for future cost increases or additional expenditures

Programs and processes implemented to limit the rate of increased expenditures

EAS Health

Examples of Cost Avoidance

- At Home
  - Routine home and auto maintenance to avoid costly repairs from failure
  - Annual check-ups to keep tabs on your health
  - Research on quality and expected life of items prior to purchase
  - Fuel efficient vehicles and energy efficient appliances

- At Work
  - Effective hiring, benefit programs and employee training to reduce the potential for turnover or employee liability/WC claims
  - Appropriate negotiation of claims settlements
  - Implementing streamlined processes to reduce employee hours or operational costs
  - Implementing programs to slow the growth of health insurance expenditures
    - Wellness programs to keep employees healthy
    - RX programs to reduce spend
    - Direct contracts with providers
    - Clinics

EAS Health

Do You Need to Measure It?

Evaluating ROI

- If a project or program is expected to save money in the long-term but could initially cost more money, you will need to track increased expenses over a period of time vs what the costs could have been
- You want to evaluate the “avoided” expected costs without the program
- Some programs have long-term cost savings or reduction in expected increases

Evaluating your programs against others

- Many current programs should be geared toward avoiding unnecessary expenditures
- Allows data to support eventual cost increases showing the lower rate of increases

Budget support

EAS Health

How Do You Measure Cost Avoidance?

Generally

- Measuring the actual cost vs the expected costs
- Determining the long-term reduction or stabilization in cost vs growth of cost – future ROI potentials

Proactive Evaluation of Programs

- Compare against US, State, Local
- Apples to apples or similar?
- Expected spend in industry

Your departments handle programs with potential cost avoidance so you can evaluate the effectiveness of their work against what would have been expected

- Claims expenses
- Vehicle purchasing/Cost of operation/Cost per mile
- Infrastructure maintenance
- Streamlined functions (automated garbage collection, radio-read water meters)
- Health Insurance and other benefits costs

EAS Health

How Can You Implement Strategies?

- Evaluate prior spend for trends
- Look for new and emerging technologies and programs
- Strategic planning for potential future cost increases
- Include the necessary people in the discussion
- Have departments continually evaluate new trends in their field
- Acknowledge that not all costs avoided will be public knowledge – you might not want to publish the details
- Acknowledge that there may be outliers and determine how to account for those

EAS Health

Questions?