



MARSH & MCLENNAN
AGENCY

Known locally as McGraw Wentworth

THE VIEWSLETTER

Volume Eighteen, Issue Four

November 2015

THE GENERIC DRUG COST PROBLEM

According to the U.S. Department of Health and Human Services, Americans use nearly \$3 trillion in medical care annually. While half of this amount is spent on physician and hospital care, prescription drugs also contribute significantly to medical care cost.

Use of prescription medications is common. According to the Agency on Healthcare Research and Quality, more than 60 percent of Americans take a prescription drug in any given year. In 2014, 4.3 billion retail prescriptions were filled. That is an average of 12 prescriptions annually for every person in the United States. Many prescribed medications improve health significantly, reducing the need for more expensive treatments.

Employers can often control their prescription drug costs by encouraging the use of generic drugs whenever possible. A competitive market for generic medications helps to keep the cost of generic drugs low.

While many factors contribute to the rising cost of prescriptions, rarely have generic drugs been the culprit. Most plans aggres-

sively drive participants to select generic options. The strategy is a good one. According to the National Center on Policy Analysis, the average price of a drug falls by 80 percent or more within a year after the brand name drug loses patent protection. It takes a year because typically a single manufacturer has exclusive rights to produce the generic drug for the first six months after a company loses its patent. It generally takes time for competition to drive the price of generics down in the first year generics are permitted.

Historically, the cost of generic medications has been significantly lower than the cost of brand name medications. Surprisingly, however, over the last couple of years, the trend for some generics has not followed this historical pattern. According to the National Center on Policy Analysis, trends varied on generic prescriptions between July 2013 and July 2014:

- Nearly half of generic medications declined in price, but the other half increased in price.



We welcome your comments and suggestions regarding this issue of our Viewsletter. For more information, please contact your Account Manager or visit our website at www.mma-mi.com.

Continued on Page 2

- More than a quarter of generic drugs increased in price by 10 percent; some prices increased 100 percent year over year.
- Only 3 percent of generic drugs fell 25 percent or more in price, while 18 percent increased in price by 25 percent or more.

A number of factors influence these higher trend rates:

- *Slower approval for new generics* – The FDA is inundated with new drug applications. It is simply taking more time to approve generic drugs. The FDA approves between 400 and 500 generic medications annually. This is just a fraction of the new drug applications it receives. For medications that have few generic alternatives, this delayed competition affects pricing. Manufacturers know new generics are coming that will drive the price down. While they wait for these new medications to enter the market, they are increasing the cost of their generic medication until the competition arrives.

- *Older drugs face quality and compliance issues* – older drugs are often made on older production lines. In some cases, these aging lines no longer comply with current FDA manufacturing standards. Also, the FDA is now trying to strictly enforce existing quality requirements. Many disruptions in producing older drugs result from quality problems in the manufacturing process. Generic drug prices increase when the manufacturer either invests capital to resolve quality issues or ceases to produce the drug, reducing competition.
- *Raw material shortages* – in some cases, shortages of generic drugs are due to shortages of raw materials. Since there are typically only one or two suppliers of the raw materials, these shortages reduce supply and drive up prices.
- *Market consolidation* – consolidation of generic drug manufacturers is reducing competition and driving up prices.
- *Wholesale drug distributors* – three large organizations control nearly 90 percent of the

distribution of wholesale drugs according to *Modern Distribution Management*. This is a marked difference from the mid-seventies when there were fewer prescription drugs and roughly 200 wholesalers. This type of consolidation tends to reduce price competition.

Many of the forces driving the increase in generic drug prices are outside a health plan's control. Historically, employers haven't looked at generics in terms of cost control strategies because they have been a cost-saving strategy. However, the increasing cost of some generic medications is an area that may require attention.

Employers concerned about the increasing cost of some generic medications should review generic utilization for year-over-year cost increases. Not all generics are trending at significantly higher rates. If employers think their drug mix is in fact driving higher increases, they should meet with the pharmacy benefit manager to determine the cause. If higher-priced generics are the issue, they should consider options to limit cost increases. Some employers have instituted two-tier generic copay structures. Their copays for generic drugs on the preferred drug list are lower than copays for generics not on the preferred list. Employers could consider coinsurance options on the pharmacy plan. These are not popular with employees. However, when employees share a percentage of the cost, they will likely ask more questions about alternative prescription options. Employers can also structure step therapy protocols to steer employees toward lower cost

DID YOU KNOW?

- In 2013, only 13% of active workers were very confident about affording a comfortable retirement; 38% were somewhat confident.
- In 2015, 22% of active workers were very confident about affording a comfortable retirement; 36% were somewhat confident. This was up markedly from 2013.
- In 2013, only 18% of retirees were very confident about affording a comfortable retirement; 14% were somewhat confident.
- In 2015, 37% of retirees were very confident about affording a comfortable retirement; 14% were somewhat confident. This was up substantially from 2013.

Source: 2015 Retirement Confidence Survey, Employee Benefits Research Institute (EBRI) and Greenwald & Associates

Continued on Page 3

generics or simply ask vendors to recommend methods for holding down generic drug cost. At a minimum, employers can review generic drug copays annually. It may be time to cap generic copays at \$15 or more.

Employers tend to be active in managing the pharmacy benefit program. Most programs are designed to drive employees to generic, lower cost options. However, employers may need to take another look at generic utilization. The costs for some generic medications are increasing dramatically. You may need to take steps in the coming years to make sure your plan is driving employees to the most cost-effective generic options. [MMA](#)

COLLECTIVE BARGAINING, UNION PLANS AND THE ACA

The Affordable Care Act (ACA) has changed some dynamics of collective bargaining with unions

when it comes to health benefits, a key issue in the bargaining process. Many ACA requirements apply directly to union plans. The new requirements now dictate plan provisions that were previously part of the bargaining process. Many of these requirements are benefit improvements. Employers cannot make tradeoffs on many of these changes because the required effective dates often fall mid-contract.

The required ACA benefit changes with effective dates not tied to a bargaining agreement end date included:

- Removal of lifetime dollar limits on essential health benefits
- Restrictions and eventually the elimination of annual dollar limits on essential health benefits
- Removal of pre-existing condition limitations
- Extension of coverage to age 26 for dependent children without limitations

- Limitations on new hire waiting periods

Most of these changes increased benefits for participants. Due to the effective dates of these changes, many employers were simply unable to make tradeoffs in the negotiating process.

The ACA affects different union plans in different ways. For example, some unions actually sponsor a health plan and employers must contribute to that plan. Employer and the union typically negotiate the contribution during the collective bargaining process. The employer involvement in the plan is quite limited. However, the employer mandate requires applicable large employers (those with 50 or more full-time and full-time equivalent employees) to offer full-time employees minimum value, affordable coverage or possibly pay a penalty. If the union sponsors the plan, the employer

Continued on Page 4

YOUR QUESTIONS

Q: Our organization offers a number of different Health Reimbursement Arrangements (HRAs) to various segments of employees and retirees. We are confused about how to handle the reporting requirements for these arrangements.

A: Good question. The guidance on HRA reporting has changed and differs depending on whether the employee is active or retired. If your organization offers an HRA paired with an employer-sponsored, fully insured group health plan to active employees, you may not have to report on the HRA. When HRA eligibility is limited to employees covered under the insured health plan, the employer does not have to report coverage under the HRA. The organization still has to produce the 1095 Cs for all full-time employees but does not need to complete Part III to reflect coverage under the HRA. Any other HRA set up for active employees would need to include the details of who is covered under Part III of the 1095 C. If a self-funded plan offers an HRA, the details of who is covered under the self-funded plan should be listed in Part III.

Retirees are handled differently. Employers typically would not have to report on retirees because they are not full-time employees. However, as a sponsor of a self-funded health plan, the employer may have to report on retirees under Section 6055 reporting. Self-funded plans have to report for individuals covered under the **self-funded** plan. Therefore, employers must report on self-funded retiree HRAs. They can report using Forms 1094-B and 1095-B or Forms 1094-C and 1095-C. If they use the C Forms, they will need to complete Part III because HRAs are considered self-funded medical plans.

TREND TIDBITS

- \$ HMOs are projected to trend at 6.8% in 2016, up from 6.2% in 2015.
- \$ Open access PPO plans trend stays steady, expected to trend at 7.8% in 2016, representing no change from 2015.
- \$ High deductible health plan trend is up slightly. These plans are expected to trend at 8.0% in 2016, up from 7.9% in 2015.
- \$ Indemnity plans are projected to trend at 9.9% in 2016, down from 10.4% in 2015.
- \$ Prescription drug carve outs are expected to trend at 11.3% in 2016, up from 8.6% in 2015.

Source: 2016 Health Plan Cost Trend Survey, Segal

is not technically providing coverage. The government has requested feedback on how to handle these situations, but has implemented temporary guidance that employers can rely on for now.

Under the temporary guidance, an employer will not have to pay the \$2,000 penalty for failing to offer coverage if:

1. The employer must contribute to a multi-employer or union plan for full-time employees under a collective bargaining agreement.
2. The plan covers full-time employees and dependent children.

If the union plan coverage passes benefits and affordability tests, the employer will not have to pay the \$3,000 penalty.

Since the IRS will use employer reporting to calculate potential penalties, it will be important for employers to use the codes to indicate the employee is subject to the multi-employer interim relief rule. The union may have added reporting responsibility as well. If the union plan is

self-funded, the union must report the covered employee and dependents. Unions will use 1095-B forms to meet their reporting obligation.

Even though the union provides coverage, the employer is still directly subject to the employer mandate. Employers are still responsible for penalties if their employees do not have minimum value, affordable coverage. Employers are responsible for creating 1095-Cs for union employees to detail that coverage was offered.

Looking forward, the Cadillac tax will also affect the benefits negotiation process. Employers negotiating now need to understand the potential impact. In 2018, the Cadillac tax will go into effect. This 40 percent excise tax will apply to medical benefits that exceed the following thresholds:

- \$10,200 single coverage
- \$27,500 for other than self-only coverage

The definition of benefits that determine whether plan cost exceeds the threshold is quite

broad. It encompasses most tax-favored health benefits. One benefit for multi-employer plans is that they can test all employees based on the "other than self-only" coverage threshold.

Not all union plans are considered multi-employer plans. Employers should understand the potential impact of the Cadillac tax on union plans today. If plan costs are close to the Cadillac tax threshold, employers should be wary of negotiating benefit improvements. If employers need to cut benefits in order to fall under the thresholds, they will need to negotiate these benefit cuts in contract negotiations.

The ACA has changed the process for negotiating with unions on benefits. Group health plans need to meet the ACA benefit requirements and eligibility rules. Employers also need to keep in mind their obligations under the employer mandate and the impact of union plans on the employer mandate. Until the IRS issues additional guidance, as long as the union plan meets certain requirements and the employer contributes to the cost, it will be considered employer-provided coverage under the mandate. Employers need to think about the Cadillac tax before their next round of union negotiations. They may be able to use the Cadillac tax's potential impact to bargain down the value of the union plan. [MMA](#)

TECHNICAL CORNER - DATA BREACHES

The news regularly has stories about data breaches. Data breaches compromise the security of personal information of customers, insureds, and even employees. Also, compromised data often leads to identity theft. Many laws across the country compel organizations to secure their data. In addition, these laws often require organizations to notify anyone whose personal data is compromised.

The Health Insurance Portability and Accountability Act (HIPAA) sets rules self-funded plans must follow to secure Protected Health Information (PHI). The HIPAA rules have very specific steps plans must follow to secure PHI in the electronic format. Employers that self-fund any element of their health plan need to comply with the HIPAA Privacy and Security rules. A recap of the HIPAA Privacy and Security rules can be found in our Benefit Advisor at http://www.mcgrawwentworth.com/Benefit_Advisor/2014/BA_Issue_2.pdf.

The security rules also cover best practices for transmitting data either over the Internet or through internal channels. It is now critical that employers secure electronically maintained PHI. Many employers still send detailed census and medical information via the Internet to consultants and health plan vendors. Employers should not be sending this data out electronically without ensuring the information is secure.

Employers need to review the compliance steps for the Security Rule. A breach of unsecured PHI triggers notifications to a number of parties, including the person the information pertains to and the Department of Health and Human Services.

A number of large insurance carriers suffered data breaches over the summer. HIPAA required that they notify the news media. The news media rarely reports on the actual impact of these data breaches; the damage is done when the breach

is made public. These breaches call into account the integrity of an organization. Organizations are often on the defensive when they explain why their security protocols were ineffective and failed to prevent the breach.

The Office of Civil Rights (OCR) is launching a second wave of HIPAA Privacy and Security audits. Employers need to be ready if they receive an audit request. Data breaches affect your credibility with your employees. Take action now to secure your employees' PHI.

MMA

Copyright Marsh & McLennan Agency LLC company. This document is not intended to be taken as advice regarding any individual situation and should not be relied upon as such. Marsh & McLennan Agency LLC shall have no obligation to update this publication and shall have no liability to you or any other party arising out of this publication or any matter contained herein. Any statements concerning actuarial, tax, accounting or legal matters are based solely on our experience as consultants and are not to be relied upon as actuarial, accounting, tax or legal advice, for which you should consult your own professional advisors. Any modeling analytics or projections are subject to inherent uncertainty and the analysis could be materially affective if any underlying assumptions, conditions, information or factors are inaccurate or incomplete or should change.

Marsh & McLennan Agency LLC

3331 West Big Beaver Road, Suite 200
Troy, MI 48084

Telephone: 248-822-8000 Fax: 248-822-4131
www.mma-mi.com

250 Monroe Ave. NW, Suite 400
Grand Rapids, MI 49503

Telephone: 616-717-5647 Fax: 248-822-1278
www.mma-mi.com

