Einstein
Advanced Health Insurance Solutions

NEWSALERT

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ACA Upheaval

Trump's Executive Orders and the Effect on Group Markets

AFTER MONTHS of failed efforts by Congressional Republicans to eliminate the Affordable Care Act, President Trump has stepped in with two sweeping changes that will likely reverberate throughout the health insurance system.

The main order he issued immediately eliminates subsidies that are paid to health insurers that participate in government-run exchanges to reduce deductibles and copays for lower-income customers.

While some pundits say the move will create chaos in the individual market, they differ on the likely fallout for group policies.

Trump also signed two orders that will have a direct effect on the group market over time:

- One would attempt to expand the use of health reimbursement accounts (HRAs), which employers would pay into so that employees can use those funds to purchase health coverage on the open market.
- The other would allow employers to band together to create "association" plans, which would offer plans that are not as comprehensive as dictated by the ACA.

Cost-sharing fallout

Nineteen states have already sued to challenge the cost-sharing reduction subsidies, saying the ACA does not appropriate funding for the subsidies and hence they are illegal. Without them, insurers will likely have to significantly increase their premiums or pull out of the health insurance exchanges.

While the order means many people buying plans on marketplaces will see large rate hikes, the order doesn't directly affect group plans.

The American Benefits Council, a national trade association based in Washington, D.C. that advocates for employer-sponsored benefit plans, said that the move to cut off the subsidies could spur some insurers to increase their fees for large employer plans in order to make up for the lost revenue in the individual market.

"Employers rely on a healthy and viable individual health insurance marketplace, since an unstable market could result in further cost-shifting from health-care providers to large employer plans," the council said in a statement.

"Erosion of the ACA exchanges would make individual market coverage a less viable option for part-time workers, early retirees, and those who would otherwise elect to secure coverage through the individual market rather than sign up for, or remain on, COBRA," it added.

But that sentiment is not universal.

Expanded use of HRAs

Another part of the executive order directed the Departments of Treasury, Labor, and Health and Human Services to study ways to expand access to HRAs and the ability of businesses to offer them to their workers.

HRAs reimburse employees for out-of-pocket medical expenses not covered by insurance. Funds are put into the accounts pre-tax.

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Pharmacy Benefit Managers

Employers Say Contracts Too Complex, Opaque

THREE IN five employers think their contracts with pharmacy benefit managers are overly complex and not transparent, according to a new study.

The study, which found that employers would prefer that PBMs are more transparent with their pricing and would like them to focus less on rebates and value-based designs, comes as PBMs are under increased scrutiny for their opaque pricing practices.

The survey of 88 very large employers, "Toward Better Value: Employer Perspectives on What's Wrong with the Management of Prescription Drug Benefits and How to Fix It," was conducted by Benfield and commissioned by the National Pharmaceutical Council.

It follows numerous reports about PBMs and concerns over their pricing practices.

The findings drive home some of the common complaints about PBMs:

Poor transparency

Employers said that current pharmacy benefit management models lack transparency:

- 30% said they understand the details of their PBM contracts.
- 40% said they fully understand their PBMs' performance guarantees.
- 63% said PBMs are not transparent about how they make money.

Complex contracts

Nearly three in five employers surveyed said PBM contracts are overly complicated, ambiguously worded, and often benefit the PBM at the expense of the employer. Tops on employer's wish list: Clearer definitions and simpler contracts.

Focusing less on rebates

Seventy percent of employers said they thought PBMs should offer other ways besides rebates to reduce prices.

Employers also said rebates detract their attention from more important factors, like reducing employee coinsurance or deductibles or getting better access to the most effective pharmaceuticals.

Two suggestions they had: Discounts or point-of-sale rebates, in which patient payments reflect a post-rebate price.

Getting value for employees

Employers want to understand the thought process when PBMs create formularies and exclusionary list decisions, such as the clinical, financial and economic impacts.

Employers had these suggestions:

- Using value-based insurance design, where high-value drugs cost patients less than low-value drugs.
- Setting payments based on the effectiveness of a drug. ❖

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Association Plans Have Not Met with Success So Far

Currently, the ACA bars employers with 50 or more employees from using HRAs to reimburse employees for purchasing health insurance on their own. Smaller firms can use them, but the law sets limitations on how.

But any changes that might be made would not be immediate as the rule-making process takes time.

So there would be no changes to the law for plans incepting on Jan. 1.

Association plans

Trump also ordered regulators to start work on new regulations that would allow small businesses to band together to buy insurance across state lines, and for those plans to be considered part of the large-group market for pricing purposes.

Unfortunately, these types of plans have not fared well in the past and currently six states have laws on the books that allow insurers to sell across state lines.

The problem is that insurers have to spend significant sums to expand their networks into new areas and contract with local doctors, hospitals and groups.

And despite those six states having these laws, "No state was known to actually offer or sell such policies," the National Conference of State Legislatures said in a new report released in October. ❖

Medicare

How Seniors Get Open Enrollment Wrong

MEDICARE CAN be hard to navigate, even if you've been enrolled for years. With open enrollment now upon us – it starts Oct. 15 and runs through Dec. 7 – you'll want to pay attention to some of the most common mistakes people make.

Confusing Original Medicare with Medicare Advantage – With Original Medicare, there is typically no premium for Part A coverage if you or your spouse paid Medicaid taxes while you were working. However, you do pay monthly premium for Part B coverage.

Also, with Original Medicare, you can usually see any doctor or specialist you like, and claims are usually filed for you.

On the other hand, with Medicare Advantage, you're faced with variable copays and deductibles depending on which plan you choose. Medicare Advantage plans have doctor networks and you are limited to visiting the doctors, hospitals and specialists in the network.

You should know the difference if you are considering moving to Medicare Advantage from Original Medicare – or vice versa.

Confusing Medicare Advantage with Medicare supplement insurance – While Original Medicare offers more flexibility in choosing health care providers, it doesn't cover everything. That's why many seniors choose a Medicare supplement insurance, commonly referred to as a Medigap plan. These plans are designed to fill some of the holes in your original.

But that's not what a Medicare Advantage plan does.

Also, because people mistake the two, they may drop Medigap coverage when they decide to switch from Medicare to Medicare Advantage. But, if you make the switch, you might not be eligible to buy a Medigap plan again if you decide to return to Original Medicare.

Failing to compare your Medicare Advantage choices – Medicare Advantage gives you a number of choices for coverage to suit your needs and budget.

Plans can vary in how they are structured, particularly in terms of copayments and deductibles and other out-of-pocket expenses. In addition, each plan will have its own network, so you have to be careful to check that the doctors and specialists you've been accustomed to seeing are still on the list.

Take into account the drug benefits, too. Make sure that the plan you choose meets your needs in terms of the prescription medications you may be taking and how much you'll be paying out of pocket for them.

Overlooking financial assistance – Even with Medicare Part D, prescription drug costs can still be astronomical, particularly if you have a condition that requires specialty drugs.

If you have limited funds, you can apply for the Extra Help program through the Social Security Administration, which estimates that the benefits are worth around $4,000 per year. You have to be enrolled in Part D to be eligible.

The takeaway

During open enrollment don't put your plan on autopilot just because you don't want to take the time or if you feel the choices are too confusing. Don't take the path of least resistance. The best way to avoid that is by marking the open enrollment period on your calendar each year, so you can adequately prepare. The more thought you put into your Medicare needs in advance, the better the odds that you'll settle on the plan that is right for you. ❖

Employee Benefits

More Firms Offer Disability Insurance, but Education Vital

WHEN CANDIDATES consider taking a job with a company, they usually look closely at the health benefits. Also, they generally read the retirement plan and look at other perks such as vacation days and sick days.

However, very few people consider disability benefits or even bother to ask about them.

Although most employees do not think of disability benefits as an important asset, studies have found that 25% of people who are 20 years old now will become disabled before they reach an age that makes them eligible for collecting retirement income.

The Employee Benefits Survey of 2016 found that most employers still offer disability benefits in their packages whether workers choose to consider them or not. Sadly though, despite the fact that more employers are offering long-term disability insurance as an employee benefit, the number of employees insured is dropping.

Here's a recap of the main findings:

Short-term disability benefits

- 75% of employers offered short-term disability benefits. These benefits help employees afford their living expenses and medical costs while they recover.
- Short-term disability benefits typically lasted for 26 weeks with most employers. Some employers offered benefits for 13 weeks instead.
- Fewer than 15% of employers offered short-term disability benefits that lasted for a period shorter than 13 weeks.
- About 40% of the surveyed organizations did not require service periods, which means that workers were eligible to receive benefits immediately after being injured or falling ill once they were hired.
- In most cases, short-term disability payments were calculated based on a fixed percentage of earnings.

Long-term disability benefits

- 65% of employers offered long-term disability benefits, broken down as follows:
  - 90% of corporate respondents offered this benefit.
  - About 75% of public employers offered it,
  - 20% of multi-employer plans offered it.

- Many firms required employees to have worked a certain period of time before they can collect benefits, as follows:
  - 35% of employers did not require a service period.
  - 20% of employers had a service period of a month or less.
  - 20% had a service period between 90 and 180 days.

How to gain some traction

Employers offering these benefits said they are trying to relate to their employees the risks of workplace accidents and even chronic health issues that are common and cause long-term disabilities.

Here are some points you can make when discussing these voluntary benefits with your staff:

Women file more claims – 56% of new long-term disability claims approved during 2016 were for women.

It's for all ages –While claims by those age 50 and older have been consistently increasing as a percentage of total claims, over 40% of new claims were made by those in their 40s or younger.

Injuries don't cause most disability claims –Musculoskeletal system and connective tissue disorders like arthritis and sciatica are the leading cause of new disability claims (they account for 29% of new claims). Cancer is second at 15% of new claims. Injuries and poisoning combined represent 10% of new claims.

Social Security disability only goes so far – 75% of workers who get private disability insurance also get Social Security disability. Social Security disability payment amounts are very low – in the $700 a month range for younger workers. ❖