Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Benefit Costs

Employers Seek New Ways to Reduce Health Insurance Inflation

AS EMPLOYERS anticipate that their employee health insurance costs will rise 5.5% for the 2018 policy year, they are also planning to step up their cost management efforts in new areas, according to a new study.

And despite the maelstrom in Washington over how to deal with the Affordable Care Act, 92% of employers surveyed said they are "very confident" their organization will continue to sponsor health benefits in five years, according to the "Willis Towers Watson 2017 Health Care Employer Survey."

Employers will try to contain costs by exploring new strategies like emerging health care delivery systems, and arrangements that help employees better navigate the health care system and improve health engagement.

Over the past few years, employers have been shifting more of the cost burden to employees and now they are looking for new ways to address future premium increases, according to the study.

Cost management focus

The areas where surveyed employers feel they can make the most progress include:

See 'Focus' on page 2

Better and less costly health delivery models

Telemedicine for office visits – 78% of employers use these consultations, with another 16% planning to or considering doing so by 2019.

Centers of excellence – The growing need for disease-based medical management of chronic-type conditions has prompted hospitals and health plans to offer centers of excellence. These programs have been developed in a number of specialty fields, including diabetes, neurosciences, spine, craniofacial surgery, musculoskeletal and orthopedics, cardiology and more.

High-performance networks – Also known as "narrow networks," these are exclusive groups of high-value health care providers and health professional organizations recruited to serve a defined patient population. These have grown in popularity because they promote higher-quality health care services while delivering better value.

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Compliance

New Summary of Benefits and Coverage Template

THERE IS A new Summary of Benefits and Coverage template that health plans will be required to use during open enrollment for the 2018 plan year.

The new templates were introduced in 2016 and took effect for plan year or open enrollment periods beginning on or after April 1, 2017.

The new template is the first major revision of the SBC template since 2012, the first year that health plans were required to use them as required by the Affordable Care Act.

The new SBC template has also jettisoned some information, such as:

- A header appearing on the top of every page. Now the header is only required for the first page.
- A question and answer section about the coverage examples.
- References to annual dollar limits on essential health benefits are no longer included, as plans may no longer impose them.
- Certain definitions have been removed.

What you need to do

Insurance carriers will create the new SBCs for you to distribute to your employees. But you will want to confirm that your insurance company is using the new form.

Also, if you are using more than one insurance company for your employee benefits, you may need to work with your health plans to create a single SBC that complies with the new template.

As open enrollment season is quickly approaching, you can plan for your communications by incorporating the new SBC. ❖

Template changes

- There is a new row on the first page where the plan must indicate if there are any services that are covered before the individual satisfies the plan's deductible. It lists a number of categories for these services.
- There is more detailed information about exclusions and limitations for services related to common medical events, like:
  - » Whether an entire category of services is excluded from coverage;
  - » When in-network cost sharing does not count towards the out-of-pocket maxmum;
  - » Any limits on the number of visits (or if a specific dollar limit applies); and
  - » When prior authorization is required.
- There is now a third example that is required on the summary to illustrate how costs are paid for. The new example illustrates treatment of a simple fracture with an in-network emergency room visit and follow-up care.
- The instructions have also changed the way cost sharing is calculated for coverage examples to account for if the individual is enrolled in a wellness program that may affect cost sharing. For example, some wellness plans include incentives or disincentives that reduce or increase plan deductible, coinsurance or copayments.

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Employers Focus on Improving Employee Engagement

Pharmacy costs and utilization

- Evaluating pharmacy benefit contract terms.
- Adopting new coverage or utilization restrictions for specialty drugs.
- Addressing specialty drug costs and utilization performance through medical benefits – 44% of employers currently do this, with another 38% planning to or considering doing so by 2019.

Improving employee engagement

- Including more voluntary benefits – 66% of employers do this.
- Using virtual shopping to make enrollment easier.
- Providing decision-support tools during enrollment – 55% of employers currently offer such tools, with another 26% considering doing so for 2019.
- Encouraging the use of mobile apps for managing health issues – 19% of employers currently provide this to their employees, with another 28% planning to or considering doing so by 2019.
- Promoting wearable devices for tracking physical activity – 26% of employers currently promote these to their employees, with another 18% planning to or considering doing so by 2019. ❖

ACA Rulemaking

Final Regulations for Wellness Plans Limit Incentives at 30%

THE U.S. Equal Employment Opportunity Commission has released final regulations for employer-sponsored wellness programs under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act.

The final rules took effect this year and affect all wellness plans for employees and their family members, even those plans that don't also require enrollment in a health plan.

Here we look at the final rules:

Incentives

Under the final rules, you can offer up to a 30% discount on self-only health coverage to employees in wellness plans, but if you offer more than one health care plan, the incentive cannot exceed 30% of the cost of the lowest-priced option.

The final rules also limit spousal incentives to 30% of employee-only coverage.

Under Health Insurance Portability and Accountability Act (HIPAA) regulations, incentives for a wellness program with a smoking-cessation component are not limited to the 30% rule and can be as high as 50%. However, if the program includes biometric screening or any other tests for the presence of nicotine or tobacco, it would be limited to incentives of 30%.

Employers are also permitted to offer in-kind incentives (e.g., employee recognition, parking spot use, relaxed dress code).

'Voluntary' defined

The final regulations define what is considered "voluntary":

- Employers must not require employees to participate.
- Employers may not deny health care coverage to employees who do not participate.
- Employers may not take any adverse employment action against or coerce employees who do not participate.

Notices

You must provide employees with a written notice that advises them about what medical information will be obtained through the wellness program, how it will be used and restrictions on its use.

Confidentiality and information protection

Information obtained under employee wellness programs is still considered protected health information for purposes of HIPAA compliance.

It is important to ensure that all information is kept confidential and that employees handling the information are well trained on their confidentiality obligations. Employers also must ensure that they do not receive the information in a manner that would disclose the identity of specific individuals.

Non-discrimination

To ensure that this exception applies, the program must be "reasonably designed to promote health or prevent disease."

For example, programs that penalize an individual because his or her spouse suffers from a disease or disorder will not meet this standard.

Information collected under the program must actually be used to design services that address the conditions identified in the information collected.

The ADA bars employers from denying access to a particular health plan because an employee does not answer disability-related questions or undergo medical examinations, the EEOC said in a statement.

Under new ADA regulations, employers must offer reasonable accommodations to allow an employee to participate in a wellness program so long as doing so does not constitute an undue burden.

Also, where an employer's wellness program provides medical care and rewards an individual for meeting a health standard, the employer must provide a reasonable alternative to earning any incentive.

For example, a program that rewards an employee for reaching a certain body mass index must modify that standard for any employee who cannot reach that BMI for medical reasons, such as a thyroid condition. That way the employee could still earn the financial incentive.

The takeaway

If you have a wellness program or are considering implementing one, you should talk to us about your options and discuss any concerns you may have regarding compliance with the new regulations. ❖

Exchange Enrollment

Many Receiving Subsidies May Not See Rate Increases

AS CONCERN continues to swirl over the future of the Affordable Care Act and reports of large-scale premium increases in some markets, average rates for a plan on an exchange for someone receiving subsidies would actually fall, according to a Kaiser Foundation study.

Kaiser likes to use the silver plan as the yardstick for rates as it is the most popular of the metal spectrum plans that are offered on the government-operated health insurance exchanges.

The study found that across all states, rates for individuals who qualify for a tax credit would actually decrease about a percent on average.

In conducting the study, the Kaiser Foundation analyzed preliminary premiums and insurer participation in the 20 states and the District of Columbia where publicly available rate filings had enough details to glean the information to calculate rates. It focused much of its analysis on the cost of silver plans, in which 71% of marketplace policyholders are enrolled.

What's happening with pricing

While much has been made of massive rate increases, many individuals who receive tax credits for purchasing on exchanges may not see any rate increases at all.

A single adult making $30,000 per year would pay about $201 per month in 2018 for the second-lowest silver plan, regardless of the base, according to Kaiser. That's compared with $207 this year (a drop of 2.9%).

According to Kaiser, 84% of people who buy insurance on the exchanges receive tax credits. It predicts that rate changes for silver plans will range from a drop of 5% to an increase of 49% across 21 major cities in its study.

It's certainly not all rosy as you can see in the boxes below.

Horror stories

The following monthly rates are the steepest in the country for an unsubsidized second-lowest silver plan for a 40-year-old non-smoker:

- Wilmington, DE: Increase to $631 from $423 this year (up 49%)
- Albuquerque, NM: Increase to $346 from $258 (up 34%)
- Richmond, VA: Increase to $394 from $296 (up 33%)

Insurer participation

Meanwhile, insurer participation in exchanges is slipping. The following is the average number of insurers participating in the exchanges in 20 states and Washington D.C.:

2018: 4.6 insurers*
2017: 5.1 insurers
2016: 6.2 insurers
2015: 6.7 insurers
2014: 5.7 insurers

* Estimated. States are still reviewing insurer participation.

Uncertainty

Some insurance companies are unsure how to proceed with participation and setting rates based on the uncertainty emanating from the White House and Congress.

Insurers have noted this uncertainty in their filings. "In the 20 states and DC with detailed rate filings included in the previous sections of this analysis, the vast majority of insurers cite policy uncertainty in their rate filings," the Kaiser Foundation writes. ❖