Einstein
Advanced Health Insurance Solutions

NEWSALERT

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ACA Rules Tweak

Be Careful That You're Complying with Affordability Test

NOW THAT the final attempt (this year) at dismantling the Affordable Care Act came to a quiet end in the last week of September, employers need to make sure that they stay on track with compliance.

First and foremost is that the ACA's employer mandate and shared responsibility provisions still stand. That includes the affordability test, to which employers need to pay special attention, as increases in premium can put some of your employees over the edge into "unaffordable" coverage territory.

And this year there's a twist that you need to be aware of.

As it's almost time for open enrollment, you'll likely soon be settling on your premium-sharing amounts for your 2018 group health policies. Pay close attention to the affordability test, which bars employers from providing coverage that will cost the employee more than a certain percentage of their salary.

When the ACA was signed into law, the percentage was set at 9.5% and would change every year based on inflation.

Affordability level reduced

For 2018, the Department of Treasury cut the affordability level to 9.56% from 9.69%.

What this means is that you may actually have to lower the amount some employees contribute to their premium to ensure that you don't fall afoul of the affordability test.

Because employers have no way of knowing what an employee's total household income is, the IRS created affordability test "safe harbors" to show that the employer has provided coverage that is considered "affordable" and hence should not be subject to any fines if an employee manages to get coverage on an exchange and receive a premium tax credit to do so.

These safe harbors, set out in the final shared responsibility regulations, provide that employer coverage will be considered affordable for purposes of the employer shared responsibility assessment if the required employee contribution for the lowest-cost option offered does not exceed 9.5% of one of the following:

Affordability Safe Harbors

- **W-2** – The employee's wages for the calendar year reported on the Form W-2.
- **Rate of pay** – The amount obtained by multiplying 130 hours by the lower of the employee's hourly rate of pay as of the first day of the coverage period or lowest rate of pay during the calendar month.
- **Federal poverty line** – An amount equal to the federal poverty line for a single individual, divided by 12. Under the FPL safe harbor, employers use the FPL in effect six months prior to the beginning of the plan year to allow time to establish premium amounts in advance of the plan's open enrollment period.

The takeaway

Be careful when setting employee contribution rates for your 2018 health plans. If you're unsure whether you are setting them correctly, you can contact us or your tax advisor. ❖

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CONTACT **US**

Missouri: **4359 Forest Park Avenue, St. Louis, MO 63108**
Illinois: **280 North Main Street, Breese, IL 62230**

Phone: 877.324.2114
Fax: 888.274.1538
Email: *info@ecgins.com*

Incentives

Court Says Employer Can Require Wellness Plan Participation

IN RECENT years, the Equal Employment Opportunity Commission has been stepping up its efforts to go after employer-sponsored wellness plans that it deems discriminatory.

The EEOC says that if a wellness plan discriminates against individuals who cannot participate in it due to physical limitations, the plan may be in violation of the Americans with Disabilities Act.

Also, under EEOC rules, employees may not be required to participate in a wellness program, may not be denied health insurance or given reduced health benefits if they do not participate, and may not be disciplined for not participating. All of these, it says, are violations of the ADA.

But, in a win for employers, a federal District Court in Wisconsin last December held that a company's policy of requiring employees to participate in its wellness program to be eligible for coverage in its group health insurance plan does not violate the ADA.

In the case of *Equal Employment Opportunity Commission vs. Flambeau Inc.*, the court ruled that the plastics manufacturing firm was protected under the ADA's safe harbor provision in requiring employees to complete health risk assessments and biometric screenings to be eligible for health coverage.

"The protection set forth in the ADA's safe harbor enables employers to design insurance benefit plans that require otherwise prohibited medical examinations as a condition of enrollment," said Judge Crabb in her ruling granting Flambeau summary judgment dismissing the case.

New discrimination regulations have increased the challenge of assembling wellness plans that do not discriminate.

In 2009, the EEOC took the position that a wellness program consisting of a health risk assessment or screening exam would comply with the ADA only if it was "voluntary." Five years later, the EEOC sent a shot across employers' collective bow when it filed lawsuits challenging the legality of three companie's wellness programs.

ACA muddies the waters

The Affordable Care Act added a new layer of regulations on wellness programs to ensure that all employees have an opportunity to participate in them.

Under proposed regulations:

- Wellness programs must promote health or prevent disease. To be considered reasonably designed to this end, a program must offer a different, reasonable means of qualifying for the reward to any individual who does not meet the standard based on the measurement, test or screening.

- Programs must be reasonably designed to be available to all similarly situated individuals. Reasonable alternative means of qualifying for the reward would have to be offered to individuals whose medical conditions make it difficult, or for whom it is medically inadvisable, to meet the specified health-related standard.
- Individuals must be given notice of the opportunity to qualify for the same reward through other means. ❖

THE LAWSUITS

Suit 1 – In August 2014, the EEOC sued Orion Energy Systems, Inc., alleging that the company's wellness program, which requires employees to complete a health risk questionnaire and screening, is unlawful under the ADA. Failure to comply with the wellness program requirements would cause the employee to forgo any employer contributions to the health plan premium.

The EEOC also alleged that an employee was terminated after she had complained about the wellness program.

Suit 2 – In October 2014, the EEOC sued Honeywell International, asking the court for a temporary restraining order enjoining the company from continuing to operate its wellness program.

The program required employee participants in the group health plan and their covered spouses to complete biometric screenings, and to refrain from tobacco use (or complete a tobacco cessation program).

The company would add a surcharge to the employees' share of their health premiums if they failed to comply.

The district court denied the EEOC's motion, saying the agency had not shown a threat of irreparable harm. The case was later voluntarily dismissed.

Suit 3 – In the aforementioned Flambeau case, the employer

required employees to complete a health risk assessment and biometric testing in order to be eligible for participation in the company's group health plan.

The EEOC said that requirement violated the ADA's prohibition against medical questions or examinations, unless they are voluntary, job-related or subject to business necessity.

Ancillary Benefits

Do Pharmacy Benefit Managers Control Costs, or Raise Them?

IN 2015, spending on prescription drugs grew 9%, which was faster than any other category of health care spending, according to the U.S. Centers for Medicare and Medicaid Services.

The report cited increased use of new medicines, price increases for existing ones, and more spending on generic drugs as the reasons for this growth. Increasingly, though, observers of the health care system point to one player – the pharmacy benefit manager.

PBMs are intermediaries, acting as go-betweens for insurance companies, self-insured employers, drug manufacturers and pharmacies. They can handle prescription claims administration for insurers and employers, facilitate mail-order drug delivery, market drugs to pharmacies, and manage formularies (lists of drugs for which health plans will reimburse patients.)

Express Scripts, which provides network-pharmacy claims processing, drug utilization review, and formulary management among other services, is the best-known PBM. CVS Caremark and UnitedHealth Group's OptumRx are other major players.

A PBM typically has contracts with both insurers and pharmacies. It charges health plans fees for administering their drug claims, and also negotiates the amounts that plans pay for each of the drugs.

At the same time, it creates the formularies that spell out the prices pharmacies receive for each drug on the lists. Commonly, the price the plan pays for a drug is more than the pharmacy receives for it. The PBM collects the difference between the two prices.

It can do this because the health plan does not know what the PBM's arrangement is with the pharmacy, and vice versa. Also, a health plan does not know the details of the PBM's arrangements with its competitors.

A PBM could charge one plan $200 for a month's supply of an antidepressant, charge another plan $190 for the same drug, and sell it to a pharmacy for $170. None of the three parties knows what the other parties are paying or receiving.

Also, drug manufacturers, who recognize the influence PBMs have over the market, offer them rebates off the prices of their products.

Questionable transparency

In theory, the PBMs pass these rebates back to the health plans, who use them to moderate premium increases. However, because these arrangements are also confidential, the extent to which these savings are passed back to health plans is unknown. Many observers believe that PBMs are keeping all or most of the rebates.

To fund the rebates, drug manufacturers may increase their prices. The CEO of drug-maker Mylan testified before Congress in 2016 that more than half the $600 price of an anti-allergy drug used in emergencies went to intermediaries.

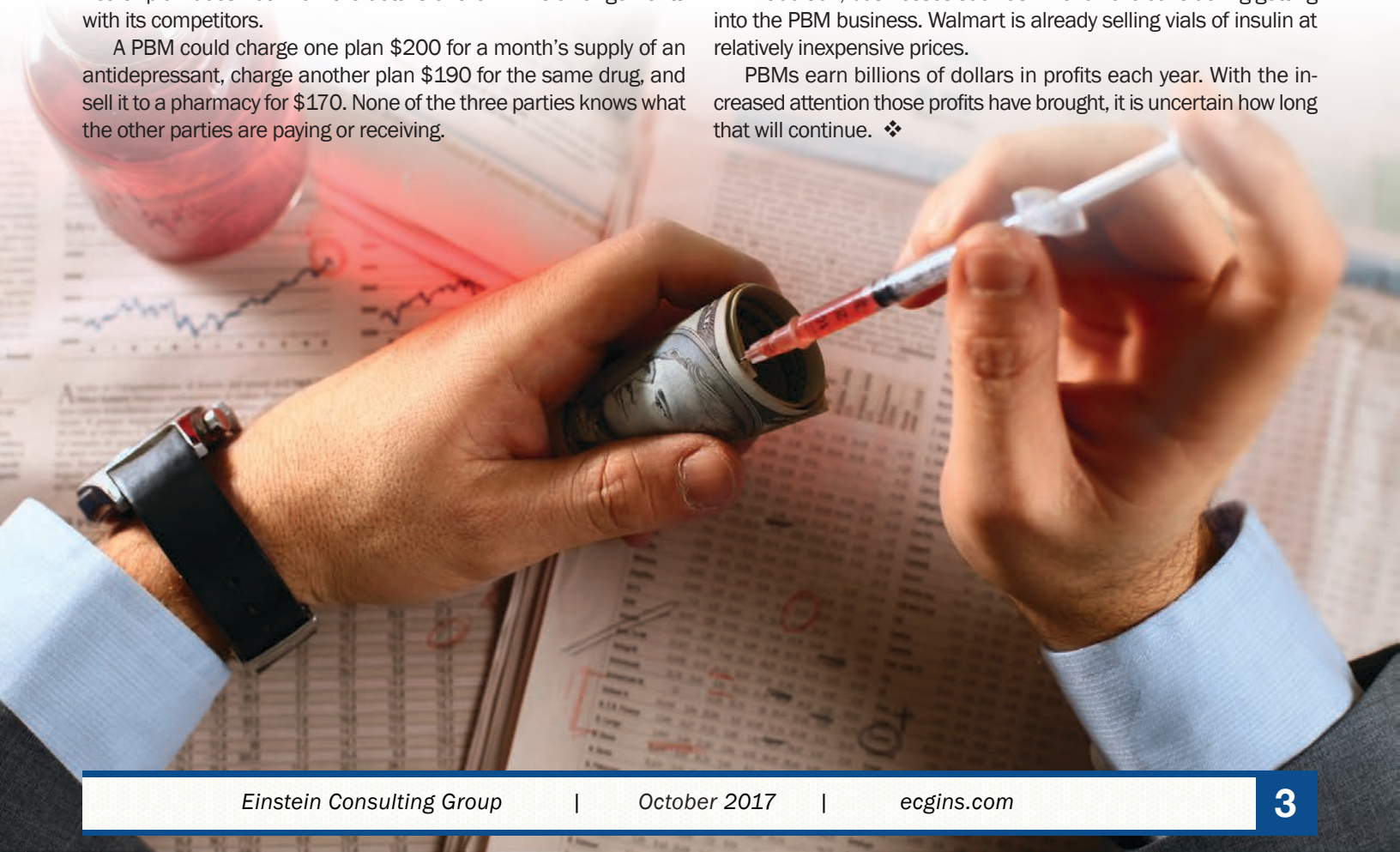
The PBMs argue that they help hold down drug prices by promoting the use of generic drugs and by passing on the savings from rebates to health plans and consumers.

They reject the notion that they are somehow taking advantage of health plans and pharmacies, pointing out that they are "sophisticated buyers" of their services. They also argue that revealing the details of their contracts would harm their ability to compete and keep prices low.

Nevertheless, PBMs are now attracting scrutiny from Congress, health plans and employers. At least one major insurer has sued its PBM for allegedly failing to negotiate new pricing concessions in good faith.

In addition, businesses such as Amazon are considering getting into the PBM business. Walmart is already selling vials of insulin at relatively inexpensive prices.

PBMs earn billions of dollars in profits each year. With the increased attention those profits have brought, it is uncertain how long that will continue. ❖



Employee Benefits

Group Plan Inflation Low, New Cost-saving Strategies Emerge

EMPLOYERS AND their workers continue gravitating towards high-deductible plans to stave off premium increases, which have been averaging about 3% a year this decade.

And with employers expecting that premiums will increase by an average of 4.3% in 2018, according to a recent study by Mercer, the trend is likely to continue.

That rate of increase is the highest since the passage of the Affordable Care Act in 2010, but it's still low compared to the decade before, which was marked by double-digit inflation. Employers have been countering this by shifting more costs to employees.

Fortunately though, while confusion has been swirling about the ACA's future as congressional efforts to repeal the law have foundered, and the individual market is seeing 20% rate hikes, the group market has been stable.

Both Mercer and the Kaiser Family Foundation are unsure as to why the rate of cost inflation has been so low in the employer market, since there have really been no substantial new efforts to control costs.

But one factor that they do point to is that policies have changed and shifted more costs to out-of-pocket spending for employees, which reduces premiums.

According to the Mercer survey, covered workers' average contribution to family coverage has increased 32% since 2012, and 74% since 2007.

As employees have taken on more of the cost burden by having to pay more in out-of-pocket costs, there are concerns that the added financial pressure is taking its toll.

As many as 30% of respondents said they have trouble paying their medical bills because the cost-sharing burden is so high, the Kaiser Family Foundation found in its report. That could result in some employees putting off care because they can't afford it.

Employee costs

In 2017:

- Employees paid on average $1,213 toward single coverage premiums, or 18% of the total premium.
- Employees paid on average $5,714 toward family premiums, or 31% of the entire premium.
- The average deductible was $1,221 for single coverage.
- 51% of workers are enrolled in a health plan with a deductible of $1,000. The rest is covered by employers.

Controlling costs

Mercer projected that the actual underlying cost growth from 2017 to 2018 would be 6%. That's the amount employers would expect to see if they didn't take steps to reduce cost growth.

Strategies employers said they would use to manage costs, without further raising employee out-of-pocket spending, include:

- Providing care coordination and support for high-cost claimants.
- Addressing quality by using incentives to direct employees to centers of excellence and other high-performance provider networks.
- Shifting away from traditional fee-for-service provider reimbursement toward new payment models that reflect the value of the services provided, rather than just the quantity.
- Taking steps to manage specialty drugs.
- Encouraging employees to seek care from accountable care organizations and medical homes.
- Promoting and growing their wellness programs.❖