Einstein
Advanced Health Insurance Solutions

NEWSALERT

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High-Deductible Health Plans

As More Employers Rethink HDHPs, They Tackle Other Costs

A NEW STUDY has found that more and more large employers are ditching high-deductible health plans as the job market tightens and they need to boost their health insurance offerings to retain and attract talent, and saddle their employees with less of the cost burden.

The change is also in response to the increasing burden that's been placed on workers in employer-sponsored health plans after a seismic shift over the last decade to high-deductible health plans. HDHPs – also known as consumer-directed plans – were also expected to put more responsibility on employees to shop around for the most cost-effective medical services, but those expectations have not materialized.

This year, 39% of large, corporate employers surveyed by the National Business Group on Health offer HDHPs as their workers' only choice. For 2019, only 30% of employers surveyed said they would solely offer HDHPs.

Pundits also say that some companies are boosting other options because of the continued postponement of the "Cadillac tax" on pricey health plans as it looks more and more likely that the tax will be scrapped and never take effect.

While nearly 40% of large employers offered only HDHPs in 2018, just 29% of U.S. workers are in HDHP job-based plans this year, the same level as in 2017, according to the Kaiser Family Foundation. That's the highest level ever since the plans were introduced about 13 years ago.

The plans have allowed employers to shift more of the cost burden to their employees by requiring them to have more "skin in the game" in terms of their health care expenditures. But that notion failed because most health care is unplanned and requires fairly quick treatment, which makes it more difficult to shop for the provider that charges the least.

Over the years, the up-front premium cost employees pay has risen, but so have deductibles in these plans and deductible levels have increased faster than wages. In fact, 25% of workers have a single-person deductible of $2,000 or more, according to the Kaiser Family Foundation.

The average total health insurance cost is nearing $15,000 per employee, and the average worker pays $5,547 of that every year.

Lowering costs

As costs increase, more employers are trying to find other ways to shave costs instead of shifting more deductibles and premium costs to their workers. Some of the ways the National Business Group survey found employers are trying to tackle costs include:

Managing expenses for the most expensive diseases – This can include cancer, terrible accidents, prematurely born babies and other diseases. Treatment for many of these afflictions can cost $1 million or more. This is being done through accountable care

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Pharmaceutical Costs

New Law Bars Pharmacy Benefit Manager Gag Clauses

PRESIDENT TRUMP has signed two bills into law that would add transparency to drug pricing by banning gag clauses imposed by pharmacy benefit managers (PBMs) that bar pharmacists from discussing drug prices with the person buying prescription medication.

The bills, passed with bipartisan support, take aim at the PBM practice of clawbacks, which occur when the copayment set by the PBM is more than the actual cash price of the drug. So instead of the policyholder being able to pay less for the drug, the PBM will usually pocket the difference.

And because of gag clauses, most policyholders never get to know that they can save money if they decide not to use their PBM benefits and instead pay cash for the drug.

Insurers contract with PBMs to manage drug benefit programs and act as intermediaries between insurers, manufacturers and pharmacies.

PBMs use their position to negotiate discounts, rebates and other cost reductions from pharmaceutical companies in exchange for their drugs' preferred placement on insurers' formularies. They also decide which medications are covered or whether they will carry a copay when the patient picks up the drug.

A number of states already have similar laws on their books, but now it will be federal law thanks to the two measures: The Patient Right to Know Act and the Know the Lowest Price Act.

What the laws do

- Allow pharmacists to tell patients they can save money on a specific drug if they pay cash, and
- Allow pharmacists to recommend trying a lower-cost alternative medicine.

How gag clauses work

A drug-maker sets the retail cash price of a pharmaceutical at say $40 per bottle. The PBM negotiates with the drug company for a lower price of $20. Pharmacies buy the drug from wholesalers and when a pharmacy dispenses the drug, the PBM will pay it the discounted rate of $20.

Additionally, the pharmacy will pay a fee to the PBM for its role in negotiating the price down.

In turn, the PBM may charge the insurance company more than the $20 it had negotiated. Often too, the PBM will receive a rebate from the drug-maker for placing the drug on its formulary.

Finally, when a patient buys the medicine from the pharmacy, he or she is charged a copay amount based on the list price ($40) rather than the negotiated price ($20). Since the $50 copayment is higher than the cash price, under a gag clause the pharmacist would be prohibited from informing their patients that they could pay less if they forwent the PBM benefit and paid cash out of pocket instead.

The new law bans such gag clauses. ❖

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Employers Want Changes in Pharmacy Supply Chains

organizations and "centers of excellence" that the insurer contracts with to focus on specific treatments.

Using more technology – This can include workers using nurse video-chat services and other types of telemedicine.

Using primary care clinics – Some insurers and self-insured employers are contracting with primary care clinics nearby their offices so that employees can get common ailments treated quickly.

Tackling pharmaceutical costs – Nearly all of the employers surveyed said the prescription drug system needs to be overhauled, drug contracts should be more transparent and the rebate system needs fixing.

Some companies are working with a select few pharmacy benefit managers that can move rebates forward to the point of sale so that employees benefit from the rebate. Thirty-one percent of employers said they are considering implementing point of sale rebates in the next few years. ❖

Report Findings

First Association Plans Comply with ACA, Offer Lower Premiums

AS THE first association plans start gaining traction, trade journals are reporting that many of the plans they are offering are not as skimpy as many had predicted they would be.

The rules enacted for these plans allow them to skirt certain requirements of the Affordable Care Act, specifically that they cover 10 essential benefits, and still qualify as plans that satisfy the requirement that employers provide their staff with coverage.

Rules for forming plans

Under the new rules, association plans can be formed across state or nationwide. Employers band together (act like one employer) based on:

- Geography (all have a principal place of business in a state [or portion of a state, such as a city or county] or in the same metropolitan area, even if the metropolitan area spans more than one state).
- Industry (be from the same trade, industry, line of business, or profession).

The old Obama-era regulations made it difficult for association plans to meet ERISA's large-employer insurance requirements. The Department of Labor estimates that some 4 million people could be covered under association plans in the coming years.

A surprise development

Yet, despite these plans having fewer restrictions on them, most of the new association plans are actually compliant after all and are not skimping on benefits as many pundits had predicted, according to press coverage.

The trade journal *Modern Healthcare* reports that most of the first association plans that are being formed are not charging people different premiums based on their health conditions or barring people with pre-existing conditions from enrolling.

It also notes that plan sponsors report that the plans cover all of the essential benefits outlined under the ACA, and even provide broad networks of doctors.

The ACA also requires that plans do not impose annual or lifetime limits on coverage, and the plans coming out of the gates also comply with that aspect of the law.

Modern Healthcare's reporting also found that despite all that, the plans' premium levels are lower than what individuals can buy on government-run exchanges.

Farmer-owned cooperative Land O'Lakes, several Nevada chambers of commerce, and the National Restaurant Association have formed association plans this year and are expanding them now.

Modern Healthcare reported on Land O'Lakes farmer-owned cooperative's self-insured association plan, which now covers two states (Nebraska and Minnesota) and is continuing to expand into other states.

The co-op said that its plans cost 25% to 35% less than comparable exchange plans in Nebraska, and about 12% less than plans on the exchange in Minnesota.

The magazine reviewed the plan documents for Land O'Lakes' eight Nebraska plans, comprising a platinum-level plan, one gold plan, and three silver and three bronze options.

"They feature a range of deductibles and appear to provide coverage for each category of essential health benefits including prescription drugs, maternity care and mental health and substance abuse treatment," it reported.

The Nebraska Farm Bureau is also rolling out an association plan for its members starting in 2019, and based on early figures, its premiums are 25% less than comparable individual plans on the state's insurance exchange.

These plans also cover all of the essential benefits and do not charge more for people with pre-existing conditions, *Modern Healthcare* reported.

Also, a number of local chambers of commerce banded together in Nevada to form a fully insured association HMO plan with premiums that are about 20% less than similar plans on the exchange. ❖

Flexible Work

More Workers Desperately Need Caregiving Benefits

AS THE costs of nursing homes and assisted living services soar, the financial burden of paying for those services often falls on the elderly individual's adult children.

Many families cannot afford these services, so they are opting for their ageing parent to live with them. Unfortunately, as those parents get older and need more care, it can take a toll on their adult children and has forced many of them to quit their jobs and take care of their parents full time.

A recent survey by Unum Insurance Company found that 39% of caregivers end up quitting their jobs to take care of their sick or ageing family members. They are forced to quit because their employers did not accommodate their disrupted work schedule.

CAREGIVING IS COMMON

- 18% of working adults are primary caregivers for sick and elderly loved ones.
- 25% of caregivers are millennials.
- The average age of caregivers is 40.

Source: Unum Insurance survey

With the job market tightening, it is wise to consider offering voluntary caregiving benefits to your staff. Studies have shown that people who juggle work and caregiving responsibilities have a higher likelihood of developing chronic health conditions.

That translates into higher health care insurance spending for their employer. Increased stress also lowers employee productivity by almost 20%, and can cost companies thousands of dollars.

What you can do

The federal Family and Medical Leave Act entitles workers to 12 weeks of job-protected leave for qualified family and medical reasons, including caregiving. But many people are reluctant to take advantage of those rights because the leave is unpaid.

It pays for employers to be more flexible. The Unum survey found that absent employees cost the U.S. economy around $25.2 billion a year. You can reduce any fallout on your business by working with your employees.

Now, an increasing number of companies offer paid and/or unpaid leave for caregiving beyond what's required by the FMLA. They may include benefits such as:

- Flexible work arrangements,
- Information resources and referrals, and
- Emergency backup care.

Often, caregivers don't need a full day off to take care of someone. Sometimes, they just need a few hours to get away to assist them or drive them to a doctor's appointment.

Flexible work arrangements could also include allowing them to do work from home in some capacity part of the week. Another option is flexible time. So if they have to leave for three hours during the day, they can come in early and/or stay late to make up for the lost time.

The key is working with your employees to find a way to accommodate their needs while still keeping them in their job and allowing them to be productive.

If you decide to offer some assistance, you should meet with employees who are currently caring for elderly parents to find a solution that works for both of you.

You may also want to consider allowing staff to use sick time to care for family members. ❖