Einstein
Advanced Health Insurance Solutions

NEWSALERT

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ACA Battle

Judge Shoots Down Administration's Rules for Association Plans

A FEDERAL judge has rejected the Trump administration's rules for association plans, saying they are an attempt to let employers skirt their obligations under the Affordable Care Act.

The rules that the Department of Labor finalized last year allow employers to band together as "associations" for the purpose of purchasing health insurance for their employees.

And under those rules, the plans do not have to comply with many of the ACA's provisions, including providing plans that are "affordable" and offer minimum essential benefits.

Judge John Bates of the U.S. District Court for the District of Columbia wrote in his decision that the rule goes beyond the department's authority under the Employee Retirement Income Security Act of 1974.

The judge particularly honed in on the fact that the associations would become the de-facto employer for members to allow them to band together for the sole purpose of having access to lower rates.

Under the rule, employers in the same industry can form a plan across state lines, as can any businesses in a specific geographic area. Sole proprietors can also join, along with small businesses, and obtain coverage for themselves and their families.

By banding together to form a pool with more than 100 workers, the employers would be considered a "large" employer under the ACA. While employee health plans for companies with fewer than 100 workers must abide by all of the ACA's provisions, including covering 10 essential benefits, large plans do not have the same constraints.

This means that sole proprietors who may be purchasing their health plans on a state exchange, would suddenly have the purchasing power of a large employer in the health insurance market.

The Trump administration is likely to appeal the ruling, but the judge has made it difficult since he struck down the linchpin of the regulation, which had changed the definition of what constitutes an employer and employee.

Existing association plans

To date, about 30 association plans have been formed around the country since the rules took effect last year.

The association plans are reportedly not up and running, but have been gearing up to start Jan. 1, 2020.

A report by the trade publication *Modern Healthcare* found that association plans that have been created since the rule took effect covered all of the 10 essential benefits as required by the ACA, and also at comparable costs, premiums, deductibles and out-of-pocket requirements.

The judge did not order a stay on existing association plans, so for now it's likely they will continue planning for a 2020 start.

But whether they actually get off the ground will depend on the courts going forward.

For the time being, employers that are interested in joining an association health plan may want to take a pause and consider other options until the air clears about these plans. ❖

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CMS Changes

Proposed Rules Tackle Group Plan Prescription Drug Prices

THE CENTERS for Medicare and Medicaid Services has floated proposed regulations that would affect drug benefits for group plans and association plans and attempt to reduce drug expenses for health plan enrollees and drug plans.

While the rules seem to be focused on individual plans sold on government-run exchanges, three of the changes would also affect small and mid-sized group plans.

Mid-year formulary changes

Under current regulations, health insurers are barred from making changes to their drug formularies mid-year. They can only introduce changes upon renewal.

The CMS says it wants to boost incentives for drug plans to use generic drugs, so it is proposing a new rule that would allow insurers to:

- Add a generic drug that becomes available mid-year.
- Remove the equivalent brand-name drug from the formulary, or
- Remove the equivalent brand-name drug to a different tier in the formulary.

Under the rules, insurers would have to notify their affected enrollees at least 60 days before the change would take effect. They must also offer a process for an enrollee to appeal the decision. This rule would affect insurers in the individual, small group, and large group markets.

Excluding certain brand-name drugs

Under existing regulations, all prescription medications covered under an insurance contract are considered an essential health benefit, including the requirements that aim to ensure that the drug coverage is comprehensive.

Under the Affordable Care Act, health plans are required to cover 10 essential benefits, and that includes the medications that are required to treat them.

The CMS wants to change this by letting insurers exclude a brand-name pharmaceutical from "essential health benefits", or EHBs, if there is a generic equivalent that is available and medically suitable.

As with the current rule, the proposal would only apply to plans in the individual and small group markets. That's because large group and self-insured plans are not required to cover all 10 categories of EHBs.

The proposal would also permit insurers to count only the cost of the generic equivalent (and not the cost of the brand-name drug) toward the enrollee's out-of-pocket limit.

Also, insurers would be permitted to apply an annual and/or lifetime dollar maximum to the brand-name drug, since the prohibition against annual and lifetime dollar limits only applies to EHBs.

Handling manufacturers' coupons

Currently, some insurers will count manufacturer coupons for brand-name drugs in addition to what the enrollee pays in calculating their out-of-pocket outlays for deductible purposes.

They may do so depending on laws in the various states in which they operate.

For example, take the scenario of a drug that costs $600, and the manufacturer provides a $400 coupon that can be used to reduce the cost of the drug and the enrollee pays $200 out of pocket.

Currently, insurers will count the full $600 towards the deductible and out-of-pocket maximum.

The CMS's proposed rule would allow insurers to only include the actual out-of-pocket expense for the enrollee when calculating how much of an out-of-pocket maximum has been satisfied.

What comes next

The comment period for the proposed regulations ended on Feb. 19, 2019, and the final rules could be out before summer. We will keep you posted once the new regulations are out and what they mean for your plan. ❖

CONCERNED ABOUT GROUP HEALTH COSTS AND DRUG COST EFFECTS ON YOUR STAFF? CALL US TO DISCUSS YOUR OPTIONS FOR THE NEXT OPEN ENROLLMENT

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Cost Containment

Helping Your Staff Pick the Right Health Plans

EVERY YEAR countless employees choose the wrong group health plans, forcing them to spend more than they should on premiums and/or out-of-pocket medical expenses.

They often make the wrong choice because they don't understand the coverage and what type of plan is best for their circumstances.

You can help them avoid leaving money on the table by educating them with helpful materials and a process that lets them find the plan that is best for their life circumstances.

The "2018 Aflac Workforces Report" found only 51% of employees had a solid understanding of their total annual cost for health care coverage and care, and just 39% of employees understood how their health insurance works.

To help your staff choose the plan that best fits them requires an educational effort and outreach, so give your communications strategy a boost to improve employee confidence in their benefits decisions and help them save money and future headaches.

Educating employees

Don't inundate your employees with lengthy educational materials that get bogged down in jargon. Often clear and concise materials are best, especially ones that use bullet points and infographics.

Benefits experts recommend providing employees bite-sized information that can help them whittle down their choice.

The materials should give different scenarios for workers to help them decide on a plan. The documents can point them towards the right type of plan depending on their life circumstances, like:

- A 27-year-old single female employee with no health problems, spouse or dependents.
- A 46-year-old married father of three young kids.
- A 58-year-old divorced woman with high blood pressure and asthma.

Online calculators

Most health plans today offer online calculators to help employees figure out which plans being offered best fit their needs. They plug in some simple details and the calculator will evaluate all of the plans on offer and recommend which one works best for them.

The tool compares out-of-pocket expenses, copays, coinsurance and premium costs to whittle down the plans. Some will even look for plans with the enrollee's family doctor.

Getting it right

Help your employees find the right plans by focusing on:

Retaining their family doctor(s) – Even if you are offering the same plan as last year, it's a good idea to tell your employees to check the plan to see if their personal physician or their kids' pediatricians are on the list of providers. Health plans make changes every year, so it's important to check.

Getting the financial balance right – Many people end up spending more up front on higher premiums in exchange for lower out-of-pocket maximums and/or deductibles when they shouldn't.

A young, healthy person that rarely visits the doctor may be better off with a plan that has lower premiums and a higher deductible, which they will not likely reach. Ask your employees to look at the deductible they had in the last year and see if they reached it.

- If they did not, they may consider reducing their premiums in exchange for a higher deductible.
- But if they surpassed their deductible or came close, paying more for a plan with a lower deductible might save them money overall.

Other things to consider are a plan's copays and coinsurance rules for medical expenses.

Worst-case-scenario calculation – Your employees should understand the implications if they suffer a medical crisis.

For a full perspective, they can:

- Calculate the total premium they will pay for the entire year (their monthly premium contribution x 12), and add
- The out-of-pocket maximum for the plan.

The total is how much they would likely have to pay in total if they suffered a medical crisis. They can ask themselves if they could handle that price tag.

One last thing…

Finally, consider offering your staff a package of other voluntary benefits that helps fill any gaps in their main health coverage.

Supplemental plans you should be offering include accident, critical illness, or long-term care coverage should they have an unexpected accident or serious illness. ❖

Easing the Burden

Critical Illness Insurance Provides Vital Protection to Employees

THE TYPICAL family's income slips by more than $12,000 in the year after a bread-winner suffers a critical illness, such as a heart attack, stroke or cancer, according to a study by Metropolitan Life Insurance Company.

This reduction of income isn't primarily due to lack of medical coverage. It is mainly attributed to the inability to work and earn an income.

The approximate out-of-pocket medical expenses add about $3,000 of costs during the first post-diagnosis year.

Despite these side effects, MetLife found that almost half of Americans with full-time jobs did not even have $5,000 worth of accessible savings to cover a major illness diagnosis.

More than 28% did not have at least $500 in savings.

The MetLife study also showed that:

- In the event of a medical emergency, two-thirds of American workers have three months or less in available savings.
- Only one-fifth of women and one-third of men were "very confident" that a financial emergency could be handled with their rainy-day fund.
- A little more than half of those with a full-time job were extremely or somewhat concerned about the possibility of a critical illness impacting the financial stability of their family.

The study concluded that many Americans are unprepared to deal with the short-term and long-term loss of income and out-of-pocket expense that is all too often associated with critical illness.

Another aspect of the study may reveal the reason why so many are unprepared; every surveyed patient had medical insurance, but only 7% had critical illness insurance and only 4% had cancer insurance.

Critical illness insurance

The purpose of critical illness insurance is to provide a one-time or lump payment to assist in offsetting the out-of-pocket expenses associated with certain critical illnesses.

Applicable critical illnesses may include an organ transplant, heart attack, stroke, cancer, loss of vision, burns, HIV or kidney failure. Critical illness insurance is not a replacement for standard health insurance or disability insurance. The design is purely to supplement such policies.

Only 28% of the surveyed full-time workers had heard of insurance for critical illness. However, from further questioning about critical illness insurance, the number might be even lower, as three of every five patients seemed to confuse it with their standard health insurance policy and one in five confused it with disability insurance or another government program.

Voluntary coverage

While the study showed a clear theme that many Americans are monetarily unprepared for a critical illness, it also provided evidence that many workers are concerned about their lack of preparation.

By expanding employee benefits to include voluntary critical illness insurance or raising awareness about existing benefits, you are offering important financial protection to employees.

In other words, you can help bridge the gap between the cost of a critical illness and what standard insurance covers, which allows the employee to better focus on recovering and possibly returning to the workforce.

If you want to know more about voluntary critical illness coverage, give us a call. ❖