Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Employee Benefits

Do a Last-Minute Sweep as Open Enrollment Starts

BY NOW you should be prepared and ready to go for your 2020 employee benefits open enrollment.

You should have all your plan documents and have prepared or held presentations for your staff to explain the benefits package and any major changes to plans that you offer.

To be on the safe side, there are a few things you should do to make sure you maximize enrollment, that your employees have the correct materials and that you are in compliance with the law. Here's a list:

Take an active role – Tell your staff to ask for help if they have questions or are confused about any aspect of their benefits, or how to use the enrollment portal.

Also, to ensure they make the best choices and have a successful experience, motivate them to take an active role in their education by encouraging questions and showing them where they can find answers in the online enrollment platform.

Last-minute blasts – You've probably sent e-mail reminders to you staff, but most certainly some of them still missed those communications. Make sure you send a few extra blasts at different times of the week, like Tuesday at 10 a.m. and another on Thursday at 2 p.m.

You should have all of your employees' mobile phone numbers, and sending them reminder text messages is a sure-fire way to get in front of the ones who may not be as diligent about monitoring their e-mail.

Check your plan materials – Double-check your plan documents for any necessary updates regarding member eligibility, plan benefits, new vendors and name changes to ensure that the current state of your benefits offerings is complete and accurate.

Also, do a final review of your summary of benefits and coverage (SBC) and your summary plan description (SPD) to make sure they reflect any changes from the prior year. This is crucial as both documents are required under the law.

The SPD may include the elements necessary to meet the requirements of the SBC, but it also needs to be a separate document that can be handed out with respect to each coverage option made available to the participants.

To account for the annual open enrollment window, double-check your open enrollment schedule, deadlines, documents and forms, coverage options and changes, phone numbers, and website and mobile information for contacting resources, statement of current coverage, and plan-specific summaries and rates.

See 'Identify' on page 2

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Pharmaceuticals

Large PBMs Balk at Push to Reduce Drug Prices

IN A MOVE that exemplifies the potential conflict of interest that some large pharmacy benefit managers have, the nation's largest PBM earlier this year said it would demand that rebates remain unchanged when drug makers roll out new price cuts.

Drug makers earlier in the year said they would start reducing prices as well as the rebates they pay PBMs to appease lawmakers and the Trump administration, saying it would reduce the cost of medicine for patients.

But not long after the announcement, the nation's largest PBM, United Healthcare, fired off a letter to drug companies telling them that if they planned to reduce prices and rebates they would have to give seven quarters of notice (that's 21 months if you're counting) when they intend to lower prices.

The letter, which was confirmed in news reports in the health care trade press, highlights what many critics say is an inherent conflict of interest among some of the large PBMs operating in the country.

Some background

When PBMs first came on the market, the services they offered were processing pharmacy claims and negotiating discounts on medications for the health insurance companies with which they contracted.

Later though, they found a new way to make money: rebates. They would approach two manufacturers that made similar versions of a drug and play them off against each other to elicit the largest rebate they could. Whichever one offered the bigger rebate would have their pharmaceutical placed on the drug plan's formulary.

The problem is that these large PBMs do not pass on the full rebate to their clients, like health insurance companies and health plan enrollees. Instead, they keep most of the rebate for themselves.

As a result, PBMs with this business model are not motivated to include the lowest-priced drug on their formulary, but rather the one for which they can receive the largest rebate check.

The latest

United Healthcare sent out the letter to drug makers after pharmaceutical manufacturer Sanofi S.A. said it would cut the price of its cholesterol-lowering drug Praluent by 60%. It did so after its competitor Amgen Inc. reduced the price of its cholesterol drug Repatha by the same amount.

United Healthcare's demand that drug companies give 21 months' notice when they plan to reduce prices has caught many drug makers off guard, since many of them have been looking to cut prices as pressure mounts on the industry from Washington.

The dominance of United Healthcare's PBM OptumRX and its competitor Express Scripts means that group health plan enrollees are often left at their mercy, as many large health insurers have contracts with them.

If a drug company does not give the rebate that a large PBM demands, it could lose access to patients – and patients could in turn lose access to that drug. The only way to play the game is to offer a larger rebate and increase prices, which then increases the prices that patients have to pay.

Fortunately, there are a number of smaller PBMs in the marketplace that have different business models that take payers' needs into consideration and aim to reduce the out-of-pocket costs for patients. They contract with employers and insurers directly to make this happen. ❖

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Identify Staff Who Didn't Sign Up for Coverage Last Year

Hit up employees who didn't enroll last year – To make sure you maximize participation and that nobody misses out, run a list of all your staff who didn't sign up for benefits last year so you can approach them individually and convey the importance of securing health coverage.

While you're at it, make sure that all of your new hires in the past year have also signed up for coverage and that you didn't miss them when sending out reminders about open enrollment.

Check compliance with ACA – If you are an "applicable large employer" under the Affordable Care Act, meaning that you have more than 50 full-time or full-time equivalent employees, you are obligated under the law to provide health coverage to your staff that is "affordable" and covers 10 essential benefits.

For your plan to be considered ACA-compliant, it must not cost an employee more than 9.78% of their household income.

ACA refresher – There have been a number of changes to the law during the last few years, the biggest of which is the elimination of the penalties associated with individuals not securing health insurance as required by the individual mandate portion of the law.

Give your staff a last-minute refresher to help them understand how the ACA affects their health insurance – and what the employer's and their obligations are under the law. ❖

Health Insurance

Study Attributes 25% of Health Spending to 'Waste'

A NEW STUDY published in the *Journal of the American Medical Association* estimates that about 25% of all health care spending in the U.S. is attributable to waste in the system.

The study, conducted by health insurer Humana and the University of Pittsburgh School of Medicine, estimated that between $760 billion to $935 billion of health care spending in the country is wasteful.

The study is eye-opening and reflects the need for new approaches in the health care system and how medical care and pharmaceuticals are paid for. It also reflects the tremendous waste caused by complex administrative procedures, which again cries out for changes in the health insurance and care delivery models.

WHERE THE WASTE IS

Administrative complexity: $265.6 billion
Pricing failure: $230.7 billion to $240.5 billion
Failure of care delivery: $102.4 billion to $165.7 billion
Overtreatment, low-value care: $75.7 billion to $101.2 billion
Fraud and abuse: $58.5 billion to $83.9 billion
Failure of care coordination: $27.2 billion to $78.2 billion

"This study highlights the opportunity to reduce waste in our current health care system," William Shrank, MD, lead author and Humana's chief medical and corporate affairs officer, said in a prepared statement. "By focusing on these opportunities, we could make health care substantially more affordable."

With that much waste in the system, the industry is crying out for more efficiency in hospitals, medical services delivery, health insurance and administration across the spectrum.

The researchers said that if the industry worked on concrete solutions, it could reduce waste by up to $282 billion a year.

They identified the most promising areas for reducing waste, and said that value-based care and reimbursement models represent a major opportunity to reduce the greatest source of waste: administrative complexity.

Value-based care

They said that value-based care models could improve administrative coordination in the system, which is currently severely lacking. The researchers wrote:

"In value-based models, in particular those in which clinicians take on financial risk for the total cost of care of the populations they serve, many of the administrative tools used by payers to reduce waste (such as prior authorization) can be discontinued or delegated to the clinicians."

That, they said, would reduce complexity for physicians and give them incentives to reduce waste and improve value in their treatment decision-making.

Using value-based care in which all parties share some in the financial risk would benefit insurers, employers who sponsor health insurance for their workers, hospitals, doctors and patients.

More and more insurers are experimenting with value-based care, which is primarily a payment model that offers financial incentives to physicians, hospitals, medical groups and other health care providers for meeting certain performance measures. Essentially, they are paid based on patient health outcomes.

Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of health care services they deliver. The "value" in value-based health care is derived from measuring health outcomes against the cost of delivering those outcomes.

Other waste

To further reduce waste, the researchers also recommended:

- Addressing the high cost of pharmaceuticals (especially for high-cost specialty drugs).
- Implementing hospital price transparency.
- Implementing market competition policies.
- Improving payer-provider collaboration to reform care coordination, safety and value.
- Implementing new measures aimed at reducing fraud and abuse.❖

Financial Backstop

Are Your Benefits Enough to Help Employees Through a Crisis?

MIDDLE CLASS families are becoming increasingly reliant on workplace benefits to ensure their financial well-being in case of a disability or critical illness.

Simple health insurance is insufficient to carry the load. The loss of a breadwinner's or caregiver's financial contribution through death or disability is often devastating.

A survey by benefits provider Guardian found that families in this category are struggling when it comes to achieving their financial goals. Of those workers surveyed only half believe they would be able to manage if the household lost an income due to death or illness.

Caught in the middle

Families with incomes significantly above $100,000 per year are generally able to create at least some financial cushion against the possibility of death or disability.

They also receive a good deal of advice from financial advisors, accountants and insurance agents in managing their financial affairs.

Working class families — those with incomes below about $50,000 – often are able to access various parts of the social safety net in times of crisis.

The "middle market," in contrast, must make do without the advantages of the more affluent, with fewer privately owned insurance products and services, and without the same access to the social safety net afforded to working class families.

Workplace benefits are critical

According to Guardian's researchers, the middle-market population is overwhelmingly reliant on the quality and breadth of the benefits they receive at work – over and above cash compensation.

Over 80% of middle-market respondents report that they got their health insurance, disability insurance and retirement plan all through their employer.

Meanwhile, six in 10 have no life insurance in place outside of the workplace. This means that a majority of working families are relying entirely on workplace benefits to see them through the death of a family breadwinner.

And in the event of disability ending a breadwinner's income, the situation is even more dire: Only 7% of the middle market owns any kind of disability insurance protection, outside of what they are able to access via their employer.

Are life insurance benefits adequate?

For young families, the primary role of life insurance is to replace the income of a deceased breadwinner. But many employers cap life insurance benefits at $50,000 – the maximum figure that allows employers to deduct premiums as a workplace benefit under IRC 7702.

The actual need for many of these families is several hundred thousand to a million dollars, and occasionally more. That's what it takes to replace the income of a worker who earns $50,000 to $100,000 per year until the children are out of college and a surviving spouse is taken care of.

A solution

One solution is to offer voluntary benefits to workers. These include a menu of benefits, such as:

- Group life insurance
- Group disability insurance
- Long-term care insurance
- Critical illness coverage

Often many of these benefits can be offered at little or no cost to the employer.

Premium costs are simply deducted from the worker's wages and forwarded to the insurance company via payroll deduction. In this way, workers can purchase much more coverage and provide protection for their families – and it doesn't cost the employer a dime.

In some instances, it can even save on payroll taxes. To learn more, call us. ❖