Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Affordable Care Act

Congress Eliminates the 'Cadillac' and Other ACA Taxes

BEFORE THE new year, Congress passed legislation repealing the so-called "Cadillac tax" on generous group health plans, as well as two other taxes, finally putting to bed an issue that has plagued the Affordable Care Act since its inception.

President Trump signed the measure and officially put an end to the much-maligned tax.

Although it had not yet been implemented, employers didn't like the Cadillac and labor unions came out against it as well.

It was so unpopular that Congress voted twice to delay implementation, which was originally set to start in 2018. The latest start date was 2022.

As originally enacted, the Cadillac tax is a 40% levy on the most generous employer-provided health insurance plans – those that cost more than $11,200 per year for an individual policy or $30,150 for family coverage.

It was designed to only tax the portion of the premium that was above the threshold.

Effect of repeal on group plans

The tax would have been levied on health plans, the legal entities through which employers and unions provide benefits to employees.

It would have been paid by employers, but its impact on employees would be indirect and would have depended on how firms and health plan managers responded to the tax in offering and designing benefits.

None of these issues now need to concern employers offering group plans.

The tax was eliminated as part of a $1.4 trillion year-end budget bill that President Trump signed in order to keep the government open.

Below are all the ACA-related taxes that the legislation eliminated:

THREE LEVIES ABOLISHED

- The Cadillac tax, which had been expected to raise as much as $197 billion over 10 years.
- Starting in 2021, the health insurance tax, which had been projected to raise $150 billion over the next decade, and
- The 2.3% excise on the sale of medical devices, which had been expected to generate up to $25.5 billion in the next 10 years.

DEAD AND BURIED: *Cadillac Ranch has a new addition after the final gasp of the Affordable Care Act's Cadillac tax.*

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New Directions

Trends Shaping Health Insurance and Health Care in 2020

AS A NEW decade begins, the health insurance industry is on the cusp of making a leap towards improved, higher-tech management of health plan participants.

A recent paper by Capgemini, an insurance technology and consulting firm, predicts the following trends that will be taking shape in the health insurance industry and how they may affect businesses that are paying for their employees' coverage.

Analysts say these trends could have a significant impact on efforts to reduce the cost of group health coverage, as well as the out-of-pocket expenses of employees covered by those plans.

Realigned relationships

Insurers are trying to shift risk between themselves and pharmaceutical companies in an effort to reduce drug outlays.

The report says insurers are also working more closely with health care providers for early intervention in medical issues that may be facing participants.

Addressing health issues early can reduce long-run treatment costs.

More fluid regulations

As we've seen, just because the Affordable Care Act became the law of the land, the regulations governing health care and health insurance have continued streaming out of Washington.

If the last two years are any guide, this will continue to be the case.

Also, the constitutionality of the ACA is now being litigated once again after an appeals court upheld a lower court's ruling that the individual mandate is unconstitutional.

Increasing transparency

More stringent regulations, along with President Trump's recent executive order to improve price and quality transparency, are forcing the health care industry and insurers to become more transparent in their pricing.

One of the biggest focuses is on the drug industry and the role of pharmacy benefit managers, the largest of which have been criticized for being opaque in their pricing, discounts and how they handle drug company rebates.

Also, insurers are increasingly providing detailed information regarding services covered under their health plans, claims processing and payments.

Additionally, some insurers are helping enrollees to make more informed decisions before they use a health care service by providing digital tools to help them reduce out-of-pocket expenses.

Increased use of predictive analytics

Health insurers are using predictive analytics for risk profiling and early intervention for enrollees with health issues. Predictive analytics provides insurers with insightful assessments of potentially high-risk customers, in order to mitigate losses.

With advancements in technologies such as big data and connected devices, insurers now have access to vast amounts of customer data, which can be used to remind people it's time for their check-ups, medications and other necessary medical services.

Insurers are using predictive analytics to identify and monitor high-risk individuals to intervene early and prevent further complications. This in turn can help reduce claims. ❖

Pharmacy Spend

Finding a PBM That Has Your Interests in Mind

ONE WAY that employers have been trying to fight the spiraling cost of drug costs for the employees covered by their group health plan is to involve a pharmacy benefit manager.

However, the largest PBMs in the nation have come under scrutiny for their opaque pricing practices and how they use drug company rebates, which don't often end up benefiting the end user of medications – your employees.

Three PBMs control more than 80% of the market and they all also have business interests in other parts of the health care supply chain, including owning their own retail pharmacies or they are owned by a larger health insurance company.

They have been accused of having conflicts of interest and being too secretive about how much they themselves pay for the drugs being prescribed to health plan enrollees.

That said, there are a number alternative PBMs expanding in the market that take a different approach to controlling drug costs for your employees.

PBMs are third party administrators of prescription drug programs linked to a health plan. They are mainly responsible for:

- Contracting with pharmacies for network services,
- Negotiating discounts and rebates with drug manufacturers,
- Developing and maintaining the plan's list of covered drugs (a formulary), and
- Processing and paying prescription drug claims.

When shopping around for a PBM, consider looking for one that has the following attributes:

Transparent contracts and payment arrangements

Watch out for contracts that are not transparent in terms of the money flow and whom discounts and rebates are negotiated with. Sometimes contracts can be overly complicated, so as to hide the PBM's revenue streams in the relationship.

You should be on the lookout for contracts that are opaque concerning:

Rebates — These are a form of price concession paid by a pharmaceutical manufacturer to the PBM.

Spread pricing— This occurs when the PBM keeps a portion of the amount paid to it by the health plans or employers for prescription drugs, instead of passing the full payments on to pharmacies.

Look for a PBM that has a clinically driven business model, instead of one driven by revenues from pharmaceutical rebates and other non-transparent income streams.

These alternative PBMs will often focus on carving out the pharmacy benefit from the medical benefit, and they focus on providing superior service with less emphasis on profit margins.

Performance incentives

Many new PBMs have a pay-for-performance business model, which rewards the PBM for the results in yields.

This model can bring more transparency to the PBM's operations and holds it accountable for the quality of its services and the savings it can achieve for the employer and its workers.

These contracts may also have provisions for reducing the PBM's take if prescription drug spending surpasses a guaranteed maximum. Pay also depends on performance guarantees that are tied to better health outcomes and lower costs.

Better coordination

New PBMs are also taking a more hands-on approach to drug spending, particularly by working with pharmacists to coordinate drug care among a patient's doctors, like primary care doctors and specialists.

The pharmacists that the PBM contracts with are the fulcrum of the drug supply chain and have insight into what all a patient's doctors are prescribing them.

The pharmacists and PBM should understand a patient's condition, symptoms, medical history and any other medications they use, in order to help ensure each prescription dispensed is medically appropriate.

It also puts the pharmacist and PBM in a better position to bird-dog medicine abuse or over-prescription of medications. Health plan enrollees benefit from this type of coordination because it can:

- Reduce the risk of side effects and adverse drug reactions.
- Reduce the risk of patients taking a medication that offers little or no benefit.
- Improve treatment and health outcomes.
- Improve their quality of life.
- Reduce the need for repeat visits to the doctor.
- Lower the risk of hospitalization. ❖

Employee Benefits

Substance-Abuse Benefits under Affordable Care Act

ONE LESS-touted aspect of the Affordable Care Act is that it provides employers more tools for assisting employees with substance-abuse problems to seek help.

According to a study by the Substance Abuse and Mental Health Services Administration, 10% of America's workers are dependent on one substance or another.

The study also found that 3.1% have used illegal drugs either before or during a shift.

Also, 79% of heavy alcohol users have jobs, and 7% of them say they've had drinks while on duty.

Drug use and abuse has been on the rise – both illegal drugs and prescription painkiller abuse, the latter of which led a more than a 500% increase in people seeking treatment for addiction to doctor-prescribed opioids between 2008 and 2018.

As an employer, the costs are great if you have someone on staff who has a substance-abuse problem. It behooves you to ensure that the group health plan you offer your workers is comprehensive amid this growing problem.

FAR-REACHING COSTS

Addicted workers have been found to have:

- Lower or lack of workplace productivity;
- Higher health care costs;
- Increased absenteeism and presenteeism;
- Diminished quality control;
- More disability claims;
- Increased workplace injuries;
- Lower morale;
- Higher job turnover; and
- A higher level of workplace theft.

Some employers have tried to help employees tackle their addictions or abuse problems by implementing workplace prevention, wellness and disease-management strategies.

These programs improve health, which lowers health care costs and insurance premiums and produces a healthier, more productive workforce.

Under the ACA, anybody covered by a health plan has access to substance-abuse treatment. That's because the law makes such treatment one of 10 benefits insurance plans must offer.

The ACA requires health plans to pay for prevention and early intervention. Health care plans also have to comply with a "parity" law, which requires them to treat mental health issues the same way they do physical diseases.

What can employers do?

You can start by adding addiction to your prevention, intervention, treatment and disease-management strategies.

Use confidential screenings and assessments. There are a number of screening, brief-intervention and referral-to-treatment modules available to help people confront their drinking or drug use and get the help they need.

Review your policy for coverage. If you have coverage for substance-abuse treatment, employees with addictions will be more apt to seek out help knowing the cost is at least partially covered.

And, importantly, make sure your substance-abuse benefit is robust, and that it covers a full continuum of care.

A strong benefit would include:

- Inpatient care;
- Residential treatment programs;
- Outpatient care; and
- Continuing care for those in need of treatment. ❖