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The Fringe Benefit Bulletin

A discussion of news and information for Individual, Group and Medicare insurances



Health Insurance

New Regulations Proposed for Short-Term Plans

AS PROMISED, the Trump administration has issued proposed rules that would allow individuals to skirt Affordable Care Act regulations and buy short-term, low-coverage health plans.

Under the proposal, individuals would be able to purchase short-term plans that last up to 12 months, compared to the three-month maximum under the ACA.

The proposal would also exempt these short-term plans from ACA rules about what kind of coverage individual health plans are supposed to have, like covering 10 essential health benefits and barring insurers from rejecting individuals with pre-existing conditions.

The administration said short-term plans are meant for people who:

- Cannot afford ACA coverage purchased on exchanges,
- Are between jobs and need temporary coverage that's cheaper than COBRA, or
- Have doctors who are not included in plans offered on public exchanges.

The Department of Health and Human Services predicted that 100,000 to 200,000 Americans would switch from individual market plans to short-term policies thanks to the new rules.

Short-term health insurance covered 148,118 people in 2015, according to the National Association of Insurance Commissioners.

Under the proposed rules, insurance companies would be required to prominently display in the contract and application materials that the policy is exempt from ACA protections.

Who would buy these plans?

Short-term health insurance is meant to provide temporary coverage for people transitioning between traditional health policies, perhaps because they are changing jobs.

Short-term plans are usually accepted at more doctors' offices and hospitals compared with traditional insurance plans, which are often limited to narrow networks. And they are usually cheaper.

Healthier and young individuals who don't think they need full coverage would likely choose these types of plans, which would pull them from the ACA markets. If that happened, marketplace plans could be left with an older and less healthy pool of covered individuals, which would likely force them to raise rates.

Short-term insurance plans cost an average of 25% less than bronze plans on the individual marketplace, or $65 less per month, according to data from AgileHealthInsurance.

The pricing is low because these plans don't offer the 10 essential health benefits as normal ACA-regulated plans do (things like pregnancy care and mental health treatment) and they are not required to cover pre-existing conditions.

Currently, there are only a few players in the short-term health plan market, as the ACA allows individuals to carry short-term insurance plans for a maximum of three months. But, since the Trump administration announced in October 2017 that it would propose new regulations for short-term plans, more carriers have been exploring entering the market.

Two major industry lobby groups – America's Health Insurance plans and the Blue Cross Blue Shield Association – have warned that the plans could harm state insurance markets. ❖

Fringe Benefit Services INCORPORATED

CONTACT US

If you have questions regarding any of the articles in this newsletter or have a question about any of your policies, please call us at:

Fringe Benefit Services, Inc.

79 East Connelly Boulevard
Sharon, Pennsylvania 16146
Phone: 724-981-3300, 800-732-9281

Affordable Care Act

'Cadillac Tax' Delayed Again – for Another Two Years

PART OF the funding bill that reopened the federal government at the end of January further delayed the implementation of the so-called "Cadillac tax" on employer-sponsored health plans – this time by two more years.

That means the excise tax will instead take effect on the most expensive of employer-sponsored plans in 2022. Employers and labor groups have generally applauded the delay, but are still calling for its complete elimination.

The Affordable Care Act imposes an annual 40% excise tax on plans with annual premiums exceeding $10,800 for individuals or $29,500 for a family, starting in 2020, to be paid by insurers. The tax only applies to the portion of the premium that exceeds the threshold amount.

While the tax would be levied on insurers, they would pass the cost on to policyholders.

The premium is the total amount that the insurer charges, regardless of how that premium is shared between the employer and employees.

American Benefits Council president James A. Klein says the move to delay implementation of the 40% tax on the most expensive plans until 2022 was crucial for maintaining strong worker benefits.

"Because companies typically make health plan decisions 18 to 24 months in advance, employers were reluctantly considering curtailing benefits or increasing workers' out-of-pocket costs to meet the prior 2020 deadline," he said.

Insurer, employer and labor groups have argued that if the law goes into effect, many employers would choose to reduce benefits in order to fall under the Cadillac tax threshold.

Almost a quarter of employers that provide health insurance to their workers were likely to be hit by the tax in the first year, according to an analysis by the Society of Human Resources Management.

The Cadillac tax was originally set to take effect in 2018. However, in December 2015, a law delayed the start date to 2020. The recent action puts that off to 2022.

Although there is wide bipartisan support for repealing the tax, Congress has been unable to pass legislation doing so because of disagreements over how to replace the future lost revenue to government coffers.

The takeaway

So for now, unless it is revoked, as an employer you should take this tax into consideration if you are making changes to your plan design.

Stay mindful of your health insurance costs and keep track of federal guidance/legislation that may alter the tax.

We will also continue keeping you informed of any legal or regulatory changes affecting the ACA, and how they impact your organization. ❖

Changing Coverage

Choosing the Right Medicare Advantage, Drug Plan

ARE YOU turning 65 in the next year? If so, it's time to consider your Medicare options. Here are the facts:

At age 65, you are eligible for Medicare Part A, hospitalization coverage, which is free for most enrollees, and Part B, which covers lab fees, physician's fees and medical equipment. There's a premium for Part B.

If you want additional benefits, you need to opt into a Medicare Advantage plan (part C), and a prescription drug plan (Part D).

Medicare Advantage

Medicare Advantage, or Part C, allows you to access your Medicare benefits via a more comprehensive managed care plan. Insurers have varying premium levels and benefit levels to fit different budgets and needs.

They come in the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Each sponsoring company has to provide at least the standard benefits available under Part A and Part B, and every Medicare Advantage carrier must be approved by Medicare to provide benefits.

In addition to the basic Medicare benefits, Medicare Advantage plans may also provide additional benefits, such as dental, vision, expanded hospitalization benefits, or more focused care for those with special medical needs, such as diabetics.

Premiums vary, depending on your plan and location. You can't be turned down for Medicare Advantage, but you may have to pay extra if you don't sign up when you're first eligible.

Note: Don't get Medicare supplemental coverage if you already have a Part C plan. You don't need both kinds of coverage.

Some things to keep in mind:

- You can only enroll during your open enrollment period, during certain times of the year based on specific circumstances.
- Once you enroll, you stay in the plan for that calendar year.
- Plans cover different procedures and treatments. Look at their list of exclusions, or check with the plan before getting treatment.
- Managed care plans typically come with a list of authorized providers. If you have a preferred physician or other care provider, consult your plan network to ensure your preferred provider is a member of the network.
- You may need to get a referral from a primary care physician before seeing a specialist, a common arrangement in HMO plans.

Medicare Part D

Medicare Part D is the federally subsidized prescription drug program.

You aren't automatically enrolled in Part D when you turn 65; you must specifically opt in to the program and apply for benefits.

In some cases, though, your Part C, or Medicare Advantage plan, will provide prescription drug coverage as part of the plan. In other cases, you may enroll in Part D by itself (a Part D "standalone" plan).

Medicare Part D requires a premium. That premium varies by plan, though.

The more benefits and fewer exclusions the plan offers, the higher your monthly premium is likely to be.

Enrolling

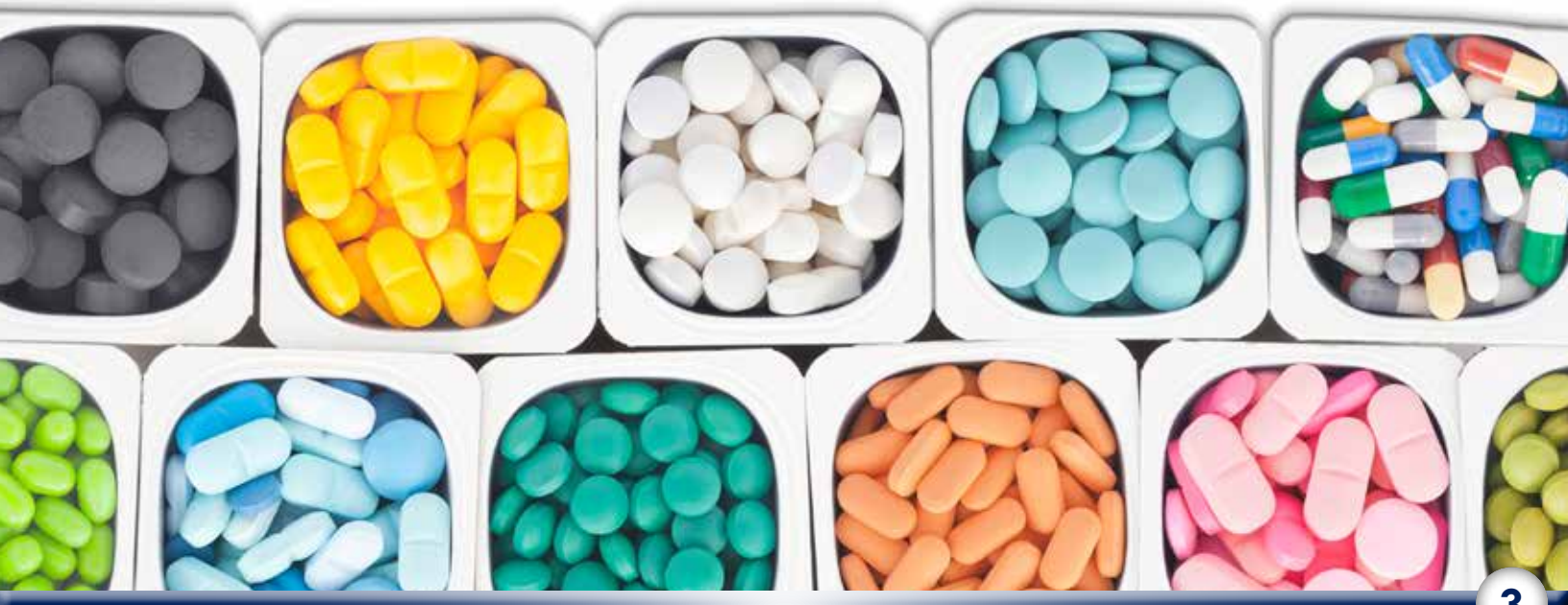
Generally, you can enroll in Medicare Part D during the 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you don't join during this initial enrollment period, you will generally have to pay higher premiums.

You must also wait until the annual open enrollment period to sign up for benefits. Usually, this period runs from Oct. 15 through Dec. 7.

To avoid paying penalties and higher premiums, ensure that you don't have a break in credible coverage before signing up for a new Part C or Part D plan.

Additional rules and provisions apply for special situations, such as if you relocate, or your plan's contract with Medicare changes. ❖



Amazon, JP Morgan, Berkshire

Big Hitter Tie-up Could Shake up Health Care

IN A MOVE that could either reshape health care delivery in America or barely register as a blip, three corporate and financial giants have unveiled a new company that they hope will reduce health care costs.

Amazon, Berkshire Hathaway, and JPMorgan Chase, which seem to have had enough with high health insurance costs for their employees, are instead taking the bull by the horns and say they will take a new approach to health care for their workers.

In announcing the venture, Berkshire Hathaway chairman and CEO Warren Buffett said that continuously climbing health care costs are "a hungry tapeworm on the American economy."

The move was greeted with excitement, with hopes that the trio of big hitters could bring an innovative approach to cost-containment that could be replicated for other employers around the country.

Without providing much in terms of details, that said they would leverage their combined scale and expertise to develop technologies that would allow their employees and dependents to enjoy "simplified, high-quality, and transparent healthcare at a reasonable cost."

Many observers are hoping that fresh sets of eyes will be able to take a creative approach to funding insurance coverage and delivering health care for less as cost inflation continues unabated.

The big question is how they will be able to influence pricing, particularly considering that there have been many different approaches to funding reimbursement to providers and none has yielded a method that seriously controls costs and cost inflation.

Tackling costs from the tech angle

The trio of companies, however, seems to be more interested in approaching the cost question from the technology angle. Amazon is already heavily involved in tech and e-commerce, and the banking industry (of which Chase is a member) is light years ahead of the health industry in terms of technology and user-friendly consumer interfaces.

Berkshire Hathaway brings capital to the equation.

Also, the companies have more than 1 million employees combined, which would allow them to wield significant clout in negotiating contracts with hospitals, pharmacies, and doctor networks. They could use this to hold them accountable for billing as well as health outcomes.

The tie-up could also focus on runaway pharmaceutical costs.

During much of 2017, it was rumored that Amazon was considering a move into the pharmacy business and it could be able to use its clout to possibly sway drug prices.

One analyst told the *New York Times* that we could see the new company introduce "an online health care dashboard that connects employees with the closest and best doctor specializing in whatever ailment they select from a drop-down "menu."

Perhaps the companies would strike deals to offer employee discounts with service providers like "medical testing facilities."

The companies said the initiative would be "free from profit-making incentives and constraints."

If the three giants develop a health care organization without a profit motive and instead an aim to shave health care costs, it could bring about serious savings. There are many parts of the health care industry that are high-cost, high-margin sectors that thrive on significant markups.

Jamie Dimon, chief executive of JPMorgan Chase, said in a statement that the effort could eventually be expanded to benefit all Americans.

For now, it's early days and as we learn more about this interesting new venture, we'll keep you abreast of developments. ❖