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The Fringe Benefit Bulletin

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



Health Insurance

New Rules Lay Down Law for Group Plans in 2019

THE CENTERS for Medicare and Medicaid Services (CMS) has released new regulations for small group health insurance plans and other matters stemming from the Affordable Care Act.

The new rules are part of the Trump administration's effort to dismantle the ACA after numerous GOP efforts to repeal the law failed in 2017.

The rules give states more control over which essential health benefits plans must offer and set new cost-sharing limits.

The move will have varying effects depending on the state, but the end result will mean more lax regulation of the ACA for individual and small group plans.

Power to the states

The new rules allow states to determine which essential health benefits individual and small group plans must offer, effective 2020.

Plans still have to offer the 10 essential benefits required by the ACA, such as maternity care or mental health coverage, but a new rule expands the these benefits to 50 options, allowing states to build their own set of benefits that could become the benchmark plan.

Once one state has adopted additional benefits, it will be easier for other states to follow suit and use the rules adopted in another state.

These rules will have a widespread and major impact on health insurance access and benefits in many or virtually all states.

Annual cost-sharing limits

The maximum annual limit on cost-sharing for 2019 will jump to $7,900 for self-only coverage and $15,800 for other than self-only coverage.

That's up from $7,350 and $14,700, respectively, for this year.

Grandfather extension

CMS has extended the transitional policy that allows states to permit insurers in small group markets to renew health insurance policies they would otherwise have to cancel because they don't comply with parts of the ACA.

Grandfathered health plans under the ACA are those existing without major changes to their provisions since March 23, 2010, the date of the ACA's enactment.

This means that insurance companies that have continually renewed eligible non-grandfathered individual and small group policies, can again renew those policies, provided that the policies end by Dec. 31, 2019.

Grandfathered plans are not required to meet a number of ACA requirements, including:

- Coverage of preventive care without employee cost-sharing, including contraception for women.
- Limitations on out-of-pocket maximums.
- Essential health benefits, metal levels and deductible limits. ❖

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Affordable Care Act

Medicare Advantage Plans Get Big Boost for 2019

REFLECTING HEALTH care cost trends, the Centers for Medicare and Medicaid Services has issued a final rule increasing payments to Medicare Advantage plans to 3.4% in 2019.

The announcement was part of a larger one on changes that will affect Medicare Advantage plans starting 2019, including more lax rules on what can be covered expenses for medical purposes.

The substantial increase is almost double the 1.84% hike the CMS had proposed in February. The 3.4% increase compares to the 2.95% that the payments were increased to in 2018, from the year prior.

But because of other changes the CMS made in its final rule to how it uses certain data to calculate patient "risk-adjustment scores," the effective increase could be closer to 6.5%, on average, according to the agency's announcement of the changes.

The payments that are being increased are made to the health insurers that administer Medicare Advantage plans. Medicare Advantage health insurers are paid a set rate by the government to help cover members' health care costs.

The rate also affects how much insurers charge for the policies. The increase should help offset part of any premium increases, and the increased level should temper some of the inflationary pressures that all payers are feeling in the health care sector.

Risk-adjustment scoring

Another factor that will affect premiums and how much CMS pays out to health plans is how "risk scores" are calculated.

Payments to Medicare Advantage plans are influenced by risk scores, which take into account differences in patients' medical diagnoses and health outcomes. The sicker the patient, the higher the risk score assigned.

In its announcement, the CMS said it would increase the use of encounter data to determine risk scores for plans. Under the final rule:

- Traditional fee-for-service data will account for 75% of Medicare Advantage risk scores (it's 85% for 2018), and
- Encounter data will account for the remaining 25% (compared to 15% in 2018).

The effect, experts say, will likely be a further increase in payments, perhaps by as much as another 2 percentage points.

New covered items

Starting in 2019, new benefits for Medicare Advantage plans may include such items as covering special air filters for air-conditioners for people with asthma and allergies, healthy groceries, rides to medical appointments and home-delivered meals.

The CMS expanded how it defines the "primarily health-related" benefits that can be included in Medicare Advantage policies.

Many Medicare Advantage plans already offer health benefits not covered by traditional Medicare, like eyeglasses, hearing aids and dental care. But the new rules will expand that significantly to items and services that may not be directly considered medical treatment. ❖

Health Insurance

Proposed Association Plan Rules May Invite Fraud

PROPOSED REGULATIONS that would allow small businesses and individuals to band together to purchase group coverage could open up a new era of fraud in U.S. health insurance, according to comments filed by a number of groups.

Former Department of Labor officials, insurance companies and employee advocacy groups sounded the warning in letters to the DOL during the proposed regulations' comment period, which ended March 6, according to a report by Bloomberg Law.

They said that twice in the past when similar rules were ushered in, they were followed by a wave of fraud and abuse that could leave workers without coverage, according to the report.

In the past, when small groups were allowed to band together to compete with health plans, they didn't work. And when association health plans offering skimpier benefits have operated, covered individuals were often left holding the bag.

The Government Accountability Office found that 200,000 people ended up owing $252 million in unpaid health care bills after buying plans from bogus group plans between 2000 and 2002, the DC Health Benefit Exchange Authority pointed out in its comments to the DOL.

Between 1988 and 1991, more than 400,000 people suffered the same fate, according to a 1992 GAO report that DC Health cited.

Over the past few decades, there have been dozens of lawsuits and enforcement actions taken by regulators against these loosely assembled association plans.

Often the plans are pushed by unscrupulous promoters who sell the promise of inexpensive health benefit insurance, but default on their obligations. The DOL in a number of these cases found that the people behind these plans diverted premiums to their personal use.

The department last year sued an association health plan for 300 small employers in Washington State, accusing its managers of mismanaging the plan's assets and charging employers more than $3 million in excessive "administrative fees."

Under current law and regulations, when small businesses with no connection with one another buy coverage through an association they are individually still treated as a small employer, which means the coverage has to comply with the Affordable Care Act.

But that could change under the executive order directing the federal government to expand small businesses' access to association health plans.

There has also been concern that the proposed final rule actually violates the ACA, as it would allow small employers and individuals to form groups that would be treated as "large employers" and hence not be subject to the ACA's coverage criteria.

Over the years, the DOL has established a serious test for association plans, including that they can only be formed by a "bona fide group or association" of employers who are tied together by genuine economic interests other than just providing insurance to their employees.

To avoid these problems, some commenters recommended that the final rule should give states oversight of these plans.

Without local oversight, it will be easy for fraudsters to flourish. ❖

Voluntary Benefits

Five Ways Employers Can Save on Health Care Costs

IN RECENT YEARS, many companies have been dealing with rising health care costs largely by transferring more of the expense and risk on to their employees.

But some employers have found smarter, more creative ways to limit health costs without further burdening valued employees. Here are some of the best solutions:

1. Pharmacy benefit managers

Pharmacy benefit managers are independent third party administrators that work with pharmacists, employers and workers to reduce costs and inefficiencies.

They may help workers migrate from expensive brand name drugs to equally effective generics for a fraction of the cost. Or they may be able to migrate workers from bricks-and-mortar pharmacies to mail order. They also assist employers with contract negotiations.

2. Telemedicine

Some companies are contracting with doctors to provide health services online, via a video feed.

It's no substitute for an in-person examination, but workers can get consultations and routine assessments done and get a prescription for a fraction of the cost of an in-person visit.

Furthermore, the worker doesn't have to take time off work for an appointment. It can be done from the office.

A typical insurance billing for a basic medical appointment can run as high as $150. On the other hand, a telemedicine visit can cost about a third of that amount, according to *U.S. News*.

3. Wellness programs

Healthy employees cost much less than sick ones over time. Smokers and the obese generate much more frequent and higher medical claims than normal-weight employees.

Employers are fighting back by offering access to smoking cessation and weight loss programs, as well as programs for managing conditions such as high blood pressure, diabetes and asthma.

About 58% of health plans nationwide offer an incentive for participating in a wellness program, according to research from CEB, the best-practice insight and technology company.

4. Consumer-directed health plans

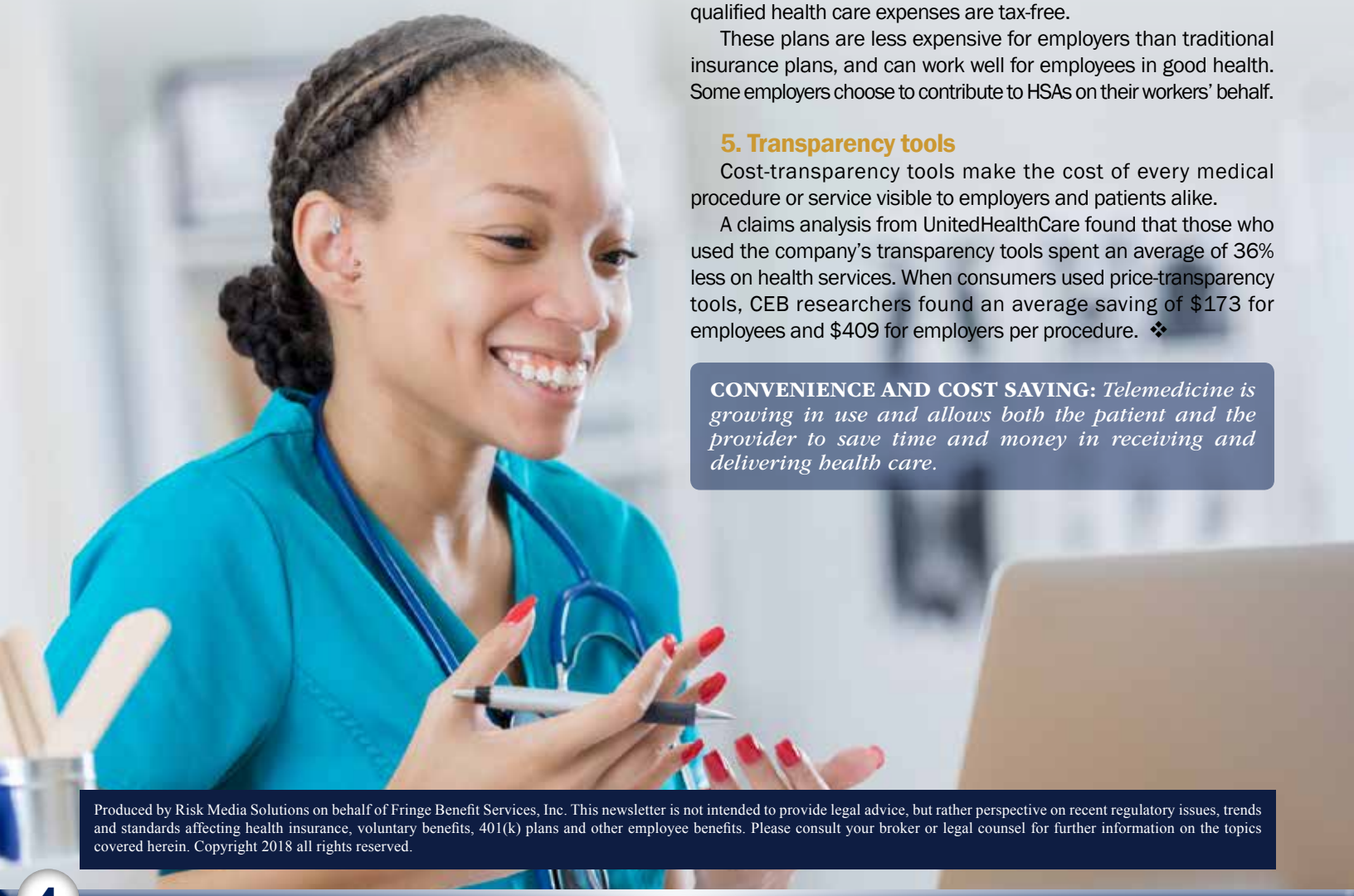
Employers are also giving employees greater control over their spending decisions with high-deductible health plans combined with health savings accounts. The employee or employer can contribute pre-tax dollars to an HSA. Withdrawals from an HSA to pay for qualified health care expenses are tax-free.

These plans are less expensive for employers than traditional insurance plans, and can work well for employees in good health. Some employers choose to contribute to HSAs on their workers' behalf.

5. Transparency tools

Cost-transparency tools make the cost of every medical procedure or service visible to employers and patients alike.

A claims analysis from UnitedHealthCare found that those who used the company's transparency tools spent an average of 36% less on health services. When consumers used price-transparency tools, CEB researchers found an average saving of $173 for employees and $409 for employers per procedure. ❖



CONVENIENCE AND COST SAVING: *Telemedicine is growing in use and allows both the patient and the provider to save time and money in receiving and delivering health care.*