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BARNARD INSURANCE GROUP

THE BARNARD BULLETIN

NEW SERVICE

Blue Cross Blue Shield of Texas Now Offers Virtual Visits

Blue Cross and Blue Shield of Texas now offers enrollees access to care for non-emergency medical issues and behavioral health needs through virtual doctor visits.

The MDLIVE service is available 24 hours a day, seven days a week, allowing you to speak to a doctor via video conferencing. You can speak to a doctor immediately or schedule an appointment.

THE SERVICE IS EASY TO USE

CONNECT
Access using the BCBSTX app, which gives you access to online video meetings. Or you can call.

INTERACT
Real-time consultation with a board-certified doctor or therapist.

DIAGNOSE
Prescriptions sent electronically to a pharmacy of your choice.

MDLIVE PHONE NUMBER 888-680-8646

REGISTER TODAY
To register, you'll need to provide your first and last name, date of birth and BCBSTX member ID number.

CONTACT US

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AFFORDABLE CARE ACT

DOJ Tells Court to Nullify ACA; What's Next?

AFTER A PERIOD of relative stability, the future of the Affordable Care Act has been thrown into uncertainty.

In a surprise move, the Department of Justice announced that it would not further pursue appeal of a ruling invalidating the Affordable Care Act and instead asked an appeals court to affirm the decision.

U.S. District Court Judge Reed O'Connor ruled last December that when Congress eliminated the penalty for not complying with the law's individual mandate, it had in fact invalidated the entire law.

But even though the DOJ won't be pursuing defense of the law and challenging the ruling on appeal, a number of states' attorneys general have stepped up to fight the ruling.

What this means for the future of the employer mandate is unclear as the court process still has a long way to go. The ruling could be overturned on appeal, and invariably whatever the 5th Circuit decides, the case will likely be appealed to the U.S. Supreme Court.

Already there has been fallout in the private health insurance market since the individual mandate penalty was eliminated, but the employer mandate, which requires that organizations with 50 or more full-time or full-time-equivalent workers offer health coverage to their employees, remains intact.

As the case winds on, it will be some time before anything changes. The 5th Circuit has not yet scheduled arguments.

Despite the DOJ's announcement, the law stands and applicable large employers must continue complying with its requirements.

Analysis

The move was surprising because in the past President Trump had signaled that he wanted to keep parts of the ACA, particularly the barring of insurers from denying coverage based on pre-existing conditions.

If the entire law is scrapped, so will that facet – as well as other popular provisions, like allowing adult children to stay on their parents' policy until the age of 26.

Trump said his administration has a plan for something much better to replace the ACA.

Democrats have introduced legislation that aims to cut premiums for individuals buying on exchanges by expanding premium tax credits.

Another bill would reaffirm the pre-existing condition protections, and restore enrollment outreach resources, which have been cut back under the Trump administration.

But with a divided Congress, the chances of anything reaching Trump's desk are slim.

ACA tribulations

Meanwhile, the success of the ACA has been spotty. In some parts of the country, usually in areas with high population density, competition among plans ensures lower prices for people shopping on exchanges. But in smaller regions, cost increases are rampant.

A new analysis by the Urban Institute, a liberal-leaning think-tank, finds that more than half (271) of the country's 498 rating regions have only one or two insurers participating in the ACA marketplace. Those regions are disproportionately in sparsely populated areas.

Regions with little competition tend to have much higher premiums. In a region with only one insurer, the median benchmark plan for a 40-year-old nonsmoker is $592 a month.

That compares to $376 for a person in a region with at least five plans. ❖

COST CONTAINMENT

Helping Your Staff Save Money on Pharmaceuticals

RETAIL PRESCRIPTION drug spending grew 36% over the four-year period ended Dec. 31, 2016, but out-of-pocket spending for health plan enrollees remained steady, according to a recent study by The Pew Charitable Trusts.

The study, "The Prescription Drug Landscape, Explored," found that patients are covering the lion's share of the cost through higher premium outlays, while large pharmacy benefit managers are passing on a larger portion of the manufacturer rebates they receive to insurance plans.

Why out-of-pocket spending is stable

The study found health plan enrollees have largely been sheltered from rapidly rising drug costs due to:

- More of the health insurance premium being dedicated to pharmacy benefits. The percentage of health insurance premiums allocated to pharmacy benefits increased to 16.5% in 2016 from 12.8% in 2012.
- Policies that cap out-of-pocket expenses.
- Cost-sharing assistance from manufacturers (like Medicare Part D coverage gap discounts and copay coupons).

Overall health retail prescription drug spending grew to $341 billion in 2016 from $250.7 billion in 2012. Here's who spent what:

Patients: $103.8 billion – This includes the percentage of the premium they pay that goes towards drug benefits, in addition to out-of-pocket spending.

Employers: $97.5 billion – The premiums that employers pay that go towards drug benefits.

Government: $139.8 billion – This is both federal and state spending on retail drug coverage through Medicare Part D, Medicaid fee-for-service, and the share of premiums for retail drug coverage in Medicaid managed care.

Employers displeased with pharmaceutical supply chains

- 14% said the pricing and rebate system needed to be more transparent.
- 35% said rebates needed to be reduced.
- 50% said the pharmaceutical supply chain was inefficient and too complex and needed to be overhauled and simplified.
- 56% said rebates were not an effective tool for helping drive down costs.
- 53% said rebates did not benefit customers at the point of sale.

Source: National Business Group on Health survey (2018)

Tackling drug costs

The National Business Group on Health study also looked at what employers are doing to combat drug costs, including:

- Adopting recently developed capability by pharmacy benefit managers to pull rebates forward at the point of sale to benefit enrollees.
- Implementing point-of-sale rebates to benefit the enrollees.
- Educating employees about the value of buying generic, so they can save money. According to the Federal Drug Administration, generic medications save more than $150 billion annually.
- Half-tablet programs – These programs aim to reduce the number of tablets participants consume, while still receiving the same strength of medication. For instance, individuals might need 15 milligrams of a daily medication, so they receive a prescription for 30 tablets.

  With the half-tablet program, individuals would receive a prescription for 15 tablets, with 30mg strength each. Instead of taking one daily, they would only take half of a tablet. Despite the higher-strength pills, participants in this program only pay half of their usual prescription copay because they are receiving half the number of tablets. ❖

ACA COMPLIANCE

Regulators Take Steps to Help Grandfathered Plans

REGULATORS ARE in the early stages of creating rules that make it easier for health plans that were grandfathered in before the Affordable Care Act took effect to continue providing coverage.

The number of workers enrolled in plans that were in effect before the ACA was enacted in 2010 has been shrinking, and as of 2018 some 16% of American workers who were enrolled in group health plans were in grandfathered plans.

Under the ACA, those plans do not have to abide by the same regulations as plans that took effect after the law's implementation.

In February 2019, the Internal Revenue Service, the Employee Benefits Security Administration and the Health and Human Services Department issued a request for information from grandfathered plans. The goal is to determine whether there are opportunities for the regulators to assist plans to preserve their grandfathered status in ways that would benefit employers, employees and their families.

While the effort will only affect a small amount of employer-sponsored plans, the move is significant as it looks like the ultimate goal is to further loosen rules for grandfathered plans.

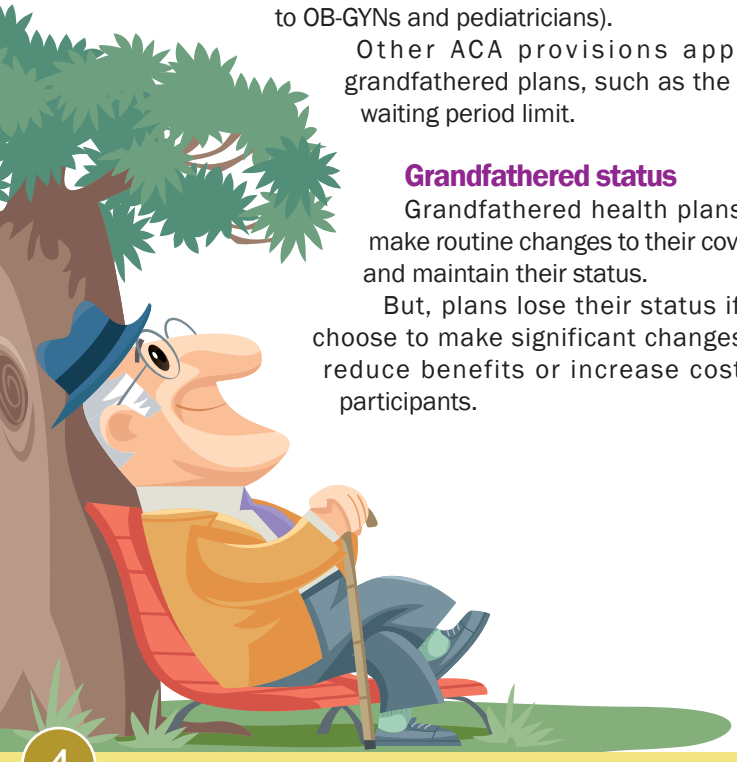
A plan is considered grandfathered under the ACA if it has continuously provided coverage for someone (not necessarily the same person, but at all times at least one person) since March 23, 2010, and if it has not ceased to be a grandfathered plan during that time.

Grandfathered plans have certain privileges that other group health plans that were created after that date do not have, as the latter are all required to comply with all of the rules under the ACA.

Under the ACA, grandfathered plans do not have to comply with certain provisions of the law.

These provisions include coverage of preventive health services and patient protections (for example, guaranteed access to OB-GYNs and pediatricians).

Other ACA provisions apply to grandfathered plans, such as the ACA's waiting period limit.



Grandfathered status

Grandfathered health plans may make routine changes to their coverage and maintain their status.

But, plans lose their status if they choose to make significant changes that reduce benefits or increase costs for participants.

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Questions for plan administrators

Some of the questions that the three departments are asking plan administrators are:

- What actions could the departments take to assist group health plan sponsors and group health insurance issuers preserve the grandfathered status of a group health plan or coverage?
- What challenges do health plans and sponsors face regarding retaining the grandfathered status of a plan or coverage?
- What are your primary reasons for retaining grandfathered status?
- What are the reasons for participants and beneficiaries remaining enrolled in grandfathered group health plans if alternatives are available?
- What are the costs, benefits and other factors when considering whether to retain grandfathered status?
- Is preserving grandfathered status important to group health plan participants and beneficiaries? If so, why? ❖