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Coverage Trend

Health Plans Cover Fewer Drugs, Add More Restrictions

AS PRESCRIPTION drug costs continue growing and pricey new pharmaceuticals add to health plans' and patient cost burdens, some insurers are starting to reduce the number of medications they'll cover and are imposing new restrictions.

According to a new study by GoodRx, Medicare Part D insurance companies in 2024 cover 54% of all drugs approved by the Food and Drug Administration, compared to 75% in 2010.

During that same time, the percentage of drugs that Medicare drug coverage plans put restrictions on rose to 50% from 25% of all FDA-approved drugs.

GoodRx notes that the statistics are likely worse for group health plans because they are not subject to the same regulations as Medicare plans are.

This trend makes it vitally important that your employees review formularies of covered medications during open enrollment to ensure they choose a health plan that covers drugs they may need for a chronic condition, or which they need to take regularly for other issues.

Formularies explained

The list of drugs that an insurance plan will cover or pay for is called a formulary. Pharmacy benefit managers, which health insurers contract with to manage drug costs, set these formularies, which determine how much a patient will pay out of pocket for their medication.

PBMs regularly add and remove drugs on their formularies based on their effectiveness, price, demand and available alternatives.

These formularies also dictate copays and coinsurance — the patient's out-of-pocket costs for each drug.

Getting squeezed

The title of the GoodRx report — "The Big Pinch" — reflects the trend of patients being pinched between high drug costs and limiting coverage through prior authorizations.

Copays and coinsurance have been increasing since 2010. As well, more American workers are now in high-deductible health plans, which feature more out-of-pocket costs in exchange for lower premiums.

Also, a growing number of people have a separate deductible applied to prescription medications. These deductibles can be anywhere from $134 to $465 per month.

On top of it all, pharmaceuticals are getting more expensive.

Meanwhile, prior authorization rules imposed by PBMs and health plans increasingly require doctors to justify why they are prescribing a medication, which may cause delays and make it more difficult for patients to receive drugs. Also, if patients encounter too many problems trying to fill a prescription, they may opt for paying out of pocket, which means absorbing the exorbitant cash price of the drug.

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What Your Workers Need to Know About Group Life Insurance

VOLUNTARY LIFE insurance is offered to employees as an optional benefit, and often employers will pay the small premium as an employee retention tool and to provide workers some peace of mind for their families.

There are various avenues for funding these group plans, and different underwriting criteria that can either reduce or increase the premium amounts.

The employer may cover the premium directly, or employees may share in the premium burden through payroll deductions after tax. In most cases, life insurance face amounts will vary from policy to policy and will usually be based in part on each employee's base salary.

Taxation

Employers often provide group term life insurance to their employees at no cost to the individual, usually with a benefit equal to a percentage of base salary.

Internal Revenue Code Section 79 governs the taxation of this employer-provided life insurance. An employee can receive up to $50,000 worth of coverage tax-free.

The cost of any insurance above $50,000, less any amount paid for the insurance by the employee, is taxable income to the employee.

Types of group life insurance

There are three different categories for group life coverage, as follows:

Guaranteed underwriting – Automatic enrollment is granted to all eligible employees who apply. But they must meet eligibility requirements that the employer and insurance company negotiate.

Guaranteed underwriting requires little paperwork, there is no medical exam and it is issued quickly. It is usually only provided for large groups where employees cannot be denied.

To qualify for guaranteed issue, employers usually agree to a minimum percentage enrollment.

Simplified underwriting – There is no blood test, no urine test and no medical exam is required. Each applicant usually answers several health-related questions in addition to agreeing to a medical record background check.

Full underwriting – Medical exams are typically required, and a full examination is taken to satisfy the full records check requirement. Full underwriting is usually required with small groups, with individuals or on larger face amounts.

Because of the more thorough vetting, the application process takes longer to complete and not all people will qualify.

Why offer group life?

Premiums are typically quite low and that's why employers will often offer this benefit at no cost to their employees.

It's a great selling point when attracting new talent and retaining your staff.

It also benefits those employees who otherwise would not purchase life insurance on their own, either because of apathy or they may not be able to afford individual life insurance policies.

Group life also allows higher-risk individuals to be given life insurance coverage where they may have a harder time obtaining coverage on their own.

As a rule, experts recommend people purchase eight to 12 times their yearly wages in life insurance when working full time. If workers are young and have a long career ahead of them, experts recommend they purchase even more coverage. This is especially true for people with multiple dependents. ❖

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Help Your Workers Pick the Plan That's Right for Them

Lending employees a hand

For workers who are healthy and young, these increasing restrictions may not have a great effect on their pocketbooks and quality of life. But for individuals with chronic conditions and other health problems that require certain medications, it's vitally important that they are diligent and do their homework during open enrollment to ensure continued access to the medications they need.

If they want to stay in their existing plan, they need to review the formulary every open enrollment to make sure their drug is still covered. And if they are looking to change plans, they'll need to do the same homework. You can offer them help in navigating open enrollment through training and personal assistance.

If an employee is struggling to pay for their medications, they may need to scale up to a more generous health plan, but it will likely cost them more in higher premiums in exchange for a lower deductible and/or lower copays and coinsurance. That's the trade-off.

The worst thing is to choose a plan that doesn't cover medications they've come to rely on, or if their plan drops their medication. ❖

Preparing for 2025

Getting a Head Start on Open Enrollment

AS OPEN ENROLLMENT is right around the corner, now is the time to gear up to maximize employee enrollment, help them make the best selections for their own personal circumstances, and stay compliant with relevant laws and regulations.

It's a lot to take in as uncertainty has been a constant during the last few years with the COVID-19 pandemic and its lingering effects on people's health and the economy.

Still, since health coverage and other employee benefits are an important part of your compensation package — and your competitive edge for talent — it's important that you get it right, particularly now with the intense competition for talent.

Here are some pointers to make open enrollment fruitful for your staff and your organization.

Review what you did last year

Review the results of the previous year's open enrollment efforts to make sure the process and the perks remain relevant and useful to workers. How effective were various approaches and communication channels, and did people give any feedback about the process itself?

Start early with notifications

You should give your employees notice at least a month before open enrollment to let them know it's coming, as well as provide them with information on the various plans you are offering. Encourage them to read the information and come to your human resources point person with questions.

Help them sort through plans

You should be able to help them figure out which plan features fit their needs, and how much the plans will cost them out of their paycheck. Use technology to your advantage, particularly any registration portal that your plan provider offers. Provide a single landing page for all enrollment applications.

That said, you should hold meetings on the plans and also put notices in your employees' paycheck envelopes.

Plan materials

Communicate to your staff any changes to a health plan's benefits for the 2025 plan year through an updated summary plan description or a summary of material modifications.

Confirm that their open enrollment materials contain certain required participant notices, when applicable — such as the summary of benefits and coverage.

Check grandfathered status

A grandfathered plan is one that was in existence when the Affordable Care Act was enacted on March 23, 2010 and is thus exempt from some of the law's requirements. If you make certain changes to your plan that go beyond permitted guidelines, the plan is no longer grandfathered.

If you have a grandfathered plan, talk to us to confirm whether it will maintain its grandfathered status for the 2023 plan year. If it is, you must notify your employees of the plan status. If it's not, you need to confirm with us that your plan comports with the ACA in terms of benefits offered.

ACA affordability standard

Under the ACA's employer shared responsibility rules, applicable large employers must offer "affordable" plans, based on a percentage of the employee's household income. For plan years that began on or after Jan. 1, 2024, the affordability percentage is 8.39% of household income. The 2025 treshhold has yet to be set.

Out-of-pocket maximum

The ACA's out-of-pocket maximum applies to all non-grandfathered group health plans. The limit for 2025 plans is $9,200 for self-only coverage and $18,400 for family coverage.

Make sure your plans are in line with these figures.

Other notices

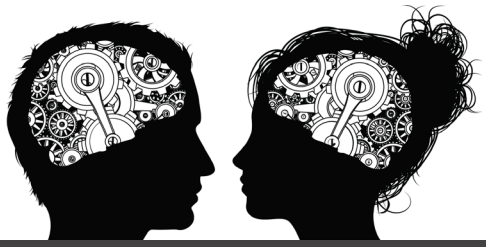
Consider also including the following notices:

- Initial COBRA notice.
- HIPAA notice. This may be included in the plan's summary plan description.
- Notice of HIPAA special enrollment rights.
- HIPAA privacy notice.
- Summary plan description.
- Medicare Part D notices.

Get spouses involved

Benefits enrollment is a family affair, so getting spouses involved is critical. You should encourage your employees to share the health plan information with their spouses so they can make informed decisions on their health insurance together.

Also encourage any spouses who have questions to schedule an appointment to get questions answered. ❖



Study Predicts 8% Group Health Plan Cost Increase

A NEW study predicts that group health insurance costs will jump 8% in 2025, on par with what employers have experienced this year and in 2023.

The higher rates reflect the costs borne by health insurers, which are seeing more claims for care that was postponed during the COVID-19 pandemic and a steady rise in the cost of pharmaceuticals as more innovative and effective drugs come to market, according to the study by PricewaterhouseCoopers.

Additionally, health plans have seen a surge in demand and utilization for mental health services, a sector that's been hampered by a limited supply of in-network mental health professionals.

Cost drivers

Drugs – Thanks to a continuing stream of pharmaceutical breakthroughs that are saving patients' lives and/or improving their quality of life, insurers have to make coverage decisions. Pharmacy benefit costs are on pace to grow 8% in 2024, the same as in 2023 thanks to inflation and surging demand for some expensive drugs, including:

- **GLP-1 agonists** (annual cost: about $11,000). Various drugs in this category treat type 2 diabetes, and can assist with chronic weight management and may reduce secondary cardiovascular events. Health plans may cover these drugs if they are not solely prescribed for weight loss purposes, but they may require step therapy using less expensive, yet effective and safe medications first.
- **Central nervous system drugs** (annual cost: about $22,000). This includes various drugs treating conditions such as Alzheimer's, Parkinson's, multiple sclerosis and schizophrenia.

Mental health services – Spending on mental health has jumped 50% since the pandemic. As a result, behavioral health services are accounting for a greater portion of health plan spending.

The main factors affecting costs are a significant supply and demand imbalance for behavioral health services. Health plans are competing with each other to sign on mental health providers from a pool that is not enough to satisfy demand.

Counterbalancing costs

Three trends that may counterbalance some cost increases.

Increased use of biosimilars – Biosimilars are biological products that are "highly similar" to and have "no clinically meaningful differences" from an existing Food and Drug Administration-approved reference product. One of the most recent drugs that has seen a flood of competing biosimilars hit the market is Humira (adalimumab), a medication that reduces the signs and symptoms of moderate to severe rheumatoid arthritis.

One report estimates that the savings generated by biosimilars in 2022 was $9.4 billion in the United States. Another analysis performed in early 2023 projects total savings from biosimilars to range from $125 billion to $237 billion between 2023 and 2027.

Health plans are increasingly focused on reducing wasteful spending, which is forcing them to look at:

Exploring new pharmacy benefit manager models – This is in light of continuing reports of the country's largest PBMs actually increasing the cost of medications for payers (health plans, self-insured employers and insureds).

Integrating medical and pharmacy benefits – An example of this is a health plan pharmacy team identifying when members haven't picked up prescriptions, aren't taking medications as prescribed or aren't refilling prescriptions on time.

Connected benefits allow for real-time medical, behavioral health and pharmacy data analysis to better manage chronic conditions, close care gaps and monitor prescription use and potential interaction.

A study of its own clients by health insurer Health Care Service Corporation found that large employer groups with integrated pharmacy and medical benefits saved an average of $516 per member per year in medical costs over a three-year period.

The takeaway

As health insurance costs continue to rise, we can work with you to find health plans that will fit your and your employees' budgets, and help you look for actions to take that could have a positive effect on your rates. ❖