Employee Benefits Report

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Which Health Plan Applies?

When your employees are covered by more than one health plan, you'll want to know which plan is "primary," insurance jargon for the one that pays claims first. Here's some guidance.

Let's consider two situations where dual — and dueling — coverage might occur. They both involve someone covered by two plans, but in one case, both plans are group plans, and in the second, one plan is group medical and the other is Medicare.

Situation One: Two Group Health Plans

The rules that regulate the coordination of benefits and de-

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This Just In

Goodbye, Affordable Care Act? Congressional Republicans have spearheaded bills that would partially repeal the Patient Protection and Affordable Care Act (PPACA). In October, the House of Representatives passed H.R. 376, Restoring Americans' Healthcare Freedom Reconciliation Act of 2015. In December, the Senate approved their version by a 52-47 margin. The House and Senate must reconcile their versions before it can become law.

The bill would eliminate the requirement that individuals maintain minimum essential healthcare coverage, as well as the employer "shared responsibility requirement." The bill is a reconciliation bill, so all provisions must directly affect the federal budget.

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fine the primary payer in a situation where two policies cover one person are set by the state where the insured resides. The regulations vary from state to state.

The National Association of Insurance Commissioners (NAIC) has developed a model regulation for coordination of benefits. States have no obligation to use the NAIC model, but many do or have written regulations that closely resemble it.

According to NAIC, states that either have taken no action on the topic or have established regulations that differ significantly from the model are Alaska, Florida, Hawaii, Maine, Maryland, Mississippi, New Mexico, Pennsylvania and Vermont. Washington, D.C., is also on that list.

Here are some nuggets from the NAIC model regulation:

- If a policyholder is also covered as a dependent on a second policy, the policy he holds is primary and the policy that lists him as a dependent is secondary.
- A dependent child of parents who both hold policies that cover the child and are living together is covered first by the policy of the parent whose birthday (month and day) falls earliest in the calendar year. If they have the same birth date, the plan that went into effect first is primary.
- A dependent child of parents who are not living together is covered first by the policy of the parent who is under court order to provide health coverage. If that parent has no coverage, coverage of the second parent is primary. If both parents have a court decree declaring them responsible, the rules are the same as for parents living together. If there is no court order, primary coverage is determined in this order: the plan of the custodial parent, the plan of the custodial parent's spouse, the plan of the non-custodial parent, the plan of the non-custodial parent's spouse.

The NAIC model suggests that claims should be filed with each insurance plan, regardless of which coverage is primary. However, the important thing is to understand the regulations in your state and clearly explain the benefits to employees.

You can order a complete copy of the NAIC model regulation by visiting www.naic.org/prod_serv_model_laws.htm.

Situation Two: When Medicare Is Involved

The good news is that uniform rules apply nationwide to employees with Medicare.

In most cases, Medicare is primary, meaning Medicare will pay claims for covered individuals first; then you can submit any balance remaining to another policy (the secondary policy).

Some of the most common situations where Medicare becomes the secondary payer are:

- The individual or his/her spouse is currently employed/working and covered under an employer group health plan as a result of current employment.

H.R. 376 would eliminate federal subsidies for approximately 6 million low- and moderate-income Americans who buy their own coverage. It would also prevent the further expansion of Medicaid. Thirty states have expanded their Medicaid programs to cover Americans under age 65 with annual incomes at or below 138 percent of the federal poverty level ($16,242 per person in 2015). The bill would also repeal the "Cadillac tax," an excise tax on high-cost employer health plans.

Most changes would go into effect after December 31, 2017, allowing Republicans to develop a plan to provide health coverage after the 2016 elections.

- The company has 20 or more employees or participates in a multiple-employer or multi-employer group health plan where at least one employer has 20 or more employees.
- The individual in question is entitled to Medicare as a result of a disability; the company has 100 or more employees, or participates in a multi-employer group

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health plan where one employer has 100 or more employees.

- The individual in question is Medicare-entitled due to end-stage renal disease. Medicare is the secondary payer to a group health plan until a 30-month coordination period has ended.

Risk note: Eligible employees of small employers sometimes do not buy optional Medicare Part B coverage, because they have group coverage. Part B covers doctors' services and outpatient care. Group plans for small employers often assume that the company's Medicare-eligible workers carry Part B and pay accordingly, leaving these workers underinsured.

Administering a group health plan is a complicated task that requires knowledgeable and dedicated staff. For more information, please call us.

How Pharmacy Benefit Managers Help You Control Drug Costs

Our October 2015 issue discussed some of the forces driving prescription costs up and gave some pointers on what employers can do to control employee prescription drug costs. Here's a brief overview of how pharmacy benefit managers (PBMs) help in that process.

Your PBM plays an important role in helping control employee drug expenses.

- PBMs manage approximately 70 percent of the 3 billion+ prescriptions dispensed each year in the U.S.
- Today, approximately 95 percent of patients with drug coverage receive benefits through a PBM.
- PBMs manage pharmacy benefits for nearly 200 million Americans.

A PBM manages prescription benefits for members of a group. Employers can contract directly with PBMs or through their insurer or managed care entity. Unlike insurers, PBMs generally don't assume any insurance risk, but do take responsibility for assuring the quality and safety of prescriptions issued, along with meeting specific cost containment goals.

In addition, many PBMs provide value-added services. These include checking medications against a patient's health condition and other medications when a prescription is filled for drug interactions, disease interactions, correct dose, excessive use, and drug expiration date.

Some also offer case or disease management, where the PBM provides education to the patient and physician, helps manage a patient's prescription drug regi-

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men—for example, sending reminders when it's time to refill—and follows up on claims to evaluate which drugs are effective at treating a condition. PBMs can also help control costs by monitoring the prescribing patterns of physicians within a network and recommending more effective drugs where available.

Who pays the PBM? The PBM receives payment in the form of administrative fees and/or rebates from drug manufacturers. PBMs develop relationships with drug manufacturers and negotiate discounted prices based on volume. Manufacturers will give the PBM rebates estimated at between 5 and 25 percent on brand-name drug spending by PBM members. Insureds generally receive a discount on their drugs over the full retail price; however, since most individuals with drug coverage receive benefits through a PBM and the industry is becoming increasingly concentrated, differences in discounts between PBMs is likely to be small.

Many employers critique their relationship with their PBM as too opaque. Only 42 percent of respondents to the 2015 PBM Customer Satisfaction Report said their PBM relationship is completely transparent. Knowing the questions to ask can help you evaluate a PBM and whether it will truly deliver the savings you expect. You will need data on how effective it is at controlling costs; how effective it is at channeling patients toward generic or mail-order prescriptions, where appropriate; and on the level of service and convenience it represents for your plan members.

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Nine Tools To Control Prescription Drug Costs

Pharmacy benefit managers, or PBMs, have nine basic tools to control the cost of prescription drugs:

1 Pharmacy payments. PBMs use their clout to negotiate volume discounts with certain pharmacies, and then steer plan members to these pharmacies.

2 Generic substitutions. Generic drugs usually cost much less than their branded equivalents. PBMs use several strategies to encourage plan members to use generic substitutions. These include structuring a formulary to pay a higher percentage of a generic drug's cost and structuring the purchase to encourage plan members to accept generic substitutions.

3 Rebates. PBMs often negotiate rebates from drug manufacturers. Whether they share rebates with their employer clients is something you might want to ask.

4 Copayments. Most plans require members to pay a small, fixed amount, such as $20, each time they fill a prescription. Some plans waive copayments for people who opt to take a generic prescription for a chronic condition.

5 Coinsurance. Some plans require members to pay a percentage, or coinsurance, of the total cost of their prescription. Some use coinsurance tiers to encourage use of generic or less-expensive medications, by requiring a smaller coinsurance percentage for generic drugs or drugs that meet certain efficacy standards.

6 Formularies. A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. PBMs usually evaluate the drugs they include on a formulary for efficacy and cost effectiveness.

7 Disease management. This integrated care approach to managing illness includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve quality of life while reducing healthcare costs for people with chronic conditions by preventing or minimizing the effects of a disease.

8 Mail order fulfillment. Mail order fulfillment of refills can save money.

9 Drug utilization review. Utilization review can have two parts: systems screen members' prescription drug claims to identify problems such as therapeutic duplication, drug/disease contraindications, incorrect dosage or duration of treatment, drug allergy and clinical misuse or abuse. The second phase (retrospective drug utilization review) involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse or medically unnecessary care.

For more information on pharmacy benefit managers or structuring your benefit plans to reduce prescription drug costs, please contact us. ■

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