# Employee Benefits & Workers' Comp News

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## New Rule Increases Small Groups Insurance Buying Power

**If you own a small company, you know the frustration of not having the same buying power as large groups when purchasing health benefit coverage.**

According to the National Conference of State Legislatures, small businesses on average pay eight to 18 percent more than large companies for the same health insurance policy.

That may change with a new rule that gives small businesses more freedom to create Association Health Plans (AHPs). The Department of Labor (DOL) began phasing in the final AHP rule on Sept. 1, 2018.

### The Benefits

An AHP gives small businesses the abil-

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## This Just In…

**One alternative to opioids that's becoming more acceptable in many states is acupuncture. Treatments, which involve inserting hair-thin needles into pressure points and pain receptors, usually cost from $60-$100 each, though multiple treatments are usually required.**

**"It's less expensive than pharmaceuticals," said Dean Stiles, Wayne, Pennsylvania-based director of network management for Genex Services Inc to *Business Insurance* magazine. "People can't return to work and do their jobs if they have (opioids) in their system. For the overall claims costs, it appears (acupuncture) is less expensive."**

**While states like California**

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ity to purchase insurance in the large group market with the same kind of leverage large companies have to negotiate prices and benefits. Companies with young, healthy employees will most likely be able to get the lowest premiums. Young men in certain low-risk industries who are currently healthy will have the lowest premiums. Companies in some industries, such as engineering companies, could be about nine percent lower than what they could get on the individual or small-group market.

The reason rates are lower is that AHPs don't have to follow certain Affordable Care Act (ACA) rules and regulations, which gives the associations more flexibility when developing their plans. Certain core ACA services, such as mental health care and newborn care, could be left out of coverage as a way to lower costs.

Keep in mind that AHPs are regulated at both the federal and state level, so the availability of AHP plans will depend on your state's regulations.

## Eligibility

To form an AHP, small employers must meet one of these requirements:

- Be in the same business, trade, industry or profession; OR
- Have a principal place of business within a region that does not exceed the boundaries of the same state or the same metropolitan area.

## How AHPs work

Association Health Plans already in place can continue to operate under the final rule. What's different is that the Trump administration's new regulation loosens the rules, allowing more small businesses, including individuals who work for themselves, to join these plans. For example, associations now can be based on geography alone or the main purpose of an association health plan can be to just provide insurance.

The final rule does not subject AHPs to the Affordable Care Act's individual and small group market rules. But it does implement safeguards and monitoring procedures to enforce anti-discrimination protections for AHP enrollees. For instance, a business cannot be left out of an AHP if its employees have higher-than-expected care costs. AHPs also cannot discriminate based on an individual's health conditions or their part- or full-time employment status. However, states have been given discretion to limit AHP enrollment in relation to other non-health factors.

Some of the ACA rules and regulations still in place include:

- Requiring plans to cover preventive care without charging consumers out-of-pocket expenses.
- Allowing parents to keep their kids on their plan until they reach age 26.

Some differences include:

- Allowing an association plan to charge higher premiums to companies that employ workers in dangerous occupations.
- Allowing association plans to charge different rates based on gender, age and location.
- Not having to include the 10 "essential health benefits" that are required under the health law for plans in the individual and small-group market. For instance, an AHP might decide to exclude coverage for prescription drugs or rehab services.
- Requiring AHPs with 15 or more employees to offer maternity coverage, but smaller groups do not have to offer that benefit.

**and Oregon are quite accepting of the treatment, states like New York have put up roadblocks. New York will approve acupuncture if performed by a licensed acupuncturist who is a medical doctor — "like finding a unicorn" in some parts of the state, according to James Shinol, Huntington Station, New York-based president of the Acupuncture Society of New York and dean of the New York College of Health Professionals.**

**Acupuncture is included in medical treatment schedules and often in fee schedules in more than half the states now.**

**And the risks associated with opioid dependence and withdrawal make acupuncture seem like a much better choice.**

**For other developments in the fight to reduce opioid dependence, please see page 3.**

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## The Down Side

The DOL and the Congressional Budget Office estimate that as many as 400,000 individuals will decide to enroll in newly expanded AHPs. Observers are concerned that this will draw healthier individuals out of the ACA plan market, leaving less healthy individuals in the risk pools. This could destabilize the market and lead to higher premiums for individuals.

Other concerns are that to save money, employees in AHPs who don't get full health plan coverage may end up needing full health plan coverage. However, if an employer doesn't offer minimum essential coverage, and the company has more than 50 full-time equivalent employees — the employees can shop for subsidized health insurance on the marketplace, and the employer could face penalties.

While the intent of AHPs is to save money, some AHPs might face higher premiums if they are located in certain regions, have a majority of female employees or have seriously ill employees.

## Your Options

Although only "bona fide" groups or associations can create an AHP, your broker can consult or help develop AHPs by providing claims administration, formulary guidance, and provider network design.

For more information, please contact us.

# Opioid Update:

**There is progress in efforts to reduce opioid use in workers, despite the hurdles.**

## Opioid Prescriptions for Workers Down 6 percent.

Overall, the use of opioids in prescriptions for injured workers dropped from 51.3 percent in January to 45.3 percent in June, a drop of 6 percent, according to the database maintained by Optum, a pharmacy benefits management firm.

In addition, the total amount of workers comp dollars spent on opioids dropped from 28.6 percent to 25.4 percent in the first six months of 2018, according to the report. Opioids as a percentage of total prescriptions also dipped from 29.8 percent to 27.3 percent, the report states.

Alternative therapies such as acupuncture, as we reported on p. 1, are helping. So are topical creams to some extent. Still, challenges remain.

## Use of Topical Creams Results in Significant Opioid Use Reduction

The benefit of topical creams has been considered problematic in the past, according to some experts. Many complained that a 2010 analysis published in the Journal of Pain Research had sample sizes that were too small and that among the control groups there had not been a systematic review of every drug class, which made it difficult to assess how well the creams worked.

In a new study though, use of topical creams after three- and six-month periods were reported to produce significant results in reducing opioid use among a group of chronic pain sufferers, according to a study published in the medical journal Postgraduate Medicine in January 2018: "Reduction of Opioid Use and Improvement in Chronic Pain in Opioid-Experienced Patients after Topical Analgesic Treatment: An Exploratory Analysis."

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Almost half of patients (49 percent) in the three-month group and over half (56 percent) in the six-month group reported they completely discontinued their opioid use. More than half of those who discontinued opioid use said they were no longer taking any pain medication.

The only problem with topical creams is the cost in some instances, according to critics. While over-the-counter creams like Bengay and Icy Hot are inexpensive, their prescription counterparts can cost patients $1000 to $5000, depending on how much the insurers are willing to pay.

Another problem with topical creams is that some states have implemented formularies to restrict compound medications, according to Ben Roberts, vice president of compliance at Wayne, Pennsylvania-based managed care services company Genex Services L.L.C, when interviewed by Business Insurance. Plus, says Roberts, compound drugs are not approved by the U.S. Food and Drug Administration.

Still, the January 2018 *Postgraduate Medicine* study is good news for the campaign to reduce opioid use.

## OSHA Seen Working Against Employers in the Battle against Opioids

The workers comp community is well aware of the lethal effects of opioid pain relievers and employers, workers' comp professionals, physicians and even patients themselves have been taking steps to reduce their use. However, many in the community complain that the U.S. Occupational Safety and Health Administration is hamstringing efforts to further reduce use.

OSHA's electronic record-keeping rule still discourages employers from mandating post-incident drug testing. OSHA is concerned that employers will use drug-testing as a way to retaliate against employees who report an injury or illness.

"Employers have really struggled with that because there's so much drug use in the workplace," said Fiona W. Ong, a partner with Shawe Rosenthal L.L.P. in Baltimore, to *Business Insurance*. "I know of one employer who said, 'I don't care what OSHA says because when we do the post-accident testing, 90 percent of our people are coming up positive, so we're going to continue to test.' And they may be able to argue that before OSHA because they have such a high incidence of use … but who knows whether OSHA would agree."

"We know this drug crisis is invading the workplace, and yet OSHA is out there pushing rules that scare employers away from drug testing," said Eric Conn, founding partner of Washington-based Conn Maciel Carey L.L.P. "I could not write a more backwards safety and health policy if I tried."

If you have questions about your efforts to reduce workers comp drug dependency, please contact us. ■

# ERISA Q&A: What You Need to Know

**If you currently offer, or are planning to offer your employees retirement benefits, make sure you're familiar with ERISA rules and regulations.**

As a plan sponsor, you must meet at least minimum ERISA standards. One way to ensure you are compliant is to work with a qualified benefits consultant who can analyze your retirement structure and determine if there are any compliance issues.

Unfamiliar with ERISA rules and regulations? Here is some basic information for you.

**Q. What is ERISA?**

**A.** ERISA stands for the Employee Retirement Income Security Act of 1974. Among other things, the law protects employers' voluntary private sector retirement plans. The law does this by setting a minimum standard of requirements the retirement and health benefit plans must meet. ERISA protects both the interests of employees enrolled in benefit plans, as well as their beneficiaries.

**Q. Which government entities oversee ERISA?**

**A.** ERISA deals with both tax issues and workers' rights, therefore the U.S. Department of Labor and U.S. Treasury Department oversee the legal aspects of benefits plans.

**Q. What does ERISA require from plan sponsors?**

**A.** Plan sponsors who establish plans must meet certain ERISA minimum standards. Some of these standards include defining:

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- Minimum standards for participation, vesting, benefit accrual and funding.
- Who is allowed to become a participant.
- How long a person may be required to work before becoming eligible to participate in a plan, to accumulate benefits, and to have a non-forfeitable right to those benefits.
- Funding rules that require plan sponsors to provide adequate funding for your plan.
- The right of participants to sue for benefits and breaches of fiduciary duty.
- Payment of certain benefits if a defined plan is terminated.
- Whether a participant's spouse has a right to a portion of their benefit in the event of their death.
- When employers must deposit withheld employee contributions into a 401(k) or other pension plan.
- How benefits are calculated
- How participants can file claims for benefits
- When and how benefits are paid

Participants also should receive a Certificate of Insurance and be informed if the plan is changed using a revised SPD or by a separate document called a Summary of Material Modifications. In addition, the administrator must give participants a copy of the plan's summary annual report (SAR) each year.

**Q. What information must a plan sponsor provide participants?**

**A.** Plan sponsors must offer participants certain documents. One document is the Summary Plan Description (SPD). An SPD outlines:

- Benefits recipients receive from the plan
- How this plan operates

**Q. What information must plan sponsors provide the federal government?**

**A.** You may need to file an annual report with the federal government.

**Q. What does ERISA not tell plan sponsors to do?**

**A.** ERISA does not tell employers what kind or how many benefits to provide.

**Q. What are the employer's plan options?**

**A.** There are defined benefit and defined contribution plans.

The employer funds a defined benefit which guarantees participants a specific monthly amount at retirement. The benefit can either be an exact dollar amount, or an amount based on a formula that takes into consideration an employee's age, salary and years they have been employed by the company.

A defined contribution plan doesn't guarantee participants a specific amount. Instead, the employee or employer or both make regular contributions to the plan. Employees choose how their contributions are invested and how much money they want to contribute each month. The amount they can take out each month at retirement is based on how much money is contributed, how the investments perform and the current interest rate. A 401(k) is an example of this type of plan.

If you have questions about ERISA, please contact us. ■

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# Wave of the Future: Value-Based Care

**The practice of insurers paying fee for services to physicians and hospitals is going the way of the dinosaurs. Look for value-based care to replace the current payment model.**

With the fee for service approach, insurers pay medical providers based on the amount of health care services they deliver. With value-based care, insurers pay providers to improve patients' health. Physicians work with patients on an ongoing basis which reduces the effects and incidence of chronic disease and keeps them healthy.

Most major insurance carriers and government health agencies are moving toward a value-based care system. Aetna expects that 75 percent of their medical payments will be for value-based care by 2020. The U.S. Department of Health and Human Services also is dedicated to the concept and has plans to move 50 percent of traditional Medicare payments to value based payment models between now and 2019.

The goal of value-based care is to improve the quality of care and reduce health care costs across the board by coordinating efforts between different health providers. According to the United Nations World Health Organization, life expectancy in the United States is lower than 30 other countries. Insurers and providers hope that the value-based care approach will improve that situation.

The benefit of value-based care is that these models focus on helping patients recover from illnesses and injuries more quickly and help

clients avoid chronic disease. As a result, patients have fewer doctor's visits, medical tests and procedures.

There also are challenges with this concept. It's been more difficult for providers to transition to this model than was expected because providers still must focus on patient care while continuing to focus on improving patient care. Also, the volume of electronic health records and other information that must be shared requires coordination and more time. ■

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