THE RJC GROUP, LLC February 2015

Employee Benefits Newsletter

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MANY INSURERS DO NOT COVER DRUGS APPROVED TO HELP PEOPLE LOSE WEIGHT

By Michelle Andrews, January 6, 2015 Kaiser Health News

In December, the Food and Drug Administration approved a new anti-obesity drug, Saxenda, the fourth prescription drug the agency has given the green light to fight obesity since 2012. But even though two-thirds of adults are overweight or obese — and many may need help sticking to New Year's weight-loss resolutions — there's a good chance their insurer won't cover Saxenda or other anti-obesity drugs.

The health benefits of using anti-obesity drugs to lose weight—improvements in blood sugar and risk factors for heart disease, among other things—may not be immediately apparent. "For things that are preventive in the long term, it makes plan sponsors think about their strategy," says Dr. Steve Miller, the chief medical officer at Express Scripts, which manages the prescription drug benefits for thousands of companies. Companies with high turnover, for example, are less likely to cover the drugs, he says. "Most health plans will cover things that have an immediate impact in that plan year," Miller says.

Miller estimates that about a third of companies don't cover anti-obesity drugs at all, a third cover all FDA-approved weight-loss drugs, and a third cover approved drugs, but with restrictions to limit their use. The Medicare prescription drug program specifically excludes coverage of anti-obesity drugs.

Part of the reluctance by Medicare and private insurers to cover weight-loss drugs stems from serious safety problems with diet drugs in the past, including the withdrawal in 1997 of fenfluramine, part of the fen-phen diet drug combination that was found to damage heart valves. Back then, weight-loss drugs were often dismissed as cosmetic treatments. But as the link between obesity and increased risk for type 2 diabetes, heart disease, cancer and other serious medical problems has become clearer, prescription drugs are seen as having a role to play in addressing the obesity epidemic. Obesity accounts for 21 percent of annual medical costs in the United States, or $190 billion, according to a 2012 study published in the Journal of Health Economics.

The new approved drugs — Belviq, Qsymia, Contrave and Saxenda —

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work by suppressing appetite, among other things. Saxenda is a subcutaneous injection, the other three drugs are in pill form. They're generally safer and have fewer side effects than older drugs. In conjunction with diet and exercise, people typically lose between 5 and 10 percent of their body weight, research shows, modest weight loss but sufficient to meaningfully improve health. The drugs are generally recommended for people with a body mass index of 30 or higher, the threshold for obesity. They may also be appropriate for overweight people with BMIs in the high 20s if they have heart disease, diabetes or other conditions.

In 2013, the American Medical Association officially recognized obesity as a disease. Nevertheless, "people still assume that obesity is simply a matter of bad choices," says Ted Kyle, advocacy adviser for the Obesity Society, a research and education organization. "At least half of the risk of obesity is inherited," he says.

Many people who take an anti-obesity drug will remain on it for the rest of their lives. That gives insurers pause, says Miller.

The potential cost to insurers could be enormous, he says. Susan Pisano, a spokesperson for America's Health Insurance Plans, a trade group, says the variability of insurer coverage of anti-obesity drugs "relates to issues of evidence of effectiveness and evidence of safety."

In 2012, the U.S Preventive Services Task Force, a non-partisan group of medical experts who make recommendations about preventive care, declined to recommend prescription drugs for weight loss, noting a lack of long-term safety data, among other things. But its analysis was based on the older drugs orlistat, which is sold over the counter as Alli or in prescription form as Xenical, and metformin, a diabetes drug that has not been approved for weight loss but is sometimes prescribed for that by doctors.

The task force did recommend obesity screening for all adults and children over age 6, however, and recommended patients be referred to intensive diet and behavioral modification interventions. Under the health law, nearly all health plans must cover preventive care recommended by the task force without cost sharing by patients. Implementation of the obesity screening and counseling recommendations remains a work in progress, say experts.

Dr. Caroline Apovian, director of the Nutrition and Weight Management Research Center at Boston University, says many of the patients she treats can't afford to pay up to $200 a month out of pocket for anti-obesity drugs.

"Coverage has to happen in order for the obesity problem to be taken care of," says Apovian. "Insurance companies need to realize it's not a matter of willpower, it's a disease."

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CREDITABLE COVERAGE DISCLOSURE DUE TO CMS

Due: March 1 for calendar year plans

CMS Creditable Coverage is due no later than 60 days from the beginning of a plan year or within 30 days after any changes in creditable coverage status.

Entities that provide prescription drug coverage to Medicare Part D eligible individuals must disclose to CMS whether the coverage is "creditable prescription drug coverage". This disclosure is required whether the entity's coverage is primary or secondary to Medicare.

Disclosure to CMS Form

NEW YEAR RINGS IN ADDITIONAL IMPLEMENTATION CHALLENGES FOR EMPLOYERS, POSSIBLE LEGISLATIVE CHANGES

Employers have been grappling with implementation of the Patient Protection and Affordable Care Act (ACA) for several years now.

In 2015, the implementation challenges will continue, especially for employers with 100 or more full-time equivalent employees (FTE) who must comply with the employer mandate. In addition, it's likely that the new Congress will attempt to tweak some of the ACA's provisions, while the Supreme Court wrestles with the law's statutory language.

New legislation and court rulings could affect employers' obligations or planning. To shed light on these and other ACA-related issues and how to prepare for them, **Wolters Kluwer** interviewed Michael M. Maddigan, partner in the Los Angeles office of Hogan Lovells.

WK: What ACA provisions will employers need to focus on in 2015?

Maddigan: I think several aspects of the ACA will continue to draw a substantial amount of focus in 2015.

First, employers will need to focus on aspects of the ACA that are taking effect for the first time. For employers with 100 or more FTE employees, the employer mandate takes effect in 2015 and employers will need to focus on their coverage offerings and employee response.

For employers with 50-99 FTE employees, the focus in 2015 will be on preparing for the implementation of the employer mandate in 2016. Similarly, the employer reporting requirements take effect for all employers with 50 or more FTEs in 2015 and the first employer reports are expected to be due in January 2016. Employers will want to focus on making sure they understand the requirements for those reports and will be in a position to satisfy them.

Second, employers will need to focus on the marketplace changes taking place as the post-ACA market continues to develop and settle. For example, new products continue to emerge (such as narrow network products, for example) and employers will want to focus on the details of those products for their own planning and ACA-compliance purposes.

Similarly, for those employers with the option of purchasing coverage from a SHOP exchange, additional coverage options will be available as those exchanges take shape and develop.

Third, employers will need to keep an eye on developments in Washington in order to be prepared if Congress makes material changes to the ACA that affect the employer's obligations or planning.

WK: What ACA guidance do you expect to be issued in 2015?

Maddigan: One very practical piece of guidance that should be issued in 2015 is a final version of IRS Form 1094-C and 1095-C, which are to be used in connection with the large group employer reporting requirement.

There also may be additional guidance in connection with the employer mandate for those employers to whom it now is first scheduled to apply in 2016.

WK: How will the new Congress affect health care reform?

Maddigan: While many in the new Senate majority talk about "repealing ObamaCare," it is much more likely that we will see bills advanced in the new Congress that seek to tweak or supplement the ACA. This type of effort could take place in a number of ways.

First, we may see bills that seek to amend the ACA to address new issues. An example of this first type of bill is the Hire More Heroes Act, which seeks to exempt post 9/11 veterans from the count of employees used for purposes of triggering the employer mandate. The bill passed the House last year and appears to have bipartisan support. Second, we may see bills that explicitly seek to revise portions of the ACA while still accepting its basic structure.

One ACA element that might be addressed through this second type of bill is the use of a 30 hour work week for purposes of calculating the number of "full time" employees. Senator Mitch McConnell and others have talked about introducing legislation to define a "full time" employee by reference to a forty-

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hour work week instead. Third, we may see bills that are aimed at outright repeal of portions of the ACA other than those provisions – like the individual and employer mandates, for example – that previously have been the focus of discussions about repeal. An example of this type of bill might be legislation aimed at eliminating the medical device "tax" or another similar, specific provision.

WK: What do you expect the Supreme Court to do regarding the pending ACA-related cases?

Maddigan: There obviously has been a great deal of speculation about this question. Some supporters of the ACA have speculated that the same considerations that previously made the Court reluctant to overturn the ACA likewise will prevent it from reaching a result that may effectively accomplish indirectly what the Court was unwilling to do directly. On the other hand, some opponents of the ACA have speculated that the deference the Court previously showed to the political branches' enactment of a major piece of economic and social legislation does not apply to the agency rulemaking and interpretations and that that difference likely will lead to a different result. The reality, of course, is that no one knows what the Court is going to do. The case is a difficult one because, while agencies regularly "correct" drafting errors or inconsistencies and address ambiguities in legislation through the rulemaking process, the "correction" here is one that is in real tension with one literal reading of the text. If I were going to guess about the outcome, I would guess that, in the end, for the reasons stated in the Fourth Circuit's opinion upholding the use of tax credits on the federal exchanges (as well as in the dissent from the DC Circuit opinion finding the use of such credits to be invalid) the Court will find the ACA's statutory language to be ambiguous and defer to the IRS's discretion in permitting such tax credits. But, as I say, no one knows what the Court will do, and I certainly don't pretend to.

WK: How should employers who will be subject to the employer mandate in 2016 prepare for it this year?

Maddigan: Employers who will be subject to the employer mandate in 2016 should begin preparing for it now. This really is an instance where preparation will become more and more difficult the longer an employer waits to start preparing. It makes sense for employers to develop a plan and a process to ensure that they are ready. Three of the elements that should be included in any such process are: (1) projecting work force needs, in order to assess both the cost of providing appropriate insurance and the potential penalties for not doing so; (2) developing plan design so that it can meet the ACA's coverage standards and affordability criteria, while holding down the employer's cost to the extent possible; and (3) designing and implementing any wellness program the employer intends to offer and any accompanying communication plans, particularly to the extent the employer intends to rely on such a wellness program to reduce cost.

WK: Is there anything else that you'd like to add?

Maddigan: I think there is one interesting aspect of the ACA tax credit cases currently pending before the Supreme Court that has not received significant press or public commentary. One of the arguments opponents make against the availability of tax credits on the federal exchange is that the ACA clearly sets up an either/or choice when it comes to exchanges: a state can either choose to run its own exchange or defer to the federal exchange. The reality, however, is more complex, as a number of states have chosen, with HHS's permission, "hybrid" or "partner" exchange models where the state elects to defer to the www.healthcare.gov federal marketplace but retains control over some aspects of plan selection, rating, monitoring, oversight, or consumer assistance functions. Thus, the "real world" of the exchanges is more complex than the simplest version of the "either a state exchange or a federal exchange" argument advanced by those who contend that the use of tax credits on the federal exchange is impermissible.

EMPLOYEE BENEFITS MANAGEMENT DIRECTIONS HEADLINES, Report No. 577, January 13, 2015

PROPOSED RULES ON EXCEPTED BENEFITS ADDRESS WRAPAROUND COVERAGE

Human Services, and Treasury (Departments) are seeking public comment on proposed rules that would amend the definition of excepted benefits to include certain limited wraparound coverage. The proposed rules would allow group health plan sponsors, in limited circumstances, to offer wraparound coverage to employees who are purchasing individual health insurance in the private market, including through the Health Insurance Marketplace.

The rule proposes two pilot programs for wraparound coverage. One pilot would allow wraparound benefits only for Multi-State Plans in the Health Insurance Marketplace and another would allow wraparound benefits for part-time workers who could otherwise qualify for a flexible savings arrangement who enroll in individual market plans.

Conditions for wraparounds to be excepted benefits. The proposed regulations set forth five requirements under which limited benefits provided through a group health plan that wrap around either eligible individual insurance or coverage under a Multi-State Plan (limited wraparound coverage) constitute excepted benefits. For this purpose, "eligible individual health insurance" is individual health insurance coverage that is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits.

Limited wraparound coverage must:

1. be specifically designed to wrap around eligible individual health insurance**;**
2. be limited in amount (annual cost of coverage per employee not to exceed $2,500 in 2014);
3. not impose a preexisting condition exclusion, not discriminate based on health status or in favor of highly compensated individuals;
4. meet plan eligibility requirements; and
5. meet reporting requirements.

Pilot program with sunset date. Under these proposed regulations, limited wraparound coverage would be permitted under a pilot program for a limited time.

Specifically, this type of wraparound coverage could be offered as excepted benefits to coverage that is first offered no later than December 31, 2017, and that ends on the later of:

1. the date that is three years after the date wraparound coverage is first offered, or
2. the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered).

The Departments invite comments on this time frame for applicability, including whether the Departments should have the option to provide for an earlier termination date.

SOURCE: 79 FR 76931, December 23, 2014. Healthcarereformnews Healthinsurancenews IRSnews DOLnews HHSnews

Employer Shared Responsibility Reporting
Sec 6055 and Sec 6056 Reporting

Forms

1094-B, 1095-B – For health insurance issuers or carriers

1094-C, 1095-C – For employers with 50 or more full-time employees

Due Dates

February 1, 2016: Individuals (Forms 1095-B/1095-C)

February 26, 2016 (March 31, 2016 if electronically submitted): IRS (Forms 1094-B, 1095-B, 1094-C, 1095-C)

Action

Employers should be ready to report on their healthcare plan coverage for 2015. To do this, employers should be gathering information and data, as well as establishing processes for reporting. Eligibility information, contribution amounts and enrollment data will be required in order to complete these forms. Employers will need to establish systems for calculating affordability and generating reports, as well as organizing communication processes to employees. Benefit administrators and/or payroll vendors may be able to assist with these processes.

Penalties

Although penalties apply in 2015 for incorrect or incomplete information reported on the return or statement, relief may be provided if a reporting entity can provide evidence of its good-faith efforts to comply with the requirements.

SPOTLIGHT ON FEDERAL GOVERNMENT ACTIVITIES

HOUSE PASSES BILL REPEALING PPACA'S 30-HOUR RULE

House lawmakers on January 8 approved, by a vote of 252 to 172, the Save American Workers Bill of 2015 (HR 30), which would alter the calculation under the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) of the number of full-time equivalent employees for the purposes of determining which employers are subject to penalties.

The Senate is expected to soon take up a companion measure but the fate of the measure is uncertain as President Obama has issued a veto threat if the bill comes to his desk.

Specifically, the bill would change the definition of full-time employment from 30 hours per week under current law to 40 hours per week.

The Obama administration, however, said that the legislation would weaken a provision of the PPACA designed to maintain employer-based health insurance coverage, protect their employees and prevent employers' health benefit costs from being shifted to taxpayers.

According to new estimates from the Congressional Budget Office CBO), it would increase the budget deficit by $53.2 billion over 10 years, reduce the number of people receiving employer-based health insurance coverage and increase the number of individuals who are uninsured.

Healthcarereformnews Healthinsurancenews Legislationnews (Jan 13, 2015) 2083L

SENATOR BEGINS HEALTH CARE AGENDA TARGETING THE ACA

Sen. Bill Cassidy, R-La., on January 14 introduced the No Obamacare Mandate Bill and the Employee Health Care Protection Bill to start moving forward on repealing the Patient Protection and Affordable Care Act (ACA) and replacing it with what he termed "patient -centered solutions for Americans."

The No Obamacare Mandate Bill would repeal the medical device tax, the employer mandate and the individual mandate. The Employee Health Care Protection Bill addresses "If you like your health plan, you can keep it," as it would allow health care plans currently available on the group market to continue being offered through 2018.

Small businesses and their workers would have the option to choose plans that are not in the ACA exchanges, according to Cassidy.

Those who choose to enroll, or keep their noncompliant health care plan, would not face a penalty under the ACA's individual mandate.

The nonpartisan Congressional Budget Office (CBO) has estimated that the bill would lower the deficit by $1.25 billion.

Healthcarereformnews Healthinsurancenews Legnews Jan 20, 2015 2083Q

SUPREME COURT SCHEDULES ORAL ARGUMENT INCHALLENGES TO ACA SUBSIDIES

The U.S. Supreme Court will hear oral arguments in King v. Burwell, a much-watched case challenging the IRS's regulations on the Code Sec. 36B premium assistance tax credit, on March 4, 2015. The plaintiffs in King argue that the Code Sec. 36B regulations are inconsistent with the language of the Patient Protection and Affordable Care Act (ACA).

Healthcarereformnews Healthinsurancenews IRSnews Courtnews Dec 31, 2014 2083D

DEMS WEIGH IN ON POTENTIAL TAX CREDIT CATASTROPHE

The Supreme Court may put $65 billion in tax credits at risk if it rules against the federal government's decision to provide tax credits to certain taxpayers, according to the Democratic Minority Staff of the Committee on Energy and Commerce. The staff released a report detailing the district-by-district impact of a potential Supreme Court ruling against the Patient Protection and Affordable Care Act (ACA) federal exchange tax credits. The report claims that that those tax credits, which provide assistance to middle-class Americans with incomes from $23,850 to $95,400 for a family of four in purchasing their health insurance coverage, would no longer be available in the states that have not set up their own health exchanges.

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