NIXON BENEFITS

Industry Notes, July 2014

- **How to Take Fewer Prescription Drugs**
According to the Mayo Clinic 70% of Americans take at least 1 prescription drug; more than half take at least 2 prescriptions; and 25% take 5 or more prescriptions. According to Dr. Weil in the Huffington Post, this puts the U.S. solidly in 1st place in per-capita drug use. He believes "Americans take too many Rx medications and a large percentage is doing more harm than good." His suggestions for avoiding over medication:

1) Don't ask for drugs. One of the biggest drivers of American Rx overconsumption is direct-to-consumer advertising. One study found that in about 40% of doctor visits, patients asked for advertised drugs, and half of those requests were successful.
2) Ask about alternatives to drug therapy. "Before I start taking the drug, is there a diet, exercise or lifestyle change I can try?" No common condition is more amenable to this approach than Type 2 diabetes, an epidemic disease often reversible via lifestyle changes. If your physician seems dismissive of any therapy except pharmaceutical drugs for most health conditions, it's time for a new physician.
3) Remember that the best therapy is often time. "Can this clear up on its own? How long is that likely to take?" are both excellent questions.
4) Don't seek drugs for trivial reasons. Minor discomforts are part of the human experience. Don't be misled by an insidious form of pharmaceutical marketing known as disease-mongering.

Andrew Weil M.D. Huffington Post April 2014

- 8.2 million people have taken up **employer-sponsored insurance** since September, and most of them were previously uninsured, according to a recent Rand survey. For all the predictions of employers dumping coverage for health insurance exchanges, this was a pretty surprising finding. *Obamacare* actually drove millions of uninsured Americans to sign up for **employer insurance**.

Washington Post April 2014

- "Until very recently, it was not uncommon for employers to reimburse employees for substantiated premiums paid for individual health insurance coverage. Many small employers saw this as a viable alternative to group insurance, in large part because employees could exclude the reimbursements from income for tax purposes.

Last year, federal regulators made it clear that these reimbursement arrangements violate the Affordable Care Act. Reportedly in response to the continued marketing of non-compliant arrangements to employers, the **IRS** reiterated the point in a Q&A published in **May of 2014**. In essence, the law considers these arrangements to be group health plans that do not satisfy the Affordable Care Act's insurance market reforms.

Noncompliance with these rules is punished severely. An employer reimbursing its employees for the cost of coverage purchased in the individual market is liable for a federal excise tax of $100 per day, per employee. That's $36,500 per employee, per year! The excise tax liability arises automatically, and an employer liable for the tax is obligated to self-report by filing an excise tax return (Form 8928) with the IRS.

There are legal ways for employers to encourage employees to get individual coverage, either through the exchanges or otherwise, and for employers to help employees pay for the coverage. For example, the IRS has suggested that an employer could offer employees a choice between a certain amount paid in cash or applied (e.g., by after-tax payroll deduction) to pay individual premiums. The key here is that the employee will receive the benefit without regard to whether he or she decides to purchase health insurance."

Poyner Spruill LLP 6/23/14

- Under the ACA, the US Department of Health and Human Services is required to use a different methodology for calculating annual out-of-pocket maximums than the IRS uses for High Deductible Health Plans (HDHP). Therefore, starting in 2015, the two limits will begin to differ as shown here:

Out-of-Pocket Limits for:	2014	2015
Individual Plans ACA	$6,350	**$6,600**
High Deductible Health Plans	$6,350	**$6,450**

  In addition to the HDHP limits being lower than the ACA individual plan limits in 2015, expenses will accumulate toward the HDHP limit more quickly because the HDHP limits apply to all covered in-network benefits, not just essential health benefits.

  Proskauer May 9, 2014

- "**Q.** My 24-year-old daughter was covered under her father's health insurance, which is a grandfathered plan. She started working and was offered coverage through her employer. My husband's employer said she had to sign up for her employer's insurance and could not stay on his policy. Is that true?"

  "A. Not anymore. Under the health law, health plans that offer dependent coverage have to allow adult children to stay on their parents' plan until they turn 26…even if the young adults are married or financially independent. The law initially allowed one major exception for grandfathered plans—those that were in existence before the health law passed in March 2010 and hadn't changed substantially since then. Those plans could refuse to cover adult children if they had an offer of employer-based coverage elsewhere, such as through their own jobs. However, starting [plan years renewing on or after] January 2014, that exception no longer applies. A 24-year-old…should be able to remain on her father's plan until she turns 26, even if her own job also offers health insurance."

  Kaiser Health News 6/20/14

- "An employer that wanted to treat the use of e-cigarettes as smoking in order to deny access to a wellness reward" might be successfully challenged in court. Unfortunately electronic cigarettes are not mentioned in the final PPACA Wellness regulations. While much of the final regulation uses the term "tobacco use" or "tobacco cessation," which would support equal treatment of tobacco smoking and nicotine vaporizing. Unfortunately the part of the regulation that defines "what constitutes a participatory wellness program refers to 'smoking cessation' and the definition of outcome-based wellness programs simply refers to 'not smoking."

  Employment Matters Blog June 2014

- **12 Most Expensive Specialty Drugs**

Drug	Purpose	Price
Sovaldi	Hep C	$1,000 / pill
Copaxone	Multiple Sclerosis	$6,072 / 30 syringes
Avastin	Cancer	$5,560 / 2 vials
Rebif	Multiple Sclerosis	$967 / mL
Avonex	Multiple Sclerosis	$1,363 / injection
Xyrem	Narcolepsy	$967 / mL
Gleevec	Leukemia	$306 / pill
Betaseron	Multiple Sclerosis	$415 / injection
Humira	Rheumatoid Arthritis	$1,501 / injection
Forteo	Osteoporosis	$708 / mL
Cimzia	Rheumatoid Arthritis	$3,322 / 2 injections
Sprycel	Leukemia	$203 / pill
Byetta	Diabetes	$395 / mL

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