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THE **RISK REPORT**

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ACA Compliance

Health Plan Affordability Level Cut Significantly for 2024

THE IRS has significantly reduced the group plan affordability threshold — which is used to determine if an employer's lowest-premium health plan meets the Affordable Care Act rules — for 2024.

The threshold for next year has been set at 8.39% of an employee's household income, down from 9.12% this year. The lower threshold will likely require employers to reduce their employees' premium cost-sharing level for their lowest-cost plans in 2024, to avoid running afoul of the ACA.

Under the ACA, "applicable large employers" — those with 50 or more full-time or full-time equivalent employees (FTEs) — are required to offer at least one health plan that is considered "affordable" based on a percentage of the lowest-paid employee's household income.

Safe harbors

The new threshold will apply to all health plans when they incept in 2024. For plans that incept after Jan. 1, the 2023 threshold will apply and change to the new rate when they renew.

Employers can rely on one or more safe harbors when determining if coverage is affordable:

- The employee's W-2 wages, as reported in Box 1 (at the start of 2022).
- The employee's rate of pay, which is the hourly wage rate multiplied by 130 hours per month (at the start of 2022).
- The federal poverty level.

Example 1

The lowest-paid worker at Company A earns $25,987 per year. To meet the 2024 affordability requirement, they would have to pay no more than $2,180 a year in premium (or $181 a month).

Example 2

Company B has a large low-wage workforce and may utilize the federal poverty level ($14,580 for 2024) safe harbor and offer at least one health plan option that costs FTEs no more than $101.94 per month.

If an employee's coverage is not affordable under at least one of the safe harbors and at least one FTE receives a premium tax credit for coverage they purchase on an ACA exchange, the employer may have to pay a employer shared responsibility payment.

This penalty for 2024 will be $4,460 per employee that receives a premium subsidy on an exchange, up from $4,320 this year.

The takeaway

As 2024 nears, you should review your health plan costs and premium-sharing to ensure that your lowest-cost plan complies with the affordability requirement.

We can help you assess affordability to ensure you don't run afoul of the law. It will be particularly crucial in 2024, considering the significant drop in the threshold. ❖

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Planning for Next Year

Report: Group Health Plan Cost Inflation to Pick Up Steam

A NEW REPORT by Aon warns employers to expect average group health insurance costs to increase 8.5% in 2024, as inflation starts hitting the cost of delivering care as well as pharmaceuticals.

The report predicts that employers will pay an average of $15,088 in 2024, compared to $13,906 this year. The cost hike is almost double the 4.5% increases employers saw in 2022 and 2023.

Despite the expected premium increases, employers still seem to be reluctant to pass on more of the premium cost to their covered workers, according to Aon. For example, for this year, employees saw their premium payments increase an average of just 1.7%.

Employers will need to carefully budget for these cost increases, particularly if they don't want to shift premium costs to their employees.

Why the cost of care is rising

The following cost drivers are affeciting health insurance costs:

Health care inflation – Health care providers have raised their rates for services due to their own costs increasing, particularly for staff wages, equipment and supplies. For example, the cost of emergency services supplies, and other critical equipment, increased by almost 33% between 2019 and 2022.

Catastrophic claims – Every catastrophic claim requires varying levels of intervention and care. Many will require specialized medical care, extensive rehabilitation, advanced medical equipment and potential vehicle and home modifications.

CATASTROPHIC CLAIMS COST DRIVERS

- Hospital staffing shortages
- More high-cost injectable drugs
- Increasing cancer rates
- Longer hospital stays resulting from multiple conditions, complications and complex procedures
- Higher medical equipment costs
- Skyrocketing costs of home modifications.

New technologies – New technologies that hospitals use are also increasing in cost, as is the cost of servicing and installing the equipment.

Pharmaceutical costs – There are two key reasons drug costs are increasing quickly:

- *Specialty drugs:* These are significantly more expensive than their traditional drug counterparts, often costing more than $2,000 per month per patient. Some pharmaceuticals cost much more. The drug Tretinoin, which helps manage complications of leukemia, costs $6,800 a month.
  Others cost upwards of $100,000 per year. The cost and utilization of these drugs is growing, according to Aon.
- *New weight-loss drugs:* The newest pharmaceutical cost driver is the proliferation of trendy new weight-loss drugs like Wegovy, Saxenda and Ozempic, which cost more than $1,000 a month.

These new drugs have proven to be highly effective in helping people lose weight and are in high demand. Insurers typically won't cover these medications if someone simply wants to lose weight, though.

Cost-shifting hesitation

The report predicts that employers will be hesitant to make significant changes to how much their employees contribute to their health plan premiums.

Aon estimates that the average employee premium contribution in 2023 is $2,682, while they pay out another $1,993 in deductibles, copays and coinsurance.

"We see employers continuing to absorb most of the health care cost increases," Farheen Dam, North American Health Solutions leader at Aon, said. "In a tight labor market, plan sponsors are hesitant to shift significant cost to plan participants."

Talk to us about your options as 2024 approaches. We can help you with different plan designs and cost-sharing arrangements that may reduce your firm's premium outlays. ❖

Industry Trend

More Insurers Scale Back on Prior Authorizations

SOME OF the nation's largest insurers have announced plans to roll back their prior authorization requirements for medical services.

Prior authorization — or prior approval — has always been a thorn in the side of patients, often keeping them from accessing care in a timely fashion. The moves by these insurers come after the Centers for Medicare and Medicaid Services (CMS) announced earlier this year that it would require health insurers to automate prior authorization and return decisions more quickly.

These developments are good news for your employees and should improve their health care experience and access to timely care. Many of these changes took effect immediately and some will start in 2024.

Under prior authorization, doctors and other health care providers must obtain advance approval from a health plan to qualify for coverage before they deliver a specific service to the patient. Health insurers have lists of services that require prior approval, in order to control their costs.

The process can sometimes be time-consuming, and doctors argue that it often delays care and results in negative outcomes.

On the other hand, insurers say that prior approval helps protect patient safety and improve affordability by increasing adherence to evidence-based standards of care.

Forcing insurers' hands

Analysts say that insurers are reacting to regulators' and lawmakers' attempts to address some of the problems that prior authorization creates.

The CMS in April 2023 announced a rule that would require health insurers to automate prior approvals and expedite decisions. That was followed by a rule addressing prior authorization in Medicare Advantage plans.

Meanwhile, there are bipartisan efforts in Congress that aim to streamline prior authorization, in order to speed it up and reduce the chances of delayed care in Medicare Advantage plans.

States are also taking matters into their own hands. Legislation in Pennsylvania, for example, requires health insurers to provide a more streamlined process for approval of non-urgent and emergency services. Texas exempts doctors with a 90% authorization approval rate for certain services from prior authorization requirements.

The takeaway

As regulators and lawmakers bear down on health insurers around the country, expect more carriers to roll out plans to reduce the use of prior authorizations for services.

The reasoning among many insurers is that they can get ahead of them by taking steps before regulations and laws are implemented. It will be your employees who will benefit from these actions. ❖

WHAT INSURERS ARE DOING

Cigna

In August, Cigna said with immediate effect that it would no longer require prior approvals for nearly 25% of medical services. That includes some 600 prior authorization codes in its commercial plans. Since 2020 Cigna has eliminated prior authorization for 1,000 codes.

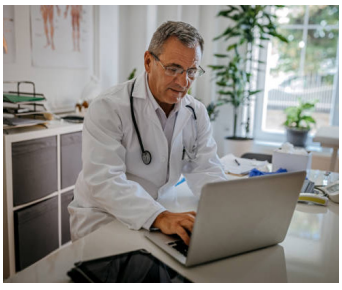
Aetna

In 2022, Aetna rolled back prior authorization requirements on cataract surgeries, video EEGs and home infusion for some drugs. Aetna said that it had also reduced automated prior authorizations by more than 10% in 2022, with plans to more than double that this year.

Independence

Independence Blue Cross and Philadelphia-based Penn Medicine are piloting a program that will allow qualifying physicians to skip prior authorization approvals needed for ultrasounds, CT scans and PET scans.

UnitedHealthcare



This year UnitedHealthcare aims to eliminate almost 20% of its current prior authorizations. In 2024, the insurer plans to roll out a "gold card" program, which will allow certain providers, whose prior authorization requests are consistently approved, to perform most procedures without needing prior approval.

DOL Rulemaking

50% Increase in Overtime Pay Threshold On Tap

THE U.S. Department of Labor has issued its long-awaited proposed changes to the nation's overtime rules for American workers, proposing to increase the threshold for exempt status by more than 50% to just over $55,000.

Under DOL rules, workers who are exempt from overtime rules — typically managers, executives and certain administrators — must make at least the threshold amount, which is currently $35,568.

If the new threshold goes into effect, employers will have a choice to either raise the pay of their currently exempt staff to the new threshold (or above) or change those workers to non-exempt, meaning they must be paid overtime wages (typically time and a half) if they work overtime.

It's rumored this proposal is on a fast track and that it could become permanent in the next two months, giving employers a short window to make changes.

WHAT'S CHANGING

- The exempt salary threshold will increase to $1,059 per week (or $55,068 per year). That's up from the current $684 a week, or $35,568 a year.
- The exempt salary threshold will automatically increase every three years based on cost of living increases.
- The propsoal will raise the threshold for the "highly compensated employee" exemption to $143,988 (from the current threshold of $107,432).

Title alone does not designate someone as "exempt." There is a two-pronged test for classifying a worker as exempt from overtime pay:

- Their salary, which can be no more than $55,068 per year, under the rule.
- The duties test, which outlines exactly what someone's duties must be in order to qualify for exempt status.

THE DUTIES TEST

A worker must have certain duties to be an exempt employee. The three main exemptions are:

Executive exemption – These employees must manage a department or division, direct the work of at least two workers and have the authority to hire and fire.

Administrative exemption – Primary duties must be office or non-manual work related to the management or general business operations, and the employee's duties must include exercising independent judgment on significant issues.

Professional exemption – The employee's primary duty must be the performance of work requiring advanced knowledge, predominantly intellectual in character and which requires the consistent exercise of discretion and judgment.

How to prepare

Start by making a list of all your current exempt employees who earn between $35,568 and $55,068 a year.

You will have a decision to make about each of these workers:

- Raise their salaries to meet the new threshold, or
- Change them to non-exempt status so they are eligible for overtime pay if they work extra hours. You'll also have to put in place systems for tracking their hours worked, including overtime.

Also, your benefits package may differ for non-exempt and exempt workers and you may have to change benefits for anyone whose status changes.

You should also plan how you are going to communicate these changes to your workforce.

Finally, you can expect business groups to protest this rule and sue to stop its implementation. ❖