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Employee Benefit Plan Review

Cost Savings Initiatives That Help Employees Prepare for Medical Expenses

By Christine Cooper

Reducing out-of-pocket medical expenses and avoiding unplanned financial burdens imposed by the escalating cost of care are especially important to employees as general inflation is once again rapidly increasing the cost of living. Many workers today are "financially fragile" – unprepared for regular household expenses, let alone out-of-pocket medical expenses. Recent general inflation adds new stress to household budgets.

Statistics

In March 2022, the Consumer Price Index[1] for All Urban Consumers rose 1.2 percent, seasonally adjusted, and rose 8.5 percent over the previous 12 months, not seasonally adjusted. And there is more inflation to come. Just one day later, the Bureau of Labor Statistics confirmed that the Producer Price Index increased 1.4 percent in March 2022; that is an annualized rate in excess of 15 percent and, looking back, 11.2 percent for the 12 months ending in March 2022.

These concerns are also well-documented by The Centers for Medicare & Medicaid Services ("CMS") which released the 2021-2030 National Health Expenditure ("NHE") report[2] that presents health spending and enrollment projections for the coming decade. Selected highlights include private health insurance and out-of-pocket spending.

According to this report, the percentage of the U.S. population with health insurance is expected to be 91.1 percent in 2022. Private health insurance spending growth is projected to average 5.7 percent, and out-of-pocket expenditures are projected to grow at an average rate of 4.6 percent over 2021-2030 and to represent nine percent of total spending by 2030. What does that mean? CMS projects that the employer and employee contributions to fund coverage will also include an increment designed to moderate increases in point of purchase cost sharing – deductibles, copayments and coinsurance.

Employers are understandably looking for ways to reduce the costs associated with the healthcare coverage portion of their overall benefits program. While cost savings opportunities do exist, there is a need for a shift in focus to designs and strategies that helps employees prepare for a change in point-of-purchase cost sharing designed to capture the improvement in cost management that only occurs where employees become better consumers.

Level of Employer Support

It is common for employer-sponsored HMOs/PPOs to offer a more generous level

of coverage than workers need. Employer and employee contributions tend to increase more rapidly when plan designs minimize point of purchase cost sharing (deductibles, copayments coinsurance).

It is past time for plan sponsors to reevaluate claims data and to consider (or reconsider) and reshape levels of employer financial support. Adding tax-preferred savings with an employer match can prompt employees to accumulate assets and be prepared for out-of-pocket medical costs – whenever they arise. Accumulating savings is a necessary component of financial wellness. Participants can accelerate improvements in financial wellness where plan designs incorporate tax-efficient savings programs. Employer sponsored health plans that respond strategically will experience noticeably improved short term and long-term outcomes.

Health Savings Account Strategy

Most employees have no savings set aside or earmarked for out-of-pocket medical expenses. So, most are unprepared when a medical bill arrives. Done right, a Health Savings Account ("HSA") strategy can reduce "financial fragility." HSAs have evolved to become part of a "health and wealth" rewards strategy capable of "Quadruple Duty" – HSAs can cover out of pocket medical costs in current and future years and Medicare premiums, while also providing for retirement income and survivor benefits.

HSAs receive America's most valuable benefits tax preference – contributions are pre-tax for federal income tax purposes, same for most state income taxes, as well as FICA (Social Security) and FICA-MED (Medicare). Earnings accumulate tax deferred and payouts for eligible medical expenses are tax free. More medical expenses qualify under HSAs than under health Flexible Spending Accounts ("FSAs"). Unlike FSA accounts, there is no "use or lose" or forfeiture provisions. Unspent money rolls over from year to year.

Leveraging automatic features in terms of both Health Savings Accounts and Health Flexible Spending Accounts requires positioning medical coverage to get the incentives right – which might include increasing the dollar amount of point of purchase cost sharing (deductibles, copayments, coinsurance), and concurrently "leveling the playing field" by adjusting coverage design for options that are not HSA-capable to parallel the HSA-capable coverage structure.

The growing adoption of self-insured health plans is often in response to significant increases in insurance premiums.

The challenge is one of implementation; getting workers to focus on the differences in contributions, deductibles, employer support in the form of contributions to HSAs and out of pocket expense maximums. The implementation challenge often arises when an employer simply adds HSA-capable coverage as an alternative to a traditional PPO and/or HMO option, without any education nor any adjustments or transitions.

To succeed at prompting workers to save, to leverage the tax preferences only available through an HSA, a plan sponsor should deploy many of the same processes widely used to prompt saving in 401k plans:

- Reduce the health coverage offers to a single HSA-capable option that applies to all who enroll in health coverage;
- Deliver employer financial support in the form of an HSA matching contribution;
- Default individuals into the HSA, both enrollment and a contribution amount at least sufficient to fund the deductible;
- Provide transition rules/features/protections for individuals when they first enroll in HSA-capable coverage; and
- Prompt mid-year re-enrollment into the HSAs, or a mid-year automatic escalation in HSA contributions.

Taking Advantage of Pricing Transparency

Price transparency puts employer-sponsored plan participants in the driver's seat as a healthcare consumer. Effective consumerism requires access to accurate provider and hospital fees and the estimated out of pocket cost of services – before receiving care. Healthcare consumerism can transform the delivery of healthcare services. The term became noteworthy with the industry's shift toward value-based care. Today, healthcare consumerism empowers patients with information so they can proactively make informed, cost-conscious decisions about their health.

For participants in an employer-sponsored health plan, healthcare consumerism brings an opportunity to engage and better understand the information incorporated in the explanation of benefits. There also are strategies that take advantage of price transparency to capitalize on cost containment initiatives and fully optimize value. This insight has potential to transform an employee's health coverage usage, putting the economic purchasing power and decision-making in their hands.

Reference-Based Pricing Provision

Even with greater transparency, significant price variations can still exist across hospitals and providers for standard procedures. Because of this, many health plans have adopted reference-based pricing ("RBP") strategies.[3] Designed to moderate excessive hospital costs, RBP

establishes a benchmark fee schedule and payment ceiling instead of negotiated fees by contracting with a provider network. Plan sponsors and participants benefit from the consistent application across all providers and health networks.

Adopting a pure RBP may avoid unreasonable or excessive provider charges – potentially lowering both the cost of coverage (employer and employee contributions, over time) and employee point of purchase cost sharing. Given the wide variation of provider charges for the same services, without any difference in quality, a pure RBP design offers you an opportunity to avoid excessive and unreasonable provider fees and charges – to reduce eligible expenses which will, in turn:

- Immediately lower participant out-of-pocket costs, and
- Lower the cost of coverage, today and in the future – lowering both employer and employee contributions.

Migration to Employer-Sponsored, Self-Insured Health Plans

The growing adoption of self-insured health plans is often in response to significant increases in insurance premiums. The average increase in the cost of health insurance has been about 4.5 percent per year[4] for the past five years. Employers who chose self-funded coverage are attracted to unique cost management opportunities when compared to the premiums, taxes, state mandated benefits, profit margins and other requirements that are typically part of traditional, fully insured plans.

Employers are attracted to self-insured coverage because of the greater level of flexibility that comes with being able to tailor the plan to meet their employee's needs. Although employers take on additional financial risk, they can limit total risk through the purchase of a stop-loss policy, and they benefit from the increased cost savings typical of the self-funded model.

Self-Insured Plans "Done Right"

Self-insured plans incorporate the most effective strategies available today. Based on all metrics and experience, this includes reference-based pricing, adequate participant protections against balance billing, participant advocacy, litigation support and effectively designed HSA-capable coverage. It also includes features and transition provisions that specifically address the needs of Americans with lower wages, as well as those living paycheck to paycheck.

Over time, a self-funded strategy has a favorable impact on the cost of coverage, meaning that it will favorably impact both employer and employee contributions, in turn, favorably impacting take home pay for lower wage workers. Making every day medical services financially feasible for lower wage workers improves health equity – minimizing the number of workers who go without care because of cost.

Harnessing Technology and Powerful Data

A tech-driven approach can provide health plans and their participants with information and tools to better manage their health care costs. Harnessing technology to understand the vast amount of data can identify potential areas of escalating health costs and identify opportunities to control health costs.

Plan sponsors recognize there is considerable room for improvement through claims analysis. Innovative medical billing services utilize powerful data-driven software and online data analytic tools that can provide a degree of price transparency and new insights by harnessing price data electronically – allowing fee comparisons that identity fair and reasonable prices.

Benefits of A Medical Billing Partner

Today, employer-sponsored health plan members benefit from billing partnerships that provide data insights through software and data-driven solutions. Real-time price information of the true cost of care enables plan sponsors and members to make the most advantageous cost-benefit decisions regarding care options. The right medical billing partner will be an agent of change, embracing innovation and advocating for "what is fair and just." The right partner will also provide value-added services through turnkey solutions, innovative plan designs, administrative and compliance support, as well as legal representation of participants. This support can provide invaluable guidance to navigate new federal and state healthcare regulations, identify areas to lower risk, reduce costs, and maximize value and returns on cost savings.

Notes

1. *https://www.bls.gov/cpi/.*
2. *https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2021-2030-projections-national-health-expenditures.*
3. *https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/reference-based-pricing-lowers-health-plan-costs.aspx.*
4. *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.*

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