Strategic and Tactical Responses to Post-Pandemic Healthcare Inflation

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Fear is quite the motivator. Our first pandemic in 100 years triggered significant change in the healthcare industry. There were dramatic investments and spending on public health. Providers initially saw significant declines in the use of elective medical procedures in 2020, followed by a gradual return to pre-pandemic levels in 2021 and 2022. Because Medicare and Medicaid services incorporate limits on reimbursements, the significant disparity in reimbursements rates for the same services remains. Enrollment in government-sponsored plans experienced significant increases during and following the pandemic, while a smaller percentage of the American population was covered under employer-sponsored health plans. Employer-sponsored healthcare has, for the most part, failed to adapt. This article provides, as its title succinctly describes, strategic and tactical responses to the situation.

INTRODUCTION

At best, the responses to two great systemic shocks, Health Reform and the pandemic, have been evolutionary, not revolutionary. Most employer-sponsored coverage continues to be in the form of a preferred provider organization (PPO) structure where conventional pricing (negotiations between providers and insurance) continues to allow wide variations in costs, some excessive.

The marketplace for employer-sponsored coverage continues to slowly evolve as America's COVID-19 experience transitions from pandemic to endemic. Some cost management tactics and strategies have gained wider acceptance over the past two decades, such as the increases use of self-funding in plans of modest size. As more and more plans assume all financial responsibility for claims as a means to avoid state and local mandates and to lower administrative costs and insurance taxes, employers are increasingly using analytical tools alongside newly transparent pricing information to get a deeper understanding of individual claims and payment.

For comparison, as the average deductible in employer-sponsored plans approaches $2,000, many more employers may decide to adjust their coverage to a health savings account (HSA)-capable structure. Continued sharing of increased costs by adjusting at the point of purchase, deductibles, co-payments, and co-insurance, has increased deductible amounts where a sizeable minority exceed the minimum required for participation in an HSA. Now, almost two de-

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cades old, HSAs offer workers America's most valuable benefits tax preference.

Importantly, the expanded use and continuation of hybrid and remote work, common during the pandemic, may be a challenge to plan's that utilize networks that are geographically limited.

THE RETURN OF DOUBLE-DIGIT HEALTHCARE INFLATION

To quote Yogi Berra: "It's tough to make predictions, especially about the future." Or, "the future ain't what it used to be."

Amazingly, post-Health Reform, post-pandemic, employer-sponsored health plans are still standing. In September 2014, less than 10 years ago, in the afterglow of The Patient Protection and Affordable Care Act of 2010 (PPACA), human resources professionals were treated to a couple of unique predictions about employer-sponsored health coverage:

- By 2020, 90% of employees currently receiving health insurance through their employers will be shifted to individual health insurance and private and public exchanges, according to a May 2014 analysis of S&P 500 companies by S&P Capital IQ Global Markets Intelligence, a financial research and advisory group.[1]
- "By 2025, few private-sector employers will still be providing health insurance," declared Ezekiel J. Emanuel, author of *Reinventing American Health Care* and advisor to the Obama administration during the drafting of the PPACA.[2]

Those predictions anticipated that Health Reform would greatly accelerate the then-existing trend of declining enrollment of Americans in employer-sponsored health coverage—which had already declined from 69.7% in 2000 to 59.5% in 2011.[3]

Estimates vary, but most recently, AHIP estimated that 54% of Americans, 177 million, have employer-sponsored coverage.[4]

For plans that continue employer-sponsored health coverage without change from 2022 to 2023, informal broker and consultant surveys suggest that the average, initial renewal estimate will reflect a high single or low double-digit cost increase. Keep in mind that averages are often deceiving. And, as in years past, we expect employers will respond both strategically and tactically.

The May 2022 Consumer Price Index (CPI) indicates that we may soon see double-digit inflation rates. In a 12-month lookback, all items index increased 8.6% before seasonal adjustment. "Core CPI" (excluding energy and food) increased 6.0%—the equivalent of a 9.1% increase using measures in place in the 1980's. For comparison, core CPI increased 13.6% in June 1980.[5]

Second, it is worth noting that CPI is not a true measure of inflation. The CPI measures price changes over time for a given basket of goods. When constructing a national CPI, it includes an array of goods and services—an average—which likely reflects no one American's actual purchases. For each American, that market basket changes every time people make purchases—snap decisions reflecting the perceived value as prices change. Price elasticity or inelasticity greatly affects what goods consumers buy or do not buy on any given day. Health coverage, services, and products are highly inelastic.

Even with those caveats in mind, recent data suggests that recent consumer inflation may worsen. The Producer Price Index (PPI) for this past May showed a 0.8% increase

(annual 10.8% over May 2021). Core PPI shows a 0.5% increase after already increasing by 0.4% in April.[6] As PPI increases, CPI is expected to either increase or remain constant for multiple months.

SURGING INCREASE IN PANDEMIC PUBLIC HEALTHCARE EXPENDITURES

In 2019, national health expenditures grew 4.6% to $3.8 trillion. Expenditures are projected to grow at an annual rate of 5.4% and reach $6.2 trillion by 2028.[7] The Centers for Medicare & Medicaid Services (CMS), which released its 2021-2030 National Health Expenditure (NHE) report, presents health spending and enrollment projections for the coming decade.[8] To counter the pandemic, public health spending more than doubled in 2020, and CMS projections show public health spending remaining high in 2021 and 2022.[9]

Surge in Demand and Utilization, Limited Capacity, and Clinical Resources

COVID-19 drove a surge in demand for emergency services and diagnostic testing. The pandemic revealed significant vulnerabilities in hospital supply chains. Healthcare is still adapting to the COVID-19 surge and its direct impact on testing, vaccinations, and hospitalizations that continue to challenge clinical processes, capacity, and resources—in 2022 and, likely, 2023.

Indirect costs of COVID-19 include increased mental health and substance use issues, obesity, and worsening population health. Poor pandemic-era health behaviors such as lack of exercise, poor nutrition, increased substance use, and smoking may lead to deterioration in U.S. population health and increase healthcare spending.

Concurrently, the aging U.S. population adds to the surge in demand. The Administration for Community Living found that, from 2009 to 2019, the population aged 65 and older increased by 36%. By 2040, the age 65+ population is expected to be 80.8 million.[10] Specifically, cases of cancer, dementia, obesity, diabetes, and injury from falls are expected to increase.[11] Such increased demand will likely prompt an increase in resource allocation to aged Americans.

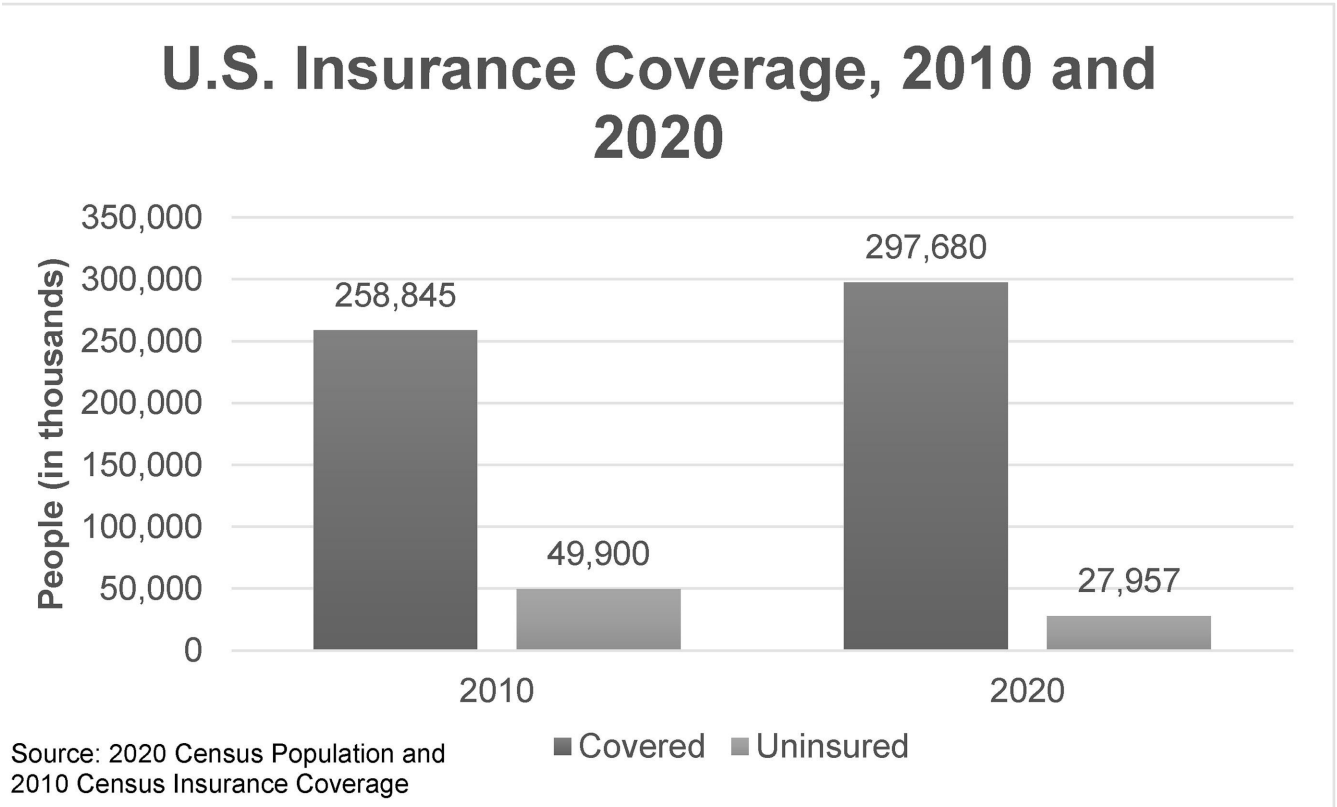
CHANGE IN HEALTH COVERAGE ENROLLMENT—2020 TO TODAY

Medicare, Medicaid and public exchanges have experienced significant increases in enrollment. From February 2020 to February 2022, Medicaid enrollment has increased by over 16 million.[12] This increase may be attributed to the combination of significant turnover in employment coupled with the current administration's outreach to historically underinsured communities. The administration's focus on healthcare is also demonstrated by their focus on the Open Enrollment Period (OEP) for the private insurance market. The 2022 OEP, from November 1, 2021, to January 15, 2022, more than 5.8 million people gained new coverage. The total enrollment via public exchanges was a record-breaking 14.5 million.[13]

The increased enrollment reduced the number of uninsured. It was prompted, in part, by an expansion in tax credits. The American Rescue Plan Act (ARPA) became law in March 2021. It provided aid to rural hospitals and vaccine development. It increased access to Medicaid.[14] It also temporarily expanded health insurance subsidies to increase access to private coverage.[15] As a result, from Q4 2020 to Q4 2021, the uninsured rate for Americans under 65 declined from 12.3% to 10.5%.[16]

Concurrently, throughout 2022, Medicare overall enrollment will increase by over 1

million.[17] Between 2010 and 2020, the number of insured individuals rose by over 38 million (see below).



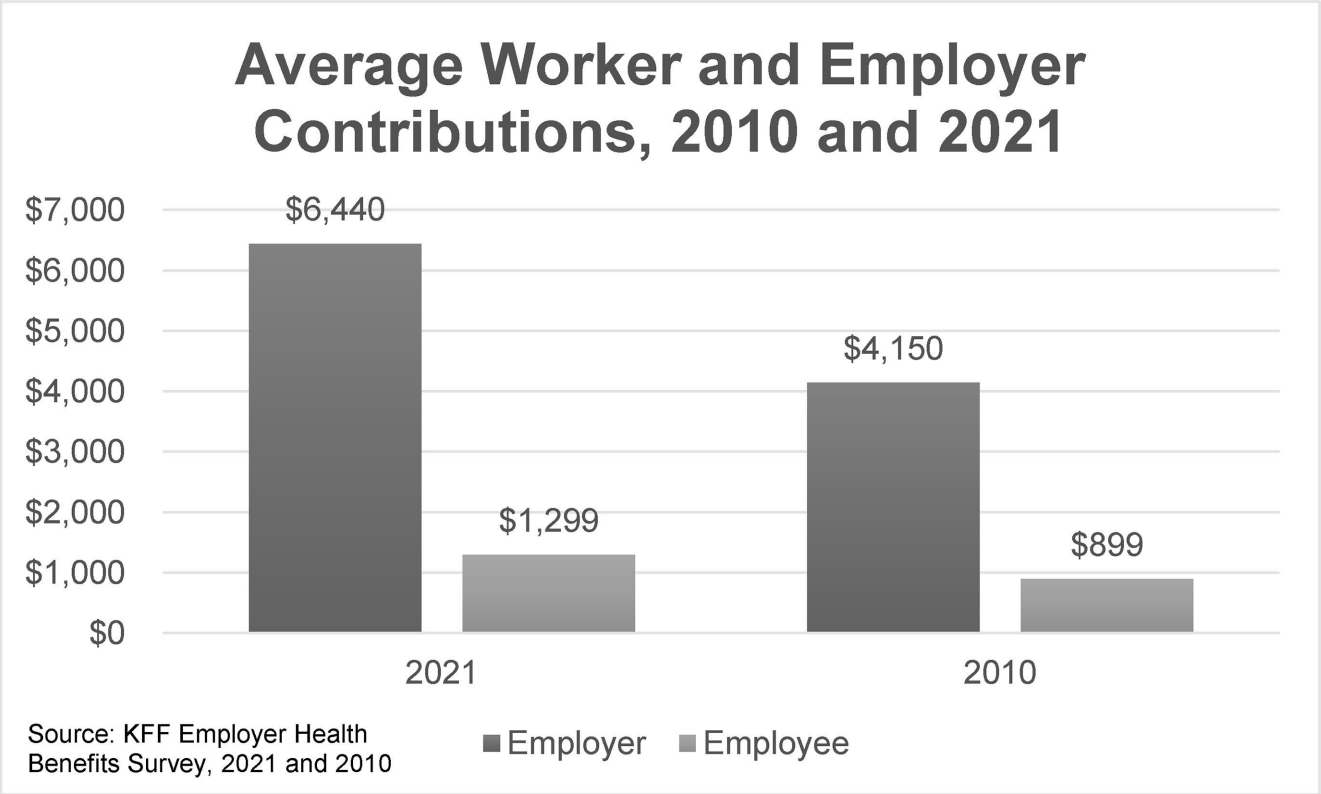
Source: 2020 Census Population and 2010 Census Insurance Coverage

Neither Health Reform nor the pandemic have accelerated the trend where an ever-smaller percentage of Americans have employer-sponsored coverage. However, working American taxpayers are shouldering more of the healthcare burden, directly in terms of their contributions and point-of-purchase cost-sharing (deductibles, co-payments, co-insurance) and indirectly through taxation to fund individuals covered under government-sponsored programs.

FUNDING OF COVERAGE—WHO PAYS, HOW MUCH, FOR WHAT

Premiums

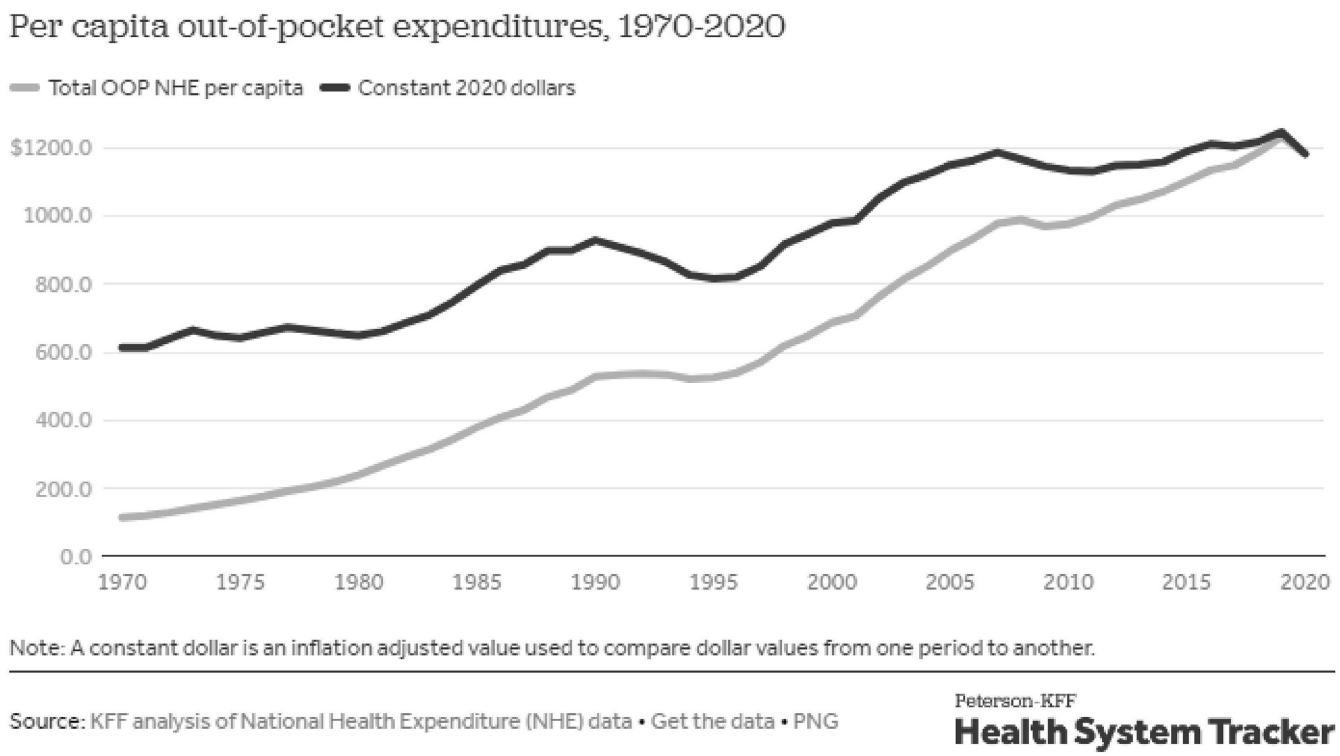
Overall, the cost of employer sponsored coverage has steadily increased. In 2021, the average premium for single coverage was $7,739 and was $22,221 for family coverage.[18] The below graph shows the split between employer and worker contribution.[19]



Although employers tend to cover the majority of the cost of coverage, recent increases in price still affect workers. From 2019 to 2021, average employee contribution for single coverage increased by 4.5%.[20]

Out-of-Pocket Costs

In 2021, the average deductible for employer-sponsored plans was $1,669, up significantly from $917 in 2010 (5.6% per year over 11 years).[21] As a result, most participants in employer-sponsored plans did not satisfy their deductible and per-capita out-of-pocket costs have continued their five-decade long decline, as a percentage of overall healthcare costs.[22]



While the costs borne by workers for their own coverage have increased steadily, at modest rates, the portion of health spend born by taxpayers continues to increase—and is expected to accelerate over the next 10 years.

Medicare's Payroll Tax

Medicare Hospital Insurance is funded by a 2.9% tax on all wage income (split evenly between a 1.45% tax deducted from paychecks and a 1.45% tax paid by employers). Health Reform added a 0.9% surcharge on wages in excess of $200,000.[23]

However, Medicare Part B (physician and other outpatient services) and Part D (prescription drugs) are not funded by that payroll tax. Instead, taxpayers fund approximately 75% of the cost of those coverages from general revenues—primarily income taxes.[24] While Medicare enrollment continues to increase as the Baby Boom generation ages into eligibility, the burden is shared by fewer taxpayers. The nonpartisan Tax Policy Center estimates that only 43% of U.S. households paid federal income taxes for 2021, down substantially from 56% before the pandemic.[25]

COVID-19 has had impacted Medicare enrollment. Its effect on funding is uncertain. However, the Part A Trust fund is still projected to be exhausted in the next five or so years (depending on the assumptions used). So, an increase in funding is likely, either an increase in the payroll tax or other new revenues such as an "excess profits tax."[26]

CONTROLLING SPEND, NOT COSTS

Medicare and Medicaid Reimbursements Do Not Cover the Full Cost of Treatment in Hospitals

Medicare beneficiaries obtain significant relief from price controls. Medicare enrollees also obtain significant relief in the form of balance billing limits.[27] For comparison, only a small percentage of employer-sponsored plans have incorporated reference-based pricing (RBP) which usually leverages

Medicare price controls like the resource-based relative value scale (RBRVS) and diagnostic related groups (DRGs). The RBRVS establishes a uniform physician payment scheduled based on the resources used to provide the service.[28] A DRG is a case-mix complexity system implemented to categorize patients with similar clinical diagnoses in order to better control hospital costs and determine payor reimbursement rates. The resulting reimbursement rates are typically less than the actual cost of the services provided. For comparison, most employer-sponsored plans have covered charges that are more than twice the Medicare Allowable Amount.[29]

HOW INCREASING HEALTHCARE COSTS AFFECT PLAN PARTICIPANTS

Allocation of Plan Benefits and Employer Cost-Sharing

Mercer's 2021 National Survey of Employer-Sponsored Health Plans found that employers expect health benefit costs to rise 4.7%. The same Mercer survey showed fewer adjusted their point-of-purchase cost-sharing (deductibles, co-payments or coinsurance) with only 38% making changes, down from 47% that made changes in 2021. Most employers held the point-of-enrollment cost-sharing steady as well—asking employees to pick up 22% of the total cost of coverage. Further, 21% of employers said they plan to add or enhance wellbeing initiatives targeted to remote workers in 2022.[30] Employers are also offering hybrid work options to accommodate for workers' desires to work from home.[31]

How Participants Respond to Cost-Sharing

In 2018, the Society for Human Resource Management (SHRM) found that 46% of U.S. adults said that availability of health insurance was either the deciding factor or a positive influence when choosing their job.[32] The pandemic has further exposed the possibility that a much larger segment of Americans may be financially fragile—living paycheck to paycheck and unprepared for regular household expenses, let alone out-of-pocket medical expenses.

Recent general inflation adds new stress to household budgets. Many have not set aside savings specifically earmarked for out-of-pocket medical expenses, including regular cost-sharing—deductibles, co-payments or co-insurance. Now more than ever, employees (and potential employees) respond to lower costs and benefits tailored toward hybrid work and virtual care.

TACTICAL SOLUTIONS

Self-Funded Plans

Although surveys vary, the general consensus is that roughly half of the U.S. population receives health coverage through their employer. The average increase in individual health insurance premiums has been about 4.5% per year for the past five years.[33] And, in nominal dollars, some Americans are paying more out-of-pocket than ever before.

Following Health Reform, more small and mid-sized employers turned to self-funding health plans. In a self-funded plan, the employer takes on the costs of claims instead of an insurance company. Insurance providers are often involved in network price negotiation, but the employer assumes the financial risk.[34] Unlike insured plans, self-funded health plans face less regulation and fewer mandates. For example, employers who offer a choice of self-funded coverage need not meet Health Reform Essential Health Benefits (EHB) requirements in every option.[35] Avoiding complex regulation, insurance taxes, and mandated benefits often helps to lower administrative costs and premiums.[36]

After Health Reform, the percentage of workers covered by

self-insured health plans has grown to two-thirds of all workers with employer-sponsored coverage.[37] Employers often limit liability through stop-loss insurance.

Healthcare Consumerism

Healthcare consumerism is transforming the delivery of healthcare services. Consumerism is most effective when workers prepare for the time when they will become patients—both in terms of saving for out-of-pocket costs as well as provider, service, and product selection in non-emergency situations. Today, healthcare consumerism empowers patients with information so they can proactively make informed, cost-conscious decisions about non-emergency health services.

Taking Advantage of Pricing Transparency

Rising inflation and its effect on healthcare costs and spending has put price transparency in the spotlight. As of January 1, 2021, CMS issued mandates that hospitals operating in the United States provide clear, accessible pricing information online about the items and services they provide.[38] Under CMS guidance and final rules, hospitals are required to make pricing information available in machine-readable format, as well as provide a list of shoppable services that a patient can schedule in advance.[39] This is intended to make information accurate and easier to access for health service consumers to compare prices, estimate the cost of care, and confirm market value.

The No Surprises Act, as a part of the Consolidated Appropriations Act, further improves transparency in healthcare. The No Surprises Act prohibits healthcare providers from entering into contracts that prevent them from disclosing "provider-specific price or quality of care information."[40] As the government removes obstacles between patients and prices, more Americans may consider price in the selection of medical services.

STRATEGIC AND COMPLIANCE-ORIENTED SOLUTIONS

Employers may find that the best response is through an approach that is both strategic *and* compliance-oriented. A dual approach will minimize the compliance challenge, reduce the cost of coverage for both the employer and employees, and, at the same time, improve both the perceived and actual value of health coverage.

Reference-Based Pricing

Even with greater price transparency, significant variations can still exist across hospitals and providers for standard procedures. Because of this, a minority of health plans have adopted reference-based pricing (RBP). Designed primarily 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.

RBP is an example of a strategic response to avoid compliance with many aspects of the No Surprises Act. RBP brings transparency to healthcare prices by using Medicare reimbursement rates and/or other provider cost data to provide an objective cost baseline. RBP offers disciplined pricing to ensure fair and rational provider reimbursements.

A RBP plan may avoid unreasonable or excessive provider charges—potentially lowering both the cost of coverage (employee *and* employer 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 RBP design offers an opportunity to

reduce eligible expenses which will, in turn:

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

The most effective way to address the No Surprises Act legislation, particularly elements of the independent dispute resolution (IDR) process, may be to adopt a "pure" RBP plan that does not contract with providers. As there is no provider network, it should remain unaffected by the No Surprises Act because there will not be any out-of-network claims[41]—nor will there be a need to calculate the median in-network rate. The No Surprises Act may prompt a significant expansion in the prevalence of pure RBP plans since RBP often eliminates the negative effects of excessive charges—charges that would otherwise be shared by the employer and the participant.

Some RBP payers use online software to determine the price they will pay for a healthcare service. RBP software methodology includes collecting data on prevailing costs for medical services from CMS' HCRIS (Healthcare Provider Cost Reporting Information System), benchmarking it against relevant types of hospitals and settings, further calibrating by severity level, and applying a margin factor.

Health Savings Accounts

Even though most employer-sponsored health plans maintained a modest level of cost-sharing, a 5% to 6% per year increase in employee contributions and deductibles doubled those costs, in nominal dollars, since Health Reform became law in 2010. Healthcare inflation is impacting both employee contributions and out-of-pocket costs. Increasingly, health plan sponsors have adopted strategies and designs that enable members to proactively build medical expense savings.

The health savings accounts (HSA) has slowly evolved to become part of a "health and wealth" rewards strategy. Although HSA-capable coverage will celebrate its 20th birthday next year, the take up by plan sponsors and participants has been modest, at best. 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.

When it comes to employer-sponsored benefits, HSAs offer the most utility. In almost all respects, an HSA provides a superior value when compared to 401(k) and 403(b) plans, as well as health flexible spending accounts (FSAs).

HSA assets 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 FSAs. Unlike FSA accounts, there is no "use or lose" or forfeiture provisions. Unspent money rolls over from year to year.

Because most employers do not offer HSA-capable coverage, adding this option can create a competitive advantage for both the employer and participants. How HSAs are implemented will significantly impact enrollment and utilization.

Both plan sponsors and participants are still learning the benefits of HSAs. Education should focus on the advantages and clear rewards—both now and in the future. Health plan sponsors should consider how HSA-capable coverage is communicated to employees to

fuel greater adoption and optimization of these accounts.

The challenge of an HSA is getting workers to focus on the differences in contributions, deductibles, and employer support in the form of contributions to HSAs and out-of-pocket expense maximums. This often arises when an employer simply adds HSA-capable coverage as an alternative to a traditional PPO and/or health maintenance organization (HMO) option, without any education nor any adjustments or transitions. Traditionally, the type of health plans needed to open and contribute to an HSA are high deductible health plans (HDHPs). "High deductible" can lead employees to believe that that plan is more expensive and disincentivize them from enrolling. A way to reframe employee perception is to shift the focus on lower monthly premiums and refer to an HSA-qualified plan as a "consumer-driven" health plan.

Employers can start implementation by conducting full-positive annual enrollments. When individuals elect medical coverage, using the HSA-capable option and a positive contribution amount as defaults prompts employees to opt out if they want a different coverage option. Opening the HSA on the first day of coverage with a nominal employer contribution gets them off on the right foot. Also, adding midyear HSA re-enrollment can help, as does altering the default investment from capital preservation to longer-term investments.

The best overall strategy is to leverage all tax-preferred benefits—the HSA, the health FSA, and a tax-qualified retirement savings plan. Leveraging automatic features in terms of both HSAs and FSAs requires positioning medical coverage to get the incentives right—which might include increasing the dollar amount of point-of-purchase cost, and concurrently "leveling the playing field" by adjusting coverage design for options that are not HSA-capable to parallel the HSA-capable coverage structure.

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 any employer financial support in the form of an HSA matching contribution.
- Default individuals into the HSA, with 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.
- Prompt mid-year re-enrollment into the HSAs or a mid-year automatic escalation in HSA contributions.

Managing Enrollment

Recently, the Internal Revenue Service (IRS) proposed a change in regulations regarding the determination of "affordability" under Health Reform.[42] While the so-called "family glitch" regulations left the definition essentially unchanged for employer-sponsored plans, it would increase the number of families who might waive employer-sponsored coverage and enroll in taxpayer-subsidized, exchanged-based coverage.

Should those regulations take effect in their current form in 2023, some employers may respond with point-of-enrollment changes (employee contributions, opt-out incentives, spousal surcharges, and so forth) for the 2023 annual enrollment cycle.

TAKING STRATEGIC ACTION

In terms of post-pandemic actions, most industry experts anticipate a continuation of the evolutionary response most experiences after Heath Reform. However, some plan sponsors will take strategic action—changes that go far beyond simple compliance with the No Surprises Act and the Consolidated Appropriations Act—to ensure that their employer-sponsored, self-insured plans incorporate the most effective strategies available today. Based on all metrics and experience, these strategies include HSA-capable coverage, along with RBP, coupled with adequate participant protections against balance billing.

The Great Resignation and Return to Work

One unique challenge following the pandemic resulted from the significant turnover in employment. During the period March 2020 through February 2021, there were 80+ million initial claims for unemployment. Later in 2021, labor demand surged as industries tried to recover from the economic downturn. Workers were expected to rush back into the labor force, but that did not occur. Roughly 3.5 million Americans were expected to start looking for a job, but only 1.8% of Americans sought employment.[43]

Financial fragility and pandemic circumstances are the key explanations for the above discrepancy. The pandemic put many workers in a situation where they needed better work conditions and benefits. Online work gave workers just that, along with a flexible lifestyle.[44] After experiencing that kind of work environment, many workers simply refuse to work at jobs with low wages and in-person work. This point is proven by segmenting the labor force; some markets actually have a surplus in workers while others have a shortage. Transportation, healthcare and social assistance, and the food sector are experiencing the worst shortages. The sectors with a labor surplus are the same sectors that have the highest potential for remote work: finance, management, professional services, and IT.[45] Workers are contributing to America's strong economic recovery—but they do not want to return to full in-person work.

These seismic shifts in employment have prompted a very high demand for workers—where the number of job openings is twice that of the number of unemployed workers.[46] Some consultants and brokers as well as human resources professionals might advance a strategy of enhanced health benefits as a lever to attract, retain, and engage top talent. However, there is no empirical data that show health benefits to be a differentiator of talent—at hire or later. There is data, however, that suggests lucrative health benefits can attract anti-selection.

At the same time, few human resources professionals are interested in strategies that would add to the disruptions and dislocations triggered by Health Reform compliance and the pandemic.

HARNESSING TECHNOLOGY AND POWERFUL DATA

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. Real-time price information of the true cost of care enables engaged plan administrators and participants to make the most advantageous cost-benefit decisions. A tech-driven approach provides information and tools to

better manage healthcare costs.

PARTNERING WITH THE RIGHT BILLING PARTNER

Plan sponsors should consider partnering with a medical billing partner that is fully engaged in ensuring that employer-sponsored, self-insured plans incorporate the most effective strategies. 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.

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