Key Strategies that Help Plan Sponsors and Participants Navigate Challenging Healthcare Costs

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While the United States spends three times[1] more per person on medical expenditures than the average developed country, the increased spend does not necessarily improve outcomes. Contributing factors to this disparity include a lack of price transparency and the tendency to over-insure and under-prepare for medical costs, in addition to pernicious health inequities. The critical need for plan sponsors and benefits managers, as well as employees, to play a more proactive role through a "health and wealth" strategy has never been more urgent. Employers continue to pursue strategies that will manage the cost of healthcare coverage—both employer- and employee-paid costs. While cost savings opportunities exist, the focus should be on designs and strategies that prepare employees to be better consumers—before they become patients. Preparation includes preventive services designed to improve health and reduce inequities. Preparation also responds to the financial realities of today. Most employees have no personal savings set aside for out-of-pocket medical expenses, and many are left unprepared when a medical bill arrives.

TODAY'S HEALTHCARE FINANCIAL CHALLENGES

A top priority for many workers is a goal of reducing out-of-pocket medical expenses and avoiding unplanned financial burdens from the cost of medical services. America's resumption of a higher level of general inflation is likely to increase the focus on medical costs.

In March 2022, the Consumer Price Index[2] for all urban consumers rose 1.2%, seasonally adjusted, and rose 8.5% over the last 12 months, not seasonally adjusted—with more inflation on the way. The Bureau of Labor Statistics (BLS) also confirmed that the Producer Price Index increased 1.4% in March 2022—an annualized rate more than 15% and 11.2% for the 12 months ending in March 2022.

The trend to ever-increasing medical costs is also well-documented by The Centers for Medicare & Medicaid Services (CMS). CMS released the Key Strategies of health spending and enrollment projections for the next 10 years. According to this report, the percentage of the U.S. population with health insurance is expected to be 91.1% in 2022. Private health insurance spending growth is projected to average 5.7%, and out-of-pocket expenditures are projected to grow at an average rate of 4.6% over 2021-2030

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and to represent 9% of total spending by 2030.

CMS also 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, co-payments and co-insurance. Many employer-sponsored health maintenance organization (HMO) and preferred provider organization (PPO) options 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.

In 2021, the Key Strategies for employer-sponsored health insurance were $7,739 for single coverage and $22,221 for family coverage. The average single and family premiums increased 4% over the past year. During this period, workers' wages increased 5% and inflation (as estimated by the Consumer Price Index) increased 1.9%. The average premium for family coverage has increased 22% over the last five years and 47% over the last 10 years. Covered workers in small and large firms have similar premiums for single coverage ($7,813 vs. $7,709) and family coverage ($21,804 vs. $22,389). Experience suggests that recent, dramatically higher levels of general inflation will trigger a surge in medical expense, further burdening many already-strained household budgets.

Benefits advisors can help plan sponsors and participants ready themselves for continuation of this new cycle of higher inflation. Improved financial wellness is possible where plan sponsors reevaluate claims data to reconsider and reshape levels of employer financial support. They can improve financial wellness by adding tax-preferred savings with an employer match to prompt employees to accumulate assets and be prepared for out-of-pocket costs—whenever they arise. Accumulating savings in tax-efficient programs is a necessary component of consumerism. A strategic response will improve both short-term and long-term outcomes, for both the plan sponsor and participants.

PRICING TRANSPARENCY

Congress passed, and on December 27, 2020, President Trump signed into law, the No Surprises Act, as part of the Consolidated Appropriations Act of 2021.[3] That legislation, coupled with Executive Order 13877—Improving Price and Quality Transparency in American Healthcare to Put Patients First—significantly expanded the requirements for hospital and other medical provider price 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 service—before receiving care. Healthcare consumerism can transform the delivery of healthcare services, which is an important aspect of 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. Strategies exist that take advantage of price transparency to capitalize on cost management initiatives and fully optimize value. These approaches have the potential to transform an employee's health coverage usage, putting the economic purchasing power and decision-making in their hands.

REFERENCE-BASED PRICING

The forthcoming increase in price transparency coupled with the "surprise" medical bill requirements is expected to prompt more plan sponsors to (re)consider the opportunity reference-based pricing (RBP) presents. A "pure" RBP design, coupled with tech-driven data support, will not only lower employer and employee spend, but will also allow plan sponsors to avoid many of the No Surprises Act requirements and costs.

Even with greater transparency, significant price variations can still exist across hospitals and providers for standard procedures. And, once the range of charges for standard procedures are publicly available, we expect providers who currently charge less than the median amount to increase their charges.

A 2019 Rand study confirmed that relative hospital prices rose from 236% of Medicare rates in 2015 to 241% of Medicare rates in 2017. Among hospital systems, prices varied nearly threefold, ranging from 150% of Medicare rates at the low end to 350% to 400+% at the high end. And, importantly, relative prices for hospital outpatient services were 293% of Medicare rates on average, far higher than the average relative price for inpatient care—204% of Medicare rates.[4]

Health plan sponsors may respond by adopting RBP 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 structure, a plan without a network of providers, may avoid unreasonable or excessive provider charges—potentially lowering both the cost of coverage 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 an opportunity to avoid excessive and unreasonable provider fees and charges. Reducing eligible expenses can:

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

CONTRIBUTING TO AN HSA

As Americans get sicker with rising rates of obesity and chronic conditions, healthcare inflation is also raising to alarming rates, impacting already financially vulnerable Americans. To offset this, experts recommend that health plan sponsors and members focus on proactively building medical expense savings rather than cost-containment.

The health savings account (HSA) is ideal for today's "financially fragile" workers—unprepared for everyday expenses, let alone out-of-pocket medical expenses. Most have no savings earmarked for regular medical cost-sharing. Done right, an HSA strategy will better prepare participants for co-payments, deductibles, co-insurance and unexpected out-of-pocket medical expenses.

HSAs offers the most utility when compared to employer-sponsored benefits. In almost all respects, contributing to an HSA is a superior value when compared to 401(k) and 403(b) plans and health flexible spending accounts (FSAs). Do not limit HSA participation as if it were a "Super FSA" and do not limit it to pre-tax contributions to pay current year qualified medical expenses. HSAs can be a powerful, comprehen-

sive solution. Sponsors can position HSAs as part of their "health and wealth" strategy—a program capable of "Quadruple Duty":

- Fund current and future year medical costs.
- Fund Medicare and long-term care (LTC) premiums and out-of-pocket medical and LTC costs in retirement.
- Use to provide an income in retirement, without tax penalty (after age 65).
- Serve as a survivor or legacy benefit—unused monies are passed on to designated beneficiaries.

HSAs receive America's most valuable benefits tax preference—contributions are pretax 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.

THE HSA CHALLENGE

One-third of Americans say they cannot afford to contribute to an HSA, according to a 2021 survey of 805 adults 18-64 years of age who had employer-based private health insurance continuously for the past two years. What is more, workers face mounting healthcare affordability issues, with health plan cost-sharing features, such as high deductibles, being a primary cause.

Eighty-five percent of covered workers in 2021 were enrolled in a plan with a general annual deductible for single coverage, similar to the percentages of the previous year (83%) and five years ago (83%) but higher than the percentage 10 years ago (74%).

For covered workers in a plan with a general annual deductible, the average annual deductible for single coverage is $1,669, similar to the average deductible ($1,644) the previous year. For covered workers in plans with a general annual deductible, the average deductibles for single coverage are $1,271 in HMOs, $1,245 in PPOs, $1,852 in point-of-service (POS) plans and $2,424 in high deductible health plans with savings options (HDHP/SOs).

For comparison, the minimum deductible for an HSA-capable plan in 2022 is $1,400 for single coverage and $2,800 for family coverage. As an offset to the deductible, the average employer contribution to the HSA was $575 single and $987 family.

Finally, the average annual worker contribution for workers in HSA-qualified HDHPs are $1,134 for single coverage versus $1,204 (HMO) and $1,389 (PPO).

OTHER KEY STRATEGIES

Disease Management

When it comes to disease management programs, one study found that 30% of employers offer a financial incentive for completing a health risk appraisal. In addition, 20% offer a financial incentive for participation in a health management program. These incentives commonly include cash (32%) and gift certificates/merchandise discounts (30%). At the same time, the use of lower employee contributions has risen from 17% to 27%. This reflects employer recognition that incentives in the form of lower contributions provides a direct link between encouraging preventive health measures, lower medical utilization, and less medical cost. The employees perceive this as sharing in the cost savings from improved health and wellness.

Optimizing Wellness

As much as 70%[5] of health-

care spending can be attributed to behavioral and lifestyle choices. Therefore, more employers are offering health improvement programs. According to a RAND Report,[6] return on investment (ROI) on wellness programs, done right, can have a substantial impact on lowering healthcare claims and costs, increasing productivity, and improving hiring and retention—all of which helps the bottom line.

A *Harvard Business Review* article confirmed how ROI can be attained through employee wellness programs that are available to high health risk employees. Of those classified as high risk (with body fat, blood pressure, anxiety level and other measures):

- Fifty-seven precent were converted to low-risk status by the end of the six-month program.
- Medical claim costs declined by $1,421 per participant, compared to the previous year.
- Every dollar invested in the employee wellness program yielded $6 in healthcare savings.

Wellness benefits can be as simple or as complex as an organization wants. Some wellness benefits help employees deal with preventable and chronic conditions, such as obesity, high glucose, and elevated cholesterol, while others are incentive programs designed to motivate employees to complete certain health and wellness activities, such as annual health risk assessments, smoking-cessation programs, or weight-reduction programs.

According to the 2019 SHRM Employee Benefits Survey, the most common wellness benefits provided by more than one-half of organizations were wellness tips and information sent to employees (64%), onsite seasonal flu vaccinations (60%), and a wellness program (58%).

Before implementing a particular wellness program or initiative, an organization should carefully consider the potential costs, advantages, levels of employee participation, and legal concerns. Employers view low engagement as the greatest obstacle to their wellness initiatives. Therefore, fine-tuning an organization's benefits communication efforts can make a difference in encouraging employees to get involved in wellness initiatives.

SELF-FUNDED PLANS "DONE RIGHT"

The growing adoption of self-insured health plans is often in response to significant increases in insurance premiums. Employers who chose self-funded coverage are attracted to its 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 also drawn to self-insured coverage because of the greater level of flexibility that comes with being able to tailor the plan to meet their employees' needs. Although employers take on additional financial risk, they can limit total risk through the purchase of a stop-loss policy and benefit from the increased cost savings typical of the self-funded model.

Under a self-funded arrangement—also called self-insured—the employer assumes the liability and risks of providing health coverage in exchange for more control over the plan's administration and funding. They are most prevalent among organizations with 500 or more employees, although self-funding can work for smaller companies as well.

An employer can use the money it would otherwise pay to an insurer and establish a special bank account to pay for claims. Again, this is where benefits advisors can play a

key role by developing a customized medical plan for the group.

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.

A third-party administrator (TPA) can receive and manage claims and arrange to have preferred PPO networks, wellness programs, and other managed care elements in place.

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, which then favorably impacts take-home pay for lower-wage workers. Making everyday medical services financially feasible for lower-wage workers improves health equity—minimizing the number of workers who go without care because of cost.

UTILIZING TECH-DRIVEN DATA SUPPORT

Today, participants benefit from data insights through innovative software and tech-driven data analysis solutions. 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.

Harnessing technology to compile the vast amount of data, followed by extensive claims analysis, can help identify areas of escalating health costs, in turn highlighting opportunities to reduce and manage spending. Innovative medical billing services utilize powerful data-driven software and online data analytic tools—allowing fee comparisons that identity fair and reasonable prices.

Capturing that data and performing the analysis ensures that information is available in a timely fashion—for a participant to use in advance of receiving services by avoiding providers with excessive charges, and for the participant and the plan administrator to use, after-the-fact, as a metric to determine covered charges.

YOUR MEDICAL BILLING PARTNER

The right medical billing partner can facilitate all these strategic designs and processes—acting as an agent of change, embracing technology innovation, and advocating for "what is fair and just." The right partner will also provide value-added services through turn-key solutions, innovative plan designs, and 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.

Plan sponsors should consider the value of a medical billing partner that is fully engaged in guiding plan sponsors though today's most effective strategies. Based on all metrics and experience, effectively designed HSA-capable coverage, along with reference-based pricing, adequate participant protections against balance billing, participant advocacy and litigation support as needed, wellness, self-funding, and other strategic initiatives, employers can gain a competitive advantage while better serving the current and future needs of their employees.

NOTES:

[1] https://www.investopedia.com/articles/personal-finance/080615/6-reasons-healthcare-so-expensive-us.asp.

[2] https://www.bls.gov/cpi/.

[3]Public Law 116-260.

[4]White and Whaley, Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely, Rand, 2019.

[5] https://www.shrm.org/resourcesandtools/tools-and-samples/toolkits/pages/managinghealthcarecosts.aspx.

[6] https://www.bravowell.com/control-rising-healthcare-costs-with-a-sustainable-wellness-program.