Medical Billing Support Provides Value to Health and Wealth Strategy During Financially Fragile Times

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This article dives into how finding the right medical billing can provide support in care during financially fragile times and how rising healthcare issues on this topic can be addressed.

VALUE OF THE "RIGHT" MEDICAL BILLING PARTNER

Employer-sponsored health plans can significantly benefit from the value of a medical billing partner that is fully engaged in guiding plan administrators though today's most effective and innovative strategies.

The right medical billing partner will be an agent of change, embracing innovation and providing value-added services through turnkey solutions, innovative plan designs, AND administrative and compliance support, as well as legal representation and advocacy of participants. The right partner will also provide invaluable operations guidance AND assistance in navigating the ever-changing federal and state healthcare regulations, identifying options to lower risk, containing and reducing costs, and maximizing plan value.

"What is fair and just" (the definition of "aequum," our company's name) is what we do as we partner with employer-sponsored health plans to protect, support, and advocate on behalf of plan members and dependents. aequum is a first-of-its kind tech-driven company in the complex field of medical billing, employing technical resources and a proprietary database that proactively protects plan members against excessive and unreasonable charges. This includes defending balance bills arising from out-of-network charges, recovery of excessive provider payments, and protection from unfair debt collection practices.

Our company's tech-driven team of specialists partners with self-funded health plans, third-party administrators, insurers, medical cost containment companies, and stop-loss carriers throughout the country, providing administrative and technical support to these partners and legal support to their members. aequum is also advancing the adoption of reference-based pricing and price transparency solutions to control costs, reduce spending, and gain potential savings. The explanation below provides a roadmap for the appropriate and necessary process for the successful medical billing partner.

Harnessing Technology and Powerful Data

Plan sponsors recognize there is considerable room for improvement through claims analysis. Innovative medical billing services utilize powerful

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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.

A tech-driven approach can provide health plans and their participants with information and tools to better manage their health care costs. Software and data-driven solutions provide real-time price information regarding the true cost of care that enable plan sponsors and members to make the most advantageous cost-benefit decisions regarding care options. Harnessing technology to understand the vast amount of data can also identify potential areas of escalating health costs and identify opportunities to control health costs.

FINANCIAL STRESS IN HEALTH CARE

Providing all Americans with access to affordable, quality healthcare is one of the greatest economic challenges of our time. Many Americans 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.

Finding the right balance between a benefit package that is both adequate and affordable yet financially sustainable has never been easy, but it is especially challenging given the current labor market and volatile economic conditions. Health care affordability is a top concern[1] for many workers, in particular low-wage earners or those coping with a chronic medical condition.

Leading up to health insurance annual enrollment, employers and employees alike are at heightened levels of concern over the potential for significant increases in renewal premiums and point of purchase cost-sharing. A near-confirmed national recession, coupled by an ever-increasing rate of inflation, has Americans anxious over "what's next" in terms of cost increases and what will add to their financial stress.

There is agreement on the need to address rising healthcare expenditures and a growing consensus on potential savings. To lower costs, we must first understand the driving sources, then employ best plan strategies and cost management practices that render value for each healthcare dollar.

Healthcare Inflation

Reducing out of pocket medical expenses and avoiding unplanned financial burdens imposed by the escalating cost of care are especially important to employees as inflation is once again rapidly increasing the cost of healthcare and living.

A surge in inflation could potentially devastate healthcare providers, payers, and ultimately patients. Lowering pricing and costs is critical to the nation's health, as well as its fiscal and economic well-being. Periodic surveys by the Kaiser Family Foundation[2] reveal that half of the U.S. population goes without healthcare due to concerns over costs, and one-quarter of those who receive care have financial hardship with paying medical bills. These concerns are further substantiated by The Centers for Medicare & Medicaid Services (CMS) which released the 2021–2030 National Health Expenditure (NHE) report[3] that presents health spending and enrollment projections for the coming decade.

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 and to represent 9% of total

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spending by 2030. As a result, 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.

Surge in Demand and Cost of Care

The U.S. spends three times[4] more per person on medical expenditures than the average developed country, yet has significantly worse health outcomes. Specifically, it costs more to administer and maintain individual health in America; the healthcare provided for those excessive costs does not necessarily improve patient outcomes; Americans do not have the cash to pay for unexpected out-of-pocket medical expenses; Americans are getting less well overall; and perhaps the ultimate insult—the United States ranks number near the bottom of Organization for Economic Cooperation and Development (OECD) countries in infant mortality and life expectancy. Most medical spend is concentrated in hospital care, physician services, new medical technologies, and prescription drugs. Healthcare spending on medical services is significant. National health expenditures[5] are projected to grow at an annual rate of 5.4% and reach $6.2 trillion by 2028.

The COVID-19 pandemic resulted in a surge in demand for care and utilization beyond normal capacity of resources. The costs of testing for COVID-19, treating patients, and administering vaccinations for the disease likely will continue into 2022. 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.

The U.S. spends more on health care than any other country, with costs approaching 18%[6] of the gross domestic product (GDP). Prior studies estimated that approximately 30% of health care spending may be considered waste. Eliminating administrative expense has the benefit of lowering health care costs without affecting spending on patient care. A lot of costs go into administering healthcare insurance. The U.S. spends about 8% of its healthcare dollar on administrative costs, compared to 1% to 3% in the 10 other countries (JAMA).[7] The complexity of the U.S. healthcare system can lead to administrative waste in the insurance and provider payment systems

Health Plan Rates Increase

Employers expect medical plan costs per employee to rise 5.6% on average, HR consultancy Mercer reported.[8] While significantly higher than the premium increase of 4.4% expected for 2022, the 2023 increase lags overall inflation, which is currently running at about 8.5% year over year.

Each year,[9] health insurers submit rate filings to state regulators, detailing their expectations for the coming year's health costs. These filings provide insight into what factors insurers expect will drive health costs for the coming year, including inflation and policy changes.

Most premium changes insurers are requesting for 2023 fall between about 5% and 14%.[10] Insurance companies have been able to raise rates without explaining their actions to regulators or justifying the reasons for their high premiums. In most cases, consumers receive little or no information about proposed premium increases. In most years, healthcare inflation and utilization rate trends are key drivers of premium growth in the coming year. There are also federal policy changes that have the

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potential to affect premiums in 2023, including the expiration of the American Rescue Plan Act (ARPA) subsidies.

The Affordable Care Act (ACA)[11] sets minimum standards for the review of these proposed increases, called effective rate review standards, bringing a level of scrutiny and transparency to health insurance rate increases. Before the ACA, insurance companies in many states increased health insurance premiums with little oversight, transparency or public accountability. This lack of authority and resources for states created an uneven playing field for consumers and contributed to unjustified premium increases in some states.

The ACA ensures that, in any state, proposed increases are evaluated to make sure they are based on reasonable cost assumptions and solid evidence. This analysis is expected to help moderate premium hikes and provide those who buy insurance with greater value for their premium dollar. Additionally, insurance companies are mandated to provide easy to understand information about their reasons for significant rate increases.

The U.S. Department of Health and Human Services (HHS) works in partnership with states to ensure that all proposed rate increases of 15% or more in the individual and small group market are thoroughly reviewed; however, most increases start out very high and settle down just marginally lower, but still more than 15%. No such review applies to employer-sponsored plans. HHS expects the cost of health coverage will declining due to Health Reform[12]—citing the premiums individuals pay, but *not* the total cost of which the majority is paid by taxpayers.

Premium rates for marketplace plans are already substantial. It is one reason why few Americans enroll in marketplace exchange coverage unless they qualify for taxpayer financial support. As part of the Inflation Reduction Act,[13] the Senate passed a three-year extension of enhanced subsidies for people buying their own health coverage on the ACA Marketplaces. These temporary subsidies were originally slated to last two years (2021 and 2022) and were passed as part of the ARPA.[14]

The timing of the Inflation Reduction Act matters for insurers, regulators, and administrators of state and federal Marketplaces. Insurers are now in the process of finalizing 2023 premiums and some[15] are already factoring in an additional premium increase because they expect ARPA subsidies to expire. Congress' action to extend the ARPA subsidies through the Inflation Reduction Act will have an even greater influence over how much subsidized ACA Marketplace enrollees pay out-of-pocket for their premiums than will market-driven factors that affect the underlying premium.

HEALTH & WEALTH STRATEGIES—COST-SAVINGS INITIATIVES THAT HELP EMPLOYERS PREPARE FOR MEDICAL EXPENSES

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.

To counter inflationary trends, it is recommended that plan sponsors focus on helping participants build savings rather than purchase more costly insurance as part of a "health and wealth" strategy

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that optimizes both savings and financial preparedness.

Employer-sponsored health plans need to take a holistic approach to employee health benefits. Plan administrators and brokers should take strategic action and make changes that ensure that their employer-sponsored, self-insured plans incorporate the most effective strategies available to address today's inflation and economic challenges.

These strategies include effectively designed acquisition cost-based pharmacy pricing, health savings account (HSA)-capable coverage, reference-based pricing, adequate participant protections against balance billing, participant advocacy, and litigation support.

Level of Employer Support

It is common for employer-sponsored health maintenance organizations (HMOs) or preferred provider organizations (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 (re)consider 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.

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% per year[16] 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 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.

Of those Americans who are employed, 64% are covered by self-insured health plans, a robust business model that has risen in popularity over 20% in the last 20 years. Under this model, organizations assume responsibility for all financial risk, which is mitigated through stop-loss insurance, in exchange for more control over the plan's administration and funding. These plans are most prevalent among organizations with 500 or more employees, although self-funding can work for smaller companies as well.

Plans are customized to employee populations and owners enjoy flexibility, increased control, reduced claim and premium expenses, managed risk, and the absence of state-levied premium taxes, to name just a few of the benefits. However, these employers still must deal with significant financial challenges. Particularly as healthcare costs are expected to grow at a rate of 5.3% reach-

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ing into 2028. Understandably, these clients are looking for ways to reduce the costs associated with the healthcare coverage portion of their overall benefits program.

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.

RISE OF HEALTHCARE CONSUMERISM

Healthcare consumerism is a growing movement, a term that 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.

Rising healthcare costs, and need to contain medical care expenses, is attributed to the increase in healthcare consumerism that places price transparency in the spotlight. Price transparency helps empower participants to be better healthcare consumers, putting the economic purchasing power and decision-making in the participants own hands. Price transparency puts patients in the driver's seat and as healthcare consumers, gives access to accurate provider and hospital fees and out-of-pocket cost of service before receiving care.

The Internet and rapid advancement of information technology and mobile devices enable consumers to shop online for healthcare services. According to *Forbes*, consumers reported using an average of three different online sources when looking for a provider. Search engines were the most common source, used by 65% of respondents, followed by insurance Web sites (used by 45% of respondents) and hospital or health system sites (used by 43%).

The past year saw a focus on rising health care costs and federal legislation that support employer-sponsored health plan access to affordable medical services with added levels of protection and fairness. To increase price transparency practices in healthcare, CMS mandates that hospitals publish meaningful price information for patients. As of January 1, 2021, hospitals operating in the U.S. are required to provide clear, accessible pricing information online about the items and services they provide. This information will make it easier for consumers to compare prices, estimate the cost of care, and confirm market value.

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Taking Advantage of Pricing Transparency Legislation

A quality health plan provides easy, direct access and understanding of pricing, benefits, and out-of-pocket expense information so plan participants can make informed and cost-effective decisions.

Currently, there is a lack of medical billing price transparency throughout the healthcare industry. There is considerable room for improvement through claims analysis. Innovative medical billing services take on this challenge, utilizing powerful data-driven software and online data analytic tools that can provide a degree of price transparency. Real-time data leads to new insights by harnessing price data electronically—allowing fee comparisons that identity fair and reasonable prices.

As of January 1, 2021,[17] CMS issued mandates that hospitals operating in the U.S. provide clear, accessible pricing information online about the items and services they provide. Under CMS guidance and final rules,[18] 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. 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.

Price transparency is expected to add to inflation. In turn, we expect it will trigger a (re)introduction of health care consumerism strategies.

Price transparency—knowing provider and hospital fees prior to receiving care—provides an opportunity to better manage participant-paid costs. This empowerment is especially important in today's economy.

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. 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.

Clarity from Advanced EOB

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 (EOB). An EOB is not a bill—however, it is very important to the billing and benefits claim process. The EOB is an after-the-fact statement from your health plan administrator that describes how a claim for payment of medical services was processed. The EOB should also provide a glossary of terms and definitions as well as instructions on how you can appeal the benefit determination.

The Advanced EOB requirement, part of the No Surprises Act (NSA)[19] transparency rule passed by Congress, is designed to give advance notice of how a claim for future, scheduled medical services might be processed for the provider and services submitted, how such a claim will be processed, and most importantly, what the plan will pay and how much the plan participant will have to pay out of pocket for a particular medical service. The NSA requires health plans and insurers to provide an Advanced EOB when requested in advance of treatment. The requirement applies whether non-emergency scheduled medical services are to be delivered in or out-of-network.

The Advanced EOB must be

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issued within certain timeframes after the provider submits to the plan or insurer a Good Faith Estimate of charges for each service. Advanced EOB is the only document that would give you sufficient information to identify the estimated costs of scheduled, non-emergency treatment.

Providers and facilities, upon an individual's scheduling of an appointment for medical services or upon request, must provide a good-faith estimate of the expected charges, including anything reasonably expected to be provided in conjunction with the scheduled services, whether through the specific provider or facility or other providers and facilities. The Good Faith Estimate is to include identification of the providers, the dates of service, and the billing and diagnostic codes for the scheduled services.

The provider is to submit this notification to the individual's plan or administrator, or to the plan participant where the individual is not enrolled in a health plan or asks that the Good Faith Estimate be provided directly to the plan participant. The plan administrator (or the designated claims administrator) must then process the Good Faith Estimate and issue an Advanced EOB to the participant. The plan participant can request a Good Faith Estimate from more than one provider for the same service (they can shop around). The Advanced EOBs generated from the Good Faith Estimate will provide the necessary information to the plan participant to make a rational decision on where to obtain the medical care.

Managing spend can also reduce costs in another way—by shopping for the most cost-effective, quality care, it may reduce the amount the plan pays, which, over time, is likely to reduce the cost of coverage and, in turn, reduce the contributions taken from a paycheck. So, even though the government agencies are not enforcing the Advanced EOB requirement at this time, plan member should still ask for a Good Faith Estimate and an Advanced EOB if they are scheduling non-emergency services. The providers and administrators are still obligated to comply with these requirements. Making the request might just save money, today and tomorrow.

Pure Reference-Based Pricing as a Most Valuable 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[20] (RBP) strategies. 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.

RBP is one of the fastest growing solutions in health benefits cost management. It brings stability to health care prices and point of purchase cost sharing by using Medicare reimbursement rates and other provider cost data to provide an objective cost baseline. This offers disciplined pricing—fair and rational reimbursement for providers. 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 an opportunity to avoid excessive and unreasonable provider fees and charges—to reduce eligible ex-

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penses which will, in turn lower participant out-of-pocket costs, and lower the cost of coverage—lowering both employer and employee contributions.

HEALTH SAVINGS ACCOUNTS OFFER "QUADRUPLE DUTY"

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, an 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 are like personal savings accounts, but the money in them is used to pay for health care expenses. The idea is that people will spend their health care dollars more wisely if they are using their own money. Funds pay for eligible health care expenses and out-of-pocket costs a health plan does not cover.

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 HSAs and FSAs requires positioning medical coverage to get the incentives right—which might include increasing the dollar amount of point of purchase cost-sharing (deductibles, co-payments, 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 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.
- Prompt mid-year re-enrollment into the HSAs or a mid-year automatic escalation in HSA contributions.

Employers should take strategic action to ensure their health plans incorporate the most effective strategies—strategic actions that go far be-

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yond simple compliance help ensure the most effective strategies for the "health and wealth" of their participants.

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