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Employee Benefit Plan Review

Will New Rules Lower Your Medical Costs?

By Jack Towarnicky

Presidents Obama and Biden made a number of commitments in response to the surging cost of medical coverage and delivered on their administration's initiatives to make healthcare services more affordable, but perhaps in ways unexpected by the majority of American households. Consider:

- *Medical Premium Reductions*: President Obama claimed that his Affordable Care Act[1] would "lower premiums by up to $2,500 per year for a typical family."
- *Lower Drug Costs*: President Biden's Inflation Reduction Act[2] promised to reduce the cost of prescriptions drugs, estimated to save an average of $400 per year, while those with the highest drug costs will save an average of $2,500 per year starting in 2025.

Did they succeed?

Yes!

For tens of millions of Americans, health coverage costs have declined because of government actions that provided access to taxpayer-subsidized coverage via Medicaid and the public exchanges/marketplace. Enrollment increased:

- In Medicaid, 3.8% per year from 54 million (2010) to 88+ million (2022) due to Health Reform's liberalized access and the COVID-19 response.
- In public exchanges from 0 (2010) to 21+ million (2024).

Health Reform's[3] mandates made health insurance coverage affordable and available for individuals who do not have access to employer-sponsored coverage or Medicare. Health Reform accomplished its goal by expanding access to taxpayer-subsidized coverage. Perhaps 30-40 million Americans saw their medical premium costs lowered via taxpayer subsidies, where those costs became part of our $1 - $2 trillion annual deficits, as our national debt increased from $12.7 trillion on March 23, 2010 to today's $34.2+ trillion (as of 2/14/24).

However, Health Reform was not designed to reduce the cost of employer-sponsored coverage for employers or employees. Surveys confirm that 160+ million Americans with employer-sponsored coverage saw their average premium increase 50+% over the past 12 years despite a tripling in the percentage of plans with deductibles in excess of $2,000 (10% to 32%).

Because wages have not kept pace with inflation, there has been a decline in real wages among American workers. Worse, since most individuals who have employer-sponsored coverage are taxpayers, their take home pay has/will be further lowered to pay for the taxpayer subsidies mentioned above.

Lower Drug Costs

Changes to prescription drug costs are coming through the Inflation Reduction Act of 2022.[4] As Medicare negotiates lower drug prices, any reduction in revenue is likely to be recovered via higher prices charged to employer-sponsored health plans, leading to higher costs for both employers and employees. That is what happens today, sometimes called cost shift,[5] where employer-sponsored plans often pay 250% or more than a Medicare beneficiary for the same treatment.

The Inflation Reduction Act caps out-of-pocket prescription drug spending at $2,000 per year – projected to save the average Medicare enrollee $400 per year, and an average $2,500 a year for those with the highest drug costs. On June 30, the Centers for Medicare and Medicaid Services (CMS) released revised guidance that describes how they will negotiate lower prescription drug prices yet this year. Finally, the new $35/month cap on insulin prices just took effect, saving Medicare beneficiaries hundreds of dollars per month.

Those changes apply to a significant number of Americans – 63+ million are enrolled in Medicare Part B and Part D. Medicare beneficiaries are over age 65 or disabled. They are clearly the largest users of medical services and prescription drugs. On average, each Medicare beneficiary spent $15,000 on healthcare per employee in 2021[6] – that is double the $7,739 average per employee cost for employer-sponsored coverage.[7]

Soon, everyone enrolled in employer-sponsored health coverage is likely to see drug costs increase – where the savings that the Medicare program achieves via price fixing are shifted to employer-sponsored coverage.

Lower Health Costs By Eliminating "Scam" Or "Junk" Insurance

In his July 7, 2023,[8] announcement, President Biden aimed at lowering health care costs for those enrolled in the public exchanges by protecting consumers from "scam insurance plans" as an initiative under his Bidenomics agenda. His proposed rules would limit American's ability to select short-term insurance plans.

President Biden stated President Trump's administration ". . . allowed insurance companies to take advantage of loopholes in the law and sell 'junk insurance' plans (that will) leave families surprised by thousands of dollars in bills. . . ."

Younger, healthier workers tend to select these plans because they:

- Need not offer certain "Essential Health Benefits" – for example, a male electing single coverage doesn't need pediatric services or maternity care
- Have premiums below those charged for marketplace options
- Are not subject to exchange/marketplace limits so the premiums may better reflect risk

The proposed regulations would significantly curtail the use of those insurance products:

- "Short-term" plans must be truly short-term – used for no more than four months
- "Fixed indemnity" plans must specifically disclose any per day benefits and other limits

The Biden administration is not actually worried about those who voluntarily purchased these so-called junk or scam insurance options. No, curtailing access to those coverage options is designed to increase enrollment and reduce the risk exposure for public exchange/marketplace plans.

Those changes became a priority in time to moderate the third quarter 2024 announcement of rate increases for calendar year 2025. Rates are expected to increase significantly once the taxpayer super subsidies added by the Inflation Reduction Act expire.

Preventing Surprise Medical Billing

The Biden administration is taking an important next step to protect patients and healthcare consumers from surprise medical bills by issuing guidance to clarify that payers cannot use certain loopholes to avoid surprise billing protections.

The NSA defined emergency services to include pre-stabilization services provided after the patient leaves the emergency department and is admitted to a hospital. For services in an emergency department of a hospital or an independent freestanding emergency department, a plan cannot limit services for emergency medical conditions solely on the basis of diagnosis codes.

Ending Abuse of In-Network Designation

Some health plans today contract with hospitals while claiming that they are not technically in-network. The new guidance confirms that is precluded under federal law: health care services rendered by these providers are either out-of-network and subject to the surprise billing protections, or they are in-network and subject to the ACA's annual limitation on cost-sharing.

Facility Fees are Treated Like Other Healthcare Costs

The Biden administration is also concerned about an increase in patients being charged facility fees for health care provided outside of hospitals, like at a doctor's office. These fees are often a surprise for consumers.

The NSA broadly define facilities as inpatient hospitals, critical access hospitals, hospital outpatient departments, and ambulatory surgery centers. Some state statutes also include skilled nursing facilities, infusion centers, and dialysis centers, among other sites, or include other services like diagnostic imaging or laboratory

services. At least two state laws also extend surprise billing protections to services delivered in physician offices or other outpatient settings. NSA also adds protections where state laws were not comprehensive, such as for facilities omitted from certain state laws and excluded medical services.

The new guidance confirms that health plans and providers must make information about facility fees publicly available to consumers. In addition, nonparticipating providers and nonparticipating emergency facilities cannot evade the protections of the NSA, including the prohibition on balance billing, by renaming charges otherwise prohibited under the NSA as facility fees.

A Strategic and Compliant Approach to NSA

To address complex issues surrounding the NSA, the best response is an approach that is both strategic and compliant. A "compliance only" approach adds to administrative burdens and increases the cost of coverage by treating certain out-of-network expenses as if incurred in-network. While most failed to strategically address NSA, brokers now have an opportunity to identify the impact of NSA compliance and prompt consideration of the most effective plan design that fulfills the requirements of the NSA.

One of the best strategic responses for NSA compliance is the adoption of Reference Based Pricing (RBP). Many plan sponsors are adopting RBP as a means to minimize application of the NSA requirements, especially the federal independent dispute resolution[9] (IDR) process. The NSA's IDR process applies when a third-party administrator (TPA) or plan can calculate a Qualified Payment Amount (QPA). RBP plans that use narrow networks or have negotiated contracts and use RBP for out-of-network claims are subject to the NSA as there is a median in-network rate for determining the QPA.

RBP done right minimizes NSA compliance and reduces health care costs for both the plan sponsor and participants. Adopting a pure RBP structure, coupled with tech-driven data support, can potentially lower both the cost of coverage and employee point of purchase cost sharing. In a pure RBP structure, there is no QPA, so NSA compliance is minimized. Given the wide variation of provider charges for the same services of the same quality, even among in-network providers, a pure RBP design offers an opportunity to avoid excessive and unreasonable provider fees and charges.

Finally, litigation over the NSA's IDR process has triggered fits in processing. Recently, a federal judge in Texas ruled that the federal government must vacate nationwide its seven-fold federal fee increase and restrictions on batching. RBP minimizes the cost of compliance every time there is new litigation or changes to regulations or FAQ.

Value of a Medical Billing Partner

The right medical billing partner facilitates all the necessary strategic designs and processes in implementing RBP - repricing, communications, participant representation-acting as an agent of change, embracing technology innovation and advocating for "what is fair and just." The right partner will provide value-added services through turnkey solutions, resources, data-driven insights, administrative and compliance support, as well as guidance on navigating new and updated federal and state healthcare regulations.

Notes

1. https://www.healthinsurance.org/obamacare/#:~:text=The%20Affordable%20Care%20Act%20(ACA)%20%E2%80%93%20also%20known%20as%20Obamacare,insurance%20in%20the%20United%20States.
2. https://www.whitehouse.gov/cleanenergy/inflation-reduction-act-guidebook/.
3. https://www.healthcare.gov/glossary/affordable-care-act/.
4. https://healthpayerintelligence.com/features/how-the-inflation-reduction-act-will-impact-employers-health-plans.
5. https://employerptp.org/rand/3-0/#:~:text=Published%20by%20the%20RAND%20Corporation%20in%20September%202020%2C,and%20professional%20fees%20for%20inpatient%20and%20outpatient%20care.
6. https://crsreports.congress.gov/product/pdf/IF/IF10830.
7. https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf.
8. https://www.whitehouse.gov/briefing-room/statements-releases/2023/07/07/fact-sheetpresident-biden-announces-new-actions-to-lower-health-care-costs-and-protect-consumers-from-scam-insurance-plans-and-junk-fees-as-part-of-bidenomics-push/.
9. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Federal-Independent-Dispute-Resolution-Process-Guidance-for-Certified-IDR-Entities.pdf.

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