Einstein
Advanced Health Insurance Solutions

NEWSALERT

December 2019 | Volume 3 | Issue 12

Employee Benefits

New Rules Aim for Hospital, Insurer Transparency

THE TRUMP administration last month announced two rules that would require more transparency in hospital pricing and health insurance out-of-pocket costs.

A final rule will require hospitals to publish their standard fees both on-demand and online starting Jan. 1, 2021, as well as the rates they negotiate with insurers. A proposed rule would require health insurers to provide enrollees instant, online access to an estimate of their out-of-pocket costs for various services.

The Trump administration has a stated mission to bring more transparency into the health care and insurance industry. That's in response to increasing consumer stories of receiving unaffordable surprise bills from providers, particularly if they went to a non-network physician or hospital.

Both rules could benefit health plan enrollees by giving them more information on hospital services, particularly if they are in high-deductible plans and can shop around for a future procedure.

Hospital pricing transparency

The new final rules will require hospitals to publish in a "consumer-friendly manner" online their standard charges price list of at least 300 "shoppable services," meaning services that can be scheduled in advance, such as a CAT scan or hip replacement surgery.

The list must include 70 services or procedures that are preselected by the Centers for Medicare and Medicaid Services. Hospitals will have to disclose what they'd be willing to accept if the patient pays cash.

Under the rule, hospitals will have to disclose the rates they negotiate with third party payers.

The new rules face some uncertainty. The American Hospital Association and the Federation of American Hospitals, and other trade groups, announced that they would sue the government, alleging that the rules exceed the bounds of the CMS's authority.

Out-of-pocket transparency

The proposed rule would require insurers to provide health plan enrollees with instant online access to estimates of their out-of-pocket costs.

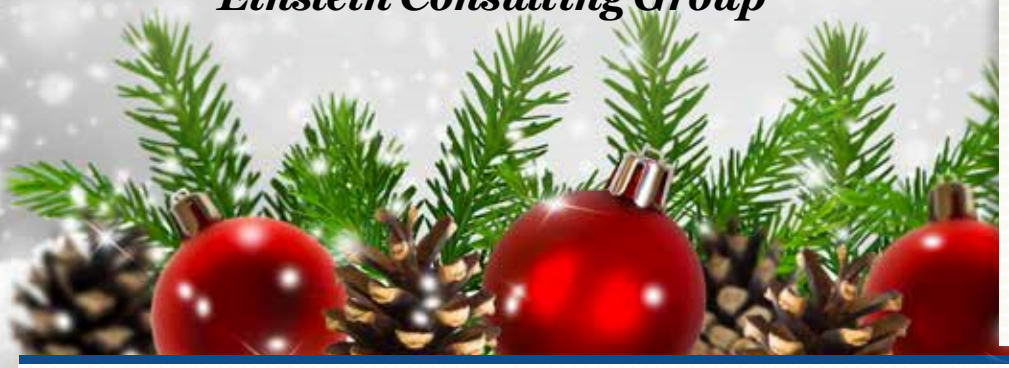
The regulations would require health insurers to create online tools their policyholders can use to get a real-time personalized estimate of their out-of-pocket costs for all covered health care services and products.

They would also be required to disclose on a public website negotiated rates for their in-network providers, as well as the maximum amounts they would pay to an out-of-network doctor or hospital.

The proposed regs would also let insurers share cost savings with their enrollees if the individuals shop around for services that cost less than at other providers.

These are for now proposed regulations. They have to go through the standard rule-making procedures including soliciting public comments before eventually issuing the final rules, probably in 2020. ❖

Happy Holidays
from all of us at
Einstein Consulting Group



Einstein
Advanced Health Insurance Solutions

CONTACT **US**

Missouri: **1120 S. 6th Street (Suite 201)**
St. Louis MO 63104
Illinois: **280 North Main Street,**
Breese, IL 62230

Phone: 877.324.2114
Fax: 888.274.1538
Email: *info@ecgins.com*

Pharmaceuticals

As Specialty Drug Costs Bite, Employers Have Options

A NEW STUDY has found that while group health plan costs will continue growing at the same rate as in the last few years (about 4% a year), the increases would be far less were it not for the spiraling costs of high-cost specialty prescription drugs.

The 2020 "Segal Health Plan Cost Trend Survey," which polled health insurers, third party administrators, pharmacy benefit managers (PBMs) and other payers, found that chemotherapy drugs and other specialty pharmaceuticals are having an outsized effect on overall health claims payments.

Unfortunately, this is forcing plan sponsors to figure out how to balance coverage of life-saving drugs with plan affordability. But there are steps you can take to rein in drug cost inflation.

Payers expect that pharmaceutical costs will increase 7.1% in 2020 from this year, and that the cost of specialty drugs will double that inflationary rate at 15.4%.

Rebates account for a significant part of the pharmaceutical equation. Survey respondents said that they expect the average impact of rebates would reduce overall drug price inflation by about 1.5%.

The rising cost of brand-name drug expenditures is due to drug price inflation primarily, although one-third of the increase is due to more prescriptions being filled.

Other findings in the report by Segal, a health and retirement consulting firm, are:

- Price increases are the primary driver of medical and drug trends.
- Double-digit specialty drug costs are mostly driven by price increases and the introduction of new and more expensive drugs.
- Reimbursement rates for hospital networks are projected to increase at a higher rate than physician claims.
- Plan cost trends continue to outpace both inflation and wage growth by a factor of more than two.

The study notes that projected costs have always been lower than actual inflation of medical treatment and drug outlays.

To deal with these increasing costs, Segal identified the top health plan cost-containment strategies that are in use in 2019:

- Use of health care transparency tools.
- Expanding pharmaceutical management for non-specialty drugs.
- Expanding pharmaceutical management for specialty drugs.
- Offering telehealth/virtual care.
- Value-based contracting.

What you can do

Segal recommends the following tactics for managing drug benefit costs, as well as for contracts with PBMs:

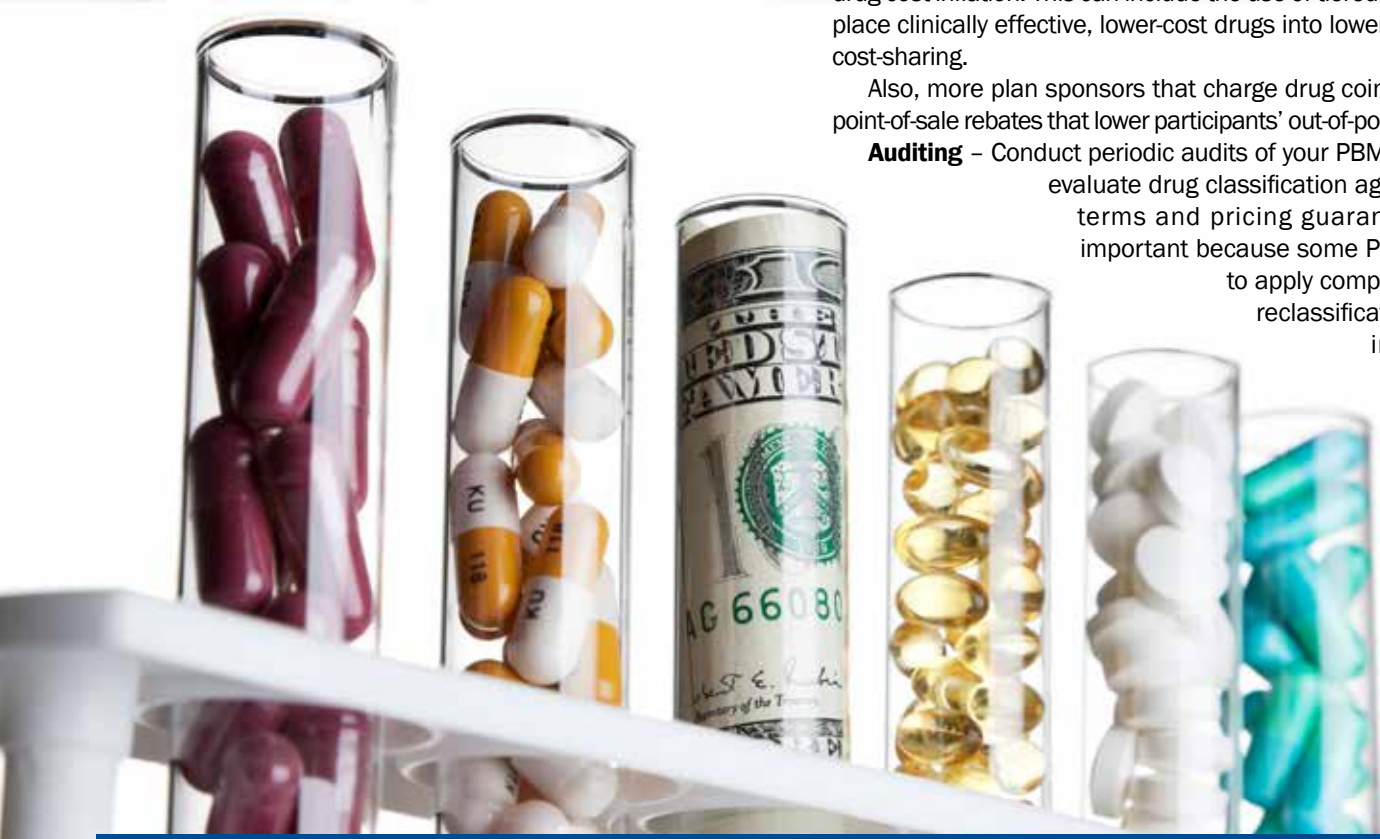
Aim for innovative contracting with PBMs – Hold PBMs contractually accountable for controlling costs. Contract terms can include unique specialty-drug pricing guarantees, performance-based rebates, direct contracting with regional specialty pharmacies and adoption of value-based formularies.

Expand clinical checks – Amend plan terms to include clinical safeguards like step therapy, targeted prior authorization for high-cost services and quantity-duration limits based on Food and Drug Administration guidelines.

Plan benefit design – Use benefit designs to increase the use of generics and lower-cost brand-name drugs, in order to help manage drug cost inflation. This can include the use of tiered designs which place clinically effective, lower-cost drugs into lower tiers at lower cost-sharing.

Also, more plan sponsors that charge drug coinsurance offer point-of-sale rebates that lower participants' out-of-pocket expenses.

Auditing – Conduct periodic audits of your PBM and carefully evaluate drug classification against contract terms and pricing guarantees. This is important because some PBMs continue to apply complicated pricing reclassifications that can increase your costs. ❖



Health Insurance

New Rules Allow Employers to Reimburse for Health Premiums

STARTING JAN 1, 2020, employers can establish accounts for their employees to help them pay for individual health insurance policies they purchase, as well as for other health care expenses.

A new regulation expands on how health reimbursement accounts can be used.

Currently, employers and their workers can contribute to these accounts, which can be used to reimburse workers for out-of-pocket medical expenses.

With these new Individual Coverage HRAs, employers can fund the account workers would use to pay for health insurance premiums for coverage that they secure on their own.

Up until this new regulation, such arrangements were prohibited by the Affordable Care Act under the threat of sizeable fines in excess of $36,000 per employee per year.

How it works

Under the new rule, if an employer is funding an ICHRA, the plan an employee chooses must be ACA-compliant, meaning it must include coverage for the 10 essential benefits with no lifetime or annual benefit maximums – and must adhere to the consumer protections built into the law.

Once the ICHRA is created, the employer will pay a set amount every month into the account on a pre-tax basis, which the employee can then use to buy or supplement their purchase of health insurance benefits in the individual market.

The law allows employers to set up as many as 11 different classes of employees for the purposes of distributing funds to ICHRAs.

The employer can vary how much they give to each group.

For example, one class may get $600 a month per single employee with no dependents, while members of another class may receive $400 a month. ❖

ALLOWABLE CLASSES

- Full-time employees
- Part-time employees
- Seasonal employees
- Temps who work for a staffing firm
- Salaried employees
- Union employees
- Employees in a waiting period
- Foreign employees who work abroad
- Employees in different locations, based on rating areas
- A combination of two or more of the above

THE RULES

- Any employee covered by the ICHRA must be enrolled in health insurance coverage purchased in the individual market;
- The employer may not offer the same class of workers both an ICHRA and a traditional group health plan;
- The employer must offer the ICHRA on the same terms to all employees in a class;
- Employees must be allowed to opt out of an ICHRA;
- Employers must provide information to staff on how an ICHRA works;
- Employers may not create a class of younger employees, who they want to keep in their plan because they're healthier;
- A class must have 10 or more workers if the firm has fewer than 100 staff. For employers with 100 to 200 employees, the minimum class size is 10% of the workforce, while for employers with 200 or more staff, the minimum class size is 20;
- While benefits must be distributed fairly to employees that fall within each class, each class can be broken down further by age and family size. Employees with families can be offered a higher amount per month and rates can be scaled by age.

Benefit Decisions

Dental Insurance: DMOs Versus PPOs

WHEN YOU look at the dental options for your employer-sponsored health plan, or if you're just looking at the options available on the market, you may encounter the terms DMO, PPO or indemnity plan in the marketing literature.

Each of these is a different type of dental insurance plan. To pick the best plan for your employees' needs, you'll need to know how each plan is structured, and the advantages and disadvantages of each.

The DMO

A dental maintenance organization is very similar in concept to a health maintenance organization, or HMO.

Essentially, DMOs are designed to reduce premiums and costs, at the expense of a certain amount of freedom when it comes to choosing your own dentist.

Under these plans, you must choose a primary care dentist. If you need to see a specialist, such as an orthodontist or endodontist, you must get a referral from your primary care dentist.

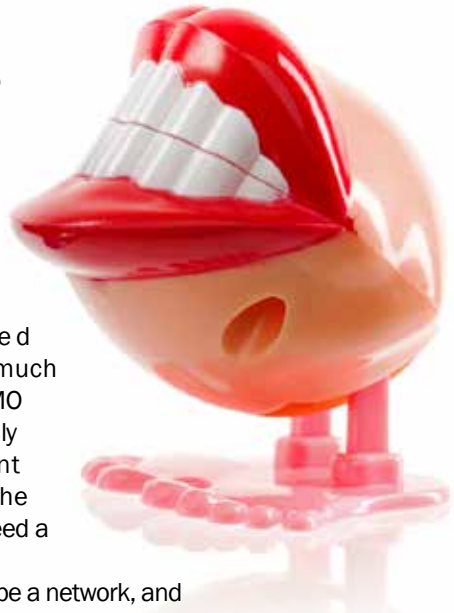
Both HMOs and DMOs attempt to save money and reduce expenses by restricting the number of care providers that the insurance company will allow in the plan.

Negotiators for the insurer approach dentists and clinics in the coverage area and ask them to reduce prices in exchange for a steady flow of referrals from the plan. The fewer providers in the network, of course, the more patients each dentist will receive, and the more valuable the DMO is to the dentist.

They also save money by reducing expenses on specialists. The primary care dentist acts as a "gatekeeper" to more advanced services, and ensures that any referrals to more advanced or specialized levels of care are legitimately medically necessary.

By using restricted networks, using their bargaining power to obtain reduced fees and reducing unnecessary expenses on specialist care, the DMO plan is usually able to realize significant cost savings – and pass those savings along to consumers in the form of reduced, affordable premiums.

These plans are usually best for those who are sensitive to premium costs, and who are indifferent about what dentists they can see under the plan.



The dental PPO

A dental preferred provider organization is much less restrictive than its DMO counterpart. You can normally visit any dentist you want who is willing to accept the insurance, and you don't need a referral to see a specialist.

However, there still may be a network, and your out-of-pocket costs may be lower if you see dentists from within these networks.

You will still have to pay deductibles and copays, but the plan may reduce or waive them for dentists and clinics within the preferred network.

These types of plans may also be referred to as participating dental networks. Their premiums are generally low, but usually not as low as comparable DMO plans.

Indemnity plans

If you have an indemnity plan, you can generally see any dentist who is willing to accept the insurance. You don't have to restrict yourself to dentists in the network. If a dentist doesn't accept direct payment from the insurance company, they may reimburse you directly for covered expenses after the fact.

These plans offer the most flexibility and freedom and the fewest restrictions on care. But they also have the highest premiums.

What's best for you crew?

If it's important for your staff to be able to choose their own dentist or access any specialist they like for covered services, they may want to lean towards the indemnity plan.

Meanwhile, DMOs generally offer the lowest monthly premiums and have low out-of-pocket costs for routine services like cleanings. But, their out-of-pocket costs may rise quite a bit if you need services beyond routine checkups and cleanings.

Dentists may try to upsell additional work, which costs more out of pocket.

If you have staff that anticipates needing more extensive treatment, or access to the services of a specialist, they may wish to select a PPO-type plan.

You can talk to us about which plans are available and which might be the right fit for your workplace. ❖