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HEALTH PLANS®

THE RISK REPORT
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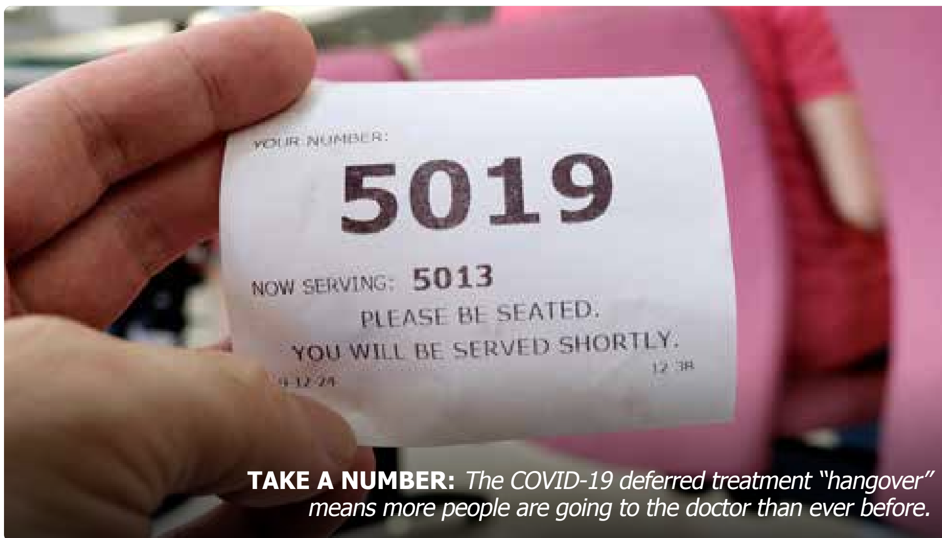
Group Health

Employer Plan Medical Costs Expected to Rise 6.5% in 2022



TAKE A NUMBER: *The COVID-19 deferred treatment "hangover" means more people are going to the doctor than ever before.*

A NEW REPORT by PricewaterhouseCoopers (PwC) predicts employer-sponsored group health plan medical costs will rise 6.5% in 2022 from this year.

Last year was the first time that medical costs decreased, thanks to the COVID-19 pandemic keeping people from going to the doctor for many ailments and delaying necessary medical procedures. The annual cost of health care for a family of four was $26,078 in 2020, 4.2% lower than the year prior, according to a separate report by global insurer Milliman.

Some influencing trends that PwC predicts for 2022 include the following:

Cost inflators

Drug spending – The report predicts that costly cell and gene therapies will increase in number as the Food and Drug Administration continues approving new drugs.

It notes that employers are covering more of the increased costs and insurance on average covers a larger share of prescription drug prices than it did 10 years ago. At the same time, enrollees' shares have leveled off.

Surprise billing – The No Surprises Act, which bars insurers from not covering out-of-network emergency services and more (see story on page 3), takes effect Jan. 1, 2022.

While the law will help health plan enrollees reduce out-of-pocket expenses, analysts expect it will result in higher spending as costs shift from the consumer to the payer or employer.

Continued spending on deferred treatments – The report says spending on treatments that were deferred in 2020 due to the COVID-19 pandemic will continue into 2022.

It predicts that this will increase overall health care spending by employer-sponsored health plans. The report notes the cost of treatment could be higher than it would have been in 2020, due to deteriorating health and higher costs.

Telehealth drives utilization – The pandemic accelerated the health care sector's investments in telehealth and virtual care, which increased patients' access to care and drove utilization.

This trend will continue. However, many analysts predict it will eventually reduce the cost of treatment as telehealth vists are less costly than in-person visits.

Cost deflators

There are also some ongoing trends and factors that are counterbalancing some health care cost increases.

More use of lower-cost care – Fewer people have been going to emergency rooms for ailments that do not require urgent care. Instead, they've been using telehealth services and going to retail clinics and alternative care sites for many run-of-the-mill ailments.

See 'Enrollees' on page 2

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Annual Update

Attention Employers: IRS Ramping Up ACA Compliance

THERE ARE signs that the Internal Revenue Service is starting to step up its enforcement of the Affordable Care Act employer mandate.

During the past six months, there's been an uptick in the number of employers receiving initial notices stating they may be out of compliance with the requirement that they offer their workers coverage.

Also, the IRS has announced that it will no longer provide "transition relief" to employers that file incomplete 1094/1095C forms, make mistakes on them or fail to file them.

Notices were recently sent out for the 2018 tax year. Many of the proposed assessments would result in penalties that are in the millions.

The IRS is charged with ensuring that employers with 50 or more full-time or full-time-equivalent workers comply with the employer mandate, which requires them to offer them health coverage that is affordable and covers 10 essential benefits, as per the ACA. These "applicable large employers" (ALEs) are subject to penalties for not complying.

Employer mandate violation penalties

Internal Revenue Code Section 4980H(a) violations: $2,700 per employee. This penalty applies when an ALE does not offer coverage or offers coverage to less than 95% of its full-time staff (and their dependents), and when at least one full-time employee receives a premium tax credit to help pay for coverage through a marketplace exchange.

Internal Revenue Code Section 4980H(b) violations: $4,060 per employee. This applies when an ALE offers coverage to at least 95% of its full-time employees (and their dependents), but at least one full-time worker receives a premium tax credit to help pay for coverage through a government-operated marketplace.

This can occur if the employer did not offer coverage to that particular employee or because the coverage they were offered was either unaffordable or did not provide minimum value.

What the IRS is doing

No statute of limitations for 4980H violations – At the end of 2020, the IRS Office of Chief Counsel issued a memo that stated there is no statute of limitations for employers to avoid penalties for violating Section 4980H.

This means that ALEs who fail to comply with the ACA can be hit with penalties at any time in the future once the IRS discovers the violation.

Ceasing its "good faith transition relief" – This was intended to temporarily give employers more time and a break on penalties when they report incomplete or incorrect information on their 1094/1095C forms. Last year was the final year this transition relief was offered.

What to do

The IRS has been sending out notices of ACA non-compliance for the 2018 policy year.

If you receive one of these notices – a Letter 226-J – you need to act quickly to avoid penalties as you have just 30 days to respond. If you need more time, the most that the IRS will likely grant you is a 30-day extension.

Regardless of if you've received a notice, you may want to review your 2018 ACA filings. If you identify any mistakes in them, you can correct the filings before the IRS will issue a Letter 226J penalty notice or another type of penalty.

To avoid penalties related to the annual filings of the 1094/1095C forms, make sure that you stay on top of filing deadlines. Also, ensure that the forms are correct and complete. You can expect the IRS to be diligent in reviewing these forms. ❖

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More Enrollees Skip Emergency Room, Go to Health Clinics

The report found that use of retail health clinics increased by 40% during the lockdowns in 2020, and urgent care center usage grew by 18%. Emergency room visits plunged 42%.

PwC estimates a 10% decrease in unnecessary emergency room visits could save employers nearly $900 million a year.

More health care for less – Health systems are reducing overhead by allowing administrative and IT staff to work remotely.

UW Medicine in Seattle shrank its office space as a result of permanent shifts to working from home, and is saving $150,000 per month after it terminated leases on two office buildings used by its IT department.

Hospitals are also increasing efficiency, reducing costs and boosting revenue by automating processes and using cloud technology.

In PwC's 2021 survey, 31% of provider executives said that adopting automation and artificial intelligence for tasks previously performed by employees is a top priority.

An increase in at-home testing – The report concludes that people are warming up to at-home, do-it-yourself testing.

According to a survey by the Human Resources Institute, 88% of respondents said they would be comfortable using an at-home COVID-19 test. ❖

CMS Issues New Regulations Barring Surprise Billing

THE CENTERS for Medicare and Medicaid Services in late June released a series of new regulations targeted at banning surprise billing in most instances, taking aim at a scourge that ends up costing many covered individuals thousands of dollars even when they are treated in-network.

The goal of the rule, slated to take effect Jan. 1, 2022, is to ensure that health plan enrollees are not gouged for out-of-network billing and balance billing for most services unless divulged to the beneficiary and approved by them in advance.

Balance billing – when a medical provider bills a covered individual for the difference between the charge and the amount the insurer will pay – is already prohibited by Medicare and Medicaid.

The interim rule will cover people who are insured by employer-sponsored health plans and plans purchased through publicly operated marketplaces. The new regulations are being implemented as required by the No Surprises Act of 2021, which passed through Congress with bipartisan support.

The effects of surprise billing

Surprise billing happens when people unknowingly get care from providers that are outside of their health plan's network, which can happen for both emergency and non-emergency care. Examples of surprise billing include:

- Someone breaks their leg in a fall and has to go to the nearest emergency room, which is not part of their insurer's network. They are billed at market rates as their insurer doesn't cover the service.
- Someone has an operation in a network hospital but one of the providers treating them (an anesthesiologist or radiologist, for example) is not in the network, so the covered individual is billed at market rates.

Two-thirds of bankruptcies are caused by outstanding medical debt, and out-of-network billing is partly to blame for that.

Studies have shown that more than 39% of emergency department visits to in-network hospitals resulted in an out-of-network bill in 2010, increasing to 42.8% in 2016.

During the same period, the average amount of a surprise medical bill also increased, from $220 to $628.

WHAT THE REGULATIONS DO

- Ban surprise billing for emergency services, regardless of where they are provided. That means if a person has no choice but to go to an emergency room that is out of network, they can only be billed at the same rate they would be charged for services at an in-network hospital.
- Bar health insurers from requiring prior authorization for emergency services, and they can't charge their higher out-of-pocket costs for emergency services delivered by an out-of-network provider. They would also be required to count enrollees' cost-sharing for those emergency services toward their deductible and out-of-pocket maximums.
- Ban out-of-network charges for ancillary care at an in-network facility in all circumstances. This happens when there is an out-of-network provider working at an in-network hospital.
- Ban other out-of-network charges without advance notice.
- Require providers and hospitals to give patients a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

What's next

This is an interim final rule that is still out for public comment. It may be changed after the CMS receives comments.

More than likely it will take effect at the start of 2022, mostly intact. ❖

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Price-Shopping Breakthrough

Few Plan Enrollees Aware of Price Transparency Rules

DESPITE A new law requiring hospitals to post detailed pricing information for their treatments and procedures online, fewer than 10% of U.S. adults are aware of the requirement.

That's a problem considering that a growing number of Americans have high-deductible health plans, which come with up-front lower premiums but with higher out-of-pocket expenses.

One of the driving forces behind HDHPs is that they give the enrollee more "skin in the game," by incentivizing them to shop around for care since they will have to pay for it themselves up to their deductible.

But if people are not aware they can find pricing for medical services on providers' websites, they may not know how to begin comparing prices.

A new study by the Kaiser Family Foundation found that only 9% of those surveyed were aware that hospitals are required to publish the prices for their services online, in line with new price transparency regulations that took effect Jan. 1, 2021.

The price transparency rule requires hospitals to post on their websites costs of services and medical items.

What hospitals must post online

- A clear description of each shoppable service and item.
- A description of charges including:
  - Payer-specific negotiated charge, or the price a third party payer such as a health insurance company would pay.
  - Discounted cash price, or the price a patient would pay without insurance.
  - Gross charge, or the charge absent any discounts.
  - De-identified maximum and minimum negotiated charges for each.
- Any primary code used by the hospital for purposes of accounting or billing

Here's what the survey found:

- 69% said they were unsure whether hospitals are required to disclose the prices of treatments and procedures.
- 22% said hospitals aren't required to disclose this information.
- 9% are aware hospitals are required to disclose the prices of treatments and procedures on their websites.
- 14% said that they or a family member had gone online in the past six months to research the price of hospital treatment.

Educating your staff

Employers should inform their staff about the price transparency rule so that they can research pricing ahead of any procedures they may have. Most health system websites should be posting their pricing by now, but it may take some digging to find them.

If they have been ordered to get a certain procedure, they can start by going to each provider available to them through their health insurance and researching the pricing on their website. If they can't find the information, they should call the provider to get it. They will need the negotiated price between their health plan and the provider.

Prices can vary dramatically between providers, and your staff need to make sure they are making accurate comparisons.

They should also consider calling the providers and inquiring about the cash price for the services. In some instances, the cash price can be less than their deductible or copay.

One problem: Some hospitals have not published their rates and there has been a lack of consistency between providers in terms of how they are providing the information.

This has prompted the Centers for Medicare and Medicaid Services to audit hospitals' websites, and it has sent out notices to hospitals that are not complying with the transparency regulations.

Finally, many insurance carriers offer searchable online databases for their enrollees where they can research the approximate cost of certain procedures among all the providers available to them.❖

CHEAPER SCAN: *Your workers can shop around for medical services like an MRI by going to network hospitals' websites, potentially saving them thousands in out-of-pocket expenses.*