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THE RISK REPORT

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CMS, Marketplace Action

Judge Deals Blow to Preventative Care Coverage under ACA

A RECENT DECISION by a federal judge in Texas to issue an injunction on a pivotal part of the Affordable Care Act requiring insurers to offer certain types of free preventative care, has raised concerns that some health plans will stop paying for these services.

However, since most employer-sponsored plans are on annual contracts, the decision is unlikely to affect policies in 2023, but beyond that it's uncertain how things will play out.

The Biden administration has appealed and called for a hold on the ruling until the decision is settled by higher courts.

If the decision by Judge Reed O'Connor of the Federal District Court for the Northern District of Texas sticks, it would roll back a staple of the U.S. health care system since 2012. The ACA requires insurers to pay for a number of preventative services.

SOME SERVICES THE RULING MAY AFFECT

- Cancer screenings, like breast cancer screenings and colonoscopies
- HIV screenings
- Diabetes screenings
- Heart disease screenings
- Pap smears
- Depression screenings
- Statins
- Immunizations and PrEP for HIV and HPV.

The judge ruled:

- That a panel of volunteer experts that issues binding recommendations on what preventative care must be covered under the ACA violated the Constitution because its members are not appointed by the president or confirmed by the Senate.
- That the ACA requirement that insurers must cover PrEP and HPV vaccines as well as certain HIV/Aids-prevention drugs violates the religious beliefs of Christians, which in turn violates the Religious Restoration Freedom Act.

The fallout

The consequences of the ruling are unlikely to be felt immediately, particularly for group health plans, the annual contracts of which include coverage for preventative services.

Matt Eyles, president and CEO of the trade association America's Health Insurance Plans, issued a statement saying that: "As we review the decision and its potential impact with regard to the

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Legislative Action

Moves Afoot to Improve Prior Authorization Times, Efficiency

AFTER THE Centers for Medicare and Medicaid Services proposed new rules aimed at streamlining the prior approval process for most health plans in the U.S., a number of the country's largest insurers announced their own steps to improve the process.

UnitedHealthcare announced in late March that it would cut the use of prior authorizations by 20% for some non-urgent surgeries and procedures. Starting in the third quarter of 2023, the insurer will remove many procedures and medical devices from its list of services that require prior approval, and continue through the rest of the year for most commercial, Medicare Advantage and Medicaid plans.

Meanwhile, insurance giant Cigna said it has been in the process of reducing the prior authorization for about 500 services and devices. And Aetna is working to automate and simplify prior authorizations.

The proposed rule

The rule is aimed at tackling one of the biggest headaches for patients and practitioners alike. Waiting for prior authorizations for care, pharmaceuticals or medical devices can lead to delays in care and increased risk of hospitalization from those delays.

The goal of the proposed rule, which would take effect in 2026, is to reduce the bureaucracy around prior authorizations and cut wait times for responses that some providers say sometimes take weeks to get approved. ❖

THE SPECIFICS

- Insurers would be required to render a decision within seven days after a request for a non-urgent service or item (compared to the current 14 days).
- If the requested care or item is urgent, the insurer must render a decision within 72 hours.
- If the insurer denies the request, it must include a specific reason for doing so.
- Most group and individual health plans, Medicare Advantage, Medicaid managed care and state Medicaid agencies would be required to build and maintain a system for electronically approving prior authorizations, known as a "fast healthcare interoperability resources application programming interface."
- The interface must be able to ascertain whether a prior authorization request is required and "facilitate the exchange of prior authorization requests and decisions" from the provider's electronic health records or practice management system.

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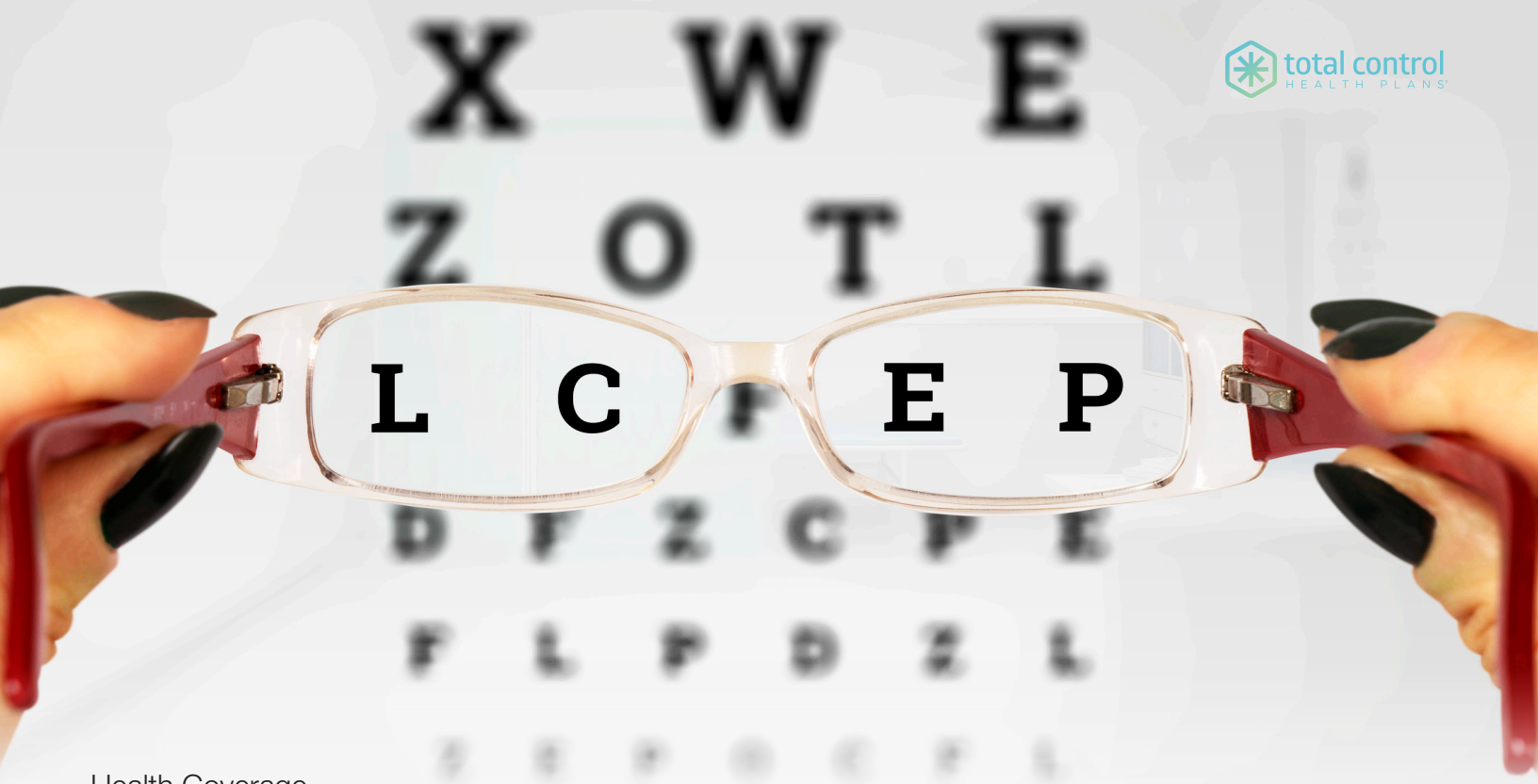
Insurers Must Give Advance Notice If Changing Plan Benefits

preventive services recommended by the United States Preventive Services Task Force, we want to be clear: Americans should have peace of mind there will be no immediate disruption in care or coverage.

"We fully expect that this matter will continue on appeal, and we await the federal government's next steps in the litigation, as well as any guidance from relevant federal agencies."

That said, if the Biden administration fails in convincing higher courts to put a hold on the injunction while the appeal of the decision plays out, changes could come over time.

In this continuing tight job market, many employers would likely be reluctant to roll back these preventative services in their health plans. And if insurers plan to make changes to their plans' benefits, they are required to give advance notice. ❖



Health Coverage

Making Your Voluntary Benefits Program a Success

BOTH EMPLOYERS and employees have much to gain from a solid voluntary benefits program.

For employees, being able to enroll in an insurance product through a workplace voluntary benefits program offers them the advantage of group pricing, the convenience of paying through payroll deduction, and perhaps access to insurance that would be difficult to get on an individual basis.

For employers, offering a range of voluntary insurance products can help increase employee satisfaction – along with loyalty and morale – and make the business more competitive in attracting and retaining the best talent.

How to ensure success

These advantages alone, however, do not ensure that a voluntary benefits program will be a success. Careful planning, including the selection of benefits to offer, choice of vendors and well-crafted communications, are keys to program success. Consider the following:

Get the right mix – Bring in the kinds of benefits that employees want and will enroll in. Survey employees as to what types of additional benefits they would participate in if given the opportunity. Depending on your employee demographics, these could include additional life insurance options, long-term care – or even pet insurance.

Voluntary benefits enable employees to self-customize an individual benefits package that is uniquely appropriate to them.

Look for gaps – Seek out gaps in your company's current benefits coverage, and consider how voluntary benefits plans can be used to fill them.

For companies that have had to scale back on their regular benefits package, voluntary benefits can be particularly helpful. If your benefits budget is tight and, for example, needs to be dedicated to helping fund medical benefits, offering dental and vision on a voluntary basis gives employees easy and affordable access to these benefits.

Get the word out – While we can often supply some communications materials, your internal communications concerning the program will help to incorporate it into your overall benefits program in the eyes of employees, making it more likely they will enroll.

Consider announcing new voluntary benefits offerings in a communication from top management, which will demonstrate the company's commitment to the program.

Make voluntary benefits enrollment a part of your annual enrollment process, and incorporate descriptions and information on voluntary benefits offerings into the communications materials for your core plans.

WORK CLOSELY WITH US

We are here to help you make a selection that best fits your company's needs, and to help you communicate with your employees and enhance enrollment.

This will be particularly important if any of the voluntary benefits have minimum participation requirements. We can come in for presentations, individual meetings or enrollment sessions, all of which can be very effective in increasing participation in these programs.

The takeaway

Voluntary benefits can be a great add-on to any company's benefits program. Careful planning and consideration of the various issues that can affect participation can increase the chances of program success. ❖

Small Firms See Larger Premium Hikes, Except Ones That Do This

A NEW REPORT has found that small businesses that purchase their group health insurance online or through payroll vendors saw the largest premium hikes in 2022, significantly higher than those that went through brokers.

Overall rates for employers with 10 or fewer employees saw their family plan health insurance premiums jump 12% from 2021, compared to just 5.4% for all small to mid-sized businesses with up to 250 employees, according to the report by HR and benefits software company Ease.

The cost for individual group health plans increased 6.7% for the smallest SMBs, compared to just 4.3% overall between 2021 and 2022.

Meanwhile, employees' share of premiums increased at a slower rate overall of 4.15% between 2021 and 2022, meaning that employers were not passing on the full increases in group health plan premiums to their staff.

Since 2018, individual premiums have increased by 21% while family premiums have increased by 18%. To put it into dollar signs, that's an extra $104 for individuals and $231 for families each month for medical insurance.

The Ease report notes that those higher premiums are likely hurting the smallest employers more than larger SMBs with between 51 and 250 workers.

The latter have seen an increase in health plan enrollment among their employees between 2018 and 2022, while those with one to 50 employees saw overall decreases. Overall, more than half of SMB employees opt out of their employer-sponsored coverage.

The high-deductible health plan effect

The report found that HMOs and PPOs continue to dominate the landscape for SMBs. While high-deductible health plan (HDHP) enrollment grew at an astounding 68% between 2021 and 2022, they only accounted for 6% of group health plan enrollment.

Some employers have gravitated towards HDHPs to reduce their and their employees' overall premium spend, but these plans come at a cost: more out-of-pocket costs for workers.

In those cases, Ease CEO and co-founder David Reid recommends pairing an HDHP plan with other voluntary benefit plans that can "insure" gaps in coverage, such as short-term disability plans and group supplemental health insurance plans called Gap plans.

Gap plans can provide additional coverage when employees have not met their health care deductible. They may cover the out-of-pocket costs for most inpatient and outpatient services.

How we can help

Reid said that the report's findings illustrate the importance of employers working with brokers and consultants to purchase their employee benefits.

"[SMBs] getting good advice are using more innovative solutions that allow them to make their dollars go as far as a large corporation's dollar-spend on benefits," he told the trade publication BenefitsPro. "Those who are bypassing a consultant and purchasing benefits through, say, their payroll vendor are generally seeing fully insured, off-the-shelf plans that increase in cost more quickly."

As your broker, we have access to plans from different carriers and can work with you to put together offerings that will best accommodate your employees. ❖