

Important news and updates from your benefits professional

Interest in Reference-Based Pricing Grows



Reference-based pricing (RBP) strategies are increasing in popularity as employers seek more affordable options for their health benefit plans. Although PPO networks and their negotiated discount agreements have been in place for decades, they provide very little transparency to the true costs of services provided.

How can an employer control health care costs when the base charges for services for the same procedures can vary dramatically between physicians and hospitals in the same region? For example, depending upon which hospital is

providing the service, hip surgery can cost anywhere from \$20,000 to \$100,000 (all incorporating PPO discounts).

Reference-based pricing is a strategy that drives plan enrollees to find and use a provider (usually a hospital) that has agreed to accept a fixed amount for certain procedures. These amounts can be directly negotiated with providers using the average fees charged within the same geographic region by providers of similar training and experience or, more often, calculated as a percentage over and above current Medicare reimbursement rates.

The U.S. Department of Health and Human Services (HHS) is comfortable with this new approach, as it provides much greater transparency to the true cost of services – with the caveat that care must be taken to ensure plan participants are provided with “adequate access to quality providers” and are not just forced to choose the least costly alternative.

A Perfect Complement to Self-Funding

Self-funded plans are particularly well-suited to this approach and many TPAs are already offering their clients alternatives that incorporate some form of reference-based pricing. With experienced plan administrators guiding the implementation and administration, self-funded employer groups can finally know the true cost of care – something that few fully-insured organizations have ever been able to identify.

Although there is a concern that plan participants may be “balance billed” – charged the difference between the provider’s retail or network pricing and what they are being paid under the RBP agreement – some TPAs take steps to ensure plan members are protected against this.

Far outweighing these considerations is the potential for savings. It is not uncommon for reference-based pricing to yield savings in the range of \$150,000 for every 100 covered employees. To learn more about reference-based pricing alternatives, contact us today.

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Health Care Reform Update

Moving Toward Full Implementation

How Many Uninsured Are There – Really?

Now that PPACA directives are reality and health insurance exchanges are in place, just what impact will health care reform really have on the number of uninsured Americans?

Circumstances or Choice?

With projections over the years having been as high as 45 million, the reality is that about 75% of uninsured were without coverage voluntarily. Who are these uninsured and why are they without coverage when they can afford it?

- *The largest group is actually insured, but lost coverage for a short period of time, such as with a job change – making counts misleading.*
- *Next are those who discovered it is cheaper to be uninsured – getting free care with no deductible or co-pay.*
- *Many young and healthy believe health care premiums cost more than they will ever spend on medical treatment.*
- *Numerous early retirees and laid-off executives elect to coast without coverage until Medicare eligibility.*
- *A large number of homeless and mentally unstable are eligible for coverage through Veterans, Medicaid, Medicare or state/local programs, but had a bad experience or distrust government.*

Some say the number of uninsured will increase over the next few years as enforcement of employer mandates drives declines in employer-sponsored coverage. No matter the numbers, once you subtract the tens of millions of voluntarily uninsured, those that remain could have been given lifetime care for a tiny fraction of the cost of reform.

PPACA, Lack of Data Challenging Actuaries

How do you price a service when you have no idea what it will cost you to deliver? That's the challenge actuaries faced as they tried to predict medical costs for the thousands of new enrollees participating in health care exchanges across the country.

Actuaries thrive on data – specifically, demographics on age, sex, location and health care history. Under Obamacare, insurers must accept all comers with no health information on enrollees. Additionally, they were asked to establish premium rates for an unknown population as participants rushed to meet the sign-up deadlines. Last minute regulatory changes provided further complication – forcing unexpected revisions to calculations that had been worked on for years in preparation for exchange deadlines.

Waiting for Claims Data

The result has been a nightmare for actuaries and a roll of the dice for insurance companies. Without valid data for actuarial analysis, insurers were forced to make big bets on how things would play out for 2014

– establishing premium rates for exchange offerings without accurate cost projections or competitive market pricing. Some companies unintentionally priced themselves high, while others won with marketplace sign-ups tracking to their predictions.



Most actuaries estimate it will take at least another year to gather enough data to make accurate cost projections to help manage plan risk and generate profit for their companies. In the meantime, many insurance companies expect double-digit rate increases for 2015.

These increases are to offset the estimated costs associated with the poorer health and pent up demand of new, previously uninsured enrollees signing up this year and next, as well as new fees being levied under PPACA. Only time will tell if these rate increases are warranted, as actual data meets 'best guesstimates'.

Many employers are choosing alternatives to these anticipated cost increases by moving from fully-insured to self-funded plans that offer greater control over plan expense as well as increased plan flexibility.

Trends Latest Happenings in Today's World

Cost Kept Some From Exchanges

About half of uninsured Americans participating in an online survey funded by the Robert Wood Johnson Foundation and The California Endowment indicated that cost kept them from signing up for health care coverage. Surveys indicated that most respondents were unaware that financial assistance and

government subsidies were available to offset the expense, making education and outreach critically important next year.

Critical Illness Coverage More Widespread

Voluntary benefits are a growing trend that allows employers to enhance their overall benefits package. While voluntary dental, vision, life

and disability insurance are familiar, the popularity of critical care insurance has been growing dramatically. Critical care coverage typically pays a lump sum directly to the insured upon diagnosis of a covered critical illness and is generally used for daily living expenses and things like co-payments, mortgage payments and childcare. This increasingly popular offering can provide a financial

Get Ready for ACA Reporting Requirements

Starting next year, the Affordable Care Act requires employers to report information about the health care coverage they offer to employees. The first reports must be filed with the IRS by February 28, 2015 (March 31, if filed electronically), so companies should begin working now to ensure compliance.

■ **Internal Revenue Code Section 6055** applies to employers with self-funded or self-insured plans and to the insurer offering an insured plan. Employers and insurers must provide a list of covered individuals with identifying information and the months coverage was provided.

■ **Internal Revenue Code Section 6056** applies to “applicable large employers” (those with over 50 full-time equivalents) (FTEs) and requires a listing of all full-time employees and coverage offered to each, by month – including the cost of single (employee only) coverage.

Employers with self-funded plans must file both forms, while those with fully-insured plans will only file the 6056 report. General reporting requirements demand that employers provide: detailed information for each calendar month on the total number of FTEs; the name, address and Social Security

number for each; whether coverage offered was “minimum essential coverage;” whether it satisfied the “minimum value” requirement; whether it was affordable and how much the employee was required to pay; and whether the coverage was offered to FTEs and their dependents. In addition to these IRS reports, employers are required to deliver annual statements to their FTEs.

If your plan is administered by a TPA, it’s likely that most of this information is already collected and readily available to meet these requirements.

What to Expect After 2016

The Affordable Care Act is in full effect, but will these mandates remain in place after the 2016 elections? Henry Aaron, senior fellow at Washington-based Brookings Institution with a PhD in health care-focused economics, outlines two scenarios for the *New England Journal of Medicine*.

If Republicans win the presidency and gain traction in Congress, a full repeal of the ACA is unlikely as popular parts of the law – insurance market reforms, subsidies for public exchange enrollment, and incentives for employers to provide affordable coverage – will have been in effect for several years. Additionally, repeal could hurt providers. What is more likely to occur is a scaling back of ACA – with cuts in affordability subsidies and a weakening of the penalties for

people who remain uninsured. We could see a cap to Medicare spending, regardless of cost increases. A Republican Congress may also allow each state to curtail or reject certain ACA elements.

If the Democrats retain power, look for ACA changes to be more technical – with the first likely change being the calculation of what constitutes “affordable” employer-sponsored coverage. Currently, coverage is deemed affordable if worker premiums are less than 9.5% of household income, even for workers with dependents whose premiums are higher.

No matter the post-election scenario, expect the ACA to remain in place, with varying adjustments depending on the party in power.



safety net against hardship driven by out-of-pocket medical expenses.

ER Visits Increase

An 18-month study of new Medicaid coverage recipients in Oregon shows a 40% higher utilization of ER services compared to those without insurance.



This spike appears to contradict predictions that Medicaid expansion would reduce ER visits and save money for participating states. Expansion supporters believe more walk-in clinics and better communication could alleviate this trend, which is being driven by virtually free ER access. Time will tell, as Oregon has recently developed programs intended to change the patterns of ER use.

More Doctors Refuse Medicaid Patients

Health care consulting firm Merritt-Hawkins released the results of a survey of doctors across 5 specialties (cardiology, dermatology, orthopedic surgery, obstetrics-gynecology and family practice) in 15 metropolitan markets. The report found the average Medicaid acceptance rate to be 45.7%, down from 55.4% in 2009.

Reasons include: some reimbursement rates below cost to deliver service, reimbursement rates lower compared to other payers, and complex billing procedures for Medicaid payment. Boston had the highest acceptance at 73%, while Dallas was lowest at 23%.

Did You Know? New Ideas for Healthy Consumers

Is Your Organization Encouraging Wellness?



A wellness program that consists of only a health risk assessment is missing out on the opportunity to impact the broader factors that influence unhealthy behavior in employees' lives – such as physical and emotional stress, both at work and home.

The Institute for Wellness Education has conducted research that shows significant gaps in understanding as to what constitutes good health and wellness. Studies show that more than one in

three Americans do not recognize the difference between wellness and the absence of diagnosed illness or disease. In addition, misconceptions are prevalent with regard to how to make effective and sustainable lifestyle changes.

For example, despite evidence demonstrating that multiple factors – including psychological, social, physiological and environmental – contribute to successful and sustainable weight loss, 73% of men and 68% of women believe willpower to be the most important element.

Sustainable change requires solutions tailored to the individual's needs, interest and desires.

Employers can impact unhealthy behaviors by offering a variety of programs that encourage or promote healthy habits and activities, both in the workplace and at home.

2015 HSA Limits Announced

The Internal Revenue Service has announced that it will increase maximum contribution levels for health savings accounts (HSA) by \$50 for individuals and \$100 for families to reflect cost-of-living adjustments. In 2015, the maximum HSA contribution for self-only coverage will be \$3,350, while the maximum allowable contribution for families will increase to \$6,650.

Employee out-of-pocket maximums are being increased to \$6,450 for single coverage and \$12,900 for families. The annual limitation on deductions for an individual with family coverage under a high-deductible health plan will be \$6,650. These increases will take effect in January of 2015.

Find the Best Sunscreen

It's Summer and sunscreen is a must, but the array of choices is confusing. An associate professor of dermatology at the University of North Carolina at Chapel Hill offers help.



Chemical (Organic) vs. Physical (Inorganic)

The most common sunscreens contain "chemical absorbers", such as PABA, which are carbon compounds made in a lab. Physical blockers like zinc oxide and titanium dioxide are natural minerals ground into fine powders and do not decompose the way chemical blockers do.

When sunlight hits the skin, chemical absorbers absorb active UV rays and release their energy in harmless ways, while physical blockers reflect the rays without allowing skin penetration.

While physical blockers are preferred, a minimum of SPF 15 should be applied every two hours while in the sun. Do not apply to babies younger than six months, who should be kept out of the sun.

Please Contact Us: This newsletter is not intended as a substitute for personal medical or employee benefits advice. Please consult your physician before making decisions that may impact your personal health. Talk to your benefits administrator before implementing strategies that may impact your organization's employee benefit objectives.



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