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Improving Delivery

New Rules Aim for Hospital, Insurer Transparency

THE TRUMP administration in November 2019 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 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 this year. ❖

Health Insurance

Group Plan Costs Hit New High – What You Can Do About It

A NEW STUDY has found that the average annual premium for a group family health plan has exceeded $20,000 for the first time in 2019, up 5% from 2018.

The average premium for single coverage plans in 2019 is $7,188, up 4% from the year prior, according to the Kaiser Family Foundation's annual report on employer coverage.

The costs of high-deductible health plans are only slightly less than the average. The average premiums for covered workers in HDHPs with an attached health savings account are $6,412 for single coverage and $18,980 for family coverage.

Increasingly, workers are picking up a larger portion of the insurance tab. In 2019, they are paying $6,015 on average in premiums for family coverage, or about 29% of the total. Workers with individual coverage contribute 17.3% of the total premium.

Additionally, the average deductible for single coverage is $1,655 in 2019, which is unchanged from the year prior; however, the deductible is often higher for workers in small firms ($2,271) compared to large businesses ($1,412).

The average annual deductible among covered workers with a deductible has increased 36% over the last five years and 100% over the last 10 years, according to the report.

Also, 66% of workers have coinsurance and 14% have a copayment for hospital admissions. The average coinsurance rate for a hospital admission is 20%, and the average copayment is $326 per admission.

Another survey by the Kaiser Family Foundation and the *Los Angeles Times* found that 40% of group health plan enrollees had difficulty affording health insurance or health care, or had problems paying medical bills.

And close to 50% said that they or a family member had skipped or postponed getting health care or prescriptions in the past year due to costs.

Easing the burden

There are steps you can take to ease the burden on both your company and your employees.

Consider plans with telemedicine – More and more employers (69% of firms with 50 or more workers) are offering health plans that cover the provision of health care services through telemedicine. Telemedicine can greatly reduce the cost of care in terms of price for medical visits, as well as the time involved for the employee to travel to the doctor.

Telemedicine can include video chat and remote monitoring.

Using retail health clinics – More health plans will pay for services rendered by retail clinics, like those located in pharmacies, supermarkets and retail stores. These clinics are often staffed by nurse practitioners or physician assistants and treat minor illnesses and provide preventative services.

They can greatly reduce the cost of care for these kinds of visits outside normal hospital systems.

Plans with narrow networks – If a health plan can contract with fewer doctors and specialists, there is often less outlay for care. At this point the jury is still out on exactly how much can be saved, but there are also drawbacks such as:

- Disruption of provider relationships
- Employee backlash
- Reduced access or convenience for employees
- Lack of specialists.

Tiered and high-performance networks – These networks typically group medical providers based on the cost, quality and/or efficiency of the care they deliver, and use financial incentives to encourage enrollees to use providers on the preferred tier. ❖

Health Insurance

Study Attributes 25% of Health Spending to 'Waste'

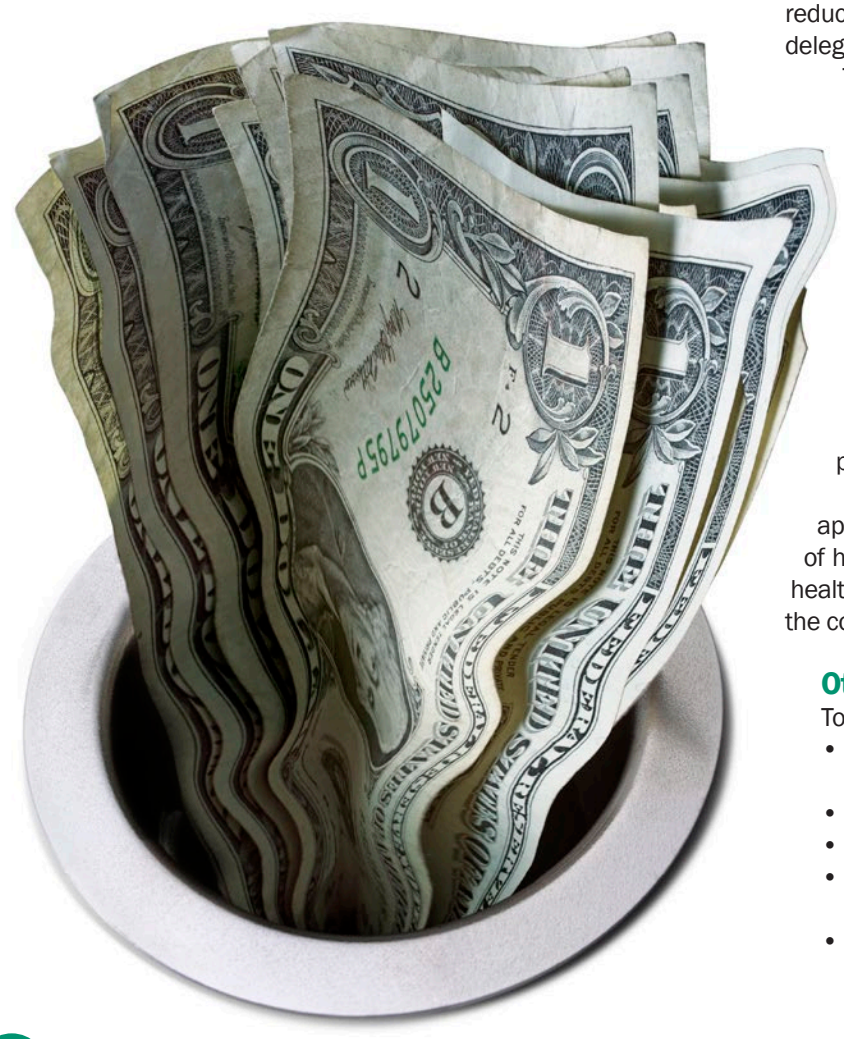
A NEW STUDY published in the *Journal of the American Medical Association* estimates that about 25% of all health care spending in the U.S. is attributable to waste in the system.

The study, conducted by health insurer Humana and the University of Pittsburgh School of Medicine, estimated that between $760 billion to $935 billion of health care spending in the country is wasteful.

The study is eye-opening and reflects the need for new approaches in the health care system and how medical care and pharmaceuticals are paid for. It also reflects the tremendous waste caused by complex administrative procedures, which again cries out for changes in the health insurance and care delivery models.

WHERE THE WASTE IS

Administrative complexity: $265.6 billion
Pricing failure: $230.7 billion to $240.5 billion
Failure of care delivery: $102.4 billion to $165.7 billion
Overtreatment, low-value care: $75.7 billion to $101.2 billion
Fraud and abuse: $58.5 billion to $83.9 billion
Failure of care coordination: $27.2 billion to $78.2 billion



"This study highlights the opportunity to reduce waste in our current health care system," William Shrank, MD, lead author and Humana's chief medical and corporate affairs officer, said in a prepared statement. "By focusing on these opportunities, we could make health care substantially more affordable."

With that much waste in the system, the industry is crying out for more efficiency in hospitals, medical services delivery, health insurance and administration across the spectrum.

The researchers said that if the industry worked on concrete solutions, it could reduce waste by up to $282 billion a year.

They identified the most promising areas for reducing waste, and said that value-based care and reimbursement models represent a major opportunity to reduce the greatest source of waste: administrative complexity.

Value-based care

They said that value-based care models could improve administrative coordination in the system, which is currently severely lacking. The researchers wrote:

"In value-based models, in particular those in which clinicians take on financial risk for the total cost of care of the populations they serve, many of the administrative tools used by payers to reduce waste (such as prior authorization) can be discontinued or delegated to the clinicians."

That, they said, would reduce complexity for physicians and give them incentives to reduce waste and improve value in their treatment decision-making.

Using value-based care in which all parties share some in the financial risk would benefit insurers, employers who sponsor health insurance for their workers, hospitals, doctors and patients.

More and more insurers are experimenting with value-based care, which is primarily a payment model that offers financial incentives to physicians, hospitals, medical groups and other health care providers for meeting certain performance measures. Essentially, they are paid based on patient health outcomes.

Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of health care services they deliver. The "value" in value-based health care is derived from measuring health outcomes against the cost of delivering those outcomes.

Other waste

To further reduce waste, the researchers also recommended:

- Addressing the high cost of pharmaceuticals (especially for high-cost specialty drugs).
- Implementing hospital price transparency.
- Implementing market competition policies.
- Improving payer-provider collaboration to reform care coordination, safety and value.
- Implementing new measures aimed at reducing fraud and abuse.❖