Benefits EBSO SPOTLIGHT

Important news and updates from EBSO, Inc.

Fall 2018 Edition

This Issue

Medical Marijuana
Experts say use far exceeds existing medical evidence.

Balance Billing
Several states have passed laws protecting patients.

Hospital Transparency
CMS is doing more to make hospital costs available.

Numbers You Need
It shouldn't be hard to count your way to better health.

Trends, News, Updates and More Inside!

Self-Funding:
More Than a Means to an End

In an effort to take control of their healthcare spend, more employers continue to move to self-funding. But as those who have used this funding mechanism for some time have learned, designing a self-funded health benefit plan is just the beginning. When a health plan is self-funded, the entire healthcare supply chain is unbundled, giving everyone a clear, unobstructed view of the health-care spend. An experienced Third Party Administrator will help you identify exactly where your healthcare dollars are going. Providers can be evaluated. Opportunities to achieve quality outcomes and lower costs can be explored. Best of all, unlike fully-insured health plans that are carrier-based, employers who self-fund their health benefits have the flexibility to act.

Target Cost Transparency

According to the Centers for Medicare and Medicaid Services, healthcare costs have increased by more than 260% since 1999. One of the biggest problems is costs for the same service can vary drastically from one provider to the next, even when the providers are located in the same marketplace. One way to attack this problem is with Reference Based Pricing, which typically allows qualified self-funded health plans to pay for medical services based on a percentage of Medicare, rather than by applying a percentage discount to a facility's billed charges. Using an accepted index such as Medicare has enabled a growing number of health plans to bring cost transparency and consistency to hospital billing, since Medicare sets prices for every procedure.

Communicate with Purpose

From mobile cost transparency tools to telemedicine, employers are doing more than ever to help plan members utilize their benefits. Engagement rates, however, often tell a disappointing story as many employees are reluctant to use these new features. Experience tells us that whether we're talking about a published provider directory or an online member portal, most people are confused by healthcare coverage.

Whether your company decides to place colorful posters in gathering spots, hold employee meetings or distribute email newsletters, emphasizing the steps you're taking to make healthcare more accessible and affordable is critical. In this time of full employment and intense competition, health benefits can play an extremely important role in attracting and retaining valued employees. Don't miss this opportunity to enhance your company culture and improve your employees' quality of life.

Keep Informed

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There's More to Know About AHPs

Many employers will find it interesting that AHPs will continue to be categorized as MEWAs – Multiple Employer Welfare Arrangements. This consideration will make association health plans subject to some state regulations that severely restrict the formation of self-funded MEWAs.

Having to comply with the rules of each state will make AHPs more difficult to organize. While associations can create a plan that extends across state lines, they will have to follow the rules of the state they are in that has the most restrictive laws. As an example, an AHP based in New Jersey that extends into New York would still have to follow the more restrictive laws of New York.

Even though the regulations are more restrictive than many would like, AHPs should enable many small employers to offer their employees better health benefits at more affordable rates.

States Crack Down on Balance Billing

Currently, only 21 states offer some protection against balance billing and most existing laws apply to emergency services required from out-of-network providers. Few, if any, address balance bills received for treatment by an out-of-network provider in an in-network hospital. In Pennsylvania, the Governor and General Assembly have introduced two bills aimed at taking consumers out of the middle of the reimbursement process. These bills have come after several other states have adopted more comprehensive laws that prohibit balance billing entirely.

Some measures addressed in Connecticut, New York, Maryland, Florida and New Jersey include:

- *Protections in emergency department and in-network hospital settings*
- *Prohibiting providers from balance billing and requiring carriers to hold their members harmless*
- *Adopting reimbursement rate standards and a payment dispute resolution process*
- *Applying these laws to all types of managed care products, including HMOs and PPOs*

The goal of the proposals is to keep covered persons out of the middle of carrier-provider payment disputes. In non-emergency procedures, healthcare facilities in New Jersey are required to disclose whether they are in-network and advise the covered person to ask if their physician is in or out-of-network. Individual healthcare professionals must inform the patient if they do not participate in the person's plan network and provide a billing estimate and applicable CPT codes. With healthcare costs continuing to rise and a lack of federal regulations, we can expect more states to take measures to protect healthcare consumers. We will strive to keep our clients informed as changes develop.

Trends Latest Happenings in Today's World

Employers Investing More in Benefits

Health and wellness are integral to employee performance, which helps explain why employers are investing more in their employee benefit offerings.

In June of 2018, the average cost of benefits rose by 2.9%, while wage costs rose by 2.7%, according to data released by the Bureau of Labor Statistics. Also on the rise is paid leave, which has seen a 4% cost per employee increase since 2017. This includes paid parental leave, which allows time off for a birth, adoption or foster placement of a new child.

Traditional Plans Decrease

Since 2007, adults ages 18 to 64 with employment-based coverage have increasingly chosen High Deductible Health Plans (HDHP), both with and without Health Savings Accounts (HSA), over traditional plans.

In 2017, the number enrolled in HDHPs without an HSA rose to 24.5%, while HDHPs with HSAs rose to 8.9%. Some employers are choosing to only offer HDHPs, helping shift employees away from traditional plans.

Q&A

How Should Your Plan Address Medical Marijuana?

There is a lot of misinformation surrounding medical cannabis, which can make it difficult to establish a plan document that accurately outlines its use. One particular obstacle is the lack of verified and sourced research regarding the medicinal use of cannabis, creating confusion around what the drug can and should be used for.

To address this confusion, benefit plans should limit coverage to areas where existing evidence supports the use. Create a benefit description that reflects approved applications determined by your state, while also limiting the care option to those members whose previous treatment options have failed. Experts agree that plan documents should clearly indicate that medical cannabis will not be authorized as a first line therapy.

Other parameters can be set, such as financial limitations within a certain time period, eligible products and dosages and even eligible suppliers. When addressing cost considerations, it's important to know that medical cannabis should not be viewed as an alternative to prescription painkillers and opioids, but rather an add-on which does not eliminate those other costs.

CMS Pushes for Hospital Price Transparency

The Centers for Medicare and Medicaid Services recently proposed a rule intended to give patients a clear look at the cost of hospital care. Beginning January 1, 2019, hospitals will be required to make a list of their current standard charges available on the internet in a machine readable format and update the information at least annually.

While CMS believes the update will promote price transparency and make more information available to the public, recent comments argue that the formatting will be confusing for patients, failing to show their actual out-of-pocket costs. CMS is reviewing these concerns.

Deductibles Keep Rising

The International Foundation of Employee Benefit Plans reports that individuals enrolled in employer-sponsored healthcare plans are now paying an average deductible of $1,491 for individual coverage and nearly $2,800 for family coverage. These numbers are up from $1,300 and $2,500, respectively, in 2016.

Individuals covered by HDHPs have average deductibles of $2,296, with families averaging $4,104 – more than twice the averages for traditional, non-high deductible plans. The online survey included nearly 700 U.S. members of IFEBP and was conducted in February.

Getting Creative About Behavioral Health

With behavioral health conditions impacting one in five Americans, it's no wonder we're seeing more employers search for ways to provide members with better access to behavioral healthcare benefits.

Statistics show that many employees, including some that are insured, fail to get the mental healthcare they need. Because self-funded health plans provide plan design flexibility, some plans are taking bold steps to address this growing need. While many are using telemedicine to improve access and lower costs, some employers are treating out-of-network behavioral health treatment as in-network, enabling employees to pay the same amount for treatment regardless of which provider they use. Others are covering out-of-network behavioral healthcare services even when their plan doesn't cover out-of-network services for other types of care.

When you consider that mental illness has become the greatest cause of disability claims in the U.S., it is not surprising that employers are looking for ways to help employees obtain the care they need.

Significant Action is Warranted

There is plenty of research to show that Americans are not getting the mental health care they need. According to Mental Health America, despite having health insurance, 56.5% of adults with mental illness received no treatment in the past year.

Another problem is that behavioral health treatments are rarely classified as primary care, and are regarded instead as specialty treatment. This makes people find an in-network provider, go out-of-network, pay higher out-of-pocket costs or avoid treatment altogether. Claims data from Collective Health shows that more than 40% of the 2017 behavioral health spend was out-of-network, which is many times the amount spent on primary or preventative care.

Fentanyl Deaths on the Rise

Fentanyl, a hyper-potent, synthetic alternative to opioids, played a roll in over 60% of the 49,000 overdose deaths in 2017. Just a few grains can be lethal, and because such a small amount is needed, it is easily shipped undetected throughout the U.S. Fentanyl and other opioids are killing more than 130 people a day, and an international push is necessary to reverse the trend.

Troubleshooting Telemedicine

The healthcare landscape is changing as providers increasingly offer virtual care options, and naturally it's taken some getting used to. A recent study by the Deloitte Center for Health Solutions found that while patients who have used virtual care reported a 77% satisfaction rate, only 44% felt that their wait time was reduced compared to an in-person office visit. Some offices are designating doctors for virtual care on specific days of the week to circumvent wait times caused by healthcare professionals bouncing between in-person and virtual patients.

More Patients Texting

Healthcare professionals that aren't utilizing text communications are failing to meet their patients where they are. A 2018 survey found 11% of patients would rather communicate via text message, a number that is expected to grow as the Millennial population begins to outnumber Boomers. Text alerts and communications can be used for a variety of services, including preventative care such as periodic appointments and flu shots, post-treatment care information, remote health monitoring and chronic disease management.

Did You Know? New Ideas for Healthy Consumers

Safe Disposal of Unused Medications

If you've stopped taking a prescription, you've probably forgotten about it. This can cause a problem when unused or outdated medications just sit around. Disposing of medications can be safe and convenient, especially since guidelines were established by the Controlled Substance Act of 2014. While regulations can vary from state to state, here are five safe ways you can dispose of your leftover medications.

Medication Take Back Programs. These take back programs have been run by the Drug Enforcement Administration for 15 years and have been effective. Local events are often held on a quarterly basis, while the DEA hosts an annual National Drug Take Back Day.

Police & Pharmacy Drop Offs. Pharmacies throughout the country have been adding medication disposal boxes to their stores. If you can't make it to a pharmacy during store hours, police stations are a 24/7 option. Before you drop off the medication, use a permanent marker to cover your personal details, but leave the medication information visible in case the contents need to be identified.

Submit Them for Incineration. If your pharmacy does not have a drop-off box, ask if they can help you send your medications off to be incinerated. The pharmacy will provide you with an envelope, which you can safely ship to the destruction site.

Destroying Your Medications. If you choose to throw away your medication with your regular trash, there are ways to prevent harmful medications from getting into the wrong hands. Pour liquid into the bottle to destroy the meds or make them impossible to take by pouring kitty litter or coffee grounds into the bottle. While not the case for every medication, flushing the medication down the toilet is the safer option. The eco-toxicological impact is negligible, and the risk of misuse is too high to just keep them around.

Know Your Numbers

Have you tried to monitor your health by counting carbs, calories or protein? While health can feel like a game of numbers, it can help to know measurements that matter most. Here are a few numbers that may help:

50%. That's the proportion of your plate that should contain vegetables. The rest of your plate should include 25% whole grain, such as brown rice and 25% of protein rich food, such as fish, beans or chicken. Using a plate model can be much easier than counting calories.

25-35 grams. Aim to take in 25 to 35 grams of fiber a day. Most Americans only take in 16 and low fiber can cause issues with high cholesterol and blood sugar levels, increased risk of certain cancers and digestion problems.

7-8 hours. Sleep is necessary for a healthy lifestyle, so try to get 7 to 8 hours. A lack of sleep can increase risk of Type 2 diabetes and obesity, and lead to complications such as loss of focus, impaired memory retention and irritability.

150 minutes. Aim for 150 minutes of activity per week, spread throughout each day, with a minimum of 10 minutes per session. Activities you enjoy are the ones you're more likely to do regularly.

120/80. Blood pressure is called the "silent killer," as it can often be present without any symptoms. Unchecked or untreated, high blood pressure can increase the risk of heart attack or stroke. Monitoring is key, as well as frequent exercise and a healthy diet.

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