BENEFITS EDGE

Marketplace Update

JANUARY 28, 2021

Heraclitus, the ancient Greek philosopher is attributed with saying, "Change is the only constant in life." This is certainly true in the benefits industry. In the last 12 months alone, we've seen an incredible amount of change as employers, health plans, healthcare providers, and governments have responded to the global pandemic. We've experienced changes in coverages to accommodate COVID-19 testing, treatment, and vaccination; significant increase in telehealth adoption; and sweeping changes to leave policies, eligibility rules, and benefits election parameters. Yet, while we've adjusted to so much, we have much still to navigate through and to anticipate in order to thoughtfully consider responses to future change.

While by no means a comprehensive analysis of things to come, we are providing the following marketplace update to summarize key issues impacted by current events and recent legislation that should be placed on every employer's broader Sightline.

HEALTHCARE REFORM

With the 2020 election results now complete given the recent inauguration of President Joe Biden and Congressional race results, we now have a clearer picture of how health care may evolve over the next several years under unified Democratic control over Congress and the Administration. The following summary breaks down the key areas to monitor and analyze for impact:

Texas vs. California

On November 10th, 2020 the Supreme Court heard oral arguments on this case which seeks to overturn the Affordable Care Act. The suit is based off the idea that the ACA is unconstitutional with the individual mandate tax penalty reduced to $0, as the ACA was originally upheld based on the taxing authority of the federal government.

The question before the Court is whether the individual mandate is "severable" from the rest of the ACA. If so, the ACA would largely remain intact despite this serious legal challenge.

The Court will come to a decision in early 2021 (at the very earliest). Despite the conservative majority on the Court, the line of questioning in the oral arguments suggests that Chief Justice Roberts and Justice Kavanaugh may be of the opinion that the individual mandate may be severed from the rest of the law, leaving the ACA to fight another day.

Senate Results

Democrats have taken back the majority in the U.S. Senate. With key wins by Joe Osoff and Raphael Warnock in Georgia, Senate control is tied 50-50 with Vice President Kamala Harris serving as the key tie-breaking vote, providing a more probable but yet still narrow path toward advancing party policy agendas.

There is likely not going to be any major healthcare policy changes that would require 60 votes in the Senate (e.g. Medicare for All) to overcome Senate filibusters. However, we will likely see the House and Senate work together to pass other healthcare changes via Congress' budget reconciliation process which does not require a super majority vote in the Senate.

Areas potentially impacted through reconciliation could be ACA premium subsidies, changes to Medicare (including lowering the eligibility age and introducing a Medicare-like public option, for example).

Biden Healthcare Plan

With the ACA likely to survive its latest attack and major healthcare policy change unlikely, we expect that various proposals included in the Biden Healthcare Plan will make it to the legislative table for consideration, as many of these proposals would look to improve upon the Affordable Care Act wherever possible.

Below is a summary of some of key proposals on the table:

- *Expanding ACA Premium Subsidies* – Biden's plan would expand the current premium subsidy strategy (currently afforded to only low- and middle income individuals and families) and allow any individual, regardless of income, access to more generous ACA premium subsidies. The question left to be answered through this proposal is how this increase and expansion of subsidies will be financed.
- *Eliminate the Employer "Firewall"* – Furthermore, the Biden Plan would eliminate the current employer firewall, which disqualifies individuals from receiving premium subsidies from the ACA Exchange if they are offered affordable, minimum value coverage by their employer. This initiative could create increased participating in the individual marketplace as those previously covered via employer-based plans may opt for more affordable individual plans on the exchanges. Assuming cheaper premiums would mainly attract the young and healthy, this policy could potentially create adverse selection & increase clams risk for employer-based plans.
- *Public Option Health Plan* – This proposal essentially suggested that a Medicare-type plan would be made available to an individual or family as another option in addition to employer-based plans or plans from the individual ACA marketplace. It is likely that the public option would set provider/facility reimbursements between standard Medicare Rates and up to 200% of Medicare, which are much lower than private insurance reimbursement rates. This, coupled with the premium subsidies that may likely apply to the public option plan would make these plans very attractive, although less desirable to health care providers due to the lower reimbursement rates.
- *Lower Medicare Age Eligibility* – Lastly, the Biden Plan includes a proposal to allow a Medicare "buy-in" option for individuals age 60 to 64, essentially lowering Medicare's age-based eligibility threshold. This proposal has the potential to benefit employer-based plans as many older employees may opt for a Medicare plan earlier than what has historically been permissible, which would reduce employer's risk and overall premium costs.

Competitive Health Insurance Act of 2020

On January 13, 2021, President Trump signed this act into law after passing the House via a voice vote in September 2020 and by unanimous consent in the Senate in late December 2020. This new law amends the McCarran-Ferguson Act of 1945 by repealing an anti-trust exemption that has protected health insurance (and dental) carriers from federal competition laws ever since. The prior exemption allowed insurers the ability to share and compare data (particularly for premium setting), to encourage new and upcoming insurers while ultimately leaving anti-trust regulation to the states. With this exemption gone, this allows the Department of Justice and the Federal Trade Commission eased ability to investigate antitrust concerns and enforce federal laws, while also allowing plaintiffs in civil litigation to bring complaints of violations of antitrust laws. Notably, the law continues a limited exemption for collecting, compiling, and sharing loss data to for actuarial and rate-factoring services as long as the collaboration does not "involve a restraint of trade".

Proponents of the law, including the American Dental Association, Consumer Reports, and the Department of Justice, have applauded the law, arguing that this move expands federal oversight in regards to abusive and antitrust practices while also paving the way to greater competition in the health insurance marketplaces.

In contrast, opponents of the new legislation (including America's Health Insurance Plans and the National Association of Insurance Commissioners) argue that this move undermines state regulators and may inadvertently create suppress new insurer competition while also increasing cost burdens through increased administration and litigation expenses.

In short, while the new law does not directly address the direct, underlying drivers of health insurance premiums, notably the cost/price of healthcare, the removed exemption may pave the way for increased market-driven competition in the years to come as well as reduced M&A activity to keep market supply power in check.

Increased Focus on Transparency

One of the most important trends occurring in healthcare today likely to positively impact employers and individuals is the movement towards transparency. It is commonly known that one of the fatal flaws of the current third-party payer system is the lack of price and quality transparency available to patients. Whether it's the cost of an MRI or a major medical procedure, healthcare consumers often lack the information needed to efficiently make informed decisions with sufficient cost and quality information, unlike other industries. Theoretically, if this information was made readily available to its consumers (and employers) it would create the pressure needed to force healthcare providers to compete on the basis of cost and quality (as would other companies in a normal economic market), resulting in increased value for the ultimate customer (patients).

Below is a summary of several key rules and laws contributing to greater transparency in the years to come:

- *Hospital Price Transparency Rule*
  - Starting 1/1/21, hospitals operating in the U.S. are required to provide clear, accessible pricing information online on services they provide in two ways:
    1. In a machine readable file containing gross charges, discounted cash prices, payer specific negotiated charges, and de-identified min/max negotiated charges.
    2. A consumer friendly display of at least 300 "shoppable" services, written in plain language and including discounted cash prices, payer-specific negotiated charges, and de-identified min/max negotiated charges.
  - CMS is planning on auditing hospital compliance throughout 2021 and enforcing the rule via warning notices, requests of corrective action plans, civil monetary penalties ($300 per day, max $109,500 per year), public shaming through publication of assessed penalties on the CMS website, and potentially of losing Medicare payments altogether.
- *Health Plan Price Transparency Rule* – A second set of transparency rules imposes new requirements on group health plans (fully-insured and self-insured).

EFFECTIVE DATE	TRANSPARENCY REQUIREMENT
Plan years beginning on or after **January 1, 2022**	Public Disclosure. Group health plans must make available to the public machine-readable files (updated monthly) that disclose three sets of information 1. In-network negotiated rates for all covered items and services between the plan/issuer and providers 2. Out-of-network allowed charges and billed amounts during a recent 90-day period 3. In-network prescription drug negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.
Plan years beginning on or after **January 1, 2023**	Required Disclosures to Participants. Group health plans must make cost-sharing information available through a self-service tool on an internet website that provides real-time responses based on up-to-date cost-sharing information, and in paper form upon a participant's request. Effectively requiring an "advance EOB," this requirement phases in as follows: Group health plans must make the self-service tool available for 500 items and services determined by the agencies.
Plan Years beginning on or after **January 1, 2024**	Group health plans must make the self-service tool available for all covered services.

- *Impact on Medical Loss Ratios* – It is worth noting that these rules are allowing health insurance issuers to credit "shared savings" payments to their Medical Loss Ratio calculations in an attempt to incentivize health plans to encourage consumers to shop for services from lower-cost, higher-value providers.

- *Surprise Billing* – Part of the Consolidated Appropriations Act, 2021 signed into law in December 2020 was the "No Surprises Act", effective January 1, 2022.
  - The law essentially adds patient protections into surprise medical bills which commonly occur for patients who unknowingly receive care from out-of-network (OON) physicians (typically in ER or some inpatient settings).
  - In summary, the law holds enrollees harmless and prohibits out-of-network providers from billing enrollees above in-network amounts for certain services, including: OON facilities and providers of emergency services, OON air ambulance services, and OON providers of non-emergency services at in-network facilities.
  - The act also outlines a process for negotiation and independent dispute resolution for cases in which health plans and OON facilities/providers disagree with certain charges.
  - The act also requires certain notice and disclosure requirements to let patients know of the protections afforded to them.
- *Health Insurance Brokerage/Consulting Compensation Disclosure* – Another part of the Consolidated Appropriations Act to be celebrated as a win for employers is a new set of ERISA disclosure requirements requiring greater transparency and disclosure regarding compensation received by health plan brokers and consultants.
  - Under these new rules no contract or arrangement for brokerage or consulting services is considered reasonable unless certain disclosure requirements are met. This includes both direct and indirect forms of compensation including insurance products, medical management vendors, benefits administration, stop loss insurance, pharmacy benefit services, wellness services, transparency tools and resources, disease management vendors and products, compliance services, employee assistance programs, and TPA services.
  - The DOL is expected to release further guidance on these new requirements that support employer plan sponsor's fiduciary obligations and will apply to any contract executed on or after December 27, 2021.

Have questions or want to learn more? Contact your Gibson employee benefits advisor for more information. Otherwise, stay tuned for other timely updates related to healthcare reform and compliance from your Benefits Edge.