PILLAR
FINANCIAL GROUP

NEWSALERT
March 2024 | Volume 2 | Issue 3

Health Insurance

New Rule Aims to Expedite Prior Authorization Requests

THE CENTERS for Medicare and Medicaid Services has published a final rule aimed at improving how prior authorizations are handled by health insurers. The measure primarily limits the time insurers have to approve or deny requests.

In addressing wait times for prior approvals, the CMS is targeting an issue that's become a problem for some patients whose health can deteriorate while waiting for their doctor's request for a service to be approved.

Besides setting standards governing how long a health insurer has to approve or deny a request, the new rule also requires them to take steps to streamline the prior approval process through technology.

The CMS said when announcing the final rule that it would improve prior authorization processes and reduce the burden on patients, providers and payers, resulting in approximately $15 billion of estimated savings over 10 years.

WHAT THE NEW RULE DOES (starting in 2026)

- Insurers will be required to approve or deny an urgent prior authorization request for medical items and services within 72 hours of receipt.
- Insurers will have seven calendar days to approve or deny standard requests for medical items and services. For some payers, this new time frame for standard requests cuts current decision wait times in half.
- Carriers must include a specific reason for denying a prior authorization request, which will help facilitate resubmission of the request or an appeal when needed.

To ensure that insurers will be able to handle the new decision time frames, the rule also requires them to implement a prior authorization application programming interface (API), essentially new software.

The interface must be able to efficiently facilitate automated approvals between providers and payers.

The CMS is delaying API compliance dates for the 2026 calendar year. Beginning in 2027, payers will be expected to have a prior authorization API in place.

The takeaway

The new rules for when prior authorizations must be rendered take effect Jan. 1, 2026.

The end result should be an improved experience for millions of insured patients nationwide, and that they get their treatment requests handled by their insurer in a timely fashion. ❖

PILLAR
FINANCIAL GROUP

7110 N Fresno St., Suite 120
Fresno, CA 93720

Phone: 559.436.6441
info@pillarcentral.com
pillarcentral.com

Technology

New Platforms Help Employees Navigate Their Benefits

MORE EMPLOYERS and health plans are offering new online tools to help their employees better navigate their health care and group plan benefits, which are typically a source of confusion and frustration for many American workers.

These tools, known as navigation platforms, are apps and websites designed to help health plan enrollees tread a path through the health care system. Companies that have adopted the tools say that they have freed up their human resources staff, whom employees will normally call for assistance when they don't understand or run into obstacles with their health insurance.

One of the biggest complaints that health plan enrollees have is that it's difficult to access care and understand how their health insurance works. A 2022 Gallup poll found that 72% of Americans report having felt confused about purchasing or using their health insurance, particularly citing their frustration with surprise bills and denied claims or prior authorization denials.

A 2023 survey by Quantum Health found that:

- Only 20% of employees say they felt "very confident" they understand and know how to use their health benefits.
- Employees said they felt most supported at open enrollment. However, after the plan takes effect and they must navigate and make decisions, they feel the support is not there.
- 67% of employees are currently navigating their health care journey alone, without enough support from their employers or health insurance to help understand the options available to them.

How they work

Some platforms focus on guiding workers through the open enrollment process while others aim to help them understand their benefits, how to use them and improve their health outcomes.

The latter will use the health history of each employee to provide customized reminders or prompts when they should be making appointments or taking other actions relative to their personal health care needs.

These platforms can be used either as part of a benefits administration dashboard or as a stand-alone tool. .

EXAMPLES

Open enrollment assistance: Nayya – Nayya's platform learns about each employee's needs through a series of questions about their medical history, lifestyle, financial situation and current health care usage. From that information it can steer them to a health plan that is the best fit for them, in addition to other recommendations.

Two case studies of employers who have contracted with Nayya yielded a number of benefits to both workers and the business:

- It drove health plan participation rates.
- Employees were more likely to opt for a health savings account or a flexible savings account and enroll in supplemental benefits like critical illness and hospital indemnity insurance.
- Clients saw a significant decrease in the administrative burden on their HR departments.

Helping access care: HealthJoy – HealthJoy's platform prompts employees to schedule preventive screenings, improving health care outcomes through early detection. The platform also includes live health care navigation support and case management.

One case study on its website states:

"Over nearly 4,000 member interactions, (the client's) employees have used HealthJoy to find a provider or facility, book an appointment, review a prescription, or access telemedicine 1,102 times.

"HealthJoy concierges also helped TCW employees find providers, facilities, or schedule appointments nearly 400 times — a massive time savings for employees who spend most of their time in a truck cab."

The takeaway

These platforms require a significant amount of engagement between the employer's HR crew, the vendors and sometimes the insurers. There are a number of variables that are unique to each plan and implementation hurdles may vary between platforms.

And once you settle on a platform, you'll have to provide ongoing communication and education to ensure effective use of navigation systems. Call us if you have questions about these platforms. ❖

Easing the Burden

Critical Illness Insurance Provides Vital Protection to Employees

THE TYPICAL family's income slips by more than $12,000 in the year after a bread-winner suffers a critical illness, such as a heart attack, stroke or cancer, according to a study by Metropolitan Life Insurance Company.

This reduction of income isn't primarily due to lack of medical coverage. It is mainly attributed to the inability to work and earn an income.

The approximate out-of-pocket medical expenses add about $3,000 of costs during the first post-diagnosis year.

Despite these side effects, MetLife found that almost half of Americans with full-time jobs did not even have $5,000 worth of accessible savings to cover a major illness diagnosis.

More than 28% did not have at least $500 in savings.

The MetLife study also showed that:

- In the event of a medical emergency, two-thirds of American workers have three months or less in available savings.
- Only one-fifth of women and one-third of men were "very confident" that a financial emergency could be handled with their rainy-day fund.
- A little more than half of those with a full-time job were extremely or somewhat concerned about the possibility of a critical illness impacting the financial stability of their family.

The study concluded that many Americans are unprepared to deal with the short-term and long-term loss of income, and out-of-pocket expenses that often accompany a critical illness.

Another aspect of the study may reveal the reason why so many are unprepared; every surveyed patient had medical insurance, but only 7% had critical illness insurance and only 4% had cancer coverage.

Critical illness coverage

The purpose of critical illness insurance is to provide a one-time or lump payment to assist in offsetting the out-of-pocket expenses associated with certain critical illnesses.

Applicable critical illnesses may include an organ transplant, heart attack, stroke, cancer, loss of vision, burns, HIV or kidney failure. Critical illness insurance is not a replacement for standard health insurance or disability insurance. The design is purely to supplement such policies.

Only 28% of the surveyed full-time workers had heard of insurance for critical illness. However, from further questioning about critical illness insurance, the number might be even lower, as three of every five patients seemed to confuse it with their standard health insurance policy and one in five confused it with disability insurance or another government program.

Voluntary coverage

While the study showed a clear theme that many Americans are monetarily unprepared for a critical illness, it also provided evidence that many workers are concerned about their lack of preparation.

By expanding employee benefits to include voluntary critical illness insurance or raising awareness about existing benefits, you are offering important financial protection to employees.

In other words, you can help bridge the gap between the cost of a critical illness and what standard insurance covers, which allows the employee to better focus on recovering and possibly returning to the workforce.

If you want to know more about voluntary critical illness coverage, give us a call. ❖

Mark Cuban's and Bill Schmaltz's Observation:

'CEOs Don't Know Where Their Benefit Dollars Are Going'

SINCE BILLIONAIRE businessman Mark Cuban entered the health care space with Cost Plus Drug Co., which he launched in May 2020, he has gotten a new perspective on the value that most CEOs place on their group health insurance benefits.

And what he has found is a lot of waste and a lack of health care buy-in among corporate chieftains, according to one of his recent posts on X, formerly known as Twitter.

Most chief executives of self-insured companies, he wrote, "don't know and don't really want to know where their health care benefit dollars are going."

In other words, employers — with some effort — should be invested in their health plans so they can find ways to reduce costs for themselves and their employees while improving health outcomes for their workers.

While his comments were aimed at CEOs of self-insured companies, business leaders can use them to look a little closer at the health plans they offer their employees and opt for ones that are focused on reducing costs and driving positive health outcomes.

Poor management buy-in

After engaging in discussions with numerous CEOs of companies that have contracted with Cost Plus, Cuban concluded that most chief executives pay little attention to how well their self-insured health plans deliver positive health care outcomes because that is not viewed as a core competency of their companies.

"As a result they waste a s**tload of money on less than quality care for their employees," he wrote on X, "and more often than not it's their sickest and lowest-paid employees that subsidize the rebates and deductibles. (Sicker employees have to pay up to their deductible, healthy ones don't.)"

"When anything that impacts all of your employees is pretty much a check list item to the CEO, there is a good chance that it's not going [to] work well and you are going to have employees who are not comfortable for a lot of different reasons."

Taking a different approach

If the C-suite is taking a hands-off approach to your company's employee benefits, it may be costing you and your employees. It's important that employers don't treat their benefits as just an unavoidable expense.

As the health care and insurance industry innovates, there are growing opportunities for cost savings and better outcomes.

There are many strategies available to contain costs. By using recent and past utilization/cost data to select the stack of vendors, savvy businesses are dramatically reducing cost.

Custom and High Performing health plans are sprouting up all over the country, replacing status quo plans.

Additionally, engagement by the company's top leaders is crucial.

For years the C Suite only involved those that are not responsible for P & L for health insurance procurement.

With benefits costs being the #2 or #3 largest cost center, the C Suite must become a part of the process. ❖