Health Insurance Cost and the Impact on Salaries

Introduction and Background

The NEA Collective Bargaining and Member Advocacy Department (CBMA) conducted research on how to best provide support for state affiliates relative to regulating costs of health insurance with the rise of salaries by analyzing research on employee health insurance cost increases for public sector plans in the past three (3) years relative to salary increases.

For this report, CBMA conducted research and compiled background information on health care costs, wage and salary increases, cost-shifting to employees, benefit plan designs, benefit advisory committees, surveying members, and data requests. The report also describes the programs used by employers and plans to limit, delay, or deny health care services and recommends strategies and programs to prevent further cost-shifting and benefit cuts to members, in both a bargaining or non-bargaining setting.

This report is intended for use before, during, and after health plan open enrollment, bargaining, and negotiating sessions with employers, as state and local affiliates prepare to advocate for higher salaries and wages that won't be eroded by increased health benefit plan costs.

The report is divided into eight parts, and each includes a list of ***Questions for Consideration*** for affiliates to discuss when they meet with employers, health plan representatives, consultants, brokers, and other vendors:

Part I. HEALTH PLAN DESIGNS AND REIMBURSEMENT ARRANGEMENTS

It may be helpful to review the common health benefit plans[1] and the tax-advantaged reimbursement arrangements that employers are now offering. These include:

- **Preferred Provider Organizations (PPOs).** With a PPO, employees pay less if they use providers that are in the plan's network. Generally, you can use doctors, hospitals, and other providers outside of the network for an additional cost. Depending on the benefit, the out-of-network extra cost can be very expensive.

- **Health Maintenance Organizations (HMOs).** With an HMO, coverage is limited to care from physicians, hospitals, and other providers who work for or contract with the HMO. HMOs generally won't cover out-of-network care except in an emergency. An HMO may require the employee to live or work in its service area to be eligible for coverage. HMOs often require that enrollees select an in-network primary care provider, and that provider functions as a sort of gatekeeper and referral source when the patient needs to see a specialist or requires imaging, lab services, or hospitalization.

- **High-Deductible Health Plan (HDHP).** While any type of plan can, and often does, have a high deductible, in this case, we are referring to a plan with a high deductible that also complies with guidelines set by the Internal Revenue Service (IRS),[2] allowing the employer and/or employee to contribute to a health savings account (HSA). HDHPs can cover certain preventive care before the deductible—similar to some non-HDHPs—but no other services can be paid by the health plan until the employee has met the deductible. HDHPs have specific guidelines for allowable deductibles and out-of-pocket costs, and the IRS adjusts these amounts annually. For 2024, an HSA-qualified HDHP must have a deductible of at least $1,600 for single coverage and at least $3,200 for family coverage. The maximum allowable annual out-of-pocket limit for these plans in 2024 is $8,050 for single coverage and $16,100 for family coverage.

- **Health Savings Account (HSA).** A health savings account (HSA) can help pay for out-of-pocket medical costs but, according to IRS rules, an HSA must be paired with a qualified HDHP. Both employees and employers may contribute to an HSA. For 2024, the HDHP-qualified HSA contribution limit for single coverage is $4,150, and $8,300 for family coverage.

- **Point of Service (POS) plan.** With a POS plan, employees pays less if they use the plan's in-network doctors, hospitals, and other health care providers. POS plans generally require employees to get a referral from an in-network primary care doctor to see a specialist. While it is similar to a PPO, a POS tends to have a smaller network.

- **Exclusive Provider Organization (EPO).** An EPO is a type of plan that covers health care services only when the employee uses doctors, specialists, or hospitals in the plan's network (except in an emergency).

- **Flexible Spending Arrangement (FSA).** A health FSA allows employees to be reimbursed for qualified medical expenses. FSAs are usually funded through voluntary salary-reduction agreements with the employer. Neither employment nor federal income taxes are deducted from the contribution. The employer may also contribute to a health FSA.

- **Health Reimbursement Arrangement (HRA).** With an HRA, employees are reimbursed tax-free for qualified medical expenses up to a maximum dollar amount for a coverage period. An HRA must be funded solely by an employer, not through a voluntary

salary-reduction agreement with an employee. An HRA may be offered with other health plans, including health FSAs.

Questions for Consideration

Categorize the types of employer-sponsored health plans and reimbursement arrangements offered to employees.

- Are your plans similar to those above?
- How many employees are enrolled in each plan?
- How many employees take advantage of making tax-free contributions to a health FSA or an HSA if enrolled in a qualified HDHP?
- Are employees enrolled in employee-only coverage, employee-plus-spouse, employee-plus-children, or family coverage?
- Are HDHPs already in place? Are they the only option? Is the employer pushing to offer/expand HDHPs?
- If an HDHP that qualifies for an HSA is in place, how much does the employer contribute to the HSA? Does state law limit the amount that the employer can contribute to the HSA?
- Is financial help available to lower-income employees enrolled in an HDHP?
- How do the benefits in an HDHP compare to those in other lower-deductible plans?
- Is the premium difference between an HDHP and a lower-deductible plan so significant that employees, especially younger and lower-income ones, feel compelled to enroll in the lower-premium HDHP?
- Are preventive prescription drugs covered in the HDHP before the high deductible is met? Which drugs?
- If the employer offers an HRA, what is the contribution amount and is it increased each year?
- Does the balance in the employee's HRA rollover each year, and is it the full amount?

Part II. THE COVID 19 PANDEMIC, WORKFORCE SHORTAGES, HEALTH PREMIUM COST TRENDS, EMPLOYEE WAGES, AND INFLATION RATES

It is important to familiarize yourself with background information on the health care worker shortage, health plan premium trends, employee-contribution rate trends, the average wage increases, the overall rate of inflation, and how all these factors can erode salaries. While these figures are based on national averages, your employees may be experiencing a better or worse scenario. You don't want to rely only on what the employer or health plan representative provides in terms of these costs.

COVID 19 Pandemic and Workforce Shortages

The COVID 19 pandemic has had a tremendous impact on health plans, health care workers, and education employees. During the height of the pandemic, employer health plans saw their costs decrease as patients delayed or skipped treatments for acute and chronic health conditions. Now

that we are in a post-pandemic period, health plans and providers are reporting a significant increase in the number of patients seeking medical care. During the pandemic and continuing today, there has been an exodus of health care workers from the profession. Many health care providers are retiring early or quitting altogether. They cite burnout from working conditions that include staffing shortages, heavy workloads, long hours, low pay, violence in the workplace, and the fear of contracting COVID 19 and other illnesses.

The education profession has experienced a similar exodus of employees during and after the pandemic. Educators retired earlier than they had originally planned or left the profession altogether because of the working conditions and burnout. Staffing shortages, heavy workloads, a lack of support by administration, low pay, inadequate leave policies, health-benefit plan cuts, retirement plan cuts, frustration with remote instruction, as well as school violence and safety issues, have all taken a toll on educators both physically and mentally.

NEA estimates a nationwide shortage of 300,000 teachers and support staff in K-12 public schools.[3] Also, school districts across the country report a severe lack of short-term, trained substitute education workers when full-time staff need to take leave.

The shortage of education employees has changed the dynamics and leveraging opportunities when affiliates meet with the employer and health plan representatives. NEA offers a report and a look at solutions for addressing educator shortages.

Questions for Consideration

- What is the staffing situation in your state and local communities for both health care and education employees?
- If there are shortages, how are employers and federal, state, and local governments responding?
- Are you advocating with employers for protections against COVID or other widespread illness? For an NEA resource on how to do this, visit Bargaining-and-Advocating-Beyond-COVID.

Health Premium Cost Trends and Employee Contribution Rates

Health care actuaries[4], [5] estimate that in 2024, health premiums will rise, on average, by 8.5 percent, up from 5.4 percent in 2023. The Kaiser Family Foundation's (KFF) 2023 Employer Health Benefits survey[6] noted that the average annual total premium for 2023 for single coverage was $8,435 and $23,968 for family coverage, an average increase of 7 percent from 2022. Employees contribute, on average, 17 percent of the total premium for single coverage and 29 percent for family coverage.[7] The contribution rate for public education employees are often below these national averages. For example, the Ohio State Employment Relations Board produces an annual report on the cost of health insurance in Ohio's public sector. The latest report finds that educators pay on average 13.5 percent for single coverage and 15 percent for family coverage.[8]

Questions for Consideration

- What have the premium trends been for your members' plans for the past two to three years?
- How do they compare to the national averages?
    - What percentage of the total premium have your members contributed over the past two to three years, for employee only, employee-plus-spouse, employee-plus-children, and family coverage?
- How do your members' premium contribution rates compare to other school districts?

Employee Wage Increases and Inflation Rates

The KFF survey noted that in 2023, wages increased by 5.2 percent while the overall rate of inflation was 5.8 percent, according to the U.S. Bureau of Labor Statistics.[9]

Questions for Consideration

- What have your members' average salary and wage increases over the past two to three years been compared to the national averages? Have pay increases kept up with inflation?
- Does the data indicate that wage increases are being wiped out by the cost of health care and/or inflation?
- What other factors are contributing to paycheck erosion?

Part III. COST-SHIFTING, MEDICAL DEBT, AND SKIPPING NECESSARY MEDICAL CARE

Cost-Shifting

Increases in inflation and in health plan premiums and contribution rates, combined with shortages of health care and education workers, will result in further wage erosion if employers try to further shift health costs to workers or cut benefits; efforts to attract, recruit, and retain employees will also be hampered.

According to a recent study published in the Journal of the American Medicine Association (JAMA), premium growth has long outpaced wage growth, with the study concluding that workers with employer health coverage may have lost an estimated $125,000 in earnings over the past 30 years due to rising premiums eating into their pay.[10]

Questions for Consideration

- Have employee contribution rates, out-of-pocket costs (premiums, deductibles, copayments, coinsurance), and benefit cuts increased over the past two to three years? Please note that you will need to compare and contrast these out-of-pocket changes for each specific plan.

- How much financial exposure do members have regarding health care costs? This can be measured by adding an employee's annual premium contribution and annual maximum out-of-pocket cost and dividing the sum by the employee's annual salary.
- List which specific contribution rates and out-of-pocket costs and benefits have been impacted. In this health plan negotiation, is there a plan to increase employee contribution rates or shift more costs to employees? If there is a plan to cut benefits, which ones and why?
- Is a replacement plan being discussed? If a replacement plan overview has been distributed to the affiliate, how does the cost-sharing and benefit package compare to the current plan?

Cost-Shifting Hurts Lower-Income Employees

Health premiums are, typically, **NOT** based on an employee's income level, making the required premium a larger percentage of total compensation for lower-wage workers.

It is also worth noting that an employer can make a more generous contribution to an FSA, HSA, or HRA for a lower-income individual's benefit but not to a highly compensated individual, under IRS guidance, ERISA, and the Public Health Act.[11]

Questions for Consideration

- Do lower- and higher-wage employees pay the same or a different premium based on salary?
- What is the health care cost for the lowest-paid members? What is it for the highest-paid members?
- To address pay inequity, a growing number of employers are setting premiums based on an employee's income. Other strategies to help reduce employees' out-of-pocket costs are included in Part VII below.

Medical Debt and Skipping Necessary Medical Care

A recent survey by the Commonwealth Fund[12] found that 45 percent of working-age adults with an employer-sponsored health plan had difficultly affording health care services. Almost 30 percent said they or a family member had delayed or skipped needed treatment or a prescribed medication because of the high cost. By the time the delayed care or treatment is obtained, patients are often sicker, more expensive to treat, encounter worse outcomes, and have prolonged recovery times.

In the Commonwealth Fund's survey, 30 percent of workers with employer-sponsored health coverage reported they were paying off debt from medical or dental care. This is usually due to either out-of-pocket costs that are incurred until the plan's deductible is met, or patients having no other option than to use out-of-network providers for care. In particular, patients seeking treatment for behavioral health and substance use (BH/SU) disorders have great difficulty

finding a provider or facility that can treat them—due to high demand and the low supply of providers—and that participates in most health plans' network.

Questions for Consideration

- Has the employer asked employees if they were dealing with medical debt? What are the reasons for the debt? Is it due to a high deductible, high out-of-pocket maximum amount, or other cost-sharing issues? Is it related to BH/SU disorder treatment charges? Other medical costs?
- Has the employee or a family member skipped care because of cost?
    - If so, talk to the employer about lowering the deductible and out-of-pocket maximum, even for HDHPs that qualify for an HSA. As noted above, for 2024, an HDHP can have a minimum annual deductible of $1,600 for self-only coverage or $3,200 for family coverage.[13] Are the HDHP deductibles as close as possible to the IRS-minimum permitted amounts? Make that your goal.
    - Furthermore, annual out-of-pocket expenses for 2024 (including deductibles, copayments, and other amounts, but not premiums) cannot exceed $8,050 for self-only coverage or $16,100 for family coverage. Try to get the out-of-pocket maximum as close as possible to the IRS-permitted minimum deductibles ($1,600 and $3,200).
    - In addition, the HSA contribution limit in 2024 for single coverage is $4,150, and $8,300 if the HDHP is for family coverage. This contribution limit is well below the allowed maximum out-of-pocket amounts. This is all the more reason to get the maximum out-of-pocket amounts for HSA-qualified HDHPs and other plans their families can avoid debt.

Part IV. THE MAIN HEALTH CARE COST DRIVERS

NEA members, in general, obtain their health benefits from state, local, county, and school district employer plans, in addition to NEA affiliate-related health care trusts. While cost drivers differ from plan to plan, four of the most common ones emerged in a recent survey by the Center on Health Insurance Reforms of the 50 state employee health plans[14]: prescription drugs; hospital services; professional services; and inappropriate or excessive utilization of services.

In general, health care costs continue to rise due to the growing use of expensive prescription drugs, especially biologics (therapies derived from living organisms, such as humans, animals, or microorganisms, as opposed to traditional non-biologic drugs synthesized in a laboratory *without* using living things); health care industry consolidations (e.g., hospital and physician group mergers), the increased ownership of professional groups and hospitals by private equity firms; health care worker shortages and rising labor costs; the increase in patient demand for services; medical inflation rates; expensive technologies and medications to treat diseases, (e.g., cell and gene therapies); and costly treatments for cancer, heart disease, catastrophic illnesses, and rare diseases.

Questions for Consideration

- What are the major cost drivers in your plan(s)?
- Are they similar to those compiled from the state health plans?

Review the following to prepare for your discussions with the employer and health plan representatives. They may have different observations about the reasons for the cost increases in your plans, but it may still be helpful to know more about these main cost drivers.

Prescription Drug Costs

Prescription drug expenditures have been a major contributor to rising health plan costs. According to a survey by the International Foundation of Employee Benefit Plans (IFEB), the median percentage of health care dollars spent on prescription drugs rose to 24 percent in 2022, up from 21 percent in 2021.[15] About 90 percent of employers in the IFEB survey said the high-cost, biologic, specialty drugs used to treat complex medical conditions such as cancer, fertility, diabetes, and autoimmune disorders, currently on the market and in the pipeline, are their biggest cost concern. In particular, employers noted that managing expensive biologic drugs, such as Humira, used for autoimmune conditions, and Ozempic, used to treat diabetes and prescribed for weight loss, continues to be a challenge. Actuaries at health care consulting firms, such as Aon, predict that one percentage point of the total increases in health care costs in 2024 will come from weight-loss drugs alone.[16]

Prescription drug cost increases have worsened due to the shortage of many generic medications that hospitals and other health care settings require to treat life-threatening conditions and for surgery. The Federal Trade Committee (FTC) and the U.S. Department of Health and Human Services (HHS)[17] plan to hold hearings to examine how prescription drug group purchasers and wholesalers—which supply 90 percent of generic drugs to hospitals, clinics, and nursing homes, and set the prices for these drugs—may be contributing to the shortage. The FTC and HHS are concerned that these groups are misusing their market power to influence the pricing and availability of generic drugs such as those to treat cancer, antibiotic resistant infections, drugs used for anesthesia, and other medications.

Also troubling is that drug makers Pfizer, Sanofi, Takeda, and others have announced that in 2024, they will raise the U.S prices for more than 500 drugs[18] and vaccines used for weight loss, asthma, shingles, heart disease, osteoporosis, and other conditions. The expected price hikes come as the pharmaceutical industry begins to comply with the Inflation Reduction Act (IRA), which allows Medicare to negotiate prices for some drugs beginning in 2026.[19] The law also requires discounted pricing for 10 high-cost drugs and caps insulin cost-sharing to $35 for Medicare beneficiaries. Drug companies must provide a rebate to Medicare if drug price increases outpace inflation.[20] The IRA, however, does **not** apply to employer-sponsored prescription drug plans. As a result, it is expected that drug makers may increase drug prices for employer plans to make up for the revenue they expect to lose from the Medicare drug price reductions.

Some good news on drug pricing is that manufacturers have announced cost cuts on certain medications, such as those treating depression (Prozac) and erectile dysfunction (Cialis). Also, the cost of some expensive biologics (e.g., Humira) used to treat arthritis and skin disorders are expected to decrease, as biosimilar drugs (generic biologics) come on the market. The FDA has already approved a number of biosimilars that are expected to be launched in 2024.[21]

Some health plans and their pharmacy benefit managers (PBMs) have removed brand name drugs from their preferred drug list if an FDA-approved biosimilar or generic medication is available. (PBMs are companies that manage prescription drug benefits on behalf of health insurers, employers, and other payers. PBMs determine drug costs for plans, patient access to medicines, and calculate how pharmacies are paid.). By switching to biosimilars and generics some plans and PBMs experienced an average price reduction of more than 50 percent in 2023 for certain medications.

Questions for Consideration

- What are the top 10 most expensive prescription drugs for your plan(s) for the past two to three years?
- What are the most commonly prescribed drugs?
- What are the copayments/coinsurance rates for generic, preferred brand, non-preferred, and specialty prescription drugs?
- At what rate are generic and biosimilar drugs being used compared to brand name drugs?
- Is there a financial incentive for employees to use generic and biosimilar drugs? Does the employer, the plan, and the PBM have strategies in place for controlling prescription drug costs? What are their strategies? Do the strategies shift more costs to employees?
- Has the PBM changed the drug formulary recently? Were employees informed of these changes? Have certain brand name drugs with a generic or biosimilar replacement been removed from the formulary's preferred drug list? Is prior authorization (PA) required for expensive drugs? Under PA, approval from the health plan is required before an employee can obtain a service or prescription covered by the plan. PA is discussed in more detail below. Has the PA process prevented employees from receiving timely treatment for illnesses and diseases?
- Is there a prescription drug step-therapy program in place where patients must start with the least costly treatment before they can fill a prescription for a more expensive drug? What are employees' experiences with step-therapy? Have they found it helpful or a waste of precious time in treating a disease or illness?

Cell and Gene Therapy Costs

Cell and gene therapy modifies a persons' cells and genes to treat or cure disease.[22] It can work in many ways, such as replacing a disease-causing gene with a healthy copy of the gene, inactivate a disease-causing gene that is not functioning properly, or by introducing a new or modified gene into the body to help treat a disease. Cell and gene therapy is being used to treat and cure diseases such as spinal muscular atrophy, retinal eye disease, sickle cell anemia, and hemophilia B. However, the price per dose for some FDA-approved gene therapies can range

from $2.1 million to treat spinal muscular atrophy to $2.8 million for sickle cell treatment to $3.5 million to treat hemophilia B.[23],[24]

Not surprisingly then, the IFEB survey[25] notes that the cost of available cell- and gene-based therapies has also become a major concern for employers. More than six gene therapies were approved by the FDA in 2023.

The employer and the health plan will need to provide information related to cell and gene therapy claims. These claims can be processed and reimbursed under many cost categories, such as prescription drugs, professional services, inpatient or outpatient hospital costs, or other settings.

Questions for Consideration

- What is the plan's policy for covering cell and gene therapy?
- What is the plan's experience with these claims?
- Have cell and gene therapy treatments affected the health plan's costs? Does the plan require PA before approving cell-and gene-therapy treatment?
- Are patients referred to Centers of Excellence for this treatment? Centers of Excellence are medical systems and providers that have demonstrated their ability to deliver superior patient outcomes at a lower cost for complex conditions, such as transplants, cancer, and heart and musculoskeletal care. Generally, the copayment or coinsurance is lowered or waived if the patient uses one of these centers.

Hospital Costs (Inpatient and Outpatient)

Inpatient hospital costs generally include a patient's stay in an acute-care facility for a severe condition or major surgery; a rehabilitation hospital or a long-term care facility following a traditional inpatient stay to receive physical or occupational therapy; or a behavioral health or addiction facility to treat a severe mental illness or substance use disorder.

Outpatient hospital and ambulatory care costs include emergency-department care, laboratory services, minor surgery, endoscopies (e.g., colonoscopy), diagnostic radiology (e.g., MRI, CT scan, PET scan), wound care, heart monitoring, ambulance costs, and other services.

Inpatient and outpatient hospital services continue to be key drivers in rising health plan costs. Hospitals are facing increased patient demand, health care workforce shortages, higher labor costs, equipment costs, and facility costs. As they negotiate with insurance plans, hospitals generally have a great deal of leverage in naming their price. This has also contributed to ever-increasing health care costs.

Federal and state governments, health plans, and employers have published cost comparison information for some common procedures and diagnoses. Price transparency lists have, so far, been met with mixed results, as patients do not always have the time to check provider prices if it is an emergency situation. Also, the choice of the care delivery setting is often out of the patient's

control. For price transparency information to be useful, it must be readily available (such as on a phone app), updated on a continual basis, and combined with provider quality information.

Questions for Consideration

- Are cost and utilization management tools available to patients to help find providers? Do the tools include price transparency and quality information?
- How often is this information updated?
- Have employees provided feedback on price transparency and provider quality-assessment tools?

Professional Services

The professional services cost category includes services provided by physicians, nurses, and other health care professionals in a hospital (inpatient and outpatient), clinic, physician's office, surgery center, stand-alone laboratory, imaging center, or other setting. With patient demand back up to pre-pandemic levels, the fees for these services have been rising as well. Health care worker shortages, labor costs, and other expenses have given health care professionals a great deal of leverage when negotiating their prices with hospitals and health plans.

The health care worker shortage, specifically registered nurses (RNs), has hit the hospital setting particularly hard. According to a recent study,[26] the nursing shortage in general has eased up since the height of the pandemic, but younger, newly trained RNs are increasingly choosing to work in non-hospital settings. Hospital professional costs are expected to continually rise as the competition for RNs grows and hospitals have to respond to the nursing shortage in creative but often expensive ways.

Further complicating this, the number of providers participating in health plan and receiving direct reimbursement from them is shrinking. By agreeing to participate in the network and agreeing to the health plan's reimbursement rate, the provider gets ease in claims submission, speedy payment, and referrals that help grow and maintain a certain volume of patients. An increasing number of professionals, especially those in high-demand specialties (e.g., psychiatry, psychology, and anesthesiology), are refusing to participate as in-network providers. They cite the low reimbursement rate and the administrative cost and burden of submitting claims for patients. The BH/SU disorder out-of-network provider and benefit issues are further discussed in Part V below.

Questions for Consideration

- Have employees voiced concerns about the shortage of inpatient or outpatient in-network providers?
- Which type of treatment and providers are people experiencing difficulty in scheduling?
- Has it impacted their ability to receive timely and affordable care?
- Have they been subject to large bills from out-of-network providers?

Inappropriate Utilization of Services

Some employees live in communities where there are few, if any, primary care providers, clinics, hospitals, or other health care settings nearby. This is often seen in geographic areas where a large number of lower-income and uninsured people reside, as well as many rural communities. Also called "health care deserts," this lack of local health care services makes it difficult for employees with inflexible work schedules or who rely on public transportation to make and keep appointments during non-working hours. As a result, the hospital emergency department is often providing patients with acute and chronic care treatments that could have occurred in a less costly setting, such as a physician's office or clinic where the patient could also receive regular and ongoing monitoring and preventive care services.

Questions for Consideration

- Does the plan and the employer provide assistance to employees that live in underserved health care areas?
- Can work schedules be adjusted to accommodate employees' needs?
- Can financial assistance for travel to a primary care provider be provided?
- Is telemedicine or virtual medical care being fully utilized?

Use of Primary Care Delivery Models to Reduce Use of Inappropriate Setting

While the following primary care delivery models may not be feasible for every group of employees or geographic location, components of them have been shown to help reduce emergency room visits for employees who live or work in underserved and rural areas. They may also improve employees' chances of finding a quality primary care provider. These models include:

Worksite Clinics. In this model, an employer provides access to medical services exclusively for its employees. Located close to or within the workplace, clinics are offered as an employee benefit for easy access to health services.

Patient-Centered Medical Homes. In this model, medical homes are accountable for meeting the physical and mental health needs of patients with a focus on prevention and wellness. Services are often delivered by a varied care team, including physicians, advance practice nurses, pharmacists, dietitians, social workers, and care coordinators. Urgent care is expected to be accessible after working hours.

Point Solutions. This model is designed to provide enhanced services to members with chronic conditions such as diabetes or high blood pressure. It also monitors and manages high-cost claimants with complex conditions. It usually has a telemedicine and virtual care component.

Questions for Consideration

- Is inappropriate use of the emergency department for acute and chronic conditions an issue for the plan? What is the data on that, and how was it calculated?
- Will the employer or health plan provide financial assistance to lower-income employees, those in underserved and many rural areas, and those dependent on public transportation?
- An enhanced telemedicine benefit, with no deductible or copayment, for employees living in underserved and rural areas would also be helpful. Telemedicine is discussed further in Part V below.

PART V. HEALTH BENEFITS THAT NEED UPDATING, ENHANCEMENTS, AND EXPANSIONS

In general, the most common areas of concern where benefits expansion and improvements can be made include:

Behavioral Health and Substance Use (BH/SU) Disorder Benefits

There is a mental health crisis in the U.S. An estimated one in five adults in the U.S. live with a mental illness (57.8 million people in 2021).[27] These illnesses can range in intensity from mild to moderate to severe. Common diagnoses include anxiety, depression, substance use disorder, attention-deficit/hyperactivity disorder (ADHD), bipolar disease, schizophrenia, and others. Many employees are struggling with job-related stress, depression and anxiety, financial concerns, alcohol problems, opioid use, and other issues.

In response to the increase in the number of people experiencing anxiety and depression, OSHA provided a checklist[28] for employers and management to help support mental health in the workplace and reduce worker stress. ***Please review OSHA's checklist and share it with employees.***

BH/SU disorders can occur at all ages. A recent survey[29] noted that:

- 21 percent of adults in the U.S. had a mental health condition such as depression, anxiety, or schizophrenia.
- 17 percent of youth had a major depressive episode.
- 11 percent of adults and 3 percent of youth had alcohol use disorder.
- 7 percent of adults and 5 percent of youth had a drug use disorder.
- 6 percent of adults were diagnosed with a serious mental illness.

According to a report commissioned by the mental health advocacy group Inseparable,[30] two-thirds of Americans with a diagnosed mental health condition were unable to access treatment in 2021, even though they had health care coverage. Only a third of people with coverage who visited an emergency department or hospital during a mental health crisis, received follow-up care within a month of being discharged, according to the report. Over

half of the U.S. population lives in areas designated as Mental Health Professional Shortage Areas,[31] and the country has less than a third of the psychiatrists needed to meet those provider shortages.

BH/SU disorder treatment involves a variety of specialty providers, such as psychiatrists, psychologists, psychiatric nurse practitioners, counselors, social workers, and marriage and family therapists. There is a shortage of BH/SU disorder providers, especially in rural communities. Wait times to see a provider can be weeks or months, especially for children.[32] It is estimated that the U.S. needs an additional 8,500 mental health providers to meet current demand.[33] People in urgent need of help with BH/SU disorders often spend hours or even days waiting in hospital emergency rooms. There is also a scarcity of available residential or hospital beds for patients suffering from a severe mental illness or a substance use disorder. Unfortunately, until the provider and bed shortage issues are addressed, the barriers to accessing care will continue.

BH/SU disorder treatment costs can be grouped according to outpatient, residential, or inpatient treatment costs, in addition to the cost of prescription drugs. However, the costs reported by the plan may be far from the actual costs that patients and their families incur out-of-pocket, because very few providers participate in plan networks. As a result, patients are required to pay a great deal more out of their own pockets for BH/SU disorder care than they do for medical and surgical care.

Patients often have no other choice than to receive care from out-of-network providers—if they can even find one accepting new patients. According to the Department of Labor's 2022 MHPAEA report to Congress,[34] patients and their families usually must pay the out-of-network provider's full charge at the time of service. This is where credit card debt comes into the picture. Patients must then submit the claim to the health plan hoping for some level of reimbursement. Some patients find the claims submission process confusing, cumbersome, and frustrating, especially if the claim is rejected at first, which happens often. Patients often fail to submit again or appeal a denied claim, due to time or feeling discouraged. We don't have a good handle of how much people pay out of their own pockets for out-of-network, unreimbursed BH/SU disorder services, but part of the medical debt problem can probably be traced back to the costs of BH/SU disorder treatment.

The Federal Mental Health Parity and Addiction Equity Act (MHPAEA)[35] requires health care plans to provide benefits and cost-sharing for BH/SU disorder services that are comparable for medical or surgical procedures. The plan's coverage for BH/SU disorder benefits and services must be comparable or less restrictive than those of medical/surgical benefits, in terms of deductibles, copayments, co-insurance, and treatment limits and access.

While the MHPAEA requires parity for medical/surgical and BH/SU disorder benefits and treatments, the provider shortage and the fairness of out-of-network coverage has taken priority over compliance with this federal law. If employees cannot find in-network BH/SU disorder providers, then the level of out-of-network reimbursement needs to be scrutinized and updated so that patients have affordable alternatives.

For additional resources on mental health, NEA offers a report, Bargaining and Advocacy Tactics to Support Educators' Mental Health, and check out NEA's new and expanded mental health website.

Questions for Consideration

- Have employees indicated they have been unable to find BH/SU disorder providers or are unable to afford the higher cost of using the providers out-of-network?
- Has the health plan and the employer addressed the shortage and higher costs?
- Has the employer and the plan improved the benefit for and reimbursement of out-of-network BH/SU disorder treatment due to the provider shortage?

Telemedicine and Virtual Care Benefits

One of the more positive things to come out of the pandemic is the greater acceptance and use of telemedicine and virtual care medicine. Telemedicine uses electronic and telecommunication technology to provide an exchange of medical information, despite a person and their doctor not being in the same room. Virtual care can include portals, where the patient emails the provider and receives a reply by email or a follow-up phone call.

Telehealth can supplement and expand current medical benefits, while allowing employees to better manage their health. Improvements in technology have made telehealth an effective, convenient way to provide health care. Patients can get greater access to treatment and reduce their time off from work.

Certain chronic conditions like diabetes, musculoskeletal issues, reproductive care, and dermatology are being treated through telemedicine. It has had a particularly positive impact on mental health services, as it helps to address the severe provider shortage and makes it more convenient for patients to obtain care. Wait times for some providers, like child psychiatrists, have decreased significantly in several states due to telehealth services, and students and parents do not have to miss school or work to travel to their mental health appointments. As such, bargaining efforts should also address telehealth coverage, particularly as it relates to behavioral and mental health services.

During the pandemic, many health plans waived cost-sharing requirements for people who chose telemedicine service rather than in-person visits with providers. Many plans have continued this and cover telemedicine and virtual care at 100 percent on a pre-deductible basis.

The 2023 Consolidated Appropriations Act (Omnibus) further extended some telehealth services by providing HDHP participants coverage for telehealth services without requiring them to first meet the minimum-required deductible and allows HDHP beneficiaries to contribute to their HSAs. Therefore, for HDHPs with plan years beginning after December 31, 2022, and before January 1, 2025, the Omnibus extends the safe harbor and allows HDHPs to continue to cover telehealth services on a first-dollar basis, without disqualifying HDHP participants from making HSA contributions.

Questions for Consideration

- Has the plan continued or expanded the use of telemedicine post-pandemic?
- Are there financial incentives for employees to obtain services on a virtual basis? If not, why?
- Is there a supplemental provider network for virtual or in-person care to address the shortage of behavioral health and substance use disorder providers?

Maternity, Fertility, and Menopause Benefits

Maternity care, especially for women in rural communities, is in crisis. One in five people in the U.S., about 60 million people, live in rural communities. Since 2014, more than 200 rural hospitals stopped delivering babies, according to a 2024 report from the Center for Healthcare Quality and Payment Reform.[36] There is a severe shortage of pregnancy specialists, such as OB-GYNs and nurse midwives, in these areas. Hospitals and professionals in rural locations have complained for years that reimbursement for maternity services in rural areas has always been too low. However, more than 40 percent of births in rural communities are paid for by private health plans.

As more rural hospitals stop delivering babies, the travel time to a hospital with labor and delivery services is likely to be at least 30 minutes and more than 40 minutes in some areas. The U.S. has one of the highest infant mortality rates among developed nations, and this shortage of pregnancy and OB-GYN specialists will only make this situation worse.

Questions for Consideration

- How many employees live in rural communities?
- What is the feedback from employees regarding OB-GYN services?
- How is the health plan addressing reimbursement to providers in rural communities and the provider shortage? Some health plans are trying mobile clinics and an increase in the telemedicine benefit.

Fertility benefits are sometimes included in health plans, even though they are not considered an essential benefit under the Affordable Care Act.[37] Many states, have passed laws requiring that some fertility services be covered,[38] and these mandates may apply to NEA member health plans. These benefits can be attractive for employee recruitment and retention and include in-vitro fertilization (IVF), artificial insemination, fertility medications, and other related services. Some plans are enhancing the fertility treatment benefit, such as modifying the maximum dollar amount covered, increasing the number of IVF cycles permitted, and paying for fertility preservation, including freezing the eggs or sperm of people who may become infertile because of medical treatments (e.g., for cancer).

The coverage of fertility and reproductive services, specifically abortion and IVF services, has been upended as a result of the U.S. Supreme Court's 2022 decision (*Dobbs v. Jackson Women's Health Organization*) to overturn *Roe v. Wade* and the recent decision handed down by the

Alabama Supreme Court. The Dobbs decision erased the constitutional right to an abortion, while the Alabama Supreme Court ruled in February 2024[39] that frozen embryos have legal rights as people. These decisions have complicated the coverage of fertility and reproductive benefits across the country.

Questions for Consideration

- Question the employer and the health plan about how the laws in their state apply to fertility and reproductive services and employee benefit plans.
- Does the state allow reproductive services, such as abortion or IVF treatment?
- What have law enforcement agencies been doing or plan to do in regards to obtaining patient data from health care providers about abortion services or IVF treatment? These questions apply to employers, health plans, and patients in all states, not just those that have total or partial bans on abortion services and/or IVF treatment.

Benefit plans are expanding and clarifying their coverage for abortion services, including in-clinic prescription medications, assistance with travel to another state, referrals for out-of-state care, mail delivery medications, mental health services, emergency care, preventative/wellness care, and other reproductive-related benefits. Some plans are also improving miscarriage care through provider referrals and increased leave time.

Plans may use a specialty prescription drug vendor to provide the drug portion of the fertility and abortion services treatment. A fertility drug vendor is often carved out of the PBM's drug benefit coverage.

For more resources on reproductive services, visit the NEA resource Bargaining & Advocacy in a Post Roe Environment.

Menopause. Plans are beginning to recognize the need for access to providers that specialize in care for menopause, from both a medical and a behavioral health perspective.

Questions for Consideration

- What feedback have employees provided about benefits for maternity, fertility, abortion services, and menopause treatment? Is it too limited in scope? If so, discuss it with the employer and ways to improve affordability, access, and quality of care.
- If a fertility or abortion services specialty drug vendor is being used, is it outside the PBM's scope of coverage and its contract with the employer plan? If so, was a financial analysis done to compare the vendor's pricing/guarantees to the PBM's pricing? If a vendor outside the PBM is used, will this impact rebates negotiated with the PBM? Is the drug rebate included in the overall drug cost, or is it separated out?
- Does the benefit plan address menopausal care? Are there designated providers in the plan that specialize in menopausal treatment? Does the plan provide employees with information and referral to these providers?

Diversity, Equity, and Inclusion (DEI)

Employers that want to promote diversity, equity, and inclusion (DEI) within their workforce should ensure their benefits reflect that. According to United Healthcare, an estimated 20 percent of the Generation Z population (those born between 1997 and 2012) identify as LGBTQI+.[40] Gen Z will want to work for employers who offer customized solutions that meet their unique needs.

Those solutions may include having a list of designated providers with experience in transgender care, support for gender identity affirmation when different from their gender at birth, adoption for non-traditional families, and fertility coverage for growing LBGTQI+ families, among other types of DEI-specific coverage.

In addition, employees living in underserved neighborhoods need to receive equal treatment to address and reduce health care disparities. Health care plans must have quality network coverage for lower-income employees and those living in health deserts. Consider lower-income employees who need fertility treatments, such as IVF, and if the benefit is too restrictive or costly for them.

Questions for Consideration

- Does the plan cover fertility treatments for employees who are single or LGBTQI+?
- Are there provisions in the health plan to assist employees who live or work in underserved health care communities?

Part VI. PREPARING TO BARGAIN/NEGOTIATE THE HEALTH PLAN

Survey the Membership

Survey employees to get a sense of how they feel about their current health benefits package. Ask them, for example, what benefits need to be added or enhanced, where costs are unaffordable, and how adequate is the provider network. Employee responses should remain anonymous so their privacy is protected.

The role of the survey is to:

- Help identify health benefit needs, concerns, and levels of satisfaction with plan offerings and costs.
- Provide members with an opportunity to voice concerns and get involved in bargaining.
- Help improve morale in the workplace for educators.
- Increase recruitment and retention by soliciting and addressing employee concerns.

A survey can be a stand-alone health survey/questionnaire or broader survey that combines health questions with those about compensation, pensions, leave, etc.

Some sample survey questions are as follows:

- Are there health care providers conveniently located to where you live? Or near where you work?
- Do you have a reliable source of transportation?
- In which health plan are you currently enrolled? Who else in your family is enrolled?
- Why did you select this plan?
- Does your current plan include long-time providers that have treated you and your family?
    - Are there specialists that you and your family see on a regular basis (e.g., cardiologist, endocrinologist, OB-GYN, neurologist)?
- Are you thinking about changing plans during the next open enrollment?
- What health benefit are you most satisfied with? Least satisfied with?
- When thinking about yourself and your covered dependents:
    - What benefits do you need or hope to be added or enhanced?
    - What benefits do you not use?
    - Are there any barriers that prevent you and your family from obtaining health services or prescription drugs?
        - Does the cost of care impact your access to certain providers or services?
            - If so, which types of providers, services, or medications?
            - Are the costs you pay at the time of services impacting your ability to obtain care (e.g., deductibles, copayment, coinsurance, etc.)
            - Do you have medical debt at this time?
            - Have you been sued by a hospital or other provider because of your inability to pay your bill? What prevented you from paying your bill (the deductible, copayment, care from an out-of-network provider, etc.)
        - Has getting approval from the plan (prior authorization) delayed or prevented you from seeing certain providers or getting certain services or medicines?
- Do you have a primary care provider?
- Do you receive health care mostly from in-network or out-of-network providers, whether physicians, hospitals, clinics, pharmacies, etc.?
- If you use out-of-network providers or facilities, how often and which ones?
- Do you use the hospital emergency room for non-emergency services and primary care?
    - If so, how often?
- How satisfied are you with the plan's deductible, copayment, coinsurance, and other out-of-pocket costs?
- Do you participate in any tax-advantaged health reimbursement arrangements, such as a flexible spending or health savings account to help pay for out-of-pocket costs?
- Do you or any of your covered dependents require special considerations with respect to LGBTQI+ issues?
- If offered, do you use the dental, vision, or hearing benefits?

The above are sample survey questions. Your plan and geographic location might raise different benefit and provider issues that you may want to include. You may also want to list possible benefit improvements under consideration and ask which benefit(s) the employee would utilize.

Establish a Joint Employer and Employee Benefits Advisory Committee (BAC)

Establishing a Benefits Advisory Committee (BAC) allows the employer and employee representatives to have a discussion throughout the year about the health benefit needs and related financial constraints of employees. It also provides the opportunity for all stakeholders—the employer, the employee, the health plan, and other vendors—to openly discuss what is and is not working with the plan, providers, and other issues.

A BAC can improve the affordability and quality of the benefit plan, claims administration process, and the adequacy of the provider network. A BAC should survey members, analyze data, discuss details and proposals, and report back to the bargaining team.

The BAC membership should have an equal number of employees and employers—but not less than two of each. A joint employer/employee chairpersonship is ideal. If there is a Collective Bargaining Agreement (CBA) in place, should it guide the process? Before the first meeting, the BAC should determine the rules, bylaws, and decision-making process.

BAC meetings should take place on a regular basis (e.g., every two to three months) to avoid any decision-making that is not in the best interest of employees. The attendance of consultants/brokers, plan reps, and other advisors at the BAC meetings should be as-needed only. Share the results of the employee survey with the BAC to get the conversation rolling.

Request Health Care Cost and Utilization Data

Before any discussion with the employer about health benefits, request data on costs, patient utilization, and claims information for the past three years for medical, surgical, prescription drugs, behavioral health, and substance use disorders. This data-gathering, distribution to stakeholders, and analyses should take place the weeks and months before the BAC meets.

Many plans provide this information to the employer on a quarterly basis. HMO data can often be a bit difficult to interpret, so try to ensure that HMO plan representatives provide a full explanation of the cost and employee/patient health services utilization and experience data.

The BAC must also discuss any benefit changes the employer or the plan is considering. Compare the current plan to any proposed plan changes. What changes are being proposed—e.g., increased cost-sharing, further switching to HDHPs, full HMO, etc.?

The cost data, provided for a three-year period, should be similar to the top health care cost drivers (as discussed above in the state employee health plan report): prescription drugs, number of inpatient hospital admissions (by medical, surgical, rehabilitation, behavioral health, etc.), and outpatient care costs (emergency department, urgent care settings, physician office, clinics, etc.).

The data should also include premiums or self-funding rates and the distribution of employees under each coverage level for each health plan.

Employee representatives on the BAC should correspond with employees on a regular basis through the survey results, prep work, asking for feedback, and providing updates on the BAC discussions.

Questions for Consideration

- Ask the health plan broker/plan/consultants/vendors questions about their roles, compensation, and why they recommend certain plans, facilities, professional providers, prescription drugs, etc. Question the strategies they recommend to maintain an affordable and quality benefit plan to members.
- When was the last time the health plans and PBM contracts were put out for bid? It is recommended that health plan contracts be re-bid every three years.

Analyze Health Plan Options

Determine whether most plans are PPOs, HMOs, HDHPs, etc. and how many participants are in each plan. Also notice growing trends, such as a shift to HDHPs by either employer offerings or employee enrollment.

Questions for Consideration

- Are HDHPs already in place? Is it the only option?
- Is the employer pushing to offer or expand HDHPs? If so, is it due to the lower premium and age of enrollees?
- If an HDHP that qualifies for an HSA is in place, how much does the employer contribute to it? Does state law limit the amount that the employer can contribute to the HSA?
- Is financial help available to low-income employees enrolled in an HDHP?
- How do the costs and benefits in an HDHP compare to those in other lower-deductible plans?
- Are preventive prescription drugs covered before the high deductible is met? Which drugs?
- In addition to the premium, closely review any proposed changes to the deductibles, out-of-pocket maximums, and copayments and coinsurance amounts both for both in-network and out-of-network care. Have the deductibles and out-of-pocket amounts changed for the coverage tier (e.g., employee only, employee-plus-one, employee-plus-children, and family)?
- Is the employer/plan proposing any benefit changes or new exclusion categories of coverage? While the plan should be well aware of the essential benefits required to be covered under the ACA, it is best to check any new exclusion being proposed.

Request Salary Data

To understand the impact of health care cost-sharing arrangements on employee wages and to make informed decisions, it is necessary to have employee salary data. When combined with premium information, training and experience grids (aka scattergrams) or individual employee wage data can be used to compare wage increases to employee health care costs.

Questions for Consideration

- What are the projected increases to premium costs for each year over the term of the negotiated agreement? What size wage increase will employees need to prevent gains from being wiped out by rising health care costs, even if the employee premium contribution percentage remains unchanged?
- What size wage increase will employees need to offset either proposed increases in their premium contribution rates or additional health care costs being shifted to them?

Part VII. STRATEGIES TO IMPROVE HEALTH PLAN OPTIONS AND AFFORDABILITY.

After you review the health plan cost and utilization, employee cost-sharing, and their experiences with the plan(s), consider discussing the following with the employer:

Improve Plan Affordability

- Base health plan premium contributions on employee's wage/salary. It is best to use a flat-rate contribution method, as it may best ensure that only lower-income employees benefit.

- Offer at least one plan with a zero premium, even if it is for employee-only coverage, based on wages/salary.

- Offer at least one plan with a zero or low deductible to offset out-of-pocket costs, based on employee wages/salaries.

- Employer will contribute the maximum IRS permitted amount[41] to employee's HDHP HSA-eligible account.

- Lower the HDHP deductibles and the deductibles of non-HDHPs. Are the HDHP deductibles close to the IRS minimum permitted amounts? Annual out-of-pocket expenses for 2024 (including deductibles, copayments, and other amounts, but not premiums) cannot exceed $8,050 for self-only or $16,100 for family coverage. Those maximums are high. The out-of-pocket maximum amounts for HDHPs and other plans should be set well below the IRS allowed amount so that employees and their families can avoid medical debt and receive the care they need.

- Employer will increase the amount of the employer's contribution to a Health Reimbursement Arrangement (HRA).

- Plan will eliminate or reduce copayment/coinsurance for maintenance drugs that treat chronic diseases.

- Add a zero copayment/coinsurance for use of generic drugs and biosimilar drugs.

- Reduce the copayment/coinsurance for certain specialty drugs, if there is no biosimilar drug, to help the employee maintain their health, quality of life, and well-being.

- Use specialty vendors to help employees find quality providers and cost-effective treatments for fertility services, menopause treatments, autoimmune diseases, cancer and other illnesses.

- Waive copayment/coinsurance requirements for members who use the hospital emergency room for non-emergency acute or chronic care, but live in communities that are underserved primary care areas.

- For employees living in underserved communities, pay for transportation from the employee's home to a primary care provider's office or an urgent care facility.

- Encourage continual coverage of telemedicine, free of charge, for chronic and acute care visits, especially for behavioral health issues.

- Continue to cover COVID and other vaccines and immunizations at zero cost.

PART VIII. NAVIGATION AND ADVOCACY SERVICES; CENTERS OF EXCELLENCE AND SPECIALTY NETWORKS; HEALTH SCREENINGS, DISEASE MANAGEMENT AND WELLNESS PROGRAMS; AND, PRIOR-AUTHORIZATION PROGRAMS

Some of these programs help employees find acute care and specialist providers (e.g., transplant specialists). In addition, many of these programs provide educational services and monitor patients with chronic health conditions. Plans use these programs as gatekeepers and approval channels to care, involving expensive prescription drug medications or gene therapy, for example. These tools must be regularly monitored for impact on employees and their families, if they are helpful or result in delaying or denying care.

Navigation and Advocacy Services. Interest in these services and associated nurse lines have been growing for many years. They are used to help employees gain access to the most appropriate provider and obtain treatment as quickly as possible. The consulting firm Mercer found that almost 30 percent of employer health plans include health care navigation or advocacy services.[42]

Questions for Consideration

- If a gatekeeper service is in place, does the plan monitor and update in-network provider information? What feedback have employees provided about this service?
- As noted in Part IV above, Centers of Excellence are medical systems and providers that have demonstrated their ability to deliver superior patient outcomes at a lower cost for complex conditions. Who administers the Center of Excellence referrals?
- Is the patient monitored for the duration of the care with providers in the Center? Which disease categories does it include?
- Is the copayment or coinsurance reduced or waived if the patient uses Center of Excellence providers?
- Can patients receive financial assistance for travel and housing expenses for patients who need to go outside of their geographic location for care?

Specialty Vendor Network. Some health plans "carve out" the administration of certain benefits—such as BH/SU disorder services, biologic medications, and/or fertility drug therapies—to a specialty vendor.

Questions for Consideration

- What specialty vendors does the plan use?
- What are the experiences of patients with these networks?
- Has the plan shown any cost savings from using these vendors?

Health Screenings, Disease Management, and Wellness Programs. These programs focus on providing treatment plans to patients with complex, chronic health needs, so they can better manage their diseases. Health education is usually included to help patients take ownership of their own care. These programs coordinate care among different providers to help patients with multiple chronic-disease conditions. Some programs encourage enrollees to adopt healthy behaviors or achieve a pre-determined health outcome (such as body mass index or cholesterol level). Health plan premiums or employee cost-sharing are often tied to participation in a wellness program or achieving a health outcome. Financial incentives to use these services are acceptable, but patients should not be penalized if they do not meet certain outcomes or decide to not participate.

Questions for Consideration

- Are there any screening, disease management, or wellness programs in place?
- What data does the health plan have on the successes and failures of these programs?
- Have employees found these programs helpful? If not, why?
- Do employees and their providers feel that these programs have resulted in delayed or denied care?
- Are these programs reviewed and put out to bid on a regular basis to ensure their quality, patient satisfaction, and cost effectiveness?

Prior Authorization (PA) Programs. PA programs require approval from the health plan before an employee can obtain certain high-cost services or expensive prescription drugs. It is a cost-cutting tool that health plans sometimes misuse to the detriment of patients. The plan and the employer must provide employees with a clear sense of the services requiring PA and the penalties that may occur if the patient seeks care prior to approval. The PA process should not be so onerous, time consuming, and difficult that employees are delayed or denied necessary treatment or services.

If PA for an inpatient BH/SU disorder is mandatory under the plan, make sure that the requirements are the same as those for an acute medical/surgical admission so that mental health parity laws are not violated; that includes deductibles, copayments, coinsurance, and out-of-pocket maximums. Quantitative limits, such as the number of visits or days of coverage, must also be the same. Physicians and other trained health care staff must give approval for an inpatient admission. Some plans use artificial intelligence (AI) to reduce administrative staff costs, so it is important to know to what extent it is being used to approve or deny a health service or medication. AI is also being used in conjunction with PA to approve expensive therapies and treatments.

Questions for Consideration

- What is the experience of employees with the plan's PA process?
- How quickly does the PA process respond to patient and doctor requests?
- What is the training and background of the providers administering the PA program?
- Does the training and background match the physician who is prescribing the treatment? For example, is an oncologist at the PA vendor reviewing a chemotherapy order from the patient's cancer doctor? The PA reviewer must match the training and background of the patient's doctor ordering the test, procedure, or medication.
- Are the reviews conducted by U.S.-based providers?
- Are there language barriers when patients contact the PA provider?
- Is AI being used in the denial and approval process? If AI is being used, make sure that the plan provides a full accounting of which services this applies to.

For further guidance as you prepare to advocate, bargain, and negotiate for higher member salaries and wages that are not eroded by increased employee health benefit plan costs, please contact Cynthia Blankenship, Collective Bargaining and Member Advocacy Department (CBMA) at cblankenship@nea.org

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