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THE **RISK REPORT**

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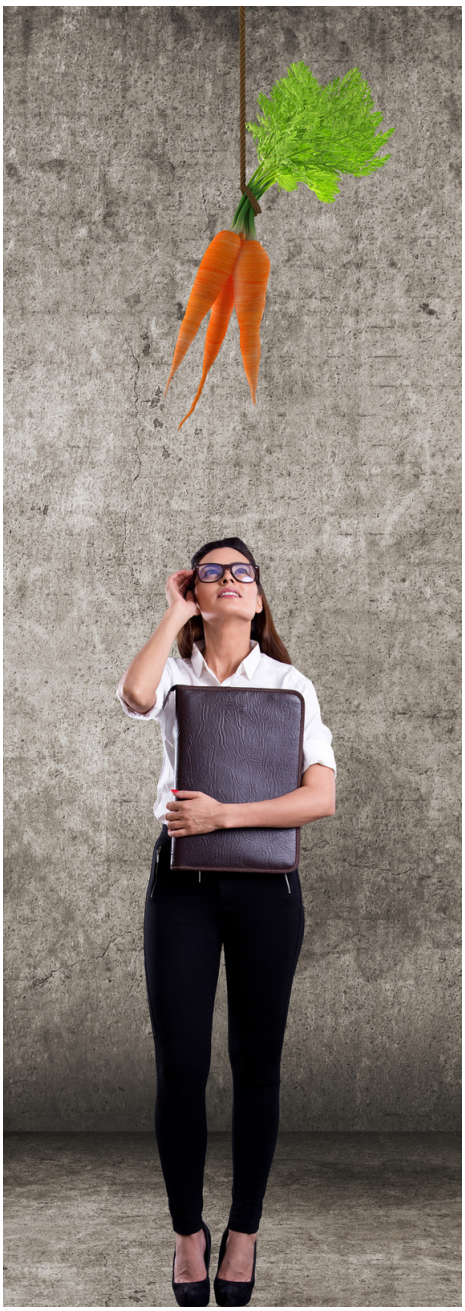
Group Health Insurance

Coaxing Disengaged Workers to Enroll in Your Plan



ONE OF the most difficult aspects of annual open enrollment is reaching workers who are disengaged from the process and never bother signing up for your group health plan and other benefits they could take advantage of.

While employers shoot for maximum employee enrollment, there are always those workers who for a multitude of reasons never take the first step of signing up for benefits. These workers are likely going uncovered for their health insurance and risk serious outlays if they have to see a doctor or go to the emergency room.

They also miss out on preventative services that insurers are required to provide without cost-sharing and that can help them maintain their health.

This disengagement is more typical with younger workers, who may feel that the extra expense for their share of their health plan premium isn't worth it since they are young and healthy. A recent study, the fifth annual "HSA Bank Health & Wealth Index," noted that targeted communications to millennials and Gen Zers are key to sparking their interest.

One way to do that is by focusing on pending life events that younger generation workers may be encountering:

Marriage and children – Employers can focus their messaging to these generations of workers by highlighting these major life milestones and the importance of having health insurance in place.

Both of these events should be a wake-up call that it's time to get serious and purchase health insurance to either cover their spouse or impending children. Childbirth is expensive and newborns require numerous doctor's visits and vaccinations in their first year and beyond.

Turning 26 – This is the age that individuals are no longer allowed to be covered by their parents' health insurance. Young workers will often forgo their employer's health plan as they are still covered by their parents' plans.

They may not be aware that this is the cut-off age. If you have Gen Z workers, you should consider sending out e-mail blasts to them about this law and that if they're turning 26 in the coming year, they'll need to find new coverage other than their parents'.

Health savings accounts

Employees with health savings accounts are the most engaged in their health insurance, according to the Health and Wellness Index.

HSAs can provide the peace of mind and the funds to cover those costs.

HSAs are savings accounts that allow your employees to put a portion of every paycheck into the account to bank for future medical expenses.

These accounts can be kept for life and transferred to new employers. They are funded with salary that has not yet been taxed and the funds in the account can be invested, much like a 401(k) plan.

See 'Target' on page 2

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Coverage Considerations

Is Health Plan Self-Funding Right for Your Firm?

AS GROUP health costs continue climbing and more employees struggle with the cost of premiums and out-of-pocket expenses, some employers are starting to take a second look at self-funded, or partially self-funded plans.

These plans give employers more skin in the game and the ability to better address cost drivers and tailor their offerings to fit the needs of their employees. But while these plans can save both employer and their workers money, they are not for every organization.

Small employer considerations

Recently, insurers have been trying to address small and mid-sized employers' concerns about risk and costs by rolling out "level-funded" plans. These vehicles provide a lower level of self-funding with a stop-loss insurance program that has lower attachment points than typical plans.

For level-funded plans, the insurer estimates the employer's expected monthly expenses, which include:

- A portion of the estimated annual cost for benefits,
- The stop-loss protection premium, and
- An administrative fee.

The employer pays the above to the insurer every month. If, at the end of the year, claims were significantly higher or lower than expected, there will be financial reconciliation between the employer and the carrier.

These level-funded plans differ from fully self-funded plans, where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. The employer will usually contract with a third party administrator or insurer to handle claims and provide administrative services for the plan.

Stop-loss insurance may be used to protect against large claims.

Stop-loss basics

There are different types of stop-loss insurance that pay the cost of claims at a certain attachment point, either becausethe plan's individual or claim spending exceeds a designated value:

Specific stop-loss coverage – This policy provides protection for the employer against a high claim on any one individual. This is protection against abnormal severity of a single claim, rather than abnormal frequency of claims in total.

Aggregate stop-loss coverage – This policy may limit the total amount the plan sponsor must pay for all claims over the plan year.

The benefits

Customization – Self-funded plans let employers customize their plan to meet the needs of their workforce.

Cost control – Self-funded plans only pay the actual costs, as opposed to fully insured plans where the premium goes towards the expected health care costs the insurer has forecast, plus its overhead, reserves, profit margin, and more.

Access to claims data – You get detailed access to claims costs so you can see what claims are driving costs. By looking at claims and plan participant needs you can better decide which benefits to provide, enhance or remove if they are not being used.

Disadvantages

Compliance – Since you would be paying for the claims, you would be responsible for fiduciary and compliance issues.

Cash flow – The plan will need to have sufficient money going into its accounts regularly to pay for claims as they arise.

Volatility – Medical outlays can be unpredictable. A spate of high-cost claims can wipe out any potential savings.

The takeaway

If you're tired of climbing group health plan premiums, we can review your current insurance arrangement and your plan costs to help you decide if it's right for you. ❖

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Target Disengaged by Appealing to HSA Users' Traits

The study recommends targeting your communications to the disengaged by appealing to the traits that most HSA users have:

Spenders – This group of HSA owners will use most of the funds in their accounts to pay for qualified medical expenses.

They want information that helps them get the most bang for their buck. You can do this by sending them lists of eligible expenses and directing them to online technology that helps them get reimbursed.

Savers – This group doesn't touch their HSA balances even for current medical expenses. Instead, they prefer to use their account to save for future expenses, even in retirement.

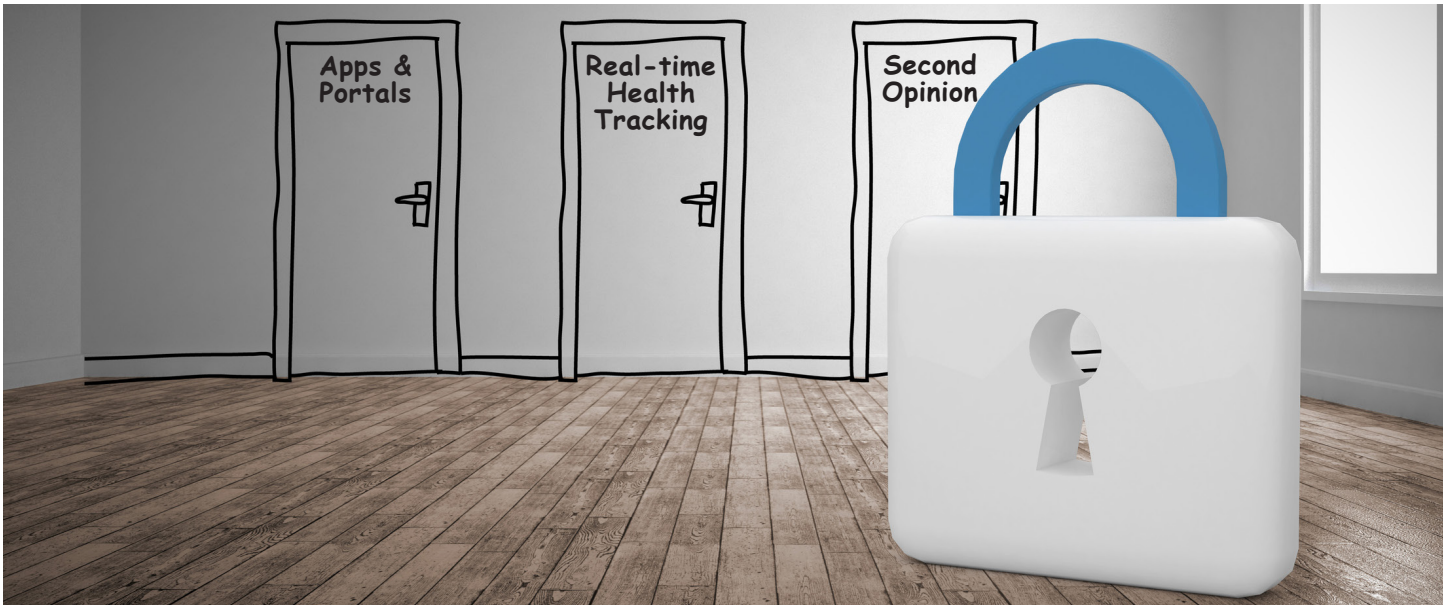
They are interested in tools to track expenses not paid from their HSAs and direct deposits for self-reimbursement.

Investors – This group are also savers. They seek to maximize growth of their HSAs by investing the funds to grow them even more.

They are interested in information that can help them make good investment decisions and changes.

Providing them with timely advice can help them start an HSA and continue investing in it in the future. ❖

Help Your Staff Get the Most out of Their Health Plans



BY NOW you will know about the rapid uptake in telemedicine after the COVID-19 pandemic drove patients to use virtual appointments with their doctors.

While telemedicine is here to stay, there are other technologies that employers can look to include in their group health plans to help employees get the most out of their benefits, better manage their health and make more informed decisions about care.

Apps and patient portals

More health plans are offering user-friendly apps and online patient portals that are one-stop shops.

Portals, Apps Can Help People...

- Find a doctor.
- Schedule appointments or doctor's visits, annual exams and other procedures.
- Receive reminders about important preventative care services, such as regular colonoscopies, blood work and vaccinations.
- Access virtual visits with their doctors.
- Renew prescriptions.
- Check test results.
- Access their medical records, and to share them with their doctors or specialists they are seeing
- Get advice on managing chronic conditions.

Real-time health tracking

One of the new frontiers in health care is remote patient monitoring, thanks to an explosion in new smartphone and tablet apps as well as wearable technology.

A 2021 survey by the Healthcare Information and Management Systems Society found that 52% of providers had recommended that patients use a smartphone or tablet app to monitor and track their care and health.

Wearable tech, the new frontier

Wearable technology is expected to play an increasingly large role in helping people maintain their health and get help when they need it. Currently it can measure:

- Heart rhythm and rate
- Blood pressure
- Temperature
- Glucose levels.

Virtual second opinions

Studies have found that 10% of patients are misdiagnosed for cancer, infections, heart attack or stroke.

Some employers are now offering virtual second-opinion services, which allow their employees to have their case reviewed by another doctor no matter where that specialist is in the country.

This service can give your workers peace of mind, even if the original diagnosis was correct.

Patients will often deal with a nurse liaison, who can:

- Gather all of the patient's records and send them to a specialist to review.
- Schedule video consultations with a specialist.
- Arrange for reports to be sent to the patient and current provider after the specialist has reviewed their case and written a report.

The takeaway

Technology will continue playing a greater role in people's health. Offering new services that include technologies that can improve your employees' health care experience is a win-win for you and your workers.

They'll be happier with their health plans and the care they receive, and you can improve your employee retention. ❖

Finding Health, Out-of-Pocket Cost Data Still Difficult

DESPITE NEWLY enacted federal transparency rules for hospitals and health plans, some large hospitals are still not posting the required price lists for their services, according to a recent report.

The Centers for Medicare and Medicaid Services' transparency rules were implemented to shine the light on what hospitals charge for their various medical services, the negotiated rates insurers have with health plans and the out-of-pocket costs enrollees can expect to pay for these services.

The rule has taken effect in stages and hospitals were the first required to comply, but the report finds their efforts have fallen short. Insurers were required to start posting negotiated rates for their health plans starting July 1, 2022, but currently much of that information is hard to find and decipher.

That means, for now, it may be difficult for plan enrollees to shop around for procedures that they will pay for partially or fully out of pocket. But hopefully, that should change as more rules take effect.

The non-profit Patients Rights Advocate found a number of omissions when recently analyzing price data for seven hospitals in Florida and Texas that are owned by two major health systems: Ascension Health and HCA Healthcare.

The transparency rule requires hospitals to publish online price lists and display rates for medical services in a format that allows consumers to comparison shop.

Insurers for their part are required to post their negotiated rates with providers in machine-readable format.

The effect on health plan enrollees

Health plan enrollees that want to shop around for medical services may currently find it difficult. While the data is posted on the insurers' and hospitals' websites, it's hard to access and decipher since each entity handles the data differently.

The hurdles of transparency

A report by National Public Radio highlighted the hurdles a health plan enrollee may encounter if they were trying to find their insurance carrier's negotiated price for an MRI:

Locating the files – First they have to find the files, which are unlikely to be posted in an easy-to-find section of the insurer's website. They may have some luck by searching on Google and typing in their insurer's name, plus "transparency in coverage" or "machine-readable files." Maybe.

Finding their plan – If they succeed with that approach, next they need to find their plan in all of those files. The files are supposed to have a table of contents, but insurers can have hundreds, if not thousands of different plans, some specific to just one employer. They'll have to find their plan among those plans, many of which will have similar names to theirs.

Deciphering the data – If they are able to find their plan and download the information, they will have to decipher the various codes for the service for which they are trying to find a price. Each procedure has a specific service code, which the enrollee may not have.

It may get easier soon

The process may become easier on Jan. 1, 2023, when a new rule that requires insurers to provide apps and other tools to help policyholders estimate costs for visits, tests and procedures takes effect.

At that time, carriers will be required to make available online, or in hard copy upon request, patient costs for a list of 500 common shoppable services. That includes things like knee replacements, mammograms, X-rays and MRIs, to name just a few.

In 2024, insurers must add all remaining shoppable items/services to their comparison tools. ❖