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THE RISK REPORT

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Employee Benefits

Employers Prioritize Enhanced Benefits, Not Cost-Cutting

DESPITE GROUP health insurance costs that are expected to rise 5.4% this year, the tight labor market is forcing employers to prioritize enhancing benefits over cost-cutting measures, according to a new report by Mercer.

With Americans increasingly struggling to pay their health care bills, more employers are shying away from only offering their workers high-deductible health plans (HDHPs) that reduce premiums up front for higher out-of-pocket costs for workers.

Also, with mental health a top concern for workers, employers are seeking out benefits and plans that include virtual mental health services to make it easier to access care.

The expected health insurance cost growth of 5.4% is still less than general inflation, which was averaging just a tad below 8% in 2022. Because of high inflation, employers should be prepared for continued accelerated cost growth in 2024 and beyond, according to Mercer.

What employers are doing

With the tight labor market and health insurance benefits high on employees' demands, employers are focusing on:

- Enhancing benefits to improve attraction and retention (84% of large employers cited this as "important" or "very important").
- Adding programs/services to expand access to behavioral health care and mental health services (73% said this was important or very important).
- Improving health care affordability (68%).
- Enhancing benefits/resources to support women's reproductive health (55%).

That's not to say that employers are not concerned about costs. Instead, they are tackling it in different ways than in the past.

"Given the focus on affordability, it is not surprising that, despite expectations of higher healthcare costs, most leaders are avoiding 'healthcare cost shifting,' or giving plan members more responsibility for the cost of health services through higher deductibles or copays," Mercer wrote.

It added that there was little change in the median amount of these cost-sharing features in 2022.

Prior to the COVID-19 pandemic, employers were shifting workers to HDHPs to reduce their costs, but while employees enjoy lower premiums with these plans, if they need care they will pay more out of pocket.

Mercer found that fewer firms are offering only HDHPs than in past years. Very large organizations (20,000 or more employees) had been adopting these plans with gusto until 2018, when 22% of them offered an HDHP as the only option for their employees.

That fell to 13% in 2021 and was only 9% in 2022.

Instead, more employers were using salary-based premiums in 2022 (34%, up from 29% in 2021). Under these

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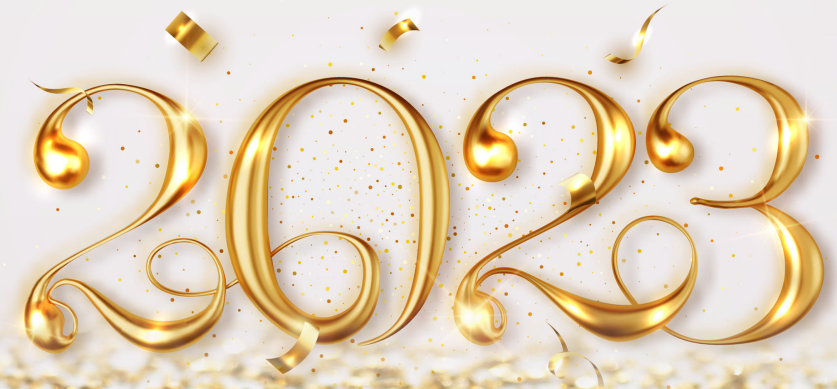

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Worker Poll

These Are the Extra Benefits Employees Value Most

BESIDES HEALTH insurance and a 401(k) plan, other benefits that employees value highly are generous paid time off and flexible or remote work, according to a new survey.

But for the first time, an annual study by employee benefits provider Unum found that the younger generations are not on the same page with their older peers when it comes to what they value most in their benefits package.

Although the generations differ in their top three priorities, when opened to the top five, there is one common denominator: emergency savings.

Emergency savings

Sixty-four percent of employees surveyed said they don't have access to an emergency savings option through their employer. This benefit ranks third for boomers (25%), third for Gen X (32%) and second for Gen Z (37%).

Emergency savings plans can help prepare your employees for unexpected expenses – without dipping into retirement funds or using credit cards.

Employer-sponsored emergency savings accounts help workers save for financial emergencies by automatically deducting an amount from each paycheck and depositing it into a separate account. If they need to cover a bill or cash gets tight, they can draw from this fund to bridge a financial gap.

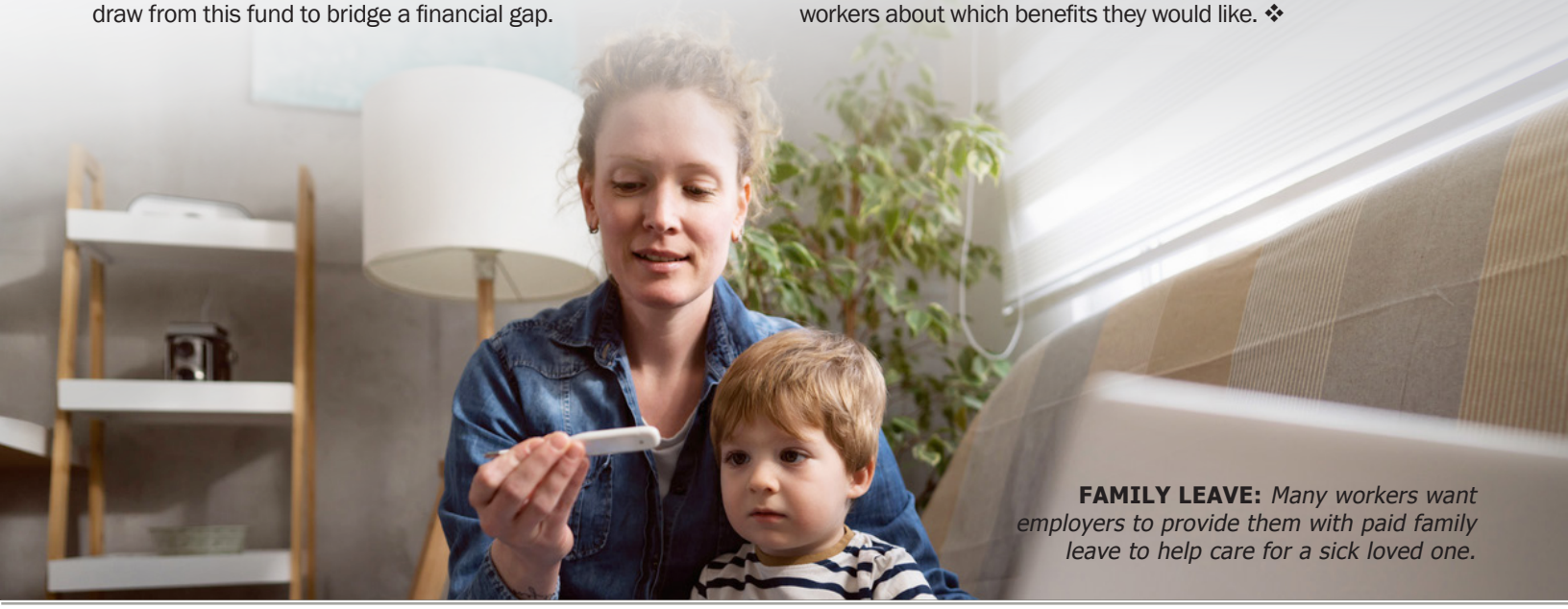
THE WORKER WISH LIST

Here are the top non-insurance benefits workers crave:

1. Generous paid time off program
2. Flexible/remote work options
3. Paid family leave (for childcare or caring for an adult family member)
4. Mental health resources/support
5. Emergency savings
6. Professional development
7. Financial planning resources
8. Fitness or healthy-lifestyle incentives
9. ID theft prevention
10. Gym membership or onsite fitness center
11. Student loan repayment benefits
12. Pet-friendly offices
13. Personalized health coaching
14. Sabbatical leave
15. Dedicated volunteer hours.

A final word

There are so many benefit options that it's important to opt for ones that your employees actually want. Consider polling your workers about which benefits they would like. ❖



FAMILY LEAVE: *Many workers want employers to provide them with paid family leave to help care for a sick loved one.*

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Some Employers Turning to Salary-Based Premiums

arrangements, lower-wage workers have smaller paycheck deductions for health coverage than those with higher salaries.

Cost-cutting

Employers are looking at other ways to cut costs for themselves and their employees. The Mercer study found that:

- 35% of large employers are steering employees to high-performing provider networks and other sources of high-value care.
- 36% of large employers offer help lines and advocacy services to help members find providers based on quality and cost.
- 17% offer digital navigation.
- 24% are focusing on managing costs of specialty drugs.

23% are working with their carriers and pharmacy benefits managers on cost and clinical management strategies. ❖

Health Insurance Funding

More Providers Charging for Health Portal Services

AS MORE HEALTH services are being rendered through providers' patient portals and telemedicine, some providers are starting to bill for some of those interactions.

A number of health systems around the country have started billing for certain types of messages, largely ones that are involved in clinical assessments or medical history reviews that take more than five minutes. Those costs will be passed on to health plan enrollees – likely in the form of copays or coinsurance – and insurers.

Online and app-based portals have become increasingly popular, particularly since the onset of the COVID-19 pandemic, as more people grow accustomed to not seeing their doctor face to face for every visit. Often these portals will allow the health plan enrollee to ask their care team questions, and that's when providers say they are not being paid for their time.

Is a new trend starting?

Patient portals were seeing little usage prior to the pandemic, which spurred demand as patients and providers needed a solution that didn't require in-person interactions. Studies have shown that more than 80% of patients used telehealth at least once since the start of the pandemic, up from about 10% prior to 2020.

These portals also sometimes obviated the need even for a televisit with a doctor and opened the door for patients to message their doctor directly.

The issue recently came to the fore when Cleveland Clinic and a handful of other medical centers started charging for this service.

Cleveland Clinic in November 2022 said it would start billing patients' insurance companies for messages requiring at least five minutes of health care providers' time to answer.

What will it cost?

Sending messages could cost as much as $50 per message depending on the time and skill necessary to answer the request. According to the announcement, people with individual or employer-sponsored group health insurance may be billed an average of $33 to $50 for each message taking more than five minutes.

In announcing the new charges, Cleveland Clinic wrote: "Over the last few years, virtual options have played a bigger role in our lives. And since 2019, the amount of messages providers have been answering has doubled."

According to a report in *Becker's Health IT*, seven more large health systems around the country have also started billing for some patient portal services: Northshore University Health System in Evanston, Illinois; Northwestern Medicine in Chicago; Chicago-based Lurie's Children's Hospital; San Francisco-based UCSF Health; Renton, Washington-based Providence; and UW Medicine and Fred Hutch Cancer Center, which both have their headquarters in Seattle.

These hospitals say they will only bill for certain messages, such as those concerning:

- Changes to a patient's medications.
- New symptoms the patient may be experiencing.
- Changes to a long-term condition.
- Check-ups on long-term condition care.
- Requests to complete medical forms.

Messages may provide information on a treatment plan or recommend that the patient get a test done or schedule an appointment with a specialist. Doctors may often refer to the patient's medical history and review their records for these communications, for example.

The providers say that other services on portals will remain free, such as:

- Scheduling appointments.
- Getting a prescription refilled.
- Asking a question that leads to an appointment.
- Asking a question about an issue the patient saw their provider for recently.
- Checking in as a part of follow-up care after a procedure, such as a colonoscopy.
- A patient giving a quick update to their doctor.

Experts predict that as more health services gravitate towards providers' portals, hospitals and doctors will look to generate revenue from these services. ❖

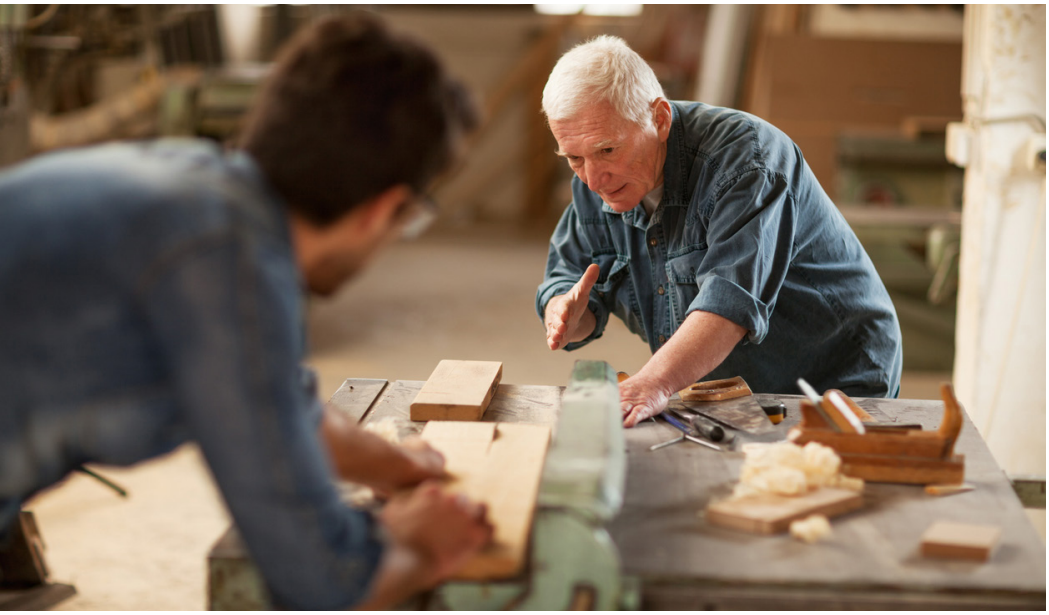
HR Considerations as More Work Past Retirement Age

AMERICANS ARE eligible to sign up for Medicare when they turn 65, but more of us are staying in the workforce longer than ever before. In fact, the average retirement age has increased three years in the last three decades.

There are a number of issues that Medicare-eligible workers face and that your human resources staff may be asked about, such as:

- Late Medicare enrollment penalties,
- Whether the employer plan is the primary or secondary payer of claims, and
- How Medicare eligibility affects health savings accounts.

The following are considerations for employers faced with workers nearing 65.



Discontinuing group health coverage

If you plan to discontinue coverage for employees who are turning 65, you should communicate with them well ahead of the time they need to sign up for Medicare.

It's important they understand that they will be dropped from your group health plan and that they have a seven-month window to sign up for Medicare (during the three months prior to the month they turn 65, the month they turn 65 and the three months after turning 65).

If they fail to sign up during this time, they will face a mandatory 10% penalty on all future Medicare Part B premiums for every year they are late in signing up.

Keeping them on the group plan

If you decide to keep them on your group health plan, how you handle their insurance depends on your company's size:

Fewer than 20 employees – Employees who work for these firms will need to enroll in Medicare when they turn 65. Medicare will be the primary payer of health insurance claims for these workers under the law.

The group health insurance is the secondary payer.

How it works:

Let's say your employee has foot surgery:

- Medicare pays first up to the limits of its coverage.
- The group health insurance only pays if there are costs Medicare didn't cover.

20 or more employees – At organizations with 20 or more workers, the employer's plan will be the primary coverage as long as they are actively employed. These employees can generally delay signing up for Medicare Part B. They will also not be subject to penalties for not signing up when they turn 65.

That said, workers who are still on your plan should sign up for Original Medicare Part A (hospital insurance) when they are first eligible.

Medicare Part A, which is premium-free, provides secondary coverage of hospital expenses that may not be covered by your plan.

Once they stop working and are no longer on the company's health plan, your employees have eight months to sign up for Medicare Part B. They can at that time opt for Original Medicare, Medicare Advantage or a Medicare supplement plan.

If they fail to sign up for Medicare Part B after eight months of losing their employer coverage, they will be subject to a premium penalty for the rest of their lives.

Ideally, workers should enroll in Part B at least a month before they stop working or their coverage ends, so they don't have a gap in coverage.

Health savings accounts

If your firm has fewer than 20 employees, workers who are 65 or older can no longer contribute to an HSA as they are not compatible with Medicare.

At larger organizations where the employer's health plan is the primary coverage, employees enrolled in an HSA-compatible, high-deductible health plan can delay enrolling in Medicare and continue contributing funds to their HSA.

Employees who are 65 or older should stop making contributions to their HSA six months before they enroll in Medicare, or before they apply for Social Security benefits if they are still working. That's because people who apply for Social Security benefits are automatically enrolled in Medicare.

Those who fail to stop making HSA contributions during that period may face tax penalties. ❖