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THE **RISK REPORT**

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Employee Benefits

As Health Care Costs Bite, Take Steps to Help Your Workers

RECENT STUDIES have highlighted an alarming trend in American health care: More and more people are struggling with medical bills and many are delaying care due to high costs.

The most recent poll by Gallup found that 38% of those surveyed said they or a family member had delayed care in 2022 due to high costs. That's up from 26% in 2020 and 2021. The rapid increase occurred in a year where inflation was at a 40-year high.

Last year's spike in delayed care was the largest over one year since Gallup first began tracking these data more than two decades ago and it illustrates the breadth of the problem, which likely stretches into the ranks of your own employees.

Even if you are providing them with a robust plan, there are often out-of-pocket cost-sharing and deductibles to contend with. For employees in high-deductible health plans, the costs can be steep.

What you can do

Fortunately, there are steps you can take to help them reduce their out-of-pocket expenses for health care:

Emphasize the importance of preventative care – The best way to prevent or stave off major health issues is through preventative care, such as going to routine checkups and having blood work done as recommended. The COVID-19 pandemic worsened the problem of delayed care and health care providers and patients are still catching up on all that missed care.

But it's not just regular checkups. Many people are not getting regular care for chronic conditions. Many preventative services are covered with no out-of-pocket cost-sharing, but checkups usually are not.

Depending on the type of plan an employee has, routine and preventative care costs can add up. Some experts suggest creating a cash-assistance fund for workers who may struggle with the costs of those visits.

Highlight digital tools – Digital tools are growing in number, from apps and telehealth options to those that can help your employees manage chronic conditions.

Many insurers and/or providers have apps to help people access care and manage their health. The apps will notify patients when it's time for checkups or other routine services.

These portals typically include telehealth options, which can be a less expensive way to meet with their doctor or a specialist.

On top of that, there are digital tools to help people monitor and manage chronic conditions, like high blood pressure and

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HEALTH TECH: *Many insurers and/or providers have apps to help people access care and manage their health.*

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Total Control Health Plans

Phone: (616) 301-6757

E-mail: Info@/totalcontrolhealthplans.com

www.**totalcontrolhealthplans**.com

Employer-Sponsored Plan 'Family Glitch' Fixed

THANKS TO new regulations that took effect Jan. 1, it will be easier for dependents of an employee with employer-sponsored family health coverage to seek out coverage and subsidies on the Marketplace if they are in a plan that is deemed unaffordable under the Affordable Care Act.

The new rules, issued by the Department of Treasury and the IRS, are aimed at fixing what's become known as the "family glitch," which is tied to the affordability test of employer-sponsored coverage.

The ACA affordability threshold for employer-sponsored coverage is 9.12% of income for 2023, meaning that if an employee is spending more than that for their portion of the premium, the coverage would be deemed unaffordable and they would be eligible to seek out coverage on an exchange and qualify for subsidies.

Under the family glitch, affordability of employer-sponsored coverage for a family member of an employee was determined by the affordability test for self-only coverage. And because of ACA rules, even if the family coverage was more than 9.12% of household income for the worker's family members, they would be ineligible for premium credits (or subsidized coverage) on the government-run exchange.

Some 5.1 million individuals are affected by the family glitch, according to the Kaiser Family Foundation. It estimates that 85% of them in 2022 were enrolled in employer-sponsored plans and paying more than they would if they qualified for subsidies on the exchange.

Another study estimated that these individuals could be spending on average 15.8% of their income on their employer-sponsored coverage.

Example of the family glitch

An employer pays 100% of the $7,500 premium for an employee's self-only coverage, but doesn't pay anything towards the individual's family members' coverage, which is an additional $8,500 per year.

As a result, the worker's dependents would be considered to be enrolled in affordable employer-sponsored coverage, which would prevent them from qualifying for tax credits on the exchange.

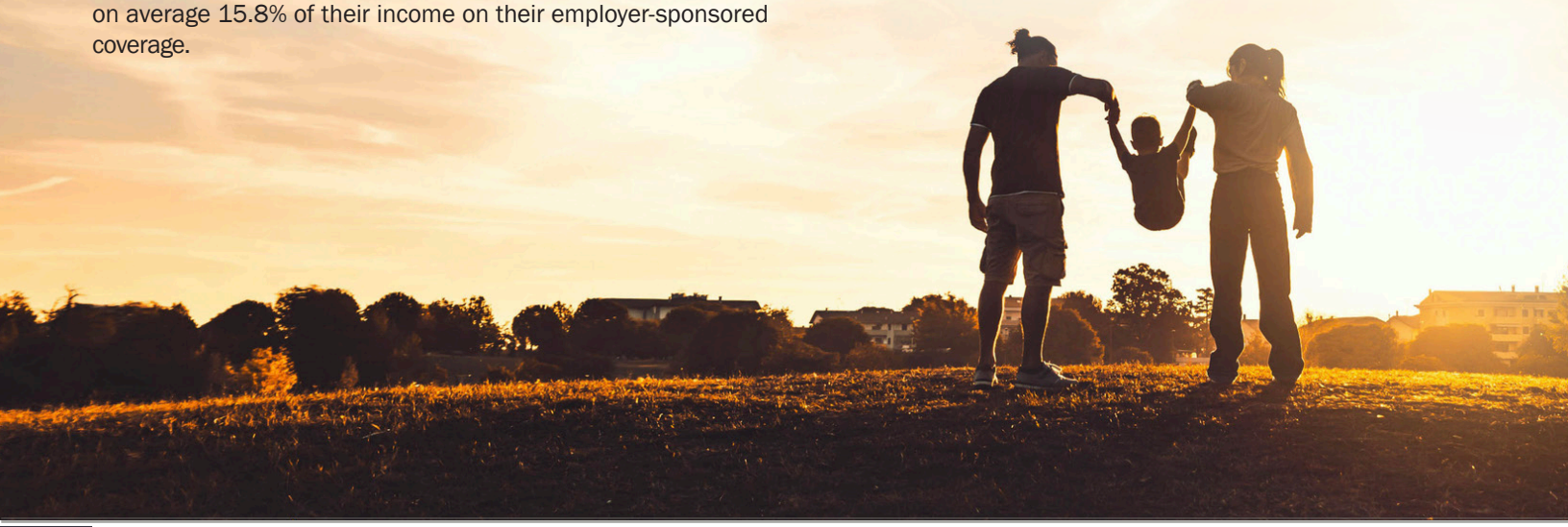
The new rules

Under the new rules, the worker's required premium contributions for self-only and family coverage would be compared to the affordability threshold of 9.12% of their household income.

If the employer offers multiple plans, the affordability test is applied to the lowest-cost plan, regardless of if the employee chooses a plan that costs them more than 9.12% of household income.

If the cost of self-only coverage is considered affordable, but the family coverage not, the employee would not be eligible to apply for subsidized coverage on an exchange, but their dependents would be.

In your communications with your staff, it may be a good idea to let them know of this new rule as it could allow some of them with family coverage to secure subsidies for their dependents on the Marketplace and pay less in premium for the coverage. ❖



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Urge Employees to Sock Away Funds in HSAs

diabetes — and even rate genetic conditions. They are an inexpensive way to keep a look out for symptoms and changes in vitals that may require a visit with their doctor. Your workers should ask their doctor about any tools that they can be using.

Don't cut back on health benefits – With the rising health insurance premiums, it may be tempting to offer high-deductible health plans with even higher deductibles. This may keep your premiums where they are compared to the prior year, but it saddles your employees with the potential for even more out-of-pocket expenses.

Urge any employees in HDHPs to sock away funds in their attached health savings accounts for future medical expenses. These accounts are funded with pre-tax dollars and can be saved up for future use. Funds are not taxed when withdrawn, either.

HSAs are portable if the employee changes jobs, and the funds can be invested, much like a 401(k) plan. ❖

Coordinated Care

Centers of Excellence Save Money, and Then Some

AS HEALTH insurance and health care costs continue rising, more employers and health plans are turning to centers of excellence to manage patients with chronic conditions.

Centers of excellence focus on containing costs and delivering quality and coordinated care from diagnoses to treatment and recovery for patients with acute or chronic conditions.

These centers will typically offer bundled-payment programs for high-cost procedures in orthopedics, cardiology, oncology and organ transplants.

A study by the Rand Corporation looked at three major surgical procedures and found that centers of excellence with bundled payments reduce the cost of surgeries by more than $16,000 per procedure. Centers of excellence are available in many health plans and more plans are incorporating them into networks, but they do more than just control costs.

The other benefits

Reduced chance of unnecessary operations – Physicians in centers of excellence will not instinctively opt for surgery for their patients. One study published in the medical journal *Arthritis & Rheumatology* found that one-third of total knee replacement operations were later deemed unnecessary.

As well, medications can be just as effective as inserting stents or conducting a bypass operation in many cases, according to research published in the *U.S. National Library of Medicine*.

Benefits of less invasive procedures

- The employee benefits from not having to undergo surgery, having to deal with anxiety and pain after the procedure, as well as from lower out-of-pocket costs. They also don't have to deal with recovery after the fact.
- The employer and/or health plan saves money by not having to shell out thousands for surgery that could have been avoided.
- The employer benefits from not having an employee off work recovering from surgery.

Happier employees – If an employee feels like they are getting top-shelf treatment from doctors that are skilled at helping them manage a chronic condition, they'll be happier.

Additionally, employees are demanding more from their health plan, including better tools to help them better manage their health.

Centers of excellence also allow patients to skip the processes of comparing different providers and trying to figure out how much they will be paying out of pocket.

Since service costs are bundled and preset, they'll know exactly what they will pay in advance.

Also, they will usually have a single point of contact in the center from the point of first examination, through treatment and recovery. This helps the employee feel like they have an active role in their treatment.

Improved recovery time – One key aspect of centers of excellence is coordinated care, which is often missing in general health care settings. It starts with initial diagnoses through treatment and recovery. And often the post-operation period will be bundled into the costs of treatment.

In many centers, patients will receive assistance in scheduling follow-up appointments and any rehab treatment they require. This close coordination involves patients more in their health care journey. That in turn ensures that they can be on a path to recovery or managing a chronic condition.

The takeaway

Due to demand and the success of centers of excellence, more health plans are including them in their networks. While these programs can reduce costs for the plan and employees, they can greatly improve your employees' health outcomes and ability to recover from surgery.

And if your employees feel like they have a say in their health care while dealing with a chronic condition, they will be more productive and, hopefully, more loyal to your organization.

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Why Your Staff Needs Short- and Long-Term Disability Coverage

NO ONE PLANS on becoming disabled and missing work, but it can happen. An illness or an accident could cause one of your employees to be unable to work for months, or even years.

While their health insurance will cover their medical expenses, it won't cover the cost of living while they recover.

Only 30% of American workers in private industry currently have access to employer-sponsored long-term disability insurance coverage, according to the U.S. Bureau of Labor Statistics.

That means most workers – and their families – do not have adequate protection against one of the most significant financial risks that they face.

That's why you should be offering your employees voluntary short-term and long-term disability insurance.

These policies provide income replacement to enable employees who are disabled to pay bills, including mortgages and college expenses, and to maintain an accustomed standard of living.

Disability insurance replaces a percentage of pre-disability income if an employee is unable to work due to illness or injury.

Employers may offer short-term disability coverage, long-term disability coverage, or integrate both short- and long-term coverage.

Policy Choices

Short-term disability policies: These policies have a waiting period of zero to 14 days, with a maximum benefit period of no longer than two years.

Long-term disability policies: These policies have a waiting period of several weeks to several months, with a maximum benefit period ranging from a few years to the rest of your life.

Disability policies have two different protection features that are important to understand:

Non-cancelable – This means the policy cannot be canceled by the insurance company, except for non-payment of premiums. This gives your employees the right to renew the policy every year without an increase in the premium or a reduction in benefits.

Guaranteed renewable – This gives your employees the right to renew the policy with the same benefits and not have the policy canceled by the company. However, the insurer has the right to increase the premiums as long as it does so for all other policyholders in the same rating class as your employee.

Other options

In addition to the traditional disability policies, there are several options that you can also offer as part of the voluntary benefit package:

- **Additional purchase options.** The insurer gives your employees the right to buy additional insurance at a later time.
- **Coordination of benefits.** The amount of benefits your employees receive from the insurance company is dependent on other benefits they may receive because of their disability. The policy specifies a target amount they will receive from all the policies combined, so this policy will make up the difference not paid by other policies.
- **Cost of living adjustment (COLA).** The COLA increases disability benefits over time based on the increased cost of living measured by the Consumer Price Index. Your employees will pay a higher premium if they select the COLA.
- **Residual or partial disability rider.** This provision allows your employees to return to work part-time, collect part of their salary and receive a partial disability payment if they are still partially disabled.
- **Return of premium.** This provision requires the insurer to refund part of the premium if no claims are made for a specific period of time declared in the policy.
- **Waiver of premium provision.** This clause means that your employees do not have to pay premiums on the policy after they are disabled for 90 days. ❖