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THE **RISK REPORT**

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Affordable Care Act

Insurers Promise to Keep Covering Preventive Services

MOST INSURERS plan to continue offering free preventive care services despite a federal judge having imposed a nationwide injunction on an Affordable Care Act requirement that these services are covered with no out-of-pocket costs on the part of patients.

In response to queries by lawmakers, some of the nation's largest insurers and industry trade associations penned a letter, stating that: "*The overwhelming majority do not anticipate making changes to no-cost-share preventive services and do not expect disruptions in coverage of preventive care while the case proceeds through the courts.*

"Our associations have long supported preventive care and continue to do so. By responding together, we wish to make clear our strong support for continued access to preventive health care for millions of Americans who rely on it."

Signatories to the letter include the Blue Cross Blue Shield Association, the American Benefits Council and America's Health Insurance Plans.

The letter was written in response to Democrats on health committees in the U.S. Senate and House or Representatives asking for information from 12 of the nation's largest health insurers on how they plan to respond to the decision by the U.S. District Court for the Northern District of Texas in *Braidwood Management Inc. vs. Becerra*.

That decision struck down the ACA requirement that most health plans and issuers cover without cost-sharing the more than 100 preventive services recommended by the U.S. Preventive Services Task Force (USPSTF).

The judge in the case reasoned that the ACA requirement to cover with no cost-sharing medications for HIV prevention violates the rights of the plaintiffs who have religious objections to these medicines.

The order immediately blocked the requirement nationwide to cover not only the HIV-prevention medicines, but all preventive services recommended by the USPSTF.

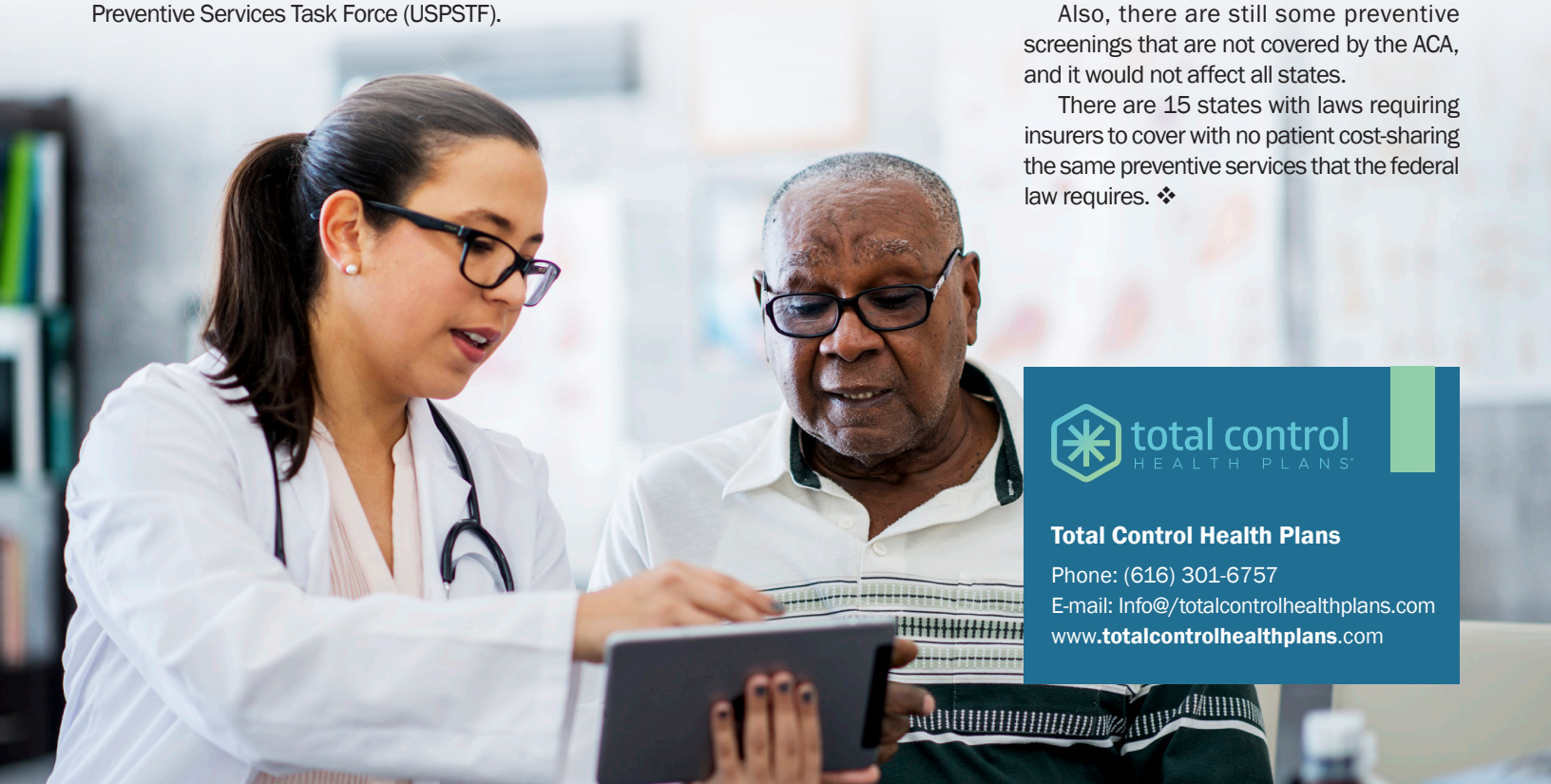
The U.S. Department of Health and Human Services has appealed the decision and has asked that it be paused as the appeal process plays out.

Fallout from the ruling

If the ruling stands and survives appeals, insurers could impose deductibles and copays for potentially lifesaving screening tests.

Also, there are still some preventive screenings that are not covered by the ACA, and it would not affect all states.

There are 15 states with laws requiring insurers to cover with no patient cost-sharing the same preventive services that the federal law requires. ❖



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Total Control Health Plans

Phone: (616) 301-6757

E-mail: Info@/totalcontrolhealthplans.com

www.**totalcontrolhealthplans**.com

Survey Results

HDHP Plan Satisfaction Lags That of Traditional Plans

A NEW STUDY has found that people enrolled in traditional PPOs and HMOs are more satisfied with their plans than those who are enrolled in high-deductible health plans. But satisfaction greatly increases when HDHP enrollees stick with their plan for more than three years, according to the Employee Benefit Research Institute/Greenwald Research "Consumer Engagement in Health Care Survey."

HDHP enrollees enjoy lower up-front premium costs in exchange for higher potential out-of-pocket costs for copays, coinsurance and deductibles, and high health care users may experience significant outlays not covered by insurance.

The sticker shock that comes with paying for those deductibles is likely partly responsible for those feelings. But the report authors noted that there may be other reasons too.

"Lack of experience with their health coverage may account – at least in part – for this difference. Higher out-of-pocket costs may also contribute to the difference in satisfaction, but other disconnects exist," they wrote.

HDHP enrollees also were less satisfied about other aspects of their coverage, with the study finding that:

- 47% of HDHP participants were satisfied with the cost of prescription drugs, compared to 63% of traditional plan enrollees.
- 47% of HDHP participants were happy with the prices they pay for other health care services, compared to 57% of traditional plan members.

That said, the poll did not find any differences in terms of the perceived quality of care that HDHP and traditional plan enrollees receive. The study authors also surmised that it is often employees who are new to the job market and group health insurance that may be most attracted to HDHPs due to the lower premiums.

Interestingly, the survey found that the longer employees stay enrolled in an HDHP plan, the more satisfied they become with it.

As Time Goes On, Satisfaction Grows

- If enrolled in an HDHP for less than one year, just 32% of participants were satisfied with their plan,
- If enrolled one to two years, 44% were satisfied.
- If enrolled three or more years, 55% were satisfied.

Key to HDHP satisfaction

The key to employees being satisfied with their HDHP comes down to educating them in how these plans work, the trade-off between higher out-of-pocket costs and lower premiums, and the importance of taking some of those premium savings and socking them away in a health savings account, if eligible.

Employees who are enrolled in an HDHP with an attached HSA can sock away $3,850 (individual account) in 2023 with untaxed income, which they can later use to pay for medical expenses they incur. For a family account, they can transfer up to $7,750.

While these plans are required to cover 10 essential services and preventive care, as mandated by the Affordable Care Act, most other services and medicines are paid for in full at the insurer-contracted rates with providers and pharmacies.

For people who have chronic conditions, and need regular medical care, an HDHP may not be the best plan. But for those who are healthier and younger and who don't regularly see the doctor, they can save on their premiums by enrolling in an HDHP.

It's important that you make them aware of the advantages and drawbacks of these plans. ❖

A Different Approach

Getting the Benefits of Self-Funding without the Risks

THERE ARE typically two approaches to securing health coverage for your staff – group health insurance or self-funding.

But, self-funding can be costly and risky and is usually only done by larger organizations with thousands of employees. However, there is a hybrid model that can help small and mid-sized employers provide their staff with affordable health coverage: partial self-insuring.

To understand how partial self-insuring workers, we should start with the basics of what a self-insured plan is. In a fully self-insured plan, the employer pays the cost incurred under the plan for claims and administration.

The employer will usually contract with a third party administrator or an insurance company to process claims and provide access to a network of physicians and other health care providers.

Partially self-insured arrangements provide some of the benefits of being self-funded, but without all the risks.

HOW IT WORKS

- Employer and employees still pay premiums, a portion of which goes into an account that will be tapped to pay the first portion of claims that are filed.
- The other portion of the premium is paid to an insurance company. This is sometimes known as a stop-loss policy.
- Plans have an aggregate deductible for all claims filed by employees, meaning that once that deductible is reached an insurer starts paying the claims instead.
- Premiums are calculated to fund the claims to the aggregate deductible amount.
- If claims are lower than expected, the employer can receive a refund at the end of the policy year or use it for the next year.

Lower risk than fully self-insured plan

Typically, an employer should have at least 25 workers if it is considering a partial self-funded arrangement, but we've seen plans with fewer enrollees.

Many employers will opt for a partially self-insured plan to save money, but these types of plans also allow the employer to design a more useful and valuable plan for their workers.

The key to making this work is cost controls, without which claims can spiral and drive up premiums at renewal.

Also, knowing exactly how much to set aside for reserves and how much you should set your employees' premiums, deductibles and other cost-sharing, can be complicated.

With the right mixture of benefits, plan design and education you control behavior, which drives claims, in order to keep renewal rates from increasing too much each year.

The fine print

That said, there some reasons partial self-insuring is not for all employers:

- There is additional responsibility as the employer basically becomes an insurer or sorts.
- There is additional paperwork for these plans since the employer also becomes a payer.
- There are compliance issues that the employer needs to consider (ERISA and the Affordable Care Act, for example).
- There is some additional risk to you as the employer since you are paying claims.
- If you have too many claims, you could face a non-renewal by your stop-loss insurer. If you are cancelled, it may be difficult to seamlessly enter the insured market. ❖

More Employers Expand Mental Health Benefits

AMERICA'S WORKERS are more stressed than ever coming out of the COVID-19 pandemic, and an increasing number of people are also struggling with mental health issues.

When someone is battling addiction or has mental health issues, it affects all aspects of their life, including work. Stress can have a significant adverse impact on business. It costs employers an average of $300 billion a year in stress-related health care and missed work, according to a recent Harris Poll.

That's why more employers are stepping up to provide their workers with benefits to support behavioral health and emotional well-being.

Employee assistance programs

One of the most common ways that businesses have offered support is through employer-paid employee assistance programs (EAPs), which offer a set amount of free mental health services sessions, typically topping out at five to eight per year. But for many people who are experiencing mental health issues, this may not be enough.

Some larger employers have started offering mental health benefits that cover a higher number of therapy sessions and wider range of treatment options, including therapy and mental health coaching.

Additionally, some employers are offering programs that cover a spectrum of behavioral health care options, such as:

- Self-care apps for dealing with occasional stress
- In-person therapy sessions
- Virtual therapy sessions
- Prescription medication to treat common, diagnosable conditions such as anxiety or depression.

Companies usually offer EAPs at no cost to their employees. Most employers operate their EAP through a third party administrator, which can be crucial to the success of your EAP.

You should train management and supervisors on the importance of confidentiality and job protection if one of your staff asks for assistance or raises mental health concerns.

Don't forget your health insurance

There is an extensive list of mental health services your health plan should provide your staff. These services include outpatient and inpatient treatment, telemedicine, medication and counseling. Each of these attributes can be vital for treating mental illnesses.

Of course, there will likely be some out-of-pocket costs for your employees that use these services under their group health plans.

One service that is growing and improving success rates is the continuing evolution of telemedicine. According to the benefits news site *BenefitsPro*, telemedicine can make getting care anonymous and convenient, so patients can receive it where they're most comfortable.

Other options

American workers are more stressed than ever, and some may not need counseling services from an EAP to reduce their life stress. Besides offering an EAP, there are other benefits that you can extend to your workers that can help them better deal with the ordeals of life and work, including:

Parental leave – Becoming a new parent is extremely stressful. If you don't offer parental leave, and instead require parents to take unpaid time off, such as under the Family and Medical Leave Act, this stress is compounded. Paternal leave is paid time off for new parents, either mom or dad, after the birth or adoption of a child.

It gives parents the opportunity to take care of their new child without the stress of work getting in the way.

The benefit to the employer is that when the worker returns from their leave, they are more productive, sooner. Consider offering this to both male and female employees.

Paid time off – PTO combines sick leave and vacation time. It gives employees a set bank of time off at the beginning of each year. Employees can then choose whenever and however they want to use this time off.

Flexible work – Flexible work is a great way to help employees with mental health issues. This benefit can include flexible hours (selecting hours they will work), flexible schedule (selecting when they work) and flexible location (like telecommuting). ❖