Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Health Insurance

HDHPs Can Hamper Employee Health Without an Attached HSA

IN RECENT years high-deductible health plans have grown in use, but if they are not attached to a health savings account (HSA), they can make it difficult for plan participants to afford their health services.

HDHPs typically have reduced premiums in exchange for the employee taking on a higher deductible for health care expenditures.

The average person enrolled in an HDHP saves 42% in annual premiums, compared to those enrolled in preferred provider organization plans, according to research from BenefitFocus.

But in order to afford paying those deductibles, an attached HSA can help them sock away funds pre-tax to ease the burden.

That's because HDHPs may leave families facing at least $2,700 in potential deductibles, and up to $13,500 in out-of-pocket medical expenses per year. In 2018, the average HDHP deductible was $4,133 per year for family coverage and $2,166 for single coverage.

This can pose a problem because:

- 60% of Americans don't have $1,000 in emergency savings.
- 44% would have trouble meeting an unexpected $400 expense.

As a result, many HDHP beneficiaries find themselves putting off care, rationing their medications, or going without altogether. But this often leads to even greater expenses down the road, lost work, productivity losses – and even disability and death.

You can help your workers avoid this by providing an attached HSA, which can be crucial in helping them meet their medical bills.

How HSAs work

HSAs are specifically designed to help people save and pay for their deductibles and out-of-pocket expenses. Benefits include:

- Contributions are tax-deductible. And, if you offer the benefit via a Section 125 cafeteria plan, contributions aren't subject to Social Security and Medicare payroll taxes.
- Balances accrue tax-deferred. If participants don't need to tap their HSA money for health care expenses, once they turn age 65, they can withdraw that money for any reason, penalty-free. All they pay is income tax.
- Withdrawals to cover qualified medical expenses are tax-free.

What to do

You can help your staff get the most out of their HDHPs and HSAs if you:

- Consider contributing to or matching employee contributions to their HSAs.
- Beef up flexible spending account benefits to help workers with current health issues, and to fund preventative care.
- Offer critical illness insurance.
- Implement or expand workplace wellness programs.
- Invest in worksite vaccination and screening programs.

Speak with your insurance carrier or us about using wellness dollars designed to help employees reduce long-term medical costs. ❖

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Health Care

Higher Spending Driven by Rising Prices, Not Over-Use of Services

HEALTH CARE spending per person enrolled in employer-sponsored health plans hit a record high in 2017, driven by increasing prices for medical services and pharmaceuticals and not by over-utilization, according to a new study.

The average medical services and drug spending per employer-sponsored health plan participant increased 4.2% to $5,641 in 2017 from the year prior, according to the "2017 Health Care Cost and Utilization Report" by the Health Care Cost Institute.

While spending increased, the overall use of health care services changed very little over the 2013 to 2017 period, declining 0.2%. In 2017, utilization grew 0.5% compared to 2016.

The total spending per person, however, does not mean that's what health plan enrollees paid on average. It includes what their health plan picked up, in addition to what the individual paid.

Out-of-pocket spending per person increased 2.6% in 2017. The growth was slower than the rise in total spending, resulting in out-of-pocket costs comprising a smaller share of spending by that year.

Out-of-pocket spending comprised 15.4% of total health care spending in 2017. This number has continued to shrink since 2013, when it accounted for 16.1%.

Spending per health plan enrollee (2017)

- Professional services: $1,898 (33.6%)
- Outpatient services: $1,580 (28%)
- Inpatient services: $1,097 (19.5%)
- Prescription drugs: $1,065 (18.9%)

Why spending has increased (2013-2017)

Total annual per-person spending increased 16.7%, rising from an average of $4,834 in 2013 to $5,641 in 2017.

- Per-person spending on pharmaceuticals and medical devices increased 29%.
- Per-person spending on inpatient care rose 10%, even though utilization fell 5% during the same period. The trend was driven mostly by rising prices in medical and surgical admissions.
- Per-person spending on outpatient surgeries jumped 14%, while the number of surgeries slipped 4%.
- Per-person spending on professional services increased 13%.

One of the most notable takeaways from the study is that many young health plan participants have zero claims.

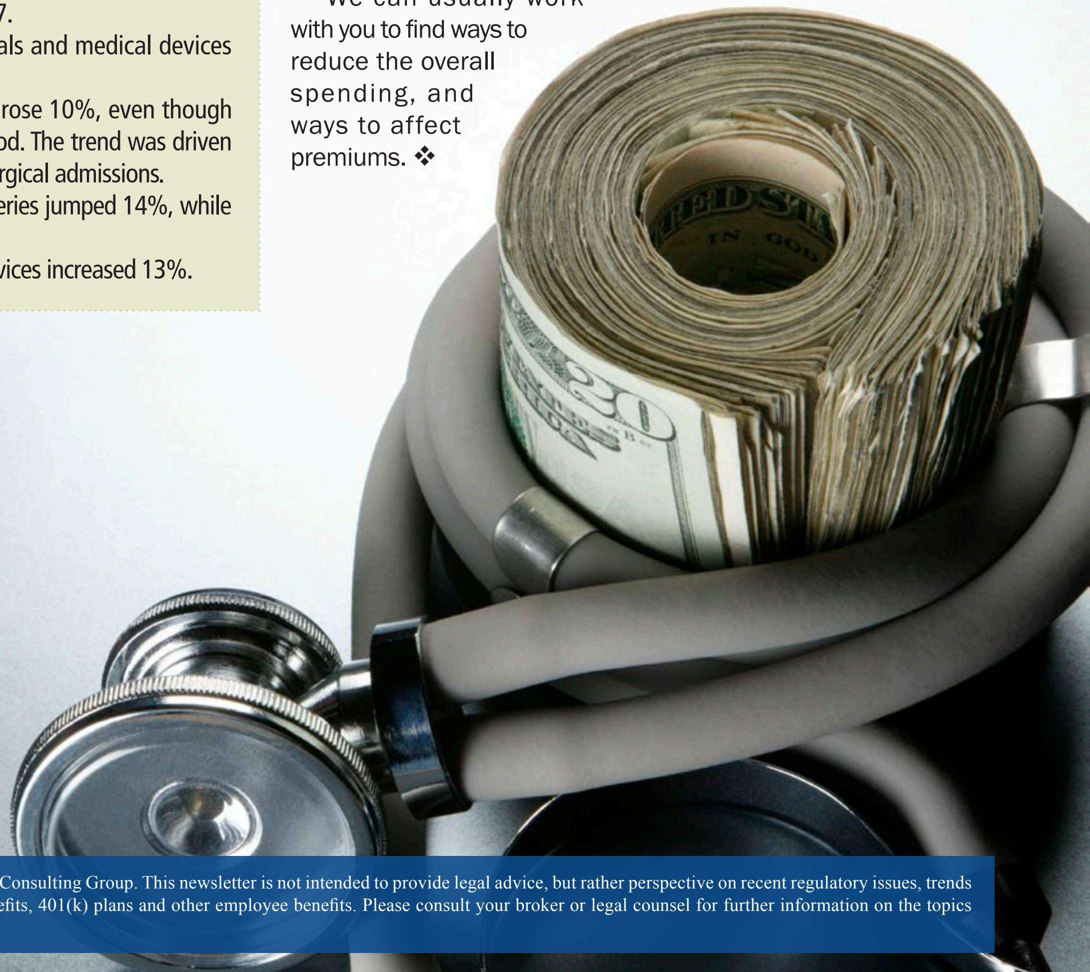
The study found that more than 40% of participants in employer-sponsored health plans between the ages of 19 and 25 had no claims for health care or medications in 2017.

That's compared to 30.4% for those aged 26 to 44, 21% for those 45 to 54 and just 15.8% for those aged between 55 and 64.

The takeaway

If you are concerned about runaway costs on your company health plan, you should give us a call to discuss your options.

We can usually work with you to find ways to reduce the overall spending, and ways to affect premiums. ❖



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Retaining Talent

Getting Benefits Right for a Multi-Generational Workplace

WITH MULTIPLE generations working side-by-side in this economy, the needs of your staff in terms of employee benefits will vary greatly depending on their age.

You may have baby boomers who are nearing retirement and have health issues, working with staff in their 30s who are newly married and have had their first kids. And there are those who are just entering the workforce, who have a different mindset about work and life than the generations before them.

Because of this, employers have to be crafty in how they set up their benefits packages so that they address these various needs.

But don't fret, getting something that everyone likes into your package is not too expensive, particularly if you are offering voluntary benefits to which you may or may not contribute as an employer.

Think about the multi-generational workforce:

Baby boomers – These oldest workers are preparing to retire and they likely have long-standing relationships with their doctors.

Generation X – These workers, who are trailing the baby boomers into retirement, are often either raising families or on the verge of becoming empty-nesters. They may have more health care needs and different financial priorities than their older colleagues.

Millennials and Generation Z – These workers may not be so concerned about the strength of their health plans and may have other priorities, like paying off student loans and starting to make plans for retirement savings.

Working out a benefits strategy

If you have a multi-generational workforce, you may want to consider sitting down and talking to us about a benefits strategy that keeps costs as low as possible while being useful to employees. This is crucial for any company that is competing for talent with other employers in a tight job market.

While we will assume that you are already providing your workers with the main employee benefit – health insurance – we will look at some voluntary benefits that you should consider for your staff:

Baby boomers

Baby boomers look heavily to retirement savings plans and incentives, health savings plans, and voluntary insurance (like long-term care and critical illness coverage) to protect them in the event of a serious illness or accident.

You may also want to consider additional paid time off for doctor's appointments, as many of these workers may have regular checkups for medical conditions they have (64% of baby boomers have at least one chronic condition, like heart disease or diabetes).

Generation X

This is the time of life when people often get divorced and their kids start going to college. Additionally, this generation arguably suffered more than any other during the financial crisis that hit in 2008.

You can offer voluntary benefits such as legal and financial planning services to help these workers.

Millennials and Generation Z

Some employee benefits specialists suggest offering these youngest workers programs to help them save for their first home or additional time off to bond with their child after birth.

Also, financially friendly benefits options, such as voluntary insurance and wellness initiatives, are two to think about including in an overall benefits package.

Voluntary insurance, which helps cover the costs that major medical policies were never intended to cover, and wellness benefits, including company-sponsored sports teams or gym membership reimbursements, are both appealing to millennials and can often be implemented with little to no cost to you. ❖

Senior Health Insurance

Medicare Changes Take Aim at Drug Costs, Push Telemedicine

A SERIES OF changes to Medicare programs may lead to lower drug prices for some Medicare Part D and Medicare Advantage enrollees, expand services to include transportation and telemedicine, and bring hospice benefits to Medicare Advantage patients.

Drug plan changes

Under the Part D Payment Modernization Initiative, the Center for Medicare Services is revising the way Medicare compensates private insurers, with the intent of increasing competition and creating incentives for them to lower drug prices and reduce costs for plan enrollees.

Under the current system, once a patient's spending reaches the "catastrophic" threshold, Medicare picks up 80% of the cost of the individual's drugs. Insurers have designed their plans to get patients to the catastrophic threshold as quickly as possible, so they can qualify for the higher federal subsidies.

As a result, federal spending for drugs under the catastrophic phase has skyrocketed 17% per year over the last decade, rising from $9.4 billion to $37.4 billion.

"This structure introduces perverse incentives to push patients to the catastrophic phase and leave plans with little reason to negotiate lower costs for the highest spending patients," said the Center for Medicare Services' administrator, Seema Verma.

Under the new plan, which takes effect in 2020, insurers will be picking up a greater share of the prescription drug tab for patients in the catastrophic spending category. In return, they will have opportunities to share in overall cost savings under the plan.

The Part D Payment Modernization Initiative is part of President Trump's broader Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs. The plan will create more incentives for plan participants, carriers and care providers to choose lower-cost drugs where possible.

Value-based insurance design expansion

At the same time, Medicare is expanding a new "value-based" benefits model to all 50 states. Under the scheme, called V-BID (Value-Based Insurance Design), Medicare Advantage plans will have more flexibility to offer cost-saving alternatives:

- Lower copays
- Better plan design for lower-income beneficiaries
- Assistance with treatment-related transportation costs
- Incentives for preventive care and healthy lifestyle changes.

Telemedicine

V-BID would also allow plans to cover telemedicine consultations – a key change that could lower overall costs while allowing plans to extend their reach into previously underserved rural areas where they had difficulty covering because of federal network adequacy rules.

The change may help improve competition and choice in underserved areas.

Hospice benefits

Plans are also afoot to allow Medicare Advantage plans to start offering Medicare's hospice benefit beginning in 2021.

Today, the hospice benefit is covered separately under fee-for-service Medicare, so patients do not have a single provider network that is managing all of their conditions and taking responsibility for their overall health.

The change is designed to increase access to hospice services and encourage better coordination between patients' hospice services and their other clinicians.

"These two models ignite greater competition among plans, creating pressure to improve quality and lower costs in order to attract beneficiaries," Verma said. ❖