ECG NEWSALERT

September 2022 | Volume 6 | Issue 9

Employee Poll

Most Workers Make Bad Health Insurance Decisions

A NEW survey has found that many people who receive employer-sponsored health coverage understand surprisingly little about their health plans and are leaving money on the table.

The "Health Insurance Literacy Survey" by *Healthcare.com* found widespread misunderstanding about how copays and deductibles work, and what premiums and benefits are.

When people don't understand their insurance they may make poor decisions, such as choosing plans that provide more benefits than they need, or too few, experts say.

Those poor choices can be costly in terms of the premiums they pay or what they pay in copays, coinsurance and deductibles out of pocket.

Key findings

- 26% of Americans surveyed say lack of health insurance understanding caused them to receive a higher-than-expected medical bill.
- 41% were unable to correctly answer what in-network means. Understanding the meaning of "in-network" is crucial when choosing where to receive treatment and avoiding paying excessive fees. Most health plans do not cover out-of-network care.
- 59% don't understand that low-deductible health insurance plans start paying out sooner than high-deductible plans.
- 43% of those surveyed could correctly identify what a health savings account is, but 20% could not describe a single feature of these tax-advantage accounts.

What it costs them

The costs of choosing the wrong plan can be in the thousands of dollars per year, according to a 2021 analysis conducted by Trevor Collier and Marlon L. Williams, both associate professors of economics at the University of Dayton in Ohio.

Collier and Williams found that 23% of employees who would have been better off choosing a plan that had lower premiums, but higher cost-sharing, instead chose a higher premium plan anyway.

They calculated that the cost of choosing the wrong plan was more than $2,000 per year.

What you can do

During your open enrollment meetings, you should go over some of the basics of coverage and explain that people who are not frequent health care users may be better off in high-deductible health plans, that have a lower premium in exchange for more out-of-pocket expenses.

Conversely, people who have chronic conditions are not good candidates for HDHPs.

Make sure to schedule a series of meetings in the run-up to open enrollment where you can go over the basics of how health insurance works. Get your human resources team to urge staff to schedule time with them if they have any questions. ❖

ECG
Einstein Consulting Group

Missouri: 1120 S. 6th Street (Suite 201)
St. Louis MO 63104
Illinois: 280 North Main Street,
Breese, IL 62230

Phone: 877.324.2114
Fax: 888.274.1538
Email: info@ecgins.com

Cost Trend

Group Health Premiums Set to Rise 6.5%: Poll

EMPLOYERS CAN expect to see their group health insurance premiums climb an average of 6.5% in 2023 from this year, according to a new study.

Economic inflationary pressures will push the average premium cost per employee to about $13,800, compared to about $13,020 for 2022, according to the study by professional services firm Aon.

While the expected increase is higher than the average 3.7% rises in 2021 and 2022, it's still lower than the current 9.1% increase in the Consumer Price Index, a key measure of inflation.

What's happening

In 2020, the first year of the COVID-19 pandemic, health care usage plummeted as many people put off routine health care. Also, many providers stopped doing non-emergency care like knee replacements.

Health insurers paid out far less in claims in 2020 than they did the year prior, even though many people were being hospitalized after contracting the coronavirus.

Since then, medical care has returned to the same pre-pandemic level, but with a twist: All those skipped procedures in 2020 and 2021 are now being performed and most hospitals have backlogs for many procedures like colonoscopies and cancer screenings.

Other contributing factors affecting rates include:

New technologies – This includes new machinery hospitals are using, as well as increased use of telemedicine.

Catastrophic claims – The severity and cost of catastrophic claims continues increasing substantially.

Chronic conditions – More Americans are battling chronic conditions, which can quickly drive up their cost of care.

Blockbuster drugs – New groundbreaking, yet costly drugs keep hitting the market.

Specialty drugs – Doctors are prescribing more specialty drugs, which also have high price tags.

Employers curtail cost-shifting

As costs have increased, employers seem to be absorbing most of the premium increases and have grown reluctant to pass on more of the premium cost to their employees.

On average, employers subsidize about 81% of the plan cost, while employees pay the remainder. According to the Aon report, in 2022, when the average annual group health insurance premium increased 3.1% to $13,020 per employee, from $12,627 in 2021, employers took on more of the premium burden.

The Shifting Cost Burden

	2021 Portion of premium	2022 Portion of premium	
Employer	$10,123	$10,500	+3.7%
Employee	$2,504	$2,520	+0.6%
	2021 Employee costs	**2022 Employee costs**	
Share of premium	$2,504	$2,520	+0.6%
Out-of-pocket	$1,800	$1,892	+5.1%
Total employee cost	$4,304	$4,412	**+2.5%**

Looking ahead

When insurers quote your group coverage, they look at your claims experience and the costs your employees incur overall. Employees with chronic conditions can quickly increase those costs.

As a result, many employers are focused on helping their workers with chronic and complex conditions rein in those costs.

One way is to offer wellness plans that help them improve their overall health, such as smoking cessation, exercise and weight loss programs. ❖

Preparing for 2023

Getting a Head Start on Open Enrollment

AS OPEN ENROLLMENT is right around the corner, now is the time to gear up to maximize employee enrollment, help them make the best selections for their own personal circumstances, and stay compliant with relevant laws and regulations.

It's a lot to take in as uncertainty has been a constant during the last few years with the COVID-19 pandemic and its lingering effects on people's health and the economy.

Still, since health coverage and other employee benefits are an important part of your compensation package – and your competitive edge for talent – it's important that you get it right, particularly now with the intense competition for talent.

Here are some pointers to make open enrollment fruitful for your staff and your organization.

Review what you did last year

Review the results of the previous year's open enrollment efforts to make sure the process and the perks remain relevant and useful to workers. How effective were various approaches and communication channels, and did people give any feedback about the process itself?

Start early with notifications

You should give your employees notice at least a month before open enrollment to let them know it's coming, as well as provide them with information on the various plans you are offering. Encourage them to read the information and come to your human resources point person with questions.

Help them sort through plans

You should be able to help them figure out which plan features fit their needs, and how much the plans will cost them out of their paycheck. Use technology to your advantage, particularly any registration portal that your plan provider offers. Provide a single landing page for all enrollment applications.

That said, you should hold meetings on the plans and also put notices in your employees' paycheck envelopes.

Plan materials

Communicate to your staff any changes to a health plan's benefits for the 2023 plan year through an updated summary plan description or a summary of material modifications.

Confirm that their open enrollment materials contain certain required participant notices, when applicable – such as the summary of benefits and coverage.

Check grandfathered status

A grandfathered plan is one that was in existence when the Affordable Care Act was enacted on March 23, 2010 and is thus exempt from some of the law's requirements. If you make certain changes to your plan that go beyond permitted guidelines, the plan is no longer grandfathered.

If you have a grandfathered plan, talk to us to confirm whether it will maintain its grandfathered status for the 2023 plan year. If it is, you must notify your employees of the plan status. If it's not, you need to confirm with us that your plan comports with the ACA in terms of benefits offered.

ACA affordability standard

Under the ACA's employer shared responsibility rules, applicable large employers must offer "affordable" plans, based on a percentage of the employee's household income. For plan years that begin on or after Jan. 1, 2023, the affordability percentage is 9.12% of household income. At least one of your plans must meet this threshold.

Out-of-pocket maximum

The ACA's out-of-pocket maximum applies to all non-grandfathered group health plans. The limit for 2023 plans is $9,100 for self-only coverage and $18,200 for family coverage.

Make sure your plans are in line with these figures.

Other notices

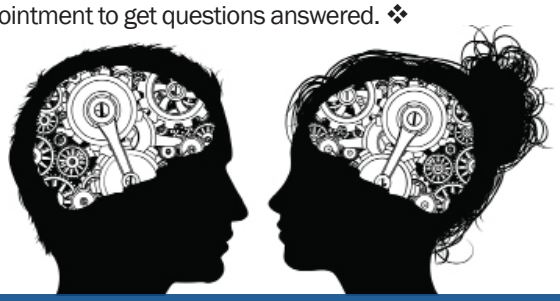
Consider also including the following notices:

- Initial COBRA notice.
- HIPAA notice. This may be included in the plan's summary plan description.
- Notice of HIPAA special enrollment rights.
- HIPAA privacy notice.
- Summary plan description.
- Medicare Part D notices.

Get spouses involved

Benefits enrollment is a family affair, so getting spouses involved is critical. You should encourage your employees to share the health plan information with their spouses so they can make informed decisions on their health insurance together.

Also encourage any spouses who have questions to schedule an appointment to get questions answered. ❖



Controlling Cost and Risk: Is an ICHRA Right for Your Business?

EMPLOYERS ARE constantly facing the battle of providing competitive health care benefits as the costs of providing group health coverage continue rising.

For companies that are on the fence about offering group health insurance, there is an option called the individual coverage health reimbursement account, or ICHRA for short.

ICHRAs were made legal by a law enacted in 2020, which in part overturned provisions of the Affordable Care Act, that barred reimbursing workers for the cost of health insurance they purchase either on a government-run exchange or in the private market.

There are both benefits and pitfalls to ICHRAs.

How they work

With an ICHRA, the employer determines a set budget to pay into the account, the funds in which are used to reimburse employees for a health insurance policy that they purchase on their own.

Some companies will also put additional funds into a health reimbursement account to help them pay for out-of-pocket expenses like copays and deductibles.

Pros

For the employer, the ICHRA provides a degree of certainty in their benefits budget. They won't be affected if they have one or two employees in their group health plan who are high users of medical benefits and cause the group's premiums to rise.

There is less administration, and fewer compliance issues.

Employers also have flexibility in that they do not have to treat all classes of employees the same.

The amount offered for reimbursement can be the same for all employees; or it can vary by class of employee, their age or family size. An employer can structure the reimbursement amount to increase for older workers and/or for workers with more dependents.

Employees do not pay income taxes on premium reimbursements.

The arrangement is simple for employees.

Employees who shop on the individual market also have more flexibility and can choose from a wider menu of health insurance plans.

Cons

Employers usually need time and resources to:

- Fully understand how they work,
- Decide whether the business will administer an ICHRA in-house or hire an outside administrator,
- Consider employee circumstances and needs in relation to health coverage,
- Decide whether the ICHRA is offered to all or certain classes of employees, and
- Explain how the ICHRA works to employees, particularly if they are moving from a group health model.

Additionally, an ICHRA is not good for all employees. These plans place restrictions on employee eligibility.

ICHRA rules require employees to purchase an individual health plan. They may not be on a spouse's employer group health plan.

Businesses Best Suited for a Plan

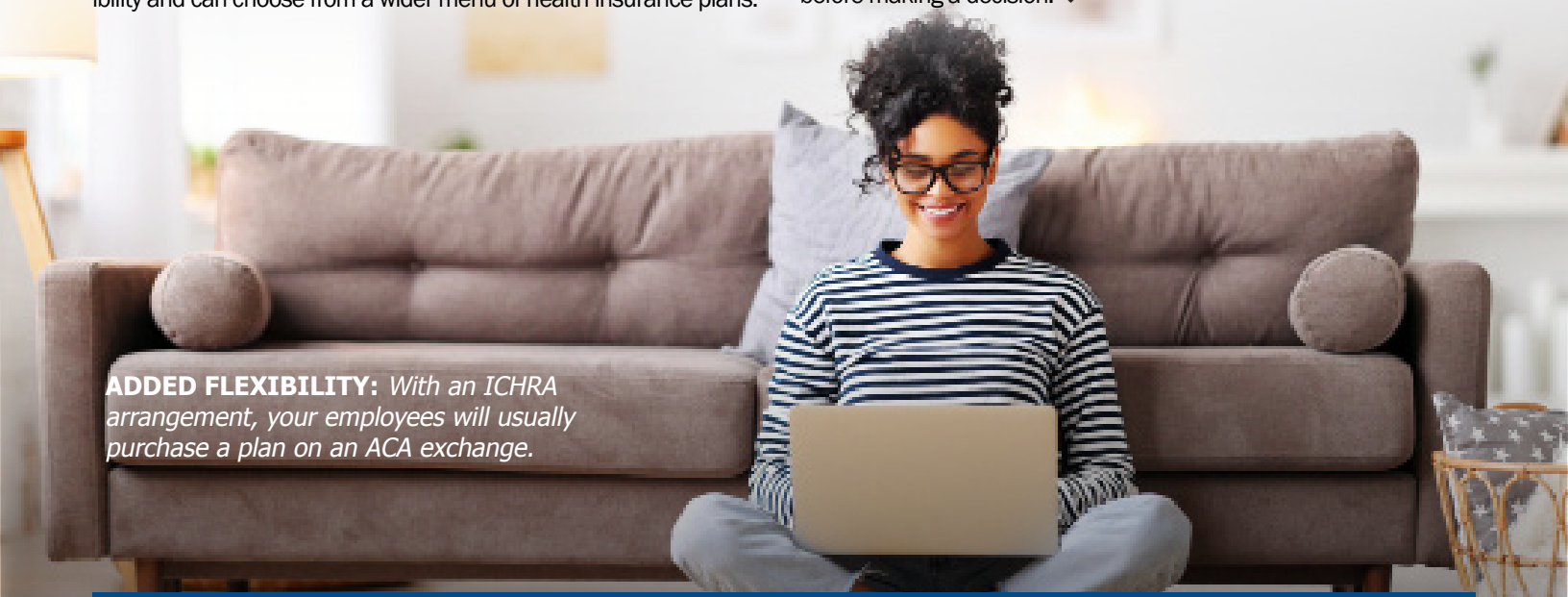
ICHRAs tend to work well for businesses with:

- High employee turnover,
- A substantial number of lower-paid workers,
- A mix of salaried and hourly workers, and/or
- A mix of workers at company site and remote workers in other regions.

The takeaway

Offering an ICHRA if you are an "applicable large employer" under the ACA comes with additional strings. These employers, which have 50 or more full-time workers or equivalents, must comply with the ACA's affordability and coverage rules.

We can help you determine whether an ICHRA is a good option for your organization and employees, or if you should offer a more traditional group health plan. It's important to understand the differences and nuances between an ICHRA and a group health insurance offering before making a decision. ❖



ADDED FLEXIBILITY: *With an ICHRA arrangement, your employees will usually purchase a plan on an ACA exchange.*