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NEWSALERT
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Coverage Trend

Gen Z Workers Go for HDHPs; Don't Forget Other Staff

WHILE THE number of U.S. workers choosing high-deductible health plans has leveled off during the last two years, uptake has been growing rapidly among one segment of the working population: Gen Z employees.

The 2024 "State of Employee Benefits Report" by benefits administration provider Benefitfocus found that 45% of Gen Z workers and 43% of millennial workers surveyed were enrolled in HDHPs. The report notes 84% of employers offer both HDHPs and traditional health plans to ensure that they can met the needs of a multi-generational workforce.

It emphasizes that employees often choose health plans that will end up costing them more than it should in terms of out-of-pocket expenses or premiums, and that employers should help by providing assistance and education.

Study results

The trend of more Gen Z workers gravitating to HDHPs makes sense, since these plans are best suited for younger individuals who generally have fewer health problems than their older counterparts — Gen Xers and Baby Boomers.

HDHPs feature higher deductibles and more out-of-pocket expenses in exchange for lower premiums upfront. The plans are typically tied to a health savings account (HSA), which employees can fund with pre-tax dollars to reimburse for health-related expenses.

But employers are cautioned against offering just HDHPs as they are not a good fit for everyone, particularly those who are regular users of their health plans or have chronic conditions that require more doctors' visits, medical procedures and medications.

Key Findings

- 64% of health plan enrollees selected a traditional plan in plan year 2024, compared to 69% in 2022.
- Higher-salaried individuals chose HDHPs over traditional plans.
- Generation X had the highest premiums compared to other generations.
- Employers covered 78% of their employees' premiums on average, up from 74% in 2022.

Choosing the wrong plan could end up costing employees in:

- Upfront premiums for an unnecessary expensive plan with strong benefits that the employee may not use because they are young and/or healthy, or

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New Fiduciary Rule Affects Employers That Offer HSAs

THE DEPARTMENT of Labor's new fiduciary rule, which mainly applies to 401(k) plans, will also affect employers who offer their staff health savings accounts.

The new rule, which takes effect September 2024, bars employers from providing advice to their workers on how they should invest the funds in the HSA they offer. It should be noted that just offering an HSA does not, in and of itself, make a sponsoring employer a fiduciary, as long as the employer doesn't cross the investment advice line.

While HSAs are used to save for medical costs in the future, account holders can invest the funds in them just like they can with 401(k) plans and allow those returns to accrue over the years. HSAs are also portable, meaning they can be moved from one employer to the next, and they can be kept until retirement years.

Since HSAs were established 20 years ago, they have typically been exempt from ERISA, but this new rule changes that.

The rule states that a fiduciary may not receive a fee in connection with providing investment advice, which could occur when, for example, an individual recommends an HSA investment, investment strategy or rollover and receives a commission.

More importantly for employers, the new rule expands the definition of fiduciary advice to cover a one-time recommendation.

Investment education

That doesn't mean that employers can't educate their workers on the features of their HSAs. That's because under current Department of Labor regulations, there has been a long-standing exception from fiduciary status if an individual or organization is providing "investment education."

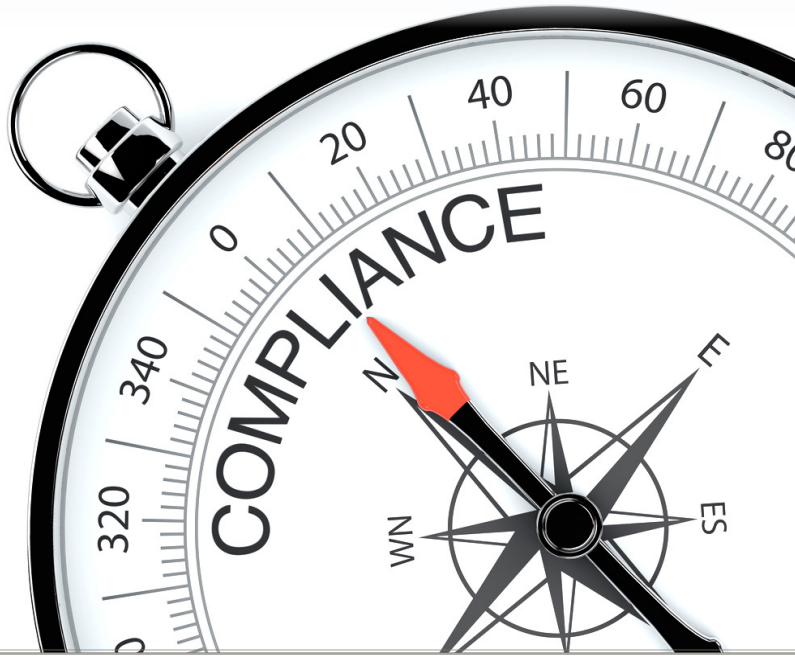
For example, employers may provide a wide range of information about the HSA program they offer, including the types of investments account holders have access to, without assuming fiduciary status.

Safe Topics

Topics that do not create a fiduciary relationship include information about:

- The benefits of participation,
- The benefits of increasing contributions,
- Investment fund strategies and objectives, and
- Fees and expenses.

To avoid fiduciary status, you simply should refrain from recommending how employees invest their HSA funds. ❖



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Seven in 10 Workers Want Help in Choosing Health Plans

- Out-of-pocket expenses if they choose a plan that has a high deductible when they are frequent users of medical services, either due to pre-existing conditions or other issues that crop up later in life.

What you can do

The report recommends that employers:

Focus on assistance and education – The study found that 70% of workers want help from their employer to better understand the employee benefits they are enrolled in or are considering.

To help your staff choose the plan that's going to give them the most bang for their buck, your guidance and advice can be crucial. During your educational sessions, provide scenarios of how choosing the wrong plan can financially burden an enrollee. Provide tools that can help them ascertain which plan is right for them.

Offer a mix of plans – To ensure that employees have access to the health plan that is best for their health circumstances and budget, you should offer a mix of HDHPs and traditional health plans like health maintenance organizations and preferred provider organizations.

You can tailor your employee benefits educational sessions to each generation. Make sure not to overgeneralize, as there are instances when a younger person should be in an HMO or PPO.

Offer voluntary benefits – Not all voluntary benefits are created equal, and some add more value than others. These plans complement an existing health insurance plan by providing a financial backstop when faced with an unexpected medical emergency (see story on page 4). ❖

Demand for Coverage Grows as Workers Try to Defray Costs

SALES OF voluntary group benefits grew at a record pace in 2023, as more employers expand their offerings and demand continues booming as employees seek out benefits that can defray costs, according to new research.

Premiums collected for employer-sponsored voluntary benefits jumped 6.7% during the year to an aggregate $9.3 billion, with all lines of coverage contributing to the growth, according to the Eastbridge Consulting Group's annual "U.S. Voluntary/Worksite Sales Report."

The findings underscore the value that employees place on these benefits, particularly in defraying health care-related costs.

Ancillary Benefit Sales Surge

- Group term life insurance premiums increased 10% from the 2022 level.
- Group universal life and whole life were up 9%.
- Critical illness insurance premiums were up 7%.
- Hospital indemnity premiums were 6% higher.
- Dental coverage was up 5%.
- Short-term disability coverage was up 4%.
- Accident insurance rose 4%.

Source: U.S. Voluntary/Worksite Sales Report 2023

The biggest driver: personal finances

One of the main drivers of this surge in employee uptake of voluntary benefits is that they can often defray expensive and sudden expenses.

With the increase of high-deductible health plans and the resulting potential high out-of-pocket expenses workers may face, they are gravitating towards products that can provide much-needed cash in case of an unexpected event. These include many of the benefits that have seen strong sales growth in the last few years:

Accident insurance – This coverage provides a lump-sum cash payment to an individual due to an event covered under the policy. The funds can be used as needed to help cover things like deductibles, out-of-pocket medical costs or everyday living expenses.

Critical illness insurance – This provides a lump-sum payment or monthly payments to help cover expenses if a policyholder is diagnosed with a serious illness covered by the policy. This type of insurance supplements their existing health insurance and is designed to help them focus on recovery instead of costs.

Hospital indemnity – Hospital indemnity insurance supplements existing health insurance coverage by helping pay expenses for hospital stays.

Depending on the plan, the insurance gives the policyholder cash payments to help pay for the added costs that may arise while they recover.

Other products that help policyholders save money include dental and vision insurance, pet insurance (in the face of massive increases in veterinary costs), income protection and telemedicine services.

The takeaway

There are a number of other voluntary benefits that employers can offer, but the above are the ones that directly can help your employees if medical bills hit unexpectedly.

Premiums for these various coverages are either paid by the employer, split between the employer and employee or solely paid by the worker. Arrangements will vary between employers. Premiums are often reasonable.

More importantly, these coverages offer peace of mind that in the event of an accident or illness, the related expenses won't break the bank. ❖

EMERGENCY COVERAGE: *Accident insurance can provide a valuable financial backstop for your workers.*

Narrow Networks, Tiered Plans May Reduce Costs

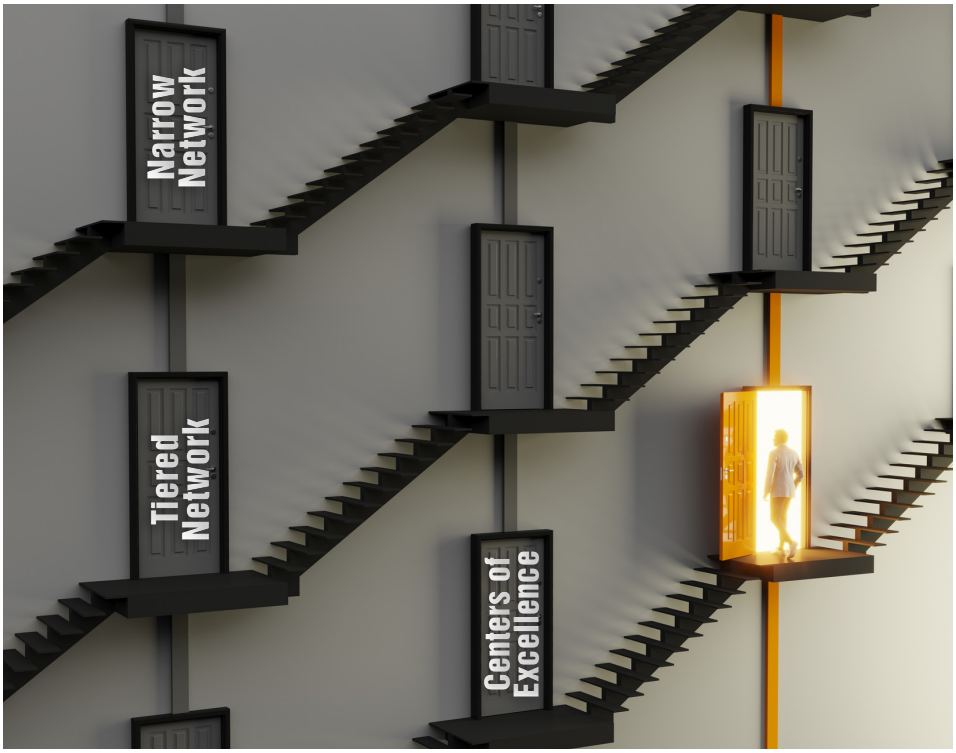
INFLATION, AN aging workforce and people catching up on care they skipped during the COVID-19 pandemic are some of the factors that will drive health benefit costs over the coming years.

Health spending dropped considerably in 2020 and 2021 as people stayed away from health care environments, but now they are back seeking care that was delayed. That's caused a sudden spike in claims for health plans across the board.

Also, more health plans have boosted their mental health offerings, which patients have been taking advantage of, leading to further outlays, according to a recent report by Marsh McLennan Agency.

Studies predict group health plan costs will rise an average of 6% in 2023, more in some markets.

Despite that, employers may be able to employ a combination of measures to defray cost increases.



Compare insurance plans and providers

If you've been offering the same plans every year, we can work with you to compare providers to see if there are better deals for you among their competitors.

Also, plans can vary among insurers plans and each insurer will have different deals to offer.

Even your current slate of insurers may have plans that you are not offering.

It is important to keep in mind that a lower premium does not mean it's the best deal. Some lower-cost plans may have very narrow networks, which could result in some employees losing access to their regular doctors.

That said, there's been a trend towards so-called "high-performance," narrow provider networks that aim to reduce costs while maintaining efficiencies and quality of care.

Other cost-saving measures

Insurance carriers have been trying out new approaches to controlling costs, while improving health outcomes for their plan enrollees.

Money spent up front on quality health services can yield future savings if the patient needs less treatment.

Some insurers and self-insured employers have been able to generate savings of 5 to 15% by employing:

Tiered networks – These health plans sort providers into tiers based on their cost and, often, quality relative to other similar providers who treat comparable patients.

Providers with higher quality and lower cost are typically given the most-preferred tier rankings.

Centers of excellence – Many self-insured employers and more health plans are also contracting with "centers of excellence." While there is no specific definition of a COE, these providers deliver positive patient outcomes, lower costs, raise member engagement and have high rates of patient satisfaction.

Often, an OEC may have a specialty, like a chronic disease or a specific service such as radiology. Working in tandem with a clinical analytics vendor, payers will connect members with health systems that demonstrate high performance in these areas.

Referral management – More health plans are also starting to use referral management software to improve efficiency and trust in care coordination.

These systems synchronize patient data transmission from one physician to another, and also to the patient.

A referral management system aims to facilitate good communication between the consultant, specialist, health care provider and the patient.

The system increases trustworthiness and transparency of treatment and diagnosis, and decreases inefficiency in care coordination and operational arrangements.

The takeaway

The above measures can be applied across the care continuum — hospitals, primary care, specialty groups, post-acute providers and ancillary care — while maintaining access and quality of care.

Getting the cost equation right will be a challenge in the coming years as premiums are expected to rise at a faster clip than they have been in the last five years.

Talk to us about finding health plans that are offering different structures for addressing costs while also improving care for your workers. ❖