Employee Benefits Report

HB Resources Insurance Services

Employee Benefit Planning

1470 Civic Court, Suite 330, Concord, CA 94520
Phone: 925-671-0248 • Fax: 925 671-0236
Email: denise@hbrinsurance.com • Web: www.hbrinsurance.com

Health Care | March 2019 | Volume 17 • Number 3

Millennials – Changing the Health Care Landscape

Studies show that millennials are not interested in having a primary care doctor. They are looking to the Internet, urgent care and employers to help with their health care needs.

Millennials are the 83 million Americans born from 1981 to 1996 and who are now 23 to 38. The U.S. Census Bureau population projections indicate that in 2019 millennials will surpass Baby Boomers as the largest living adult generation.

For decades, patients have had trusted relationships with primary care physicians. These internists, family physicians or general practitioners coordinated the patients' care, ordered tests, offered treatments and made referrals.

That is changing. According to a Kaiser Family Foundation survey, of the 26

continued on next page

Expanded Hardship Distribution Rules Proposed for 401(k) Plans

The Internal Revenue Service (IRS) has proposed regulations that will make it easier for employees, who are facing a hardship, to take money out of their 401(k) retirement accounts. The IRS defines a hardship as an "immediate and heavy financial need" and is "necessary to satisfy the financial need."

The changes will be made to the hardship rule section of the Bipartisan Budget Act of 2018 that took effect Jan. 1, 2019, and make hardship distributions more widely available and easier for plan sponsors to administer.

The proposed regulations eliminate the rule under the non-safe harbor standard that currently requires a plan sponsor to

continued on next page

percent of respondents who said they don't have a primary care physician, almost half were 18-to-29 year olds.

Observers say some of the disinterest can be attributed to age. As people age, it's more likely they'll need a doctor who understands their medical history. In addition, experts believe millennials eat healthier than their parents and may rebound faster from illnesses.

As an employer, it's important you understand why the need for a primary care doctor is declining and how it affects you.

Insisting on Convenience

In the past, when people wanted treatment after hours, their only option was an expensive trip to an emergency room. Millennials now have the option of reasonably priced visits to retail clinics in drugstores, big-box retailers or free-standing urgent care centers. These are open evenings and weekend hours and cost as little as $40 per visit.

Telehealth also offers convenience. Millennials can call or video conference with a physician any time of day — sometimes for free. These physicians often can prescribe and send prescriptions directly to the pharmacy.

This care-on-demand option is a good fit with millennials' schedules. They don't have to miss work or change their schedules for an appointment. By comparison, a 2017 survey by Merritt Hawkins, a physician search firm, found that the average wait time for new-patient appointments with a primary care doctor is 24 days — partially explaining why retail clinics are growing in popularity and number. Rand Corporation researchers say there are more than 2,700 retail clinics in the United States.

Technologically Savvy

Millennials grew up using technology. They interact with their friends on social networks, and book services, such as flights, hotels, and hair appointments through the Internet or smartphones. A takeout meal is just a quick call away.

The health care industry, which in many offices, still uses fax machines, for example, has not kept pace with technology. Some doctors have websites, but patients still need to phone the office when making appointments.

Millennials demand easier access to their providers and are more likely to use the Internet to research their symptoms. Google and WebMD are two favorites for self-diagnosing.

When they decide to see a doctor, millennials often will check online reviews or ask friends for recommendations. Nuance Communications conducted a survey finding that 54 percent of millennials use online reviews to find a doctor before scheduling an appointment and are twice as likely as non-millennials to trust personal and social network reviews when selecting health care providers.

Cost Considerations

The average millennial income is lower than that of previous generations and many young people are saddled with high student loan debt. Health care coverage costs are a prime concern. Only seeking treatment when needed or delaying treatments are two ways millennials manage costs.

Looking to Employers to Provide Assistance

Data from the 2014 Consumer Health Mindset report, conducted by consultancy Aon Hewitt, the National Business Group on Health and The Futures Company, show that more than half of millennials want employers to play an active role supporting their overall health and wellbeing. It also showed millennials are open to having their direct manager play an active role in encouraging them to stay healthy.

To better meet these needs, Aon Hewitt experts suggest employers get to know this generation better. For instance, more than half of millennials reported that they are more motivated "to look good", than to "avoid illness". Therefore, employers will find it more effective to tailor their strategy and communications to show how poor health can impact an individual's energy and appearance.

determine whether a distribution is necessary to satisfy a financial need based on all the relevant facts and circumstances. The IRS has provided one general standard for determining whether a distribution is necessary.

While you, as an employer, may implement some of these changes retroactively to apply as of Jan. 1, 2018, you are not required to amend your plans this year.

As always, consult your broker for guidance on steps you will need to take for your plan administration. For more information about the Bipartisan Budget Act of 2018, visit www.congress.gov/bill/115th-congress/house-bill/1892/text. For more information about the proposed changes, visit https://tinyurl.com/ybp3ucpn.

continued on next page

Bearing in mind that millennials are technologically savvy, employers should take advantage of apps and mobile-friendly websites to help engage employees in health and wellness campaigns.

Programs that aim to improve employee health should be easy and convenient. Examples include: walking meetings, group fitness events or onsite health and fitness programs such as yoga or Zumba.

Also, consider adding a competitive element, such as games or mini-challenges because millennials are likely to be interested in friendly competitions.

Long-term Effects

Convenience and cost savings are great, but some experts warn that moving away from a primary care relationship can actually worsen health and raise costs for individuals in the long run. Undiagnosed physical and mental health problems can worsen. A primary care doctor, particularly for people with chronic conditions, can provide continuous and personalized care.

A recent report in *JAMA Internal Medicine* found that nearly half the patients who sought treatment at an urgent care clinic for a cold, flu or a similar respiratory ailment left with unnecessary and potentially harmful prescriptions for antibiotics, compared with 17 percent of those seen in a doctor's office.

Although walk-in clinics may be fine for some illnesses, few are equipped to provide holistic care. ■

Hospital Prices Now Must be Published Online – But is it a Game Changer?

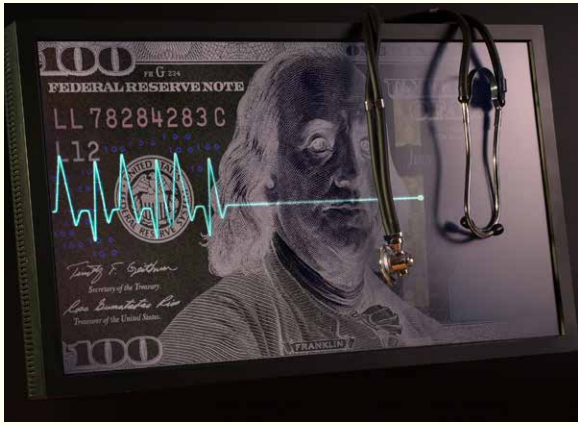
Want to know how much a procedure is going to cost you at a particular hospital or medical facility? Look no further than the Internet.

The Centers for Medicare and Medicaid Services (CMS) previously required hospitals and other health care providers to make a list of their standard charges available to the public. New CMS regulations mandate that the pricing information for procedures and services also be posted online. Hospitals can use any format, as long as the information is accessible on the Internet and machine readable. The regulations went into effect at the beginning of the year.

A hospital's list of prices for billable items and services is called a Charge Description Master or chargemaster. Hospitals use the list to negotiate prices with insurers — therefore the list is more of a bargaining tool and not a realistic reflection of the actual cost of delivering a service.

The federal rule is intended to increase transparency and make it easier for patients to compare costs between facilities. The prices, however, only tell patients what a procedure will cost if the hospitals and insurance companies are out of network or do not have contract agreements.

Advocates for transparency point out that consumers would never buy anything at a grocery store or restaurant without knowing the price. Why would they want to get a medical procedure without knowing the costs or being able to compare prices?



Challenges to Overcome

Patient advocates point out that the data alone might not necessarily achieve the goal of transparency.

Usually, only those who are uninsured pay the listed price. Individuals who have private health insurance pay a discounted rate for procedures if they go to a medical facility that is considered "in network." The facility charges a lower price and the insurance company covers part of the cost. The final bill depends on the patient's plan's co-pays, co-insurance and deductibles. Therefore, the list price won't tell a patient how much they'll really have to pay.

continued on next page

However, if a patient goes to a medical provider that is out-of-network, they might be "balance billed" the difference between what the chargemaster lists and what the insurance company pays.

Sometimes hospitals will use the threat of lists prices and balance billing a policyholder as a way to get insurers to negotiate with them and include them in their network.

Price shopping works best for elective, non-emergency procedures. For example, Lasik eye surgery prices have steadily decreased because of competition driving down the price more than three-quarters over 15 years. In 2017, Sen. Rand Paul, R-KY, pointed out that the average consumer wanting Lasik surgery calls four different doctors to compare costs.

Consumers also can check the prices for elective procedures such as physician office visits, lab and diagnostic tests and non-emergency surgery.

However, price alone should not be the determining factor. Quality of work is also very important, along with how many procedures the facility performs; patient satisfaction rates; and recommendations of physicians and friends.

In addition, medical-industry pricing can be complicated when a patient doesn't understand medical terms. For instance, if your doctor wants you to have an MRI, you also would need to know whether the test will be done with or without "contrast."

Going Forward.

Since the price of a procedure often depends on the discount negotiated by an insurance company, many insurance companies have started to offer price comparison tools. However, these tools have their limitations. It's not always possible to compare prices ahead of time, particularly when there's an emergency. Also, other attributes such as location or a doctor's reputation are not accounted for.

There is also concern that the price comparison tool does not help at all. *The Journal of the American Medical Association* surveyed employees at two large companies in 2016 and learned that use of price comparison tools did not seem to lower health care spending for the companies' employees.

Keep in mind that even if you do look at the list prices to compare costs between medical facilities, they may not be be completely accurate. For example, Cartersville Medical Center in Cartersville, Ga., notes on its website that it doesn't guarantee the accuracy of the pricing information online.

Retirement Plan Options for Former Employees

When employees leave a job, they often have to decide what to do with their 401(k) retirement account. Encourage them to investigate their options based on their financial situation and long-term goals. The decision they make could affect their retirement funds size.

Here are options to investigate — along with some pros and cons:

Leave the Plan Where it is

Employees can leave their employer-sponsored retirement plan where it is if they have at least $5,000 in the account. However, they cannot add any funds. The funds in the account remain invested.

Pros: This is the easiest option because employees don't have to do anything. It's also a good option for employees who are tempted to borrow from the fund. And, it would be to their advantage to keep the fund if the plan has access to quality investments closed to new investors.

Cons: Employees cannot change how their money is invested. If they're near retirement they may be stuck with a plan that is invested too aggressively or it may be too conservative if they have many investment years ahead.

Roll the Plan into the New Employer's Plan

Employees who are leaving one company for another can just roll the old plan balance into the new plan.

Pros: With this option, they avoid taxes and penalties and can take advantage of the employer's matching funds. They also avoid having to keep track of multiple plans and can change their investment strategy as their investing style and risk tolerance change.

Cons: They won't gain anything if they don't ensure their plan has a diverse mix of stock and bond funds from and a low annual expense ratio. The ratio on each fund shouldn't be more than 0.75 percent.

continued on next page

Roll the Plan into an IRA

If the employee is between jobs or is going to a company without a group retirement plan, there are other options. They can move their funds into an Individual Retirement Account (IRA), either traditional or Roth; however, they will owe taxes on the amount of pretax assets rolled over from a 401(k) into a Roth IRA. Traditional IRAs defer taxes until retirement, when the employee may be in a lower tax bracket and owes less tax on earnings. With a Roth IRA, the employee pays the taxes on contributions now, while earnings grow tax free. Distributions are tax free at retirement.

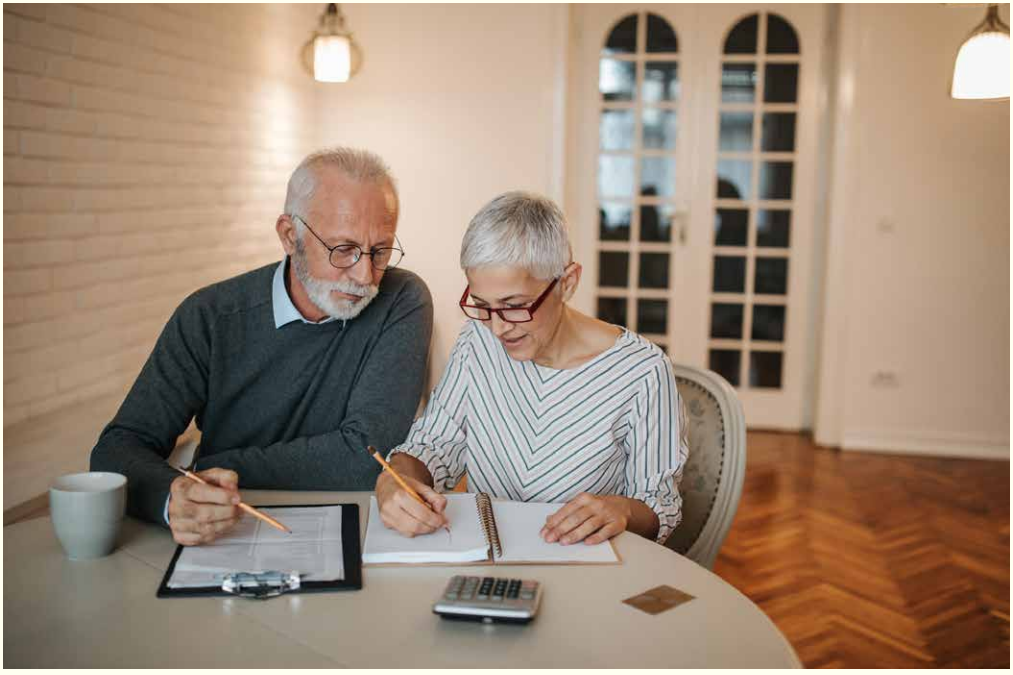
Pros of an IRA: By transferring the balance of a retirement plan into an IRA, the money will remain tax-deferred. Contributions are deductible up to 100 percent, but are limited to a maximum individual annual contribution of $5,000 per person.

Pros of a Roth IRA: If the employee retires before age 59 and a half, they can withdraw Roth IRA contributions without a penalty and taxes. Roth IRA distributions have no effect on Social Security tax status and individuals can contribute to their Roth IRA after age 70 and a half.

Cons: Unlike a 401(k), there may or may not be matching funds from an employer.

Roll the Plan into an Annuity

There are two categories of annuities — deferred and income. Tax-deferred annuities can be a good way to boost retirement savings once the maximum allowable contribution has been made to a 401(k) or IRA. Deferred annuities have no IRS contribution limits and can be used for a guaranteed retirement income stream.



Pros for tax deferred: Earnings compound over time, providing growth opportunities that taxable accounts lack.

Pros for income: Depending on how annuities are funded, they may not have minimum required distributions (MRDs).

Cons for tax deferred and income: Withdrawals of taxable amounts from an annuity are subject to ordinary income tax. If taken before age 59 and a half, funds may be subject to a 10 percent penalty. Annuities also have annual charges.

Taking Cash

Employees can take some or all of the funds in cash. This can be tempting for employees experiencing financial difficulties.

Pros: Most people could use a windfall, and that is why so many people often turn to cashing out or borrowing from their fund.

Cons: If employees opt to take cash, they will miss tax-deferred compounding interest. Plus, they'll owe income tax on the amount they take out, and must pay a 10 percent early withdrawal penalty if they are under the age of 59 and a half. That penalty may be waived in certain hardship situations.

Please contact us if you have questions about retirement options or need advice about retirement planning for your employees.

How to Determine Whether Your Voluntary Plans Fall Under Safe Harbor

Your benefit programs can have an exemption to ERISA if they meet certain requirements.

Don't assume you're in compliance with the Voluntary Plans Employee Retirement Income Security Act (ERISA) safe harbor rules just because you don't contribute to the cost of your employees' voluntary benefits. ComplianceBug, LLC, a provider of online risk assessment and compliance monitoring tools, reported that more than 80 percent of worksite and voluntary benefits plans are actually subject to ERISA. This is despite employers believing the plans were exempt from compliance requirements under the safe harbor rules.

Most employee benefit plans offered through a private employer are subject to ERISA. The requirements provide minimum standards for retirement plans, group health plans and other welfare benefit plans.

There is a safe harbor exemption (DOL Reg. § 2510.3-1(j)) from ERISA for certain voluntary plans such as life, vision, dental, disability, critical-illness and accident insurance. However, these programs can be subject to ERISA if the employer fails to meet these requirements:

1. Employee participation is voluntary.
2. The benefit plan must be completely employee paid. Salary contributions made on a pre-tax basis through a Cafeteria/Section 125 plan are employer contributions, so all employee contributions must be after-tax to meet the safe harbor.
3. The employer cannot endorse, educate or market the plan to employees. The insurer can collect premiums through payroll deductions.
4. Employers receive no compensation or profit from the program, although they can be compensated for administrative services.

Most employers have difficulty with the third rule. To be in compliance, employers must ensure that all documents or explanations of voluntary benefits are removed from the materials you give your employees about their benefits. For instance, you must have one packet for employer-provided plans and one for voluntary benefits in order to comply with Safe Harbor protection.

Talk to your broker or counsel if you have questions whether your voluntary benefit plans are subject to ERISA regulations. ■