Berkley
Accident and Health
| a Berkley Company

2022 REPORT

# Health Care Pressures Facing U.S. Employees

# How can this report help you?

As companies strive to recruit and retain employees by offering high-quality, affordable benefits, information is key. Reliable insights are needed to help you shape your company's health care strategy in the coming years. Berkley Accident and Health is pleased to provide useful views into health plan funding, high-dollar claims, and more.

In this report, we examine how U.S. consumers interact with and respond to their health benefits.

**We sought to answer three main questions:**

*What pressures are facing employees and their families related to employer-sponsored health benefits?*

*How are health benefits working – and not working – for employees?*

*What should be considered as companies plan their future benefits strategy?*

**About Berkley Accident and Health**

Berkley Accident and Health seeks to empower our clients with cutting-edge products, solutions, and services that protect them from the risks they face. We use our deep understanding to help make health care more affordable and improve the health and well-being of those we serve. We specialize in protecting self-funded health plans, provider groups and HMOs, organizations, and consumers from the costs of unexpected accidents and illnesses.

# Key Findings

**1**

Cost-sharing is a major problem for many, causing medical debt, skipped care, and choosing to self-pay rather than use health insurance.

**2**

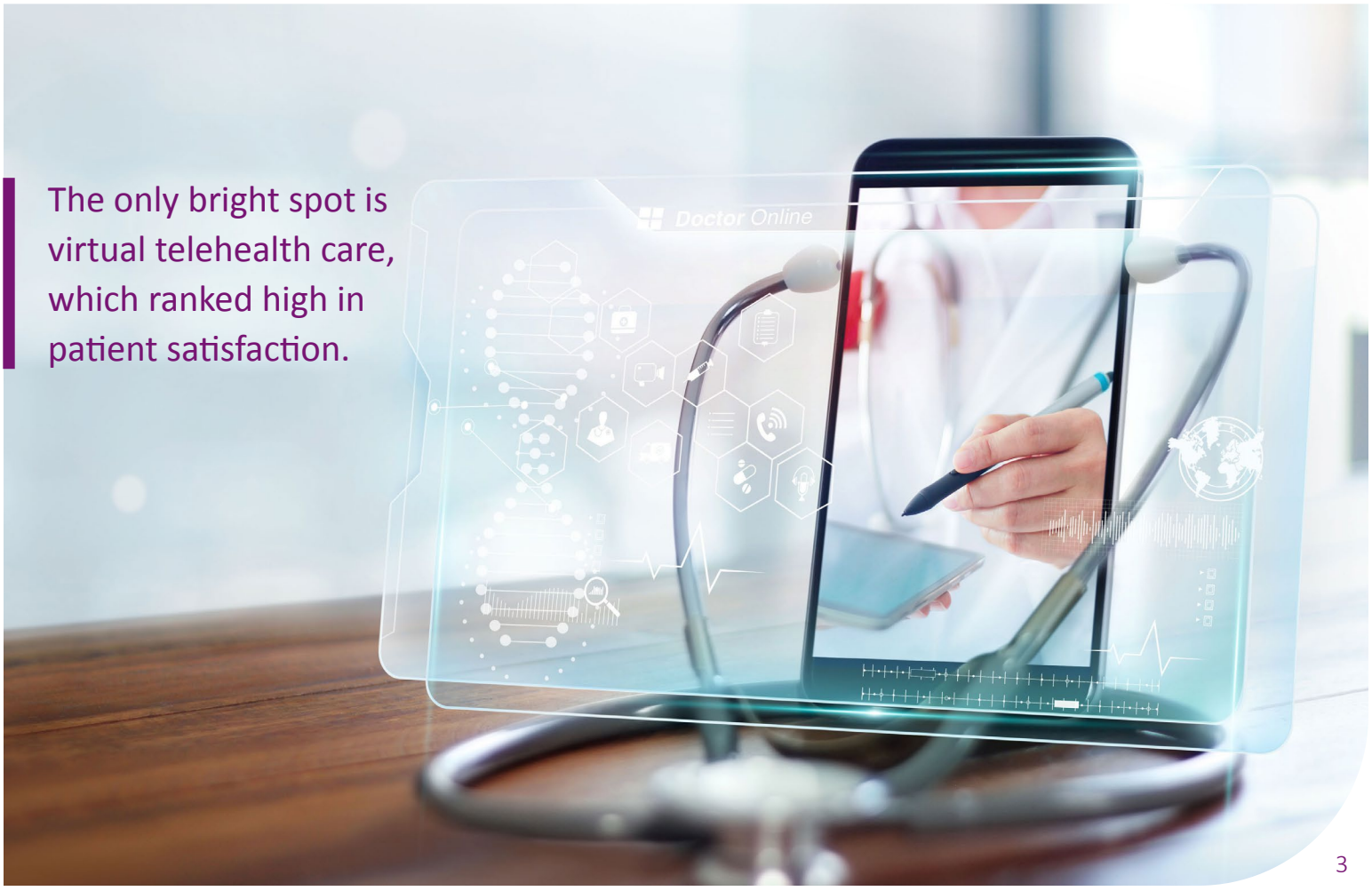
Lack of transparency makes health care hard to navigate and is a source of frustration.

**3**

The only bright spot is virtual telehealth care, which ranked high in patient satisfaction.

Overall, we found frustration with the current health care system due to its complexity, lack of transparency, and burdensome cost sharing. Patients are also suffering financial repercussions, in the form of medical debt and surprise bills when they use their health benefits. The only positive note we found was with virtual visits. COVID-19 accelerated the adoption and use of virtual health care, and patients are now more comfortable with it.

The only bright spot is virtual telehealth care, which ranked high in patient satisfaction.



Let's look at the findings more closely:

# 1

## Cost-sharing is a major problem for many

More than 8 out of 10 respondents admit to worrying about the cost of health care. Unexpected illnesses and injuries top the list of concerns, with the cost of prescription drugs coming in as the second biggest concern.

In addition, nearly half (45%) are concerned about the cost of premiums and payroll contributions. A recent report indicates that health premium increases for 2022 will return to historically higher, pre-pandemic levels.[1]

[1] SHRM, Health Plan Cost Increases for 2022 Return to Pre-Pandemic Levels, https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/health-plan-cost-increases-return-to-pre-pandemic-levels.aspx

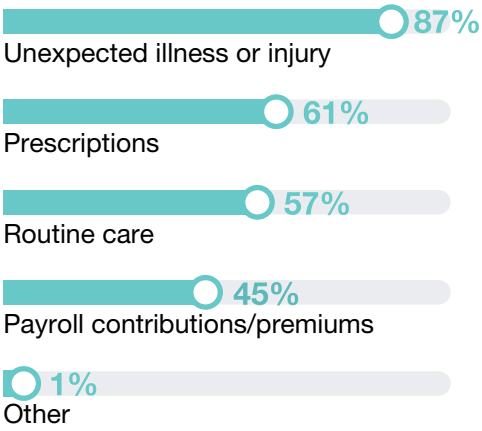
*Do you ever worry about the cost of health care?*

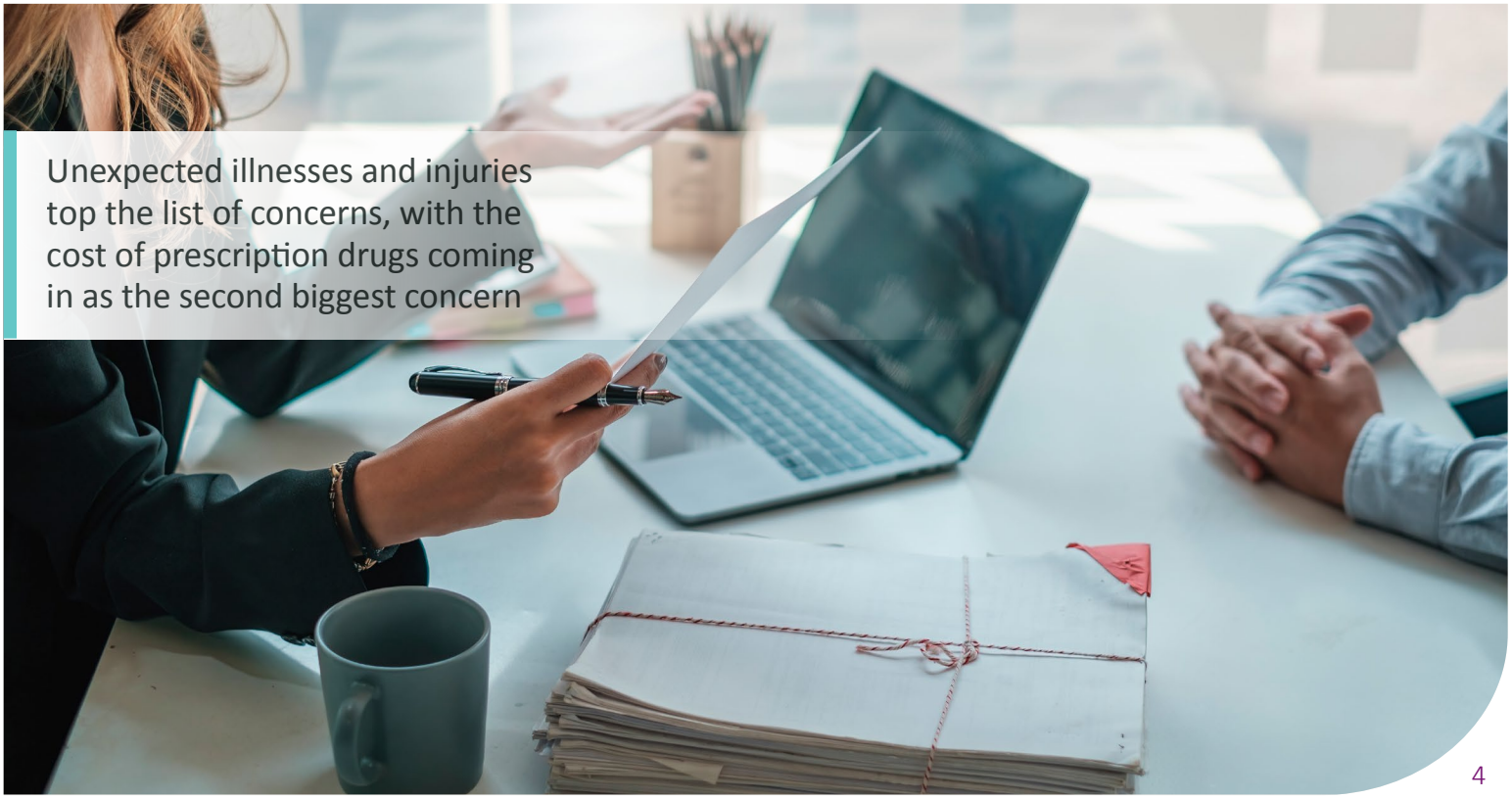
84% Yes

16% No

*Top Financial Concerns of those that said Yes*

*(multiple answers possible)*



Unexpected illnesses and injuries top the list of concerns, with the cost of prescription drugs coming in as the second biggest concern

The financial challenges of high deductibles, copays, and other cost-sharing arrangements are causing downstream effects on patients, including:

## Skipped care

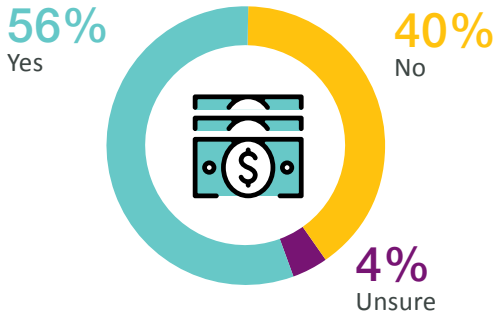
3 out of every 5 respondents indicated that they skip medical care because of the cost.

*Have you ever skipped a medical visit, test, or prescription due to cost?*


## Self-pay

Even among consumers with employer-provided health benefits, some find it so difficult or expensive to use that some opt out of the process entirely. More than half of respondents admit to paying cash for health services because it was cheaper than using their insurance.

*Have you ever paid cash for a prescription or medical service because it was cheaper than using your insurance?*

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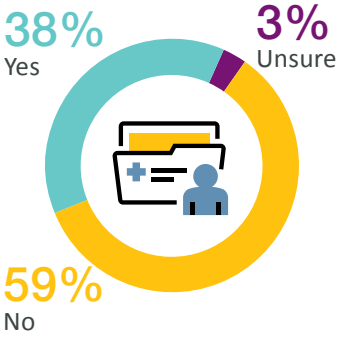
## Medical debt

Although medical debt is less common than skipping care and self-pay, more than one-third of respondents reported having medical debt. Of those, the typical debt amount is between $1,000 and $10,000. Significantly, 8% reported having more than $10,000 in debt.

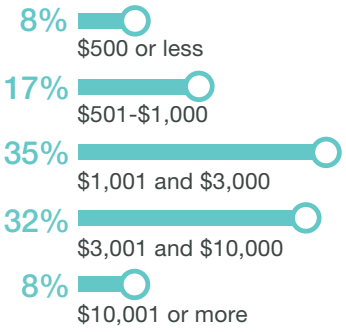
This level of debt is remarkable, given the low savings rate among many Americans. Average savings varies widely by household type and age, with younger people having less in savings and older people having more. Single Americans between the ages of 18-34 without children have an average of $2,729 in savings. Married couples between the ages of 35-44 with children have an average of $10,399 in savings.[2]

When asked why they had medical debt, one-third of respondents reported it was due to their health plan's cost-sharing features, such as deductibles or co-insurance. Considering many high deductible health plans have deductibles of $3,000, $5,000, or more, this can create real problems for younger employees without a lot in savings.

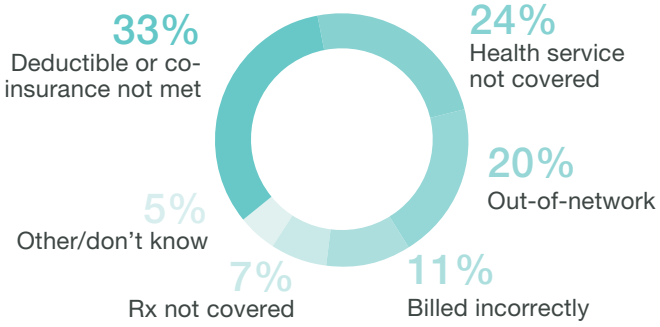
*Do you currently have medical debt?*




*If yes, how much medical debt do you owe?*




*Why do you have medical debt?*




[2]CNBC, How Much Money Americans have in Savings at Every Age, https://www.cnbc.com/2019/03/11/how-much-money-americans-have-in-their-savings-accounts-at-every-age.html, based on data from the Federal Reserve's 2019 Survey of Consumer Finances.

# 2

## Lack of transparency makes health care hard to navigate and frustrating

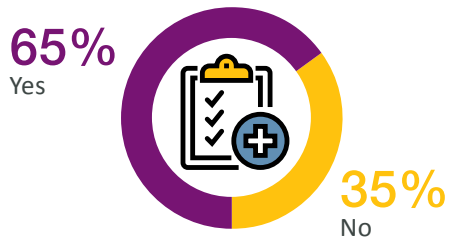
U.S. health care does not operate like other free markets, where sellers and buyers come together. Instead patients have limited information and often make important health care decisions in a vacuum. Even when Americans have good insurance, their plan can be complicated and hard to decipher.

Here's what we found:

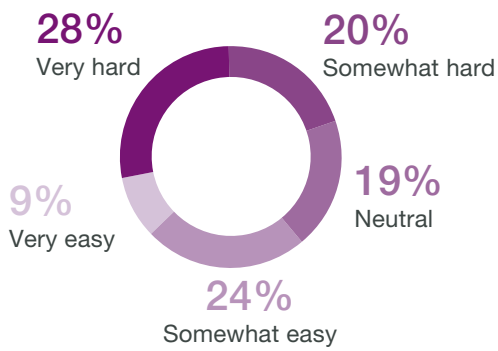
### Consumers try to shop around for the lower price, but often can't

Most respondents try to find out the price before scheduling a medical service or filling a prescription, but find it a challenge. It is slightly easier to find the price of a prescription than a medical service.

*Have you tried to find out the price before a medical visit or test?*

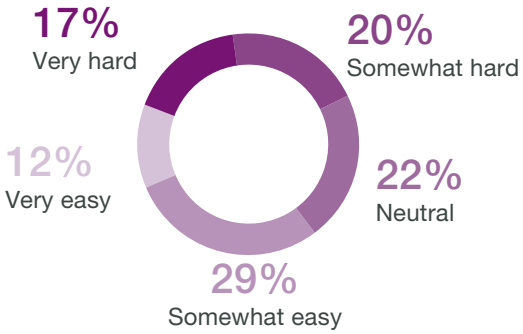


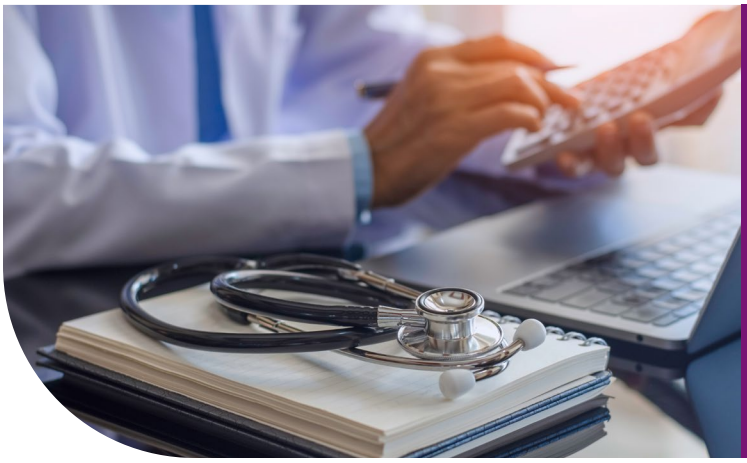

*If yes, how easy was it?*




*Have you shopped around for a lower price for a prescription?*


*If yes, how easy was it?*



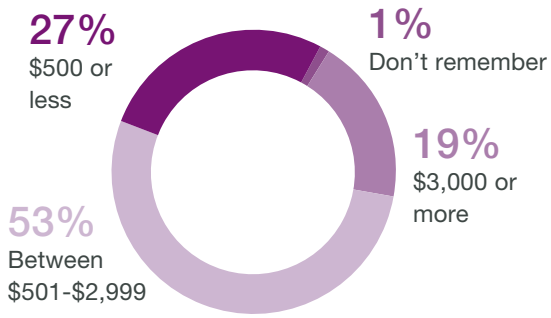
Even when Americans have good insurance, their plan can be complicated and hard to decipher.

## Consumers receive medical bills they don't expect, typically between $500-$3,000

Nearly 70% of respondents said they have received an unexpected medical bill, usually between $500 and $3,000. With the passage of the No Surprises Act on January 1, 2022, consumers should see some relief from surprise out-of-network charges, but not all types of surprise bills.

*Have you ever received a medical bill you did not expect?*


*If yes, how big was the unexpected bill?*




## No Surprises Act

The No Surprises Act of 2022 establishes new federal consumer protections against surprise medical bills.[3] Surprise medical bills occur when patients inadvertently receive medical care from out-of-network doctors, hospitals, and other providers that they did not choose. This can happen during emergency room visits or scheduled, in-network hospitalizations with an out-of-network provider (such as an anesthesiologist) that the patient did not choose. The Act puts limits on surprise bills and establishes a process for independent dispute resolution.

The Act targets three main sources of surprise bills: emergency care, non-emergency from out-of-network providers at in-network facilities, and out-of-network air ambulance services. The new rules ban certain types of balance bills, but do not cover all types of health plans and all services, such as ground ambulance transportation.

[3] Centers for Medicare & Medicaid Services, https://www.cms.gov/nosurprises

# 3

## Telehealth was a bright spot during the pandemic

The lockdowns and social distancing of COVID-19 caused a massive acceleration in the use of telemedicine. Almost two-thirds of respondents had a virtual health visit during the pandemic and were generally satisfied with the experience.

This is a great example of medical innovation that worked for consumers. The pandemic forced state and federal governments to suspend the patchwork of state licensure processes and give health providers the flexibility to practice across state lines.[4] This was a big win for patients in rural communities and underserved communities with health provider shortages. While some of these regulatory changes were temporary, others have been made permanent.

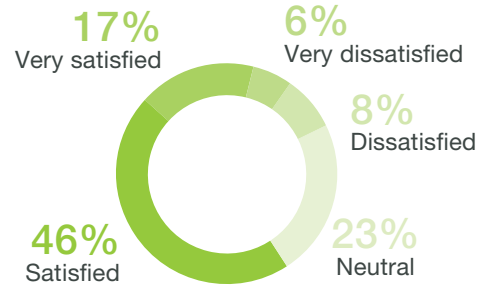
In addition, the shift to virtual care increased access to mental health and substance abuse services. An analysis by McKinsey found that in February 2021, 50% of psychiatry claims and 30% of substance abuse treatment claims were delivered by telehealth.[5] Many areas of the country have a shortage of mental health providers, and many patients feel a stigma associated with mental health care. There is a real opportunity for telehealth to permanently improve patient access, experience, and privacy.

[4] Bipartisan Policy Center, What Eliminating Barriers to Interstate Telehealth Taught Us During the Pandemic, https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/11/BPC-Health-Licensure-Brief_WEB.pdf

[5] McKinsey, Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?, https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality

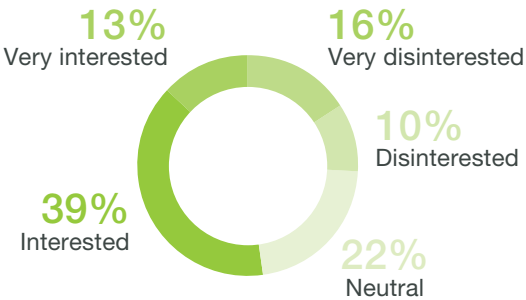
*Before the pandemic, did you ever have a telehealth visit?*


*If yes, how satisfied were you with your most recent telehealth visit?*




*Since the pandemic, have you had a telehealth visit?*


*After the pandemic, how interested do you think you'll be in telehealth visits?*

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# Questions for Employers and Benefit Brokers

In light of the consumer anxiety and concerns with current health benefits, we recommend that employers and benefit brokers consider three broad questions:

**1**
**How can we make health care more affordable for employees and their families?**

**2**
**How can we help make health care easier and more transparent for those seeking medical care?**

**3**
**What role do we want health benefits to play in our talent retention strategy?**

The answers will vary, depending on each group and their needs. However, one thing is certain – innovative thinking is needed to change the status quo of patient frustration and confusion. Some possible avenues to consider:

*To address employee costs and concerns:*

Offer **high-tech, high-touch services** to improve the patient experience and help employees navigate the complexities of health care

Provide **price transparency tools** to help employees find the cost of elective procedures, tests, and prescriptions

**Re-examine if cost-sharing features are too high**, given the average income and savings of your employee group

**Continue access to telehealth services**, especially for mental health and substance use treatments

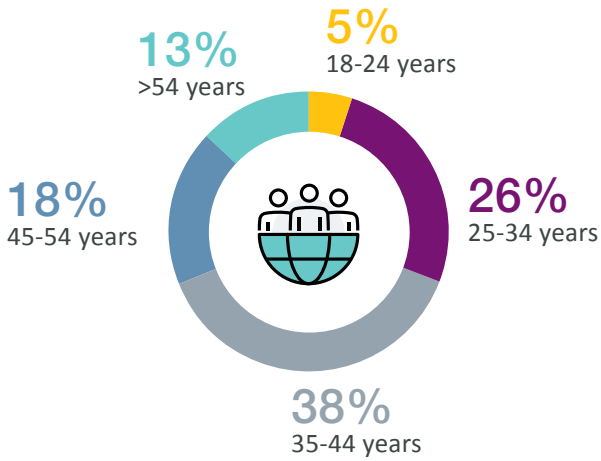
*To address overall health plan performance:*

- ✔ Consider a **self-funded health plan**, which offers significant economic and strategic advantages. If you are a small to midsize employer, ask your broker about joining a **group captive program** to reap the benefits of self-funding.
- ✔ Look into a **pre-payment claims audit** service to ensure your medical claims are billed accurately and fairly.
- ✔ Examine your prescription claims – often a sizable portion of overall health costs – and switch to a **transparent Pharmacy Benefit Manager (PBM)** or **alternative drug sourcing** method that can yield significant savings.
- ✔ If you have employees who travel overseas, adding a **business travel accident** policy can help reduce the stress for workers. This coverage can provide medical assistance during an emergency, cover medical expenses while outside the country, and arrange hospital payment guarantees.
- ✔ Consider better ways to deliver routine care to your employees, such as **direct primary care**, and better manage high-dollar claims, such as dialysis and cancer, through **care coordination** and **case management** programs.

*As stated earlier, we hope this report will spark dialogue between employers and their benefit brokers. Balancing employee needs with financial realities will require new ways of thinking and hard work. There is a lot of opportunity for companies that can act decisively, invest in employee health, and work hard to rewire the health benefit model.*

# About This Study

In March 2022, Berkley Accident and Health commissioned a survey of 1,000 adults through a third-party research firm. Survey participants were U.S. residents over 18 years old, with employer-based private health benefits. Participants had used their health plan in the last 12 months for health care, testing, or filling prescriptions.




**Participant Demographics**

- They received their health coverage through employers of all sizes, but the greatest concentration were through companies with 251-1,000 workers.
- Participants were from 49 states, with the greatest concentrations in California, Florida, New York, and Texas.

The objective was to gain a better understanding of the health insurance challenges and financial pressures facing U.S. consumers. Of particular concern was the impact of cost-sharing on consumers' behavior against the backdrop of rising costs for health services and prescription drugs.

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