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Commercial Newsletter 2025

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Commercial Newsletter

IN THIS ISSUE:

40% of small employers 'very likely' to adopt new health models

By Allison Bell

What You Need To Know

- About 18% of the employers surveyed said they think they understand coverage options like ICHRAs.
- Roughly 40% want to try options like ICHRAs.
- Vitable thinks the providers of the new options need to provide more performance data to convert employer enthusiasm into actual sales.

Many small and midsize U.S. employers may be so angry about the cost of health benefits that they will rush to try something completely different, even if they don't know much about the new coverage strategy.

Vitable, a direct primary care plan manager, has published data on employers' fight to hold down health benefits costs in a summary of the results from a survey of 510 U.S. businesses with fewer than 500 employees.

The firm found that 18% of the employers surveyed described themselves as being "very familiar" with benefits options such as direct primary care practices, individual coverage health reimbursement arrangements and qualified small employer HRAs. But far more of the employers — 40% — said they were "likely or very likely to adopt new models" for providing other benefits.

Mike's Notes

What is Workers Compensation?

Workers compensation insurance provides for the cost of medical care, rehabilitation, and wage replacement for injured workers and death benefits for the dependents of persons killed in work-related accidents. In recent years, it has been the most profitable property/casualty line of business.

With workers compensation, an employee gives up the right to sue the employer for injuries caused by the employer's negligence and in return receives benefits, regardless of who or what caused the accident, if it happened in the workplace because of and in the course of workplace activities.

In 2022 workers compensation premiums for private carriers and state stood at $42.5 billion up from $38.5 billion in 2021.

The industrial growth that took place in the United States during the 19th century was accompanied by a significant increase in workplace accidents. At that time, the only way injured workers could obtain compensation was to sue their employers for negligence. Proving negligence was a costly, time-consuming effort, and often the court ruled in favor of the employer. But by the early 1900s, a state-by-state pattern of legislative proposals designed to compensate injured workers had begun to emerge.

Wisconsin enacted the first permanent workers compensation insurance law in 1911 (New York had enacted a law a year earlier but it was found unconstitutional). By 1920, all but eight states had enacted similar laws. By 1949, all states had a workers compensation system that provided compensation to workers hurt on the job, regardless of who was at fault. The costs of medical treatment and wage loss benefits were the responsibility of the employer which were paid through the workers compensation system.

How does workers compensation work?
Employers can purchase workers compensation coverage from private insurance companies or state-run workers agencies, known as state funds. According to a Conning study, "Workers Compensation State funds, Evolution of a Competitive Force," 20 states have funds that compete with private insurers. In four states, the state is the sole provider of workers compensation insurance. Along with residual market pools, many state funds function as the insurer of last resort for businesses that have difficulty getting coverage in the open market.

Some businesses finance their own workplace injury benefits through a system known as self-insurance. Large organizations with many employees can often estimate the cost of routine types of injuries. Self-insurance, along with large deductibles (effectively self-insurance) account for more than one-third of traditional market premium.

Workers compensation systems are administered by the individual states, generally by commissions or boards whose responsibility it is to ensure compliance with the laws, investigate and decide disputed cases, and collect data. In most states employers are required to keep records of accidents. Accidents must be reported to the workers compensation board and to the company's insurer within a specified number of days.

To rein in expenditures and improve cost effectiveness, many states have adopted cost control measures, including treatment guidelines that spell out acceptable treatments and diagnostic tests for specific injuries such as lower back injuries and fee schedules that set maximum payment amounts to doctors for certain types of care.

Most states pay benefits for the duration of the injury, but some specify a maximum number of weeks, particularly for temporary disabilities. For workers with a total disability, the benefit amount is some percentage of the worker's weekly wage (actual or state average). Cash benefits may not be paid until after a waiting period of several days.

What does workers compensation cost employers?

Costs to employers include premiums, payments made under deductibles, and the benefits and administrative costs incurred by employers that self-insure or fund their own benefit program. The percentage of total compensation costs that workers compensation premiums represent fluctuates.

There is a wide variation in costs among states and industries, so that the highest rated (the inherently riskiest) groups could pay several hundred times that of the lowest rated (safest) groups, as a percentage of payroll. Also considered is the firm's own safety record.

How can workers compensation costs be reduced?

Workers compensation system costs are rarely static. Reforms are implemented and then, over time, one or more element in these multifaceted systems get out of balance. Soon employers and legislators complain that the cost of coverage is hurting the state's economy by reducing its ability to compete with other states for new job-producing opportunities.

Research shows that the faster the insurer receives notice of an injury and can initiate medical treatment, the faster the injured worker recuperates and returns to work and the less likely they are to seek out an attorney for help in dealing with a claim.

There are two important aspects to facilitating the return-to-work process: First, getting the most effective medical care as soon as possible and reducing the emotional stress that may follow an accident; and second, improving communications about the workers compensation system before accidents.

Another factor pushing up costs of workers compensation in some states is attorney involvement. Workers compensation programs were originally intended to be "no-fault" systems and, therefore, litigation-free.

However, a 2018 study found that of 50,840 claims 14,183 involved attorneys, giving an overall attorney involvement rate of 28 percent. Additionally, the research noted that litigated workers comp claims were 388 percent more expensive than non-litigated claims. Claims also took considerably longer to close.

The involvement of an attorney does not necessarily indicate formal litigation proceedings. Sometimes, injured workers turn to attorneys to help them negotiate what they believe is a confusing and complex system.

If you need any help with Workers Compensation contact our commercial experts at 1-800-362-2809 or visit www.getagreatquote.com

Continued from page 1-40% of small employers 'very likely' to adopt new health models

The results mean that about 22% of the employers are thinking about switching to nontraditional options such as direct primary care practice memberships, ICHRA plans and QSEHRA plans despite having little familiarity with those options.

A direct primary care practice charges periodic membership dues, or membership fees, and in return promises to give the members access to everyday health care.

ICHRAs and QSEHRAs are arrangements that employers can use to provide cash for their employees and let the employees buy their own individual or family health coverage.

Vitable analysts said they think many of the employers that say they will switch to nontraditional options still need to see more evidence that the new options will really improve employees' care and hold down costs before they'll really switch.

About 20% of the employers worry about whether employees will use the new options, and 18% worry about lack of information, the analysts said.

For 80% of the employers, one persuasive way for a nontraditional option provider to demonstrate its value would be to show that it helps sick and injured workers get back to work faster than traditional health plans do, the analysts said.

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Employers 'hungry for ideas' to hold down health claims without cutting coverage

Employers are worried about the rising cost of health coverage, and they are hungry for ideas about ways to hold claims down without eliminating benefits, according to J. Powell Brown, the chief executive officer of Brown & Brown.

Brown & Brown, a big insurance and benefits advisor, is getting many questions about ideas for managing the costs of claims for high-cost claimants, coping with the high cost of very expensive "specialty" drugs, and improving "population health" efforts, such as efforts to address conditions such as obesity and high blood pressure, Brown said.

Executives noted that Brown & Brown is often paid a flat fee per enrollee for group health plans in some states and does not benefit in those states when the cost of coverage rises.

At some plans, J. Powell Brown said, employers are trying to maintain the breadth of coverage by cutting out certain high-cost items, such as coverage of Wegovy and other GLP-1 agonists for weight loss.

"People are trying to maintain quality coverage for their employees," Brown said. "That said, they can only bear a certain amount of increase. And so we are constantly and consistently talking with our customers and prospects about creative ways to deliver value to their employees but to help manage their cost."

Overall, Brown said, the state of the economy appears to be relatively stable.

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Meet Our Commercial Account Manager

Michelle Vincent

Name – Michelle Vincent
Title – Senior Account Manager
Email – mvincent@cobensrv.com
How long have you worked at ABM – 8 Years
What do you do at ABM – Health Insurance New Business & Renewals
What do you love about your job – I love the challenge, helping others, constant learning due to ever-changing industry, providing people with protection for individuals and their loved ones
Why do you think ABM is a great company – ABM is a great company because everyone cares about each other and the services we provide to others. The culture is great and we are always looking for ways to grow and be better.
Fun Fact about yourself – When I was around 10 years old I went to the making of a Michael Jackson video and got to meet Michael Jackson.

Global health plan costs projected to rise nearly 10% in 2026

By Alan Goforth

The United States is not alone in anticipating a substantial increase in health plan costs next year. In its latest report, Aon projects a worldwide price hike of nearly 10%, including an 8.8% rise in North America.

"The 2026 Global Medical Trend Rates Report arrives at a time of economic and geopolitical uncertainty, including global tariffs," said Kathryn Davis, a global benefits vice president for the professional services firm.

"Even as global inflation cools in some markets, health care costs remain under significant pressure. Rising health care costs have become a pervasive business challenge, requiring organizations to proactively plan and adopt predictive analytics alongside innovative cost-management strategies to stay ahead. These approaches are essential for navigating ongoing volatility and supporting long-term benefit strategy."

The report identified the top three medical conditions that are driving cost increases:

- Cardiovascular disease remains the leading condition expected to influence plan costs in 2026. This trend is consistent across all regions, with more than 20 countries identifying it as the most significant condition.
- Cancer and tumor growth rank among the top five cost-driving condition in every region in every region, with 20 countries identifying it as having the greatest impact. The most commonly diagnosed cancers globally include lung, breast, colorectal and prostate cancers.
- High blood pressure and hypertension continue to be leading risk factors for numerous other conditions and are consistently cited as key drivers of medical claims. Eighteen countries identify them as the most serious conditions.

"In addition to macroeconomic global factors, trends in the health care space are also contributing to persistently high medical inflation rates compared to historical norms," Davis said. "These include higher utilization rates, the adoption of new, advanced technologies and a growing demand for private health care services."

Continued from page 5-Global health plan costs projected to rise nearly 10% in 2026

As a result, employers increasingly are focused on cost containment and management strategies. These include negotiating with insurance carriers, implementing wellbeing initiatives, introducing flexible benefits and increasing employee cost sharing. Among these, wellbeing initiatives remain the most widely adopted measure, reported by 86% of countries.

"As organizations navigate rising health care costs, mitigation strategies are essential to sustaining workforce wellbeing and business resilience," said Michael Pedel, head of global benefits at Aon. "By proactively leveraging data and analytics and implementing targeted strategic interventions, employers can better manage their investment, bring to life wellbeing strategies and foster healthier, more-engaged teams. This holistic approach enables organizations to achieve long-term sustainability of costs, adapt to evolving employee needs and mitigate risk."

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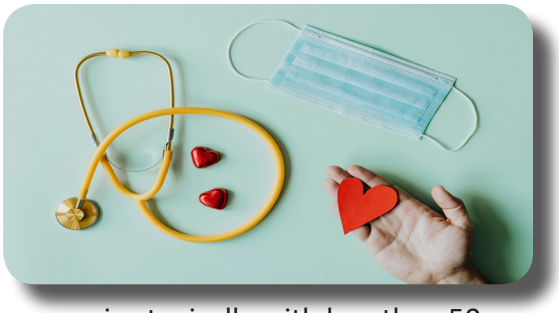
Small business health care premiums set to jump 11% next year

By Kristen Smithberg



Small businesses face health care premium increases of about 11% next year, as health care costs continue to rise, according to Peterson KFF's Health System Tracker.

The analysis is based on rate filings submitted to state regulators by health insurers outlining their expectations for the coming year and proposing premium changes for Affordable Care Act-compliant plans. The small group market covers plans offered to companies typically with less than 50 employees.

Projected increases for next year among small group market insurers ranged from a decrease of 5% to an increase of 32%. The majority are requesting premium increases of between 5% and 15%, the report said. About 10%, however, are proposing premium increases in excess of 20%.

Overall increases in health care costs are a primary driver of the proposed premium increases, with insurers citing the rising costs of hospitalizations, physician care and prescription drugs. Insurers indicated the underlying increase in the cost of health care is about 9%.

Insurers also point to broader economic factors in their requests for premium increases. General inflation and labor shortages are contributing to increased provider reimbursement rates, and some insurers pointed to provider consolidation as a factor reducing market efficiency and rising reimbursement rates.

The potential impact of tariffs was cited in some requests, with insurers saying higher tariffs could raise the cost of pharmaceuticals and medical supplies. About one-quarter of the insurers studied included tariff-driven uncertainty in their rate-setting analysis.

The increasing cost, prevalence and utilization of GLP-1s and other specialty drugs were frequently cited by insurers to justify proposed rate increases. Some insurers have excluded coverage of GLP-1s for weight loss purposes to mitigate upward pressure on premiums, said the report.

Volatility in the small group market is also driving premium changes, driven by decreases in enrollment for small group plans and a simultaneous increase in relative costs for the remaining risk pool.

Continued from page 6-Small business health care premiums set to jump 11% next year

Competition from lower-cost individual and self-insured options could be a reason behind enrollment declines, as could state stop-loss rules that make self-insurance a more attractive alternative for small employers, said the report.

"Employers may find coverage less expensive because self-funded plans are not subject to state benefit mandates or premium taxes, and their costs are tied directly to the health of their own workforce," said the report. "For small employers with healthier-than-average workers, this can be especially attractive." The growing availability of "level-funded" plans, which pair a steady premium structure with substantial reinsurance protection, has further reduced the financial volatility that once deterred smaller firms from self-insuring, said the report.

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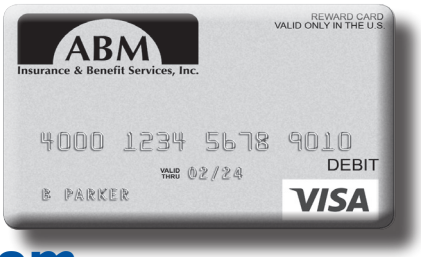

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