Employee Benefits Report

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Health Benefits March 2007 Volume 5 • Number 3

Using Hybrid Health Plans to Control High Healthcare Costs

Layering plans can help you keep premiums and employees' out-of-pocket costs low.

Despite the hype over "consumer-driven health care," consumers have been slow to embrace Health Savings Accounts (HSAs) and their companions, high-deductible health plans (HDHPs). Employers like the lower premiums under HDHPs, but many employees have balked at their high deductibles.

Section 105 of the IRS code lays the ground rules for most consumer-driven health care products. It also allows employers to self-insure for the gap between the high deductibles and out-of-pocket expenses required under HDHPs and the smaller deductibles lower employee costs traditionally seen in managed care plans. Plans that bridge this gap are called hybrid health plans.

Self-insurance by any other name…

Hybrid plans, which also go by the nicknames of "under wraps" and "gap insurance," offer employers the lower premiums of an HDHP while eliminating the daunting high deductibles for employees. In these plans, employers buy HDHPs for their employees, then self-insure for the difference between the HDHP's deductible and out-of-pocket expenses and what an employee might pay under a managed care plan. Some plans even offer PPO-style first-dollar coverage. The employer can operate on a "pay-as-you-go" basis or set aside an amount per insured individual in an HRA (Health Reimbursement Arrangement). Fund balances can roll over from one year to the next, and the employer retains control of the funds.

The employee's view

For employees, the plan is virtually seamless. Usually, claims not paid under the HDHP are returned to the HRA administrator, which pays them from HRA funds. If deductibles apply, the administrator notifies the employee of the amount paid and any remaining balance. The HRA administrator may be the employer, the insurer or a third-party administrator.

For employees who pay a portion of their health insurance premium, it's a true win-win scenario. HDHP premiums generally cost about 40-50 percent less than those of HMOs or PPOs. These employees will see lower healthcare costs with little or no drop in benefits.

And the boss?

Hybrid plans also offer ad-

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This Just In

As of September 2006, only about 1 percent of the privately insured adults of working age had either an HSA or HRA, according to a survey by the Employee Benefit Research Institute (EBRI). "Another 7 percent, or 8.5 million adults, had plans with deductibles high enough to qualify for health savings account, but of these only 2.6 million were offered or aware of the option to open an HSA," said the nonprofit research and education organization. These numbers might indicate that employees need more education about HSAs.

Group Disability Insurance: Know All the Facts

Group long-term disability plans offer affordable benefits, but have some limitations.

One in seven workers will be disabled for five years or longer during their working years. Workers' compensation will cover your employees if they are hurt on the job, and health insurance will help cover their medical bills. But if an off-the-job injury or a non-work related illness makes them unable to work for an extended period, how will they meet their regular expenses? Disability insurance will pay a portion of an injured or ill worker's salary while he or she is disabled, giving him or her one less thing to worry about during recovery.

Disability and unpaid medical bills are among the leading causes of bankruptcies nationally, and those figures do not tell the whole story of sudden poverty, broken marriages and ruined lives. In fact, five states (New York, New Jersey, Rhode Island, California, and Hawaii) and Puerto Rico consider disability insurance so important they require employers to provide short-term disability insurance to their employees.

Short vs. long-term, group vs. individual

Short-term disability coverage is the most commonly found type of group disability insurance. Short-term disability (STD) products typically provide benefits for six months to one year, while long-term disability (LTD) policies often pay benefits until the disabled individual either returns to gainful employment or reaches age 65.

All types of disability insurance have an "elimination period" during which the insured must be disabled and unable to work (or partially disabled and suffering a loss of income) before benefits begin. For STD policies, the elimination period usually ends when sick leave benefits end. For LTD policies, elimination periods generally range anywhere from three to six months of continuous total or partial disability.

Usually, group plans have very streamlined or no underwriting requirements so employees do not have to answer a lot of health questions. Your less than healthy employees will find it easier to obtain coverage through the group market than through individual policies. In addition, group coverage usually costs less than an individual policy. But those low premiums come at a cost, and the difference is most obvious under long-term disability policies.

The disability two-step

Most group LTD policies have one definition of disability that applies at the start of the claim and another in the later stages. Policies usually define disability more liberally during the first two years of a claim, which can lead the insured into a false sense of security.

Specifically, group LTD policies use a "modified own occupation" definition of disability during the first two years. Such a definition considers an insured disabled when "…unable to perform the material and substantial duties of your occupation, and are not engaged in any other occupation…" Under this definition, deciding to go back to work or even taking a part-time job can jeopardize benefits.

After two years, however, the definition of disability changes. Exact definitions vary, but most require the insured to be unable to perform any of the material and substantial duties of *any occupation* for which he or she is reasonably qualified by education, training or experience. This forces insureds to navigate changing disability definitions, accepting no work other than their own occupation during the first two years, and then taking any job for which they are qualified after that.

Communication

People facing a sudden disability do not take additional unpleasant surprises well. Educating employees about what they can expect from their group disability plan can help avoid misunderstandings. Benefits will replace only a portion of an insured's salary, typically 60 percent. Employees should also know that most insurers will coordinate group benefits with benefits from individual disability policies the employee owns. In most cases, insurers will not let anyone collect more than 80 percent of his or her pre-disability pay; some may have a specific dollar amount cap.

Group disability benefits can also have tax consequences. If your plan is employer-paid, any benefits received will be taxable income to the employee. Benefits from employee-paid (or voluntary) plans will be tax-free.

Group coverage: a mixed verdict

Group disability coverage can provide vital coverage at a relatively low cost, but it has limits. Higher-income workers and those with dependents will likely want the additional protection of an individual disability income plan. Better individual LTD plans provide "own occupation" coverage until age 65 and are noncancellable, so they provide greater security. For more information on disability income insurance plans and how they might benefit your employees, please call us.

New HIPAA Regulations Apply to Employer-Sponsored Wellness Programs

A new regulation clarifies what financial incentives employers can and can't offer under HIPAA's nondiscrimination requirements.

On December 13, 2006 the Departments of Treasury, Labor and Health and Human Services jointly issued nondiscrimination requirements for employer-sponsored wellness programs. The new regulations exempt certain types of wellness programs from the nondiscrimination standards of HIPAA, the Health Insurance Portability and Accountability Act of 1996.

This is good news for employers concerned their wellness programs might run afoul of HIPAA's nondiscrimination standards. Generally, HIPAA prohibits a group health plan from charging a higher premium based on a health factor. The regulations will make it easier for employers to offer wellness programs.

The following programs are not subject to the standards:

- A program that reimburses all or part of the cost for membership in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that encourages preventive care through the waiver of the co-payment or deductible requirement under a group health plan for the costs of pre-natal care, well-baby visits, or other types of preventive care.
- A program that reimburses employees for the cost of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending monthly education seminars.

Programs covered by the HIPAA non-discrimination standards must meet five requirements:

1) There must be limitations on the size of the award.

2) The program must be reasonably designed to promote good health or prevent disease.

3) The program must give individuals eligible for the program the opportunity to qualify for the reward at least once a year.

4) The reward must be available to all similarly situated individuals unless the program provides for a reasonable alternative standard or waiver for individuals who have difficulty meeting the standard due to a medical condition.

5) Plan materials describing the program must disclose waiver options. Brief mentions of the wellness programs in employee handbooks do not have to reveal all details, but publications specifically addressing wellness programs must.

The regulations specifically limit the reward to 20 percent of the cost of employee-only coverage for employees. If the reward is available to dependents, it is limited to 20 percent of family coverage.

HIPAA is not the only federal law to keep in mind when developing wellness programs. The Americans With Disabilities Act forbids inquiries that are likely to reveal an employee's disability. Make sure participation in wellness programs is purely voluntary. ■

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vantages for employers. The lower premiums of an HDHP can cut upfront costs. Employers provide the low-cost gap coverage as need arises.

Hybrid plan coverage is capped at the HDHP's deductible level. (For 2007, an HSA-qualified HDHP must have a minimum deductible of $1,100 for individual coverage and $2,200 for family coverage. Plans must have a maximum annual out-of-pocket expense of $5,500 for individuals and $11,000 for families.) Most employees will not use the entire amount, and employers save by paying the lower HDHP premiums.

Generally, hybrid plans work well for employers with between 100 and 500 employees. Some insurers may restrict the type of HDHPs employers can use with the hybrids to ensure a seamless transition between the two.

Is the hybrid plan truly consumer-driven?

Some employers have resisted hybrids out of concern that employees will just see low deductibles and not control their health spending. But hybrid supporters point out that, true to its name, a hybrid plan includes the preventive care features of managed health care plans with the cost controls of consumer-driven plans. For more information on hybrid plans, please contact us. ■

Clarification: *The January issue's article on the Family and Medical Leave Act (FMLA) said, "Employees who have been employed by the employer for at least one year and worked at least 1,250 hours in the current or previous calendar year are eligible for leave." Instead of "…in the current or previous calendar year…" the sentence should have read, "…during the 12-month period immediately preceding the commencement of the leave…"*

Diversifying 401(k)s under the PPA

Employers have until March 30 make sure provisions of their 401(k)s dealing with employer stock meet the new requirements of the Pension Protection Act.

Congress passed the Pension Protection Act of 2006 (PPA) to fix numerous problems retirement plans experienced over the previous decade. One of the more notable changes deals with 401(k) programs that are heavily invested in employer stock. Everyone remembers the terrible losses Enron workers experienced when the company's stock price collapsed. Congress saw it too, and took measures to address the problem.

Specifically, the PPA phases out any restrictions on moving retirement plan funds out of employer stock for most workers. The PPA requires employer to issue a mandatory notice to all plan participants who are eligible to diversify their investments.

Generally, defined contribution plans must permit immediate diversification of all salary deferral contributions invested in employer stock. For matching contributions or discretionary employer contributions invested in employer stock, diversification must be offered after the participant has at least three years of service.

A transition rule makes diversification effective for employee contributions invested in employer stock in the first plan year beginning after December 31, 2006. For company contributions invested in employer stock acquired by the plan prior to January 1, 2007, the new diversification election phases in gradually, one-third per year in 2007, 2008 and 2009. This is intended to prevent mass sell-offs of employer-issued stock.

The transition rule does not apply to participants who had attained age 55 and completed three years of service before the first plan year beginning after December 31, 2005. For them, the new diversification rule is effective in the first plan year beginning after December 31, 2006. The PPA requires plans to offer at least three investment options other than employer stock. According to IRS guidance, these options "must be diversified and have materially different risk and return characteristics."

Plans that treat employer stock differently from other investment options must change these provisions by March 30, 2007. Some of the ways in which plans give preferential treatment to employer stock include placing more stringent restrictions on transferring retirement funds out of employer stock or providing higher matching contributions for funds invested in employer stock. Employees affected by any plan changes must be notified so they can plan to diversify their investments.

The new law still permits plan administrators to limit the amount of any participant's portfolio invested in employer stock. Also, employers may close funds invested in employer stock without running afoul of the law. The PPA does not affect Employee stock ownership plans that operate outside of 401(k)s.

For an overview of other changes implemented by the PPA, please see our December 2006 issue. ■

What to look for in a group disability plan

The National Business Group on Health, a national non-profit organization representing large employers and providing solutions to their health care problems, offers three suggestions to provide disability benefits workers can truly use while controlling employer costs:

1) Create "early return to work" policies. Studies show that workers who return to work sooner heal more quickly. This cuts both lost productivity and insurance payments. Establish workplace programs such as light-duty positions that get workers back into the work routine, even if they are not performing all of the functions of their old job. A group disability plan that offers return to work or partial disability benefits eliminates employees' concern they will lose benefits by returning to work.

2) Pick the right plan. As mentioned above, some disability plans actually encourage workers to stay off work longer. Plans with no waiting periods for benefits to start but tight requirements for medical certification of the disabled worker's condition can help contain costs.

3) Select your carrier wisely. Choose a carrier that understands the value of returning the employee to work quickly. Ask questions to determine whether the carrier really helps to get employees back to work. For instance, does the insurer pay for rehabilitation? Does it make medical resources available to disabled workers? Sometimes it's best to talk to other businesses to get references.

For more information on group disability, see P. 2. ■