Employee Benefits Report

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COBRA: An Overview

Valuable benefit can create a compliance burden for employers.

If you employ 20 or more people and offer them group health insurance, you generally are required to provide COBRA continuation health coverage, which allows insureds and their dependents to continue in the group plan at their own expense for a period of time after termination.

While that is of great benefit to the employee, it can be an administrative difficulty for the employer. The rules governing COBRA are detailed and complex and compliance can be time-consuming.

In fact, Hewitt Associates, a human resources outsourcing firm based in Illinois, surveyed 125 large companies in 2005 and found that 77 percent of them outsourced COBRA administration. Only three other human resource functions were outsourced more often, according to the survey: outplacement services (91 percent), employee assistance programs (84 percent) and defined contribution plans (83 percent).

About COBRA

Continuation health coverage has been available since 1986, when Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA). Medical, dental, vision and prescription coverage can be extended under COBRA.

The U.S. Department of Labor says three things determine whether an insured qualifies for COBRA benefits:

- Your group health plan covered 20 or more employees for more than 50 percent of typical business days during the previous calendar year. Count both full- and part-time employees for this

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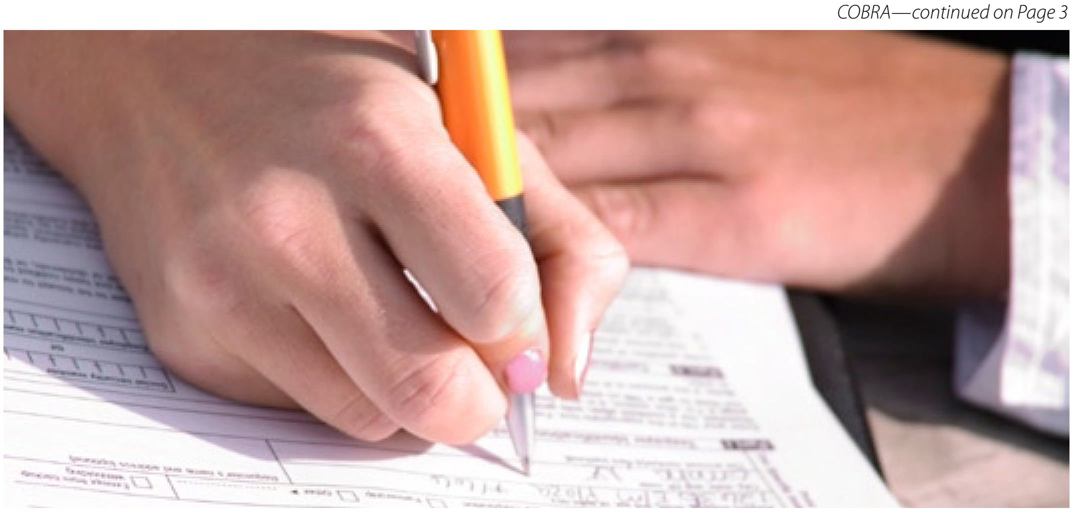
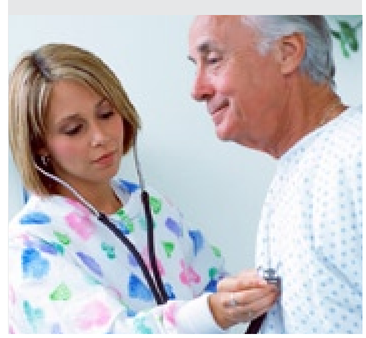


This Just In

Montana has launched an initiative to see that all its workers have health care benefits. A bill being drafted would provide a health care exchange to link existing private insurance companies with individuals and small companies.

Montana is using as a model the Massachusetts program, which has an ultimate goal of insuring every resident. Massachusetts will eventually require that everyone who can afford insurance acquire it, with Medicaid covering those who cannot.

The Massachusetts plan provides portability of coverage and gives individuals a choice of health care options. It also requires all employers with more than 10 full-time equivalent employees that do not provide health insurance to pay an annual $295 per-employee assessment to the commonwealth health care trust fund.



Small Companies Find It Easier to Adapt to Roth 401(k)

New investors and those with high household incomes are early adopters.

Small employers have had the easiest time adapting to offering a Roth 401(k) retirement option, partly because it is easier for them to implement the required payroll changes, according to a report from the Vanguard Center for Retirement Research.

Roth 401(k) investments are made with taxed dollars, whereas traditional 401(k) investments come from pre-tax dollars. All employer contributions under either option are made with pre-tax dollars.

Small companies may have felt the demand sooner, too, the report says. Their plan participants tend to have higher incomes and investment balances, which helps drive demand.

Sponsors of 401(k) plans that have automatic enrollment can choose whether to automatically enroll participants on a pre-tax basis, a Roth basis, or a combination of the two.

Five percent of participants in Vanguard retirement plans opted to use the Roth 401(k) feature the investment management company offered last year, the first year it was available.

"The Roth 401(k) is a very new concept for most plan participants, which is reflected in the overall participant adoption rate of only 5 percent," the report says.

Those who opted in tended to be younger, new plan enrollees, high savers, those who registered on the Web or high-income households, according to a report issued by Vanguard after it assessed the Roth 401(k)'s first year.

Vanguard notes that, although conventional thinking would predict that the wealthy would be interested in a Roth 401(k) option, participants who had been on the job for a year or less and were new to the plans were the single largest group to select the Roth 401(k).

The company has marketed the Roth 401(k) as having benefits for both low- and high-income households, the report says. It recommends that plan participants hold both pre-tax and Roth savings because future income tax rates are uncertain. Traditional 401(k) investors deposit pre-tax dollars and pay taxes at future tax rates when they withdraw their investments in retirement. As with Roth IRA investors, those saving through a Roth 401(k) pay taxes at the front end at today's tax rate and withdraw it tax-free.

The company says new investors do not suffer from the same inertia that affects more seasoned retirement plan investors. The group has always been the most involved in terms of moving their assets from plan to plan or regularly contacting the company for information.

More than half of the people who invested in a Roth 401(k) did so exclusively. Another 39 percent split their saving between a Roth 401(k) and a traditional 401(k). Eight percent invested in the Roth 401(k) and then pulled out, re-routing their money back into a traditional 401(k), Vanguard says.

Only 14 percent of the company's nearly 2,000 retirement plans offered the Roth 401(k) option in 2006, but about a third are expected to include it by the end of this year.

The fact that new investors are choosing the Roth 401(k) leads Vanguard to predict that the option could become increasingly popular.

"After only one year's experience with the Roth 401(k), it is difficult to foresee the future in ten years. But given the potential advantages offered by the feature, as well as the overall change in tax policy, it is possible to imagine a world in which Roth 401(k) savings emerge as the norm for future generations of plan participants," the report concludes.

For more information on Roth 401(k)s and traditional 401(k) plans, please call us.

Investor Comparison

Here's Vanguard's rundown of those most likely to select a Roth 401(k), as compared to 401(k) investors overall:

- **By age: 4 years younger than the average**
- **By job tenure: 3.5 fewer years**
- **By household income: More than $125,000**
- **By retirement plan account balance: More than $500,000, or less than $1,000**
- **By plan contribution rate: 14 percent of income, versus 9 percent for non-adopters**

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purpose, with part-time employees counted as fractions of full-time employees. To determine the fraction, divide the number of hours the part-time employee worked by the number of hours an employee must work to gain full-time status.

✷ Beneficiary was an employee or an employee's spouse or dependent child on the day before a qualifying event. In some cases, a retired employee or that employee's spouse or dependent children may also qualify. And any child born to or adopted during the period of extended coverage qualifies. Agents, independent contractors and directors who are covered by the group health plan may also qualify.

✷ One of two qualifying events occurs for employees: voluntary or involuntary termination of the covered employee for reasons other than gross misconduct, or a reduction in the number of hours worked by the covered employee. Those same qualifying events apply to spouses, with three more added: the covered employee becomes entitled to Medicare, divorce or legal separation of the covered employee, or the death of the covered employee. The qualifying events that apply to dependent children mirror those for spouses, with this addition: the child loses dependent status under plan rules.

COBRA extended health care coverage mirrors the group plan coverage for active employees and COBRA beneficiaries. Any plan changes apply to both groups, and beneficiaries have the same opportunity to make decisions as employees during enrollment periods.

Extended coverage generally lasts for 18 continuous months, but it can be used for an additional 11 months if the Social Security Administration rules that the beneficiary became disabled within the first 60 days of the extended coverage.

A copy of the Social Security ruling must be sent to the plan within 60 days of the latest of one of four trigger events: the receipt of the ruling, the date of the qualifying event, the date the beneficiary would lose coverage, or the date the beneficiary was told of the notification requirement.

The entire family will qualify for the 11-month extension.

The maximum period may extend to 36 months in some cases if a second qualifying event occurs during the first 18-month (or 29-month) period.

There is nothing to prevent a group health plan from extending benefits beyond the standard maximum period, according to the IRS. And benefits can end early if, say, the employer goes out of business and the group health plan is no longer in effect.

Generally the beneficiary pays the full cost of continued health coverage, which cannot exceed 102 percent of the total amount paid by the company and the employee before the qualifying event, the Department of Labor says. The extra 2 percent covers administrative costs.

If coverage is extended an additional 11 months due to disability, the cost to the beneficiary during the 11-month extension rises to 150 percent of the total amount paid before the first qualifying event.

The role of employers

Employers are required to comply with a number of standards in administering COBRA benefits. The law has been modified several times, creating layers of regulation.

The key to managing COBRA extended health benefits lies in the record keeping. In the event of a review, an employer must be able to produce records that show a "good faith" effort to comply with COBRA regulations. Penalties for failure to comply are substantial.

For openers, you must notify employees who have had a qualifying event that they are eligible for COBRA coverage. The notice has to be understandable to your average employee, which requires that you take into account the abilities (including English proficiency) of your staff.

If COBRA coverage is unavailable or is denied, the employer has 14 days from the qualifying event, second event or disability to inform the employee.

You must also inform the plan administrator within 30 days that a qualifying event has occurred, the Department of Labor says. An employee can decline coverage and then change his mind as long as coverage is accepted within the election period.

Premiums must be determined annually, but monthly payments must be allowed (although monthly notices are not required), and weekly or quarterly payments may be allowed. There must be a 30-day grace period.

If premiums are not paid by the first day of the period of coverage, the plan has the option to cancel coverage until payment is received and then reinstate it retroactively to the beginning of the period of coverage.

Several agencies administer COBRA coverage continuation laws. The Departments of Labor and Treasury have jurisdiction over private-sector health group health plans. The Labor Department is charged with the disclosure and notification requirements of COBRA. You can call your local office for information or call the department's hotline at 1-866-444-3272. Or you can write to:

U.S. Department of Labor
Employee Benefits
Security Administration
Division of Technical
Assistance and Inquiries
200 Constitution Avenue NW,
Suite N-5619
Washington, DC 20210

You can also call the Department's hotline to obtain a copy of its employer's guide to COBRA health continuation coverage. ■

Five Steps to Controlling Health Care Costs

Health care costs will reach $4 trillion by 2015, or 20 percent of GDP, according to the National Coalition on Health Care.

That means health insurance cost increases are likely to continue. What can employers do to minimize the impact?

1 Do a diagnostic review. Examine costs and how employees use your group health plan to identify the factors influencing health care cost increases. Include an analysis of: (1) member demographic information, (2) key plan cost and utilization indicators, (3) large claim activity, including frequency and severity, (4) data on expenses by diagnostic category, with comparisons to industry norms, and (5) plan design, including coverage and benefit levels. Once you've identified problem areas, it's easier to prioritize the rest of your cost-management tactics.

2 Promote disease management. Disease management programs can offer a significant ROI if implemented effectively. Analyze your company's cost and utilization data to identify the top two or three most prevalent chronic disease categories and focus disease management efforts on those conditions. Programs generally focus on asthma, diabetes, heart disease and fitness and nutrition. Because the programs are voluntary, employers should provide financial or non-financial incentives to encourage participation.

3 Offer health education and decision support tools. The Internet has enabled many organizations to develop rich health information and decision support sites, such as WebMD.com and others. Health care consumers may visit these sites free of charge and research their conditions, treatment alternatives, and even some provider quality data. Employees can then use the information to work with their doctors to develop treatment strategies and make the necessary decisions regarding their care.

4 Modify pharmacy benefits. Employers are responding to prescription drug price hikes with tactics including: (1) plan design incentives to use less-expensive generic drugs, (2) carve-outs of pharmacy benefits from the medical plan, (3) aggressive clinical/utilization management techniques and (4) close monitoring of drug market developments and rapid incorporation of design changes.

5 Consider offering a consumer-directed health plan. By pairing a high-deductible health plan and a health savings account (HSA), you can control your health care cost increases by putting employees

in charge of their own health care spending. The high-deductible health plan covers them for catastrophic illnesses and expenses, while they can use funds in their HSA as they choose for more routine medical expenses—whether to pay for office visits, fund dependent coverage or buy prescriptions. Funds in the HSA belong to the employee and are portable, which gives employees incentive to control their spending.

For more information on consumer-directed health plans or for a review of your existing benefit program, please call us.

Healthcare Ratings

How do providers in your healthcare network measure up? The federal government's Agency for Healthcare Research and Quality has an online tool to help you find "report cards" that measure clinical quality, patient experience and other qualities for a variety of health care providers. Find out how they rate, from individual physicians to dialysis centers, hospitals and health plans. You can obtain report cards containing data for the entire U.S. or find state-specific results. See the Health Care Report Card Compendium, www.talkingquality.gov/compendium/index.asp.

Employees Pay More for Benefits

Most employees are paying for a portion of their medical benefits. As of 2006, 75 percent of employees contributed toward their group medical premiums, according to the U.S. Bureau of Labor Statistics. That percentage is constantly growing – between 1999 and 2006, the percentage of employees who contributed toward their group medical premiums increased from 67 to 75 percent.

As of 2004, employees paid a national average of 23.6 percent of their single-only healthcare costs. But the employee-paid percentage varied greatly by state. According to the Agency for Healthcare Research and Quality, employees in Georgia paid the highest percentage of premiums among employees in the ten largest states, forking over 21.5 percent of premiums for single-only healthcare. Employees in Michigan paid the lowest percentage, with an average contribution of 14.2 percent of premiums.

Much of the difference could stem from the types of employees: a large percentage of workers in Michigan are unionized, with negotiated benefits, while Georgia is one of the least unionized states.