Employee Benefits Report

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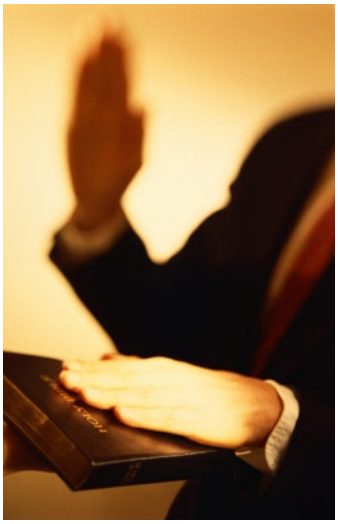

Legal Plans: What's the Verdict?

A 2007 study by Russell Research/ARAG found that 70 percent of full-time U.S. workers had experienced some kind of "legal life event" in the past year. Of these, 20 percent said they were less productive at work, and one-third took time off of work — an average of 13 days — to deal with legal needs.

Despite the prevalence of legal problems, the ARAG study reported that only one of eight employees had access to group legal coverage through their employer.

Do you already provide legal coverage for employees? If not, you might be missing an opportunity to provide a valuable benefit at no cost. Seven out of 10 participants in the ARAG study said they would find legal insurance useful. And although some employee assistance programs (EAPs) provide legal services, benefits are usually very limited.

Group legal plans can fill this benefits gap. And because they are voluntary, only employees who want them participate — costing you, the employer, nothing. Before you offer a plan, though, here are a few facts to consider:

1 There are two types of legal plans: **an access plan** and a **legal insurance plan**. According to the American Prepaid Legal Services Institute's 2004 survey, most people enrolled in group legal service plans have an access plan, also known as a prepaid legal plan. This type of plan gives the participant access to an attorney from a pre-selected network, who will provide a specified number of hours of legal advice or consultation per year at no charge. Typical services might include a simple real estate contract review or simple will. When participants need more in-depth services, they pay the lawyer directly, but the plan typically guarantees a discount off the lawyer's usual hourly rates.

The legal insurance plan has several differences from the access plan. A legal insurance plan is an insurance contract that works like an HMO, where the participant buys an insurance policy, pays monthly premiums and uses a "preferred provider" for services. And like most HMOs, as long as the service you require is covered and you use a network provider, you do not have to fill out claim forms and wait for reimbursement. If you use an out-of-network lawyer, your service will be reimbursed up to a certain (lower) amount.

Legal insurance policies are designed to meet the legal needs of most middle-class families. They cover simple family law matters, such as simple wills, uncontested divorces, uncontested adoptions, juvenile court

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This Just In

Enrollment in consumer-driven health plans (CDHPs) grew 44 percent during 2008, found the 2009 Survey of Consumer-Driven Health Plans by the American Association of Preferred Provider Organizations (AAPPO). That made CDHPs the only type of health benefit option to experience growth during 2008.

The survey found that 8 percent of all U.S. employees were enrolled in CDHPs in 2008, and 7 percent of employers offered this type of plan. However, by 2010, 15 percent of all employers responding expected to offer CDHPs to their employees. In the long term, 43 percent of all employers expect to offer a CDHP, either as one option among several or as the only health plan option.

The Kaiser Family Foundation 2009 Employee Health Benefits Survey reported the average cost of premiums for single coverage in 2009 is $4,824 per year, with the average premiums for workers in HDHPs with a savings option (either HSA or HRA) lower, at an average of $3,986. Your premiums might be higher or lower, depending on the size of your group, geographic region and experience.

Limited Benefit Policies: Is Some Coverage Better than None?

In 2007, nearly 20 percent of working age adults (19-24) had employer-provided coverage, 17 percent had coverage under some type of government plan, and nearly 20 percent were uninsured. Limited benefit plans might appeal to many of these uninsured individuals. Here are some of the pros and cons.

One reason why some adults of working age are uninsured is because they work in part-time or service jobs — jobs where employers find it difficult to provide full medical benefits because of the cost and relatively high turnover among these workers. Others are new employees who haven't met the company's service requirements for coverage under its group major medical plan.

Some employers have explored offering limited benefit or "mini-medical" policies to these workers. Limited medical plans have been in existence for nearly 30 years, but their popularity has significantly increased in recent years. Reasons include double-digit increases in major medical insurance costs and the movement of employees to part-time work and the resulting loss of eligibility for employer-paid major medical insurance.

Limited benefit policies cost less for several reasons. First, they do not have to include state-mandated coverages. Most states require insurers to include certain coverages in all health insurance policies they sell, such as coverage for annual mammograms, alcoholism and addiction treatment, etc. These "mandated benefits" push up the cost of insurance. In response, several states have passed legislation to allow certain types of health plans — including limited benefit plans — to bypass these mandates.

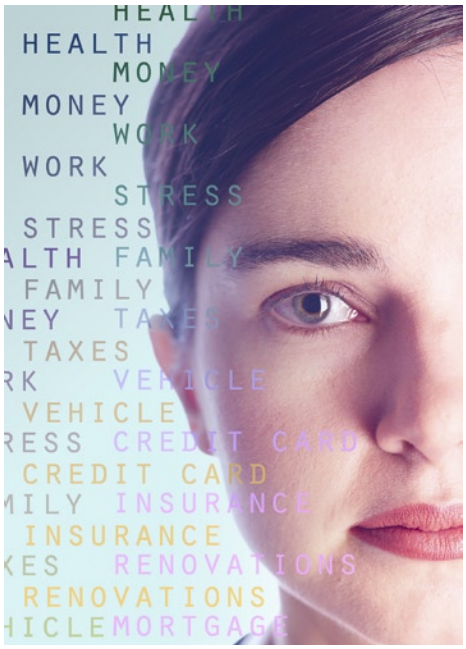
Second, as the name implies, they provide more limited benefits than major medical plans do. Limited benefit plans fall into one of two basic categories: **indemnity plans** and **co-insurance** or **co-payment plans**. Indemnity plans provide a fixed benefit according to a schedule. For example, if you're hospitalized, your plan might pay a hospital benefit of $100 to $1,500 per day, depending on the plan. Under a copayment plan, for the same hospital visit you might have a deductible, a copayment of 30 percent for charges of up to $1,500…and no coverage above that, along with exclusions for specific treatments and tests.

How much coverage do individuals really need?

In 2006, only one-quarter of adults ages 45-64 had annual health care expenditures over $4,552. The median annual expenditure for adults in this age range was $1,627, while about one-quarter had expenses under $385.

Among adults under age 45, only 25 percent had annual health care expenses over $1,737. The median annual expenditure for adults in this age group was $463, while about one-quarter had expenses under $39.

Source: Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality (a division of the U.S. Department of Health & Human Services)



Pros & Cons of Limited Benefit Plans

Pros

They cost less: Some insurers advertise limited medical plan premiums as low as $588 each year per employee (or $49 per month) — compared to an average of $4,824 for single coverage under an employer-sponsored major medical plan. According to State Coverage Initiatives, an initiative of the Robert Wood Johnson Foundation, limited benefit plans cost an average of 5 to 9 percent less than other health insurance plans, even high-deductible health plans (HDHP)s. However, sometimes the old saying holds true — you get what you pay for.

They might provide enough coverage for most employees: According to a recent survey, most individuals of working age never come close to using the maximum benefits of a major medical plan (see sidebar), so the low maximum benefits under some of these plans won't pose a problem for many insureds.

They can provide valuable benefits: A typical limited benefit plan might include coverage for hospital expenses, surgery, anesthesia, and durable medical goods. Some also offer coverage for wellness services, as well as tools for self-care, including telephone or online health information.

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LEGAL PLANS—continued from Page 1

proceedings, minor motor vehicle proceedings (such as speeding, reckless driving, etc.) and IRS audit protection and defense services. Some plans also offer an unlimited number of phone consultations, identity theft services and immigration services.

2 Not everyone can sell legal insurance. Only a licensed insurance agent or broker can sell a legal insurance plan. And while an agent or broker can sell a legal access plan, unlicensed individuals cannot sell legal insurance. If you're not sure which type of plan would best meet your employees' needs, you'll need to talk to a licensed insurance agent to get complete information on both.

Some companies sell prepaid legal plans using multilevel marketing. While there is nothing wrong with this per se, if you deal with this kind of company, check how long your salesperson has been in the field before buying a plan. You will want to deal with someone who will be there when you need service, not someone who was seduced into multilevel marketing and might be doing something else in six months.

3 Not all employees will participate. An article in *HR Magazine* reported that participation rates of 15 to 20 percent of the workforce were typical. Other sources note that employees tend to opt in and out of legal plans as their circumstances change. For example, employees who plan to adopt or buy a house might buy legal insurance, knowing they could use the contract review services. By allowing employees to buy a legal plan on a lower-cost group basis, you give them a valuable benefit that helps them balance work/life demands.

For more information on legal access plans, legal insurance or other voluntary benefits, please call us. ■

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payment in the form of administrative fees and/or rebates from drug manufacturers. PBMs develop relationships with drug manufacturers and negotiate discounted prices based on volume. Manufacturers will give the PBM rebates estimated at between 5 and 25 percent on brand-name drug spending by PBM members. Insureds generally receive a discount on their drugs over the full retail price; however, since most individuals with drug coverage receive benefits through a PBM and the industry is becoming increasingly concentrated, differences in discounts between PBMs is likely to be small.

To evaluate a PBM, then, you will need data on how effective it is at controlling costs; how effective it is at channeling patients toward generic or mail-order prescriptions, where appropriate; and on the level of service and convenience it represents for your plan members. For information, please call us. ■

COVERAGE—continued from Page 2

They can be offered on a voluntary basis: Employers who cannot afford to provide a major medical plan can offer their employees a limited benefit plan on a voluntary basis. This costs the employer nothing, while giving employees access to medical benefits on a lower-cost group basis, with the convenience of payroll deduction.

Some coverage is better than none: Since many workers, particularly low-income workers, are more concerned with the cost of everyday healthcare needs rather than protection from catastrophic costs, the lack of comprehensive benefits might mean less to them than saving money on premiums.

Cons

Some policies provide very low maximum benefits: Look at the annual coverage cap. Some policies have caps as low as $10,000 — not much coverage when the cost of the average hospital stay exceeds $13,000.

Some do not limit the insured's annual out-of-pocket expenses: A major medical plan will cap your maximum out-of-pocket costs each year. After out-of-pocket costs reach the maximum, the policy will eliminate the coinsurance percentage and pay covered services at 100 percent. The better limited benefit plans offer this feature.

Many plans do not cover pre-existing conditions. If your plan does not cover pre-existing conditions, make sure employees know this.

Plan structures can be confusing for employees. In general, indemnity plans are easier to understand and therefore are less likely to cause employees to overestimate their coverage when they need healthcare services.

Plans do not count as "creditable coverage" for HIPAA. HIPAA, the Health Insurance Portability and Accessibility Act, limits the preexisting condition exclusion period under group policies for most people to 12 months (18 months if you enroll late); however, insurers cannot exclude coverage for pre-existing conditions for individuals who have had continuous "creditable coverage" with no break of more than 63 days. Coverage under a mini-medical or limited benefit policy does not count as creditable coverage, although coverage under another group health plan, individual health policy or COBRA does.

Before offering a limited benefits or mini-medical plan, take a look at the maximum benefits provided. Premiums might be relatively high under some plans when you consider the potential maximum payout.

When offering any type of limited benefit plan, make sure you and your employees understand exactly what type of coverage they are receiving and its limitations. Although a quality limited benefits plan can provide valuable benefits to your employees at a reasonable cost, in some cases a high-deductible health plan paired with a health savings account might cost less than you think. This type of health plan can provide employees the catastrophic coverage they need and the funds for day-to-day healthcare they want, at a relatively affordable price.

For more information or a comparison of various healthcare options, please call us. ■

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How Pharmacy Benefit Managers Help You Control Drug Costs

Our September issue covered some of the factors driving prescription costs up and gave some pointers on what employers can do to control employee prescription drug costs. Here's a brief overview of how pharmacy benefit managers (PBMs) help in that process.

Your PBM plays an important role in helping control employee drug expenses.

- PBMs manage approximately 70 percent of the 3 billion+ prescriptions dispensed each year in the U.S.
- Today, approximately 95 percent of patients with drug coverage receive benefits through a PBM.
- PBMs manage pharmacy benefits for nearly 200 million Americans.

A PBM manages prescription benefits for members of a group. Employers can contract directly with PBMs or through their insurer or managed care entity. PBMs generally don't assume any insurance risk, but do take responsibility for assuring the quality and safety of prescriptions issued, along with meeting specific cost containment goals.

Every PBM has a network of retail pharmacies where plan members receive preferred prices on their prescription drugs. (Some PBMs are owned by retail pharmacy chains.) The PBM works with these pharmacies to reduce dispensing fees, lower ingredient costs, and possibly negotiate rebates. Most also have a mail order pharmacy.

In addition, many PBMs provide value-added services. These include checking medications against a patient's health condition and other medications when a prescription is filled for drug interactions, disease interactions, correct dose, excessive use, and drug expiration date.

Some also offer case or disease management, where the PBM provides education to the patient and physician, helps manage a patient's prescription drug regimen — for example, sending reminders when it's time to refill — and follows up on claims to evaluate which drugs are effective at treating a condition. PBMs can also help control costs by monitoring the prescribing patterns of physicians within a network and recommending more effective drugs where available.

Who pays the PBM? The PBM receives

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Employers Give PBMs High Marks

Most employers like their PBM, according to the 2008 PBM Customer Satisfaction Report by the Pharmacy Benefit Management Institute.

For the survey, 275 employers representing 11.3 million members ranked their PBM on three factors: overall service and performance, delivering savings as promised and delivering services as promised. Their ratings averaged a very respectable 8.0 out of 10.0, with 10 being the highest.

What to look for in a prescription drug plan:

1 Plan design: Is the plan structured to encourage your employees to use generic, formulary or mail-order drugs? Members respond to incentives that help them save money, particularly in these economic times. Jack Bruner, executive vice president of PBM marketing at CVS Caremark, recently told *Drug Benefit News,* "We saw our generic substitution rate in our book of business go from 60% to 65% in the past year alone…that's quite an impressive movement."

2 Education: Does your PBM (or its network pharmacies) provide patient education on drug dosage, use, possible side effects and interactions? Does it provide education to physicians?

3 Automatic enrollment: Some PBMs are taking a page from 401(k) sponsors and automatically enrolling group members who need prescriptions for chronic conditions into mail order programs, unless they specifically opt out. Filling prescriptions by mail order usually costs significantly less than filling them at a retail store, and the laws of inertia say that most employees who are automatically enrolled will not bother to opt out. ■