Employee Benefits Report

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The Argument for Employee Benefits

Every year, the cost of benefits goes up. Rules and regulations governing their administration grow more complicated. And then there's the Affordable Care Act… It's enough to make an employer wonder whether to stop offering benefits and face the ACA's penalties next year. But doing so could put your firm at a disadvantage… here's why.

Employees Want Benefits

In survey after survey, employees rank benefits as one of the most important factors in their job satisfaction. They also affect your ability to recruit and retain talented employees. EBRI, the Employee Benefits Research Institute, says, "… one-quarter (25 percent) of employees report they have accepted, quit, or changed jobs because of the benefits, other than salary or wage level, that an employer offered or failed to offer." (*EBRI Notes, November 2013, Vol. 34, No. 11. www.ebri.org*)

Aflac's 2013 WorkForces Report says, "Workers who are extremely or very satisfied with their benefits program are three times more likely to stay with their employer, compared to those workers who are dissatisfied with their benefits program. Moreover, 69 percent of workers who are not satisfied with their current benefits package indicated that by improving their benefits package, their employer could entice them to stay."

Employees Like Their Benefits

In a survey by EBRI, a majority of workers described the U.S. healthcare system as poor or

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This Just In…

In December, the IRS released further guidelines on administering benefits after the Supreme Court ruling in United States v. Windsor. The Windsor ruling struck down a portion of the Defense of Marriage Act (DOMA), creating federal recognition of same-sex marriages in those states where they are permitted. As a result, employees with same-sex spouses can:

- **Make mid-year changes in cafeteria plan elections. Cafeteria plan rules typically forbid changing elections mid-year. However, since *Windsor* applies retroactively, employers that offer health benefits to spouses must allow employees with same-sex spouses to**

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fair (21 percent and 34 percent, respectively). EBRI says their "dissatisfaction with the health care system appears to be focused primarily on cost." While the healthcare system as a whole earns poor grades, most workers with health insurance like their health plan, with half (51 percent) either extremely or very satisfied.

Benefits Have Tax Advantages

Proponents of removing employers from the benefits business say doing so would allow them to pay higher salaries. However, this would make both employers and employees lose important tax advantages. Employers can deduct the cost of providing qualified benefits (which include health, dental, life, disability and retirement plans) as a business expense, while employees receive the value of these benefits tax-free. Providing a portion of compensation in the form of benefits also allows the employer to reduce payroll tax obligations.

Benefits Affect Health, Productivity

Cost causes 25 percent of uninsured adults to go without needed healthcare each year, and 22 percent to go without needed prescription drugs, reports the Kaiser Family Foundation. Having medical insurance removes some of the barriers to receiving health services when needed, which could prevent minor conditions from worsening and reduce reliance on emergency care.

People who have health and dental insurance are generally healthier than those who lack it. Health and financial problems (which can often stem from health problems) also affect employee productivity. In surveys for the Aflac 2013 WorkForces Report, 37 percent of workers attributed their inability to work to financial or health problems. The U.S. Centers for Disease Control estimates employers' cost of lost productivity due to personal and family health problems at $1,685 per employee per year, totaling $225.8 billion annually.

Healthcare Reform Causes Confusion

What about healthcare reform? Couldn't you just give employees a set dollar amount and let them shop for their own coverage on an exchange?

Although the health insurance exchanges were supposed to level the playing field between individual and group insurance purchasers, the fact remains that coverage on the group market is generally less expensive—much less expensive if your organization self-insures or has a grandfathered plan. Individuals also typically have much less leverage over providers and have fewer information resources on quality and effectiveness than buyers of group plans do.

Further, putting the coverage decision-making process directly in employees' hands could leave you with confused employees. Aside from technical problems with the exchanges, selecting a health plan can be a daunting process. It requires individuals to estimate their health costs for the upcoming year, then review plans to see which will cover their expected costs most effectively, when balancing premiums, deductibles and out-of-pocket costs.

A recently released study of individuals selecting health plans on the state and federal insurance exchanges found the majority make poor financial choices. When asked to make the most cost-effective choice, "…respondents perform at near chance levels and show a significant bias, overweighting out-of-pocket expenses and deductibles." Although study subjects did not realize they were making poor decisions, those decisions will

enroll their spouse on a pre-tax basis, beginning with the plan year that includes the date of the *Windsor* decision (June 23, 2013).

- **Obtain reimbursement from a flexible spending account for a same-sex spouse, for expenses the spouse incurred after the *Windsor* ruling or the marriage, if later.**
- **Seek a refund of federal income or federal employment taxes paid on after-tax contributions toward health coverage on a same-sex spouse. Employees may exclude these amounts from gross income when filing an income tax return for the year.**

The *Windsor* ruling will also extend COBRA, FMLA and ERISA protections to same-sex spouses.

If you have questions on administering your employee benefits, please contact us.

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cost them and taxpayers approximately $10 billion per year. Simply changing choice architecture to provide calculation aids and a "smart" default can encourage insurance buyers to make better financial decisions.* In a group setting, employers perform this function by providing a selection of pre-screened plans and plan education to their employees.

A good benefit program can help your employees stay healthier, both physically and financially. We can help you evaluate your benefits program to ensure you are getting the best value for your budget. You can also enhance your benefits package at no cost by offering voluntary benefits. For more information, please contact us.

**Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture, Eric J. Johnson et al, U of Penn, Inst for Law & Econ Research Paper No. 13-28; Columbia Business School Research Paper No. 13-56, July 9, 2013.*

How Do Your Providers Rate?

Before buying something online, you can check reviews from previous purchasers. When you buy a car or appliance, you can check Consumer Reports and other rating services. But when you buy healthcare services, where do you turn for pricing and quality information?

Why Information Matters

High-deductible health plans are supposed to encourage competition by giving consumers financial incentives to seek the most cost-effective, high-quality care providers. HCI3, the nonprofit Health Incentives Improvement Institute Inc., says the U.S. healthcare industry is " …by and large, completely opaque…. And since fear of market loss is a significant concern for many providers, there has been a tendency to block attempts at greater transparency."

In most states, you'll have to look hard to find comprehensive healthcare provider quality information. In HC13's State Report Card on Transparency of Physician Quality Information, released in December 2013, California received a C, while Minnesota and Washington earned A's for providing comprehensive physician quality information. All other states received failing grades.

Minnesota residents can thank the state's 2008 health reform law, which requires the Commissioner of Health to establish a standardized set of quality measures for providers across the state, which resulted in www.minnesotahealthinfo.org. In Washington, consumers can go to www.wacommunitycheckup.org, an initiative of Washington Health Alliance, a nonprofit, nonpartisan organization. Residents in other states have to look a little harder to find physician and hospital quality and pricing information, and comprehensive, easily comparable information might not be available in your area, although more resources are coming online.

Online Health Provider Ratings

A healthcare quality rating might consider a variety of factors, including a provider's reputation, mortality rates (for specific procedures), accreditation status, surveys and participation in various quality initiatives. Here are some possible sources for quality information:

Aligning Forces for Quality, http://forces4quality.org, works with 16 "alliances" across the country to collect and publicly report data on healthcare quality, cost and patient experience. Sponsored by the Robert Wood Johnson Foundation, AF4Q has alliances in seven metropolitan areas and nine states (including Min-

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nesota and Washington), but many have only limited information available to the public at this point.

Physician Compare, www.medicare.gov/physiciancompare/search.html, is a Centers for Medicare and Medicaid Services (CMS) website that provides consumers with basic information on physicians and other healthcare professionals, including primary and secondary specialties, medical school education and residency information. The site includes Medicare-accepted providers only and limits information on quality to whether a provider participates in Medicare quality programs. However, participation can indicate a provider's commitment to quality of care.

Hospital Compare, www.medicare.gov/hospitalcompare/search.html, is a consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. As with Physician Compare, it ranks only hospitals that accept Medicare patients, but it can help non-Medicare patients select quality care by providing useful information on how a hospital performs in several important areas, including providing timely and effective care; rates of readmission, complications and death; and how recently discharged patients rate their hospital experience.

ConsumerHealthRatings.com provides no information on its own; instead it offers a comprehensive listing of organizations that rate or report performance on specific hospitals, health plans, physicians, nursing homes, home health agencies and other healthcare providers in the United States. The ratings information is free.

The National Committee for Quality Assurance (www.ncqa.org) is a private, nonprofit organization offering free interactive report cards. The group is governed by a board of directors that includes employers, consumer and labor representatives, health plans, quality experts, policy makers and representatives from organized medicine. For employers, it offers information on health plan quality, efficiency and ratings. (Note that it ranks only NCQA-accredited plans; not all health plans opt to go through the NCQA accreditation process.) Your employees can find listings of physicians whom the NCQA has recognized as meeting important standards of care in certain practice areas. (Lists are very limited at this time.)

The New York State Health Accountability Foundation (www.nyshaf.org) is a public-private partnership dedicated to promoting transparency in the healthcare system and providing employers and consumers in New York and New Jersey with information on hospital pricing and quality.

The state of California's Office of the Patient Advocate (www.opa.ca.gov/report_card/) provides quality ratings for healthcare plans, hospitals, medical groups and long-term care services, searchable by medical condition, hospital or location.

Consumer Reports, www.consumerreports.org, recently ranked many hospitals nationwide on the quality of their surgical services. The report didn't consider individual surgeon performance, which can greatly affect patient outcome, but based ratings on the percentage of a hospital's Medicare patients undergoing scheduled surgery who stayed longer than expected for their procedure or died in the hospital—information that's publicly available.

In general, we've limited this list to governmental or nonprofit sources. Some commercial rating services, such as Angie's List, use customer feedback to rate physicians and health providers. Patient satisfaction is one, although hardly the most objective, indication of physician quality. Angie's List is moderated, but others sites, such as Yelp!, are not, so take their ratings with a (large) grain of salt. Other commercial physician "ratings" exist, but most are little more than paid directories.

Health insurers play an important role in promoting quality in health services. They do not want to pay for unneeded care or medical mistakes, so they have incentive to steer plan members toward quality healthcare providers. A good insurance plan will contract with physicians and hospitals that have met accreditation standards. Many health insurers are also taking a leading role in developing outcome-based treatment protocols, which promote the use of effective and financially sound treatments. For more information on managing healthcare cost and quality in your organization, please contact us. ■

Dental Plans for Every Budget

Dental health coverage is the second most requested benefit—right behind medical insurance. With a variety of plan types, any employer can find an affordable dental insurance plan to enhance its benefit package.

A fully insured dental plan typically costs no more than 10 percent of the cost of medical coverage, and annual increases are much smaller — usually falling in the single digits. Even nicer, employees who have access to dental coverage tend to use it.

Coverage Options

Although prices vary by region, group and plan, the following generally represent the most to least expensive coverage options:

- **Dental indemnity plans.** Employers pay a monthly premium for this traditional insurance plan. Members then select their own dental provider; the plan will reimburse the provider for covered charges. Many policies encourage regular preventive care by covering 100 percent of the cost of preventive services (such as semi-annual cleanings and annual x-rays) after the member meets the annual deductible. Plans generally require a copayment, such as 20 percent, on restorative treatments, which include fillings and crowns. Some plans also cover orthodontics, typically at a lower percent.
- **Dental PPO and HMO plans.** Like managed care health plans, these fully insured dental plans attempt to control patient spending by steering members to network providers, who have negotiated fee agreements with the insurer. A PPO plan will reimburse the cost of covered services a member obtains from an out-of-network provider, but at a lower percent, such as 50 percent. Many HMO plans will not cover charges from out-of-network providers, except for emergency treatment.
- **Direct reimbursement plans.** In a direct reimbursement plan, the employer creates a written plan, agreeing to reimburse employees up to a certain amount for dental services every year. Employers can determine the annual cap on benefits (usually from $500 to $2,000 per employee per year), as well as what sort of services the plan will cover. When an employee receives dental care, he or she pays up front, then submits receipts for reimbursement. Employers can handle claim verification and reimbursements in-house or hire a third-party administrator to do this.
- **Discount dental plans.** Employers may buy discount plans for their employees, or offer them on an employee-paid voluntary basis. For the cost of about $72 annually, plans promise to save enrollees 15 to 50 percent off average costs for a variety of dental services, such as fillings, braces, exams and routine cleanings. Plans often include discounts on cosmetic procedures that most dental insurance plans exclude. Before offering employees a discount plan, however, check whether the benefits are worth the enrollment fee. Some dentists will discount services for uninsured patients or for payment in full at time of service. Dental discount plans

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also lack the protections of other options, since state insurance departments do not regulate them and most states do not require licensing. Dentists can opt not to accept discount plans at any time, so employees should check before scheduling expensive work.

- **Voluntary dental plans.** With voluntary plans, employees who want dental insurance buy individual dental insurance plans at a discounted rate and pay premiums through payroll deduction. Larger groups may be able to obtain group coverage, which usually costs less, if enough employees participate. The employer has no expense or paperwork, since the insurer handles all administration, including enrollment. With the addition of a premium conversion cafeteria plan, employees can pay their premiums with pre-tax dollars and enjoy a 25-40 percent tax savings on their premium payments.

Oral health has a very strong connection to overall health, and dental benefits encourage your employees to get regular dental care. Please contact us to discuss your company's dental plan options. ■

Life Insurance: Employer Programs Can Eliminate Dangerous Gap

Recent research from LIMRA reveals that most Americans lack adequate life insurance. Employer programs can help fill that gap.

According to LIMRA, with disposable income at an all-time low, American families have to make difficult decisions on what financial priorities take precedence. Unfortunately, life insurance is not at the top of the list. Consider the following statistics:

- **Thirty percent of U.S. households have no life insurance at all; only 44 percent have individual life insurance.**
- **Fifty percent of U.S. households (58 million) say they need more life insurance.**
- **Among consumers who believe they need life insurance, 86 percent haven't bought it because they think it is too expensive.**
- **The average amount of coverage for U.S. adults has declined to $167,000, down $30,000 from the average amount in 2004.**
- **Although 4 in 10 households with children under 18 now include a mother who is either the sole or primary earner for her family, women who have life insurance have only 69 percent of the average coverage amount that men have.**

About 2 in 10 households say they would prefer to buy life insurance through the workplace in the future. They say this because they:

- **View it as an easy and convenient way to buy (33 percent).**
- **Believe it will cost less or be a better value (26 percent).**
- **Trust their employers (20 percent),**
- **Like the ability to have premiums deducted from their paychecks (13 percent).**

If you'd like to add life insurance to your benefits package or enhance the coverage you already offer with a voluntary plan, please contact us for more information on this low-cost, high-return benefit. ■

Source: LIMRA's 2013 Facts of Life, www.limra.com