

Benefit Insights

Voluntary Benefits: A Win-Win that Satisfies Employee Interests and Employer Needs

The voluntary benefits market is growing, and with good reason. Voluntary benefits-offered through the workplace but paid for fully by employees-enable an employer to make a wide array of supplemental benefits available to employees, at little or no cost to the company. Voluntary benefits products are so attractive that, according to one study, more than six in ten employers now offer at least one type of voluntary benefit.

The advantages of voluntary benefits are well known. Because a voluntary benefit product is marketed and sold in a group setting, employees can purchase the benefits at a group rate, pay for them through payroll deduction, and save the time of shopping for them on their own.

For eight consecutive years, Metlife has conducted research on employees and employers regarding the U.S. benefits industry, and compiled the results in its annual Study of Employee Benefits Trends. The 2010 study reveals the apparent resilience of workplace benefits even during a tough economy. It also shows that although employers and employees continue to deal with the effects of the economic downturn, they are focused on the long term, and value voluntary benefits. However, there is a slight disconnect on how much worth employers/employees place on voluntary benefits.

According to the 2010 study, 57% of employees agree that voluntary benefits provide access to options that better fit their needs. Furthermore, 60% of employees surveyed believe that voluntary benefits are valuable to provide them with extra coverage that supplements employer-sponsored benefits.

From the employer's perspective, the study found that many employers underestimate the value employees place on voluntary benefits. Just as employees expressed greater interest in voluntary benefits, the importance of these benefits

has declined among employers. As a result, there may be a missed opportunity for employers to improve satisfaction with benefits program.

The most in-demand voluntary benefits continue to be those that supplement core medical, life, or disability coverages. These include dental, critical illness, specific illness, hospital supplemental, medical supplemental, disability buy-up, and supplemental life coverages. However, demographic trends are contributing to growing interest in long-term care and financial planning products. As more people become faced with their parents' eldercare needs, they begin to appreciate the cost of extended care and anticipate what their own needs may be in a few short years. And, many workers, beginning in mid-career, face the double crunch of saving for retirement at the same time they are attempting to finance their children's college education.

Other products in the voluntary benefits market include vision insurance, legal services plans, auto/homeowners'/renters' insurance, and pet care insurance.

In deciding upon a particular voluntary benefit product or vendor, an employer should keep several things in mind:

- Is the type of product one for which employees have expressed an interest (as demonstrated by requests made or surveys done of the workforce) or one that you are comfortably sure employees will want?
- If administrative processes by the company's human resources/benefits staff will be required, are they easy to understand and economical in terms of the amount of time they will require?

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We hope this quarterly newsletter finds you well rested after the summer. Fall is fast approaching and many are dreading the winter blues when outside activity is limited. Good news! Borislow Insurance offers a comprehensive suite of services to help you create a culture of wellness and encourage healthy lifestyles at the workplace. Contact us for more information - we are here to help.

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HSA Enrollment Exceeds 10 Million; Plans Cut Premium Cost, Attract All Ages

As of January 2010, more than 10 million people were covered by health savings accounts (HSAs), according to a survey conducted by America's Health Insurance Plans (AHIP), a national association representing companies that offer health insurance (and other types of) coverage to individuals, employers, and public purchasers. This represents a 25% increase in HSA enrollment since last year.

HSAs, which were created in late 2003 by the Medicare Prescription Drug and Modernization Act, offer individuals who are covered by a qualified high-deductible health plan (HDHP) a tax-favored way to save for and pay for medical expenses.

Of the total HSA enrollment, about 20% were in the individual market; 30% were in the small group market (defined as businesses with 50 or fewer employees); and the remaining 50% were in the large group market (businesses with more than 50 employees).

In the small group market, the annual premium for the HSA/HDHP product averaged \$3,944 for single coverage and

\$10,048 for family coverage. This bought a policy with an average annual deductible of \$2,239 single/\$4,418 family, and an average annual out-of-pocket limit of \$2,641 single/\$5,064 family.

In the large group market, the annual premium for the HSA/HDHP product averaged \$3,691 for single coverage and \$9,767 for family coverage. This bought a policy with an average annual deductible of \$2,203 single/\$3,907 family, and an average annual out-of-pocket limit of \$2,664 single/\$4,497 family.

Though HSAs sometimes are criticized as being appropriate only for young, healthy individuals, 52% of the people covered by HSA-eligible insurance in the AHIP census were over age 40.

The states with the largest HSA/HDHP enrollments were: California (1,018,000); Ohio (651,000); Florida (639,000); Texas (637,000); Illinois (575,000); and Minnesota (361,000).

The AHIP census was conducted by the organization's Center for Policy and Research. More information on the census can be found through AHIP's Web site, <http://www.ahip.org>

Comprehensive Approach to Wellness and Prevention Yields Best Return

As health care costs continue to rise, discussions abound as to the causes. There is, of course, plenty of blame to go around—an aging population, new treatments and therapies for a variety of diseases, advances in technology. Statistics show, however, that diseases and illnesses that are preventable—at least to some degree—account for anywhere between 75% and 90% of health care costs. Statistics also show that the bulk of health care spending goes toward the treatment of illness and disease, rather than their prevention.

That so much of health care spending stems from conditions that are preventable should come as no surprise, when one considers the American lifestyle. Nearly a third of Americans now fall into the obese category, and at least another third are considered overweight. Packing on extra pounds can lead to a wide range of health conditions: diabetes, high blood pressure, cardiovascular disease, problems with bones and joints, and even some kinds of cancers. Failing to lead a physically active lifestyle worsens the potential consequences. Tobacco use continues to be a problem, with nearly a quarter of men and more than 20% of women smoking, potentially leading to lung- and heart-related diseases for themselves (along with mouth and throat cancers), and for nonsmokers through second-hand smoke.

U.S. employers are beginning to catch on to this reality, and shifting strategies in their efforts to bring health care spending

under control. According to research from Hewitt Associates, 80% of large companies surveyed said they planned to focus on improving employee health and productivity over the next three to five years. As a means to improving employee health, many are using both carrots and sticks: 63% offered a cash incentive for completing a health risk questionnaire and 37% offered cash incentives for participation in health improvement and wellness programs, while 18% employed penalties, including higher benefit premiums or deductibles, for unhealthy behaviors such as smoking or failing to participate in a disease management program (and 29% said they would use them in the next three to five years).

One of the most effective ways to encourage employees to engage in preventive health care measures is to make it as affordable as possible. An increasing number of health plans cover preventive care at 100%, or close to it. (Health care reform mandates coverage of certain preventive care services without cost-sharing for employees, except for grandfathered plans.) Full coverage motivates employees to stay on top of their health, through annual physical exams, screenings for hypertension, cholesterol levels and blood sugar levels, mammograms/prostate exams, health risk assessments, and the like. Such measures, of course, can detect potential health issues at an early stage, when they are more treatable, head off

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When Management and Employees Work Together, Benefits Costs Go Down

A commonality in many workplaces is the rift between the employees and management when it comes to health care benefits. Employees usually accuse the company of being too frugal, and management is unable to find a compromise that makes everyone happy. In the end, employees of the company are left feeling like their hands are tied.

Luckily, a recent session at the Society for Human Resource Management's 2010 Annual Conference explained how one company, with less than 150 employees, saved around \$2 million by simply creating a partnership between the employees and management staff. Together, the company was able cut the soaring costs of medical coverage while still providing excellent benefits to employees and their families.

SHRM recommends an ongoing four-stage method to help control health care costs. Through evaluation, education, communication, and motivation, management and employees can work together to keep the costs of health care down.

Evaluation

Health insurance claims are processed by the provider or a third-party administrator, and in most cases, employers do not see the complete picture of how the benefits are being used. By requesting summative claims data, employers are able to see how money is being spent and who it's going to.

An evaluation of claims data can reveal unnecessary expenses, like miscoded treatments, erroneous charges, and misuse of the system. Employers will also notice ways to cut costs without reducing the benefits, such as when employees are prescribed medicines that are either available over-the-counter or in the formulary. The data will provide insight into the amount of out-of-network care that is being used.

A thorough evaluation gives employers the information needed to better educate their employees on how to efficiently use their health benefits and eliminate unnecessary spending at the same time.

Education

Just as people tend to breeze through owner's manuals and other instructions, the Explanation of Benefits statements

from the insurance provider usually gets the same treatment. Without a total understanding of how costs are determined and why rates go up, many employees operate under the guise that "if it's covered, then just tack it on my bill."

Meeting with small groups of employees is a great way to educate the staff on how the prices of their insurance premiums are directly related to how the employees, as a staff, use the insurance. Higher annual costs equal increased premiums for the following year and lower annual costs result in cheaper rates.

Give cost efficient suggestions to the staff, letting them know how they can help reduce the amount they spend each year. Recommend using only in-network physicians and clinics, and explain how doctors can provide samples of medication before writing expensive prescriptions for drugs that may not work. Since health care plans often cover the families' of employees, make sure to host educational sessions where spouses can attend, as well.

Communication

Communicating the positives of cost effective health care coverage should begin at new employee orientation and continue throughout employment. Dedicating a wall or bulletin board to display current usage data and dollar figures is a key component to keeping employees up to speed on the state of their insurance programs. By making this general data known, employees are able to hold themselves accountable and see how the improvements they have made are affecting the system.

Motivation

With a little motivation from management, employees can see that their bosses are serious about reducing the amount they have to pay for insurance. Rewarding the employees when quarterly costs go down with picnics or even a one-month reprieve of premium charges can motivate the staff to continue to work towards more efficient health care usage.

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more serious developments and avoid costly interventions down the road. They also present the opportunity to direct employees with chronic conditions to disease management programs.

What is the payback for employers who devote more resources to implementing strategies that engage employees in prevention, wellness and overall health education? The return on investment for health promotion and disease management programs ranges from \$1.49 to \$4.91 (with a median of \$3.14) in benefits for every dollar spent, according to information published by NutriScience Corporation. A report from U.S. Corporate Wellness states that health

promotion programs have demonstrated a successful history of both improving health and providing a significant return on investment for the employers implementing them, with ROIs ranging from 3:1 to 5:1, or higher.

No one approach to wellness and prevention is likely to bring about these kinds of returns on investment. Rather, a comprehensive strategy-one that encompasses generous coverage for preventive care, opportunities to engage in wellness activities, carrots and/or sticks for participating in such activities, and plenty of health education-helps create a workplace culture of wellness...along with healthier, more productive, employees.

A Look at Healthcare Reform's Impact on HSAs and FSAs

If your company currently sponsors a flexible spending (FSA) or health savings account (HSA) to allow employees to pay out-of-pocket medical expenses with pre-tax dollars, be prepared for upcoming changes. New health care reform legislation could make these "cafeteria plan" benefits less appealing to employees.

Under the new law, maximum annual FSA contributions are reduced, and there are new regulations affecting how the funds can be used. The intent of the new rules and penalties is to generate revenue which can be used to fund aspects of the health care reform package.

FSAs and HSAs (assuming the employee is covered under a qualified high deductible health plan) allow an employee to contribute tax-free funds that can be used to pay for deductibles, drug co-pays, treatments that are not covered by health insurance, and other qualified medical expenses.

Beginning on January 1, 2013, the annual limit for FSAs will be set at \$2,500. Previously, the IRS had stipulated that employers could establish their own FSA contribution limit, and according to the Center on Budget and Policy Priorities, these limits generally fell into the \$2,000 to \$5,000 range. In 2009, Mercer's National Survey of Employer-Sponsored Health Plans stated that the average yearly employee contribution was \$1,424.

Annual limits for HSAs, however, were not affected by the new legislation.

Be aware that some restrictions will become effective more quickly. For example, as of January 1, 2011, FSA and HSA participants will no longer be able to spend the funds on over-the-counter medications unless a physician has specifically prescribed them. Also starting next year, non-qualified withdrawals from HSAs will be subject to a 20% penalty instead of the 10% penalty which is currently applied.

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- After examining detailed information on the product, does it seem to provide what its name implies?
- Is the carrier/vendor financially stable and reputable?

If chosen properly, voluntary benefits can be a welcome, win-win supplement to an employer's benefits package.



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