FOCUS SECTION

Health Care: Benefits, Electives

Workers have appetite for voluntary menu

Optional benefits can balance reduction in their core offerings

By Christine Stutz
Special to The Daily Record

MAXIMILIAN FRANZ

John Kelly, president of Kelly Benefit Strategies, says offering voluntary benefits can communicate to employees that an employer values them.

As health-care costs continue to rise, employers increasingly are turning to voluntary benefits to offset reductions in what they are able to provide employees in terms of core health benefits.

At one time, employers could be expected to cover the full cost of health benefits for employees, says Greg Dawson, a group benefits consultant with **Chesapeake Benefits Services** in Chestertown. But with spiraling insurance costs and other pressures on profits, benefits brokers say, employers are having to decrease their contributions to employee health insurance premiums, and in many cases they are offering medical plans with higher deductibles and copays than in previous years.

A menu of optional benefits allows an employer to continue to offer an attractive benefits package without the burden of additional cost, because employees pay most or all of the premiums for these benefits. Employees receive the convenience of payroll deduction for premium payments, as well as more relaxed underwriting standards and generally lower premiums than if they tried to purchase such policies on their own.

"Employers provide benefits in order to attract and retain quality employees," says John Kelly, president and senior consultant of **Kelly Benefit Strategies**, the direct sales and consulting division of **Kelly & Associates Insurance Group** in Hunt Valley. "When you consider a job offer, you're looking at salary and benefits." Adding voluntary benefits to the array of offerings "goes into an employee's perception of an employer and how they value their employees," Kelly says.

Some examples of voluntary benefits include accident coverage, critical illness protection and cancer policies. "Cancer is a significant issue for people and a significant fear," Kelly says.

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>
> **Greg Dawson**
> Chesapeake Benefits Services

"You can buy a policy so that, if diagnosed, you will get a $10,000 check to help with expenses."

Employees appreciate the opportunity to supplement major medical coverage with elective plans, Dawson says. "People realize that even good health insurance doesn't cover everything," he says. Policies that help with out-of-pocket costs, such as deductibles and copays, can be very attractive.

In the past decade, consumer-driven health care has led businesses to encourage employees to lead healthier lifestyles because it helps lower premiums. Asking employees to shoulder a greater portion of their health-care costs is a significant part of this movement, as it provides financial incentives for staying healthy. Some employers reward workers who lose weight or quit smoking.

"There's a lot of wellness built into these plans," Dawson says. "If you were to go have screenings, for example, you could get some money back. Aflac offers plans in which they will send members a check for getting a physical."

Not surprisingly, pending health-care reform is causing employers to reconsider all of their benefit offerings. When employers look at mandates associated with the implementation of the Affordable Care Act in January 2014, they anticipate having to insure more employees than they currently are offering coverage to, says Mitch Stringer, managing partner of **Select Benefits Communications Group** in Owings Mills.

A common solution is to switch to plans with much higher deductibles and offering health savings accounts, health reimbursement arrangements and/or gap plans to help employees manage the sudden jump in out-of-pocket costs.

"Some companies contribute to the HSA, HRA or gap plan for the first year," Stringer says, to ease employees' transition to the higher-deductible policy. But employees can fund these policies on their own and still realize meaningful savings in out-of-pocket expenses, he says.

The challenge of providing attractive benefit packages in spite of rising costs should not be taken lightly, according to a recent survey by Aflac, a leading provider of supplemental insurance products. In its 2011 WorkForces Report, 76 percent of workers surveyed said benefits influence their job satisfaction, and 63 percent said they influence whether they will look for a new job.

When it comes to benefit packages offered by their employers, just 9 percent of those responding to the Aflac survey said they believed their current benefits package served their family's needs extremely well.

On the issue of voluntary benefits, the survey found a big gap between what employees want and what employers think they want. Employers who do not offer voluntary benefits make this choice because they do not believe it's important to employees. But 59 percent of employees surveyed by Aflac said they would be interested in buying voluntary benefits.

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>
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> Select Benefits Communications Group

Employers who do choose to increase their offerings of voluntary benefits would be wise to work with a broker who not only can help select the right products, but who will also make sure they complement the entire suite of benefits, including major medical coverage, Stringer says.

"It's very important that the voluntary benefits that are offered to a group are HSA- or HRA-compliant, if you offer those plans," he says. "Having good benefit communications is critical."

For small businesses, big challenges

Affordable Care Act means adjustments ahead for employers

By Christine Stutz
Special to The Daily Record

For years, owners of small businesses have been struggling to provide affordable health benefits to employees and their families. The advent of health-care reform has helped level costs in recent years, but it is also creating some anxiety among employers. As businesses gear up for the implementation of the Affordable Care Act in January 2014, insurance brokers predict challenges as employers and employees adjust to new sets of rules.

"Everybody is already frustrated with costs," says Rodger Bayne, vice president of sales and marketing at **Group Benefit Services** in Hunt Valley. "The act has actually added benefits, added certain provisions and added certain taxes. And probably the most perplexing thing is challenges going forward in terms of compliance."

Small-business tax credits are available to certain employers, but the formula for determining eligibility is complex, Bayne says. In addition, employers have new responsibilities for reporting benefits activity to the federal government and to employees, with "significant penalties" for failure to do so, he says.

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Mike DuVall Jr., an advisor with the Foster Thomas consulting firm in Annapolis, says businesses with 50 to 500 employees may consider partial self-insurance as a means to manage their health benefits.

Beginning with open enrollment in October 2013, small employers will be able to use the Maryland Health Benefit Exchange to offer employees a variety of insurance options, says Rebecca Pearce, executive director of the Exchange. Currently, employers with fewer than 50 employees can only offer plans from one insurance carrier, Pearce says. The Small Business Health Options Program, or SHOP, will allow employees to compare employer-sponsored plans from multiple carriers and choose the plans that best suit their needs and budgets. The Exchange will be accessible at marylandhealthconnection.gov.

The Exchange also will be the vehicle for small businesses to receive tax credits for providing insurance to employees. Currently, organizations with up to 25 employees and average wages below $50,000 are eligible for tax credits to help offset the cost of the insurance. These credits are offered on a sliding scale by the Internal Revenue Service, Pearce says. They phase out as firm size and average wage increase.

"Between now and 2014, small employers will be trying to decide whether they should continue to offer group coverage or let employees go to the Exchange and get federal funds," Bayne says.

Employers with 50 or more employees are subject to penalties if they fail to offer health coverage that is deemed both valuable and affordable. These potential penalties represent "an additional wrinkle" to an already daunting set of new regulations, says Mike DuVall Jr., a human resources and benefits advisor with **Foster Thomas**, a human resources management consulting firm based in Annapolis.

"The fines are pretty easy to calculate. The tricky part will be comparing all employees on an Exchange as compared to a group plan," he says. The biggest challenge for small employers, he adds, is "providing affordable coverage and keeping abreast of all the changes in health-care reform."

While health-care reform will make it easier for consumers to compare plans, consumers will be asked to pay a greater

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FOCUS SECTION

Health Care: Benefits, Electives

What plan to choose? It's an open question

Consumers must carefully weigh multiple factors at enrollment time

By Emily Mullin
Special to The Daily Record

As the open enrollment season for health insurance approaches, consumers are probably thinking more about their coverage options for the coming year. They may also be wondering how the federal Affordable Care Act will impact how they go about making their benefits choices and how the law might affect them and their families.

Results from a September survey conducted by Aetna, a leading national provider of health insurance that operates in Maryland, show that Americans rank choosing health-care benefits as the second most difficult major life decision behind saving for retirement.

Among consumers who found health-care benefits decisions difficult, 88 percent indicated that the available information is confusing and complicated, 84 percent said there is conflicting information and 83 percent said it is difficult to know which plan is right for them.

"In many cases, consumers who spend time reviewing their health plan options can find ways to save money on their health-care costs — whether it's through selecting a plan that will cover more of their expected health costs for a major event in the coming year, such as having a baby or surgery, reviewing which doctors are in-network or evaluating prescription drug coverage," said Dr. Sandra Nichols, chief medical officer of the Northeast region for UnitedHealthcare Clinical Services. UnitedHealthcare is a major health insurance provider in Maryland.

A lack of information or misunderstanding of benefits can lead to consumers wasting money on plans that don't fit their needs. An open-enrollment survey conducted in July by insurance provider Aflac found that 56 percent of employees estimate they waste up to $750 because of mistakes made with insurance benefits elections. In fact, about 24 percent said they chose the wrong level of insurance coverage or benefits options they didn't need, and only 16 percent of employees feel confident they weren't making mistakes during the enrollment process.

Dr. Wendy Shanahan-Richards, a primary-care physician and national medical director for Aetna, said the first step to choosing the right coverage is individuals must assess their health and wellness needs from the previous year.

Shanahan-Richards recommends that individuals look back on the number of doctor appointments in the past year, if they visited any specialists and if they received any special treatments, surgeries or medications. Looking at these factors can help determine what kinds of health services individuals might be consuming in the coming year.

Shanahan-Richards said one of the most common mistakes that consumers make during open enrollment is not giving themselves enough time to review their plan options before the enrollment period closes.

"You should also never assume the benefit plan you had last year is the same plan that will work for you in the upcoming year," Shanahan-Richards said.

Of course, cost also factors into the equation."Consumers need to balance their health-care needs with their financial needs," said Robert Zirkelbach, spokesman for the Washington-based industry group America's Health Insurance Plans.

Zirkelbach said another common mistake individuals make when choosing coverage is looking only at a health plan's cost. Instead, Zirkelbach said, consumers need to look at the whole package.

Nichols agreed that there's more to each plan than copays and premiums.

"For example, some plans offer different prescription drug coverage, while others may offer wellness programs that can lead to discounts on your premiums," Nichols said.

When choosing your health plan, Nichols said, also make sure your primary-care physician and any specialists you visit on a regular basis are in-network. This can save consumers money on out-of-pocket costs.

"Even if you don't plan to make any changes to your health insurance this year, it's always good to confirm that any doctor you see regularly — or plan to visit in the coming year — is in your plan's provider network," Nichols said. "If you plan to visit a doctor or hospital outside of the network, be sure to understand how your costs may differ from an in-network provider, and some plans may not cover out-of-network services at all."

Starting in September, the Affordable Care Act mandated that health insurance companies must make new "Summary of Benefits and Coverage" forms available for every plan they sell. The new forms are designed to help consumers better understand and evaluate their health insurance choices. They will also include a uniform glossary of terms commonly used in health insurance coverage, such as "deductible" and "copayment."

As part of the new law, young adults up to age 26 can be enrolled as dependents on their parents' plans, and many preventive services, such as immunizations and certain disease screenings, are now covered by health plans with no cost-sharing on the consumer side.

The health reform law has also given way to some innovative ways in which health insurance plans can be compared and purchased, Zirkelbach said. For example, retail insurance stores like HealthPlan Headquarters, which opened its doors in December 2010 in Overlea, are beginning to crop up. The store provides self-service kiosks and one-on-one consultations with insurance specialists.

More insurance companies are now offering online tools to help consumers find coverage. Free mobile applications, like UnitedHealthcare's Health4Me app, help locate doctors, review claims and find more information about health plans.

"What you're seeing is that insurers are responding to the individual needs of consumers and employers," Zirkelbach said.

For individuals shopping for their own insurance, www.healthcare.gov can be used to search for and compare plans available in their ZIP code.

UNITEDHEALTHCARE

Dr. Sandra Nichols of UnitedHealthcare says consumers should consider expected medical procedures when selecting a health plan.

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share of their insurance costs than they had under typical employer-based coverage, according to an April 2012 Kaiser Family Foundation white paper, "Patient Cost-Sharing Under the Affordable Care Act." The foundation concludes: "Policymakers will face the challenge over time of finding the right balance between the minimum level of insurance people should be required to have and providing an appropriate level of protection."

As a response to these concerns about health-care reform, some businesses in the 50- to 500-employee range are looking at partial self-insurance as a solution. One of the attractive features of partial self-insurance — also known as captive insurance — is the information employers get on benefit utilization. "It gives you a window to your future claims, so you can plan for them," DuVall says.

In addition, these plans require wellness initiatives, DuVall says. "It helps to catch people who have, or are on the verge of having, untreated chronic disease," he says.

With captive insurance, each employer is responsible for covering its smaller and more predictable claims, using a third-party administrator to handle claims and contracts. Each employer also pays into a group captive "pool" to cover its medium-sized claims. If claims exceed the pool amount, the group shares the loss. Likewise, if the payouts are less than the amount in the pool, the group splits the profit.

For large, catastrophic claims, each employer pays premiums to an insurance company.

Risk management experts say that when implemented properly, a captive insurance strategy can help businesses better manage insurance costs, control claims, build surpluses in anticipation of unforeseen risk and allow for the accrual of wealth on a tax-deductible basis.

But companies and their advisors must be thorough when considering a captive program, experts caution. Programs vary greatly, and they are complex. While there is potential for economic gain, there also can be significant tax and economic detriment.