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This Just In...

Employee benefits' share of payroll expenses rose to 42.3 percent in 2002, from 39 percent in 2001, according to a United States Chamber of Commerce survey. Medical benefits accounted for 15.2 percent of payroll; holiday, vacation and sick pay accounted for 11.6 percent, and retirement and savings payments accounted for 6.2 percent. Total benefit expenditures per employee averaged $18,000 in 2002.

Health care cost-shifting is increasing, as employers who are no longer willing to absorb double-digit rate hikes require employees to share more of the burden. A survey by the National Business Group on Health found that firms are increasing premiums, shifting point-of-care costs and offering high-deductible plans, usually without a reimbursement arrangement. However, companies are also educating workers to help them make better purchasing decisions.

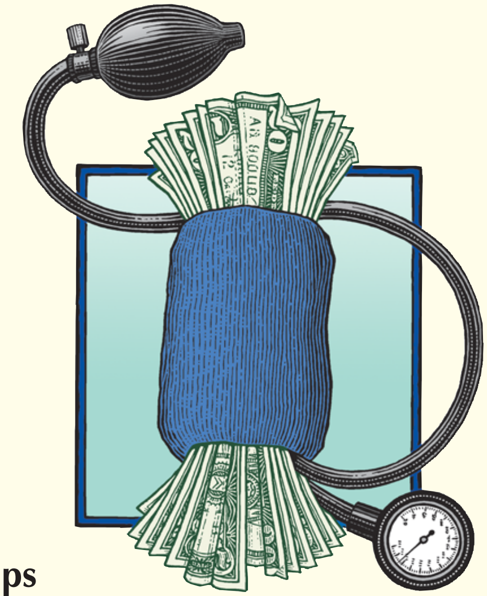
Only 29 percent of surveyed employers said they were willing to absorb health care cost increases, compared with 52 percent in 2000. Companies with a more aggressive approach to cost-shifting reported median cost increases of 7 percent, compared with 17 to 19 percent for most other employers. The 2003 survey included responses from 450 employers.

EMPLOYEE BENEFITS REPORT
Vol. 3, Number 8
August • 2004

How Do You Rate?

Most insurance buyers know there's a relationship between ever-increasing medical costs and their group health premiums...but exactly how does the insurance company come up with your final bill?

When you buy any type of health insurance policy, the insurer will underwrite the policy to determine the group's eligibility and premiums. In the underwriting process, the insurer considers the risk of loss, as measured in claims, that a particular group presents. The set of classifications and statistical standards an underwriter uses to set premiums is called "rating."



Underwriting for large groups

Generally, insurers will use medical rating, or medical underwriting, for large groups (those with more than 100 employees). The insurer will base a larger employer's rates on a combination of the carrier's manual rates and the employer's claims experience. The credibility of the company's own experience depends on its size—the larger the employer, the more accurately its claim history will reflect probable future claims.

To rate these large groups, the underwriter will look at three factors:

1. Expected claim costs, or the insurer's net cost of medical services (after deductibles and copayments). This usually equals 75 to 90 percent of your premiums, according to actuary Steve Kaczmarek, FSA. (Source: *HIU* magazine, April 2004, "Risk and Adverse Selection — Determining Profit Loads When Setting Large Group Premium Rates.") To determine expected claims, the underwriter will look at the health histories of your employees and any past claims history.
2. Administrative costs, or the costs of the insurer's services, "including claim processing, account set-up and administration...typically 7% to 20% of the total premium." (*Ibid.)*
3. The profit load, an amount that "should be related to the level of risk, or volatility in claims, that the company is undertaking." (*Ibid.)*

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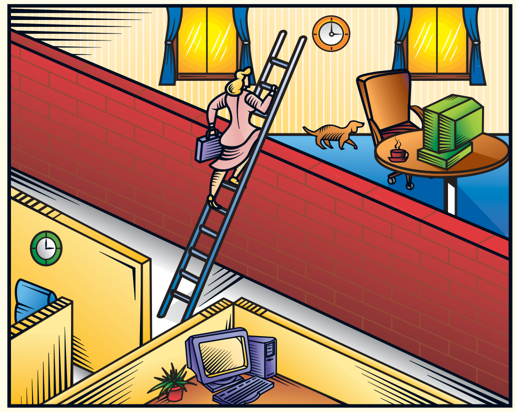
Telecommuting as an Employee Benefit



As the economy picks up, employers might have to increase salary or benefits to attract qualified employees. Not all benefits have to be expensive, though. As employees find it increasingly difficult to juggle demands of work, personal lives and longer commutes, telecommuting or flexible hours become benefits that cost employers little or nothing, yet can reap great rewards for both employers and employees.

Telecommuting a growing trend

Many people do some work at home to catch up—usually unpaid. However, according to May 2001 data from the U.S. Bureau of Labor Statistics, 17 percent of all employees had a formal agreement with their employer to do paid work at home at least one day a week. Those in management, executive positions, professional specialties and sales were even more likely to have a telecommuting arrangement, with at least 20 percent of people in these occupational categories reporting they did some work at home. The American Interactive Consumer Survey found that the number of employed teleworkers jumped from 11.6 million in 1997 to 23.5 million in 2003—an increase of more than 50 percent.

Telecommuting can help employees avoid difficult commutes and better juggle work and personal responsibilities. But what's in it for employers?

- **Greater productivity.** According to congressional testimony, "Companies with telework programs have found that telework can boost employee productivity 5 percent to 20 percent, thereby saving businesses valuable resources and time." Telecommuting simply saves time—employees lose less time to travel, getting ready to work, socializing and other distractions. And because employees choose their own hours, they can work during their peak times—which, for a night owl, might be quite different from the typical 9-to-5. All these factors contribute to greater efficiency.
- **Greater job satisfaction.** One-third of workers polled in a 2003 survey by TrueCareers said that having more scheduling flexibility would increase their job satisfaction. This was more than double the number who said that they wanted more decision-making autonomy, more variety in work projects, more collaboration or "something else." Employees who are satisfied are less likely to leave, reducing turnover costs.
- **Cost savings.** Employees who work at home don't need office space; those who work at the office only part of the time can probably share space with others. This can translate to big savings in areas where office rents are costly. In real terms, "Companies that encourage their employees to telework can reallocate underused office space and realize additional facilities prorated savings of $2,227 per teleworker," calculated the International Telework Association and Council's Telework America Survey 2002. The survey calculated office space at $36/sq. ft.; if your rent is higher, your savings would be higher.
- **ADA compliance.** The Equal Employment Opportunity Commission (EEOC) allows employers to use telecommuting as a "reasonable accommodation" for employees with disabilities under the Americans with Disabilities Act (ADA). The EEOC offers a fact sheet on telework as a "reasonable accommodation" at www.eeoc.gov/facts/telework.html.
- **Easing relocations.** Telecommuting can also help employers that are relocating. According to a 2003 survey by Prudential Relocation, 64 percent of employers surveyed said the top barrier to relocation cited by employees is the cost of living in a new location. Another 55 percent of respondents indicated the cost of housing is a key barrier to relocating. Companies are responding to these concerns in a number of ways. Forty-two percent of the respondents' companies use short-term assignments in lieu of relocation; 35 percent allow employees to work from home and another 32 percent offer telecommuting.

Flextime another option

If your organization isn't ready to make the move to telecommuting, or if your operations demand employees put in "face time," you do have other alternatives. Many employers are moving away from a rigid 8 to 5 business schedule and allowing flexible scheduling.

As with any human resource policy, you must administer telecommuting and flextime options fairly. Not every job can be completed offsite or in off hours, but for those that can, you must offer every eligible employee the option to telecommute. To ensure the success of any telework or flextime program, make sure employees have detailed job descriptions and performance goals, and the technology they need to work from home.

For information on other work/life benefits, please contact us. ❏

The United States Business Telework Act would authorize the U.S. Secretary of Labor to develop a pilot program to raise employer awareness of telework and to encourage employers to give their employees the option to telework. HR 3780, the Balancing Act of 2004, contains this act, as well as others designed to make the workplace more flexible and family-friendly. At press time, no significant action had been taken on the bill.

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An insurer may subject individuals with a pre-existing condition to a waiting period before they can obtain coverage for that condition—in other words, the individual will have coverage for all conditions the policy covers, except for that particular condition.

Underwriting for small groups

Underwriting for the small group market differs from large group underwriting. Medical underwriting makes sense for large groups, because they are better at spreading risk than smaller groups. For example, if two or three people out of a group of 2,000 had a chronic health condition such as diabetes, the effect of the expected increase in claims would be fairly small. But the existence of just one employee with a chronic or serious health condition could make premiums unaffordable for an employer with only ten employees.

To solve this problem, some states require “community rating” for small group policies. Under “pure” community rating, insurers must accept all applicants and charge all applicants the same premium for similar coverage, regardless of their age or health history. Instead of medically underwriting each group on a case-by-case basis, the underwriter uses composite demographic and claims information by geographic area to determine premiums. The underwriter would consider the cost of medical services in your area and estimate costs accordingly. Thus, if your employees live in an area where the population is older than average and where medical expenses are high, you would probably pay more for your group coverage than an employer in a low-cost area whose population skews younger.

Pure community rating might sound good in theory, but it leaves younger (and presumably healthier) individuals and groups paying a higher share of costs than their experience would merit. In a contributory plan, this creates adverse selection, a situation where those with the greatest loss exposures want insurance and those with the lowest exposures might opt out. As a result, your claim costs increase, driving premiums up.

Some insurers use demographic rating, which bases rates on the age and gender of the group members, regardless of health. However, demographic rating creates its own problems. Women of childbearing age usually consume more health services than average, as do men over the age of 50. A group with a high proportion of these populations will pay higher premiums than a group with fewer women under 40 or men over 50—regardless of the health of the individuals in the group.

Of course, how your group is rated is not the only factor affecting your premiums. Plan design plays a very important role in your final premium. A plan with all the bells and whistles naturally costs a lot more than a bare-bones plan.

If you have questions on your group health plan, please contact us. We can look at the various factors that affect your premiums, including plan design, to help you design the best possible coverage for your needs. ❑

HIPAA and group plans

States regulate health insurance, so the underwriting requirements and mandated coverages you will encounter in small group plans depend on where you’re located. However, HIPAA, the federal Health Insurance Portability and Accessibility Act of 1996, has imposed certain conditions on all small group plans, those with 2 to 50 individuals. Before HIPAA, some states had “guaranteed issue” laws that required insurers to provide insurance to small groups. HIPAA made guaranteed issue a requirement in all 50 states.

HIPAA also limits the amount of time insurers can exclude coverage for preexisting conditions from group plans to 12 months for conditions that exist within six months before coverage begins.

Do you know where your tuition reimbursement money is going? U.S. companies spent $10 billion on tuition reimbursement in 2003, according to a survey by Eduventures, a nonprofit research company. Of the 500 companies surveyed 45, percent reported “not very good” management of tuition-reimbursement funds. Asked if they viewed tuition reimbursement as a strategic investment, 23 percent of companies surveyed answered “always.” Thirty-one percent replied “sometimes,” while 27 percent answered either “occasionally” or “rarely.” Only two percent of companies said they calculated the return on investment of supporting their employees’ continuing education.

Employees need more education on their retirement plans, according to results of Merrill Lynch’s 2004 Retirement Preparedness Survey. Most survey respondents expected a 22 percent rate of return on assets during retirement and to withdraw 21 percent of their retirement savings each year. In addition, 58 percent believe that federal law guarantees 401(k) accounts.

Clarification: Our July issue contained an article on qualified sick pay plans, or QSPPs. In the second paragraph, the article said, “Many advisors recommend that companies buy individual disability insurance; however, these policies cannot provide companies the most protection, nor do they cover employees.” It should have read: “Many advisors recommend that *business owners* buy individual disability insurance; however, these policies cannot provide companies the most protection, nor do they cover *employees’ salaries* when an owner becomes disabled and cannot bring in income.”

The article further says that, “The [QSPP] plan is preferable to an overhead disability insurance policy because it allows a business owner to pay his or her own salary.” In reality, a QSPP and overhead disability policy can work together to provide complete salary protection for employees. The QSPP protects employees from loss of income during their own disability; the overhead disability policy protects them when an owner becomes disabled.

Using Benefits to Cut Absenteeism Costs

According to the U.S. Bureau of Labor Statistics, employee injuries and illnesses cost companies approximately 2.8 million workdays each year. On a given day, that means between three to six percent of any workforce is absent, said Matt Lewis, national sales director of Synchrony, an integrated absence-management program from Metlife (Source: *Workforce Management* magazine, September 2003). A 2001 survey by Mercer Human Resource Consulting and Marsh Inc. found that time-off and disability programs cost 15 percent of payroll. Unscheduled absences accounted for nearly one-third (4.7 percent) of these costs. For an employee making $35,000 per year, that translates into more than $1,400 in unscheduled absence costs – not including the cost of lost productivity.

Many employers are increasingly concerned with controlling the cost of unscheduled absences. Although you can never eliminate unscheduled absences, you can tailor your benefits programs to minimize their impact. A list of programs other companies have successfully implemented follows; you can choose the ones that might work for your company:

- **Promote wellness.** Wellness programs can reduce the incidence, duration and cost of illnesses. Depending on your needs and budget, a wellness program might consist of screening and management programs for chronic conditions such as diabetes or high blood pressure, weight-loss programs, exercise programs (such as in-house fitness centers, discounts to area gyms and incentive programs for regular exercise) and smoking-cessation programs.
- **Offer financial incentives for wellness.** You can increase the impact of a wellness program by offering financial rewards for compliance. Before offering financial incentives, make sure they do not violate the nondiscrimination provisions of HIPAA, the Health Insurance Portability and Accessibility Act. The U.S. Department of Labor has proposed rules that would limit any discount on group health premiums to 10-20 percent of the total cost of employee-only coverage.

Under the proposed rules, to avoid discrimination, any incentive program must: **1)** be "reasonably designed" to promote good health or prevent disease, **2)** be available to all "similarly situated individuals," **3)** offer and disclose a "reasonable alternative standard" for those for whom it is medically inadvisable to attempt to meet the wellness standard. For example, if your wellness program offered discounts for walking a certain number of miles each week, you might offer a wheelchair-bound employee a reasonable alternative. Also, remember that no group health plan can require an employee to pass a physical exam to be eligible for coverage!

- **Start an in-house medical clinic.** Lab Safety Supply in Janesville, Wis. added an in-house medical clinic in 2000. The clinic reduced absence time for office visits from a half-day to less than an hour. Although the company has only 800 employees, it saved $400,000 in group medical costs a year—in part through lower doctor office visit costs, which went from an average of $150 to $25 per visit. These savings did not include reduced costs of disability and chronic illness. However, the on-site clinic makes it easier for employees to get screenings and early treatment for chronic conditions such as high blood pressure and diabetes, which they might not see their regular doctor for.
- **Implement a paid time-off bank.** Instead of the traditional time-off program, which separates days off into sick days and vacation days, consider creating a paid time-off bank. This allows employees to use their days however they need. If an employee can use a "personal day" instead of a sick day to take care of personal business, he or she might be more likely to schedule it in advance.
- **Implement a disability management program.** When employees are off work due to disability, whether work-related or not, a disability management program can help speed recovery by ensuring that they receive appropriate treatment and modified-duty assignments when returning to work, if appropriate. Studies have shown that early return-to-work reduces the duration of a disability.

For more information on wellness programs and other benefit programs, please call us.