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**This
Just
In...**

HUMAN INSURANCE



New Treasury Department HSA rules expand the role of preventive care. The guidelines issued this summer state that wellness programs, employee assistance plans and disease management programs are preventive care – and thus can be covered under a Health Savings Account through first-dollar or copayment arrangements. Certain prescription drugs, such as those used to prevent a heart attack, treat obesity, or help someone quit smoking, also count as preventive care. The guidance answers many other HSA-related questions, including rules about salary reduction, out-of-pocket maximums, and employer matching contributions. For a complete summary see: www.treasury.gov/press/releases/reports/hsanotice200450072304.pdf



How popular is your company's Internet investment advice? After rolling out Web sites designed to help 401(k) participants, plan sponsors are now coping with an uncomfortable realization: most people don't use them, according to a 2004 survey by Greenwich Associates. Only about one-third of defined contribution plan participants use the 401(k) Internet information tools provided by their companies, and participants taking full advantage of these tools seem to be a mere fraction of that. This failure represents a major financial hurdle for plan sponsors and service providers. Not surprisingly, the proportion of mid-size companies offering investment advice via the Internet dropped to 43 percent in 2003, from 55 percent in 2002.

The Lowdown on Consumer-Driven Health Plans

How high have your company's health care premiums risen in the last few years? If "through the roof" comes to mind, you're not alone. Sharply rising premiums are leading many employers to consider consumer-driven health plans.

Consumer-driven health plans (CDHPs) are designed to give workers a broad choice of providers while raising awareness of health care costs through increased patient responsibility. And the savings are measurable: companies adopting CDHPs face premium increases of seven percent compared to 17 percent for those with traditional plans, according to Mercer Human Resource Consulting.



Since the Medicare Reform Act of 2003 made health savings accounts (HSAs) available beginning January 1, 2004, many new consumer-driven health plans consisted of a catastrophic (high-deductible) insurance plan combined with an HSA. HSAs make consumer-driven health plans easier to administer for employers and more attractive to employees. Only individuals covered by an eligible HDHP can open an HSA, but either the individual or employer can fund it—in 2004, up to \$2,600 for someone with individual coverage or \$5,150 for family coverage. With an HSA, the account holder's funds can accumulate from year to year, giving employees incentives to shop for more cost-effective treatment. And although they do not give employers the cash flow advantages of health reimbursement accounts, where funds remain under employer control until the employee submits an eligible reimbursable expense, they also do not require administrative work on the part of the employer.

Not all employers sold

Despite the lower employer costs with consumer-directed health plans, not all employers are convinced they will reduce health system costs. Although employees under CDHPs have greater access to providers than employees under a PPO or other managed care plan, they might not have the information they need to make truly informed health care decisions. For this reason, such plans might put less-educated, non-English speaking or workers without access



EMPLOYEE BENEFITS REPORT

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Are You Paying Too Much in Retirement Plan Fees?

You have a fiduciary duty to assess 401(k) and other retirement plan fees not only when you first hire investment consultants, money managers and other providers, but again every few years. But do you really know what you're paying, let alone if the assessment is fair? Here's a rundown of typical fees.

✓ Investment management fees are typically the largest portions – often 70 to 80 percent – of total plan costs. Generally calculated as a percentage of assets invested, these fees are deducted directly from investment returns, and are not specifically identified on investment statements. Investment products that require significant management, research and monitoring services usually will have higher fees – which may or may not mean better performance. These fees are the most manageable and predictable costs to reduce, as employers typically have a number of funds to select from that meet their 401(k) plan needs.

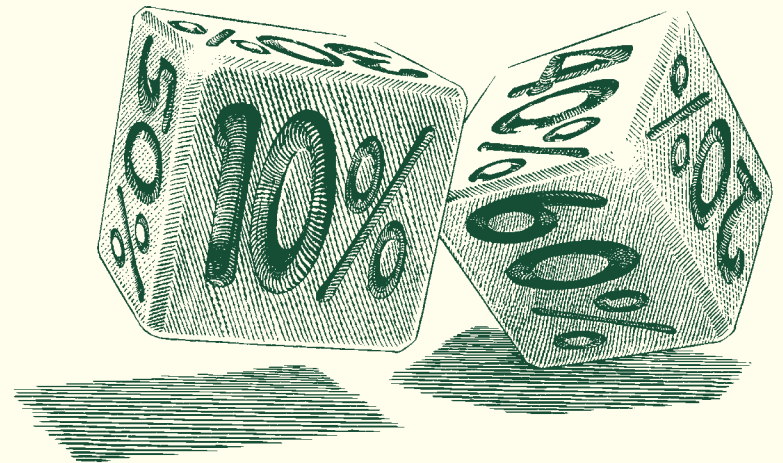
✓ Plan administration fees involve expenses for basic functions such as record keeping, accounting, legal and trustee services. The plan also may offer investment advice, customer support systems, electronic access to plan information, online transactions or other services. Administrative costs may be covered by investment management fees and deducted directly from returns. When billed separately, you may cover them or they may be charged against plan assets. For a plan with individual accounts, fees are either allocated among individual accounts on a pro rata basis, or charged as a flat fee against each participant's account.

✓ Individual service fees are associated with optional features offered under an individual account plan. Fees are charged separately to the accounts of those who choose to take advantage of a particular plan feature, such as a loan from their account assets.

✓ Revenue sharing. While “hard dollar” fees charged by providers are detailed in service agreements, many more fees go undisclosed. With few exceptions, mutual fund families pay marketing agents and administrators money—referred to as “revenue sharing”—for using their funds as investment options. Paid out of plan assets, these fees total as much as \$1.5 billion annually. Despite the recent publicity about hidden fee arrangements, revenue sharing remains an entrenched if questionable practice. It's legally permitted if disclosed, but often it's not and nondisclosure is rarely enforced. Revenue sharing mostly affects small and mid-sized plans serviced by bundled providers. Large plans have the size and expertise to negotiate low fees, but small plans pay a higher percentage of assets in fees.

What can you do?

Try a fee audit. These audits are in-depth investigations that aim to uncover any hidden fees being paid, determine a plan's total costs and, if possible, negotiate waived or reduced costs going forward.



While audits don't necessarily lead to recovered funds, plan sponsors that undertake them at least find out if they're being overcharged.

Experts advise plan sponsors to hire a fee-only, non-commissioned professional who has no other interest in the plan. Consultants stress the importance of asking the right questions—and knowing if you receive straight answers. Few service providers volunteer revenue-sharing data. Some will provide it when asked, and up to a certain point. If they refuse to provide the information you need, use publicly disclosed amounts in your calculations—and note the lack of cooperation from the vendor(s).

Armed with information about the true costs of their plans, you can often negotiate lower fees and/or additional services. Experts advise that no plan should pay more than 1.5 percent of assets, inclusive of everything. If negotiations don't work, it may be time to shop for a new vendor. □

OTHER COMMON MUTUAL FUND FEES

12b-1 fees: Disclosed amount paid to brokers, record keepers and others for distribution and shareholder services, including marketing and advertising. Cannot exceed 1 percent of assets.

Subtransfer agency fees: Undisclosed amounts paid to brokers and third-party administrators for record keeping, accounting and other administrative functions. Rates are negotiable, commonly at least 0.25 percent of assets.

Finders' fees: Undisclosed fees paid to brokers and others who bring in new money to the plan. Commissions are typically one percent of the first \$1 million in assets delivered.

Sales charges: Basically transaction costs for buying and selling shares. A front-end load is deducted up front, reducing the amount of the initial investment. A back-end load, or redemption fee, is paid when the shares are sold.

Long-Term Care Insurance Helps Productivity, Saves Money

Healthcare costs rise dramatically as we age, so it's no surprise that more than one-third of large companies and a quarter of midsize firms now offer some type of long-term care insurance (LTCI), according to a recent report by the American Council of Life Insurers.

LTCI provides insurance to meet health care needs should a person become chronically ill or disabled, generally after age 65. Policies pay benefits over a much longer time span compared with standard accident and health policies. Coverage includes the cost of custodial care as well as skilled nursing care. These two advantages often make LTCI a preferred way of pre-funding nursing home care for the elderly. The main disadvantage is the high cost of coverage, due to escalating health costs in general and uncertainty about long-term usage of LTCI by the burgeoning elderly population.

Employers who offer group LTCI to employees and retirees view LTCI as part of their recruitment and retention strategy. As Baby Boomers get older, they are more concerned with their long-term financial security—an LTCI plan can help you retain valued experienced workers. Interested in learning more? You have three basic options:

- ✱ **True group plans.** These plans are usually guaranteed issue (no qualifying health questions) for all full-time employees. With guaranteed issue, no employee is discriminated against if he or she has a disabling or potentially disabling condition. As a group plan, a select set of identical benefits can be offered to all employees no matter which state they live in. Benefits other than the select set may be available but usually require medical underwriting. True group plans can be converted to an identical individual plan—at group cost—when the employee leaves the group.

- ✱ **Modified guaranteed issue.** Modified guaranteed issue means there is no medical underwriting, but employees must answer one or more qualifying questions to eliminate disabled or very sick workers. For groups with low participation, rates for modified guarantee issue plans are generally less than true group rates. Because modified guaranteed issue programs issue individual policies, the employee can keep the policy and rates when he or she leaves the group.

- ✱ **Individual plans with group discounts.** These are identical to plans that are offered to the public but the premiums are discounted from five to 15 percent for members of the group. The employee can choose any of hundreds of benefit options since everything is medically underwritten.

The key components of the LTCI policy include:

- ✱ the daily benefit, a maximum dollar amount
- ✱ the benefit period - usually two to six years or “lifetime”
- ✱ the elimination period - usually 20 or 100 days, during which employees must pay LTC costs out of pocket

Policies with higher daily benefits and longer benefit periods provide the most protection; however, they also cost more.

Other features to look for:

- ✱ **an inflation rider (optional).** This increases the daily benefit amount as costs rise, protecting your employees from the effects of inflation.

- ✱ **a waiver of premium (optional).** Many policies include this option, which waives an insured's premium payments when he or she is receiving long-term care services, usually after an elimination period of one to several months.

- ✱ **pre-existing condition clauses.** If you buy a program that is not guaranteed issue, insurers might put pre-existing condition clauses in the policies of those individuals with pre-existing health conditions. These clauses eliminate coverage for up to six months AFTER policy inception for long-term care services caused by any condition for which the insured has received medical advice or treatment from a licensed provider within the six months BEFORE the start of the policy. From a practical standpoint, however, insurers use pre-existing condition clauses less frequently in LTCI policies than in other types of health insurance, because the insurer would prefer not to sell a policy to someone who might need long-term care within six months.

- ✱ **guaranteed renewability.** A guaranteed renewability provision allows an insured to renew coverage no matter what his/her current health condition. This feature is

extremely important, because it ensures that the LTC coverage will be available when needed.

Common exclusions from LTCI coverage are: mental and nervous disorders, other than Alzheimer's disease; drug or alcohol addiction;

LTCI – continued on Page 4



“More than half of all workers are concerned about the need for long-term care coverage ...yet insurers have sold only about eight million LTCI policies nationwide”

The good news for smaller companies is that health insurance cost increases slowed down in 2003.

The not-so-good news is that rate increases will accelerate through the end of this year, according to a survey by Marsh, Inc. Companies with fewer than 2,000 workers saw premiums increase by 9.8 percent in 2003, down from 18.4 percent in 2002. But these companies expect premiums to rise another 14 percent in 2004. Nearly half of employers with between 1,000 and 1,999 workers are planning to raise employee contribution amounts, and 43 percent intend to increase deductibles and copays. The survey also revealed that more than 33 percent of medium-sized firms that offer preferred provider plans now have deductibles of \$1,000 or higher, up from as low as \$250 in early 2000.

Most employee benefits held steady or expanded this year,

according to a 2004 survey by the Society for Human Resources Management. Certain benefits, such as housing subsidies, wellness programs and schedule flexibility, are growing in popularity. Twelve percent of companies provide mortgage assistance for their employees, compared with 6 percent four years ago, while 58 percent of companies now encourage wellness programs for their workers, up from 51 percent in 2000. Other benefits have slipped, as some employers eliminated 401(k) matching contributions or scaled back their defined-benefit pension plans and increased 401(k) matches.

Nearly two-thirds of workers eyeing early retirement expect to have health insurance coverage,

though few know how they will pay for it, according to a recent Health Affairs report. Of those not covered through an employer or union, 11 percent planned to purchase a policy on their own, nine percent would go without coverage, six percent said they would use COBRA, and only five percent said they would rely on public coverage such as Medicaid or veterans' benefits.

LTCI – continued from Page 3

war-related injuries or illnesses; treatment paid by government; and injuries or deaths that are self-inflicted. Employees who pay LTCI premiums receive a tax deduction, while company-paid premiums are deductible for the employer and tax-free for the employee. Premiums paid through a cafeteria plan or FSA, however, are taxable.

More than half of all workers are concerned about the need for long-term care coverage, according to a recent U.S. Chamber of Commerce study, yet insurers have sold only about eight million LTCI policies nationwide. For more information on how you can provide your employees with this valuable benefit, please call us. ☐



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to the Internet at home or work at a disadvantage. Further, objective information on the relative quality of providers or treatment plans can be difficult to find.

Other employers that have provided more traditional plans with first-dollar coverage fear a CDHP will be too much of a shift for employees—both in terms of learning to navigate the healthcare system and in terms of cost-shifting. Employees themselves agree—in a recent study by Towers Perrin, only 28 percent of employees surveyed felt “it would be appropriate for their employers to ask them to absorb additional cost increases...”; last year, nearly half of employees (46 percent) said it would be appropriate.

Getting employees on board

The Towers Perrin study found employers spend too much time explaining that rising costs affect the company, but don't devote enough attention to what employees should do to be more effective health care consumers. To make a successful switch to a CDHP requires some advance planning and work on the part of an employer:

- * Look for a plan that offers information and decision-making tools participants can really use.
- * Build in time to educate employees about the new plan. Targeted advance communications can help a company substantially increase its first-year enrollment rate.
- * Focus education efforts on wellness and how to use health data to make care decisions.

CDHP Pros and Cons

Employers

Benefits	Problems
Higher cost sharing = lower costs	Employee acceptance
HRA contributions easier to budget	Pressure to increase contributions than premium increases to offset higher cost sharing
Decreased role as health plan selector	Administrative issues
Chance of reduced utilization	

Employees

Benefits	Problems
Better personal health information	Participants' ability to gather and evaluate health information may differ.
Greater accountability for health choices ongoing, active management of health care	Passive or frustrated users.
Winners – some better off financially	Losers – some worse off financially

For more information on consumer-driven health plans, please contact us. ☐