Employee Benefits Report

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Health Benefits May 2012 Volume 10 • Number 5

Mental Health: Heal the Mind, Heal the Body

More than one in five American adults live with a diagnosable, treatable mental health condition and can go on to live full and productive lives. That fact makes May, Mental Health Month, a good time to take stock of your organization's mental health benefits and how a properly structured benefit program can support the very real link between mental health and overall wellness.

Employers that offer health benefits typically include some level of mental health care in their benefits package. Now that many employers are forced to cut costs, cutting back on mental health benefits might sound tempting. However, scaling back mental health benefits may raise health costs in the long term for the 22 percent of adults in the U.S. who suffer from a diagnosable mental health disorder, according to the National Institute of Mental Health.

The Mental-Physical Connection

The most common mental health disorders that arise in the workplace are anxiety and depression. Yet mental problems often present themselves as

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This Just In…

Does your business qualify for the small business health care tax credit? Employers with fewer than 25 full-time equivalent employees that pay an average wage of less than $50,000 a year and pay at least half of employee health insurance premiums may qualify.

The amount of the credit you receive works on a sliding scale: The smaller the business or charity, the bigger the credit. For tax years 2010 through 2013, the maximum credit is 35 percent for small business employers and 25 percent for small tax-exempt employers such as charities. An enhanced version of the credit will be effective beginning Jan. 1, 2014. In general, on Jan. 1, 2014, the rate will increase to 50

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physical problems, and employees are more likely to seek assistance for a physical problem. Studies have shown that if workers don't get the treatment needed for their underlying condition, they use a lot of services they don't need. A medical doctor may not be able to determine what is wrong with a patient and will do a battery of expensive tests because he/she doesn't want to miss anything. The end result? Physical healthcare can cost a whole lot more when mental health benefits are not available.

Further, employees who have ready access to good mental health benefits are less likely to be out on disability leave. Employees on behavioral health disability tend to stay out longer than those with any other condition, says the Society for Human Resource Management (SHRM).

Untreated behavioral illnesses can have other consequences as well. Not only can productivity drop, but mental illnesses such as depression also can compromise employee safety.

Many employers have developed cost-sharing structures to encourage workers to use mental health benefits, including eliminating employee out-of-pocket expenses for initial consultations or employee assistance program (EAP) services. EAPs can offer a wide range of mental health-related services. Some companies have on-site EAPs, providing free counseling in the workplace, while others believe employees are more likely to use an EAP located off-site. Benefits managers often characterize their EAP as a "gateway" to services, rather than the traditional "gatekeeper" that limits access to services. EAPs can often serve as a direct link to the benefit plan's network of mental health providers.

To improve employee access to mental health care, consider the following best practices in benefit design, plan management and monitoring and evaluation:

Benefit design. Analyze the characteristics of your company's workforce. Look at gender, age, profession, etc. to identify any special mental health needs unique to your employee populations—then structure your benefits plan accordingly. Offer a wide variety of physical and mental health work-site wellness programs to help your employees balance work and home life.

percent and 35 percent, respectively.

Even if your business did not owe tax during the year, you can carry the credit back or forward to other tax years. Tax-exempt employers may be eligible for a refundable credit. Also, since the amount of the health insurance premium payments are more than the total credit, eligible small businesses can still claim a business expense deduction for the premiums in excess of the credit. That's both a credit and a deduction for employee premium payments.

Consider on-site counseling or psychiatric care, including consultative and administrative services such as case management, patient advocacy and general advice about the company's benefits plan. Customize a network of mental health specialists based on employee preference and past claims data.

Plan management. Take an active role in directly managing both plans and vendors. Be sure to clearly communicate the company's approach to mental health benefits to insurers, EAP vendors and providers, who frequently focus only on controlling costs.

Monitoring and evaluation. Evaluate plan options regularly and work to improve inadequacies. Use performance data to assess the relationship between access to services and employee productivity and treatment costs. Establish a mechanism to monitor disability and absenteeism to determine the link between increased mental health spending and decreased employee health problems.

Employee feedback should play a significant role in shaping the benefit design and influencing policies. Assess employee satisfaction to improve areas of poor performance and be willing to change policies based on employee complaints. Solicit employee input through focus groups and direct interviews.

By offering comprehensive mental health benefits, your company invests in employees' overall wellness. Meeting your employees' mental health needs produces long-term savings by decreasing health care costs, increasing productivity and reducing absenteeism. If you would like assistance with your mental health benefits program, please contact us.

Avoid Nondiscrimination Nightmares by Increasing Retirement Plan Participation

You might have the best retirement plan available, but if employees aren't participating, what's it worth? The following plan changes could make your plan more attractive to all employees.

Nondiscrimination rules prohibit top-heavy plans, or plans that involve too many high-income earners and not enough lower earners. It's usually easier for high-income employees to set money aside because they have more free cash. Low-income earners often have to make tougher decisions, such as whether to save a little or to make the rent or mortgage payment on time.

So what can you do to encourage your employees — all of them — to commit to a retirement savings program?

1 **Offer a 401(k) plan and discuss its advantages:**
   - ✔ Contributions are made with pre-tax dollars, which lowers the income tax bill each year. Earnings are not taxed until they are withdrawn, and since many employees move to a lower tax bracket after retirement, taxes will take a smaller bite then.
   - ✔ Matching employer contributions, if you decide to make them, help employees' savings grow faster.
   - ✔ Automatic payroll deductions mean the employee has only one advertised chance a year to decide not to save for retirement. If they are saving on their own, it is easy to decide not to save every pay day.

2 **Offer automatic enrollment.** Enrolling employees automatically in a 401(k) plan essentially switches the retirement savings decision from opt-in to opt-out. The U.S. Treasury Department notes that this creates a "positive presumption" in favor of saving — even though the employee must be

The Employee Benefit Research Institute (EBRI) reports that, among full-time wage and salary workers ages 21-64, 54.2 percent had access to an employer-sponsored retirement plan, and 44.9 percent participated. Despite this, about one-half of workers are "at risk" of not having sufficient retirement resources to pay for "basic" retirement expenditures and uninsured health care costs, according to EBRI's 2011 Retirement Readiness Index. ■

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given adequate notice and an opportunity to opt out. Case studies show that automatic enrollment has a positive effect on participation, particularly among low- and moderate-income workers.

Unless employees decide to make their own investment decisions, contributions are invested according to program terms.

3 **Make it simpler to borrow against the plan.** 401(k) plans have a loan provision that allows investors to borrow against their savings in times of need. While financial experts generally say that borrowing against a 401(k) works against the ultimate goal of saving for retirement, the ability to borrow cash from yourself can be a lifesaver.

And knowing the money is not locked up until they reach a certain age may encourage people to save. In fact, a 1997 study by the federal government's Government Accountability Office showed that allowing loans increased participation in 401(k)s and increased the size of contributions, particularly among lower-income employees.

4 **Give them confidence with a lifecycle fund.** Selecting among funds to create diversity of risk can be a daunting task for employees, even with the narrowed choices of a typical 401(k) plan.

Lifecycle funds relieve some of that pressure. These are 401(k) funds that automatically diversify a participant's assets according to a planned retirement date.

There are two types of lifecycle funds. In a **target-date fund**, a manager, using a standard defined by the plan, gradually shifts investments from aggressive to conservative as the employee ages. In a **target-risk fund**, the employee/investor decides the level of risk he wants and the manager adjusts holdings to create that risk. The employee can change risk level as time goes by.

Lifecycle funds do have drawbacks, and their one-size-fits-all approach might not work for certain individuals. Still, employees intimidated by the selection process might find lifecycle funds an inducement to save. And savings — even with drawbacks — are better than no savings at all.

For more information on making your company's retirement plan more attractive to employees, please contact us.

Save Money with a COBRA Audit

A COBRA audit can help you trim your rolls of ineligible beneficiaries. Doing so can help you save money in three ways.

The health provisions of COBRA, the Consolidated Omnibus Budget Reconciliation Act, require most group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children who would otherwise lose coverage due to specific "life events," such as divorce or job termination.

COBRA generally applies to all employer group health plans maintained by employers that had the equivalent of at least 20 full-time employees on more than 50 percent of typical business days in the previous calendar year. COBRA also applies to plans sponsored by state and local governments, but not to plans sponsored by the federal government or by churches and certain church-related organizations.

When an eligible individual elects to continue group coverage through COBRA, the employer or plan sponsor can require beneficiaries to pay the full cost of coverage, plus 2 percent for administrative expenses. Despite this, keeping COBRA beneficiaries on your insurance rolls costs you money. How?

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Administrative Costs: First, that extra 2 percent doesn't go far. Handling COBRA costs you staff time and money. One third-party administrator estimated that a staff person handling COBRA administration in-house spends at least one hour per month per COBRA beneficiary.

Compliance Costs: Second, there are the costs of noncompliance. The more beneficiaries on your plan, the more likely a mistake is to occur, which can lead to fines and even lawsuits. COBRA gives employers specific duties, including informing the health plan within 30 days if a plan beneficiary has a "qualifying event" that will cause the loss of coverage. These qualifying events are:

- Termination or reduction in hours of employment of the covered employee;
- Child ceases to be a dependent (e.g., turns age 26);
- Death, divorce or legal separation of the covered employee; or
- The covered employee becoming entitled to Medicare. (in very limited circumstances)

The covered employee or qualified beneficiary must notify the plan administrator if the qualifying event is divorce, legal separation or the child's loss of dependent status under plan rules.

After receiving the qualifying event notice, the group plan then must provide the beneficiaries with a specific set of notices regarding their rights to continue group coverage through COBRA. If you have a fully insured plan, your insurer may handle these notices. However, if you fail to notify the insurer of the qualifying event, you could be liable for fines of up to $110 per day, per beneficiary.

In addition, failure to comply with COBRA recordkeeping and reporting requirements can lead to IRS plan audits and fines of $100 per day, per participant. Failure to comply can also lead to civil lawsuits by former covered employees or qualified dependents who lack insurance coverage because they failed to receive proper notices or were wrongly denied their rights under COBRA.

Higher Claims: Finally, maintaining a lot of COBRA beneficiaries on your insurance rolls will likely boost your claims. Because COBRA coverage costs a lot, people who take it are likely to be older and less healthy on average than the rest of your group. Studies prove this translates into extra costs for plan sponsors — Spencer's Benefit Reports 2009 COBRA survey found claim costs for COBRA beneficiaries averaged 54 percent more than claims for active employees. Higher claims costs could boost your premiums in future years.

What to Look for in a COBRA Audit

An eligibility audit can help you weed out individuals who no longer qualify for coverage. COBRA coverage generally lasts a maximum of 18 months for employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Employers or their plan administrators can require COBRA beneficiaries to provide proof of eligibility. This might include copies of a marriage certificate, birth certificate or adoption final decree, affidavits of dependency, along with a copy of the top half of the first page of the employee's Form 1040 tax return, showing the spouse's or dependent's name. In the case of disability, the plan administrator can require certification from the insured's physician.

For more information on determining who is eligible for COBRA benefits, please contact us.

What to Look for in Mental Health Benefits

In times like these, many employers are looking to cut back wherever possible. But eliminating coverage for mental health care could prove to be false savings. How do you know if your plan isn't making the grade? Experts cite the following signs — and risks — of inadequate mental health care benefits:

Limited choice of providers. The network should include enough experienced mental health specialists to deal with a wide range of disorders. Since a good relationship with a mental health provider is crucial for treatment success, the plan should also allow visits to out-of-network providers for slightly higher out-of-pocket costs.

Difficult access. Employees may be reluctant to seek needed mental health treatment because of a perceived stigma attached to behavioral illnesses. Employers can reduce that risk by making access to benefits quick, simple and confidential.

Medication-only coverage. Employees can obtain medications from their primary care physician. But they may not receive the best medication in the proper doses from non-specialists. Studies show that a combination of medication and therapy is often the fastest way to recovery from mental illnesses.

Diagnoses from non-psychiatric professionals. Without the correct diagnosis, an employee cannot obtain the most effective treatment. An employee with a significant emotional problem should be evaluated by a psychiatrist or psychologist, who can determine which psychotherapy or medication is appropriate.

The Mental Health Parity and Addiction Equity Act of 2008 requires group health insurance plans (with more than 50 insured employees) that offer mental health and substance abuse disorder benefits to offer them with no more restrictions than for covered medical and surgical procedures. This law supplanted the Mental Health Parity Act of 1996, which did not cover treatment of substance abuse or chemical dependency. It also allowed employers to "retain discretion regarding the extent and scope of mental health benefits," and allowed them to impose cost-sharing requirements and limits on numbers of visits or days of coverage that applied to mental health benefits and not to medical/surgical benefits.

We can help you evaluate your plan 's mental health benefits—please call us for more information.

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