Employee Benefits Report

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Self-Insurance Offers Flexibility, Savings

Should your company self-insure its health plan? Here's what you need to know to decide.

Almost all (nearly 95 percent) of U.S. companies with at least 5,000 employees currently self-insure their employee health plans. But health cost inflation and increasing regulatory burdens make self-insurance a more attractive option even for smaller employers. Today, the self-funded market now includes nearly 60 percent of all employers, small and large.

With a self-insured or self-funded group health plan, the employer assumes the financial

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This Just In

Large employer" redefinition helps keep group coverage affordable. On October 7, President Obama signed the Protecting Affordable Coverage for Employees (PACE) Act. This bill amends the Patient Protection and Affordable Care Act (PPACA) and Public Health Service Act to define employers with 51 to 100 employees as large employers for purposes of health insurance markets. Without the PACE Act, the definition of "small employer" would have automatically expanded to include employers with 51-100 employees on January 1, 2016.

States still have the option to treat these employers as small employers. Currently, the PPACA defines employers with 51 to 100 employees as small employers.

continued on next page

risk for providing health care benefits to employees. In practical terms, self-insured employers pay for each claim as it's incurred instead of paying a fixed monthly premium, as they do under a traditional health plan.

Flexibility and lower overall costs are two main reasons companies self-insure. Unlike insured plans (also known as fully funded plans), self-funded plans are exempt from state regulation, including mandated benefits, premium taxes and consumer protection regulations.

Self-insured plans fall under regulation of the Department of Labor and ERISA, the federal Employee Retirement Income Security Act. Self-funded plans are also exempt from some provisions of the Affordable Care Act. For example, all insured health plans must provide coverage for services and supplies within ten "essential health benefits" categories. They must also provide these benefits with no annual or lifetime caps. The law exempts self-funded plans. However, if they do provide coverage for any of these "essential health benefits," they cannot place annual or lifetime caps on them.

Control and flexibility. Having a consistent set of benefits for a nationwide workforce is a good reason to self-insure. Many states require certain coverage levels for mammograms, cancer therapies, mental health services, contraceptives or diabetic supplies, for example. While a fully insured company operating in more than one state must deal with each state's varying health insurance regulations and benefit mandates, a self-insured plan is not bound by state statutes. Companies with facilities in different states can streamline their health plans, offering only those services required under federal law. The employer is free to contract with any providers or provider networks to customize a plan, instead of purchasing a "one-size-fits-all" policy.

Cost savings. Self-funded companies save on state premium taxes, which can be up to three percent. Administration fees for self-insured plans generally amount to no more than seven percent of total costs, according to healthcare consultants, compared with 10 percent or more of insurance premiums. And employers can save up to five percent without the profit and risk charges that insurers factor into their premiums.

Self-funding also keeps any cost savings within the company. The employer maintains control over health plan reserves, enabling the employer to maximize interest income. Under an insured plan, the insurance carrier would invest reserves and earn any profits. And since there is no pre-payment for coverage, self-insured companies can benefit from improved cash flow.

Worth the risk? The main downside of self-insuring is assuming the risk of unpredictable medical claims and the annual fluctuations in costs that the insurer often absorbs for a fully insured plan. Self-insured employers can protect themselves against unpredicted or catastrophic claims by purchasing what is known as stop-loss insurance to reimburse them for claims above a specified dollar level. Note that a stop-loss policy is a contract between the stop-loss carrier and the employer, not a health policy covering individual plan participants.

But even with stop-loss coverage for catastrophes, self-insured employers might face unexpected costs due to underwriting tools such as "lasering." This occurs when reinsurance carriers charge a small company a much higher deductible to cover employees with serious illnesses than the rest of the group. And the employer would have to cover the deductible for those employees if they have major medical expenses during the year. Self-funding may also cause companies to lose some of the deeper discounts that insurers can arrange with providers. And, after switching to a self-insured plan, an employer that wants to revert back after a few expen-

Why is this significant? Under PPACA, health insurance offered in the small group market must meet certain requirements that do not apply to the large group market, including the requirement to cover the "essential health benefits." The PPACA also requires small group plans to use community rating beginning on January 1, 2016. For a discussion on the significance of community rating and how it might affect your premiums, please contact us for more information.

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sive claims would likely find a sharp increase in premiums, as the insurer would factor in the risk of covering those individuals.

Yet self-funding might be worth the risk for many smaller employers. Estimates show that self-insured businesses with 200 employees have a 14 percent probability that actual claims will exceed projected budgets, while companies with 1,000 employees have a 26 percent chance of surpassing their health insurance budgets. Why? The larger the number of employees, the more likely that one or two will incur catastrophic health care costs.

Self-insured employers can either administer claims in-house or subcontract with a third party administrator (TPA). TPAs can help set up self-insured health plans, coordinate stop-loss insurance coverage and oversee provider network contracts and utilization review services. For plans that require employee contributions toward coverage, the company's payroll department handles employee contributions, as it would in a fully funded plan. However, instead of sending employee contributions to an insurance company for premiums, the employer holds contributions until claims become payable. If the employer is using contributions as reserves, it holds them in a tax-free trust controlled by the employer.

The bottom line: Employers that self-fund control their own destiny. Self-insuring changes the focus to managing healthcare dollars, instead of negotiating premiums with an insurer. For further information on self-insuring your employee health plan, please contact us.

The Cost of Fatigue

A study published in the *Journal of Occupational and Environmental Medicine* found that nearly 40 percent of U.S. workers experience fatigue. Why should employers care?

Fatigue is a feeling of tiredness, exhaustion or lack of energy. Fatigue diminishes alertness, slows reactions, impairs decision-making abilities and reduces productivity. It can also affect a person's mental and physical health… and an employer's healthcare costs.

How Fatigue Affects Health

Fatigue can harm mental health by:

- Increasing mood swings.
- Impairing judgment.
- Decreasing adaptability to certain situations.
- Heightening sense of threat.
- Increasing anxiety or depression.
- Increasing the chances of mental illness.

Fatigue can harm physical health by:

- Reducing eye-hand coordination.
- Causing weight gain.
- Causing pain (e.g., backaches, headaches).
- Making an individual unable to

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relax (e.g., cause restless sleep, provoke heightened alert response).

- Causing gastrointestinal problems (e.g., loss of appetite, abdominal distress or ulcers).
- Damaging the cardiovascular system (e.g., causing heart disease, arteriosclerosis or congestive heart failure).

Worker fatigue can also lead to lost productivity. Total lost productive time averaged 5.6 hours per week for workers with fatigue, compared to 3.3 hours for their counterparts without fatigue. Even when they were working, workers with fatigue symptoms had much lower rates of productivity than their sprightly counterparts — mainly due to low concentration and increased time needed to accomplish tasks.

Just as importantly, fatigue can lead to accidents. According to Clockwork Consultants, a UK-based company that helps enterprises manage fatigue risk, fatigued employees are also three times more likely to have an accident at work.

Recognizing Fatigue

Fatigue has many causes. It can result from physical or mental exertion, lack of sleep, stress, depression, use of certain medications or alcohol. It can also result from a physical condition or illness, such as anemia, heart disease, diabetes or thyroid disease. No accurate measures of fatigue exist, so how can you tell if a worker is becoming dangerously fatigued?

Work Safe Alberta, a public/private initiative to reduce injuries and improve safety, lists these physical signs and symptoms of fatigue:

- Tiredness
- Sleepiness, including falling asleep against the individual's will (micro sleeps)
- Irritability
- Depression
- Giddiness
- Loss of appetite
- Digestive problems
- An increased susceptibility to illness

What should you do if you notice symptoms of fatigue in one of your workers? Asking about his/her health could violate privacy. However, if the worker has been involved in accidents, near-misses or his/her productivity has suffered, you can use those as reasons to bring up fatigue as a possible cause. When workers with regular daytime shifts experience fatigue for two weeks or longer, they may need to see a doctor.

When shift workers experience fatigue, it could be time to re-examine your scheduling practices. Are workers getting enough time between shifts to recuperate? Do night workers have frequent rest breaks? Have you optimized night-time working conditions to minimize sleepiness?

Organizations can take several wellness initiatives to address the causes and effects of fatigue in the workplace:

Organizations should adopt a variety of methods to make themselves "fatigue safe." The most common include:

- Offer special training for workers, particularly shift workers, to help them understand their personal levels of fatigue.
- Develop "fatigue safe" work schedules, including compliance with any applicable regulations.
- Develop fatigue risk management policies and procedures.
- Offer "nap rooms" or quiet rooms for employees to rest in.
- Promote exercise by offering an exercise room or discounted fitness club memberships and flexible scheduling to allow employees to exercise. Exercise breaks can help counteract fatigue brought on by monotonous or repetitive work and improve alertness, along with improving general health.

For more suggestions on addressing fatigue and other workplace wellness problems, please contact us. ■

Why Everyone Needs Long-Term Disability Insurance

What would your employees do if they became injured or ill and couldn't work for an extended period? How does this affect morale?

By the time people reach age 35, they have a one in three chance of being disabled for more than 90 days during the rest of their working life, according to America's Health Insurance Plans, a trade organization. A MetLife survey indicated that an increasing number of employees are more concerned with having financial security in the event of a disability than they are with premature death.

Group long-term disability income (LTD) insurance provides your employees funds to help them meet daily expenses when they cannot work. This security can enhance recruiting, retention and productivity.

Employers can cover the entire cost of LTD, cost-share with the employee or offer coverage as an employee-paid, voluntary benefit. You can also offer group or individual coverage.

Studies show that almost half of mid-size to large employers provide coverage that pays benefits for at least five years. Typical group policies replace 50 to 60 percent of income, which balances disabled employees' need to meet expenses with the employer's need to provide incentives to return to the job. Many employers fund a basic plan to protect employees, who can then add supplemental coverage to meet their individual financial needs.

Most *individual* disability policies are non-cancelable, so the insurance company cannot cancel the policy (except for nonpayment of premiums, of course). This gives employees the right to renew the policy every year without an increase in premium or a reduction in benefits, regardless of their health. Group disability income insurance policies differ: they are usually "guaranteed renewable." If a policy is guaranteed renewable, the insurance company cannot change your benefits if you pay your premiums on time, but it can increase your premium on a policy anniversary as long as it makes a similar premium increase for your entire class of policyholders. You typically pay more for a non-cancelable policy because you are paying for the protection against a premium increase.

What to look for

As with all benefit programs, employers have many options when selecting a group LTD plan:

- Ease of use. Employees and employers should have easy, timely access to information. Many employers like having online access to plan information and usage data, including the number of people on leave, average length of leave, and at which locations. For employees, plans often work best when they offer multiple ways to get information, whether mail, phone or online.

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- Rehabilitation. Evaluate the insurer's capabilities in rehabilitation and case management. How successful has the carrier been in helping employees return to productive work?
- Guarantee issue. Employees can get coverage up to a specific limit regardless of health conditions. This means the insurer might place a limitation on pre-existing conditions in the first 12 months, for example. But the insurer issues coverage rather than denying it, so the insured can get immediate coverage for disabilities resulting from accidents or non-pre-existing conditions.

Group long-term disability coverage provides a valuable addition to a well-rounded benefits program. If you'd like to learn more, please contact us and we'll help find you a policy that's right for you.

Rating Changes Coming: Are You Prepared?

The Affordable Care Act requires insured small group health plans (now redefined as 50 and fewer people under the PACE Act) to use community rating starting on January 1, 2016. What is community rating, and how will it affect your insurance costs?

The set of classifications and statistical standards an insurance underwriter uses to set premiums is called "rating." Generally, insurers will use medical rating, or medical underwriting, for large groups (those with more than 50 employees). A larger employer's rates will depend on a combination of the expected claim costs, plus administrative costs and profit load.

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 likely 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 have long required "community rating" for small groups. Under "pure" community rating, insurers 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 a high-cost area where the population is older than average, 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 younger (and presumably healthier) individuals and groups pay a higher share of costs than their experience would merit.

So what should you expect for 2016 rates? If your small group is typically young and healthy, your rates might go up. If your group is mixed or skews older, your rates might go down. To discuss your insurance costs and options, please contact us.

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THE INSURANCE 411 What you need to know about insurance

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