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This Just In

Employees may be listening to their employers' advice about retirement after all, according to a recent study by Hewitt Associates. Companies that help workers save for retirement—by putting 401(k) plans on autopilot, simplifying plan choices, and targeting communication—report 14 percent higher participation than the overall participation rate for employer retirement plans. For the greatest impact on overall participation and contribution levels, offer automatic enrollment to all employees or combine it with tools like streamlined enrollment and tailored communication. If your company already has automatic enrollment, you can encourage further savings by adding contribution escalation features or third-party investment advice.

A new study reveals how little work time the average worker can afford to lose — for any reason. Should a personal crisis strike, nearly 75 percent of workers say they could afford to take one month or less of unpaid leave before expenses would force them to go back to work, according to a recent survey by the LIFE Foundation. Nineteen percent of employees said they could afford to take just one week of unpaid leave. Meanwhile, eight percent say they couldn't afford any time off. Projections suggest that a significant number of 35-year-olds—nearly 30 thirty percent of women and 20 percent of men—will likely become disabled for a period of three months or more. Now may be the time to expand your company's disability coverage.

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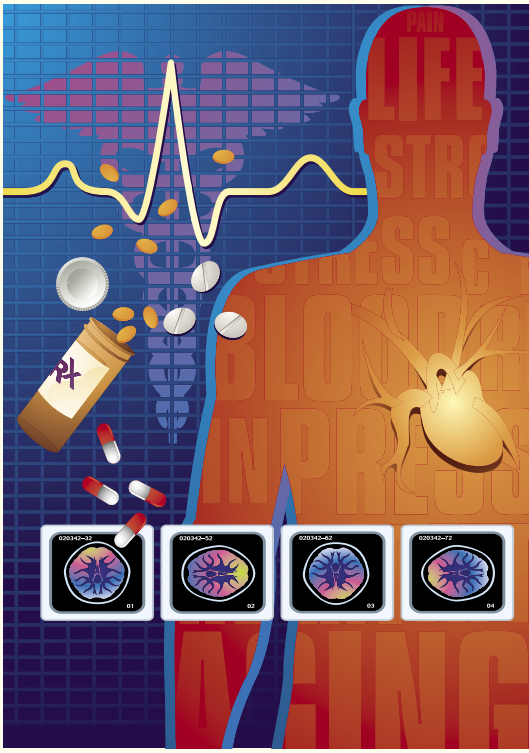
Medical Benefits

Critical Illness Insurance: Filling the Benefits Gap

As medical technologies and treatments improve, more people are surviving once-fatal forms of cancer, heart disease and other conditions. But surviving a critical illness can be very costly, and ongoing medical and non-medical expenses often fall outside coverage by traditional health or disability insurance. These trends are creating a growing demand for supplemental health care benefits such as critical illness policies. Here's what your company needs to know about critical illness coverage and benefits.



Coverage. A critical illness policy pays a lump sum benefit if a plan participant is diagnosed with a serious health condition, such as cancer, heart attack or stroke. Illnesses covered under the policies vary, but can include a far longer list of ailments, including Alzheimer's, paralysis, coma, multiple sclerosis and loss of hearing. Lump-sum payments can be used for any expense—co-payments, travel costs, experimental treatments, or even to replace wages of a family member leaving work to provide support.

Payouts for critical illness policies typically average around $25,000, with premiums costing about $300 to $500 annually, depending on the health, gender, age and location of the insured. Higher-end policies covering a dozen or more conditions generally pay benefits of more than $100,000 and cost about $1,500 to $2,000 a year. As a voluntary benefit, the employee is responsible for premiums, although an employer may choose to offset part of the cost. Most policies qualify under Section 125 plans, so workers using payroll deductions can allocate pre-tax dollars to pay premiums.

Critical illness policies are generally portable, and benefits are not reduced after the insured reaches a certain age. In addition, equal benefit amounts are available for each family member when the employee buys family coverage. Some insurers offer a "return of premium" feature. If the insured

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The Future of Cash Balance Plans

Many call them the last, best hope for saving defined benefit pensions. This year, however, cash balance plans are at a legal and legislative crossroads that could decide the future of employer-provided retirement benefits. Here's a closer look at cash balance plans and recent developments that will affect whether and how companies use them.

Cash balance plans are defined benefit plans that combine the advantages of a 401(k) plan with those of a traditional pension plan. They are part of a group referred to as "hybrid plans," which incorporate elements of both defined benefit and defined contribution plans. Legally, a cash balance plan is a defined benefit plan—the employer, not the employee, assumes the financial risk of achieving a preset benefit. But it's structured like a defined contribution plan—somewhat like a 401(k), it features a stated account balance. Compared with traditional pension plans, cash balance plans can provide employers with more funding flexibility while often demanding lower payouts.

Conversion. While companies may choose to implement a new cash balance plan, most plans have been converted from traditional benefit plans via a plan amendment. Federal law places some restrictions on plan changes, including amendments that convert traditional pensions to a cash balance plan formula. Plan amendments cannot reduce benefits that participants have already earned. Employers must provide participants with advance notification—usually 15 days—of plan amendments, particularly if the future benefit earnings rate is significantly reduced. But the company has complete discretion to determine new plan eligibility and whether to allow employees to remain in the old plan formula.

For some employees close to retirement, the cash balance conversion may upset future expectations. In fact, a 2005 Government Accounting Office (GAO) analysis of 133 conversions found that monthly benefits decreased on average by $59 a month at age 30 and by $238 a month at age 50. And distributions like that have run afoul of ERISA. As a result, 47 percent of the conversions studied by the GAO grandfathered benefits from the former plan to at least some older workers. Even so, the flood of conversions to cash-balance plans during the 1990s has turned into a trickle. And this change in expectations has led to charges of age discrimination.

Litigation. Most courts have concluded that these cash balance plans—including the plans of PNC, CBS, Southern California Gas and Onan Corporation—do not violate age discrimination rules. But one case finding to the contrary has dominated the debate. Last year, IBM settled charges of age discrimination that involved its benefit plans in the mid-1990s; the company is committed to paying out $315 million and will pay $1.4 billion more if it loses on appeal. Regardless of how the IBM appeal turns out, this issue is likely to remain the subject of litigation for some time unless a legislative solution is found.

Legislation. As this newsletter went to press, Congress was still debating a pension reform bill that likely will revise cash balance regulations. The House bill, H.R. 2830—the Pension Protection Act of 2005—would create a nondiscrimination standard that applies to all cash balance and hybrid defined benefit pension plans. It would deem such plans nondiscriminatory as to age if they comply with certain requirements, in cases where accrued benefits are reduced because of attainment of any age.

However, the law's provisions would apply prospectively only—in other words, they would apply only to plans created after the law's implementation, or to conversions made due to mergers, acquisitions or similar transactions. The Senate originally introduced a bill that included comprehensive clarification and also required the retroactive application of safe harbors and mandates in addition to a litigation carve-out.

Many companies oppose hybrid legislation that is prospective only, as such a measure would not protect existing plans and would create a negative inference about their legality. In addition, the special provisions for conversions include benefit mandates and create a bias against conversions that were not done in the same manner. The House recently approved a motion to accept Senate provisions for new mandates governing employers that convert to a hybrid plan, though employers have opposed those provisions.

If unfavorable legislation is signed into law or a major court decision turns out badly for employers, cash balance plans could face a wave of shutdowns this year. If the outcomes are favorable, there may be a rush of conversions from defined benefit to cash balance plans. Ultimately, a key feature of a great retirement program is ensuring employees understand the value of their benefits, whether it's a cash balance plan or traditional pension. For further information about cash balance legislation or setting up a plan for your company, please contact us. ❑

The How-To's of Mental Health Benefits

Earlier this year, Congress extended the protection of mental health benefits under the 1996 Mental Health Parity Act (MHPA) through the end of 2006. MHPA prohibits companies with more than 50 employees from capping mental health care benefits unless they also limit services for other medical or surgical benefits. Here's what you need to know about structuring health benefits to meet current mental health parity regulations.

While MHPA requires health plans to offer similar aggregate lifetime and annual dollar limits for mental health and medical/surgical benefits under a group health plan, companies are not required to provide mental health benefits. Nor are they prohibited from offering mental health patients fewer services and higher out-of-pocket costs. Employers also determine the extent and scope of the company's mental health benefits—including cost sharing, limits on numbers of visits or days of coverage, and requirements about medical necessity. And the law does not apply to benefits for substance abuse or chemical dependency.

Despite these caveats, many employers consider the mental health of employees to be crucial to company success. They recognize that mental health problems are common in the workforce and that early intervention and continuing treatment can effectively address such issues. And they understand that overall health care costs may rise when mental health benefits are restricted.

Costs of parity. Parity mandates generally have not been linked to higher insurance costs. A recent study from Yale Medical School found that companies providing equivalent levels of coverage for mental health and general medical care do not face major increases in health care spending, particularly under a managed care system. Introducing or increasing the level of managed care can significantly limit or even reduce the cost of implementing parity laws, according to the study.

Increased access to mental health services may also result in savings through reduced use of medical services. Certain patients, including people developing serious illnesses, adults with alcoholism, and primary care outpatients with somatic problems, may use medical care excessively because of psychological factors. Companies can save costs by offering appropriate mental health services to patients who tend to overutilize other medical benefits. In some cases, employers could see an appropriate increase in utilization rates, since underserved populations may not have been receiving the mental health care they needed.

"...mental health problems are common in the workforce and...early intervention and continuing treatment can effectively address such issues."

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 when it is 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, type of 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.

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. In addition to managing multiple vendors, employers must integrate data from a variety of vendor database systems that may not be compatible with the company's system.

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dies of something that's not covered by the policy—say, a car accident or a very rare disease—the provider will give back all of the premiums, minus any benefits already paid.

Eligibility and enrollment. Employees usually have to complete a detailed medical questionnaire as part of the critical illness insurance enrollment process. Policyholders might be denied coverage if they already have a covered illness or if several direct relatives have had one. Policies under $100,000 generally don't require a medical exam. Some plans require waiting periods of 30 days or even several months before coverage begins. Others stop paying benefits after a fixed period of two or three years.

Limitations. Most policies have age limitations. New policies often can't be issued after ages 59 or 65, although the age cut offs vary by insurer. After the cut-off age, many policies reduce the lump-sum payout by half, but don't reduce the premiums. In other words, if a policyholder has a stroke at age 75, she might only get half the benefit. Many critical illness policies also have fixed dollar limits, paying a maximum amount for individual services or limiting total benefits to a fixed amount, such as $5,000 or $10,000.

Some financial advisors and consumer advocates claim that aggressive marketing by insurers might be scaring some individuals into purchasing coverage unnecessarily. They believe consumers would be better off devoting the premium dollars to savings, investments, or even to fitness programs to help reduce the risk of illness. In many cases, comprehensive health and disability coverage might be enough protection.

It's a good idea to educate employees about their options regarding traditional health and disability insurance to ensure they make an informed decision about the need for supplemental benefits. Coordinating proposed benefits before adding critical care insurance can help avoid duplication of coverage.

Critical illness insurance is might hold special appeal for employees who are caring for children or aging parents. By lessening the financial blow of a serious illness, the employee can focus on recovery, rather than the added stress of staggering medical expenses. Supplemental benefits work to boost morale and foster loyalty—both of which enhance productivity. For more information about the right critical illness or other supplemental benefit policies for your employees, please contact us. ❑

Critical illness insurance vs. cancer insurance.

Critical illness insurance differs from "cancer insurance and other so-called "dread disease" coverages," which have been available for some time. First, critical illness policies cover illnesses in addition to cancer. What's more, cancer policies are typically indemnity plans that pay for specific treatment costs, such as hospital stays or radiation treatments. For an additional premium, riders may be added to cover emergency room visits, certain inpatient and outpatient procedures, and other disability benefits.

While cancer treatment accounts for about 10 percent of U.S. health expenses, no single disease accounts for more than a small proportion of the overall national health care bill. That's why it is essential to offer coverage for all conditions, not just cancer. And because cancer patients often face large non-medical expenses, such as home care, transportation and rehabilitation costs, many prefer the flexibility of critical illness coverage.

Web-based health care options help reduce employer costs, found a recent survey by the National Business Group and Watson Wyatt. While 58 percent of respondents provide Internet resources that enable workers to compare health care insurance options side by side, those employers that offer additional Web tools were best at controlling health costs, said the study. Among these tools, for example, is an online program that allows employees to model the tax impact of their health care decisions, such as signing up for a flexible spending account.

The U.S. Supreme Court has affirmed a health plan's right to recover medical expenses from beneficiaries reimbursed by a third party, a process called "subrogation." The decision settles a question that has divided federal courts: whether ERISA allows plans to seek reimbursement out of funds in the participant's possession. The Court found that since the funds requested were "specifically identifiable" funds in the control of the plan participant, taking action to obtain these funds is "equitable relief" appropriate under ERISA. Employers should review their benefits plan language carefully to ensure that the terms meet the "specifically identifiable fund" standard. Some states prohibit subrogation on fully insured plans, so the decision might only affect self-funded plans in your state.

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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 health care 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 communicates a corporate culture that emphasizes the value of investing in employee overall wellness. Meeting the mental health needs of your employees produces long-term savings by decreasing health care costs, increasing productivity and reducing absenteeism. So you'll not only have a healthy workforce, but a healthy bottom line as well. If you would like assistance with your mental health benefits program, please contact us. ❑