

Employee Benefits Report



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Benefit Administration

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Strategies for Successful Open Enrollments

Open enrollment can be a stressful time for benefit administrators and enrollees alike. These strategies will make open enrollment easier for all involved.

Paper shuffling, bewildered looks, and frantic note taking. It's another open enrollment season—the annual 30-day period during which workers choose their benefits for the coming year. For many employees, the associated meetings and paperwork generate as much enthusiasm as yearly tax forms. But it doesn't have to be that way.

With open enrollment seasons at most companies still a few months away, now is the time to conduct a checkup to evaluate the effectiveness of your company's enrollment processes. The following best practices can provide a solid foundation for building your most successful season ever.

Plan ahead. Preparation is the key to a winning open enrollment campaign. Start by re-

viewing benefit plan designs, then consider which options best fit employees' needs and the company's goals—whether it's health savings accounts or reimbursement arrangements, fully insured plans, a self-insured plan, or some combination thereof. In selecting plan choices, allow adequate lead time for adding new populations or changing vendors. Decide whether you will use in-house administrative resources or outsource the job, and create a budget for related costs.

Once you have administrative resources in place, identify enrollment period dates and announce them well in advance. Try to create a little public relations buzz. Develop a training schedule for the benefits team and customer service representatives. Determine whether and how to use technology, such as

online enrollment and/or education, to make the process more efficient. Technology provides excellent self-service tools for both employees and benefits administrators to make benefits decisions and manage options.

Communicate clearly. Most employees believe their companies need to provide better benefits education. Beyond understanding health plan designs, employees need information to help them navigate the health care system along with guidance on how to develop personal criteria for making sound health care decisions. Some of the most popular communication resources include computerized knowledge bases, direct mail benefits information, health and wellness fairs, employee meetings and online decision support tools, such as benefits calculators.

This Just In

Despite confidence in 401(k) investment decisions, most are still not sure their savings will last in retirement, finds a new survey from NY Life Investment Management. While 60 percent of participants agree they are making sound investment decisions, only about half said they feel they know how much money they will need in retirement. And less than 40 percent believe they are in a good position to meet their financial goals when they retire. Instead of emphasizing retirement account balances, companies should assist workers in calculating what they will need to retire in comfort, so that employees can monitor their investments with a specific financial goal in mind. For more information on improving your 401(k), see P. 2.





Fixing Your Defined Contribution Plan

Employers like defined contribution plans because they limit their liabilities. But employees don't always fare as well under these plans. Here's how you can help employees get the most out of their defined contribution plan.

Defined contribution pension plans have overtaken traditional defined benefit (DB) plans since the 1980s. By 2006, only 20 percent of U.S. workers participated in a DB plan, while 43 percent participated in a defined contribution (DC) plan, such as a 401(k).

Employers like defined contribution plans because they limit their pension liabilities. But how are workers doing with DC plans? Here's the score:

Pluses:

1 Portability. Employees own the funds in their DC accounts and can roll them into a new employer's plan when they leave your employ. This contrasts with DB plans, which can create "job lock" by discouraging long-tenure workers from leaving a job they no longer like because they will lose retirement benefits.

2 More immediate benefits. DC plans appeal to younger workers, for whom the traditional pension plan's formula, which re-

wards older, long-time workers, has little appeal.

3 Safety. Because funds are held by a trustee (such as a mutual fund company), workers don't have to worry whether their employer will be around to pay retirement benefits. This can appeal to employees in high-risk industries or entrepreneurial companies.

4 Lower income taxes. Salary deduction DC plans let workers reduce their taxable income by making contributions with pre-tax dollars. Eventual withdrawals will be taxed as income; however, many individuals are in lower tax brackets after retirement.

Problems:

1 Low participation rates. Without automatic enrollment, only 54 percent of workers eligible to participate in a 401(k) actually do.

2 Low contribution rates. The average non-highly compensated worker contributed only 5.4 percent of pre-tax pay; highly compensated workers contributed an average of 6.9 percent in 2006. Some plans allow con-

tributions of up to 20 percent of pretax salary, subject to statutory maximums.

3 Lower yields. Returns on funds invested in 401(k)s averaged one percentage point lower per year than funds invested in private pension plans, found a Boston College study of private retirement plan yields between 1988 to 2004. Over several years, this can make a significant difference in a plan's balance.

4 Lack of diversification. When the employer's stock is an investment option, 401(k) participants invest an average of 14 percent of their funds in it—too much to invest in one stock, according to experts. Many investors also invest too little in stock funds. Historically, stock funds have experienced better rates of return over the long term than more conservative funds, such as money markets or bonds.

5 Living too long. A traditional pension pays benefits for the retiree's life. Under a DC plan, participants decide how much to withdraw over the course of their retirement. When their account runs out of funds, benefits end. Employees who save too little during their work years risk running out of funds during retirement.

Solutions:

1 Start automatic enrollment. In companies with automatic enrollment, participation jumps to 76 percent of eligible employees, according to Fidelity Investments. Making employees opt out rather than opt in eliminates the decision-making process that can hold many workers back.

2 Automatically increase contribution percentages every year. For example, tailor your automatic enrollment so employees contribute 3 percent in their first year, 4 percent the next, etc. The idea is to have workers bank their raises—they can't miss "extra money" they never had.

3 Take a look at management fees, which can take a big bite out of 401(k) returns. Go with a low-cost fund manager.

4 Limit the percentage of funds employees can invest in employer stock. You can also automatically enroll employees in one of the newer "lifecycle funds," which allocate assets according to the participant's risk profile or targeted "maturity date." Under the first method, fund managers continually reallocate the fund's assets for aggressive, moder-





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With the rising cost of benefits, it's important to communicate to workers about benefit trends, particularly in your industry or area; how much the employer is contributing on its employees' behalf; and when it adds more value to the plan offerings. This will help convey to employees the total worth of their benefits. Many companies have made a concerted effort to help employees and managers understand the business implications of rising health care costs, as well as their role in helping control costs.

Focus on the facts. Whether you mail printed information packets to employees' homes, direct workers to postings online or do both, there is a limit to the amount of information they can absorb. Focus on what matters most to your employees, including any changes to:

- ★ the number and types of plans offered;
- ★ lists of participating doctors;
- ★ the extent of coverage (i.e., categories of prescription drugs covered);
- ★ dollar amounts for co-pays, deductibles, or out-of-pocket maximums; and
- ★ premium rates or other payroll deductions.

If workers have a choice between more than one provider, benefits experts recommend that companies develop a printed sheet or webpage that compares each plan's features in a uniform manner. A uniform presentation not only helps employees find facts, it also demonstrates that the employer—and not the provider—is presenting information objectively. Whether distributed online or in print, materials should have a consistent appearance. If your vendors brand their communication materials, ask whether they can provide a template on which to put your own company's branding.

Keep it simple. The stakes are high when communicating something as valuable, sensitive and visible as employee health care benefits. Beyond legal liability, there's the risk of confusing employees and making administrative mistakes. To maintain accuracy and quality, ask insurance carriers and plan administrators to review all materials. Consult ben-

efits counsel to ensure legal and technical accuracy and to make certain communications include the required legal disclosures. Some companies post summary plan descriptions on the company benefits intranet or make paper copies available for review. This fulfills legal requirements without bogging employees down in every detail of the plan description.

Prepare for post-enrollment. Health care decision-making doesn't end once employees have made their selections. When open enrollment ends, your work has just begun. In addition to administrative follow through (i.e., member ID cards, payroll deductions, vendor audits), it's critical to continually improve the process. Some companies conduct surveys during online enrollment. Others solicit comments during benefits fairs. Survey feedback can help you determine which educational materials were helpful and which need improvement. It can also help you determine what delivery method—mail, online or e-mail or a combination—works best for your employees.

Providing good information during open enrollment minimizes the number of people who need to contact a benefits manager or company call center with questions. And that saves the company time and money—and may even bring smiles to the faces of your employees. For assistance in planning your next open enrollment season, please contact us. ■

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ate and conservative investors. Under the second, fund managers allocate assets according to the participants' projected retirement date, investing a higher proportion of funds in higher-yield, higher risk stocks when they're young, and moving funds to more stable bond and other funds when they're closer to retirement. Employees who want to take a more active role in managing their funds can opt out.

5 Offer an annuity at retirement. The Pension Protection Act makes it easier for employers to let retirees purchase an annuity with a lump-sum distribution. Annuities

adjusted community rating, went back to its community rating system less than a year later, following the large premium increases faced by small firms with less-healthy workers under the rate band system adopted in 2003.

Insurance works by allowing insurers to spread risk over a wide range of people. But when insurers can't reject anyone or adjust rates based on risk, they end up charging everyone more. Under "guaranteed issue" laws passed in several states, everyone pays the same rate for similar coverage. Rates have skyrocketed in these states because insurers must accept all applicants regardless of their health status. As prices rise, many healthy people have chosen to take their chances and drop coverage, while sick people continue coverage. As risk pools worsen, some insurance companies have decided to pull out of particular states.

In regulating health insurance pricing, states must balance policy goals with questions of fairness. If the goal of health insurance is to make insurance readily available to those who most need health care, pricing insurance at one rate for the whole community makes insurance more affordable to people who need health care and avoids price discrimination—and perhaps employment discrimination—based on factors that individuals cannot control. For more information on group health insurance, please contact us. ■

provide lifetime benefits; without one, a retiree will have to plan withdrawals carefully to avoid running out of funds in a DC plan. The Financial Economists Roundtable recommends joint life annuities that will protect both employees and spouses. Plan sponsors can use their bargaining power to get group rates on annuities.

Education can also play an important role in making sure your employees get the most out of their defined contribution plan. The Pension Protection Act makes offering such education easier for employers.

For more information on retirement plans, please call us. ■





Insider Secrets: How States Regulate Insurance Premiums

Did you ever wonder how insurers calculate premiums? They're not just pulling numbers out of a hat—state law helps determine how much you pay for group coverage.

The question of who should pay for health care—the community as a whole or those likely to use more services—remains a fundamental issue in many state legislatures. In the small group insurance market, nearly all states have laws that limit variations in insurance premiums or prohibit insurers from applying certain factors to set premiums. Here is a look at the three approaches states use to limit disparities in premiums: rate bands, pure community rating, and adjusted community rating.

Rate bands set limits on the amounts that insurers can alter premiums based on health status. Insurers typically will establish an “index rate” or average premium. A rate band establishes a minimum and maximum around that index rate. This restricts how much an insurer can increase premiums above the index rate for people in poor health, as well as how far below the index rate the premium can drop for those in ex-

cellent health. Similarly, states may set a maximum variance from the index rate based on age, utilization or on other factors.

Some states allow insurers to establish separate premiums for different “classes of business.” These include groupings of small employers likely to have expenses for claims and administration that differ significantly from other businesses. Associations of small businesses may thus receive more favorable pricing on insurance products than individual small businesses. In addition, insurers that market to small businesses may price HMOs differently from PPOs. States that use rate bands often reward groups that renew their policies by limiting price increases to no more than 10 to 15 percent based on the group's health status or claims experience.

Community rating requires insurers to set the same premiums for everyone in a community. Under pure community rating,

plans cannot vary premiums at all based on health status, claims history or age, but they may be allowed to differentiate premiums within a state based on geographical location and/or family composition. **Adjusted community rating** also prohibits insurers from varying premiums in a community based on health status or claims history. However, this method does allow insurers to vary rates, with some limitation, based on factors other than geography and family composition.

Since community rating disallows pricing based on health status, medical underwriting is not available either when policies are issued or when they are renewed. Pure community rating and adjusted community rating are particularly helpful in limiting variation in premiums for the smallest employers. New Hampshire, which has experimented both with rate bands and with

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Tax bill will ease HSA administration

The Tax Relief and Health Care Act of 2006, signed into law on December 20, will help participants build HSA (health savings accounts) balances.

The most significant changes the bill will make include:

- ✦ Increasing contributions. Previous law limited HSA contributions to the lesser of the individual's HSA-eligible plan deductible or a statutory maximum. The new rules allow participants to make the statutory maximum contribution, regardless of deductible. For 2007, the maximum contribution for self-only coverage is \$2,850, and the maximum contribu-

tion for family coverage is \$5,650.

- ✦ Allowing those who enroll in an HSA-eligible plan in a month other than January to make the maximum annual contribution rather than a pro-rated one.

- ✦ Allowing employers to make higher contributions to the HSAs of non-highly compensated employees.

- ✦ Allowing employers to make a one-time transfer of funds from employees' Flexible Spending Arrangements (FSAs) or Health Reimbursement Arrangements (HRAs) to an HSA. The maximum contribution is the balance in the FSA or HRA as of September 21, 2006, or the balance as

of the date of the transfer, if less. This transfer does not count toward maximum annual contribution limits.

- ✦ Allowing individuals to make a one-time transfer from an Individual Retirement Account (IRA) into their HSA, up to the maximum HSA contribution amount.

The bill also requires Treasury to announce the next year's contribution limits by June 1. Formerly, these notices came out later. Earlier notification will simplify education and enrollment processes. For more information on HSAs or high-deductible health plans, please call us. ■