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THIS JUST IN

Employers with SIMPLE IRAs must amend their plans by December 31, 2006 for the provisions of the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA). Employers that have yet failed to update their SIMPLE IRA plans for EGTRRA may either adopt the latest version of the IRS model plan or their financial institution's updated plan document. Plans not in compliance with this requirement could lose all retirement savings and tax benefits for both employer and participating employees. If you are using an IRS model plan, Form 5304-SIMPLE or Form 5305-SIMPLE, and the date in the upper left-hand corner is either March 2002 or August 2005, your SIMPLE IRA plan is in compliance. For more information about this limited relief opportunity, go to www.irs.gov/retirement/article/0,,id=154950,00.html

Retired executives at many corporations continue to receive lifetime health benefits, despite reduction or elimination of benefits for other retirees, the *Wall Street Journal* recently reported. This trend spans industries, the *Journal* analysis found, and is common at airlines, which have been among the most aggressive in cutting retirement benefits for the rank and file. Companies are more likely to offer lifetime health benefits when they hire mid-career or older executives. This has angered retired workers who face rising premiums and copayments or loss of retirement health benefits entirely. While there are few figures currently available to estimate the total cost of retired executive benefits, companies should examine their own allocation of benefits resources among all retirees.



Benefits administration

Self-Insurance Offers Flexibility, Savings

Should your company self-insure its health plan? Plan size is an important factor, with large companies generally regarded as better able to self-insure. But as health care premiums outpace the cost of their employees' claims, more small and medium-sized companies are considering self-insurance an attractive alternative. Here's what you need to know to decide if self-insurance is right for your company.



With a self-insured—or self-funded—group health plan, the employer assumes the financial 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 annual premium 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. Since self-insured companies must comply only with federal regulations, they can save money and tailor their health benefits to better meet their employees' needs.

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. 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.

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Dental Benefits: Still Something to Smile About



Dental health coverage is the second most requested benefit—right behind medical insurance—so it's no surprise that nearly 90 percent of large employers currently offer their workers some type of dental benefit. Employee dental health can help mitigate overall health care expenses, and benefits run about one-tenth the cost of medical insurance. So dental plan providers are polishing up their product options to attract new plan sponsors and entice them to expand their offerings. Among the enhancements being added by dental plans:

Voluntary benefits. According to the National Association of Dental Plans (NADP), about 20 percent of dental plan enrollees are covered by a voluntary plan, in which the participating employees pay premiums or fees, not the employer. Voluntary dental plans allow companies to offer benefits at group rates, with reduced or no employer contributions. Plans can be tailored to meet employee needs, with options ranging from including or omitting orthodontic coverage to using either larger or smaller PPO (preferred provider organization) networks.

While some providers offer voluntary plans in conjunction with more comprehensive dental plans, others are phasing in voluntary benefits over time. These “transition” plans cover members for diagnostic, preventive and some basic services during the first year. After the twelfth month, the member qualifies for more basic services and major dental services. That way, employers can minimize the potential for turnover and create some rate stability in the program.

Direct reimbursement. Under a self-funded benefit plan, the employer pays for employee dental care directly, rather than paying premiums to an insurance company or having a third party process claims. Employees pay for dental services out of pocket, then employers reimburse them for part or all of the costs, depending on the benefits provided by the plan. These plans require no premiums, and employees can choose any dentist. Cost to the employer depends on the number of employees and benefit caps, which usually run between \$500 and \$1,500 annually. Direct reimbursement plans offer flexibility, as you can tailor the plan to your needs. They also stretch your benefit dollars, as you are not paying for insurer overhead through premiums. However, the employer must handle claim payments or hire a TPA to administer them.

Consumer-directed features. Many dental insurers are beginning to incorporate consumer-directed health features into their dental plans, such as tiered networks or consumer decision-support tools. A number of plans that already offer a choice of two PPO networks are in the process of developing a three-tier dental network, with tiers likely to be based on reimbursement levels. Look also for online tools that allow enrollees to calculate how much they spend on dental benefits each year in order to

estimate needed contributions into a health savings or flexible spending account. However, unlike in medical insurance, high-deductible plans will probably not become popular in dental insurance, since high-deductible health plans require a minimum annual deductible of \$1,050 for individuals or \$2,100 for families in 2006. In an “average” year, most people's dental expenses seldom greatly exceed these deductible amounts, making insurance less appealing.

Multi-policy discounts. Some plans are making changes to help employers manage administration of dental benefits. For example, several insurers offer integrated health insurance products to employers with 51 to 125 workers in multiple states. Other providers combine medical, dental, life and disability insurance, with employers saving a certain percentage off premiums if they choose more than one policy.

Discount dental plans. These plans are not insurance, but instead typically provide participants with discounted negotiated rates for dental care in exchange for an annual fee. For example, an individual enrollee may pay about \$72 annually to save 15 to 50 percent off average costs for a variety of dental services, such as fillings, braces, exams and routine cleanings. Plans often include discounts on cosmetic procedures that most dental insurance plans exclude. Employees must go to a participating dentist who has agreed to offer services at a discounted price.

Discount plans are generally available to groups with 51 or more workers, as well as retirees and individuals. Before offering employees a discount plan, however, check whether the benefits are worth the enrollment fee. Some providers will offer discounts to uninsured patients or discounts for payment in full at time of service.

The benefits of dental plans. While more research is needed to definitely establish a cause-and-effect link between oral health and overall health, evidence continues to point to a solid clinical connection. A recent study from Aetna and the Columbia University College of Dental Medicine found that appropriate and early periodontal treatment reduces the cost of care for diabetes, strokes and coronary artery diseases. Poor periodontal care also has been linked to low birth weights. Preventive dental care is estimated to save \$4 for every \$1 spent, as it can eliminate cost on the other end for expensive, invasive and painful procedures.

Employers should continue to look at the connection between oral health and overall health when evaluating the value of dental benefits. But those that provide dental coverage have found it to be a very popular benefit – one people actually use. It's visible, it's valued, and the price is right. And that's really something to smile about. Please contact us to discuss your company's dental plan options. □

Debit Cards Add Convenience, Challenge to Consumer-Driven Plans

As companies shift from copayment to deductible-based health plans, more providers are offering benefit debit cards to employees, giving them easier access to various consumer-directed benefit accounts. This convenience comes with a significant challenge: how to handle claims in real time at the point of service. As debit card vendors move closer to solving the problem, it's unclear if there will be enough cooperation between health plans and providers to make the technology useful. Here's the latest on how technology is enhancing plan administration to save companies time and money.

What are benefit debit cards? Benefit debit cards have been part of the health care industry for several years. They work just like a “regular” debit card, except that instead of being linked to a checking account, the card is linked to funds that employees have set aside in health care cash accounts. With the advent of health savings accounts (HSAs) and growth in health reimbursement accounts (HRAs), the popularity of debit cards has increased, with an estimated 37 percent of large employers offering them in 2006. Due to reporting and investment aspects of HSAs, these accounts require the involvement of a bank or financial institution. Now health plans, financial institutions, plan administrators and employers must all coordinate payments and manage deductibles.

Tracking eligibility and expenses. Several companies have introduced technology that can electronically substantiate HSA-eligible over-the-counter (OTC) drug purchases at the pharmacy. Walgreen's, the nation's leading drugstore chain, has implemented a system that will electronically track and verify that the items are eligible expenses—eliminating the typically tedious, paper-based substantiation and reimbursement process for claims administrators and consumers. For most plan participants with debit cards, the program virtually eliminates the need to provide receipts to their administrator when they use their HSA dollars at the pharmacy.

Atlanta-based Clearwater Corporation is the final stages of testing small kiosks, where debit-type cards could be “swiped” through a machine similar to an ATM to verify a patient's insurance and determine co-pay and deductible amounts—and even upload medical records to spare patients from filling out tedious forms. With claims processing linked to one benefit debit card, transaction payment software could determine



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eligibility, deduct funds from the proper source (FSA, HSA or HRA) as well as manage deductibles. For participants with multiple health benefit accounts, linking several tax-free accounts to one nationally accepted benefit card is critical, as it provides a single way to manage all of a consumer's benefits funds and expenses in real time. The benefit card technology that provides easy access to account funds must also enable workers to conveniently manage deductibles, transfer funds and track payments.

“Real-time” challenges. Although real-time claims processing would streamline plan administration tremendously, complex health insurance plans could make such an application extremely difficult. Tiered provider networks, for example, could mean tiered copays. For real-time adjudication to take place at the point of service, claims have to be unbundled and bundled back again. A simple office visit, for example, might include procedure codes for several tests. But determining provider discounts and the amount owed by the patient can be difficult. Real-time adjudication depends not only the complexity of the claim, but getting all of the pieces together at the right time.

Provider resistance could prove another significant barrier to real-time claims adjudication. Doctor's offices are unaccustomed to collecting more than copays from patients. Under a typical copayment plan, providers can collect copayments from patients at the time of service and submit clean claims to payers after the service is provided. Once that patient is in a deductible-based plan, the provider won't be able to collect if he or she doesn't know what the patient is being charged. For real-time claims adjudication to work, providers need to agree to expand the information

Cost savings. Companies with traditional health plans saw costs climb by an average of 15.6 percent in 2005, compared with a 12.4 percent increase for self-insured companies, according to a Kaiser Family Foundation survey. 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 health care 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, rather than partially with an insurer and its profit margin. The employer maintains control over health plan reserves, enabling the company to maximize interest income. Otherwise, an insurance carrier would invest premium dollars. In an insured plan, the insurer would control reserves and any earnings they generate. 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. Its purpose is to reimburse the employer for claims, so it is often referred to as “reimbursement insurance” or “re-insurance.” Note that a stop-loss policy is a contract between the 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 specific employees with serious illnesses than the rest of the group. The employer would have to cover the additional deductible for those employees if they have major medical expenses during the year. And, after switching to a self-insured plan, an employer that wants to revert back after a few expensive 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. Employers can elect to self-insure medical, dental, vision or short-term disability benefits.

The bottom line: Employers that self-fund control their own destiny—self-insuring changes the focus to managing health care dollars, instead of negotiating premiums with an insurer. For further information on setting up self-insurance for your company, please contact us. □

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they can deliver at the point of service to a health plan and health plans need to change their systems to make real-time claims adjudication less cumbersome.

The ultimate convenience for employees will be to have one health care card that serves as the health plan ID and have debit card functionality, linked to all employee benefit accounts. When a consumer pays for a physician visit, the process of approving the claim, paying for services from the proper source—health plan, HSA, FSA, HRA or checking account—should be instant. To achieve that goal, the health care system will need to integrate various providers to create a more seamless, single-source process to manage payments, deductibles and claims processing.

Real-time claims adjudication will likely require a series of progressive steps, rather than happening with a single solution, according to debit-card vendors. But these integrated point-of-service initiatives are a major step in revolutionizing the health care industry. The industry needs to continue to adopt technology that will meet employees’ demand for convenience and the growing level of consumerism in health care. For more information on integrating technology into your company’s consumer-directed plans, please contact us. □

Massachusetts has enacted the nation’s most comprehensive universal health coverage law.

Under the new mandate, state residents must obtain health insurance by July 1, 2007 – either individually, through various state-subsidized programs, or from an employer-sponsored plan. Employers with at least 11 employees must offer coverage and a section 125 plan to allow workers to pay premiums with pretax dollars. Penalties for noncompliance are up to \$295 per employee. The law allows companies to offer cheaper, pared-down plans – including, for example, catastrophic insurance, limited doctor’s visits and only generic drugs, or high-deductible plans with low premiums.

Proponents believe employers will also reap long-term benefits due to fewer worker sick days and emergency room visits. If the Massachusetts plan succeeds, wherever you work, get ready to see your state legislature seriously consider similar changes, particularly if the local uninsured rate is 10 percent or higher. □

