

Benefit Insights

Making the Case for Long-Term Care Insurance

The case for long-term care (LTC) insurance becomes more compelling with each passing year. According to figures published by the Bureau of Labor Statistics (BLS), the cost of receiving LTC services in one's home (for five hours per day, five days per week) averages \$20,000 annually, while the cost of a semi-private room in a nursing home averages \$52,000. The latter figure becomes more dramatic when one considers projections that this cost will rise to \$190,600 by the year 2030, and that the average length of stay in a nursing home is 2.6 years.

With fewer individuals able to rely on family members to provide assistance, the likelihood that one will need to purchase LTC services has increased. Given the cost figures cited above, an individual requiring LTC services is likely to need help in paying for them. Contrary to common perception, neither health insurance nor Medicare covers LTC services (unless they are short-term rehabilitation services for an acute condition). Medicaid will pay for LTC services, but only after an individual has spent-down his or her assets.

As yet, private LTC insurance has not played a significant role in the payment of LTC expenses. According to the BLS, in 2000, private insurance paid for only 11% of aggregate LTC expenditures. However, a growing number of LTC policies are being sold, both to individuals and in the employer-group marketplace.

According to research from America's Health Insurance Plans (AHIP), a national trade association, more than 9 million LTC insurance policies have been sold from market inception through 2002, with 900,000 of these sold in 2002. While the large majority of existing LTC policies (80%) were sold in the individual market, AHIP reports that 32% of the policies sold in 2002 were purchased through the workplace. (The Federal Long-Term Care Insurance program opened in mid-2002, and accounts for some of this growth.)

By the end of 2002, more than 5,600 employers were offering LTC insurance to employees, AHIP reports, and more than half of these employers were establishments with 1-100 employees. Policies offered through the workplace are almost always 100% employee-paid, yet they offer employees advantages over buying the product in the individual market—group rates, guaranteed issue, and the conveniences presented through worksite marketing and payroll deduction.

Employers recognize that by helping employees meet their LTC needs (or those of a spouse or parent), they can improve employee loyalty and morale, increase productivity, and reduce absenteeism. However, employers that offer LTC insurance usually see participation rates that are much lower than those for other types of voluntary coverages (such as supplemental life insurance, or short- or long-term disability). A report published by the Employee Benefit Research Institute (EBRI) reviewed various surveys on the topic and found they reported average participation rates ranging from 1% to 8% (Issue Brief No. 221; Jeremy Pincus, author). Competing demands for employees' financial resources, unfamiliarity with LTC insurance or a misunderstanding of how it differs from health insurance, and a failure to recognize how costly LTC services are all contribute to low participation rates.

Industry experts agree that employer support for the LTC program, along with strong employee education and communication efforts, are critical factors in driving employee participation. The EBRI Issue Brief sets out "best practices" for maximizing participation. Some of these include—

- a suitable environment for LTC enrollment, as determined by employee demographics (a median age of 40 or older), employee wages (a median salary of \$35,000 or higher), and job satisfaction and stability;

continued on page 2

Benefit Strategies, Inc. is pleased to present our quarterly newsletter which contains important information on current and/or emerging employee benefit topics. Ultimately, our goal is to provide you relevant benefit information that will enable your organization to fulfill both its financial and benefit objectives now and into the future. As always, we welcome your thoughts and suggestions. We appreciate your confidence in us and thank you for allowing us to serve your organization.



Benefit Strategies, Inc.
921 E. 86th Street, Suite 100
Indianapolis, IN 46240
Website: <http://www.bsi-indiana.com>

Joseph E. Guzman, Jr.
Phone: 317-466-1336
Fax: 317-466-1340
Email: jguzman@bsi-indiana.com



Monitoring Dependent Eligibility Can Catch Coverage Errors, Reduce Unnecessary Spending

With health care costs annually on the rise, employers continue to search for ways to get a handle on overspending. One approach that does not involve plan redesign or cutbacks, cost shifting or vendor switching is to make sure that the plan is covering—and paying the claims of—only those individuals who indeed are eligible. Monitoring dependent eligibility through a dependent eligibility audit offers the opportunity to catch coverage errors and cut potentially costly overspending.

Individuals who are ineligible for coverage under the terms of the plan could be on the plan rolls for many reasons. These individuals include divorced spouses, dependent children who have reached the age of majority, and grown children who remained eligible due to their full-time college student status but who no longer attend school. The continued presence on plan rolls of such individuals could be the result of sloppy recordkeeping, administrative error, or employee oversight...or fraud.

Whatever the reason, continuing these individuals in an “eligible” status can result in the plan paying claims it does not need to, and thus incurring unnecessary—and possibly very high—extra costs. Also, compliance with COBRA continuation rights and COBRA notice requirements could be an issue, for individuals who once were eligible and then lost eligibility due to a COBRA qualifying event.

An eligibility audit helps to determine whether the plan is carrying any individuals who are enrolled as dependents but who do not meet the plan’s requirements for “eligible dependents,” and thus should be removed from the plan’s rolls. Through the process, employees who are eligible for the plan and who have enrolled dependents will be asked to show proof that these individuals do in fact meet the plan’s requirements for dependent status. Such proof could include (depending on the plan’s terms): a marriage license; a domestic partnership

affidavit; a birth certificate; an adoption decree; college transcripts; or a disability determination.

Going into the audit, the employer has a number of decisions to make. Should the audit be conducted of all plan members, or on a more limited basis (such as requiring verification only of certain dependent classes, for example, full-time college students)? What type of dependent eligibility verification will be required (will copies of the relevant documentation suffice)? Who will examine the documentation that employees provide—the employer’s human resources/benefits department, or will this task be contracted out? These decisions can impact not only the cost of the audit process, but also the quality of the results.

The timing of the audit also must be decided. One choice is to time the audit to run with benefits renewal, when employees will be thinking about benefits coverage and can readily make appropriate changes. However, whenever conducted, dependent eligibility standards must be clearly communicated to employees, along with what they must do to verify their dependents’ eligibility status and the consequences for maintaining an ineligible dependent. In regard to consequences, an employer also must decide whether to permit an “amnesty” period, i.e., a time during which employees are encouraged to report any covered but ineligible dependents, with no adverse consequences.

In addition to the prospect of substantial cost savings, a dependent eligibility audit presents an employer with the opportunity to review plan provisions concerning eligibility for dependents, and to make any revisions or clarifications in the definitions.

A dependent eligibility audit can result in immediate, definite and substantial cost savings for a health plan. It is a logical and effective supplement to other cost-savings measures.

continued from page 1...Making the Case for Long-Term Care Insurance

- an appropriate plan design, which includes benefits in line with the cost of care in the region, a range of coverage options including those on both the low and high ends, and a payroll deduction option for payment;
- multi-media communications that show visible and enthusiastic employer support for the program; and
- simplified enrollment procedures that are on-cycle with enrollment for other benefits.

If you desire more information about LTC programs, please contact us and ask to speak with Kim McCarsen. He will be able to answer your LTC questions. Also, if there is interest, he can identify for your organization an employer paid (wholly or partially subsidized...) or employee-pay-all LTC program that provides the best (protection / cost) value.

Employers Must Provide Electronic Medicare Part D Disclosure Notice to CMS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 added a new prescription drug program to Medicare. Medicare Part D is a voluntary program that provides outpatient prescription drug coverage to eligible individuals. Because some individuals who are eligible for Part D also might be eligible for prescription drug coverage from another source—such as an employer-sponsored health plan—these individuals are entitled to receive a Notice of Creditable Coverage (or, if appropriate, Notice of Non-Creditable Coverage), which explains how this other coverage compares to Medicare Part D. Drug coverage is “creditable” if its actuarial value is at least as great as the actuarial value of the standard Part D coverage. This information is important because individuals who decline Medicare Part D when first eligible are assessed a penalty if they later decide to enroll, unless they have had creditable coverage in the meantime.

In addition to providing the appropriate notice to individuals who are eligible for Medicare Part D, affected employers must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the prescription drug coverage they provide is creditable. Disclosure is provided through an electronic Disclosure Notice form that is available on the CMS Web site (<http://www.cms.hhs.gov/apps/ccdisclosure/default.asp>). This electronic form is the only option for providing the required notice.

Most employers—even those that do not offer any type of prescription drug coverage to retirees—are affected by the Disclosure Notice requirement, because it is required if the employer plan provides prescription drug coverage to any Medicare-eligible individuals (for example, active employees over age 65 and spouses or other dependents who are Medicare-eligible for any reason, including age, disability or end-stage renal disease). Disclosure is required whether an employer plan is primary or secondary to Medicare.

Employers that contract with a Part D plan to provide prescription drug coverage (or that contract directly with Medicare as a Part D plan) are exempt from the disclosure requirement. Also, an employer that does provide prescription drug coverage to retirees, and that has been approved for the Retiree Drug Subsidy, does not need to file the Disclosure Notice with CMS with respect to the retirees for whom the

employer is claiming the subsidy.

The Disclosure Notice must be submitted to CMS annually. The initial Disclosure Notice must be provided by March 31, 2006, for plan years that end in 2006. For 2007 and later plan years, disclosure must be provided within 60 days after the beginning of the plan year. Also, a Disclosure Notice must be submitted within 30 days after a prescription drug plan’s termination, and within 30 days after any changes that affect the creditable coverage status of the plan.

Generally, an employer will be required to submit only one disclosure form. Though prescription drug coverage may be provided under different benefits options (HMO, PPO, etc.), separate Disclosure Notices are not required for each option (but the form does ask for the number of different options).

The information required by the Disclosure Notice includes the following—

- Identifying information about the entity filling out the form, including employer name, EIN, address and telephone number.
- Period of time covered by the Disclosure Notice (i.e., the beginning and ending calendar dates of the “plan year” covered in the Notice, which CMS defines as the beginning and ending dates of the employer’s annual renewal or contract period).
- Number of benefits options offered to Medicare-eligible individuals.
- Creditable coverage status of the benefits options offered.
- Estimated number of Medicare Part D eligible individuals who are expected to be covered under the benefits options as of the beginning of the plan year, and an estimated number of the individuals expected to be covered under a retiree health plan.
- Latest date on which the Notice of Creditable Coverage (or Notice of Non-Creditable Coverage) was provided to eligible individuals.

The CMS Web site (www.cms.hhs.gov/creditablecoverage) provides guidance on this and other questions about Medicare Part D. Contact us for additional information.

continued from page 4...Should You Offer Incentives to Keep Your Employees Thin?

- Ask on-site cafeterias and vending machine providers to ensure that 60 to 80 percent of food choices are healthy options.
- Make exercise an attractive option: Put a sign near the elevators that asks, “Have you thought about taking the stairs?” Make stairwells attractive with paint or piped-in music.
- Consider sponsoring on-site Weight Watchers meetings.
- Encourage more use of on-site fitness centers. Sponsor a “Newcomers to Fitness Day” to encourage those who are new or reluctant to exercise.

According to the group, implementing these guidelines will result in a 32 percent decrease in sick leave, a 55 percent reduction in healthcare costs and a 50 percent increase in productivity.

Should You Offer Incentives to Keep Your Employees Thin?

The growing problem of obesity is taking its toll in the workplace. Obese employees tend to be less productive and use more sick days because of health issues related to their obesity. It goes without saying that covering the medical needs for obese employees increases already skyrocketing group healthcare coverage costs.



In an effort to combat the problem, employers have turned to a Pavlovian solution to spur overweight employees to lose weight. They are using incentives such as cash bonuses, vacations, and paid days off from work to reward employees who fight the battle of the bulge. It may seem like an extremely expensive bell to ring, but when you compare the cost of the incentives to the amount of money lost because of poor productivity, it doesn't seem so extreme. According to the Centers for Disease Control, obesity is costing American business \$56 billion in lost pro-

ductivity resulting from disability, illness and death. It is no wonder companies are pushing the envelope in search of a solution.

If you are considering offering this type of program, start by walking a mile in your obese employees' shoes. Overweight people, contrary to popular myth, are not jolly about their condition. They are already sensitized to what people are saying about them, so make sure your program doesn't stigmatize them any further. The program focus should be on progress, no matter how small. And of course, there should be no retribution for employees who fall off the bandwagon.

The program also needs to be grounded in something more substantial than the immediate gratification of a reward. It should encourage overall healthy living and wellness, not just shedding pounds.

America on the Move is a national campaign whose goal is to convince employers to get involved in their employees' eating and exercise habits. It works with employers to offer a 15-week program that encourages employees to work up to walking 10,000 steps each day. They also offer some other suggestions for implementing an effective obesity prevention program:

continued on page 3



921 E. 86th Street, Suite 100
Indianapolis, IN 46240