



# Benefit Review

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## Avoiding Common COBRA Mistakes Is the Best Way to Manage Costs

With high COBRA costs and steep penalties for noncompliance, employers have plenty of incentive to make sure that they—and their administrators—are doing all that is necessary to administer COBRA exactly according to the law. Yet, errors frequently occur, due in large part to the complexity of the COBRA law and its regulations, but also sometimes to misunderstandings and miscommunications that occur between the employer and administrator as to who is responsible for what aspects of COBRA compliance.

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Just how costly is COBRA for employers? According to an annual survey from Spencer's Benefits Reports, in 2006, the average annual cost for employers per COBRA enrollee was 45% more than the average annual health care cost for an active employee, or \$9,914 compared with \$6,831. And when a plan encounters administrative problems, noncompliance penalties can add significantly to COBRA's costs: an excise tax penalty from the Internal Revenue Service of

\$100 per day (\$200 if multiple qualified beneficiaries are involved), an ERISA penalty of \$110 per day, and potential court costs, legal fees, and even medical claims costs if an individual is not properly covered by the health plan due to COBRA noncompliance.

With all this at stake, it's worth taking a look at some of the common and most frequent COBRA errors—

- Failing to provide the initial or general COBRA notice. This is the notice that must be provided to all employees, and spouses, which tells them about the COBRA law and their responsibility to notify the employer if they experience certain qualified events. If this notice is part of the health plan summary plan description (SPD), and the SPD is only distributed on-site to employees, the notice-to-spouse requirement will not be satisfied.
- COBRA notices that do not contain language as required by the most recent COBRA regulations.
- Poor documentation that the required notices have been provided. If challenged that a required COBRA notice actually was provided, an employer will need to show that its methods for meeting the notice requirement are reasonably calculated to result in receipt by employees. This requires established procedures and proof that those responsible actually are adhering to these procedures.
- Not offering COBRA for coverages besides the core medical coverage, such as dental, vision, and the flexible spending account.
- Not holding qualified beneficiaries to coverage election deadlines by accepting COBRA elections late. What may seem like a nice gesture can cost a company significant dollars, given the data cited above concerning average claims costs incurred by COBRA beneficiaries.
- Keeping COBRA beneficiaries on the coverage rolls for longer than necessary (not terminating coverage when required premium payments are missed or are received beyond the grace period; not terminating coverage at the end of the 18- or 36-month coverage period, plus the disability or multiple qualifying event extension, if applicable; not terminating coverage when a COBRA beneficiary becomes entitled to Medicare or becomes covered under another plan).
- Assuming the health plan insurer is providing COBRA notifications, though it has not been specifically contracted to do so. COBRA is an employer law, and though employers can allocate contract specific COBRA responsibilities to other parties, don't assume that the insurer is providing notices simply because it pays any claims under the plan.
- Trying to save a few dollars by self-administering rather than hiring a qualified COBRA administrator. Remember the dollar signs cited

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## Wellness Program Incentives Grow, As Does Return on Investment

The use of health and wellness programs continues to grow, with more than three-quarters of the employers in a recent survey offering them, and more than half of those without programs planning to implement one. Increasingly, these employers are encouraging employee participation in wellness initiatives by offering incentives for participation, with more than seven in 10 employers doing so in 2008. Why? Employers are becoming more successful in measuring these programs' return on investment, and finding that they are more than breaking even.

The survey is the second annual from Health2 Resources, and respondents were employers that are members of the National Association of Manufacturers and the ERISA Industry Committee.

According to the survey, in 2008, 77% of the employers offered health and wellness programs—a 5% increase over 2007—and 48% offered disease management programs. Among the health and wellness programs were—

Type of Program	% of Employers Offering
Health Risk Assessment	64%
Safety Program	62%
Smoking Cessation	61%
Physical Activity/Exercise	55%
Weight Management	52%
Stress Reduction	34%
Work-Loss Prevention	32%
Maternity Management	25%

From 2007 to 2008, there also was an increase from 62% to 71% in the proportion of employers offering incentives to employees for taking part in these programs. Incentives are most likely to be offered in connection with health risk assessments, but they are used with other types of programs as well—

Type of Program	% of Employers Offering
Health Risk Assessment	62%
Physical Activity/Exercise	50%
Smoking Cessation	43%
Weight Management	40%
Safety Program	23%
Stress Reduction	12%
Maternity Management	11%
Work-Loss Prevention	10%

Between 2007 and 2008 the survey reported a “substantial shift” in the types of incentives employees could earn for taking part in health and wellness programs. The use of gift cards—now the most prevalent incentive—increased from 17% to 28%, while offering a premium reduction declined from 41% to 26%. In 2008, employers used these incentives—

Incentive	% of Employers Offering
Gift Cards	28%
Premium Reduction	26%
Cash/Bonuses	24%
Small Token	23%
Merchandise	19%
Health Club Membership	18%
Recognition	16%
Health Account Contribution	13%

The value of incentives ranged between \$100 and \$300 per person per year, with the average incentive value being just under \$200.

The most common behaviors rewarded with an incentive were participation in the health and wellness initiative (48% of employers provided the incentive for this), completing a program (38%), and signing up for or enrolling in a program (25%). The survey notes that these behaviors are easy to track, and they “steer clear of regulatory caps on monetary incentives” that the Health Insurance Portability and Accountability Act (HIPAA) place on programs tied to a health-related standard. That said, some employers did require the employee to achieve an outcome or goal before awarding the incentive (16% for achieving this during the program, 12% for achieving it after the program, and 6% for maintaining it after the program).

Most employers implementing health and wellness programs still do not measure return on investment (ROI), with only 36% of respondents saying they had attempted to do this in 2008 and 26% saying they had done so successfully. Among those who were able to measure ROI, 83% estimated an ROI greater than break-even in 2008, up from 66% in 2007.

The complete survey results are available through the ERISA Industry Committee's web site, [www.eric.org](http://www.eric.org).



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at the beginning of this article. Proper administration will help you to avoid penalties, and also to keep your COBRA costs as low as legally possible.

Though you can charge COBRA beneficiaries 102% of the “cost of coverage for similarly situated employees,” most employers will

find that the individuals who elect COBRA under their plan will incur costs well beyond this amount. Precise compliance is your best chance to keep your COBRA costs as low as legally possible.

## Self-Funding Basics: Should Your Company Consider a Self-Insured Health Care Plan?

Most employers are always searching for ways to lower their company's spending on their health benefit plans. Some modify plan design, some change carriers, some shift more costs to employees. And some employers move from offering an insured health plan to self-funding.

In a self-funded—also known as self-insured—health plan, the employer takes on direct financial responsibility for employees' health care costs. Rather than being part of a larger risk pool, an employer that self-funds takes on the risk for its employee group alone. All of a health plan may be self-funded, or an insurance contract might be purchased to cover certain types of claims. Most self-funded employers buy stop-loss insurance to cover against catastrophic claims.

**In a self-funded—also known as self-insured—health plan, the employer takes on direct financial responsibility for employees' health care costs**

Being exempt from state insurance laws and mandates and not having to pay premiums on a regular basis to an insurance company can result in substantial cost savings. Yet, many employers, especially smaller employers, shy away from self-funding, perceiving it as too risky. According to the 2007 Kaiser Family Foundation Health Benefits Survey, 55% of all employees covered for health care are in self-funded plans. Among employers with 200 or more workers, 77% of employees are in self-funded health plans, compared to 12% of employees in

firms with 3–199 workers.

Self-funding health benefits will be the right approach for some companies, and not for others. If your company is mulling over moving to a self-funded health plan, here are some basic preliminary considerations—

- Self-funding can give you more control over your health plan than you have with an insured plan. Your company can customize coverage, since you are not buying a prepackaged product. Though self-funded plans are subject to ERISA, they are not bound by state insurance laws, so a self-funded plan is not required to include types of coverage required by state insurance law. You can create a plan that truly meets your employees' health care needs. And, except for stop-loss premiums, you also won't pay premium taxes as you do with an insured plan.

- With a self-funded plan your company pays health claims as they are incurred, rather than paying a premium to an insurance company on a regular basis regardless of whether employees are filing any claims. This can be attractive, especially during periods when claims are low. The flip side, of course, is that you need to be able to handle large claims or a steady stream of moderate claims when they do arise.
- A company with a self-funded plan does not need to worry about the financial wherewithal of an insurance company. If you self-fund, however, you do need to consider your own company's cash flow, to be able to handle claims as they arise, and also your company's position in the event of a series of large claims, or even one truly catastrophic claim. As noted above, most employers that self-fund carry stop-loss insurance, to limit their liability for either or both large individual claims or claims in the aggregate in excess of a specified amount.
- When you pay a premium to an insurance company, you're paying for more than just claims; the premium will take into account the insurer's administrative and other costs (overhead, advertising, technology, etc.), some allowance against risk, a profit margin, etc. Companies that self-fund won't have to pay all these hidden costs, but they will incur other expenses, e.g., the cost of claims administration (whether handled internally or by a third-party administrator) and the cost of stop-loss insurance.
- Most insured health plans are packaged with a well-developed provider network, and if you've had the same plan for a while, your employees are likely settled with their choice of doctor, hospital, etc. If you move to a self-insured plan, you'll need to make sure you arrange to have a suitable network in place.
- Workforce demographics can make self-funding a more or less attractive option. Of course, young and healthy employees can suffer large claims, and older workers won't necessarily break the bank. But remember that self-funding means that your company alone (other than the stop-loss carrier) will bear the risk for your employee group, so it's worth closely analyzing this risk with a professional who can give you well-reasoned estimates of your potential liability.

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with their current provider. However, they may be more likely to take online advice if they are unhappy with their doctor, have been diagnosed with a medical condition or if they have recently moved.

#### Keeping A Close Eye on Ratings Sites

Although these sites have yet to take off, the American Medical Association and other organized medicine groups are keeping watch over the market. In some cases, the AMA has opposed

ratings sites. As a matter of fact, the association joined forces with other medical groups in Missouri to push back UnitedHealth Group's plan to use claims data to rank physicians.

Additionally, some states are regulating physician ranking and ratings networks. For example, some states require health plans to use quality measures for rankings instead of price. Plus, some rules allow physicians to see the basis for their ratings and have an opportunity to appeal.

## Physician Ratings Websites Are Slow to Catch On

Although hordes of consumers use the Internet as a tool for seeking out medical information, new studies show that only a scarce few are using physician ratings sites to choose their doctor. More than 80% of California based adults say they use the Internet for health-related information, such as medical symptoms and diagnoses, according to a Harris Interactive poll commissioned by the California HealthCare Foundation. However, only a handful of adults are visiting and using the information from physician ratings sites.

As a matter of fact, less than 25% of those surveyed say they have visited physician ratings sites, and only 2% of those actually made a physician change based on the information they found. Even fewer, less than 1%, say they made a hospital or health plan switch based on online ratings.

### Will Ratings Sites Ever Take Off?

Some experts say these statistics prove it will be a long while before physician ratings sites grow in popularity—and that they may never catch on at all. However, other industry professionals believe that few patients visit these sites because the market is still in its infancy. They believe that as the ratings information becomes more in-depth, more consumers will flock to the sites.

Additionally, some insurers are encouraging members to use their own ratings sites. In these types of networks, members pay less out of pocket if they visit a physician that meets the insurer's "quality criteria." However, many doctors claim this system is flawed.

### Physicians Should Still Watch Their Online Reps

Although physician ratings sites aren't skyrocketing in popularity as of yet, industry experts say that physicians should still be concerned about their online reputation. For many decades, word-of-mouth has been deemed the most influential advertisement for any business. Therefore, continuous negative word-of-mouth could lead to a medical professional's downfall.

Patients are already sharing information online about medical conditions and other health issues, and this communication can spread like wildfire. Some experts predict the details about specific physicians, especially those who are either exceptionally great or really terrible, will soon follow suit in the online world.

### Small, But Growing

Although few patients are actually using the information gleaned from physician ratings sites, these sites have seen an uptick in visitors over the past few years. According to a Harris Interactive survey of 1,007 Californians, the number of people who say they have visited one of these sites has grown from just 14% in 2004 to 22% in 2007.

Some medical industry experts believe the only reason more patients aren't taking action based on the information they find is because the sites often don't include details specific to their needs. Additionally, most patients are not willing to switch physicians if they are happy

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Employee Benefits

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