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Plenary Bulletin

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How to Make Your Workforce's HEALTH and PRODUCTIVITY Your Most Competitive Asset – Part 2

By Douglas H. Helm, Senior Vice President and COO of Plenary Insurance Services, Inc.

In our last issue, we focused on two key components of health and productivity, workers' compensation and health insurance. We now address how an alignment of these two programs can produce the best results.

There is no dispute that workers' comp and health care insurance are big ticket items for most businesses. While workers' comp costs have come down for California employers in the early years of this decade, comp claims are suddenly getting a lot more expensive, and medical costs are soaring. What used to be a straight-forward comp claim for a broken leg is now several claims: the broken leg, sleep deprivation, cumulative trauma, psychological disorder, and more. Applicant lawyers and some medical providers seem to have overcome many of the limitations of the California workers' comp reforms intended to stop abuse of the system, but it appears to be open season again. Based on information provided by California's rating organization, the Workers' Compensation Insurance Rating Bureau (WCIRB), we believe that rates are deficient by as much as 15%. Some experts believe that the rates need to be raised by over 20% to keep up with claims trends. In this bleak economy, a double digit increase for workers' comp would be hard for many California businesses to handle.

Health care insurance is not about to provide any relief either. The current rate of increase in health care is around 9.9% per year according to a recent Pricewaterhouse Coopers Health Research Institute (HRI) report. Historical and prospective Medical Cost Trends (a term meaning what the same health insurance plan would cost next year) were measured.

Why is this all happening? The unspoken truth is that businesses pay a huge premium for unhealthy and unfit employees who suffer from health issues that are lifestyle-related. The usual suspects are smokers, alcohol and drug abusers, the chronically ill or depressed – often undiagnosed, and the unfit or obese. These are high-risk employees, and all employers have them. Experts explain that 70% of all medical costs and a large portion of your workers' comp costs are incurred due to employees' lifestyle-related diseases. Just look around your office and take a mental inventory of your workforce or their families at the next company picnic. Even if you are not a medical expert, you can quickly spot the problems. A typical workforce will comprise the following: over 30% have poor exercise habits; over 20% have poor nutrition; 20% have extreme weight problems; nearly 20% use tobacco regularly; and another 37% either have high cholesterol or high stress. The number of people with undiagnosed illnesses including Diabetes and depression are the scariest of all potential large claims waiting to happen. When these claims are reported as job-related, they can sink corporate profits as workers' comp costs increase.

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Workers' Comp Aligned with Benefit Plan Strategies

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Legislative News – Sacramento's Health Care Agenda

There are quite a few things occupying the minds of legislators this summer in Sacramento. The most significant and well-publicized is the budget. Beyond that, Governor Schwarzenegger has declared a state of emergency over the drought conditions in the state, prisoner health care is the subject of a multi-billion dollar demand by the federal courts, and the fire season began early. After the failure of Assembly Bill x1 1 (Nuñez) to pass the Senate Health Committee early this year, it seems as though health care reform has not only been relegated to the back burner, but instead, is off the stove entirely.

However, not so fast. While comprehensive and costly health care reform is no longer on the agenda, a number of concepts that were first floated in proposals by the Governor and legislative leadership are still working their way through legislative committees. Some of these even have bi-partisan support. Assembly Bill 1945 (De La Torre), revamps the individual market, requiring standardized policy forms and approval from regulatory authorities before an individual policy is canceled or rescinded. This bill passed the Assembly with substantial Republican votes. Another bill on this subject, Senate Bill 1522 (Steinberg), is being aggressively opposed by health care plans and is a more comprehensive regulatory proposal for the individual market. Its prospects are uncertain.

Other legislation, however, is more contentious. While the Governor and Assembly leaders agreed to regulating medical loss ratios – the amount of money spent in direct patient care – how to make that calculation is still being debated in a number of bills still alive in the legislative process. Senate Bill 1440 (Kuehl), establishes a medical loss ratio of 85%, the same number in the Governor's proposal. How that number is calculated, however, is quite different. While the bill is moving, it is moving without Republican support, and there remains a number of significant policy issues yet to be resolved as the Assembly takes up the measure. Senate Bill 1300 (Corbett) is a "transparency" bill that would require plans to disclose more cost and health quality data. This bill is supported by AETNA and Blue Cross, as well as many unions, AARP, and the National Federation of Independent Businesses. It is opposed by the California Hospital Association and the California Medical Association, among others. A similar Assembly measure, Assembly Bill 2967 (Lieber) is working its way through the Senate.

It is too early to tell whether any of these bills will receive sufficient bi-partisan support to be signed by Governor Schwarzenegger. Reforms of the individual market and greater transparency in empowering consumers to make good health plan decisions are important to this administration. Whether this means that the Governor will support something less than comprehensive reform, however, remains to be seen. Stay tuned.

Seminar News

Employers Direct and Plenary will host a seminar on November 12 in the City of Industry – about 25 miles east of Downtown Los Angeles. If you would like to receive details and an invitation, send an email to **dlaskey@plenary.com** and include "Plenary Seminar" in the subject. Also include your name, title, company, mailing address, telephone number, and email address.

Impact of Same-Sex Marriage Decision on California's Welfare Benefit Plans

Alfred B. Fowler, Attorney at Law

BACKGROUND

On May 15, 2008, the California Supreme Court determined that State laws prohibiting same-sex marriage violate the California State Constitution. Objectors immediately appealed to the State Supreme Court to stay its decision until California voters could vote on a referendum appearing on this November's General Election ballot. The Supreme Court refused to grant the stay, thus allowing County clerks to issue marriage licenses to same-sex couples beginning on June 16, 2008. So how will this Supreme Court decision impact group health plans offered in California?

DISCUSSION

1. Domestic Partnerships. For a number of years, insurers issuing group health policies in California must make health care coverage available to domestic partners who are in the California Domestic Partner Registry. The gay marriage decision has no effect on the laws relating to domestic partners. Employer plan sponsors whose group health plans provide coverage to domestic partners must continue to do so without change in their federal or state income tax status. The domestic partner laws do not extend to same-sex marriage partners.

2. Defense of Marriage Act. This federal statute requires that all federal laws, regulations, and administrative processes be construed in light of the following: spouse is defined as "a person married to the opposite sex who is husband and wife" with marriage defined to be "between one man and one woman." Plan sponsors/employers must follow the "opposite sex" view in all federal benefit laws including: COBRA, FMLA, HIPAA and qualified plans under the Internal Revenue Code (IRC) and ERISA. For purposes of this article, plan sponsors cannot provide coverage to same-sex spouses through a cafeteria plan, whether it is premiums or spending account benefits.

3. Group Health Policies. Policies issued in California contain standard definitions for dependents, crafted and filed by each insurer issuing policies in California. HMO contracts likewise contain dependent definitions filed with the state. Insurers typically do not include eligibility for same-sex spouses in their definition of "spouse." It may be possible that a same-sex spouse may qualify as a dependent for IRS tax purposes. Until insurers/HMO's modify their policy language to include same-sex spouses, plan sponsors have no basis for enrolling a same-sex spouse (not a tax dependent) for group health coverage.

4. Self-Insured Group Health Plans. These are not subject to California insurance laws. They are subject solely to federal law including ERISA and the IRC. Plan sponsors will not have the option of providing tax-favored benefits to same-sex spouses. If they do, then they must report imputed income taxed on the fair market value of the coverage provided. They cannot collect pre-tax contributions for same-sex spouses.

5. California Family Rights Act or Federal Family Medical Leave Act. The California Family Rights Act (CFRA) appears to have the duty to honor request for leave to "care for one's spouse, whether he/she is of the opposite sex or same sex." Some consultants speculate that an employee could exercise rights under CFRA (maximum 12 weeks) and then assert other leave rights under FMLA (12 weeks) resulting in a 24-week leave in a 12-month period.

6. Privacy and Discrimination Issues. Some writers have speculated that employers may violate an individual's privacy rights by asking for marriage proof to distinguish between opposite sex and same-sex couples for eligibility purposes. Some employers maintain a corporate policy that prohibits discrimination based on sex or marital status. Some do not. The California Supreme Court decision has ruled that the California Constitution forbids discrimination based on sexual orientation to the same extent as bias based on race, sex, or religion. California State non-discrimination rules appear in the Fair Employment Housing Act (FEHA). The FEHA prohibits discrimination on the basis of marital status or sexual orientation. It is important to note that federal civil rights laws do not include these additional protections. In summary, the privacy and non-discrimination issues resulting from the California decision will be an important element in our national dialogue on same-sex marriage.

ACTION PLAN

California employers should consider these steps:

1. Seek direction from your insurers/service organizations regarding their position on allowing same-sex spouses to obtain coverage under their contract.
2. Contact your tax advisor regarding the tax treatment for any welfare plan benefits made available to same-sex spouses.
3. Review your personnel policies and employee handbooks for any explicit or implicit position on employee rights, non-discriminatory policies, etc.
4. Contact your benefits professional with questions.

For more information, we invite you to contact Debbie Laskey by phone at 818.575.2709 or via email at dlaskey@plenary.com.

Guy Muranka

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Get Ready to REALLY Know Your Retirement Plan Advisor

In the near future, the U.S. Department of Labor is expected to release regulations that will require retirement plan service providers to provide written service contracts to clients that disclose compensation, as well as any possible conflicts of interest.

The compensation information will include all fees for service, including administration and record-keeping fees, as well as investment expenses such as 12b-1 fees, sub-transfer agency fees, commissions, management fees, incentive and bonus programs.

Most plan fiduciaries do not understand the payment of fees among their service providers and their intricate relationships. The industry term used to describe the payment of fees to service providers is called "revenue sharing."

If adopted as proposed, organizations and persons who provide services to your plan will need to comply with the regulations. The proposed regulations will require that, for fees to be considered "reasonable" under Section 408(b)(2), service providers must specifically outline in a written contract with you:

- All services provided to the plan
- All direct and indirect compensation that they and their affiliates receive for those services
- The manner in which they receive the compensation
- Whether fiduciary services are being provided
- Any conflicts of interest
- Whether the provider can affect its own compensation without approval of a plan fiduciary
- Whether the provider has policies that prevent any potential conflicts of interest from adversely affecting its services to the plan

The new regulations will force you to "underwrite" services in order to determine what is reasonable. You may be faced with the decision of whether an advisor who is paid from plan assets should be involved in your plan for fear of having to justify his/her fees to plan participants.

A recent trade publication found that the participation rate and the average amounts contributed to the plan by participants were virtually the same for those plans that used advisors and those that did not. The increasing "automation" of retirement plans through the automatic enrollment feature and using target-date funds for the default investment make it more difficult for advisors to warrant their services.

You will need to carefully review advisor services and monitor their results. If plan participation is not increasing, participant contributions are remaining the same, and the investment allocation remains heavily weighted toward conservative investments over time, you will not be able to justify that the advisor fees your participants pay for enrollment and education services are reasonable. You might consider changing your advisor's compensation to one that is based on providing results and value to your plan and your participants.

Please contact Debbie Laskey by phone at 818.575.2709 or via email at dlaskey@plenary.com to learn how your Plenary consultant can provide an investment fee benchmark report for your 401(k) provider. The report is educational in nature and will help you understand the investment fee structure of your 401(k) provider.

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Workers' Compensation IS ONLY ONE COMPONENT OF YOUR COMPANY'S HEALTH AND PRODUCTIVITY INVESTMENT

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So, what can you do? Employers have a choice. Employers can focus on a band-aid remedy or take steps to fix the problem on a long-term basis. The band-aid version is a short-term fix and is called cost-shifting – which passes additional costs along to customers or employees. However, the process of passing along costs to customers is problematic since customers may choose to buy products or services elsewhere. The process of passing costs off to employees is easier. To reduce your company's health care costs, a cost-shifting strategy increases the amount that employees pay themselves: 1) Raise their co-payments and deductibles; 2) Limit their choice of providers and prescriptions drugs; or 3) Limit their plan options. Keep in mind, however, employees are resistant to cost-shifting, and employers are wary of taking this option too far.

But, what if you, as a business owner or decision maker, could find a way to decrease the cost drivers of high workers' comp costs and medical/disability costs, and in the process become more competitive (reduce your prices and increase market share)? What if a modest investment in your workforce could make it become your most powerful competitive asset – an asset that others would have a tough time duplicating without a similar effort? This is exactly what *Fortune 1000* companies and a growing number of smaller companies are already doing. They are focused on the concept of "wellness" as a corporate mantra. They understand that for every $1 they invest, their average ROI will be $3. One company in particular, Johnson & Johnson, found a way to average a compounded ROI of 30% from their investment in wellness over a 12-year period.

Just as a business owner drives costs down on every other aspect of his or her business, the theory is the same when investing in health and productivity. Items that work well are not cut. Items that do not work well are fixed. First, list the objectives. We like the list recommended by Global Business Systems, a firm with international experience in the area of increasing corporate productivity through investing in workforce wellness. Note that every item in the following list can be measured. Once we identify the cost drivers for each of these factors, like any disease once diagnosed, we can develop and apply specific regimens with near pin-point accuracy in order to support our objectives:

- Reduction of absenteeism
- Increased productivity
- Reduced employee turnover
- Reduced medical costs and claims
- *We would add: reduction in workers' comp experience modification rate*

What is the profile of high-risk employees? They probably suffer from undiagnosed chronic illnesses and miss several more days of work than their peers. They are probably also victims of Presenteeism – when an employee shows up at work but is unable to work productively due to illness or disease. Employees who are in unfit physical condition will often suffer from Diabetes, high cholesterol, and high blood pressure. Although smokers can usually be identified, those who abuse alcohol and drugs are not always easy to spot. Depression, often undiagnosed, is a huge driver of health care and workers' comp costs. Some high-risk employees need prescription medication but do not take as directed. Many of these employees will be dissatisfied with their jobs and their lives. Of all the health care and workers' comp claims filed by employees, it is with this group that you can and must make your most significant impact. If this group of high-risk employees will not make the necessary lifestyle changes to keep their own lives from being at risk, left alone, they will probably not make necessary changes to improve their companies' productivity (profits).

So, what does it take to get high risk employees to change? A combination of initiatives, none quick or easy, is the answer. When orchestrated for the long term with a consistent message and management buy-in, this may be one of the best returns on investment that a business owner can make, but you will need to focus on support and incentives. Your opening move is the most important, but one thing is certain: This entire process cannot be about you as the employer – it has to be about your employees with a message that you care about them. And, the truth is that you do, because when you, as the employer, support these high-risk employees and provide incentives so that they improve the quality of their lives and regain their health and fitness, you will reap the rewards by improving productivity and profits. Everyone wins – because everyone is part of the process together.

In our next issue: *Beginning with the Health Assessment, A Step-By-Step Guide to Creating A Wellness Program.*

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