

# Benefit Insights

## Welcome to the Hamilton Brewart Insurance Newsletter!

It is with great satisfaction that we bring this newsletter to you. In this issue and in coming months, we will discuss pertinent risk management topics which may affect your organization. We sincerely hope that you will find this newsletter informative and please do not hesitate to contact us should you have any questions or needs.



## Cost-Containment Strategies Needed for the Few Employees with the Highest Health Care Spending

Conventional wisdom has it that 20% of health plan participants run up 80% of health plan costs. Now, an analysis of health plan expenditures paints an even starker picture, concluding that 4% of participants account for nearly half of health plan costs.

The analysis of health plan expenditures from Watson Wyatt Worldwide found—

- 4% of participants with serious health conditions—chronic or catastrophic conditions—account for 49% of health care costs. These individuals average more than \$10,000 in annual health care spending.
- 24% of participants—who Watson Wyatt characterized as being in the early stages of chronic conditions or having acute health episodes—account for 40% of spending. These individuals average \$1,500-\$9,999 in health care costs.
- The remaining 72% of participants—who are relatively healthy—account for only 11% of health care costs, and have less than \$1,500 in annual health care spending.

These statistics send a clear message that disease and case management programs are crucial elements in any plan's overall cost management strategy. While much attention has focused recently on consumer-directed health care and the financial incentives these programs use to encourage employees to be smart health care consumers, such incentives are unlikely to make much of a dent in the 49% of spending by the 4%-of-participants group. These individuals need large amounts of health care, thus it becomes critical that such care is appropriately managed. Possible strategies include disease management programs, case management programs and centers of excellence.

Disease management programs focus on a particular condition, usually a chronic one such as asthma, diabetes or

hypertension. The program offers care monitoring and coordination, along with patient education and care strategies. The end goal is to enable the patient to manage the condition in a way that enhances quality of life and day-to-day functioning, while providing appropriate care, avoiding complications, reducing hospitalizations and, hopefully, containing costs.

Case management programs usually focus on individuals who have suffered a catastrophic injury or have life-threatening—and sometime multiple—conditions (such as cancer, stroke or head trauma). As with disease management, care is coordinated, usually through a case management nurse with extensive knowledge of the condition. However, a catastrophic case manager also acts as a liaison between the patient and the health care professionals (in catastrophic cases, there usually are many) involved in the patient's care, coordinating the different health care resources and treatment plans that may be involved. Such attention minimizes redundancies and the risks of counterproductive and contra-indicated treatments, and enhances a patient's and family's understanding of the health care received. Again, contained costs are among the hoped-for goals.

Centers of excellence are health care facilities that have been determined to provide high quality, cost-effective care in one or more specialty areas. Directing individuals to these facilities when appropriate (for example, a cancer patient to hospital that has been identified as an oncology center of excellence) can aid in cost management, especially if the center is a provider in the plan's network.

Financial incentives and consumer-directed initiatives hold great promise for helping the large majority of employees become better health consumers. For the few who have the most spending, however, strategies that focus on managing the needed care likely will be more effective tools.

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## States Modifying Insurance Laws to Address Problem of Uninsured Young Adults

With an estimated 46 million individuals in this country without health insurance, and young adults comprising a large—and growing—portion of this group, some states have enacted measures to extend the time that adult children can be covered as dependents under their parents' employer-sponsored health insurance plans.

Typically, employees in group plans can cover dependent children until they reach age 19, or until graduation for children who are full-time college students (but generally with an age limit of 23 or 24). For disabled adult children who are dependent on a parent for support, group plans generally allow continued coverage, so long as proof of the disability is provided upon request.

By requiring that children can remain covered under their parents' insurance plans for a longer period of time, states shift some of the burden of paying for what otherwise would be uncompensated care.



An analysis by the National Conference of State Legislatures on the "Changing Definition of 'Dependent'" details legislative enactments and proposals dealing with this issue. According to the analysis, several states now require that adult children who previously would have passed the age of eligibility for dependent coverage continue to be considered eligible for such coverage. The most forward of these is New Jersey, which according to a state senate committee statement on the measure, now allows adult children to remain on a parent's health insurance policy until age 30, so long as a number of conditions are met. The individual must be unmarried, without a



dependent of his or her own, a state resident or a full-time college student, and not actually covered under any other plan. An employer is not required to pay any portion of the cost of coverage, which may be charged at 102% of the premium previously paid for that dependent's coverage.

Some of the other states that have increased the age at which a child presumptively is no longer considered a dependent for insurance coverage purposes include—

- Colorado, where an unmarried child remains a dependent for insurance purposes until age 25, so long as the child is financially dependent on the insured or has the same legal residence as the insured.
- New Mexico, where health insurance for dependents may not be terminated based on age before age 25.
- Utah, where coverage for an unmarried dependent child must continue to age 26, regardless of whether the individual is enrolled in school (enacted in 1994).

A few states (such as Illinois and Pennsylvania) require extensions of coverage if the adult child has been on active military duty or on reserve/National Guard call-up, once that service has been fulfilled. Others set a specific, older age at which full-time students are no longer considered dependents (South Dakota, 24; Texas, 25). A few have expanded the definition of dependent to include grandchildren who are living with the policyholder and dependent on the policyholder for support.

With state budgets facing growing demands and the ranks of the uninsured increasing, it's likely that this trend toward expanding the definition of a dependent will only continue. Remaining aware of whether and how your jurisdiction is addressing this issue is important for all business owners.

## **Make Your LTD Plan More Executive-Friendly**

Employer-sponsored long-term disability (LTD) plans typically replace 60% of pre-disability earnings, with some companies providing a slightly higher replacement percentage. When an employer pays the premiums for the LTD plan, benefits are taxable to the employee in the event of a disability. For executives or senior level employees with upper-range salaries—and thus upper bracket taxation—the tax hit on the disability benefit can generate a significant gap between pre-disability earnings and the amount of actual disability benefit received.

Suppose a senior level employee with an annual salary of \$200,000 becomes disabled, and the company-sponsored LTD plan replaces 60% of salary. This individual receives an annual disability benefit of \$120,000, or \$10,000 monthly. This benefit will be reduced by an additional 25%-35% (depending on the executive's other taxable income sources, deductions, the state income tax rate, etc.). So, this highly paid individual could see the monthly disability benefit fall to \$6,500, creating a huge gap between the pre-disability salary and disability benefit and causing a radical adjustment in the employee's standard of living.

What can employers do to help their executives and senior level employees fill this gap, or avoid creating such a huge gap in the first place?

The executive employee in the example was taxed on the disability benefits when paid because the employer had paid for the LTD plan premiums. If, however, the disability premium is paid by the employee with after-tax dollars, or is paid by the employer but imputed as income to the employee, any benefits paid are not subject to tax.

An Internal Revenue Service ruling (Rev. Rul. 2004-55) permits employers to allow employees to elect on a year-by-year basis whether to include any premium paid by the employer

as income. The election must be irrevocable and must be made before the beginning of the plan year. An employee can make a different election for each subsequent plan year. If a disability occurs in a year when premiums are included in income, then disability benefits paid are not subject to tax. (The ruling also could be applied to short-term disability benefits.)

This approach enables employers to give executives the flexibility to determine whether, for the particular executive's financial situation, it is important that any disability benefits paid flow free from tax. Executives can change their minds, annually, in line with their current financial situation (impact of an income loss) and their perceived chances of becoming disabled (current overall health).

By creating a situation that allows disability benefits to avoid tax, the employer helps the executive or senior level employee to narrow the gap between pre-disability earnings and post-disability benefits. An alternative—or additional—remedy looks at ways to fill that gap, by supplementing the basic company-sponsored LTD plan with additional, enhanced coverage. As noted above, typical LTD plans replace 60% of pre-disability earnings. They also may limit the maximum monthly benefit that can be paid, or exclude certain types of compensation that figure heavily into an executive's annual pay (such as bonuses or other incentives). A supplemental plan can moderate the impact of these limits and/or exclusions, by including incentive compensation, eliminating or raising the monthly benefit cap, and raising the replacement percentage. While the executive's pre-disability income won't be matched, the gap between it and the disability benefit can be substantially reduced.

Tweaking your company's LTD plan to make it more executive-friendly can be an important element in attracting and retaining this valuable level employee.

### ***continued from page 4...Highest-Cost Medical Conditions Are Also Biggest Disability Claims Drivers***

through a more formal program or occasional articles in company or health plan newsletters can remind employees of simple accident prevention tips—wearing bicycle and motorcycle helmets; using seat belts; not drinking and driving; installing home safety features, like smoke and carbon monoxide detectors and fire extinguishers—and smart behavior when an accident does occur (first-aid/CPR basics, having emergency numbers nearby, etc.).

- Mental disorders: Educating employees about the symptoms of mental illness increases awareness and can also serve to remove stigmas about seeking help for common conditions, like depression. Wellness programs that focus on anger management, stress reduction, and

the role of physical fitness in mental health can play an important role in helping employees avoid a mental health crisis.

- Pulmonary conditions: With the growing prevalence of asthma, programs that offer education and care management to asthmatics can be vital to controlling both the condition, and its costs. This category of cost-driving medical conditions also includes less common disorders such as chronic obstructive pulmonary disease and emphysema.

While these five health conditions are the costliest nationwide, an employer should examine its own data to see what triggers medical and disability claims in its workforce, and develop health and wellness programs accordingly.

## Highest-Cost Medical Conditions Are Also Biggest Disability Claims Drivers

The five most costly medical conditions also account for the majority of missed workdays under short-term disability (STD) insurance, according to an analysis of STD claims. This correlation highlights the potential advantages of developing wellness, preventive care and disease management programs that target these conditions, since the benefits of an investment in such programs can pay off in multiple ways for an employer.

The five conditions—heart conditions, cancer, trauma, mental disorders and pulmonary conditions—rank higher than all other medical conditions in terms of direct medical spending, according to an examination of the Household Component of the Medical Expenditure Panel Survey from the Agency for Healthcare Research and Quality. The analysis, published in 2005, found that together, these conditions affected almost 150 million Americans in 2002 and accounted for approximately \$265 billion in health care spending, or almost a third of all medical expenditures in that year.

In an analysis of its STD claims data, MetLife found that approximately half of all its STD claims from 2001 through 2005—and 60% of all lost workdays—stemmed from these conditions. According to MetLife, by understanding the link between medical expenses and disability absences, employers can leverage “the right resources at the right time” to keep employees healthy and at work, thus potentially lowering both medical and disability plan costs. Appropriate resources

include wellness and preventive care programs that educate employees by addressing risk factors and steps to take to avoid these conditions, as well as disease and care management programs for afflicted employees.

What would such programs encompass? Depending on the targeted conditions, the possibilities include:

- Heart conditions: Diseases of the heart cover a broad range of maladies—stroke, high blood pressure, high cholesterol levels, heart attack, etc. Both individuals at high risk due to family history and age, and those who are not, can benefit from prevention initiatives that focus on factors that are under an individual’s control. Smoking cessation education and programs, Weight Watchers at Work, fitness/exercise initiatives, nutrition counseling, and stress management all address behaviors that can lead to heart disease (and that those with heart conditions must manage).
- Cancer: Screenings are an essential element in detecting cancer. Early detection of many cancers dramatically improves treatment options and survival rates. Encouraging periodic check-ups through education—and plan provisions with generous coverage for check-ups and screenings—increases the chances that employees will receive age-appropriate (and risk-appropriate) screenings.
- Trauma: Accidents do happen, and their consequences can be catastrophic and costly. Basic education provided

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