Employee Benefits Report

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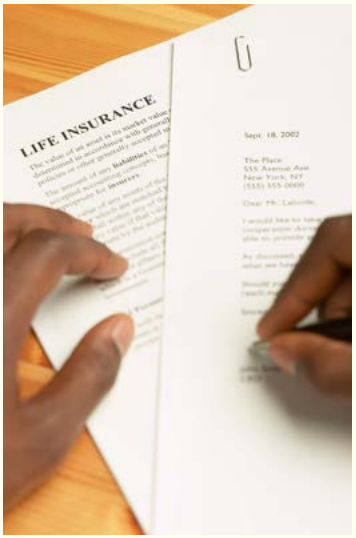
Solving the U.S. Life Insurance Crisis

Parents consider it extremely important to have life insurance, found the 2013 State Farm Life Insurance survey. But 95 million Americans have no life insurance coverage at all, according to LIMRA. What does this mean for your employees?

The lack of life insurance could mean financial ruin for a family. More than half of American adults surveyed said losing the family's primary wage earner would have a "financial impact" within a year, while nearly half (47 percent) would feel the impact in only six months. And one-third said they would feel the impact within a month of the salary earner's passing, according to LIMRA research. Younger people would feel the impact sooner than older respondents.

Underinsurance poses a serious problem for Americans as well. Most families use life insurance to replace a wage earner's income if he or she should die prematurely. But most American families with life insurance



do not have enough to replace a wage earner's lifetime earnings. A 2013 survey by Nationwide Financial found that 98 percent of consumers who are married, partnered or have dependents are underinsured. They have,

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This Just In…

Look for increasing employee turnover. Monthly job quits — an indicator of worker confidence — recently hit the highest level in six years, according to data released recently. There were about 2.53 million quits in the last reporting period — the greatest monthly tally since June 2008 and up 15 percent from a year earlier, U.S. Labor Department data show. Workers quit their jobs when they have confidence in the economy and their personal prospects, and are willing to trade some stability for career advancement and other opportunities.

A recent survey by Securian Financial Group showed the importance of employee benefits in employee retention. Although 92

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on average, $300,000 in life insurance coverage but lifetime earnings potential of $1.5 million. If they die prematurely, they would leave their families about $1.2 million short of replacing their income. Families who don't have life insurance to replace a high percentage of a deceased wage earner's income face the risk of a reduced standard of living.

The problem of underinsurance or lack of life insurance doesn't exist in a financial vacuum. In a recent survey by the Society for Human Resource Management (SHRM) a combined 61 percent of human resource professionals rated their employees' overall financial situation as no better than fair (50 percent fair, 10 percent poor and 1 percent very poor). As you might expect, employers with higher numbers of hourly workers were more likely to rate their employees' financial situation as poor.

Financial insecurity spills over into the workplace. Thirty-seven percent of HR professionals surveyed by SHRM said that employees at their organization have missed work due to a financial emergency in the last year. Many studies have found that financial stress also leads to more health problems… which means more costs for employers.

Most Americans wouldn't dream of leaving their other assets uninsured, such as their house or car. So why don't people buy life insurance to cover their lifetime income potential, which has a greater value than the average house? People give various reasons, but often it boils down to lack of urgency and opportunity.

In the 2014 Insurance Barometer survey, 30 percent of consumers who lacked insurance said they hadn't "gotten around to" buying it. Others cited cost. About 70 percent of consumers surveyed by LIMRA said required cost of living expenses prevent them from buying any or more life insurance. And 50 percent cite "additional living expenses," such as Internet, cable and cell phone costs, as a barrier.

The Role of Employers

In many cases, however, consumers might just be confused. A new study calls 19 million Americans "stuck shoppers" of life insurance, because they believe life insurance is valuable and necessary, but they find shopping for it confusing and overwhelming.

The joint study, by insurance trade organization LIMRA and Maddock Douglas Research, lays the blame on insurers, saying their communications lack clarity and relevance for consumers. Information overload also plays a role, since consumers faced with too many choices frequently decide not to buy at all. Employer-sponsored plans make it easy for consumers to obtain the life insurance coverage they need by eliminating some of the guesswork.

Even if you offer life benefits on a contributory basis, your employees are likely to respond. In the Nationwide Financial survey, consumers said they were willing to pay an average of $99 per month to ensure their family could maintain its standard of living after the death of a salary earner. For that amount, a healthy 35-year-old could bridge the coverage gap. A healthy 35-year-old man could buy more than $2.3 million in term life coverage, while a 35-year-old woman could buy more than $2.6 million in coverage.

percent of workers surveyed like the work they do, 40 percent would leave their job if they could buy insurance on the individual market that is comparable to their existing coverage, including out-of-pocket expenses. Among respondents, 43 percent have already turned down job offers due to unacceptable health insurance coverage.

What does this mean for employers? To avoid employee turnover, make sure your health plans provide better coverage and lower out-of-pocket expenses than plans on the health insurance exchanges, and compare your other benefits to your competitors'. Please call us for a complete benefit package review.

Group term life insurance plans offer many benefits over individual policies. Insurers will write employer-sponsored plans on a guaranteed issue basis. This means the insurer will issue at least a minimum amount of coverage to any employee who meets the group eligibility requirements (such as tenure or hours worked), regardless of their health. This allows employees whose poor health would prevent them from buying individual coverage to obtain life insurance. Guaranteed issue amounts vary with the size of the group—the larger the group, the larger the maximum guaranteed issue amount will be. Guaranteed issue amounts typically range from $10,000 for smaller groups to $75,000 or more for larger groups. Employees who

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meet the insurer's underwriting standards can obtain higher coverage limits. Maximum limits vary with group size; members of larger groups may be able to buy as much as $500,000 in group term coverage.

Employers can also offer group term life on an entirely voluntary (employee-paid) basis. Insurers may set lower guaranteed issue amounts for voluntary plans to avoid "adverse selection." This occurs when people who are more likely to file a claim buy a disproportionate percentage of policies. In a voluntary plan, you might find a guaranteed issue limit of $10,000, or perhaps as high as $100,000 for larger groups.

Employers can help their employees overcome the life insurance crisis by offering financial education. Employees who are better educated about financial matters appreciate the value of their benefits more, save more for retirement and have fewer financial stresses—which can affect productivity.

For more information on providing life insurance benefits for your employees, please contact us. ■

ERISA Turns 40

On Sept. 2, 1974, President Gerald Ford signed ERISA, the Employee Retirement Income Security Act. Since then, benefits managers have dreaded running afoul of this huge law. Does ERISA apply to your benefit programs? If so, what do you need to know?

ERISA established standards for private sector pension and health benefit plans to increase protections for plan participants and their families. It covers retirement, health and other welfare benefit plans (e.g., life, disability and apprenticeship plans).

ERISA gives EBSA, the Employee Benefits Security Administration, authority to oversee employee welfare plans. This division of the U.S. Department of Labor oversees approximately 707,000 private sector retirement plans, along with 2.23 million health plans and a similar number of other plans that provide benefits to approximately 141 million Americans.

As a federal law, ERISA takes precedence over any state or municipal laws governing benefits. However, it does not preclude states or municipalities from enacting their own laws governing benefits. (For example, certain cities, including San Francisco, have laws that require employers to provide health benefits to their employees.) Despite ERISA, states still have licensing and oversight authority over insurance programs.

When Does ERISA Apply?

ERISA applies to any "employee welfare benefit plan" that is "established or maintained by an employer" to provide benefits to the plan's participants and their beneficiaries. This includes some, but not all, voluntary or employee-paid plans. Even if the employer does not contribute a single dollar to the plan, ERISA might apply.

To determine whether your voluntary plan falls under ERISA, start with the Department of Labor's rules detailing "safe-harbor exemptions" from ERISA regulations.

To fall within the safe harbor:

1. The employer can make no contributions.
2. Employee participation must be voluntary.
3. The employer's function must be limited to collecting premiums through payroll deductions and remitting them to the insurer.
4. The employer cannot receive consideration in connection with the program (other than reasonable compensation for administrative services performed).

Intent doesn't determine whether ERISA governs a voluntary plan or not. If a plan doesn't meet all these criteria, ERISA applies.

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What ERISA Requires Plan Sponsors to Do

The ERISA statute and regulations require benefit plans to produce specific paperwork. If your plan is fully insured, your insurer might handle this for you. However, it remains the plan sponsor's responsibility to ensure compliance.

At a minimum, every employee welfare plan must have a written document that describes the benefit structure. These and other requirements make administering an ERISA plan more complex than administering other plans.

All types of benefit plans must provide summary plan descriptions (SPDs) to all participants, adhere to ERISA claims procedures, and file an annual Form 5500 financial status report. Employee welfare plans with fewer than 100 participants that are unfunded, insured or a combination of unfunded and insured might be exempt from Form 5500 filing. Other exceptions may apply. Please contact us to see whether your plans require a 5500 filing.

Pension plans have further requirements. They must have:

- A document that guides day-to-day operations;
- A trust fund to hold the plan's assets;
- A recordkeeping system to track the flow of monies going to and from the retirement plan; and
- Documents to provide plan information to participating employees and the government.

The EBSA provides a 28-page document describing the various disclosures employers might have to make for pension and health plans at www.dol.gov/ebsa/pdf/rdguide.pdf.

Compliance Check

If your plan falls under ERISA,

- Check your plan's eligibility criteria. ERISA sets minimum standards for participation, vesting, benefit accrual and funding. For example, if an employer maintains a pension plan, ERISA specifies when employees must be allowed to participate, how long they have to work before they have a nonforfeitable interest in their pension, how long participants can be away from their job before it might affect their benefit, and whether spouses have a right to part of their pension in the event of the participant's death.
- Be fiscally prudent. ERISA established detailed funding rules that require plan sponsors to provide adequate funding for their plans.
- Understand your fiduciary responsibilities. Anyone who exercises discretionary authority or control over a plan's management or assets or who provides investment advice to the plan becomes a fiduciary. Fiduciaries have an obligation to put plan participants' interests ahead of their own and act for the plan participants' benefit. Fiduciaries who fail to follow these principles of conduct may be personally responsible to restore any losses to the plan. Plan participants have the right to sue for benefits and breaches of fiduciary duty.

Please keep in mind that ERISA does not require any employer to establish any benefit plan. It only requires those who establish plans to meet certain minimum standards. The law generally does not specify how much money a participant must be paid as a benefit.

ERISA has been expanded to include new health laws. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA to give certain former employees, retirees, spouses, former spouses, and dependent children the right to temporarily continue their health coverage at group rates if certain events would otherwise result in a reduction in benefits. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended ERISA to make health insurance more portable and secure for employees. And finally, ERISA was amended to conform to the Affordable Care Act of 2010. All insured health plans that are not grandfathered must comply with the Affordable Care Act's provisions.

For more information on ERISA, please contact us.

How Much Does Obesity Cost Your Business?

It's a fact: your overweight and obese employees cost you more. How much more…and what can you do about it?

Consider the following statistics:

- Reuters estimated obesity costs U.S. businesses a total of $13 billion a year. This includes costs such as additional fuel to transport obese people.
- The May/June *American Journal of Health Promotion* reported that total health claims for morbidly obese employees cost their employers more than double what claims for normal-weight employees cost. Total health claims include claims for medical, sick day, short-term disability and workers' compensation benefits. Employers spend an average of $3,830 per year on benefits for normal-weight workers, and $8,067 for obese workers (2011 dollars).
- Extreme obesity increases the risk of dying at a younger age from cancer and many other causes, including heart disease, stroke, diabetes, and kidney and liver diseases. The study, led by researchers from the National Cancer Institute (NCI), found that extreme obesity reduced lifespan more than smoking.
- More than one-third of U.S. adults (34.9 percent) are obese, while 6.3 percent are morbidly obese, with a body mass index of 40 or more. This roughly translates to an average-height person carrying an extra 100 pounds.

Many organizations are realizing the effect obesity has on their bottom line. To estimate costs for your organization, see the free online Obesity Cost Calculator from the U.S. Centers for Disease Control at www.cdc.gov/leanworks/costcalculator/index.html.

Weight Loss and Wellness

While some employers see overweight and obesity as matters of personal responsibility, others are evaluating the benefits of wellness programs to help employees better manage their health. A wellness program aims to improve and promote health and fitness. Examples include smoking cessation programs, diabetes management programs, weight loss programs and health screenings.

The Affordable Care Act allows an employer or health plan to offer premium discounts, cash rewards, gym memberships, and other incentives to participate. It also makes available $200 million in grants to help employers with 100 employees or fewer to implement wellness programs.

Wellness programs fall into two categories: "participatory programs" and "health-contingent programs." Rewards under participatory programs do not depend on an individual's health status. They can consist of reimbursing participants for a fitness center membership or rewarding employees for attending a health education seminar or completing a health risk assessment. A "health-contingent wellness program" requires individuals to meet a specific health-related standard to earn a reward.

To encourage participation, employers and plans can offer premium discounts of up to 20-30 percent for most wellness programs, and up to 50 percent for smoking cessation programs. To avoid discriminating against individuals with disabilities, any health-contingent wellness program must provide alternative actions for participants who cannot meet their biometric targets.

Some studies have found that wellness programs return an average of $6 for every dollar spent; others have found results to be less clear-cut. To get the most from your wellness program, start by conducting a health risk appraisal with employees. HRAs obtain information on demographic characteristics

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(e.g., sex, age), lifestyle (e.g., diet and physical activity habits), personal medical history, and family medical history. They can also collect physiological data (e.g., height, weight, blood pressure, cholesterol levels) to use as baseline measures for planning and evaluation purpose. Conducting HRAs to collect employee information on risk factors helps target your worksite obesity program toward employee needs.

To gain employee support for your wellness program, be aware that employees don't like the idea of tying rewards to participation or achieving health goals. In a recent Kaiser Health Tracking Poll, 80 percent of employees who get health coverage through their employer say it is appropriate for employers to offer participatory wellness programs. However, 62 percent disapproved of charging higher premiums for not participating, and 75 percent disapproved of charging more for being unable to meet wellness goals.

Please note that employers should not use weight as a criterion in hiring or other personnel decisions. Weight discrimination is a serious problem, and other wellness factors also contribute to healthcare costs, such as tobacco use, misuse of alcohol or drugs, a sedentary lifestyle and poor diet.

For assistance in setting up an effective wellness program to address obesity and other health problems, please contact us. ■

Affordable Care Act Update

The open enrollment period for health coverage during 2015 runs from November 15, 2014 to February 15, 2015. Coverage can start as soon as January 1, 2015. This applies to individual plans only; businesses can offer coverage to their employees at any time.

Starting in 2015, employers with 100 or more full-time employees must offer health coverage to their full-time employees or pay an "employer responsibility" penalty. The penalty will apply to employers with 50 or more full-time employees starting in 2016. To avoid a payment for failing to offer health coverage, employers will need to offer coverage to 70 percent of their full-time employees in 2015 and 95 percent in 2016 and beyond. This helps employers that, for example, may offer coverage to employees who work 35 or more hours, but not yet to those who work 30 to 34 hours. (Unlike most employers, the Affordable Care Act considers employees who work 30-39 hours per week "full-time.")

The Affordable Care Act exempts businesses with 50 or fewer full-time equivalent (FTE) employees from having to provide health insurance. However, if you want to offer coverage, you can use the Small Business Health Options Program (SHOP) Marketplace. Employers that offer SHOP coverage and have fewer than 25 full-time equivalent employees may qualify for a Small Business Health Care Tax Credit. Employers must pay at least 50 percent of their full-time employees' premium costs. The tax credit is worth up to 50 percent of the employer contrubution (up to 35 percent for tax-exempt employers).

As licensed insurance agents, we can help you compare SHOP plans to other available options and help you enroll in whichever is the best fit for your business… at no extra cost to you. ■

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