



A S T R A  H R



**Employee Benefit Programs
Your Business**

Today's Presenters

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Today's Presenters

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Agenda

- **Developing Your Employee Benefit Strategy**
- **Medical Coverage**
- **Dental Coverage**
- **Disability Coverage**
- **Life Coverage**
- **Other Benefit Options**

Things To Consider When Designing Your Employee Benefit Strategy

- Employee Demographics
- Employee Life Stages
- Employer Culture
- Overall Benefits Budget
- Who you want to retain
- Who you want attract
- Future growth plans

Medical Coverage

Where We Are Today

- According to the Kaiser Foundation, in 2009 healthcare spending accounted for 17.9% of the GDP
- From 2002 to 2009, the average annual health care cost per employee has increased from \$4,914 to \$8,863 or 80%
- Upward trend in health care costs are slowing, yet cost increases are still outpacing the rate of inflation
- In March of 2010, President Obama signed into law a landmark health care reform legislation, the Patient Protection and Affordable Care Act

Several Factors That Have Led To Increased Costs

- Increase Age of Population
- Increase in diseases such as diabetes, heart conditions and strokes
- Dramatic rise of prescription drug usage and costs
- Consolidation of carriers/HMO's
- Political environment and government regulations
- Increased consumer utilization and demand
- New medical technology

Health Maintenance Organization (HMO)

- A managed care organization that provides, offers, or arranges for coverage of designated health services for plan members for a fixed, prepaid premium
- Patients must choose doctors, hospitals, and other health care providers from the plan's provider list in order to be fully covered
- Emphasis is placed on preventive care and cost management

There Are Two Basic Types of HMO's

Group Model HMO

- Health Plan builds and manages facilities and insurance functions
- Health Plan contracts with physician group who practice exclusively for that health plan in the health plans facilities or those in which they are contracted with
- All medical care decisions are made by the physician group
- Kaiser Permanente is a great example of a Group Model HMO

Independent Practice Association (IPA) Model HMO

- A HMO in which the plan contracts with individual independent physicians and physician groups to provide services in their own private offices
- IPA physicians are free to contract with multiple HMOs and health plans at once and to see any individual patients they choose
- Traditionally members choose a Primary Care physician (PCP) who is responsible for monitoring and coordinating a patient's overall health care, and refers the patient to appropriate specialists when necessary

Independent Practice Association (IPA) Model HMO (Continued)

- Traditional IPA Model HMO's members pay co-payments when accessing services
- Primary Care Physicians traditionally have been paid a capitation fee
- Over the last few years, open access HMO have emerged. The plans will allow members to self-refer to a specialist inside the HMO network

Point-of-Service (POS) Plan

- Standard HMO benefits with an option to utilize out-of-network services at will
- Out-of-network services are usually subject to deductibles and coinsurance
- Patient is required to pay more out-of-pocket costs when seeking these services
- As with the traditional HMO, open access plans have emerged over the last few years allowing members greater flexibility to access services

Preferred Provider Organization (PPO)

- A managed care plan in which the network of doctors and hospitals provides services to plan members at discounted rates
- No primary care physician to oversee patients' overall care
- No referrals to specialist needed
- Allow members to access out-of-network benefit at will
- Coverage is usually less for out-of-network providers

Indemnity Plans

- Also known as “fee-for-service” plans
- These existed primarily before the rise of HMOs and PPOs
- The individual pays a predetermined percentage of the cost of health care services, and the insurance company pays the other remaining charges for example 20% - 80%

Indemnity Plans (Continued)

- Fees for services are determined by individual providers
- Individuals to choose their own health care professionals
- There are no provider networks from which to choose

Consumer-Driven or Consumer-Directed Health Care (CDHC)

- Health insurance plans that are intended to make the individual more informed about their health
- The individual has more control over their health care dollars and thus may use health care services more efficiently
- Plans offer reduced premiums in exchange for higher deductibles
- The two most common programs are Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs)

Health Savings Account (HSA)

- An HSA must be used with a qualified high-deductible health plan (HDHP) that covers catastrophic health care expenses after the deductible
- Minimum deductibles are \$1,200 Single/\$2,400 Family
- Employees sets up and owns an HSA accounts
- The account that can consist of both employer and employee contributions

Health Savings Account (HSA)

(Continued)

- HSA maximum annual contributions for 2010 are \$3,050 Single/ \$6,150 family.
- Employees age 55 and older may be eligible for catch-up contributions of \$1,000
- After age 65, you can be used your funds for non-health-related expenses without facing a penalty
- The HSA account can be taken from employer to employer

Health Reimbursement Arrangement (HRA)

- HRAs are often designed to operate with a high deductible health plans, which reduce premium costs while encouraging employees to spend wisely
- The account is totally employer-funded and designed to reimburse employees for qualified medical expenses
- The employer determines the amount of money available in each employee's HRA for the coverage period

Health Reimbursement Arrangement (HRA)

(Continued)

- Employer establishes the types of expenses that can be funded
- There are no annual contribution limits on HRAs; however, the employer usually sets the contribution below the annual deductible
- Some employers allow employees to roll their unused funds from year to year

Dental Coverage

The Relationship Between Medical & Dental Disease

- Studies show that millions of work hours are lost each year to workers with dental problems
- A strong link between oral health and overall health has been established
- As a result, dental benefits are becoming a more significant component of total wellness programs.

Did You Know? Studies Show

- Oral cancer is more common than liver, ovarian, brain, thyroid and stomach cancer
- Diabetes is associated with an increased occurrence and progression of periodontitis
- Periodontal disease is linked to the development of coronary heart disease and stroke
- Periodontal disease during pregnancy can lead to delivering pre-term and low-birth weight babies. Premature birth increases a child's risk of illness and death in the first year of life

What Are Basic Type of Dental Plans

Indemnity or Fee-for-Service Dental Plans

- Employees can choose any provider
- Dentist is paid for each service according to the fees established by the dentist

Preferred Provider Organization (PPO)

- Patients select a dentist from a list of in-network providers who have agreed to discount their fees.
- Patients can choose to see an out-of-network provider with increased out-of-pocket costs

What Are Basic Type of Dental Plans (Continued)

Dental Health Maintenance Organization Plan (DHMO)

- Member must choose a Primary Dentist
- Plan pays contracted dentists a capitation fee based on the number of families or individuals enrolled, regardless of utilization
- Dentists agree in return to provide specific types of treatment at no charge at a discounted fee
- These are typically the least expensive dental plans

Disability Coverage

Disability Insurance

- For most workers, the ability to earn a living is their most significant financial asset
- Disabilities affect 19 percent of Americans
- On average, about 3,000 disabling injuries occur every hour
- Thirty percent of employees age 35 to 65 will become disabled for 90 days at least one time while working

Disability Insurance

(Continued)

- By age 35, there is a 50 percent chance of becoming disabled for three or more months
- The Social Security Administration claims that there will be a 37% percent increase in disability insurance incidences because the workforce is getting older

Short Term Disability (STD)

Typical Plans Provision Include:

- Benefit waiting period of 7 or 14 days of disability
- Benefits payments of either 13 or 26
- Benefit payments are either based on a percentage of weekly earnings (i.e. 50% or 60%) or a flat amount (i.e. \$500 per week)
- Maternity is paid as any other disability

Long Term Disability (LTD)

- Benefit waiting period of 90 or 180 days of disability
- Benefits payment durations to the normal social security retirement age are most common. Occasionally we see benefit durations of 5 years
- Benefit payments are based on a percentage of monthly earnings (i.e. 50% or 60%) to a maximum benefit of \$5,000 to \$10,000
- Maternity complications are paid as any other disability
- Benefits coordinate with social security disability benefits

Life Coverage

Basic Group Term Life Plans

Benefits are usually based on the following:

- Term Life Insurance
- Flat amount such as \$50,000 per employee or a percentage of salary such as 2 times annual earnings to a maximum of \$100,000
- Most plans included an accidental death and dismemberment provision
- Many plans included a living benefit provision

Other Benefits

Other Benefits To Consider

- Flexible Spending Account Programs
- Vision Coverage
- 401K and other retirement programs
- Group Long Term Care
- Cancer Coverage
- Accident Policies

Astra HR

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Questions



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