

Employee Benefits Report



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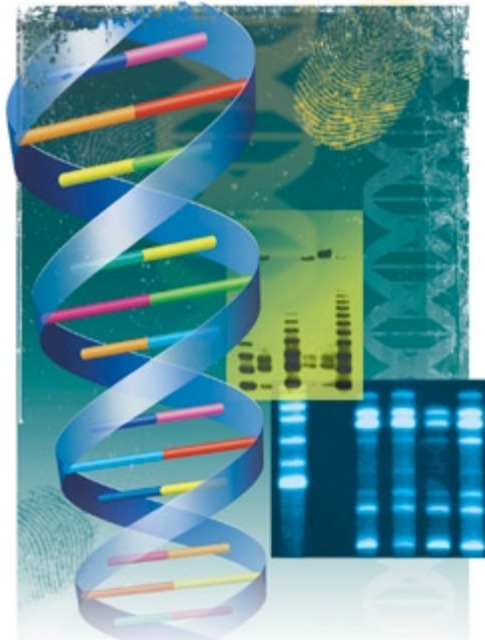


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GINA and Your Health Plan



In May, the Genetic Information Nondiscrimination Act of 2008—or GINA—was signed into law. The Act will affect two areas of an employer's operations: its group health plan and its relations with employees. Provisions affecting group health plans go into effect on May 21, 2009; employment-related provisions will go into effect on November 21, 2009.

What exactly does GINA cover?

Congress had two intentions when it passed GINA: to prohibit health plans and employers from discriminating against employees on the basis of genetic information and to encourage genetic research by reducing fears that genetic information could be misused in this way.

Title I of the law deals with genetic discrimination in group health plans. It applies to plans of all sizes effective May 21, 2009.

In general, Title I prohibits a group health plan from using

genetic information in underwriting policies or the setting of rates. More specifically, it prohibits a plan from:

- ✳ adjusting premium or contribution amounts for a group on the basis of genetic information
- ✳ requesting or requiring an individual or family member from undergoing a genetic test
- ✳ requesting, requiring or purchasing genetic information for underwriting purposes
- ✳ requesting, requiring or purchasing genetic information on any individual in connection with enrollment, unless ob-

tained incidentally, prior to that enrollment.

The law will also affect health plans by including genetic information under HIPAA, the Health Insurance Portability and Accessibility Act. This will require group health plans, health insurers and Medigap policy issuers to treat genetic information as protected health information and prohibit them from using or disclosing it for underwriting purposes.

Although the law prohibits discrimination on the basis of genetic information, it will not limit a health insurer's ability to

This Just In

According to a June report in the *Wall Street Journal*, availability of health insurance is becoming an increasingly important factor in making major life decisions, and not only which job to take. The *Journal* reported that some couples are getting married earlier and others are delaying divorces just to hang on to their group health insurance.

Despite this, another report (*Monthly Labor Review*, June 2008) found that "takeup rates" have declined within group health insurance plans. This means the percentage of employees who participate in an employer group plan when it is offered has declined. A 2007 report by the Kaiser Family Foundation found that takeup rates decline when employee contributions to health premiums increase.

Even when employees must contribute to their health insurance premiums, they are still receiving a valuable benefit. Group plans, in general, cost less than individual plans. And because all but the smallest groups are not individually underwritten, individuals who might not qualify for individual coverage can obtain coverage through a group. For assistance in promoting the value of your benefits package to employees, please call us.





Long-Term Care Insurance: Not Just for the Elderly

In 2007, only 31 percent of full-time private industry workers had access to long-term care insurance through their employers. Yet the National Academy of Social Insurance reports that nearly 75 percent of baby boomers and seniors are concerned about paying for long-term care.

Why it matters

Many baby boomers have lived lives different from those of their parents. The National Academy of Social Insurance forecast that nearly 10 percent of those born between 1956 and 1964 (the youngest baby boomers) will have never married by the time they reach an age between 55 and 64. Today, 21 percent of those age 63 to 72 today live alone, the academy says. In 10 years, 24 percent of that age group will live alone, and 37 percent of the youngest baby boomers will be living alone when they reach that age.

It may be safe to say that the traditional system of the young caring for the old in their declining years is likely to break down. Baby boomers will be more likely than their parents to need to find care outside their extended families.

Furthermore, your boomer and other employees might need care before they become elderly. The U.S. Government Accountability Office estimates that 40 percent of the people receiving long-term care services are between the age of 19 and 64, so besides helping employees plan for the distant future, it may help sooner than they think.

What care costs

The costs for outside care are continuing to rise. The Bureau of Labor Statistics, citing a report by MetLife, points out that the average cost of home health care (five hours a day, five times a week) was \$20,000 a year

in 2004, while nursing home care cost an average of \$52,000 a year for a semi-private room.

The Bureau of Labor Statistics predicted that by 2030, the annual cost for a semi-private nursing home room will reach \$190,600.

Medicare and health insurance policies do not provide for long-term care, and Medicaid covers care only after one's personal assets are depleted. These facts make group long-term care insurance policies even more attractive. They often offer cheaper rates than are available in the open market and may not require group members to meet any medical requirements to obtain coverage. [Note that there are some states that have enacted "partnership programs" that allow people who purchase qualifying partnership LTCI policies to retain a specified amount of assets and still qualify for Medicaid.]

What LTCI policies cover

LTCI policies can vary widely. However, they may include coverage for home health care and care in a nursing home or assisted living facility.

Premiums are usually paid by the employee, with no contribution from the employer. However, if the employer does pay some or all of the premium, long-term care insurance is a qualified benefit — as long as it is a standard group policy and the employer is not providing the LTC coverage



through a "cafeteria plan."

Coverage kicks in when a person cannot perform what are known as activities of daily living, or is cognitively impaired due to senile dementia or Alzheimer's disease.

In state-licensed nursing homes, policies usually cover skilled, intermediate and custodial care. At home, they usually cover nursing care, physical therapy, homemaking assistance and home health aides provided by state-licensed and Medicare-certified home health agencies, according to a report by America's Health Insurance Plans (AHIP), a trade association. Pre-existing conditions generally are not covered until after a set waiting period.

Most policies are known as either indemnity or expense incurred policies. An indemnity policy pays a fixed benefit amount per day. An expense incurred policy pays actual expenses up to a fixed amount per day, week or month. Home health care benefits are usually about half those offered for nursing home care, according to the Bureau of Labor Statistics.

There are also integrated policies with pooled benefits that provide a total dollar amount that can be used for different types of services, AHIP says. These usually carry a daily, weekly or monthly dollar cap.

Typically, benefits are paid for a set peri-



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increase premiums for a group plan based on the manifestation of a genetic disease. It also will not limit a health care professional's authority to request an individual to undergo a genetic test or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding a claims payment.

The law encourages genetic research by stating that a plan can request (but not require) an individual to undergo genetic testing, and by placing certain safeguards on individuals' rights when the plan does so.

Title II of the law applies to employers, employment agencies, labor organizations and joint labor-management committees. It makes it an "unlawful employment practice" for any of these entities to take discriminatory employment actions against an individual because of genetic information. The Act includes specific prohibitions against an employer failing to hire or discharging an employee and an employment agency refusing to refer an individual for employment on the basis of genetic information.

It also prohibits any of these entities from requesting, requiring or purchasing an employee's genetic information, except when such information is (1) requested or required

to comply with certification requirements of family and medical leave laws; (2) the information involved is to be used for genetic monitoring of the biological effects of toxic substances in the workplace; or (3) the employer conducts DNA analysis for law enforcement purposes as a forensic laboratory or for purposes of human remains identification. The law also allows employers to request genetic information for health or genetic services offered by the employer, such as under a wellness program, when the employee provides prior voluntary and written authorization.

In all circumstances, however, the employer must treat an individual's genetic information as confidential medical information and maintain it in separate medical files. HIPAA's penalties for violating an individual's protected health information will apply if it fails to do so.

Employees who believe an employer has used genetic information to discriminate against them must file a claim with the Equal Employment Opportunity Commission (EEOC). If the EEOC finds evidence of discrimination, it might file a lawsuit on behalf of the plaintiff in federal court or give the plaintiff a "right to sue" notice. If the

employee prevails in a federal court case, he or she can recover damages as authorized by the Civil Rights Act of 1991, including compensatory damages, back and front pay, and equitable relief.

For information on how GINA will affect your company's health plan, or for information on protecting employees' confidential genetic and other health information, please call us. ■

We are family

GINA protects individuals from being discriminated against because of the genetic information of family members, as well as the individual's own genetic information. It defines family members as dependents and any other first-degree, second-degree, third-degree or fourth-degree relative, and extends protections to the genetic information of a fetus carried by a pregnant woman and an embryo legally held by an individual or family member using assisted reproductive technology. ■

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od of time or up to a dollar cap. Benefits may be adjusted for inflation, but annual adjustments may be capped at a fixed percentage.

Most policies carry a deductible in the form of a period of time during which coverage does not apply. A 30-day deductible on nursing home care would mean the coverage would start paying on the 31st day the insured person was in a nursing home.

Those covered by a group policy are allowed to continue coverage when they leave the employer, as long as they pay their premiums on time.

For these reasons, your baby boomer (and older) employees will likely be interested in long-term care insurance. Even if a contributory plan doesn't fit your benefits budget, voluntary (employee-paid) plans can

often provide better benefits or lower premiums than an individual plan. For more information, please call us. ■

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specific services you would like from a service provider, such as loans, Internet trading, telephone transfers and retirement planning. Your review should include the number of plan participants and the amount of plan assets as of a specified date.

Once you have a clear idea of your requirements, you are ready to begin receiving estimates for new plans or seeking adjustments for your current plans.

Ask each prospective provider to be spe-

cific about which services are covered for the estimated fees and which are not. To help in gathering information and making comparisons, you may want to use the same format for each prospective provider. You can use the very handy uniform fee disclosure form available from the U.S. Department of Labor (www.dol.gov/ebsa/pdf/401kfem.pdf).

Once you have selected a service provider or investments, be prepared to monitor the level and quality of the services and performance of investments to make sure they continue to be reasonable and suit the needs of your employees. Make provisions to receive information on a regular basis so that you can monitor investment returns and service provider performance. We can help you evaluate different plans — for information, please contact us. ■



Understanding 401(k) Fees (and how to reduce them)



Fees can make a big difference in 401(k) returns. Here's an overview of fees providers charge.

Fees are a fact of life for any investment instrument. But as a plan fiduciary, it's your duty to "prudently and solely act in the interest of the plan's participants and beneficiaries." That means understanding — and whenever possible, reducing — the cumulative effect of fees and expenses on retirement savings programs.

When it comes to 401(k) and other retirement plans, fees and expenses generally fall into three categories:

Plan Administration Fees. These fees cover the day-to-day operation of a plan, such as recordkeeping, accounting, legal and trustee services, and potentially a host of additional services like telephone voice response systems, access to customer service representatives, educational seminars, retirement planning software, investment advice, and electronic access to plan information. Generally the more services provided, the higher the fees.

In some instances, these fees will be cov-

ered by investment fees that are deducted directly from investment returns. In other instances, they may be borne, in whole or in part, by the employer or charged directly against the assets of the plan.

Investment Fees. By far the largest component of plan fees and expenses is associated with managing plan investments. These fees usually are assessed as a percentage of assets invested. Pay close attention because these fees are often paid in the form of an indirect charge against the participant's account or deducted directly from investment returns. As a result, these fees may not show up on investment statements.

Individual Service Fees. If assessed at all, these fees may be charged separately to the accounts of those who choose to take advantage of a particular plan feature, such as taking a loan from the plan.

Depending on the investment plan, there may be other charges as well, including sales charges (also known as loads or commissions) and management fees (also known as investment advisory fees or account maintenance fees).

Reducing fees

Obviously fees aren't the only factor to consider when selecting service providers and investments. You'll also want to consider the level and quality of service and the investment's risk and potential return.

In any case, you should be fully aware of every fee charged and the ramifications of each. Begin with a review of all charges. Think about the levels of responsibility and

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The High Cost of Hidden Fees

A percentage point here, a percentage point there. It doesn't really add up, does it? Indeed, it does. Take, for example, an employee with 35 years until retirement and a current 401(k) account balance of \$25,000. According to the U.S. Department of Labor, if returns in the account over the next 35 years average seven percent and fees and expenses reduce the average returns by 0.5 percent, the em-

ployee's account balance will grow to \$227,000 at retirement — even if there are no further contributions to the account.

If fees and expenses are 1.5 percent, however, the account balance will grow to only \$163,000. That one percent difference in fees and expenses would reduce the account balance at retirement by 28 percent. ■