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Employers Report Mixed Experiences With Health And Wellness Programs

Employers with onsite health services tend to be highly satisfied with their investment, reporting that employee participation is high and that these programs have contributed significantly to employee health and productivity; however, employers report less satisfaction with other wellness initiatives, according to a survey conducted by human resources consultancy Hewitt Associates.

The survey of 248 large and mid-sized companies found that companies are increasingly offering a number of health-related programs that provide a wide range of services, from health risk identification to assistance for the chronically ill. When asked what factors they consider in rating the success of their health and productivity

programs, 89% of respondents cited year-over-year changes in overall benefit costs, 86% said year-over-year changes in health and prescription drug costs, and 72% cited employee participation rates.

Although just 19% of the companies surveyed have onsite medical

clinics and only 11% have onsite pharmacies, respondents that offer these services reported that 25% of employees use the onsite medical clinics and around 50% of workers take advantage of onsite pharmacies. In addition, 81% of companies that offer onsite clinics said they are satisfied with the results achieved from the programs, and 95% of respondents with onsite pharmacies indicated they are satisfied with these services.

The findings further indicated that satisfaction levels are high among employers offering flu shots and biometric screenings, but lower among those using health risk questionnaires (HRQs). Some 88% of the surveyed employers said they offer flu shots; 68%, HRQs; and 37%, biometric

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screenings. For each of these services, employee participation rates were reported to be around one-third.

The survey also showed, however, that many of the most commonly offered health programs suffer from relatively low participation rates. While 73% of the companies said they offer a nurseline, they also reported that only 7% of employees actually use the program, and just 45% of employers are satisfied with the program's results. Similarly, more than half of the employers said they offer smoking cessation (54%) and weight management (53%) programs, but few of the employers offering the programs are satisfied with the results, as these services are used by only a very small group of employees.

Researchers noted that more than half (51%) of employees or their dependents have a chronic health condition that requires ongoing care. The survey found that most employers are engaged in efforts to address these needs, with 74% saying they offer disease/condition management programs to employees. However, the survey found that just 10% of employees eligible to participate in the programs actually took advantage of the services, and just 39% of employers are satisfied with the results of these programs.

"Companies have implemented a number of health and wellness programs over the past few years aimed at improving employee health, increasing worker productivity, and reducing health care costs, but low participation levels and employer satisfaction rates suggest that many of these initiatives are not resulting in the outcomes employers had expected," said Marie Kobos, leader of Hewitt's health and productivity solutions group.

Kobos pointed out that, while employers have been slow to adopt onsite health care programs, in part due to the complexities involved in offering them, these services are attractive to employees because of their convenience and the level of personal interaction they provide. She advised companies to assess their current

health initiatives to determine whether the programs they offer are accomplishing their goals.

The survey also found that relatively few employers use formal and comprehensive measurement tools to determine the success or failure of their health and wellness programs. According to the survey, less than one-quarter (24%) of respondents use a scorecard system to evaluate or track the level of program participation and compare vendor performance, and only 43% regularly receive comprehensive engagement and health outcome reports from their vendors.

"For most companies, what's missing from their current health and productivity strategy is the ability to measure program performance in actual outcomes, and not just on employer perceptions of the program or employee participation levels," said Elaine Corrough, leader of measurement solutions for Hewitt's health management practice. "Comprehensive analytics that look at medical data, drug compliance, and health risk can help companies determine which programs are actually lowering costs and improving employee health."

Retirement Plan Rollovers Fuel IRA Asset Growth

Hitting a record \$4.75 trillion, assets held in individual retirement accounts (IRAs) grew 12.5% in 2007, representing the fifth consecutive year of double-digit growth in IRA assets, according to a study published by the Employee Benefit Research Institute (EBRI).

Yet, despite the fact that IRAs are likely to be the largest non-Social Security asset in retirement for many workers in the next generation of retirees, only 10% of eligible taxpayers actually contribute to an IRA, the study found. Instead, IRAs remain primarily a holding vehicle for assets rolled

over from employment-based retirement plans, such as pensions and 401(k) plans, and they are not being used for new retirement savings.

Drawing upon a variety of data sources, including IRA data compiled by the Investment Company Institute (ICI), the analysis showed that, while IRA assets increased at a healthy pace in 2007, growth fell short of the 15.6% increase recorded in 2006. At the same time, however, total IRA assets in 2007 remained substantially larger than those held in other retirement plan types: Defined contribution retirement plans in the private sector held \$3.49 trillion, while private-sector defined benefit plans held \$2.33 trillion in assets in 2007.

Examining historical trends, the study's authors noted that the average annual percentage increases in IRA assets during the 1990s amounted to 17.2%. Following the stock market retrenchment that occurred in 2000–2002, annual increases again began climbing at double-digit rates in 2003, with IRA assets reaching \$4.22 trillion in 2006.

Researchers noted that rollovers from other types of retirement plans are fueling IRA growth, not new contributions: Whereas rollovers amount to around \$200 billion annually, yearly contributions to IRAs amount to just \$40 billion. However, while traditional IRAs hold about 90% of all IRA assets, most new contributions are going into Roth and other types of IRAs.

In addition, the findings indicated that the percentage of eligible taxpayers who contributed to IRAs was around 10% for each year from 2000–2004, ranging from 9.5% to 10.6%. The average contribution was approximately \$2,400 in both 2000 and 2001, before the contribution limits increased in 2002. The average contribution rose to \$2,894 in 2002 and increased again to \$3,324 in 2004.

“The increased limits that went into effect in 2002 did increase the size of the average contribution, but they did not attract a larger percentage of contributors,” study author Craig Copeland commented.

“Therefore, most Americans are not using IRAs to save for retirement, but those who are doing so have taken a significant step toward retirement security.”

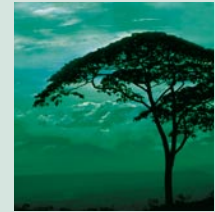
Health Insurance Must Balance Moral Hazard And Health Security

Health insurance differs from other types of insurance; not only does it protect against catastrophic financial losses, but it also promotes ongoing health security. Policymakers and plan sponsors must consider these disparate priorities when planning their approaches to providing health care coverage to Americans, an issue brief published by the American Academy of Actuaries has recommended.

In a report prepared by the American Academy of Actuaries' Uninsured Work Group, researchers outlined traditional definitions of what constitutes “insurance” and compared current forms of health care coverage to these models.

Insurance, the study's authors said, is generally understood to be an arrangement that allows one party, the insured, to gain financial security by transferring the risk of loss to another party, the insurer. In this arrangement, the insurer collects regular premium payments from a large number of insured individuals, so that the provider has a pool of money to cover losses when a small number of insured individuals file claims. “Insurance is only possible when a sufficient number of insured pool their risk such that the few who have a loss can be financed by the many who do not,” researchers pointed out.

There are several fundamental principles traditionally used to determine whether a risk is insurable, the report said. First, the insurer must assess whether it is “economically feasible” to insure the



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risk, with the insured having the ability to pay a premium that is high enough to cover the administrative costs of the insurer. Second, the loss must be “demonstrable,” meaning that both the triggering event and the associated insurer liability should be clearly demonstrated. Third, the economic value of the insurance must be “calculable,” making it possible for the insurer to accurately determine the expected loss in order to calculate the insurance premium. Fourth, losses should be “random,” or uncertain for all members of the pool. Fifth, the insured exposure units should be “independent” in time and place, so that if one insured individual experiences a loss, it will not lead to another insured person having a loss.

As they are currently designed, most health care coverage programs meet some of these criteria, but not others, researchers observed. For example, people with health insurance coverage are much more likely to file a claim than those with other types of insurance, which is counter to the principle that losses should be random. In addition, the administrative costs associated with processing large numbers of relatively small health care claims, such as those for routine office visits, makes providing this type of coverage less economically feasible. Losses are not always easily demonstrable because it can be difficult to determine whether the insured is in need of medical care and what type of treatment is appropriate. Moreover, health risks are not always independent, as contagions, epidemics, and genetically inherited diseases are contrary to this principle.

When designing health care policies and plans, consideration should be given to the principles of random loss and economic feasibility, the authors advised. They pointed out that, while roughly 10% of auto insurance policyholders and 6% of homeowners insurance policyholders

file claims in a given year, more than 80% of people with health insurance file claims annually. Because comprehensive benefit coverage lowers the cost to the insured, many individuals use more services than they would if they were paying the full cost themselves, a problem sometimes referred to as “moral hazard.”

Moreover, researchers noted, 50% of annual private medical insurance claims were for amounts less than \$1,000 in 2005, but these claims represented only 9% of the total health care expenditure in that year. This is because comprehensive benefit packages encourage individuals to pay a premium to insurance companies for processing small claims that could have been anticipated and paid for out of pocket.

To reduce moral hazard and increase consistency with insurance principles, insurers commonly require beneficiaries to share in the cost of health care through deductibles, coinsurance, copayments, and maximum coverage limits. Yet, at the same time, researchers cautioned, any incentives to make insured individuals more sensitive to benefit costs must be weighed against the desire to avoid penalizing people for whom certain services are non-discretionary and to avert outcomes that are counter to other public policy goals.

Any compromise of these core insurance principles will have significant implications for a stable and self-sufficient private marketplace for health coverage, the report’s authors warned. “Failing to consider these principles when developing coverage initiatives could lead to adverse consequences that undermine the system, such as the inability to set premiums accurately, consumer incentives that work against cost control goals, and in the worst case, the inability to provide insurance at a reasonable cost,” researchers concluded.



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