EMPLOYEE BENEFITS (GEHRETT)

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Employee Benefits (Gehrett)

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Mabel Gehrett – Human Resource Management, and Business Management

I developed the new Employee Benefits course to be used in the HR Management program at Western Technical College. This course is designed to explore the area of employee benefits with HR students including regulations, health insurance, retirement plans, time off programs, and other total rewards.

This project has great potential to eliminate unnecessary costs and time to students by offering them resources with readings, graphics, and videos all located in one convenient place. I was happy to incorporate opportunities for students to learn in different ways. Students will have an opportunity to learn about this area of human resources in appropriate detail and prepare for their future in an HR department.

Overall, this project has been a great experience. I hope to hear positive feedback from faculty and students once this class begins in Fall 2024 in a 7-week format.

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Detailed Licensing

Licensing

*A detailed breakdown of this resource's licensing can be found in **Back Matter/Detailed Licensing**.*

CHAPTER OVERVIEW

1: Introduction and Regulation

Module 1: Core Competencies

At this end of this module you will be able to:

- **describe** the significance of federal regulation on benefits administration
- **explain** the legal and strategic importance of benefits programs
- **relate** the value of benefits to the compensation and benefits package
- **identify** laws that impact employee benefits programs

Module 1: Key Terms and Concepts

In this Module we will focus on introducing employee benefits as well as reviewing the regulations employee benefits must be compliant with.

Key Terms in this module include:

- **PPACA -** Patient Protection and Affordable Care Act
- **COBRA -** Consolidated Omnibus Budget Reconciliation Ac
- **HIPAA -** The Health Insurance Portability and Accountability Act
- **ERISA -** Employee Retirement Income Security Act
- **FMLA -** Family and Medical Leave Act

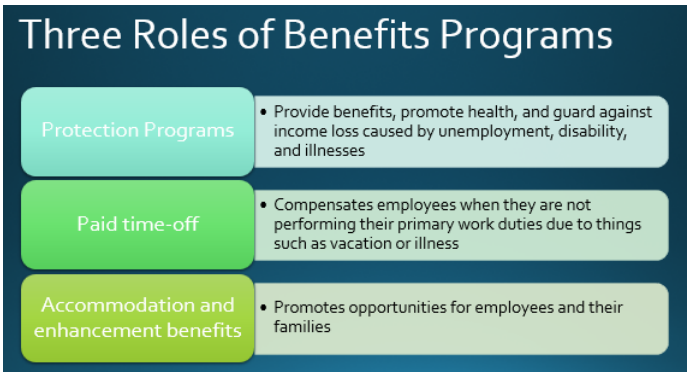
Key Concepts in this module include:

- Legally Required Benefits
- Discretionary Benefits
- Creativity of Benefits
- Lower Cost Benefits

1.1: Employee Benefits - An Overview

Why Do We Have Employee Benefits?

- Began as a form of social insurance during industrialization and the Great Depression
- Retirement plans were the earliest benefit - begun in the late 1800s
- Welfare practices described anything for the comfort of the employee and not required by law
- Today, employees view benefits as entitlements.. Why do you think this is?



Three Roles of Benefits Programs

- **Protection programs** - guards against loss of income caused by illness, disability, or unemployment
- **Paid time-off** - guarantees payment for holidays, vacation, or illness
- **Accommodation and enhancement benefits** - promotes opportunities for employees and their families

Legal and Regulatory Influences

- **Social Security Act of 1935**
  - Mandates a variety of programs such as federal retirement and unemployment insurance
  - Learn more: Historical Background and Development of Social Security
- **Employee Retirement Income Security Act of 1974 (ERISA)**

  Sets minimum standard for most voluntarily established retirement and health plans in private industry

  - Provides protection for individuals in these plans
  - Learn more: ERISA website

Strategic Planning and Benefits

- Todays's market is competitive!!
- Companies need to offer benefits that employees want or need
- According to the US Chamber of Commerce: The top 3 reasons employees are changing jobs
  - Work-life balance
  - Flexible scheduling
  - Positive culture

Informations Sources to Consider in Strategic Planning

- **External Market Environment**
  - Economic conditions and forecasts
  - Employer costs for compensations and benefits
    - benefits average 30% of total compensation costs
  - Government regulations of employee benefits
  - Changing demographics of the labor force
- **Internal Company Environment**
  - Workforce demographics
  - Collective bargaining agreements

NOTE: A PowerPoint covering this information can be downloaded below.

1.2: Employee Benefits and Total Compensation

Employee Benefits by Nick Youngson CC BY-SA 3.0 Alpha Stock Images

Employee Benefits within Total Compensation

Employee benefits are compensation OTHER than their hourly wage or salary.

Total Compensation

Total Compensation represents both core compensation (wages, salaries, etc.) AND employee benefits such as holidays, vision insurance, etc.

- **Core Compensation:** hourly wage or annual salary
  - Base pay money that employees receive for performing their jobs
-
  - COLA - cost of living adjustment: periodic adjustments often matching CPI (Consumer Price Index)
  - Seniority pay - raise based on length of service
  - Merit Pay - increased in pay to praise performance
  - Incentive Pay - rewards employees for attaining work goals
  - Person-Focused - rewards employee for acquiring new knowledge and/or skill
-
  - Federal retirement system
  - Unemployment insurance
- Family and Medical Leave Act of 1993 (FMLA)
  - Entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.
  - Read more about employee benefits under the Family and Medical Leave Act website
- The Patient Protection and Affordable Care Act of 2010 (PPACA)
  - Requires employers to offer health care benefits to their employees
  - Read more about these requirements at the Patient Protection and Affordable Care Act website

Legally Required Benefits (Mandated by Law)

- Laws mandate and regulate:
  - Social Security
  - Medicare
  - Unemployment Insurance
  - Workers Compensation,
  - FMLA
  - PPACA

Discretionary Benefits (Voluntary)

- Additional benefits offered on a discretionary, or voluntary basis, often based on the current competition in the market.
  - **Protection programs**
    - Disability insurance - replaces income if employee is unable to work
    - Life insurance - protects employees family members by paying a specified amount upon a employee's death
    - Retirement plans - provides income to individuals and beneficiaries throughout retirement.
      - Defined contribution plans,
      - Defined benefit plans
      - Hybrid plans
  - **Paid Time off**
    - Compensates employees when not performing primary work duties: holidays, vacation, jury duty, bereavement leave, military leave, sick leave
    - Unionized settings will establish time off based on collective bargaining
  - **Accommodation and Enhancement**
    - Promote opportunities for employees and their families
      - Mental health counseling
      - Physical well-being - gym membership reimbursements
      - Stress management classes
      - Child care
      - Tuition reimbursement
      - Transportation services
- **Designing Discretionary Benefits**
  - Considerations
    - Eligibility (who qualifies?)
    - Kinds of benefits to include (based on competition)
    - Levels of benefits (the same for everyone, different levels)
    - Waiting periods (when are employees eligible?)
    - Who pays?
      - Non-contributory
      - Contributory
      - Employee-financed

1.3: WATCH- HR Basics - Employee Benefits

WATCH this 8:40 video about Employee Benefits. Take note, **this video identifies 5 mandatory benefits**. This is because they did not separate Social Security benefits. When separated, there are a total of 6.

Social Security can be divided into the following two benefits:

1. Old-Age, Survivor, and Disability Insurance (OASDI)

2. Medicare

1.4: READ- Employee Benefits in 2024 - The Ultimate Guide

Image: Benefits by Nick Youngson CC BY-SA 3.0 Alpha Stock Images

The Importance of Employee Benefits

If the Great Resignation climate has taught us anything, it's that employee benefits are more important now than they've ever been. The U.S. Bureau of Labor Statistics reported a record-breaking 47.8 million people quit their jobs in 2021, up 33% from 2020. With 10.1 million job openings as of August 2022, employers are scrambling to find the right employee benefits to attract, engage and retain top talent—all while trying to stay within their budget.

What Are Employee Benefits?

Employee benefits are employee compensation packages that include extras such as health insurance, retirement savings plans, paid vacation days and more. Employers offer employee benefits to attract and retain top talent, as well as improve employee productivity and engagement. These are important because studies have shown that employees who feel valued and appreciated by their employer are more likely to stay with the company and be productive. Some benefits are even required by law.

Why Employee Benefits Matter

Employee benefits are a key part of the employee compensation package and can be a deciding factor when candidates are considering multiple job offers. They can also help improve employee productivity, engagement and retention.

A recent study by the Society for Human Resource Management found that 90% of survey respondents said healthcare is an extremely or very important employee benefit. Eighty-three percent say flexible work and leave time are extremely or very important.

Employee benefits can also help improve employee productivity and engagement. A study by the International Foundation of Employee Benefit Plans found that employers with high levels of productivity and engagement offer benefits such as paid leave, healthcare, retirement, flexible hours and wellness benefits.

Finally, employee benefits can help improve employee retention. A study by the Society for Human Resource Management found that 60% of employees said employee benefits were extremely or very important when considering whether to stay with their current employer.

TYPES of EMPLOYEE BENEFITS

There are four main types of employee benefits:

1. Health and wellness benefits

2. Financial and retirement benefits

3. Time-off and leave benefits

4. Work-life balance benefits

Health and wellness benefits include health insurance, dental insurance, vision insurance, prescription drug coverage, employee assistance programs and wellness programs. Financial and retirement benefits include 401(k) plans, pension plans, employee stock ownership plans, profit-sharing plans and financial planning assistance. Time-off and leave benefits include vacation days, sick days, paid holidays, parental leave and extended leave. Work-life balance benefits include flexible work arrangements, telecommuting, child care assistance and eldercare assistance.

There are some benefits that are required by law, such as workers' compensation, unemployment insurance and Social Security. The Affordable Care Act (ACA) also requires employers with 50 or more full-time equivalent employees to offer health insurance to their employees or pay a penalty. Employers should consult with an attorney or HR professional to ensure they are complying with all applicable laws.

Pension and Retirement Plans

Image: Pension by Nick Youngson CC BY-SA 3.0 Alpha Stock Images

Pension and retirement plans are employee benefits that help employees save for retirement. There are two types of retirement plans: defined benefit and defined contribution.

Defined benefit plans provide a source of income for retirees that is typically based on their years of service and salary history. This income is paid out in regular monthly payments. Defined contribution plans, on the other hand, allow employees to contribute a set amount of money to their retirement account each month. The employer may also make contributions to the employee's account.

There are several different types of retirement plans, including 401(k) plans, 403(b) plans, 457 plans and pension plans. Each type of plan has different rules and regulations regarding employee eligibility, employee contributions and employer contributions.

401(k) Plans

401(k) plans are the most common type of retirement plan offered by employers. Under a 401(k) plan, employees can contribute a percentage of their salary to their retirement account each month. Employers may also make matching or discretionary contributions to employee accounts.

403(b) Plans

403(b) plans are similar to 401(k) plans, but they are available to employees of public schools and certain nonprofit organizations. Under a 403(b) plan, employees can contribute a percentage of their salary to their retirement account each month. Employers may also make matching or discretionary contributions to employee accounts.

457 Plans

457 plans are available to state and local government employees and employees of certain charitable organizations. Under a 457 plan, employees can contribute a percentage of their salary to their retirement account each month. Employers may also make matching or discretionary contributions to

employee accounts.
Pension

Pension plans are defined benefit plans that provide a monthly income to retirees, usually based on their years of service and salary history. Pension plans are regulated by the Employee Retirement Income Security Act (ERISA).

Healthcare and Dental Benefits

Image: Health Benefits by Nick Youngson CC BY-SA 3.0 Alpha Stock Images

An employee benefit that helps pay for medical expenses is health insurance. Health insurance plans vary in terms of the services covered, the deductibles and copayments required and the premiums charged. Health insurance plans can be offered by employers, health insurance companies or the government.

There are several different types of health insurance plans, including PPOs, HMOs and HDHPs. PPOs allow employees to see any doctor or specialist without a referral. HMOs require employees to select a primary care physician who will coordinate their care. HDHPs have high deductibles but lower premiums.

An employee benefit that helps pay for dental care expenses is dental insurance. Dental insurance usually pays for preventive measures, such as teeth cleanings and X-rays, as well as common procedures such as fillings or a tooth removal. Some dental insurance plans also cover major procedures, such as crowns and bridges.

Employers can offer health insurance and dental insurance as part of a group health plan. A group health plan is an employee benefit plan that is sponsored by an employer and provides health and/or dental coverage to employees and their dependents.

Transgender Healthcare

Transgender-inclusive health benefits are employee benefits that cover medically necessary care for transgender employees. Depending on the provider, this type of coverage may include hormone therapy, mental healthcare and surgical procedures.

Healthcare discrimination on the basis of race, color, national origin, sex, disability and age is prohibited by the ACA. However, at the time of publication, the ACA's application to transgender individuals has been challenged in several pending court cases. The outcomes of those cases may affect whether employers are required to offer transgender-related healthcare as part of their employee health insurance plans.

Considering how rapidly this space is changing, we recommend discussing these options with your benefits provider to ensure your healthcare coverage is compliant with current regulations.

Telemedicine/Telehealth

Telemedicine, also known as telehealth, is the use of electronic communications to provide medical care from a distance. Telemedicine can be used for a variety of purposes, including diagnosing and treating patients, providing consultation to other healthcare providers and delivering distant learning opportunities. Telemedicine services are typically provided via video conferencing, but can also be delivered by phone, email or text message.

There are many potential benefits of telemedicine, including increased access to care, improved patient outcomes and lower healthcare costs. Telemedicine can also benefit employers by reducing employee absenteeism and increasing productivity.

Although telemedicine is not a new concept, the COVID-19 pandemic has spurred a significant increase in the use of telemedicine services. This is due in part to the fact that telemedicine can help reduce the spread of infectious diseases, such as COVID-19.

Fertility Benefits

Fertility benefits are employee benefits that help cover the costs of fertility treatments, such as in vitro fertilization (IVF). IVF is a process by which eggs are harvested from a woman's ovaries and fertilized with sperm in a laboratory. The resulting embryos are then implanted in the woman's uterus. Fertility benefits may also cover the costs of freezing eggs or sperm. This can be useful for employees who want to preserve their fertility for future use.

Prescription Drugs

Prescription drugs are medications that are prescribed by a doctor to treat a medical condition. Prescription drugs can be obtained from a pharmacy with a valid prescription. Employers often provide prescription drug coverage as part of a group health plan. This type of coverage typically pays for a portion of the cost of prescription drugs, with the employee paying the remainder.

Mental Health

Benefits that help cover the costs of mental healthcare are called mental health benefits. Mental healthcare includes counseling, treatment for mental illness and substance abuse treatment. Mental health benefits may be provided as part of a group health plan or as a separate employee benefit.

Employers are increasingly recognizing the importance of mental healthcare and are offering mental health benefits to their employees. This is due in part to the fact that mental health problems can have a significant impact on employee productivity and well-being.

Employee Assistance Programs

Image: Employees. Marko Milivojevic Photography. Pixnio.com

An employee assistance program (EAP) is a type of benefit that gives confidential counseling and support services to workers who are having personal or work-related difficulties. Employee assistance programs can provide employees with support for a range of issues, such as stress, anxiety, depression, substance abuse, financial troubles and relationship problems.
EAPs are typically provided by employee assistance professionals, who are trained to provide confidential counseling and support. EAPs can be accessed by employees through a variety of methods, including face- to-face meetings, telephone hotline numbers and online resources.
EAPs can be beneficial for both employees and employers. Employees can get the help they need to

resolve personal or work-related problems, which can improve their productivity and well-being. Employers can also benefit from lower employee turnover and absenteeism rates.

Paid Time Off

Paid time off (PTO) is leave that is provided to employees at no cost to the employee. PTO can be used for vacation, sick days, personal days or other purposes. Employers may offer PTO as a benefit to attract and retain employees. PTO can also help employees manage their work-life balance.

The federal Family and Medical Leave Act (FMLA) allows employees to take up to 12 weeks of unpaid time off for specified family and medical reasons. It applies to employers with 50 or more employees for at least 20 weeks in the current or preceding year. Many states also have laws requiring employers to provide certain types of paid leave, such as sick leave or family leave.

Employers typically offer PTO as part of a comprehensive employee benefits package. PTO is often one of the most popular employee benefits.

Child and Dependent Care Benefits

Employee benefits sometimes help cover the costs of child and dependent care. Child and dependent care benefits may be provided as part of a group health plan or as a separate employee benefit.

These benefits can help employees with the costs of daycare, babysitters and other child care expenses.

Employers often offer child and dependent care benefits to attract and retain employees. Child care benefits can also help employees with young children manage their work-life balance. Some employers even offer on-site child care facilities.

Life Insurance

Life insurance is a type of insurance that provides financial assistance to the beneficiaries of an employee who dies. Life insurance benefits may cover the cost of funeral expenses, debts and other final expenses.

To qualify for life insurance, employees must be enrolled in their employer’s life insurance plan.

Life insurance benefits are typically paid to the employee’s beneficiaries upon their death.

Disability Insurance

Disability insurance is a type of insurance that provides financial assistance to employees who are unable to work because of a serious injury or illness. Disability insurance pays workers a percentage of their paychecks, helping them remain financially stable until they can return to their jobs.

To qualify for disability insurance, employees must be unable to work due to an injury or illness.

Short-term disability insurance benefits are typically paid for up to 26 weeks. Five states and one territory require short- term disability insurance by law. These are California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico.

Legally Mandated Benefits

Image: Labor Law by Nick Youngson CC BY-SA 3.0 Pix4free.org

Legally mandated benefits are employee benefits that are required by federal, state or local laws. These benefits can include minimum wage, overtime pay, unemployment insurance, FMLA, COBRA and workers' compensation.

Employers must provide legally mandated benefits to all eligible employees. Failure to do so can result in significant penalties. While most employers are compliant with the law, some employers do attempt to skirt the law by mis-classifying employees or failing to provide required benefits.

Employees who believe they are not receiving all of their required benefits have the option of submitting a complaint to the Department of Labor or their state labor department.

Minimum Wage

The lowest hourly wage that a business may pay its workers is the federal minimum wage. The current federal minimum wage is $7.25 per hour. While the federal government has established a minimum wage, some states have chosen to set their own wages, which could be more or less than the nationally determined amount.

Employers must pay all employees at least the federal or state minimum wage, whichever is higher.

Employees who are paid less than the minimum wage may be entitled to back pay and other damages.

Overtime

Overtime pay is compensation that is paid to employees for working more than 40 hours in a workweek. The federal overtime pay rate is time and a half, which means employees must be paid one and a half times their regular hourly rate for any overtime hours worked. Some states have their own overtime pay laws, which may be higher or lower than the federal overtime pay rate.

Employers must pay all employees at least the federal or state overtime pay rate, whichever is higher. Employees who are paid less than the overtime pay rate may be entitled to back pay and other damages.

Unemployment Insurance

Unemployment insurance is a government-provided assistance that aids individuals who have lost their employment owing to circumstances beyond their control. Unemployment insurance helps workers who are out of work cover their basic expenses while they search for new employment.

Workers must be unemployed through no fault of their own in order to receive unemployment. Workers who are unemployed and meet the requirements will receive a weekly payment that is determined by their previous earnings. The amount of time a worker can receive unemployment insurance payments varies by state.

FMLA

The Family and Medical Leave Act (FMLA) is a federal law that gives employees job-protected, unpaid leave per year for certain family and medical reasons. Employees can take FMLA leave for 12 consecutive weeks, or on an intermittent basis, provided they don't exceed 12 weeks in a 12-month period. Not all employees are eligible, however. Employees must have worked for their employer for at least 12 months and have worked at least 1,250 hours in the previous year to be eligible for FMLA leave. The FMLA applies to employers with 50 or more employees for at least 20 weeks in the current or preceding year.

COBRA

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows employees to continue their group health insurance coverage after they leave their job or otherwise lose their employer- sponsored health coverage. COBRA applies to employers with 20 or more employees. COBRA continuation coverage is typically available for up to 18 months. COBRA beneficiaries are responsible for paying the full premium, plus a 2% administrative fee.

Workers' Compensation

Workers' compensation is a state-mandated benefit that provides financial assistance to workers who get hurt at work. Workers' compensation benefits may cover the cost of medical bills, lost wages and death benefits. To qualify for workers' compensation, employees must be hurt on the job.

Fringe Benefits and Perks

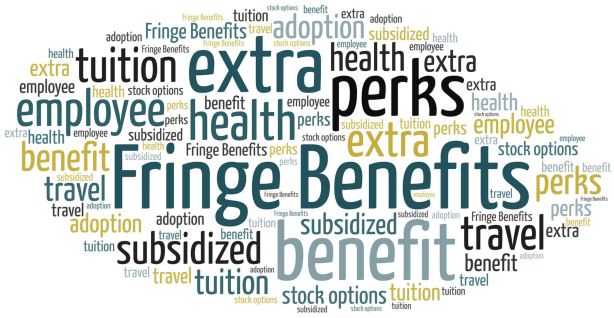


Image: Fringe Benefits. by Epic Top 10 Site

Fringe benefits, also known as employee benefits or perks, are extra compensation that employers may provide to their employees. Fringe benefits can include child care, company holidays, at-work perks and educational assistance.

While fringe benefits are not required by law, they may be offered to attract and retain employees. Some fringe benefits may be tax-deductible for employers.

Parental Leave

Parental leave is an employee benefit that provides paid or unpaid time off for new parents.

Parental leave can be used for bonding with a new child, caring for a sick child or dealing with a pregnancy-related health condition. Some types of parental leave are required by law (such as when FMLA applies), while other types are optional.

Parental leave can be paid or unpaid. Paid parental leave may be offered by employers, employee assistance programs or government agencies. Unpaid parental leave is generally only available to employees who meet certain eligibility requirements, such as having worked for their employer for a certain period of time.

Commuter Benefits

Commuter benefits are employee benefits that help cover the costs of commuting to and from work.

They can help employees save money on their commute, which can be a significant expense for many workers. Commuter benefits can also help reduce traffic congestion and pollution. Employers often offer commuter benefits to attract and retain employees. Commuter benefits can also help employers meet their corporate sustainability goals.

Flexible Hours and Telecommuting/Remote Work

Flexible hours and telecommuting are employee benefits that allow employees to have a more flexible work schedule. Flexible hours may involve working fewer hours overall or working different hours on different days. Telecommuting allows employees to work from home, either all or part of the time.

Flexible hours and telecommuting can be beneficial for employees who have children or other obligations outside of work. These employee benefits can also help reduce traffic and save employers money on office space.

Employers may offer flexible hours and telecommuting as employee benefits to attract and retain employees. Some employers may require employees to work a certain number of hours per week or to be available during specific hours.

Relocation Assistance

Relocation assistance is an employee benefit that helps cover the cost of moving to a new location for a job. Relocation assistance may cover the cost of moving expenses, such as transportation and storage fees.

Some employers may also offer a per diem allowance to help with temporary living expenses.

Employers may offer relocation assistance to attract and retain employees. Relocation assistance may be offered as a lump sum or as a reimbursement for actual expenses incurred.

Sabbatical

A sabbatical is an employee benefit that allows employees to take a paid or unpaid leave of absence for a period of time. Sabbaticals may be used for personal or professional development, such as studying for a degree, writing a book or taking care of personal business.

Sabbaticals are typically offered to employees who have worked for their employer for a certain period of time. Employers may offer sabbaticals as a way to retain employees.

Unlimited Time Off

Unlimited time off is an employee benefit that allows employees to take as much time off as they want, without having to request or receive approval from their employer. Unlimited time off may be used for vacation, personal business or anything else the employee wants.

Employers may offer unlimited time off as a way to attract and retain employees. Some employers may require employees to work a certain number of hours per week or to be available during specific hours.

Employee Discounts

Employee discounts are employee benefits that allow employees to receive discounts on products or services. Employee discounts may be offered by the employer or by companies that have agreements with the employer.

Employee discounts can be used for personal or business purposes. Employee discounts may be offered on products, services, travel or entertainment.

Unpaid Leave

Unpaid leave is an employee benefit that allows employees to take a leave of absence from work without pay. Unpaid leave may be used for personal or medical reasons.

Employees may be eligible for unpaid leave if they have worked for their employer for a certain period of time. Employers may offer unpaid leave as a way to retain employees.

At-Work Perks

At-work perks are employee benefits that are available to employees while they are working, made popular by tech giants such as Google, and by startups looking to attract a new generation. At-work perks may include things such as free or discounted meals, on-site child care, nap rooms, pets at work, coffee service, unlimited snacks, no dress code, transportation assistance or gym memberships.

Employers may offer at-work perks as a way to attract and retain employees. At-work perks can improve employee morale and productivity.

Educational Assistance or Reimbursement

Educational assistance or reimbursement is an employee benefit that helps employees pay for education- related expenses. Educational assistance may cover the cost of tuition, books, supplies or other education- related expenses. Some employers may also offer a per diem allowance to help with temporary living expenses.

Employers may offer educational assistance or reimbursement to attract and retain employees.

Educational assistance may be offered as a lump sum or as a reimbursement for actual expenses incurred.

Best Practices for Your Employee Benefits Package

Image: Successful Results crested by VectorPortal.com. CC By 4.0

When designing your employee benefits package, there are a few things to keep in mind:

- Make sure the benefits you offer are ones that your employees will actually use and appreciate.
- There’s no point in offering a benefit that no one will take advantage of.
- Consider the needs of your employee base. Offering benefits that meet the needs of your employees will make them more likely to use them.
- Make sure the benefits you offer are affordable for your business. Offering too many expensive benefits can strain your budget and make it difficult to offer other perks or salary increases.
- Be sure to communicate the details of your employee benefits package to your employees. They should know what benefits are available to them and how to take advantage of them.
- Know the law. Make sure you’re offering all benefits that are legally required in your state for the size of business you operate.

Bottom Line

Employee benefits are a key part of any compensation package. By offering employee benefits, employers can attract and retain talented employees. There are many different types of employee benefits, so employers should consider the needs of their employees when designing a benefits

package, as well as the affordability of the benefits. Employers should also be sure to communicate the details of their employee benefits package to their employees. And because there are certain benefits required by law, employers should consult with an employee benefits attorney to ensure they are in compliance.

Source: Employee Benefits In 2024: The Ultimate Guide Forbes, May 1, 2024

1.5: REVIEW- COBRA Compliance Checklist

COBRA Compliance Checklist

This COBRA Compliance Checklist can be used as a tool to do a quick assessment of some key aspects of federal COBRA compliance and help you identify gaps in compliance. This is not an all-inclusive list but covers the more common deficiencies and areas that are often overlooked.

Group Health Plans

Does your company sponsor group health plans that are subject to COBRA and does your company have 20 or more employees?

- A group health plan includes plans such as major medical, dental, vision, Health Care flexible spending account (FSA), Health Reimbursement Arrangement (HRA), and some employee assistance and wellness plans.

 Yes. Your company is obligated to comply with various COBRA obligations. The remaining questions address some key COBRA obligations.
 No. There are no COBRA obligations. However, various states impose COBRA-like continuation requirements, so be sure to consult with your company's legal counsel about applicable state law.

COBRA

Does your company include an offer of COBRA for all its COBRA-eligible group health plans?

• Have you included your group health plans, such as your medical, dental, vision plans (even if they are 100% employee paid)?
• Have you included your Health Care FSA?
• Have you included your Health Reimbursement Arrangement?
• Have you included any wellness plans or employee assistance plans subject to COBRA?
• Have you included your on-site medical clinic if it provides for certain care?

 Yes. Your company has met an important COBRA compliance obligation.
 No. Failure to meet COBRA obligations can result in significant penalties and legal fees. COBRA litigation is on the rise, so we recommend you
confirm that your company has proper processes and procedures in place and/or has engaged a trusted COBRA administrator.

COBRA Communication

Does your company provide all the required accurate COBRA-compliant notices to plan participants and qualified beneficiaries (QB) regarding their COBRA rights timely?

 Yes. Your company has met an important COBRA obligation.
 No. Failure to provide all the required accurate COBRA-compliant notices to plan participants and QBs can result in significant penalties, legal
fees, and liability for medical expenses not covered by insurance if the carrier will not reinstate coverage for elections made as a result of an
incomplete or late notice. A trusted COBRA administrator can help your company maintain compliance by providing COBRA notices to plan
participants when required.

COBRA Requirements

Does your company's HR department know when it is required to offer COBRA to an employee and/or their spouse and dependents?

Qualifying events that trigger a loss of coverage and an offer of COBRA include:
• Termination of employment (voluntary or involuntary).
• Reduction in hours that results in loss of eligibility.
• Death of employee.
• Divorce.
• Loss of dependent eligibility.
• Medicare entitlement, but only in the rare circumstance where it causes loss of eligibility.

 Yes. Your company has met an important COBRA obligation.
 No. Failure to offer COBRA timely when there is a triggering event to all the appropriate individuals can result in significant penalties and legal fees.

COBRA Eligibility

Does your company offer COBRA to all individuals who are entitled to COBRA?

 Yes. Your company has met an important COBRA obligation.
 No. Failure to offer COBRA timely to all QBs when there has been a triggering event can result in significant penalties and legal fees.

COBRA Procedures

Does your company have clear procedures in place to correctly offer COBRA in the following situations?

• Employee goes on non-FMLA leave of absence.
• Employee and/or their spouse or dependents is eligible for or enrolled in Medicare.
• Employee retires and is offered retiree coverage.

 Yes. Your company has met an important COBRA obligation.
 No. Failure to have clear procedures in place for these situations can lead to disputes over coverage with plan participants and/or insurance carriers, and can in extreme situations lead to litigation, potential self-insurance, and possibly civil penalties and/or excise taxes imposed by the government.

COBRA Coverage Periods

Does your company offer COBRA for the correct maximum COBRA coverage periods, including proper application of coverage period extensions or early termination of coverage?

• Coverage can be extended in case of a QB being disabled.
• Coverage can be extended for a spouse and/or dependent in the case of a second qualifying event (divorce, death, loss of dependent status, Medicare entitlement prior to electing COBRA).
• Coverage can be extended for someone dropped in anticipation of a divorce.
• Coverage should end early when QB in disability extension is determined to not be disabled.
• Coverage should end early if a QB becomes enrolled in another group health plan.
• Coverage should end early if a QB becomes entitled to Medicare after electing COBRA.

 Yes. Your company has met an important COBRA obligation.
 No. Failure to offer COBRA for the right amount of time can result in litigation or a DOL investigation. Offering COBRA for more than the required maximum coverage period may result in self-insuring the additional time that exceeds the maximum coverage timeframe.

COBRA Tracking System

Does your company have a tracking system to manage the offers of COBRA and payment deadlines and maintain all supporting documentation?

 Yes. You have met an important COBRA obligation.
 No. It is essential to correctly manage offers of COBRA, administer payment deadlines, and maintain all supporting

documentation. Failure to do so can result in litigation, a DOL audit, coverage disputes with participants, and/or coverage disputes with insurance carriers. Failure to maintain COBRA records will limit your ability to defend against an audit or litigation.

COBRA Open Enrollment

Does your company provide open enrollment information to individuals enrolled in COBRA and individuals in their COBRA election period?

 Yes. Your company has met an important COBRA obligation.
 No. Failure to treat individuals enrolled or eligible to enroll in COBRA the same as active employees may result in lawsuits, potential self-insuring,
and possibly civil penalties and/or excise taxes imposed by the government.

Need Assistance?

If you answered no to any of the questions above, we're here to help. EBC is a trusted COBRA administrator with a team of in-house compliance experts who work to apply their skills and knowledge to your specific situation. At EBC, we know one size does not fit all and we're dedicated to collaborating with you to understand your needs and implementing solutions that will best serve the needs of your employees.

Let us help meet your compliance needs! Contact us to start a conversation or if you have any questions.

Contact Us:
Web: ebcflex.com
Email: EBCflex.com
Phone (800) 346-2126 | (608) 831-8445

The compliance checklist created by Employee Benefits Corporation is for general information purposes only. This does not constitute legal or tax advice and may not be relied upon by anyone as such. Nor may the information be disseminated in any form. You should contact your own legal advisor about your specific situation.

NOTE: A printable PDF of this checklist is attached below.

1.6: READ - COBRA Requirements and Benefits

Image: Doctor. OpenClipArt via File:Female_physician.svgWikimedia Commons

What is COBRA?

- The law requires certain group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is only available when coverage is lost due to certain specific events.
- Employers decide whether or not they will contribute to their employee's premiums under COBRA.Consumers may be responsible for the entire monthly premium by themselves, plus a 2 percent administrative fee. As a result, group health coverage for COBRA participants is usually more expensive than health coverage for active employees.
- The full premium for COBRA participants cannot exceed 102 percent of the cost of the plan for similarly situated individuals who have not incurred a qualifying event.

Who Qualifies for COBRA

- COBRA contains provisions giving certain former employees, retirees, spouses, former spouses, and dependent children the right to temporarily continue coverage under the employer's group health plan.
- If your client's employer is required to comply with COBRA, then your client is eligible for COBRA after just having one day of coverage as an active member on the group health plan.
- In combination with whether your client's employer is subject to COBRA, a COBRA “qualifying event”is what triggers a client's ability to exercise her or his COBRA rights.

COBRA Qualifying Events

- Death of the current employee
- An employee loses eligibility due to voluntary or involuntary termination or a reduction in hours as a result of resignation, discharge (except for “gross misconduct”), layoff, strike or lockout, medical leave,or slowdown in business operations
- An employee becomes entitled to Medicare and this results in a loss of plan coverage for the employee's dependents
- Divorce or legal separation that terminates the ex-spouse's eligibility for benefits
- A dependent child reaching the age at which she or he is no longer eligible for active coverage under the group plan (generally age 26)

How Long Can a Consumer Stay on COBRA?

- Consumers who experience a COBRA qualifying event can stay on the plan for a certain period oftime, which varies depending on the situation.
- In most cases COBRA allows for extended coverage for up to 18 months.

Timelines to Apply for COBRA Coverage

- Upon experiencing a qualifying event, consumers have 60 days after receiving the election notice to decide whether to enroll in COBRA coverage. Consumers who choose to enroll in COBRA coverage have 45 days after making the election to pay the first month's premium.
- COBRA coverage can retroactively begin on the date consumers’ job based insurance ended, as long as the election is made within the 60-day election period for COBRA coverage.

Table 16.1. COBRA Extension & Description

1. Disability: If the COBRA participant is deemed disabled by the Social Security Administration, then coverage may continue for up to an additional 11 months. Total length of COBRA coverage is 29 months.
2. Divorce and Death: A COBRA participant who experiences a divorce or death qualifying event is eligible for an 18-month extension. Total length of COBRA coverage is 36 months.
3. Medicare Eligibility(Special Rule for Dependents): If a covered employee becomes entitled to Medicare benefits (Part A or Part B) and later terminates employment or reduces hours, the period of COBRA coverage for the employee's spouse and dependent children lasts until the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period that begins on the date of the covered employee's termination of employment.
4. Second Qualifying Event: A spouse and dependent children who already have COBRA coverage, and then experience a second qualifying event, may be entitled to a total of 36 months of COBRA coverage.

Which Employers Need to Offer COBRA

1. Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage.
2. COBRA applies to plans sponsored by private-sector employers and sponsored by most state and local governments.
3. Many states have COBRA expansion programs (sometimes called “mini COBRA”) that extend similar coverage options to employees of firms with fewer than 20 employees. Check with your state Department of Insurance to see if this applies in your state.

What Benefits Must be Covered by COBRA?

Coverage must be identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage).

A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries.

Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

COBRA Coverage and Eligibility for Marketplace Coverage

- Many individuals and families may have better and more affordable options in the Marketplace or through their spouse's employer.
- Consumers who are eligible for, but have not elected, COBRA coverage may still qualify for advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs) through the Marketplace, if they are otherwise eligible.
- These consumers may be eligible for a special enrollment period (SEP) to enroll in a Marketplace plan if they lost their employer-sponsored coverage within the last 60 days, or will lose such coverage within the next 60 days.
- Direct your clients to the See Plans and Prices tool at HealthCare.gov to help them compare their COBRA coverage offer with Marketplace options.

Things to Consider When Deciding between COBRA and Marketplace Coverage

- Continuity of coverage
- Access to care/provider network Total cost (e.g., COBRA coverage including premiums, deductibles,and coinsurance)
- Quality of care
- Potential savings in the Marketplace

Can a Consumer Change from COBRA to a Marketplace Plan?

TimePeriod

- If COBRA is running out
- If consumer is ending COBRA early
- If COBRA costs change because the former employer stops contributions and consumer must pay full cost

During Open Enrollment

- Yes, consumer can change

Outside Open Enrollment

- Yes, consumer can change due to qualifying for an SEP
- No, consumer cannot change until the next Open Enrollment period, COBRA runs out, or if consumer qualifies for an SEP another way
- Yes, consumer can change due to qualifying for an SEP

This chapter includes text excerpted from “COBRA Overview and QSEHRA Assistance,” Centers for Medicare & Medicaid Services (CMS), February 1, 2018.

Download a printable copy below.

1.7: READ- Are We Legally Required to Offer Benefits to Part-Time Employees?

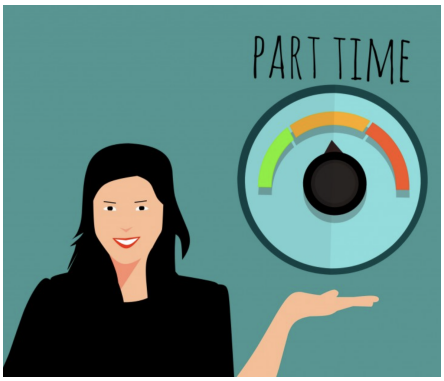


Image: Muhamed Hassan. PxHere.com

Are we legally required to offer benefits to part-time employees?

Some laws require employers to offer certain benefits to part-time employees, yes. State and local laws vary and may require that benefits such as paid sick leave, short-term disability, or health insurance plans or premiums be offered to part-time employees. Employers will want to check the laws in every state where they employ workers to ensure compliance.
Some federal laws also require that benefits be offered to part-time employees:
The Affordable Care Act (ACA) requires employers to offer health insurance to employees working at least 30 hours per week (or 130 hours per month) to avoid paying penalties.

Part-time employee eligibility to participate in a company's retirement plan must comply with the Employee Retirement Income Security Act (ERISA) "1,000-hour rule." Employees who have completed 1,000 hours of service in a 12-month period are eligible to participate in any retirement plan that is offered to other employees. This requirement applies to both full-time and part-time employees.

For plan years beginning after Dec. 31, 2020, the Setting Every Community Up for Retirement Enhancement (SECURE) Act of 2019 requires employers to allow long-term part-time workers to make elective deferrals to the employer-sponsored 401(k) plan, except in the case of collectively bargained plans. Eligible employees are those who have completed at least 500 hours of service each year for three consecutive years and are age 21 or older. Years of service prior to 2021 do not have to be counted;however, employers may choose to have more generous eligibility rules. The 2023 Consolidated Appropriations Act (also known as the Secure Act 2.0) reduces the three consecutive years of service to two years for plan years beginning after Dec. 31, 2024.

Executive Order 13706, Establishing Paid Sick Leave for Federal Contractors, requires certain contractors to provide paid sick leave to all covered employees, including part-time workers. Both the Service Contract Act (SCA) and the Davis Bacon and Related Acts (DBA) require covered federal contractors to provide certain fringe benefits (or monetary equivalents where allowed) to all employees.

Outside of state or federal requirements, eligibility for voluntary benefits is at the discretion of the employer. Policies should be very clear on what benefits are offered to full-time versus part-time employees and what the eligibility requirements are for these benefits (number of hours, types of benefits, etc.) Policies should be administered in a fair and consistent manner.

Further, there are mandated employee benefits such as unemployment and workers' compensation insurance that may be required under state law for all employees.

Source: Q & A: "Are we legally required to offer benefits to part-time employees?" Society for Human Resource Management (SHRM). January 11, 2023.

1.8: READ- What is the Summary of Benefits and Coverage Required by the Affordable Care Act?

The Affordable Care Act (ACA)

Under the Affordable Care Act (ACA), U.S. health insurers and group health plan providers are required to provide a **Summary of Benefits and Coverage (SBC)** to consumers.

The U.S. Department of Labor (DOL) provides SBC instructions and templates. The SBC is a document intended to help consumers compare and select health insurance coverage that best meets their needs by providing easy-to-understand language of health plan benefits. The SBC cannot be more than four pages in length and must be printed in 12-point font or larger.

The SBC must include 12 content elements:

1. Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage.
2. A description of the coverage, including cost sharing, for each category of benefits.
3. The exceptions, reductions and limitations of the coverage.
4. The cost-sharing provisions of the coverage, including deductible, co-insurance and co-payment obligations.
5. The renewability and continuation of coverage provisions.
6. Coverage examples.
7. With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements.
8. A statement that the SBC is only a summary and that the plan document, policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage.
9. Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate or contract of insurance).
10. For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers.
11. For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage.
12. An Internet address for obtaining the uniform glossary, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

The SBC must be provided to consumers:

- Enrolling or re-enrolling in health plans beginning on the first day of the open enrollment, including COBRA coverage.
- Newly eligible to enroll on the first day of the plan year.
- During a special enrollment.
- When there are coverage changes or material modifications.
- Upon request.

If the SBC is sent to an address in a county where at least 10 percent of the population is literate in a language other than English, the health insurer or group health plan provider will need to provide language services and notices upon request in the non-English language. Also, all English versions of the SBC must include a statement in the non-English language indicating how to access the language services and copy of the notice. To assist health insurers and group health plan providers with this process, the Centers for Medicare and Medicaid Services (CMS) provide county data and information on translating these documents to other languages.

The SBC may be provided via hard copy or electronic format (e-mail or posted to a website) upon meeting three conditions: the SBC is accessible, can be received in paper form free of charge upon request and is available on the Internet. The SBC does not replace a Summary Plan Description (SPD) but may referencethe SPD in the footer of the document.

Source: Q&A "What is the Summary of Benefits and Coverage Required by theAffordable Care Act?" Society for Human Resource Management (SHRM), 2024.

1.9: READ- Employers are Getting More Creative on Benefits

Image: Employee Benefits by Nick Youngson CC BY-SA 3.0 Alpha Stock Images

Employers are Getting More Creative on Benefits

Employers bracing for a major hike in health care costs are retooling their benefits, aiming to provide perks better targeted to workers' needs as they closely mind the bottom line.

Why it matters: Employer health costs are expected to see their largest jump in a decade, but many companies facing an ongoing workforce crunch are hesitant to pass along those costs or cut back benefits.

Rather than adding on a host of new benefits, employers are trying to shore up gaps in coverage of areas like mental health and women's health while also keeping a lid on costs, experts say.

What they're saying: "In the past, especially with COVID, there may have been a proliferation of, 'Let's offer all of these services,'" said Ashok Subramanian, CEO of health plan administrator Centivo.

- "Now employers are asking: How do we avoid having to change our 401(k) match because of health care?"
- At the same time, employers are doing what they can to stand out in a shallow labor pool, said Kevin Robertson, chief revenue officer for HSA Bank.
- "Right now, the name of the game for employers is differentiation, right? It's a dog-eat-dog labor market right now," he said.

Here's what experts are watching for during this fall's benefits season:

Better mental health options: In a recent Mercer survey of large employers, most identified mental health resources as one of their most valued benefits — perhaps unsurprisingly, given increasing demand and expectations from workers.
But recognizing the shortage of mental health professionals, employers have added supplemental provider networks, often through virtual offerings like Ginger or Teladoc, said Mercer researcher Beth Umland.

Menopause support: While there's been a lot of focus on supporting reproductive-age women through fertility, pregnancy and lactation services, there's growing recognition around menopause.

- "I've never heard so much conversation on that," said Michael Thompson, CEO of the National Alliance of Healthcare Purchaser Coalitions.
- In many cases, the support offered isn't complicated or expensive — it may be more days off or ensuring access to specialists. But there's greater focus on removing stigma and barriers for those seeking care.

Inclusive benefits: Employers have placed greater emphasis on addressing equity. For instance, employers are taking a closer look at provider networks to ensure they reach underserved populations and neighborhoods.
They are also investing more in products that help LGBTQ employees or employees of color find providers that more effectively meet their health needs, said Robin Glass, president of virtual care company Included Health.

Health-adjacent perks: A newer addition to the benefits toolbox is what is known as a lifestyle spending account, or LSA, said Robertson of HSA Bank.

- These are typically used to help employees pay for a gym membership or buy home workout equipment like a new Peloton. Employers can use these accounts to support non-health-related benefits such as home office renovations, tax preparation services or tuition reimbursement, he said.
- "These would be taxable benefits to an employee but allow for reimbursement in, really, practically an unlimited manner by an employer," he said.

Free care: Employers are getting more intentional about steering workers to certain care, which ultimately saves money by preventing a person from needing costlier services.

- "We're moving away from what I would call the Amazon model, which is kind of a laissez-faire consumerism to more of a Costco model, which is more guided choice, getting people in where everything is better value if you just follow the yellow brick road," Thompson said.
- Some companies have begun offering almost all care — from primary care to surgery — for free while employees are expected to pick up the tab for urgent and emergency care, Subramanian told Axios.

Source: "Employers are getting more creative on benefits" Axios, September 26, 2023.

1.10: Regulating Employee Benefits

Image: Regulation by Mike Cohen via Flickr.com

Regulating Employee Benefits

The goal of regulation is to protect individuals/employees. Below are some of the laws/regulations you need to be aware of when working with employee benefits:

National Labor Relations Act of 1935 (NLRA)

The NLRA protects workplace democracy by providing employees at private-sector workplaces the fundamental right to seek better working conditions and designation of representation without fear of retaliation.

Importantly, this act protects the rights of employees to discuss:

- Wages
- Hours
- Working conditions

Internal Revenue Code (IRC)

Tax laws are important to HR professionals because they impact:

- Paying employees
- Benefits coverages
- Settling employment lawsuits
- Paying of pensions

Anything and employer provides to an employee or former employee is income to the employer, and therefore is obligated to withhold income and payroll taxes appropriately.

The Fair Labor Standards Act of 1938 (FLSA)

Establishes minimum wage, overtime pay, recordkeeping, and youth employment standards affecting employees in the private sector and in Federal, State, and local governments.

Covered nonexempt workers are entitled to a minimum wage of not less than $7.25 per hour effective July 24, 2009.

Overtime pay at a rate not less than one and one-half times the regular rate of pay is required after 40 hours of work in a workweek.

Employee Retirement Income Security Act of 1974 (ERISA)

ERISA is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

Consolidated Omnibus Reconciliation Act of 1985 (COBRA)

COBRA gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as:

- voluntary or involuntary job loss,

- reduction in the hours worked,
- transition between jobs,
- death, divorce, and other life events.

Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

The US Department of Health and Human Services (HHS) issued the HIPAA **Privacy Rule** to implement the requirements of HIPAA.

The HIPAA **Security Rule** protects a subset of information covered by the Privacy Rule.

Pension Protection Act of 2006 (PPA)

The PPA was designed to improve pension plan funding requirements of employers, as well as 401(k), IRA, and other retirement plans.

Patient Protection and Affordable Care Act of 2010 (PPACA)

PPACA has three main goals:

1. Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level (FPL).
2. Expand the Medicaid program to cover all adults with income below 138% of the FPL. Not all states have expanded their Medicaid programs.
3. Support innovative medical care delivery methods designed to lower the costs of health care generally.

Equal Pay Act of 1963 (EPA)

The Equal Pay Act of 1963 is a United States labor law amending the Fair Labor Standards Act, aimed at abolishing wage disparity based on sex.

Title VII of the Civil Rights Act of 1964

The Civil Rights Act protects employees and job applicants from employment discrimination based on:

- race
- color
- religion
- sex
- national origin.

Age Discrimination in Employment Act of 1967 (ADEA)

A United States labor law that forbids employment discrimination against anyone, 40 years of age or older.

Pregnancy Discrimination Act of 1978

Prohibits discrimination on the basis of pregnancy, childbirth, or related medical conditions.

Americans with Disabilities Act of 1990 (ADA)

The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

Civil Rights Act of 1991

Amended the Civil Rights Act of 1964 to strengthen and improve Federal civil rights laws, to provide for damages in cases of ***intentional*** employment discrimination, to clarify provisions regarding disparate impact actions, and for other purposes.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA was enacted to prohibit discrimination on the basis of genetic information with respect to health insurance and employment.

Pregnant Workers Fairness Act (PWFA)

NEW in 2023!!

PWFA is new law that requires covered employers to provide “reasonable accommodations” to a worker’s known limitations related to pregnancy, childbirth, or related medical conditions, unless the accommodation will cause the employer an “undue hardship.”

NOTE: A printable PDF is attached below.

CHAPTER OVERVIEW

2: Health Insurance Benefits

This module will focus on Health Insurance Benefits.

Health Insurance is a Legally Required Benefit

Some types of health insurance are listed below:

- Self-Insured
- COBRA
- HIPAA
- Qualifying Events
- HSA, HRA, FSA

Key Ideas:

Competitive and Creative Benefits in a Total Rewards Program

2.1: WATCH- How Health Insurance Works

Notes:

(6:06 min) If you have health insurance or are in the market for an insurance plan, you may be feeling terminology overload. What is a deductible? What is coinsurance? How does a co-pay work? What is an insurance premium? How about an individual out of pocket maximum? In this video, we're going to break down these essential health insurance terms, explain how the costs work for both you and your insurance company, and hopefully help you feel more confident about how your plan works.

2.2: Health Insurance- Key Vocabulary Terms

Review this list of term and definitions to learn more about health insurance.

Health Insurance Vocabulary

Indemnity – type of insurance policy where the insurance company guarantees compensation for losses or damages sustained by a policyholder.

Fee-for-service - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

HMOs - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. HMOs often provide integrated care and focus on prevention and wellness.

PPOs - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

POSs - A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

HSAs - A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

HRAs - Health Reimbursement Arrangements (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year.

HDHPs - A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (also called your deductible).

A high deductible plan can be combined with a health savings account (HSA), for you to pay for certain medical expenses with money you set aside in your tax-free HSA. This is why it's more commonly called an HSA-eligible plan.

CDHPs - a high-deductible health plan which allows you to pay for part of the cost of out-of-pocket medical services using pre-tax dollars in a specified savings account.

Self-Insured - Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims.

Utilization Review - the evaluation of the necessity, appropriateness, and efficacy of a health care service to determine whether the health care service is medically necessary for a patient. A health insurer may conduct utilization review of a health care service that a health care provider recommends for a patient, or may contract with a utilization review organization to perform utilization review.

Wellness Program - A program intended to improve and promote health and fitness that's usually offered through the workplace, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate.

Managed-Care Plans – Control access to providers and/or services through economic incentives to stay in network to cover services or avoid penalties.

FSAs - An arrangement through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars.

PCP – Primary care physicians are physicians (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Premium – The amount you pay for your health insurance every month.

Deductible – The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself.

Coinsurance – The percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible.

Copayment – A fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible.

A printable copy of this glossary can be downloaded below.

2.3: READ- HSA Health Savings Accounts

Photo courtesy of rawpixel.com

HSA like a Pro!

Stretch your dollars further and put more money in your pocket. Health Savings Accounts empower you to save more, spend smarter and invest in your healthcare.

What is a Health Savings Account?

HSAs are tax-advantaged member-owned accounts that let you save pre-tax[1] dollars for future qualified medical expenses. You can invest in mutual funds tax-free—and funds never expire.

Am I eligible for a Health Savings Account?
HSAs are available exclusively to those with a qualifying health plan.

- You are eligible if you have a High-deductible health plan
- You are not eligible if you have Healthcare coverage beyond qualified health plans (including Medicare enrollment)
- You are not eligible if you are being claimed as a dependent on someone's tax returns.
- You are not eligible if you are Receiving Veterans Affairs benefits within the past three months

How do I sign up?
You can enroll in an HSA-qualified health plan and sign up for an account during your organization's annual open enrollment. If you have a high-deductible health plan on your own—not offered through an employer—you can sign up right now.

Save

- Put more money in your pocket.
- Enjoy lower health plan premiums
- Qualified health plans offer lower premiums, enabling you to save potentially thousands every year.
- Keep your premium savings
- Just put the extra money you would've paid toward traditional premiums into your account. Voila!
- Long-term savings.

Comparison FSA and HSA Plans

FSA	HSA
Traditional health plan	HSA-qualified health plan
Higher premiums	Lower premiums
Lower deductibles	Higher deductibles
Doesn't cover premium payments	Cover premium payments
Funds expire	Funds don't expire

Unlike Flexible Spending Accounts (FSA), you own your HSA. That means your entire balance rolls over every year—even if you change health plans, retire, or leave your employer.

HSA vs FSA comparison

The more you contribute, the more you save
Each contribution potentially reduces your annual tax bill. Link a bank account and make tax-deductible contributions anytime.

HSA Annual Contribution Limits

Tax year Individual coverage limit Family coverage limit

2024 $4,150 $8,300

2025 $4,300 $8,550

At age 55, members can contribute an additional $1,000 beyond IRS limits.

Spend

Stretch your dollars further.

HSA qualified medical expenses

Because of the tax savings on contributions, you can save an average of 30 percent on qualified medical expenses, including but not limited to:

- Acne Medicine
- Braces
- Crutches
- Dentures
- Eyeglasses
- Eye Surgery
- Flu Shot
- Hearing Aids
- Motorized Wheelchair
- Prescriptions
- X-Rays
- Allergy Medicines
- Contact Lenses
- Dental Cleanings
- Doctor Fees
- Eye Exams
- Face Masks
- Hand Sanitizer
- Ibuprofen
- Orthodontia
- Sanitizing Wipes

Your Savings Can Add Up Fast

Here’s an example based on $4,000 annual spending and a 30 percent effective tax rate.

Medical expenses
$3,000

+

Vision expenses
$500

+

Dental expenses
$500

Annual tax savings

=
$1,200

Consider generics
Generic medications cost 20 to 70 percent less than branded medications.

Prefer urgent care
Emergency room visits cost up to 5X more than urgent care.[8] Unless it's a life-threatening event, consider urgent care instead.

Comparison shop
Whether you need a simple procedure or even major surgery, be sure to get prices from several healthcare providers.

Invest
Build long-term health savings.

HSA investing
Invest your money just like a 401(k)

- Access liquid funds anytime
- Enjoy lower fees and transparent pricing

Comparison 401(k) and HSA Investments

401(k)	HSA
FICA taxed contributions	100% tax deductible contributions
Tax-free earnings	Tax-free savings
Medical expenses taxed as ordinary income	Tax-free distribution for medical expenses
Regular expenses taxed as ordinary income	Regular expenses taxes as ordinary income
Minimum distributions required	No required minimum distributions

HSA vs. 401(k)
Both accounts let you make pre-tax contributions and grow tax-free earnings. But only an HSA lets you take tax-free distributions for qualified medical expenses. After age 65 you can use your health savings account for any expense, you'll simply pay ordinary income taxes— just like a 401(k).

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

Source: "HSA like a pro." HSA Guide. HealthEquity.

2.4: READ- An Employee's Guide to Health Benefits Under COBRA

Image: Two Women by Amy Hirsch. Unsplash.com.

Introduction

A health plan helps workers and their families take care of their essential medical needs. It is one of the most important benefits provided by an employer.

There was a time when employer-provided group health coverage was at risk if an employee was fired, changed jobs, or got divorced. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), many employees and their families who would lose group health coverage because of serious life events are able to continue their coverage under the employer's group health plan, usually at their own expense, at least for limited periods of time. This booklet explains your rights under COBRA to a temporary extension of employer-provided group health coverage, called COBRA continuation coverage.

This booklet will:

• Provide a general explanation of your COBRA rights and responsibilities;
• Outline the COBRA rules that group health plans must follow;
• Highlight your rights to benefits while you are receiving COBRA continuation coverage.

AN EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA

What Is COBRA Continuation Coverage?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated. COBRA requires continuation coverage to be offered to covered employees, their spouses, their
former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. Those events include the death of a covered employee, termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, divorce or legal separation from a covered employee, a covered employee's becoming entitled to Medicare, and a child's loss of dependent status (and therefore coverage) under the plan.

Employers may require individuals who elect continuation coverage to pay the full cost of the coverage, plus a 2 percent administrative charge. The required payment for continuation coverage is often more expensive than the amount that active employees are required to pay for group health coverage, since the employer usually pays part of the cost of employees' coverage and all of that cost can be charged to the individuals receiving continuation coverage. While COBRA continuation coverage must be offered, it lasts only for a limited period of time. This booklet will discuss all of these provisions in more detail.

COBRA generally applies to all group health plans maintained by private-sector employers (with at least 20 employees) or by state and local governments. The law does not apply, however, to plans sponsored by the Federal Government or by churches and certain church-related organizations. In addition, many states have laws similar to COBRA, including those that apply to health insurers of employers with less than 20 employees (sometimes called mini-COBRA). Check with your state insurance commissioner's office to see if such coverage is available to you.

Under COBRA, a group health plan is any arrangement that an employer establishes or maintains to provide employees or their families with medical care, whether it is provided through insurance, by a health maintenance organization, out of the employer's assets on a pay-as-you-go basis, or otherwise. "Medical care" typically covered by a group health plan for this purpose includes:

- Inpatient and outpatient hospital care;
- Physician care;
- Surgery and other major medical benefits;
- Prescription drugs;
- Dental and vision care.

Life insurance is not considered "medical care," nor are disability benefits. COBRA does not cover plans that provide only life insurance or disability benefits.

Group health plans covered by COBRA that are sponsored by private-sector employers generally are governed by ERISA – the Employee Retirement Income Security Act of 1974. ERISA does not require employers to establish plans or to provide any particular type or level of benefits, but it does require plans to comply with ERISA's rules. ERISA gives participants and beneficiaries rights that are enforceable in court.

Alternatives to COBRA Continuation Coverage

If you become entitled to elect COBRA continuation coverage when you otherwise would lose group health coverage under a group health plan, you should consider all options you may have to get other health coverage before you make your decision. There may be more affordable or more generous coverage options for you and your family through other group health plan coverage (such as a spouse's plan), the Health Insurance Marketplace, or Medicaid.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you or your dependents are losing eligibility for group health coverage, including eligibility for continuation coverage, you may have a right to special enroll (enroll without waiting until the next open season for enrollment) in other group health coverage. For example, an employee losing eligibility for group health coverage may be able to special enroll in a spouse's plan. A dependent losing eligibility for group health coverage may be able to enroll in a different parent's group health plan. To have a special enrollment opportunity, you or your dependent must have had other health coverage when
you previously declined coverage in the plan in which you now want to enroll. You must request special enrollment within 30 days from the loss of your job-based coverage.

Losing your job-based health coverage is also a special enrollment event in the Health Insurance Marketplace (Marketplace). The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments), and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Eligibility for COBRA continuation coverage won't limit your eligibility for Marketplace coverage or for a tax credit. You can apply for Marketplace coverage at HealthCare.gov or by calling 1-800-318-2596 (TTY 1-855-889- 4325). To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, during an open enrollment period, anyone can enroll in Marketplace coverage. If you need health coverage in the time between losing your job-based coverage and beginning coverage through the Marketplace (for example, if you or a family member needs medical care), you may wish to elect COBRA coverage from your former employer's plan. COBRA continuation coverage will ensure you have health coverage until the coverage through your Marketplace plan begins.

Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can apply for and enroll in Medicaid or CHIP any time of year. If you qualify, your coverage begins immediately. Visit HealthCare.gov or call 1-800-318-2596 (TTY 1-855-889-4325) for more information or to apply for these programs. You can also apply for Medicaid by contacting your state Medicaid office and learn more about the CHIP program in your state by calling 1-877-KIDS NOW (543-7669) or visiting insurekidsnow.gov on the Web.

If you or your dependent elects COBRA continuation coverage, you will have another opportunity to request special enrollment in a group health plan or a Marketplace plan if you have a new special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA continuation coverage, you or your dependent must receive the maximum period of continuation coverage available without early termination. Keep in mind if you choose to

terminate your COBRA continuation coverage early with no special enrollment opportunity at that time, you generally will have to wait to enroll in other coverage until the next open enrollment period for the new group health plan or the Marketplace.

Who Is Entitled to Continuation Coverage?

There are three basic requirements that must be met in order for you to be entitled to elect COBRA continuation coverage:
• Your group health plan must be covered by COBRA;
• A qualifying event must occur; and
• You must be a qualified beneficiary for that event.

Plan Coverage
COBRA covers group health plans sponsored by an employer (private-sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part- time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.

Qualifying Events
"Qualifying events" are events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualified beneficiaries are for that event and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage.

The following are qualifying events for a covered employee if they cause the covered employee to lose coverage:
• Termination of the employee's employment for any reason other than "gross misconduct"; or
• Reduction in the number of hours of employment.

The following are qualifying events for the spouse and dependent child of a covered employee if they cause the spouse or dependent child to lose coverage:
• Termination of the covered employee's employment for any reason other than "gross misconduct";
• Reduction in the hours worked by the covered employee;
• Covered employee becomes entitled to Medicare;
• Divorce or legal separation of the spouse from the covered employee; or
• Death of the covered employee.

In addition to the above, the following is a qualifying event for a dependent child of a covered employee if it causes the child to lose coverage:
• Loss of "dependent child" status under the plan rules. Under the Affordable Care Act, plans that offer coverage to children on their parents' plan must make the coverage available until the adult child reaches the age of 26.

Qualified Beneficiaries

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. Only certain individuals can become qualified beneficiaries due to a qualifying event, and the type of qualifying event determines who can become a qualified beneficiary when it happens. A qualified beneficiary must be a covered employee, the employee's spouse or former spouse, or the employee's dependent child. In certain cases involving the bankruptcy of the employer sponsoring the plan, a retired employee, the retired employee's spouse (or former spouse), and the retired employee's dependent children may be
qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is automatically considered a qualified beneficiary. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Your COBRA Rights and Responsibilities: Notice and Election Procedures

Under COBRA, group health plans must provide covered employees and their families with certain notices explaining their COBRA rights. Plans must also have rules for how COBRA continuation coverage is offered, how qualified beneficiaries may elect continuation coverage, and when it can be terminated.

Notice Procedures

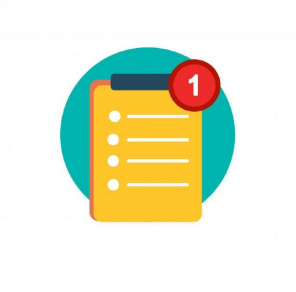


Image: Clipboard and Checklist by Raw Pixel. Freerange.com

Summary Plan Description

The COBRA rights provided under the plan must be described in the plan's Summary Plan Description (SPD). The SPD is a written document that gives important information about the plan, including what benefits are available under the plan, the rights of participants and beneficiaries under the plan, and how the plan works. ERISA requires group health plans to give you an SPD within 90 days after you first become a participant in a plan (or within 120 days after the plan is first subject to the reporting and disclosure provisions of ERISA). In addition, if there are material changes to the plan, the plan must give you a Summary of Material Modifications (SMM) not later than 210 days
after the end of the plan year in which the changes become effective; if the change is a material reduction in covered services or benefits, the SMM must be furnished not later than 60 days after the reduction is adopted. A participant or beneficiary covered under the plan may request a copy of the SPD and any SMMs (as well as any other plan documents), which must be provided within 30 days of a written request.

COBRA General Notice

Group health plans must give each employee and each spouse who becomes covered under the plan a general notice describing COBRA rights. The general notice must be provided within the first 90 days of coverage. Group health plans can satisfy this requirement by giving you the plan's SPD within this time period, as long as it contains the general notice information. The general notice should contain the information that you need to know in order to protect your COBRA rights when you first become covered under the plan, including the name of the plan and someone you can contact for more information, a general description of the continuation coverage provided under the plan, and an explanation of any notices you must give the plan to protect your COBRA rights.

COBRA Qualifying Event Notices

Before a group health plan must offer continuation coverage, a qualifying event must occur, and the group health plan must be notified of the qualifying event. Who must give notice of the qualifying event depends on the type of qualifying event.

The employer must notify the plan if the qualifying event is:
- Termination or reduction in hours of employment of the covered employee;
- Death of the covered employee;
- A covered employee becoming entitled to Medicare; or
- Bankruptcy of a private-sector employer.

The employer must notify the plan within 30 days of the event.

You (the covered employee or one of the qualified beneficiaries) must notify the plan if the qualifying event is:
- Divorce;
- Legal separation; or
- A child's loss of dependent status under the plan.

You should understand your plan's rules for how to provide notice if one of these qualifying events occurs. The plan must have procedures for how to give notice of the qualifying event, and the procedures should be described in both the general notice and the plan's SPD. The plan can set a time limit for providing this notice, but the time limit cannot be shorter than 60 days, starting from the latest of: (1) the date on which the qualifying event occurs; (2) the date on which you lose (or would lose) coverage under the

plan as a result of the qualifying event; or (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

If your plan does not have reasonable procedures for how to give notice of a qualifying event, you can give notice by contacting the person or unit that handles your employer's employee benefits matters. If your plan is a multi-employer plan, notice can also be given to the joint board of trustees, and, if the plan is administered by an insurance company (or the benefits are provided through insurance), notice can be given to the insurance company.

COBRA Election Notice

When the plan receives a notice of a qualifying event, the plan must give the qualified beneficiaries an election notice, which describes their rights to continuation coverage and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event. The election notice should contain all of the information you will need to understand continuation coverage and make an informed decision whether or not to elect continuation
coverage. It should also give you the name of the plan's COBRA administrator and tell you how to get more information.

COBRA Notice of Unavailability of Continuation Coverage

Group health plans may sometimes deny a request for continuation coverage or for an extension of continuation coverage. If you or any member of your family requests continuation coverage or an extension of continuation coverage and the plan determines that you or your family member is not entitled to the requested coverage for any reason, the plan must give the person who requested it a notice of unavailability of continuation coverage. The notice must be provided within 14 days after the request is received, and the notice must explain the reason for denying the request.

COBRA Notice of Early Termination of Continuation Coverage

Continuation coverage must generally be made available for a maximum period (18, 29, or 36 months). The group health plan may terminate continuation coverage earlier, however, for any number of specific reasons. (See "Duration of Continuation Coverage" later in this booklet.) When a group health plan decides to terminate continuation coverage early for any of these reasons, the plan must give the qualified beneficiary a notice of early termination. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage.

Special Rules for Multi-employer Plans

Multi-employer plans are allowed to adopt some special rules for COBRA notices. First, a multi-employer plan may adopt its own uniform time limits for the qualifying event notice or the election notice. A multi-employer plan also may choose not to require employers to provide qualifying event notices, and instead to have the plan administrator determine when a qualifying event has occurred. Any special multi-employer plan rules must be set out in the plan's documents (and SPD).

Election Procedures

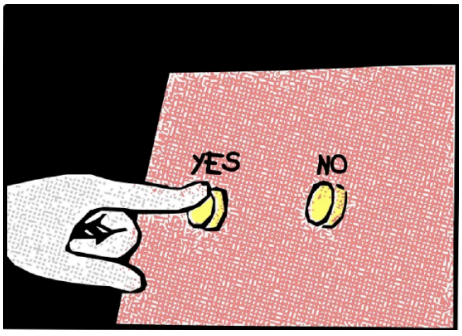


Image: Yes, No by RawPixels.com

If you are entitled to elect COBRA continuation coverage, you must be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

Each of the qualified beneficiaries for a qualifying event may independently elect continuation coverage. This means that if both you and your spouse are entitled to elect continuation coverage, you each may decide separately whether to do so. The covered employee or the spouse must be allowed, however, to elect on behalf of any dependent children or on behalf of all of the qualified beneficiaries. A parent or legal guardian may elect on behalf of a minor child.

If you waive continuation coverage during the election period, you must be permitted later to revoke your waiver of coverage and to elect continuation coverage as long as you do so during the election period. Under those circumstances, the plan need only provide continuation coverage beginning on the date you revoke the waiver.

Certain Trade Adjustment Assistance (TAA) Program participants have a second opportunity to elect COBRA continuation coverage. Individuals who are eligible and receive Trade Readjustment Allowances (TRA), individuals who would be eligible to receive TRA, but have not yet exhausted their unemployment insurance (UI) benefits, and individuals receiving benefits under Alternative Trade Adjustment Assistance (ATAA) or Reemployment Trade Adjustment Assistance (RTAA), and who did not elect COBRA during the general election period, may get a second election period. This additional, second election period is measured 60 days from the first day of the month in which an individual is determined eligible for the TAA benefits listed above and receives such benefit. For example, if an individual's general election period runs out and he or she is determined eligible for TRA (or would be eligible for TRA but have not exhausted UI benefits) or begin to receive ATAA or RTAA benefits 61 days after separating from
employment, at the beginning of the month, he or she would have approximately 60 more days to elect COBRA. However, if this same individual does not meet the eligibility criteria until the end of the month, the 60 days are still measured from the first of the month, in effect giving the individual about 30 days. Additionally, a COBRA election must be made not later than 6 months after the date of the TAA-related loss of coverage. COBRA coverage chosen during the second election period typically begins on the first
day of that period. More information about the Trade Act is available at doleta.gov/tradeact/.

Benefits under Continuation Coverage

If you elect continuation coverage, the coverage you are given must be identical to the coverage that is currently available under the plan to similarly situated active employees and their families (generally, this is the same coverage that you had immediately before the qualifying event). You will also be entitled, while receiving continuation coverage, to the same benefits, choices, and services that a similarly situated participant or beneficiary is currently receiving under the plan, such as the right during an open enrollment season to choose among available coverage options. You will also be subject to the same rules and limits that would apply to a similarly situated participant or beneficiary, such as co-payment requirements, deductibles, and coverage limits. The plan's rules for filing benefit claims and appealing any claims denials also apply.

Any changes made to the plan's terms that apply to similarly situated active employees and their families will also apply to qualified beneficiaries receiving COBRA continuation coverage. If a child is born to or adopted by a covered employee during a period of continuation coverage, the child is automatically considered to be a qualified beneficiary receiving continuation coverage. You should consult your plan for the rules that apply for adding your child to continuation coverage under those circumstances.

Duration of Continuation Coverage

Maximum Periods

COBRA requires that continuation coverage extend from the date of the qualifying event for a limited period of time of 18 or 36 months. The length of time for which continuation coverage must be made available (the "maximum period" of continuation coverage) depends on the type of qualifying event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

When the qualifying event is the covered employee's termination of employment or reduction in hours of employment, qualified beneficiaries are entitled to 18 months of continuation coverage.

When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for his/her spouse and children would last 28 months (36 months minus 8 months).

For all other qualifying events, qualified beneficiaries must be provided 36 months of continuation coverage.[1]

[1] Under COBRA, certain retirees and their family members who receive post-retirement health coverage from employers have special COBRA rights in the event that the employer is involved in bankruptcy proceedings begun on or after July 1, 1986. This booklet does not fully describe the COBRA rights of that group.

Early Termination

A group health plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis;
- The employer ceases to maintain any group health plan;
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. (See "Your COBRA Rights and Responsibilities" earlier in this booklet.)

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of the open enrollment period. (See "Alternatives to COBRA Continuation Coverage" earlier in this booklet.)

Extension of an 18-month Period of Continuation Coverage

If you are entitled to an 18-month maximum period of continuation coverage, you may become eligible for an extension of the maximum time period in two circumstances. The first is when a qualified beneficiary (either you or a family member) is disabled; the second is when a second qualifying event occurs.

Disability

If any one of the qualified beneficiaries in your family is disabled and meets certain requirements, all of the qualified beneficiaries receiving continuation coverage due to a single qualifying event are entitled to an 11-month extension of the maximum period of continuation coverage (for a total maximum period of 29 months of continuation coverage). The plan can charge qualified beneficiaries an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension. The requirements are, first, that the Social Security Administration (SSA) determines that the disabled qualified beneficiary is disabled before the 60th day of continuation coverage and, second, that the disability continues during the rest of the 18-month period of continuation coverage.

The disabled qualified beneficiary or another person on his or her behalf also must notify the plan of the SSA determination. The plan can set a time limit for providing this notice of disability, but the time limit cannot be shorter than 60 days, starting from the latest of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) the date on which the qualified beneficiary is informed, through the furnishing of the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

The right to the disability extension may be terminated if the SSA determines that the disabled qualified beneficiary is no longer disabled. The plan can require qualified beneficiaries receiving the disability extension to notify it if the SSA makes such a determination, although the plan must give the qualified beneficiaries at least 30 days after the SSA determination to do so.

The rules for how to give a disability notice and a notice of no longer being disabled should be described in the plan's SPD (and in the election notice if you are offered an 18-month maximum period of continuation coverage).

Second Qualifying Event

If you are receiving an 18-month maximum period of continuation coverage, you may become entitled to an 18-month extension (giving a total maximum period of 36 months of continuation coverage) if you experience a second qualifying event that is the death of a covered employee, the divorce or legal separation of a covered employee and spouse, a covered employee's becoming entitled to Medicare (in certain circumstances), or a loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused you to lose coverage under the plan in the absence of the first qualifying event. If a second qualifying event occurs, you will need to notify the plan.

The rules for how to give notice of a second qualifying event should be described in the plan's SPD (and in the election notice if you are offered an 18-month maximum period of continuation coverage). The plan can set a time limit for providing this notice, but the time limit cannot be shorter than 60 days from the latest of: (1) the date on which the qualifying event occurs; (2) the date on which you lose (or would lose) coverage under the plan as a result of the qualifying event; or (3) the date on which you are informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

Summary of Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. **Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.**

QUALIFYING EVENT

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF CONTINUATION COVERAGE
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 months[2]
Employee enrollment in Medicare	Spouse Dependent Child	36 months[3]
Divorce or legal separation	Spouse Dependent Child	36 months
Death of employee	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

[2] In certain circumstances, qualified beneficiaries entitled to 18 months of continuation coverage may become entitled to a disability extension of an additional 11 months (for a total maximum of 29 months) or an extension of an additional 18 months due to the occurrence of a second qualifying event (for a total maximum of 36 months). (See "Duration of Continuation Coverage" earlier in this booklet.)

[3] The actual period of continuation coverage may vary depending on factors such as whether the Medicare entitlement occurred prior to or after the end of the covered employee's employment or reduction in hours. For more information see "Duration of Continuation Coverage" earlier in this booklet or contact the Department of Labor's Employee Benefits Security Administration (EBSA) electronically at askebsa.dol.gov or by calling 1-866-444-3272.

Paying for Continuation Coverage

Your group health plan can require you to pay for COBRA continuation coverage. The amount charged to qualified beneficiaries cannot exceed 102 percent of the cost to the plan for similarly situated individuals covered under the plan who have not incurred a qualifying event. In determining COBRA premiums, the plan can include the costs paid by employees and the employer, plus an additional 2 percent for administrative costs.

For qualified beneficiaries receiving the 11-month disability extension, the COBRA premium for those additional months may be increased to 150 percent of the plan's total cost of coverage for similarly situated individuals.

COBRA charges to qualified beneficiaries may be increased if the cost to the plan increases but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to pay the required premiums on a monthly basis if you ask to do so, and the plan may allow you to make payments at other intervals (for example, weekly or quarterly). The election notice should contain all of the information you need to understand the COBRA premiums you will have to pay, when they are due, and the consequences of late payment or nonpayment.

When you elect continuation coverage, you cannot be required to send any payment with your election form. You can be required, however, to make an initial premium payment within 45 days after the date of your COBRA election (that is the date you mail in your election form, if you use first-class mail). Failure to make any payment within that period of time could cause you to lose all COBRA rights. The plan can set premium due dates for successive periods of coverage (after your initial payment), but it must give you the option to make monthly payments, and it must give you a 30-day grace period for payment of any premium.

You should be aware that if you do not pay a premium by the first day of a period of coverage, but pay the premium within the grace period for that period of coverage, the plan has the option to cancel your coverage until payment is received and then reinstate the coverage retroactively back to the beginning of the period of coverage. Failure to make payment in full before the end of a grace period could cause you to lose all COBRA rights.

If the amount of a payment made to the plan is incorrect, but is not significantly less than the amount due, the plan is required to notify you of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The plan is not obligated to send monthly premium notices.

Some employers may subsidize or pay the entire cost of health coverage, including COBRA coverage, for terminating employees and their families as part of a severance agreement. If you are receiving this type of severance benefit, talk to your plan administrator about how this impacts your COBRA coverage or your special enrollment rights.

Health Coverage Tax Credit

Certain individuals may be eligible for a refundable Federal income tax credit that can help with qualified monthly premium payments. The Health Coverage Tax Credit (HCTC), while available, may be used to pay for specified types of health insurance coverage (including COBRA continuation coverage).

Those potentially eligible for the HCTC include workers who lose their jobs due to the negative effects of global trade and who are eligible to receive certain benefits under the Trade Adjustment Assistance (TAA) Program, as well as certain individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). The HCTC pays 72.5 percent of qualified health insurance premiums, with individuals paying 27.5 percent. For more information on TAA, visit doleta.gov/tradeact/.

Individuals who are eligible for the HCTC may claim the tax credit on their income tax returns at the end of the year. The tax credit also may be available as an advance monthly payment beginning in 2017. Qualified family members of eligible TAA recipients or PBGC payees who enroll in Medicare, pass away, or finalize a divorce, are eligible to receive the HCTC for up to 24 months from the month of the event.

Individuals with questions about the Health Coverage Tax Credit should visit IRS.gov/HCTC.

Coordination with Other Federal Benefit Laws

The Family and Medical Leave Act (FMLA) requires an employer to maintain coverage under any “group health plan” for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Group health coverage that is provided under the FMLA during a family or medical leave is NOT COBRA continuation coverage, and taking FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer’s
obligation to maintain health benefits under FMLA ceases, such as when an employee taking FMLA leave decides not to return to work and notifies an employer of his or her intent not to return to work.

The Affordable Care Act (ACA) provides additional protections for coverage under employment-based
group health plans, including COBRA continuation coverage. These include:
• Extending dependent child coverage to age 26;
• Prohibiting limits or exclusions from coverage for preexisting conditions;
• Banning lifetime or annual dollar limits on coverage for essential health benefits; and
• Requiring group health plans and insurers to provide an easy-to-understand summary of a health plan’s benefits and coverage.

Additional protections that may apply to your employer’s plan include coverage for:
• Certain preventive services (such as blood pressure, diabetes and cholesterol tests, regular well-baby and well- child visits, routine vaccinations and many cancer screenings) without cost sharing, and
• Emergency services in an emergency department of a hospital outside your plan’s network without prior approval from your health plan.

Medicare is the Federal health insurance program for people who are 65 or older and certain younger people with disabilities or End-Stage Renal Disease. If you are enrolled in Medicare as well as COBRA continuation coverage, there may be special coordination of benefits rules that determine which coverage is the primary payer of benefits. Check your Summary Plan Description to see if special rules apply or ask your plan administrator.

Role of the Federal Government

COBRA continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private-sector group health plans. The Department of Health and Human Services administers the continuation coverage law as it applies to state and local government health plans.

The Labor Department's interpretive responsibility for COBRA is limited to the disclosure and notification requirements of COBRA. The Labor Department has issued regulations on the COBRA notice provisions. The Treasury Department has interpretive responsibility to define the required continuation coverage. The Internal Revenue Service, Department of the Treasury, has issued regulations on COBRA provisions relating to eligibility, coverage, and payment. The Departments of Labor and the Treasury share jurisdiction for enforcement of these provisions.

Resources

If you need further information about COBRA, ACA, HIPAA, or ERISA, visit the Employee Benefits Security Administration's (EBSA's) Website at dol.gov/agencies/ebsa. Or you may contact EBSA electronically at askebsa.dol.gov or call toll free 1-866-444-3272.

The Centers for Medicare and Medicaid Services offer information about COBRA provisions for public-sector employees.

To find out more, visit cms.gov or contact the agency via email or by calling toll free at 1-877-267-2323, option #4, ext. 61565.

Federal employees are covered by a Federal law similar to COBRA. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

To find out more about enrolling in the Health Insurance Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit HealthCare.gov.

Further information on FMLA is available on the Website of the U.S. Department of Labor's Wage and Hour Division at dol.gov/whd or by calling toll-free 1-866-487-9243.

For more information on Medicare, visit Medicare.gov or call 1-800-MEDICARE.

For information on the Trade Adjustment Assistance (TAA) Program, visit doleta.gov/tradeact/.

For information about the Health Coverage Tax Credit (HCTC), visit IRS.gov/HCTC.

AN EMPLOYEE'S GUIDE TO HEALTH BENEFITS UNDER COBRA 13

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR
September 2016

A printable copy of this is attached below.

Source: "COBRA Continuation Coverage ." Employee Benefits Security Administration. U.S. Department of Labor.

2.5: REVIEW- FAQ's about HIPAA

Image: HIPPA Administrative Simplification. AMA.org

FAQs: HIPAA Portability and Nondiscrimination Requirements for Workers

U.S. Department of Labor Employee Benefits Security Administration

Q. What is the Health Insurance Portability and Accountability Act (HIPAA)?

HIPAA offers protections for workers and their families. The law provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events. HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information.

Taking Advantage of Special Enrollment Opportunities

Q. What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Q. What are some examples of events that can trigger a loss of eligibility for coverage?

Loss of eligibility for coverage may occur when:

- Divorce or legal separation results in you losing coverage under your spouse's health insurance;
- A dependent is no longer considered a "covered" dependent under a parent's plan;
- Your spouse's death leaves you without coverage under his or her plan;
- Your spouse's employment ends, as does coverage under his employer's health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the health plan;
- Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);
- You no longer live or work in the HMO's service area.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

Q. How long do I have to request special enrollment?

It depends on what triggers your right to special enrollment. The employee or dependent must request enrollment within 30 days after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment within 60 days of the loss of coverage under a state CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

Q. After I request special enrollment, how long will I wait for coverage?

It depends on what triggers your right to special enrollment. Those taking advantage of special enrollment as a result of a birth, adoption, or placement for adoption begin coverage no later than the day of the event.

For special enrollment due to marriage or loss of eligibility for other coverage, your new coverage will begin on the first day of the first month after the plan receives the enrollment request. If the plan receives the request on January 3, for example, coverage would begin on February 1.

Q. What coverage will I get when I take advantage of a special enrollment opportunity?

Special enrollees must be offered the same benefits that would be available if you are enrolling for the first time. Special enrollees cannot be required to pay more for the same coverage than other individuals who enrolled when first eligible for the plan. 3

Q. Can my new group health plan deny me benefits because I have a preexisting condition?

While HIPAA previously provided limits on preexisting condition exclusions, new protections under the Affordable Care Act (ACA) prohibit group health plans from imposing any preexisting condition exclusion. Under this protection, a plan generally cannot limit or deny benefits relating to a health condition that was present before your enrollment date in the plan.

Q. Where do I find out more about special enrollment in my plan?

A description of special enrollment rights should be included in the plan materials you received when initially offered the opportunity to enroll.

Q. How will I know if I am eligible for assistance with group health plan premiums under CHIP or Medicaid?

You need to contact your state's CHIP or Medicaid program to see if your state will subsidize group health plan premiums and to determine if you are eligible for the subsidy under these programs. For information on the program in your state, call 1-877-KIDSNOW (543-7669) or visit InsureKidsNow.gov on the Web. If you are eligible for this premium assistance, you need to contact your plan administrator or employer to take advantage of the special enrollment opportunity and enroll in the group health plan.

HIPAA's Protections from Discrimination

Image: Privacy Compliance. Glorium Technolgies Blog. 2023

Q. What are HIPAA's protections from discrimination?

Under HIPAA, you and your family members cannot be denied eligibility or benefits based on certain "health factors" when enrolling in a health plan. In addition, you may not be charged more than similarly situated individuals based on any health factors. The questions and answers below define the health factors and offer some examples of what is and is not permitted under the law.

Q. What are the health factors under HIPAA?

The health factors are:

- Health status;
- Medical conditions, including physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability (see below);
- Disability.

Conditions arising from acts of domestic violence as well as participation in activities like motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, and skiing are 4 considered "evidence of insurability." Therefore, a plan cannot use them to deny you enrollment or charge you more for coverage. (However, benefit exclusions known as "source of injury exclusions" could affect your benefits. These exclusions are discussed in more detail below.)

Q. Can a group health plan require me to pass a physical examination before I am eligible to enroll?

No. You do not have to pass a physical exam to be eligible for enrollment. This is true for individuals who enroll when first eligible, as well as for late and special enrollees.

Q. Can my plan require me to fill out a health care questionnaire in order to enroll?

Yes, as long as the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

Q. My group health plan required me to complete a detailed health history questionnaire and then subtracted "health points" for prior or current health conditions. To enroll in the plan, an employee had to score 70 out of 100 total points. I scored only 50 and was denied a chance to enroll. Can the plan do this?

No. In this case the plan used health information to exclude you from enrolling in the plan. This practice is discriminatory, and it is prohibited.

Q. My group health plan booklet states that if a dependent is confined to a hospital or other medical facility at the time he is eligible to enroll in the plan, that person's eligibility is postponed until he is discharged. Is this permitted?

No. A group health plan may not delay an individual's eligibility, benefits, or effective date of coverage based on confinement to a hospital or medical facility at the time he becomes eligible. Additionally, a health plan may not increase that person's premium because he was in a hospital or medical facility.

Q. My group health plan has a 90-day waiting period before allowing employees to enroll. If an individual is in the office on the 91st day, health coverage begins then. However, if an individual is not "actively at work" on that day, the plan states that coverage is delayed until the first day that person is actually at work. I missed work on the 91st day due to illness. Can I be excluded from coverage?

No. A group health plan generally may not deny benefits because someone is not "actively at work" on the day he would otherwise become eligible. However, a plan may require employees to begin work before health plan coverage is effective. A plan may also require an individual to work full time (say, 250 hours per quarter or 30 hours per week) in order to be eligible for coverage.

Q. Can my group health plan exclude or limit benefits for certain conditions or treatments?

Group health plans can exclude coverage for a specific disease or limit or exclude benefits for certain treatments or drugs, but only if the restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.).

However, compliance with this rule under HIPAA does not affect whether the plan provision or practice is permitted under other laws including the ACA such as the requirement to offer essential health benefits in the individual and small group markets.

Q. How do you determine "similarly situated individuals"?

HIPAA states that plans may distinguish among employees only on "bona fide employmentbased classifications" consistent with the employer's usual business practice. For example, part time and full time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as different groups of similarly situated individuals.

A plan may draw a distinction between employees and their dependents. Plans can also make distinctions between beneficiaries themselves if the distinction is not based on a health factor. For example, a plan can distinguish between spouses and dependent children, or between dependent children age 26 and older based on their age or student status.

Q. I have a history of high claims. Can I be charged more than others in the plan based on my claims experience?

No. Group health plans cannot charge an individual more for coverage than a similarly situated individual based on any health factor.

However, be aware that HIPAA does allow an insurer to charge one group health plan (or employer) a higher rate than it does another. When an insurance company establishes its rates, it may underwrite all covered individuals in a specific plan based on their collective health status. The result can be that one employer health plan whose enrollees have more adverse health factors can be charged a higher premium than another for the same amount of coverage. Note that compliance with this rule under HIPAA does not affect whether the practice is permitted under the ACA including the rating requirements in the small group market.

Think of it this way: HIPAA's protections from discrimination apply within a group of similarly situated individuals, not across different groups of similarly situated individuals. For example, an employer distinguishes between full-time and part-time employees. It can charge part-time employees more for coverage, but all full-time employees must pay the same rate, regardless of health status.

Also, for insured plans, state law may govern rates for health coverage. More information is available at NAIC.org.

Q. I am an avid skier. Can my employer's plan exclude me from enrollment because I ski?

No. Participation in activities such as skiing would be "evidence of insurability," which is a health factor. Therefore, it cannot be used to deny eligibility.

Q. Can my health plan deny benefits for an injury based on how I got it?

It depends. A plan can deny benefits based on an injury's source, unless an injury is the result of a medical condition or an act of domestic violence.

Therefore, a plan cannot exclude coverage for self-inflicted wounds, including those resulting from attempted suicide, if they are otherwise covered by the plan and result from a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or from domestic violence. For example, a plan generally can exclude coverage for injuries in connection with an activity like bungee jumping. While the bungee jumper may have to pay for treatment for those injuries, her plan cannot exclude her from coverage for the plan's other benefits.

Q. My group health plan says that dependents are generally eligible for coverage only until they reach age 26. However, this age restriction does not apply to disabled dependents, who seem to be covered past age 26. Does HIPAA permit a policy favoring disabled dependents?

Yes. A plan can treat an individual with an adverse health factor (such as a disability) more favorably by offering extended coverage.

Q. Are all family members, including a spouse, covered by HIPAA?

If your group health plan permits coverage of family members ("dependents"), and if they participate in the plan, then they will have the same HIPAA protections as employees.

Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) expands the HIPAA nondiscrimination provisions discussed above by generally prohibiting the use of genetic information to adjust group premiums or contributions, the collection of genetic information and requests for individuals to undergo genetic testing.

HIPAA and Wellness Programs

Image: Doctor. AI-generated by Arfas_STD via Freepik.com

Q. I've learned that my health plan will include a wellness program next year. What is a wellness program?

Wellness programs encourage employees to work out, stop smoking or generally adopt healthier lifestyles by offering some type of financial or other incentive. If a wellness program is part of a group health plan, it must comply with rules created by HIPAA and the ACA that prevent the employee from being impermissibly discriminated against based on a health factor.

There are two types of wellness programs - participatory and health-contingent. A participatory wellness program is one that offers a reward simply for participating in the program. For example, the program reimburses employees for all or part of the cost for membership in a fitness center. Participatory wellness programs are allowed under the nondiscrimination rules as long as they are available to all similarly situated individuals.

A health-contingent wellness program is one that rewards an employee for satisfying a standard related to a health factor. If the standard is an activity-only one, you need to perform or complete an activity, like walking or other exercise, to get the reward. If the standard is outcome-based, you must achieve a specific health outcome, like a certain result on a health screening, to get the reward. Health-contingent wellness programs must meet certain requirements.

Q. I belong to a group health plan that rewards individuals who volunteer to be tested for early detection of health problems, such as high cholesterol. Can a plan do this?

Yes, as long as the program is available to all similarly situated individuals. If the health plan offers a reward based on participation in the program and not on test results, the program is considered a participatory wellness program and the plan does not have to comply with the additional requirements applicable to health-contingent wellness programs. For instance, a health plan can offer a premium discount for those who voluntarily test for cholesterol, as long as the discount is available to everyone who takes the test and not just those who get a certain result. If the discount was based on individuals having certain results, additional requirements discussed below would apply.

Q. My plan's wellness program offers a lower deductible to those who participate in a specific walking program. How can I tell if this is permissible?

Because the reward (the lower deductible) is available to all who participate in a walking program, this is an activity-only health-contingent program. The program will be permissible if:

- Individuals have a chance to qualify for the reward at least once per year;
- The total reward for all of the plan's health-contingent wellness programs is not more than 30% of the cost of employee-only coverage in the plan. If dependents can participate, the reward cannot be more than 30% of the cost of the coverage in which an employee and dependents are enrolled. For wellness programs designed to prevent or 8 reduce tobacco use the allowable percentage is higher – the reward for those programs cannot be more than 50% of the cost of coverage;
- The walking program is reasonably designed to promote health or prevent disease;
- A reasonable alternative standard (or a waiver of the walking requirement) is offered to those for whom it is unreasonably difficult because of a medical condition, or medically inadvisable, to participate in the walking program; and
- The plan discloses the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program.

Q. I would like to participate in my plan's wellness program. Under the program, to get a discount on my premiums, my body mass index (BMI) must be 26 or lower. Is there any way for me to get the premium discount if my BMI is higher than 26?

Yes. The reward is provided to those who achieve a specific health outcome (BMI of 26 or lower), so this is an outcome-based health-contingent wellness program. If your BMI is above 26, the plan must provide you with a reasonable alternative standard to qualify for the reward. The reasonable alternative standard could be activity-based such as completion of an educational program, participation in a diet program, or following the recommendations of your personal physician; it could also be another outcome-based standard, such as a one-point reduction in your BMI over a set period of time. If it is unreasonably difficult because of a medical condition, or medically inadvisable, for you to complete the alternative, the plan must work with you to find a second alternative based on your physician's recommendations.

In addition, as with an activity-only program, you must be given the chance to qualify for the reward at least once per year; the total reward for the plan's health-contingent wellness programs cannot be more than 30% (or 50% for tobacco-related programs) of the cost of employee-only coverage (or the cost of the coverage enrolled in if dependents can participate); and the plan must disclose the availability of a reasonable alternative standard (or the possibility of a waiver) in all materials describing the terms of the program. This notice must also be included in any disclosure that you did not satisfy the initial standard.

Q. Can a plan charge a lower premium for nonsmokers than it does for smokers?

The plan is offering a reward based on an individual's ability to stop smoking so this is an outcome-based program. For this type of wellness program to be permissible:

- Individuals must have a chance to qualify for the nonsmoker's discount at least once a year;
- The difference in premiums between nonsmokers and smokers cannot be more than 50% of the cost of employee-only coverage (or 50% of the cost of coverage if dependents can participate);
- The program must be reasonably designed to promote health and prevent disease;
- There is a reasonable alternative standard to those who do not meet the otherwise applicable standard. For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and
- Plan materials describing the premium discount (and any disclosure that an individual did not satisfy the standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

Coordination with Other Laws

Image: Personal Data. Glorium Technolgies Blog. 2023

Q. Can states modify HIPAA's requirements?

State laws may complement HIPAA by allowing more protections than the Federal law. For example, states may increase the number of days parents have to enroll newborns, adopted children, and children placed for adoption or require additional circumstances that entitle you to special enrollment periods beyond those in the Federal law. However, these state laws only apply if your plan provides benefits through an insurance company or HMO (an insured plan). To determine if your plan offers insured coverage, consult your Summary Plan Description (SPD) or contact your plan administrator. You also can visit your state insurance commissioner's office or the National Association of Insurance Commissioners' Website (select your state) for more information.

Q. How can I use HIPAA in conjunction with COBRA to extend my health coverage?

COBRA is a law that can help if you lose your job or if your hours are reduced to the point where the employer no longer provides you with health coverage. COBRA can provide a temporary extension of your health coverage – as long as you and your family members, if eligible, belonged to the previous employer's health plan and generally the employer had 20 or more employees.

Usually, you pay the entire cost of coverage (both your share and the employer's, plus a 2 percent administrative fee). As long as the prior plan exists, COBRA coverage lasts up to 18 months for most people, although it can continue as long as 36 months in some cases.

If you enroll in COBRA, HIPAA provides you with the opportunity to request special enrollment in a different group health plan if you have a special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA, you must receive the maximum period of continuation coverage available (usually 18 months for job loss) without early termination. If you choose to terminate your COBRA early, or fail to pay your COBRA premiums, you generally will not be entitled to special enroll in other group health coverage.

Q. Do I have other special enrollment rights?

In addition to the special enrollment rights in a group health plan under HIPAA (described above), there are also special enrollment rights under the ACA for individual coverage including through the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance and other options (such as Medicare and CHIP coverage). Losing your job-based coverage, marriage, birth, and adoption are a few of the special enrollment events that may allow you to purchase Marketplace or other coverage outside of the regular enrollment period.

To qualify for special enrollment, you must select a plan either within 60 days before losing your job-based coverage or within 60 days after losing your job-based coverage.

You can apply for Marketplace coverage online or get more information at HealthCare.gov or by calling 1-800-318-2596 (TTY users should call 1-855-889-4325). When you fill out a 10 Marketplace application, you also can find out if you and your family qualify for free or lowcost coverage from Medicaid and/or the Children's Health Insurance Program (CHIP).

Q. Where can I get more information on my rights under HIPAA?

The Employee Benefits Security Administration offers more information on HIPAA and other laws mentioned above. Visit the Employee Benefits Security Administration's Website to view the following publications. To order copies or to request assistance from a benefits advisor, contact EBSA electronically or call toll free 1-866-444-3272.

Source: "FAQs on HIPPA" Employee Benefits Security Administration. U.S. Department of Labor HIPP

NOTE: A printable copy of HIPPA Facts is attached below.

2.6: READ- How HR Can Help Employees Use Their FSA Funds

Image: How to Spend Your Leftover FSA Money by Michela Buttignol. Investopedia.com

How HR Can Help Employees Use Their FSA Funds

With the end of the year quickly approaching, HR and benefits leaders have yet one more task to add on to their busy end-of-year checklist: reminding employees about approaching deadlines to use up remaining cash in their health care flexible spending accounts (FSAs).

The popular employer-sponsored benefit allows employees to set aside a portion of their pre-tax earnings—up to $3,050 in 2023—to pay for qualifying out-of-pocket health care expenses. But FSAs come with a caveat: They have a use-it-or-lose-it clause, meaning that any account balances left at the end of the year are usually forfeited, often to the employer, by Dec. 31.

Some employers, however, offer a grace period that allows employees extra time in the new year to use the prior year's FSA funds (the IRS allows employers to permit a grace period of up to two and a half months)or allow employees to carry over a limited amount into the next year. The 2023 FSA carryover limit is $610.

"Employers have a vested interest in making sure that their employees understand the benefits they have available to them and are using them," said Sara Taylor, senior director of employee savings accounts at consulting firm WTW. "It's part of their overall total rewards strategy. FSAs, in particular, have a really unique focus because of the use-it-or-lose-it rule, so employers should, especially now, highlight to employees how their plan works—telling those who haven't already used their funds for the year to use them, explain how their specific plan works. They also need to tell them whether they have a grace period or rollover provision, and generally just make sure employees can truly take advantage of their account."

Employees who don't use their funds are missing the opportunity to leverage their benefits, she said.

It's not a small loss, either: According to figures from the Employee Benefit Research Institute, roughly 40 percent of workers forfeited at least part of their FSA contributions in the past few years, with the average loss ranging between $339 and $408 annually.

Employees often forget to use their funds or confuse their accounts with health savings accounts, which do not have the same use-it-or-lose-it rule.

Given how widespread the issue is, it's even more important for employers to encourage employees to spend their FSA dollars, said Michael Dinich, personal finance expert and founder of Wealth of Geeks, a financial blog.

"It's vital that employees are reminded to use their remaining FSA dollars well in advance of the expiry date,as many will likely have put off claiming expenses in order to burn through their remaining balance, and perhaps even held off on seeing a doctor or topping up their essential medication so that they can use their funds in the event of a medical emergency."

Time to Ramp Up Communications

So how should employers share end-of-year news about FSAs? And what should they say?

One of the best ways to remind employees is to send multiple emails during the remainder of the year, Dinich said, adding that if company leaders simply raise the issue in a company meeting, anyone who is on leave or out sick won't get that reminder.

"Make sure to reiterate any terms and conditions within that email and advise on checking which expenses are eligible, so that employees can refer back to this when making claims before the end of the year," he said. "Also ensure that it's clear when the expiry date is, as some plans are tied to specific dates rather than defaulting to the end of the year."

Taylor added that HR leaders can conduct broad messaging to the entire workforce—through mediums like emails, home mailings or company intranet announcements—reminding them about looming FSA deadlines and general FSA information. They can also tailor messages specifically to employees with FSAs or tell them exactly how much money they have left in their accounts.

"There is some benefit to both broad and personalized messaging," she said. "You can say, 'Hey, did you know that you have this much in your account still?' Employers can always work with their administrator to create that type of communication, which makes it a little more relevant for the employee."
HR and benefits leaders might also offer suggestions on what employees could use the funds on, Taylor said. This can range from traditional items such as dental and eye care, like eyeglasses or contact lenses,and over-the-counter medications, to more surprising items, like thermometers, bandages, first aid kits,pregnancy tests or menstrual products.

"It's a really good idea to offer employees creative ideas on what they can use [their FSA money] on," she said. "Employees can also stock up on some of their items for their families, as well."

Additionally, employers that do allow employees a grace period to use their FSA funds or rollover provision will need to make sure that information is communicated.

The important thing, Taylor said, is to send multiple messages to employees, and ensure they understand the approaching deadlines.

This shouldn't be just a one-and-done situation," she said. "Take the opportunity to do at least two or three messages before the end of the year—or beginning of the year, if you have the grace period—and make an effort to think about what kind of messages your employees need."

Source: Mayer, Katherine. "How HR Can Help Employees Use Their FSA Funds." Society for Human Resource Management (SHRM), December 6, 2023.

2.7: Group Health Insurance - An Overview, Indemnity Health Plans, Managed-Care Plans, and Other Health Plans

Learning Objectives

In this section we elaborate on the following topics regarding group health insurance plans:

- Changes with respect to employer-sponsored health coverage over time
- Indemnity health insurance plans—traditional fee-for-service plans: features, coordination of benefits, and cost containment initiatives
- The transition to managed care: indemnity plans with networks, HMOs, PPOs, POSs, HSAs, and HRAs

Group Health Insurance: An Overview

Today, health insurance is very different from what it was two or three decades ago. Most of us do not pay providers of health care directly and submit an insurance form for reimbursement. In addition, most of us do not have complete freedom in choosing our physicians but must select from a list of in-network providers. The days of seeing any doctor and being reimbursed for any procedure the doctor orders are gone. We live in an era of receiving health care under managed care: controlled access to doctors, procedures, and medicines. While limited access is the disadvantage of the managed-care systems, there are many advantages. The most important is cost containment through efficiency. Another advantage is that most patients no longer have to deal with paperwork. Insureds simply make a copayment to the health care provider, and the remaining reimbursements are done behind the scenes. Additional advantages include preventive care and higher standards for quality care.

Costs are no longer controlled because the underlying issues that created medical cost inflation never disappeared. The main underlying factors are medical technology development, medical malpractice lawsuits, drug and medication development, the aging population, and the fact that a third party pays for the cost of obtaining medical services. People made the transition from the open choice of indemnity plans into the more controlled managed-care plans such as PPOs, point of service (POS) plans, and the various types of HMOs, but medical technology improvements, introduction of new medications, aging of the population, and medical malpractice continued in full swing. The cost-control factors of managed care that eased medical cost inflation during the transition period are not as effective as they once were. Once most of the U.S. population enrolled in managed-care plans, the cost saving factors no longer surpassed medical cost inflation factors. The situation in the health market is discussed in the box “What Is the Tradeoff between Health Care Costs and Benefits?”

The old managed-care plans are no longer viable and new ideas have emerged to supplement them. While the old systems are considered defined benefit health programs, the new ideas call for defined contribution health plans in which the consumer/employee receives a certain amount of money from the employer and then selects the desired health care components. Rather than employers negotiating with insurers or managed-care organizations for the group health plans, consumers are encouraged to negotiate directly with providers because these new plans are considered consumer-driven health plans. In some form, these are the HSAs and the HRAs.

Table 22.1 Not all types of plans are included in the table. Exclusive physician organization (EPO) is another plan that does not permit access to providers outside the network. Also, HRA is not featured here. describes the managed health care plans prevalent in the marketplace today. Note, however, that the various health plans are no longer as distinct from one another as they appear in the table. Since these plans were introduced, changes in health care regulations, coupled with new laws concerned with patients’ rights, have eliminated some of the differences among the plans and they now overlap greatly. (For example, it is no longer true that HMOs are necessarily cheaper than PPOs and HMOs with open access.) Figure 2.7.1 provides the five most prevalent health insurance plans on a continuum of choice and cost. There are other health care plans, such as exclusive physician organizations (EPOs), where doctors have created their own networks in response to the competitive environment, specifically, hospital chains, medical centers, and insurance companies acquiring group practices. These networks do not provide access to out-of-network providers.

Table 22.1 Spectrum of Health Plans

	Indemnity	Indemnity with Network	PPO	POS	health savings accounts	HMO

	Indemnity	Indemnity with Network	PPO	POS	health savings accounts	HMO
Choice Level	Highest					Lowest
Cost Level	Highest					Lowest
Main Characteristics	Comprehensive medical coverage with deductibles and coinsurance. Open access to providers.	Comprehensive medical coverage with deductibles and coinsurance. Access to providers in large networks and outside the network (with penalty).	Comprehensive medical coverage with deductibles, copayments, and coinsurance. Access to providers in networks and outside the network (with penalty).	Comprehensive medical coverage with deductibles, copayments, and coinsurance. Access to providers in networks and outside the network (with penalty). A gatekeeper.	Any type of health plan with a high deductible of at least $1,050 for a single individual and $2,100 for a family (in 2006). Rollover savings account with maximum of $2,700 for a single individual or $5,450 for a family—or up to the amount of the deductible (2006). Employer and employee contributions.	Comprehensive medical coverage with low copayments. Access to providers only in networks (except for emergencies). A gatekeeper.
Access to Providers	Access to any provider—no restriction.	Access to any provider in a large network and outside the network (with penalty).	Access to any provider in a large network and outside the network (with penalty).	Same as PPO, but required to see primary care physician (PCP) first. Referral from PCP to see a specialist. (PPO+PCP)	Depending on the underlying health plan	Staff model: facility only. Other models: in networks only, with PCP as a gatekeeper.
Methods of Reimbursing the Providers	Fee-for-service: patient pays total fee directly to the doctor for service rendered.	Fee-for-service, subject to usual, customary, and reasonable (UCR) limits.	Discounted fee-for-service.	PCPs by capitation; specialists by discounted FFS.	Depending on the underlying health plan after the high deductible.	Staff model: salaries. Other models: capitations. Individual practice association: capitation for PCP, discounted FFS for specialists.

	Indemnity	Indemnity with Network	PPO	POS	health savings accounts	HMO
What Is Required of the Patient?	Patient files claim forms; insurer reimburses coinsurance after the deductible, up to a maximum.	Same as indemnity, but reimbursement is only for UCR.	CopaymentsCopayments can run from $10 for PCP to $35+ for specialists. Each plan is negotiated, so copayments may differ. See examples later in this chapter. in networks; out of networks are similar to indemnity with penalties, up to a maximum.	Same as PPO.	Encourage participants to make more informed, cost-conscious decisions about their health care. Patient has to open a savings account, pay deductible and other coinsurance, and copays up to a maximum.	Copayment only; traditionally, no out-of-network reimbursement except for emergency care.

	Indemnity	Indemnity with Network	PPO	POS	health savings accounts	HMO
The Benefits—Levels of Preventive Care All plans are required to provide preventive care such as mammography screenings and Pap tests.	Comprehensive medical package with minimal preventive care.	Comprehensive medical package with minimal preventive care.	Same as indemnity, with increased preventive care and well baby care.	Same as PPO.	Preventive care required by law is covered, as in other comprehensive plans (deductible does not apply).	Same as PPO with most preventive care, well-being, baby, physical exams, immunizations, extended dental, vision, and prescription plans.The distinction among the managed care plans—PPOs, POSs, and HMOs—has become more fuzzy in recent years because HMOs are required to provide emergency benefits outside the network and more choice. HMOs have begun unbundling the preventive care services and charge additional premiums for more benefits such as vision and dental care.
Prevalence	Lowest	Low	High	high	Growing (newest)	

Figure 2.7.1: Continuum of Health Plans

The student who is new to this topic might best comprehend the changes of the past three decades by first learning about the profiles of HMOs and the indemnity plans of the late 1970s and early 1980s. These two types of plans were truly far apart. Patients had unlimited provider choice in the indemnity plans and the least choice in the HMOs. The HMOs supplied a person's medical needs for about $5 a visit. The subscriber to the staff model HMO would visit a clinic-like facility and see a doctor who was paid a salary. Baby, eye, and dental care were included. A new baby would cost a family very little. On the other side of the spectrum, the subscribers of the indemnity plans could see any provider, pay for the services, and later apply for reimbursement. The premiums for HMOs were substantially lower than those for the indemnity plan. In most cases, the employer paid the full premium for an HMO and asked the employee to supplement the higher cost of the indemnity plan.

Of these two extremes, who would select the HMO and who would select the indemnity plan? You answered correctly if you said that young and healthy employees most likely selected the HMOs. It turned out that there was adverse selection against the indemnity plans, which saw the more mature and less healthy employees. The managers of the indemnity plans began looking at the other extreme of the continuum for help in reducing costs. This is how managed care in traditional indemnity plans began. First, there were indemnity plans with large networks limiting access to providers and reimbursing only for **usual, customary, and reasonable (UCR)** costs for that area based on studies of the appropriate cost for each medical procedure. But this was only the first step. The low copayment (copay) that HMOs asked was very desirable. The newly formed **preferred provider organizations (PPOs)** adopted the copay method and used managed-care organizations to negotiate with doctors and all providers for large discounts, with some more than 50 percent off the usual, customary, and reasonable charges. The next step was to bring the gatekeeper, the primary care physician (which the HMOs used in most of their models and is discussed later in this chapter), into the structure of the PPO. When a gatekeeper was introduced, the new plan was called a **point of service (POS)** plan. This new plan is the PPO plus a gatekeeper, or the individual practice association (IPA) HMO model discussed later in the chapter.

The HMOs include various models: the model of one facility with doctors on staff (the staff model), the group model, the network model of doctors, and the **individual practice association (IPA)** of many doctors in one practice. The doctors in an IPA could see HMO and non-HMO patients. In many cases, the POS and IPA are very similar from the point of view of the patients, except that when the POS is based on a preferred provider organization rather than an HMO, there is more access to out-of-network providers (but with penalties). These days, many IPAs allow some out-of-network access as well, especially in cases of emergencies. In both the PPO and IPA-based networks with a gatekeeper (POS), the provider specialists receive discounted fees for service, while the gatekeepers (primary care physicians) receive **capitation** (a set amount paid to each provider based on the number of subscribers in the plan). These are the areas where the distinctions among the plans become fuzzy. HMOs were forced to give more choices and services. Their subscribers, originally young, healthy employees, had become aging baby boomers who needed more quality care. Many states have passed bills requiring HMOs to loosen many of their restrictions. With all these changes came a price. HMOs became more expensive; with the best practices widely emulated, the offerings of all plans converged. The pendulum of choice versus cost has probably moved to be somewhere in the middle of the continuum shown in Figure 2.7.1. For learning purposes, this chapter will regard HMOs as the plans with minimal access to out-of-network providers. A comparison of the actual benefits under the various plans is available in the employee benefits portfolio in Case 2 of "23: Cases in Holistic Risk Management".

What Is the Tradeoff between Health Care Costs and Benefits?

Health care coverage costs are growing at a faster pace than almost any other segment of the economy. One of the nation's largest benefits purchasing groups, the California Public Employee Retirement Systems, saw its PPO rates rise 20 percent and its HMO plans increase 26 percent. Many other employers saw similar increases. To balance their books, employers have to either pass these additional costs along to employees, find ways to cut benefits or transition into health savings accounts (HSAs).

HMOs were once seen as the saviors of the health insurance system. Offering lower costs, they often attracted younger, healthy workers. But now, as their costs are rising, even HMOs no longer look like good deals. Many of the benefits they once offered are being cut. For many older individuals, or those with greater health needs, HMOs do not provide the level of care and flexibility they desire. The PPOs they prefer, however, are becoming more and more expensive. And even with PPOs, benefits such as low copayments for drugs are now being reduced. With the creation of HSAs, it appears that the satisfaction level is lower than that of comprehensive health coverage. A survey conducted by the Employee Benefit Research Institute (EBRI) and discussed in its December 2005 conference revealed that patients who are using the consumer-driven health plans and high-deductible health plans, in the form of HSAs and HRAs, said that they (1) were less satisfied, (2) delayed seeing a health care provider, and (3) behaved in a more cost-conscious way.

At the same time, doctors are also feeling the pinch. Pressured by insurance companies to cut costs, they are forced to see more patients in less time, which can lead to medical mistakes. Insurance companies are also questioning expensive tests and medical procedures and refusing to pay doctors the full amount submitted. Soaring medical malpractice costs are causing some doctors to leave the profession. President George W. Bush called for tort reform to alleviate this problem during his State of the Union address on January 31, 2006.

In the United States, those individuals who have insurance, primarily through their employers, are the lucky ones. Some 47 million Americans have no insurance at all. Those who earn too much to qualify for Medicaid but not enough to purchase private health insurance often find themselves paying huge out-of-pocket bills. Often, uninsured patients neglect treatment until their condition becomes an emergency. When they cannot pay, hospitals and doctors pick up the cost, and they make up for it by increasing prices elsewhere, which contributes to escalating health care costs.

Is rationing health care the answer? Canada and many European countries have adopted systems of universal coverage, but such coverage comes with a price. Benefits, while universal, may be lower. It may be difficult to see specialists, especially about nonemergency conditions. Long waiting times are not uncommon. A universal health care system proposed during the first Clinton administration never got off the ground. Legislation aimed at giving patients a greater voice in determining what procedures health insurers would cover under a patients' bill of rights did not materialize. However, the advent of HSAs is an attempt to allow patients to carefully choose their own coverage and allocate the appropriate costs.

In addition to the defined contribution health plans, some employers are looking to cut costs through disease management programs. With the majority of costs resulting from chronic conditions, such as asthma, diabetes, heart disease, and arthritis, human resource executives believe that they can reduce costs by developing better ways to manage the health care of employees with such conditions.

In an effort to alleviate the strain of unaffordable medical bills on the 48 million Americans without insurance, President Barack Obama brought renewed focus to the issue of health care reform throughout his 2008 presidential campaign. President Obama advocates universal health insurance and expressed his desire to see such a system implemented in the United States by the end of his four-year term. The Obama proposal emphasizes cost reductions to guarantee eligibility for affordable health care through measures such as insurance reform, abolishing patent protection on pharmaceuticals, and requiring that employers expand group coverage. A National Health Insurance Exchange would also be established for individuals not covered under employer arrangements, giving them access to plans pooled by private insurers and limited coverage through the government (in an arrangement similar to Medicare). Anyone, regardless of preexisting conditions, would have access to coverage at fixed premiums. Although more specific details have yet to emerge, President Obama says that this plan would reduce premiums by $2,500 for the typical family and would cost $60 billion to provide annually.

Critics contend that the Obama initiative would add a new government entitlement program whose funding, like Social Security and Medicare, would impose severe burdens because it does not resolve the fundamental issues responsible for escalating medical costs (discussed previously in this chapter). The eligibility requirements could also encourage adverse selection, leading to large deficits if an allowance for this is not built into the premiums. Employers might view the plan as a substitute for employee benefit options that they sponsor and a justification for discontinuing certain types of group coverage. Finally, nationalized health insurance risks alienating individuals who are content with their existing coverage and might resent having to finance a program they could not see themselves utilizing. This, of course, invites discussion about the merits of government intervention to such an extent in an individualistic society such as the United States. Still, the insurance industry finds the concept of cooperating with a national exchange preferable to the alternative of having to compete with a wholly public health insurance plan.

In his speech before a joint session of Congress on February 25, 2009, President Obama reiterated his position, stating, "Health care reform cannot wait, it must not wait, and it will not wait another year," and he called for comprehensive reform efforts by the end of 2009. Shortly thereafter, the White House Forum on Health Reform was hosted on March 5. It presented findings from the group reports of over 30,000 participants in all 50 states who held HealthCare Community Discussions in December 2008. Once the forum had concluded, the Obama administration launched the Web site HealthReform.gov, detailing intended reform efforts. A preliminary health budget prepared by the Department of Health and Human Services was also made available on the site. Highlights of the budget include the following:

- Accelerated adoption of electronic health records
- Expanded research comparing the effectiveness of medical treatments
- $6 billion investment for National Institutes of Health cancer research

- $330 million in spending to increase the number of health professionals in areas with personnel shortages
- Additional outlays for affordable, quality child care
- Fortifications to Medicare

The interested student is invited to go to healthreform.gov for complete details of the health budget. Ongoing developments can be tracked at the interactive Web site, which also features the formal report from the HealthCare Community Discussions presented at the White House Forum and group reports from discussions in all states.

In March 2009, Senate Finance Committee chair Max Baucus (D-Mont.) published a white paper highlighting the proposals that have been floated since President Obama took office. A consensus is forming in terms of reform priorities: containing medical costs, decreasing the number of uninsured people, and producing better results for patients. Cost containment emphasizes better value for health care dollars—streamlined payment systems and elimination of redundancies. A greater insured population, it is reasoned, contributes to increased use of primary and preventive care so that people do not suffer severe, debilitating, and expensive-to-treat ailments by the time they seek medical intervention.

Lawmakers are focused on providing the best possible health care experience at the lowest possible cost. Such a balancing of the scales may not be possible, as pointed out by Congressional Budget Office (CBO) director Douglas Elmendorf. Elmendorf explained, “The available evidence suggests that a substantial share of spending on health care contributes little if anything to the overall health of the nation, but finding ways to reduce such spending without also affecting services that improve health will be difficult.” To reconcile this problem, the CBO director stressed changing the incentives within the current health care system, such as moving Medicare payments out of the fee-for-service realm, altering tax exclusions on employer-based coverage, and requiring greater transparency regarding the quality of services and treatments by care providers.

Despite the burdens of the economic recession, health reform has remained on the frontlines of President Obama’s first-term agenda. The stimulus authorized by the American Recovery and Reinvestment Act of 2009 (discussed in the box “Laws Affecting Health Care” in "20: Employment-Based Risk Management (General)") included over $20 billion in health-related targeted spending consistent with recent reform measures. In February 2009, President Obama signed a bill expanding the State Children’s Health Insurance Program to guarantee coverage of 11 million children, at a cost of $33 billion. How these actions and proposals affect the quality of care remains to be seen, but Americans can certainly expect changes in the days, weeks, and months ahead.

Questions for Discussion

1. Who should be responsible for individuals’ health care coverage? The employer? The individual? The government?
2. How would it be possible to solve the health care crisis under the current health care system in the United States? Should it be socialized, as it is in many European countries and Canada?
3. Where do you stand with respect to President Obama’s proposed National Health Insurance Exchange?

Sources: Lucette Lagnado, “Uninsured and Ill, a Woman Is Forced to Ration Her Care,” *Wall Street Journal*, November 12, 2002, A1; Allison Bell, “Group Health Rates Still Rocketing,” *National Underwriter, Life & Health/Financial Services Edition*, August 19, 2002; Lori Chordas, “Multiple-Choice Question: Disease Management, Cost Shifting and Prescription-Drug Initiatives Are Some of the Strategies Insurers Are Using to Stabilize Health-Care Expenses,” *Best’s Review*, August 2002; Barbara Martinez, “Insurer Software Shaves Bills, Leaves Doctors Feeling Frayed,” *Wall Street Journal*, July 31, 2002, A1; Frances X. Clines, “Insurance-Squeezed Doctors Folding Tents in West Virginia,” *New York Times*, June 13, 2002; Mary Suszynski, “Survey: HMO Rate Increases Are Highest in 11 Years,” *Best Wire*, July 2, 2002, www3.ambest.com/Frames/FrameServer.asp?AltSrc=23&Tab=1&Site=bestweekarticle&refnum=19513 (accessed April 22, 2009); “Dueling Legislation on Patients’ Rights in the House and Senate,” *Washington Post*, August 5, 2001, A5; Mark Hofmann, “Senators, White House Deadlock on Patient Rights,” *Business Insurance*, August 2, 2002; John A. MacDonald “Survey of Consumer-Driven Health Plans Raises Key Issues,” *EBRI Notes* 27, No. 2 (2006), www.ebri.org/publications/notes/index.cfm?fa=notesDisp&content_id=3618 (accessed April 22, 2009); President G. W. Bush, State of the Union address, January 31, 2006; Victoria Colliver, “McCain, Obama Agree: Health Care Needs Fixing,” *San Francisco Chronicle*, October 1, 2008, http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/09/30/MNLG12Q79L.DTL, accessed March 4, 2009; Kevin Freking, “Coverage Guarantee Can Hit Young The Hardest: Obama Health Plan Follows Where Some States Have Struggled,” Associated Press, September 11, 2008, http://www.usatoday.com/news/politics/2008-09-11-2075765460_x.htm, accessed March 4, 2009; HealthReform.Gov, healthreform.gov/, accessed March 13, 2009; Department of Health and Human Services, Proposed Health Budget, www.whitehouse.gov/omb/assets/fy2010_new_era/Department_of_Health_and_Human_Services1.pdf, accessed March 13,

2009; Ruth Mantell, "Meaningful Health-Care Reform Getting Closer: Outline of Changes Likely to Be Enacted Begins to Take Shape," *Wall Street Journal* (MarketWatch), March 16, 2009, http://www.marketwatch.com/news/story/story.aspx?guid=%7B6723EF15%2D7E92%2D4118%2D928A%2DF9FCA8DB592D%7D&siteid=djm_HAMWRSSObamaH, accessed March 17, 2009.

We will now give more detailed descriptions of the plans featured in Table 22.1 and Figure 2.7.1. Following these descriptions, additional plans such as dental and long-term care plans will be discussed.

Indemnity Health Plans: The Traditional Fee-for-Service Plans

The traditional method for providing group medical expense benefits has been by paying health care providers a fee for services rendered. **Health care providers** include health professionals, such as physicians and surgeons, as well as health facilities, such as hospitals and outpatient surgery centers. Medical expense benefits may be provided on an indemnity, service, or valued basis.

Indemnity benefits apply the principle of indemnity by providing payment for loss. The insured (the covered employee or dependent) would receive, for example, the actual costs incurred up to but not exceeding $300 per day for up to ninety days while confined in a hospital. Other dollar limits would be placed on benefits for other types of charges, such as those for ancillary charges (such as X-ray, laboratory, and drugs) made by the hospital.

There are five major classifications of traditional **fee-for-service** medical expense insurance: (1) hospital expense, (2) surgical expense, (3) medical expense, (4) major medical, and (5) comprehensive medical insurance. The first three types are called basic coverage and provide a limited set of services or reimburse a limited dollar amount. As the names suggest, major medical and comprehensive medical insurance provide coverage for large losses.

Basic Health Care Benefits

Basic health care benefits cover hospital, surgical, and medical expenses. These coverages are limited in terms of the types of services (or expenditure reimbursements) they provide, as well as the dollar limits of protection. As Figure 2.7.2 shows, basic medical coverage generally provides first-dollar coverage instead of protection against large losses.

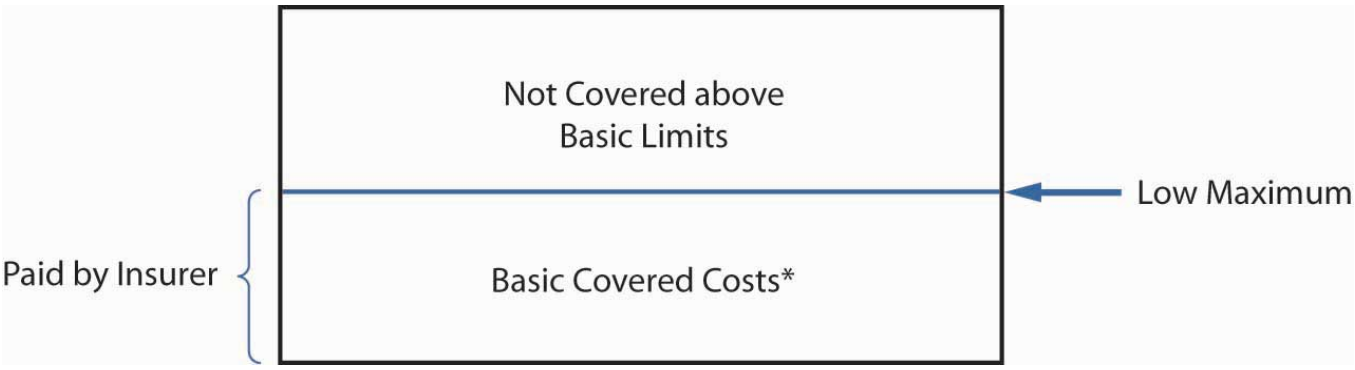


Figure 2.7.2: Basic Medical Coverage * *Basic coverage excludes some expenses, and some policies have a small deductible.*

The **basic hospital policy** covers room and board (for a specified number of days) and hospital ancillary charges, such as those for X-ray imaging and laboratory tests. The basic hospital policy primarily provides benefits during a hospital confinement. In addition, it covers outpatient surgery and limited emergency care in case of an accident. Many policies have a small deductible. Ancillary charges may be covered on a schedule basis, or more commonly on a blanket basis for all X-rays, laboratory work, and other ancillary charges, with a maximum limit such as $5,000 for all such charges. Maternity coverage is included in group medical expense insurance policies because the Civil Rights Act forbids employer-sponsored health insurance plans from treating pregnancy differently from any other medical condition.

The **basic surgical policy** usually pays providers according to a schedule of procedures, regardless of whether the surgery is performed in a hospital or elsewhere. The policy lists the maximum benefit for each type of operation. A second approach sometimes used by insurers is to pay benefits up to the UCR surgical charges in the geographical region where the operation is performed. UCR charges are defined as those below the ninetieth percentile of charges by all surgeons in a geographical region for the same procedure.

A **basic medical expense policy** covers all or part of doctors' fees for hospital, office, or home visits due to nonsurgical care. Often a plan only provides benefits when the insured is confined to a hospital. Most policies have an overall limit of a daily rate multiplied by the number of days in the hospital. Common exclusions are routine examinations, eye examinations, X-rays, and prescription drugs.

Basic health care coverage has been criticized for encouraging treatment in the hospital, the most expensive site for medical care delivery. For example, both the basic hospital and medical policies cover services primarily delivered on an inpatient basis. Newer basic policies provide better coverage for outpatient services. For example, some provide X-ray and laboratory benefits on an outpatient basis (up to a small maximum benefit) and cover the cost of preadmission tests done on an outpatient basis prior to hospital admission.

Major Medical and Comprehensive Insurance

The hospital, surgical, and medical expense insurance policies previously discussed are basic contracts in the sense that they provide for many of the medical expenses on a somewhat selective basis and with rather low limits. They are weak in the breadth of their coverage as well as their maximum benefit limits. Two health insurance plans have been developed to correct for these weaknesses: major medical insurance and comprehensive medical insurance.

Major Medical Insurance

Major medical insurance covers the expense of almost all medical services prescribed by a doctor. It provides coverage for almost all charges for hospitals, doctors, medicines, blood, wheelchairs, and other medically necessary items. Major medical policies have four fundamental features: high maximum limits (such as $1 million) or no limits, a large deductible, coverage of a broad range of different medical services, and coinsurance provisions.

Maximum limits apply to the total amount the insurer will pay over the insured's lifetime. It may apply to each injury or illness separately, but it typically applies to all injuries and illnesses regardless of whether they are related.

Internal policy limits often apply to specified services. Hospital room and board charges are usually limited to the hospital's most prevalent semiprivate rate. All charges are subject to a usual and customary test.

As Figure 2.7.3 shows, the deductible in policies is large, ranging from $300 to $2,000. The purpose of the deductible is to eliminate small claims and restrict benefits to the more financially burdensome expenses, thus making possible high limits and broad coverage at a reasonable premium rate. A new deductible must be satisfied each **benefit period**. In group insurance, the benefit period is usually a calendar year. The deductible applies to each individual; however, many policies require only that two or three family members meet the deductible each year. This reduces the possibility of deductibles causing financial hardship when several family members have serious illnesses or injuries during the same year.

The **coinsurance provision** gives the percentage of expenses the insurer will pay in excess of the deductible. It may vary from 70 to 90 percent; 80 percent is common. The insured bears the remainder of the burden up to a **stop-loss limit**, for example, $3,000, after which 100 percent of covered charges are reimbursed. Some group contracts include the deductible in the stop-loss limit and others do not. Figure 2.7.3 shows the deductible included in the stop-loss limit.

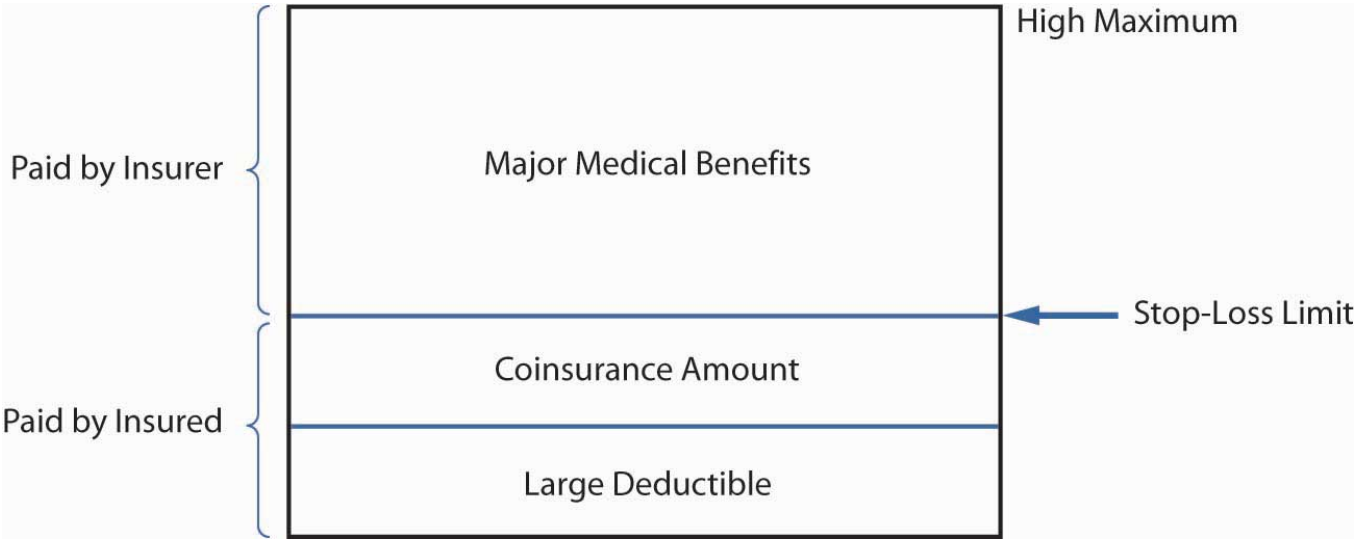


Figure 2.7.3: Major Medical Insurance

Deductibles and coinsurance requirements are **cost-sharing** provisions that increase the personal cost to the insured of using medical services. When insureds pay part of the cost, they tend to use fewer unnecessary or discretionary medical services. That is, deductibles and coinsurance provisions reduce moral hazard and help keep group insurance premiums affordable. The stop-loss limit protects the insured from excessive cost sharing, which could be financially devastating.

Comprehensive Medical Insurance

With major medical policies, the insurer pays most of the cost for medical services. However, major medical policy cost sharing may still be sizeable, putting a heavy financial burden on the insured. **Comprehensive medical insurance** deals with this problem by providing smaller deductibles, typically $100 to $300 per individual per calendar year (see Figure 2.7.3). Comprehensive medical insurance is designed as a stand-alone policy that provides broad coverage for a range of in-patient and out-patient services. Except for the smaller deductible, the provisions of a comprehensive plan are usually the same as those in a major medical plan. The comprehensive policy is sold mainly on a group basis.

Coordination of Benefits

Many employees and their dependents are eligible for group medical expense coverage under more than one plan. For example, a husband and wife may each be eligible on their own employer's plan as well as their spouse's. Children may be eligible under both the father's and the mother's plans. Workers with more than one permanent part-time job may be eligible for coverage with more than one employer. Coordination is needed to prevent duplicate payment of medical expenses when employees or their dependents are covered under more than one group policy.

The **coordination of benefits provision** establishes a system of primary and secondary insurers. The primary insurer pays the normal benefit amount, as if no other insurance were in force. Then the secondary insurer pays the balance of the covered health care expenses. The total payments by the primary and secondary insurers are limited to 100 percent of the covered charges for the applicable policies. Estimates are that coordination of benefits reduces the total cost of health insurance by over 10 percent by reducing duplicate payment.

An employee's group plan is always considered primary for expenses incurred by the employee. For example, a husband's primary coverage is with his employer, a wife's with her employer, and each has secondary coverage through the spouse's plan. When a child is insured under both parents' plans, the policy of the parent whose birthday falls first in the year is the primary policy. However, in the case of separation or divorce, the primary coverage for the child is through the custodial parent. Secondary coverage is through stepparents, and coverage through the noncustodial parent pays last. In some cases, these rules may not establish a priority of payment, and then the policy in effect for the longest period of time is primary. Any group plan that does not include a coordination of benefits provision is considered the primary insurer by all insurers that have such provisions. This encourages almost universal use of the coordination of benefits provision.

Allowing insureds to be covered under more than one policy means that these insureds may not have to meet deductible or coinsurance requirements. However, group policies sometimes stipulate that the secondary payer cannot reimburse the deductible

amounts required by the primary policy. This is designed to preserve the effect of the cost-sharing requirement, namely, to control the use of unnecessary or excess services by the insured and to reduce moral hazard.

Following is an example of a dependent insured who has double coverage. Sharon and John Shank are both covered by indemnity health plans under their respective employers. They also cover their three children. Sharon is born on October 1, 1970, and John on November 30, 1968. On January 3, 2009, their son, Josh, was hurt in a soccer tournament and had to have surgery on his ankle. The cost of the procedure was $5,000. John's plan provides for a $250 deductible and 90 percent coinsurance, while Sharon's plan has a $400 deductible with 80 percent coinsurance. Because Sharon's birthday is earlier in the year, her insurer is the primary carrier. The reimbursement under her carrier is ($5,000 – $ 400) × −0.80 = $3,680. The out-of-pocket cost would be $1,320, but because the family is covered by both parents' health plans, the amount will be covered in full under the plan of John's employer. John's employer, as a secondary payer, does not impose the deductibles and coinsurance. Note that if Sharon's health plan were self-insured, her plan would not be the primary insurer, regardless of her birthday.

Cost Containment Initiatives for Traditional Fee-for-Service Policies

As noted above, escalating medical costs propelled high-cost plans to look for effective methods to control costs. These **cost containment techniques** can be categorized as follows:

1. Plan design techniques
2. Administration and funding techniques
3. Utilization review

Plan Design Techniques

Plan design techniques relate to deductibles, coinsurance, limits on coverage, and exclusions such as experimental procedures or purely cosmetic surgeries. Most of the plans charge extra for coverage of routine eye examinations, eyeglasses, hearing examinations, and most dental expenses.

Administrative and Funding Techniques

When employers decide to self-insure their employees' group coverage, insurers continue to have an administrative role. The insurers enroll the employees, pay claims, and reinsure catastrophic claims. Through self-insurance, employers may be able to avoid state premium taxes (usually 1 or 2 percent of premiums) levied on insurance; eliminate most of the insurers' potential profits; and, in some cases, earn higher investment returns on reserves for health claims than those normally earned by group insurers. In addition, self-insured plans do not have to comply with state laws mandating coverage of medical care benefits (e.g., alcoholism and infertility benefits). A small percentage of employers administer their plans themselves, eliminating any insurer involvement. The overall effect of these changes on the cost of health care can be characterized as significant in absolute dollar savings yet minor as a percentage of total costs.

Utilization Review

Efforts to control costs include utilization review techniques developed by insurers and employers to reduce the use of the most costly forms of health care—hospitalization and surgery. Some of these techniques are listed in Table 22.2. Most group plans use some or all of these methods to control costs. The first ten are discussed briefly in this section, and the others are described later in more detail.

Insurers will pay full coverage when the insured seeks a second surgical opinion before undergoing elective or nonemergency surgery and a lower percentage or no coverage if the insured proceeds with surgery after obtaining only one opinion. Second surgical opinions do not require that two surgeons agree that surgery needs to be done before the insurer will pay for the procedure. A **second surgical opinion provision** requires only that the insured get a second opinion to increase the information available before making a decision about whether to have the surgery.

Insurers encourage patients to use ambulatory surgical centers or have outpatient surgery at the hospital or surgeon's office rather than opt for a hospital stay. The reimbursement rates also encourage **preadmission testing**, where patients have diagnostic tests done on an outpatient basis prior to surgery to reduce the total time spent in the hospital.

Table 22.2 Health Care Cost Containment Methods

- Second surgical opinions
- Ambulatory surgical centers
- Preadmission testing
- Preadmission certification
- Extended care facilities
- Hospice care
- Home health care
- Utilization review organizations
- Statistical analysis of claims
- Prospective payment
- Business coalitions
- Wellness programs
- Health maintenance organizations
- Preferred provider organizations
- Managed-care plans

Most group fee-for-service plans require **preadmission certification** for hospitalization for any nonemergency condition. The insured or the physician of the insured contacts the plan administrator for approval for hospital admission for a specified number of days. The administrative review is usually made by a nurse or other health professional. The recommendations are based on practice patterns of physicians in the region, and an appeals process is available for patients with conditions that require admissions and lengths of stay outside the norm.

Extended care facilities or nursing facilities, hospice care for the dying, or home health care following hospital discharge may be recommended to reduce the length of hospitalization. **Extended care facilities** provide basic medical care needed during some recoveries, rather than the intensive and more expensive medical service of a hospital. With **hospice care**, volunteers and family members help to care for a dying person in the hospital, at home, or in a dedicated hospice facility. **Home health care** is an organized system of care at home that substitutes for a hospital admission or allows early discharge from the hospital. The insurer covers the cost of physicians' visits, nurses' visits, respiratory therapy, prescription drugs, physical and speech therapy, home health aids, and other essentials. Cancer, diabetes, fractures, AIDS, heart ailments, and many other illnesses can be treated as effectively and less expensively with home health, hospice, and extended care.

Employers or their insurers often contract for reviews by an outside utilization review organization, sometimes called a professional review organization (PRO). **Utilization review organizations**, run by physicians, surgeons, and nurses, offer peer judgments on whether a hospital admission is necessary, whether the length of the hospital stay is appropriate for the medical condition, and whether the quality of care is commensurate with the patient's needs. When problems are identified, the utilization review organization may contact the hospital administrator, the chief of the medical staff, or the personal physician. When treatment deviates substantially from the norm, the physician may be asked to discuss the case before a peer review panel. The medical insurance policy may refuse to pay for care considered unnecessary by the reviewing organization.

Utilization review organizations, third-party administrators, and many large employers collect and analyze data on health care claims. This **statistical analysis of claims** has the purpose of identifying any overutilization or excessive charges by providers of medical care. These studies usually establish standard costs for a variety of **diagnostic-related groups (DRGs)**. Each DRG is a medical or surgical condition that recognizes age, sex, and other determinants of treatment costs. By looking at each provider's charges on a DRG basis, the analyses can identify high- and low-cost providers.

Another cost containment technique using DRGs is **prospective payment**. In 1983, the federal government adopted the practice of paying a flat fee for each Medicare patient based on the patient's DRG. Prospective payment provided an economic incentive to providers, specifically hospitals, to minimize the length of stay and other cost parameters. Use of prospective payment proved effective, and other insurers and employers now use similar methods. But the downside is that the level of reimbursement is too low and many providers do not accept Medicare patients. Assignment of incorrect or multiple DRGs to obtain higher fees can be problematic, and monitoring is necessary to keep costs as low as possible.

Another cost containment initiative by employers has been to sponsor **wellness programs** designed to promote healthy lifestyles and reduce the incidence and severity of employee medical expenses. The programs vary greatly in scope. Some are limited to educational sessions on good health habits and screening for high blood pressure, cholesterol, diabetes, cancer symptoms, and other

treatable conditions. More extensive programs provide physical fitness gymnasiums for aerobic exercise such as biking, running, and walking. Counseling is available, usually on a confidential basis, as an aid in the management of stress, nutrition, alcoholism, or smoking.

Managed-Care Plans

The central concept in the area of health care cost containment is managed care. The concept of managed care has grown in the last fifteen to twenty years, and several characteristics are common across health care plans. **Managed-care** plans control access to providers in various ways. Managed-care fee-for-service plans control access to procedures through provisions such as preadmission certification, PPOs control access by providing insureds with economic incentives to choose efficient providers, and HMOs control access by covering services only from HMO providers. Managed-care plans typically engage in utilization review, monitoring service usage and costs on a case-by-case basis. In addition, managed-care plans usually give economic incentives to stay in networks by charging penalties when nonpreferred providers are seen.

Preferred Provider Organizations

Preferred provider organizations (PPOs) were first formed in the 1980s as another approach to containing costs in group health insurance programs. PPOs are groups of hospitals, physicians, and other health care providers that contract with insurers, third-party administrators, or directly with employers to provide medical care to members of the contracting group(s) at discounted prices. They provide a mechanism for organizing, marketing, and managing fee-for-service medical care.

Unlike most HMOs, PPOs give employees and their dependents a broad choice of providers. The insured can go to any provider on an extensive list, known as the in-network list, supplied by the employer or insurer. The insured can also go to a provider not on the list, known as going out of network. If the insured goes to a preferred provider, most PPOs waive most or all of the coinsurance, which is a percentage of the fee paid to the doctor by the insurer. PPOs always charge a copay that can range from $10 to $30 or more depending on the specialty or the contract the employer negotiated with the insurance company. Providers such as doctors and hospitals are in abundant supply in most urban areas. Most operate on a fee-for-service basis and are concerned about competition from HMOs. To maintain their market share of patients, providers are willing to cooperate with PPOs. The income that they give up in price discounts they expect to gain through an increase in the number of patients. Employers and insurers like PPOs because they are not expensive to organize and they direct employees to low-cost providers. The primary incentives for employees to use preferred providers are being able to avoid deductibles and coinsurance provisions and only having to make copayments.

Cost effectiveness would not be achieved, even with discounts, if providers got insureds to accept more service(s) than necessary for the proper treatment of injury or illness. Therefore, many PPOs monitor their use of services.

Health Maintenance Organizations

Health maintenance organizations (HMOs) have been around for over sixty years. In the 1970s, they gained national attention for their potential to reduce health care costs.

History of HMOs

The HMO concept is generally traced back to the Ross-Loos group, which was a temporary medical unit that provided medical services to Los Angeles construction workers building an aqueduct in a California desert in 1933. Henry J. Kaiser offered the same service to construction workers for the Grand Coulee Dam in the state of Washington. During World War II, what is now called the Kaiser Permanente plan was used for employees in Kaiser shipyards.Today, Kaiser Permanente is one of the largest HMOs in the United States, with operations scattered across the country.

The major turning point in popularity for HMOs occurred with the passage of the Health Maintenance Organization Act of 1973. This act required an employer to subscribe exclusively to an HMO or to make this form of health care available as one of the options to the employees, provided an HMO that qualified under the act was located nearby and requested consideration. By the time this requirement was retired, employers were in the habit of offering HMOs to their employees. Sponsors of HMOs include insurance companies, government units, Blue Cross Blue Shield, hospitals, medical schools, consumer groups, unions, and other organizations.

Nature of HMOs

As noted above and featured in Table 22.1, HMOs provide a comprehensive range of medical services, including physicians, surgeons, hospitals, and other providers, and emphasize preventive care. The HMO either employs providers directly or sets up

contracts with outside providers to care for subscribers. Thus, the HMO both finances care (like an insurer) and provides care (unlike an insurer).

The scope of HMO coverage is broader than that of most fee-for-service plans. For example, HMOs cover routine checkups even when the employee is not ill. Copayments apply only to minor cost items, such as physician office visits and prescription drugs (e.g., a $10 copayment may be required for each of these services). The employee has lower cost-sharing requirements than with traditional fee-for-service plans.

Two basic types of HMOs are available. Some of the oldest and largest plans are the not-for-profit **group practice association** and the staff model. In this arrangement, HMO physicians and other providers work for salaries or capitation. In **individual practice associations (IPAs)**, which can be either for-profit or not-for-profit organizations, contractual arrangements are made with physicians and other providers in a community who practice out of their own offices and treat both HMO and non-HMO members. A physician selected as an HMO member's primary physician is often paid a fixed fee per HMO member, known as capitation fee.An example of the calculation of capitation provided by the American Society of Dermatology is featured in "Develop a Realistic Capitation Rate" at the society's Web site: http://www.asd.org/realrate.html. When a physician is paid by salary or per patient, the primary physician acts as a gatekeeper between the patient and specialists, hospitals, and other providers. The group association, the staff model, and the individual practice association all pay for and refer subscribers to specialists when they consider this necessary. However, if the HMO subscriber sees a specialist without a referral from the HMO, the subscriber is responsible for paying the specialist for the full cost of care. HMOs either own their own hospitals or contract with outside hospitals to serve subscribers.

Cost-Saving Motivation

Because HMO providers receive an essentially fixed annual income and promise to provide all the care the subscriber needs (with a few exclusions), they are financially at risk. If the HMO providers overtreat subscribers, they lose money. Consequently, no economic incentive exists to have subscribers return for unnecessary visits, to enter the hospital if treatment can be done in an ambulatory setting, or to undergo surgery that is unlikely to improve quality of life. This is the key aspect of an HMO that is supposed to increase efficiency relative to traditional fee-for-service plans.

A major criticism of HMOs is the limited choice of providers for subscribers. The number of physicians, hospitals, and other providers in the HMO may be quite small compared with group, staff, and individual practice models. Some individual practice plans overcome the criticism by enrolling almost every physician and hospital in a geographic region and then paying providers on a fee-for-service basis. Paying on a fee-for-service basis, however, may destroy the main mechanism that helps HMOs control costs. Another concern expressed by critics is that HMOs do not have proper incentives to provide high-quality care. A disadvantage for many of the baby boomers is the inability to seek the best health care possible. As noted in the Links section of this chapter, health care is a social commodity. Every person believes that he or she deserves the best health care. Thus, if M.D. Anderson in Houston, Texas, were the best place to receive cancer treatment, everyone would want to go to Houston for such treatment. Under HMOs, there would not be any reimbursement for this selection. Under a PPO or POS plan, the insured may use the out-of-network option and pay more, but at least he or she would receive some reimbursement. However, a recent national survey of 1,000 insureds under age sixty-five revealed that customer dissatisfaction with HMOs is lessening."HMOs Tightening Consumer Satisfaction Gap: Survey," *National Underwriter Online News Service*, July 15, 2002. The explanation may be the narrowing gap in services and access to out-of-network providers that has resulted from an increased concern for patient rights, such as the 2002 Supreme Court decision that allows the states to challenge HMOs' treatment decisions.Robert S. Greenberger, Sarah Lueck, and Rhonda L. Rundle, "Supreme Court Rules Against HMOs on Paying for Rejected Treatments," *Wall Street Journal*, June 21, 2002. Many states have subsequently created independent boards to review coverage decisions.Steven Brostoff, "High Court Upholds States' HMO Rules," *National Underwriter Online News Service*, June 20, 2002.

Other Health Plans

Health Savings Accounts (HSAs)

Health savings accounts (HSAs) were created by the Medicare bill signed by President Bush on December 8, 2003, and are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. HSAs are modeled after the **medical savings accounts (MSAs)**. MSAs were used for small employers and the self-employed only and were not available to individuals or large employers. Employers or employees could contribute to the MSA but in limited amounts relative to HSAs. The annual insurance deductible for MSAs ranged from $1,650 to $2,500 for individuals, of which no more than 65 percent

could be deposited into an MSA account. The range for families was $3,300 to $4,950, of which no more than 75 percent could be deposited in an MSA.

The Treasury Department created a document explaining the features of HSAs, some of which are described here. An HSA is owned by an individual, and contributions to the account are made to pay for current and future medical expenses. The most important requirement is that an HSA account can be opened only in conjunction with a **high-deductible health plan (HDHP)**, as was the case with MSAs. Only preventive care procedures are not subject to the high deductible. The HSA can be part of an HMO, PPO, or indemnity plan, as long as it has a high deductible. Eligibility is for individuals who are not covered under other comprehensive health plans or Medicare. Children cannot establish their own HSAs, and there are no income limits to open an account. Contributions to the account are made on a pretax basis, and the monies are rolled over from year to year, unlike the flexible spending account explained in "20: Employment-Based Risk Management (General)". Health coverages that are eligible for HSAs include specific disease or illness insurance; accident, disability, dental care, vision care, and long-term care insurance; employee assistance programs; disease management or wellness programs; and drug discount cards.

In 2009, a high-deductible plan that qualifies for the HSA is a plan with a $1,050 deductible for a single person and a $2,300 deductible for a family. The maximum allowed out-of-pocket expense, including deductibles and copayments, cannot exceed $5,800 for single person coverage and $11,600 for family coverage. These amounts are indexed annually for inflation.Internal Revenue Service (IRS), “Health Savings Accounts and Other Tax-Favored Health Plans,” Publication 969 (2008), http://www.irs.gov/publications/p969/ar02.html#en_US_publink100038739 (accessed April 22, 2009). The benefits are designed with limits. Not all expenses are added toward the out-of-pocket maximum. For example, the extra cost of using providers who charge more than the usual, customary, and reasonable (UCR) amounts is not included in the maximum annual out-of-pocket expense. Preventive care is paid from first dollar and includes the required copayment. If the individual goes out of the network, out-of-pocket expenses can be higher because the limits apply to in-networks costs. Deductibles apply to all plan benefits, including prescription drugs.

Contribution to an HSA can be made by the employer or the individual, or both. If made by the employer, the contribution is not taxable to the employee. If it is made by the individual, it is a before-tax contribution. Maximum amounts that can be contributed in 2009 are $3,000 for single individuals and $5,950 for families or up to the deductible level. The amounts are indexed annually. For individuals age fifty-five and older, additional catch-up contributions are allowed (up to $1,000 in 2009).Internal Revenue Service (IRS), “Health Savings Accounts and Other Tax-Favored Health Plans,” Publication 969 (2008), http://www.irs.gov/publications/p969/ar02.html#en_US_publink100038739 (accessed April 22, 2009). Contributions must stop once an individual is enrolled in Medicare. Any amounts contributed to the HSA in excess of the contribution limits must be withdrawn or be subject to an excise tax.

HSA distributions are tax-free if they are taken for qualified medical expenses, which include over-the-counter drugs. Tax-free distributions can be taken for qualified medical expenses of people covered by the high deductible, the spouse of the individual, and any dependent of the individual (even if not covered by the HDHP). If the distribution is not used for qualified medical expenses, the amount of the distribution is included in income and there is a 10 percent additional tax, except when taken after the individual dies, becomes disabled, or reaches age sixty-five. Distributions can be used for COBRA continuation coverage (discussed in "20: Employment-Based Risk Management (General)", any health plan coverage while receiving unemployment compensation, and for individuals enrolled in Medicare who encounter out-of-pocket expenses. It can also be used for the employee share of premiums for employer-based coverage but not for Medigap premiums (discussed later in this chapter). HSA distributions can be used for qualified long-term care insurance (see later in this chapter) and to reimburse expenses in prior years.

HSAs are owned by the individual (not the employer), and the individual decides whether he or she should contribute, how much to contribute, and how much to use for medical expenses. The employer has no right to restrict the employee or not allow rollover from year to year. The money is to be put in accounts with an HSA custodian or trustee. The custodian or trustee can be a bank, credit union, insurance company, or entity already approved by the IRS to be an IRA or an MSA trustee or custodian. Trustee or custodian fees can be paid from the assets in the HSA without being subject to tax or penalty, and the HSA trustee must report all distributions annually to the individual (Form 1099 SA). The trustee is not required to determine whether distributions are used for medical purposes.

HSAs are not “use it or lose it,” like flexible spending arrangements (FSAs). All amounts in the HSA are fully vested (see "21: Employment-Based and Individual Longevity Risk Management"), and unspent balances in an account remain in the account until they are spent. The objective of the HSAs is to encourage account holders to spend their funds more wisely on their medical care and to shop around for the best value for their health care dollars. The idea is to allow the accounts to grow like IRAs (see "21:

Employment-Based and Individual Longevity Risk Management"). Rollovers from HSAs are permitted, but only once per year and within sixty days of termination from the plan.

A survey by the Employee Benefit Research Institute (EBRI; featured in the box "What Is the Tradeoff between Health Care Costs and Benefits?") pointed out that owners of HSAs are less satisfied than those in comprehensive health care plans. They also found that the owners delay seeking care and are making cost-conscious decisions as intended, but lack of information makes those decisions very difficult.

The *Wall Street Journal* reported in its February 2, 2006, issue that many large employers are adopting the HSAs for their employees. They regard it as giving the employees an opportunity to open a tax-free account. Among the companies that offer HSAs to their U.S. workers are Microsoft Corporation, Fujitsu Ltd., Nokia Inc., General Motors Corporation, and DaimlerChrysler.Sarah Rubenstein, "Is an HSA Right for You? President Proposes Sweetening Tax Incentives As More Companies Offer Latest Health Benefit," *Wall Street Journal Online*, February 2, 2006, online.wsj.com/public/article/SB113884412224162775-jMcNHLtKsbwT1_WhQ90yKd2FDfg_20070201.html?mod=rss_free (accessed April 22, 2009). Most major banks offer HSA services.

Health Reimbursement Arrangements

The move to consumer-driven health care plans described in "What Is the Tradeoff between Health Care Costs and Benefits?" includes another plan that can be provided by the employer only. This plan is also a defined contribution health program accompanied by a high-deductible plan. It is the **health reimbursement arrangement (HRA)** in which employees use the accounts to pay their medical expenses or COBRA premium, and they have their choice of health care providers. Under the IRS ruling, accounts funded completely by the employer are not taxable to the employees and can be carried over from year to year. At the time, this IRS ruling was considered an important step toward creating the innovative ideas of defined contribution health plans."Hewitt Praises New IRS Health Account Rules," *National Underwriter Online News Service*, July 2, 2002. The IRS has posted more information about the HRA guidelines on the Internet at www.ustreas.gov/press/releases/po3204.htm.

As noted, HRA plans are funded by the employer with nontaxable funds. While these funds can be rolled over from year to year, the amount of carryover and the way in which the plan operates is determined by the employer. This is the exact opposite of what happens with HSAs. Because the funds are the employer's, any amount in an HRA usually reverts back to an employer if the employee leaves the company, although employers may fold HRA funds into a retiree benefit program. HRA funds cannot be used to pay for health insurance premiums pretaxed though a cafeteria plan (as described in "20: Employment-Based Risk Management (General)"). The only exceptions to this rule are that COBRA premiums or premiums for long-term care can be paid for from an HRA.

Key Takeaways

In this section you studied the evolution of group health insurance and the components of different group plans:

- Employers have transitioned from traditional defined benefit health insurance arrangements to defined contribution plans that shift costs and responsibilities to employees.
- Factors responsible for the rising cost of medical care include technological advances, malpractice lawsuits, and drug/medication development.
- Traditional fee-for-service indemnity plans provided open access to subscribers, required high premiums, and reimbursed patients for care received (less deductibles).
- Basic coverages of fee-for-service plans include the following:
  - Basic hospital policy—covers room and board for a set number of days and hospital ancillary charges
  - Basic surgical policy—pays providers according to a schedule of procedures, regardless of where the surgery is performed
  - Basic medical expense policy—covers all or part of doctors' fees for hospital, office, or home visits related to nonsurgical care
- Additions to basic coverages in fee-for-service plans are the following:
  - Major medical insurance—covers the expense of nearly all services prescribed by doctors, subject to maximum and internal policy limits
  - Comprehensive medical insurance—covers a broad range of in-patient and out-patient services for a small deductible
- Coordination of benefits specifies the order and provisions of payment when individuals have coverage through two different group plans.

- Fee-for-service cost containment techniques focus on plan design, administration and funding, and utilization review.
- Managed-care plans control access to providers as a way to deal with escalating costs in the traditional fee-for-service system.
  - Health maintenance organizations (HMOs)—negotiate large discounts with health care providers and require low copays, but they limit access to in-network providers
  - Preferred provider organizations (PPOs)—provide more freedom of choice when it comes to providers (for somewhat higher costs than HMOs) and provide incentives for in-network coverage
  - Health savings accounts (HSAs)—available only in high-deductible health plans, accounts owned by individuals funded by employer or employee contributions of before-tax dollars to use for out-of-pocket medical costs
  - Health care reimbursement arrangements (HRAs)—similar to HSAs, but accounts are owned by employers

Discussion Questions

1. What is the purpose of including deductible and coinsurance provisions in group medical insurance policies?
2. What characteristics should be contained in a managed-care plan?
3. What problem was managed care supposed to help solve? Did it succeed?
4. What are some of the health care cost containment methods that an insurer might utilize?
5. Explain how second surgical opinion provisions work to control health care costs.
6. What services are provided by a home health service? How do home health services reduce overall health care expenses?
7. How do PPOs differ from group practice HMOs? Is there much difference between a PPO and an individual practice HMO that pays its providers on a fee-for-service basis?
8. How does a PPO differ from a POS?
9. Describe health savings accounts (HSAs).
10. Jenkins Real Estate provides its employees with three health plan options:
    - An indemnity plan with a $200 deductible and 80 percent copayment for all medical care and prescriptions ($70 a month + $70 for spouse and dependents).
    - A **PPO**, with a $200 deductible and a $10 copay within the network, a 70 percent copay out of network, and a $15 copay for prescriptions ($50 a month for an individual, $75 for an entire family).
    - An **HMO** with no deductible and a $10 copay for all visits within the network and a $10 copay for prescriptions; no coverage out-of-network (free for employees, $20 a month for spouse and dependents).

    Which plan do you think the following employees would chose? Why?

    a. Marty Schmidt, real estate agent (age thirty-six, married, two children, wife is a stay-at-home mom, earned $80,000 last year). Neither he nor his wife have any health problems. The family is not particularly attached to any doctor.
    b. Lynn Frazer, real estate agent (age forty-five, not married, no children, earned $75,000 last year) suffers from diabetes and has a longtime doctor she would like to keep seeing (who is not in either the PPO or HMO network).
    c. Janet Cooke, receptionist (age twenty-two, single, earns $18,000 a year). She has chronic asthma and allergies, but no regular doctor.

2.8: HIPAA and the Privacy Rule

HIPAA Compliance and the Privacy Rule

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. A major goal of the **Privacy Rule** is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

CONSIDER: What does HIPAA stand for, and when will you need to comply as an HR Professional?

Source: Summary of the HIPPA Privacy Rule. U.S. Department of Health and Human Services.

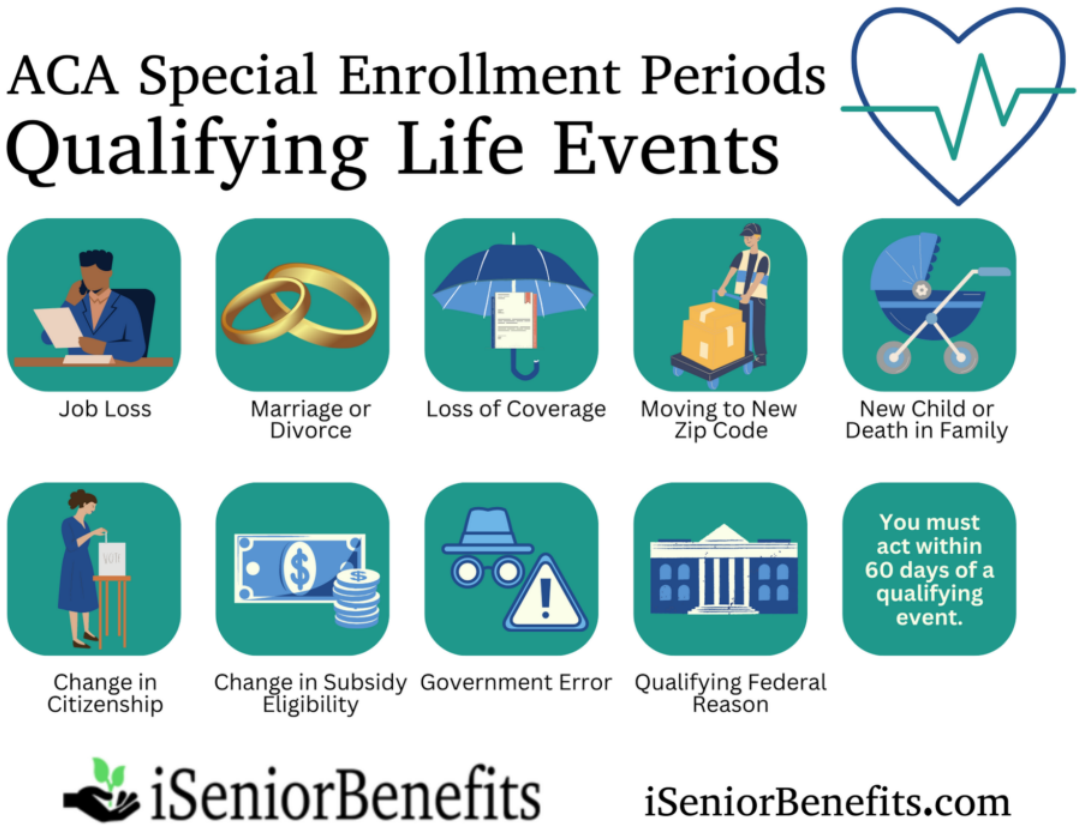
2.9: Qualifying Events

ACA Qualifying Events

There are specific circumstances that will allow someone to enroll in a healthcare plan **outside** of the Open Enrollment Period. Called a Special Enrollment Period (SEP), the following events are considered acceptable reasons, or qualifying life events:

- job loss
- marriage or divorce
- loss of insurance coverage
- moving to a different zip code
- new baby
- death of a family member
- change in citizenship
- change in eligibility for the ACA subsidy
- government error

NOTE: an event is a **qualifying event** only if it would **cause the qualified beneficiary to lose coverage** under the plan.



Source: "Health Insurance." iSeniorBenefits.com. 2021.

2.10: WATCH- 5 Things About the Affordable Care Act

5 Things About the Affordable Care Act

WATCH this 3:56 video to learn more about PPACA, also known as the Affordable Care Act or Obamacare. This video was created by a comedian, please disregard his comedic phrases if you don't enjoy them, but his points about ACA are good!

2.11: WATCH - What is a Consumer Driven Health Plan (CDHP)?

What is a Consumer Driven Health Plan (CDHP)?

(2:43 min) A CDHP gives more control over healthcare decisions, such as choosing to go to the emergency room vs. urgent care (there is a major cost difference here!). Watch this video to learn more!

3: Retirement Benefits

Learning Objectives

Module 3 will focus on competitive and creative benefits in a total rewards program, and includes the following:

- Defined Benefit Plan
- Defined Contribution Plan
- Qualified vs. Non-Qualified Plan
- Vesting
- Fiduciary

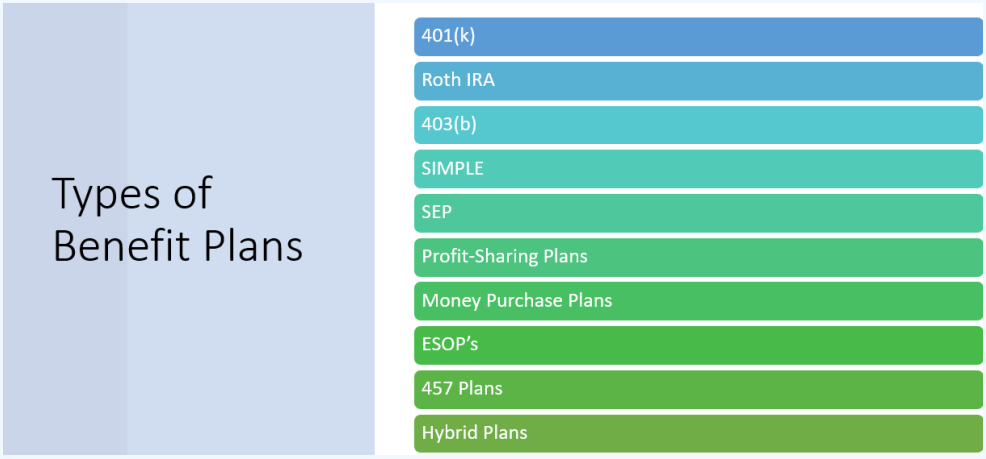


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Image: Muhamend Hassan. Retirement Savings. PxHere. CCO Public Domain.

3.1: Employer-Sponsored Retirement Plans

Image: Pension. EpicTop10.com via Flickr

Introduction to Employer-Sponsored Retirement Plans

What is a retirement plan?

- a retirement plan allows you to invest now in order to have financial security for you and your family in the future when you are ready to stop working
- first private sector plan was offered in 1875 by the American Express Company

Why would an employer offer one?

- retirement plans are part of a competitive total compensation package in today's market
- can attract quality candidates and keep high performing employees which reduces new employee training costs

Types of Retirement Plans

Defined Benefit Plans

- **Promises a specified monthly benefit at retirement**.
  - The plan may state this promised benefit as an exact dollar amount, such as $100 per month at retirement. Or, more commonly, it may calculate a benefit through a plan **formula** that considers such factors as **salary** and **service** - for example, 1 percent of average salary for the last 5 years of employment for every year of service with an employer. The benefits in most traditional defined benefit plans are protected, within certain limitations, by federal insurance provided through the Pension Benefit Guaranty Corporation (PBGC)

Defined Contribution Plans

- **Does not promise a specific amount of benefits at retirement.**
  - In these plans, the employee or the employer (or both) contribute to the employee's individual account under the plan, sometimes at a set rate, such as 5 percent of earnings annually. These contributions generally are invested on the employee's behalf. The employee will ultimately receive the balance in their account, which is based on contributions plus or minus investment gains or losses. The value of the account will fluctuate due to the changes in the value of the investments. Examples of defined contribution plans include 401(k) plans, 403(b) plans, employee stock ownership plans, and profit-sharing plans.

Qualified Plans

- A qualified plan must satisfy the Internal Revenue Code in both form and operation. That means that the provisions in the plan document must satisfy the requirements of the Code and that those plan provisions must be followed.
- A Guide to Common Qualified Plans (IRS.gov) lists 21 plan requirements to help employers in implementing practices, procedures and internal controls to monitor plan operations.

Non-Qualified Plans

- NOT subject to ERISA rules and are often only used for high-ranking executives
- funded with post-tax dollars
- arrangement between employer and employee to receive payment in the future in order to defer income taxes on their earnings

Additional Terms

Vesting

- “vesting” in a retirement plan means ownership.
  - each employee will vest, or own, a certain percentage of their account in the plan each year.
  - an employee who is 100% vested in his or her account balance owns 100% of it and the employer cannot forfeit, or take it back, for any reason
- amounts that are **not vested** may be forfeited by employees when they are paid their account balance
  - when the employee terminates employment
  - when they don’t work more than 500 hours in a year for five years
- an employee’s own contributions are always 100% vested, meaning the only money at risk is the employer’s contribution
- **cliff vesting** occurs when an employee becomes fully vested in an employer-sponsored savings plan on a specified date rather than becoming partially vested over an extended period
  - more about **cliff vesting** at Investopedia.com

Non-discrimination Rules and Testing

- non-discrimination testing rules were created by the IRS and are generally designed to prevent plans from discriminating in favor of individuals who are either highly compensated or otherwise key to the business.
- a nondiscrimination rule states that all employees of a company are able to receive the same benefits, regardless of their position within the company.

Safe Harbors

- a safe harbor 401(k) plan is a simpler 401(k) that is exempt from many of the tax rules and compliance requirements of traditional 401(k) plans

Fiduciary

- fiduciaries are persons or organizations that act on behalf of others and are required to put the clients’ interests ahead of their own, with a duty to preserve good faith and trust
- fiduciaries are legally and ethically bound to act in the other’s best interests
- fiduciaries may be personally responsible to restore losses to the plan or restore profits made through improper use of plan assets

Automatic Enrollment

- automatic enrollment allows an employer to automatically deduct from an employee’s wages unless the employee makes an election not to contribute or to contribute a different amount.
  - any plan that allows elective salary deferrals (such as a 401(k) or SIMPLE IRA plan) may have this feature
- an employer must give notice before any deferrals are withheld from wages to allow none withheld or to have a different amount withheld.
  - employees have the option to withdraw their money within 90 days of the date the first automatic contribution was made, depending on the plan

Note: A PowerPoint is attached below for download.

3.2: WATCH- Retirement Plans for Beginners

Which type of retirement plan is best?

(15:30 min) Retirement plans include the 401k, the IRA, the Roth versions (Roth 401k and IRA), as well as the SEP IRA, the 403b, and 457b plans. People ask many questionswhen it comes to investing in these retirement accounts. Watch this video, updated for 2023/2024.

3.3: WATCH- Traditional 401(k) or Roth IRA?

What is the difference between a Traditional 401(k) and a Roth IRA?

As an HR Professional, you will be helping employees with their employer-sponsored retirement plan. It's important to understand the difference between the Traditional 401(k), and the Roth IRA. Watch these videos to learn more.

What is a 401(k)?

What is a Roth IRA and how will it benefit your retirement savings?

Consider: Which one would you choose for yourself? Don't forget about employer match programs to help increase your savings!

3.4: WATCH- Are You Saving Enough?

Are You Saving Enough?

Saving for retirement can be a daunting task. Watch this video to understand how planning ahead can help you be the most prepared.

3.5: READ- Gen Z Retirement

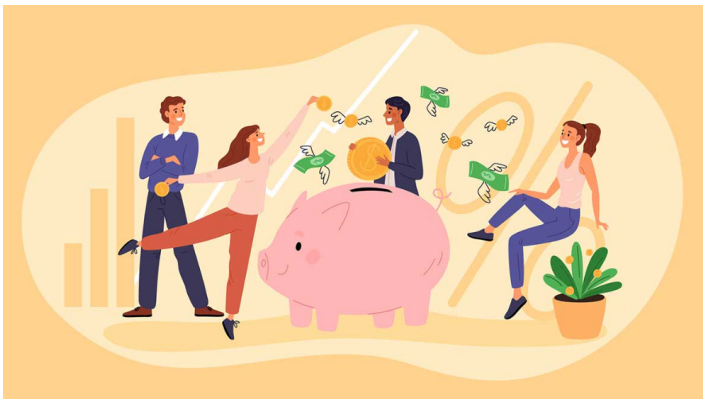

Image: Nadezhda Kurbatova. Gen Z, Millennials to Seek Employer Support for Retirement Savings. PlanSponsor.com

Study Finds Gen Z doing an "extraordinary" job saving for retirement.

A recent study from TransAmerica Center for Retirement Studies shows that, despite being the youngest working generation, Gen Z is doing a remarkable job saving for retirement. Over 30% of Gen Z is prioritizing retirement savings, and 67% of those that have been offered a retirement plan are saving for it.

Gen Z — the post-Millenial generation, born roughly between 1997-2012 — are mostly in their teens, but the oldest among them is already 22 and by 2025, they'll account for 27% of the workforce. The study shows that for workers ages 18 to 25, the median they have saved — across retirement accounts — is $33,000. This focus on future financial security is not surprising given the instability in the work market caused by the pandemic and Gen Z's clear-eyed pursuit of good pay and compensation — a shift from the Millenial values of personal development and wellbeing at work.

The median retirement savings for Baby Boomers is $162,000, it's $87,000 for Gen X and $50,000 for Millennials. Compared to these older generations, Gen Z is saving a larger percentage of their salary towards retirement. They’re putting away an impressive 20%, and starting at a much earlier age than older generations.

Challenges to retirement savings

There are still hurdles Gen Z faces when it comes to saving for retirement, however. While 30% are prioritizing savings, another 31% of Gen Z have saved nothing for retirement in the past couple of years. Since the oldest members of Gen Z are only in their mid-twenties, they haven’t had much time in the workforce. Therefore, they also haven’t had much time to build up their savings. Plus, since many are just starting their careers in entry-level positions, they aren’t like to be making as much as workers with more experience under their belt.

High inflation has also impacted how much Gen Z can save on retirement. As prices increase, it leaves less to put toward retirement savings.

Tips for Gen Z to save for retirement

While Gen Z is already on the right track with retirement savings planning, there’s always room to improve. These tips can help Gen Z save as much as they can towards retirement.

- **Take advantage of your employer match:** Why turn away free money? If your employer offers a 401k match, take advantage of it, as it’ll help grow your retirement savings without you having to do anything.
- **Cash in on compounding interest:** Investing as early as you can helps you maximize the value of compounding interest.
- **Contribute to a Roth IRA:** If you don’t have a 401k through your employer, consider setting up a Roth IRA. The annual contribution limit for 2023 is $6,500 and is a great vehicle for retirement savings. You can only contribute to a Roth IRA if your income is below a certain threshold, $144,000 for a single filer or $214,000 for those married filing jointly.
- **Start contributing now, even if it’s just a little:** While many Gen Z workers might not have a lot to contribute, every dollar counts. Working retirement savings into your budget, even if it’s a small amount, can help get you in the habit of thinking of long-term financial success.

A printable PDF is attached below.

Source: Study Finds Gen Z doing an "extraordinary" job saving for retirement. Kiplinger, February 14, 2023.

3.6: Social Security Income and Retirement

Social Security Income and Retirement

- Social Security income provides a source of income for retirees in the U.S. that is financed through a payroll tax.
- The amount of your Social Security check will depend in part on when you start taking payments.
- You can take Social Security payments as early as age 62, but if you delay taking payments the amount you are paid will be larger.
- Social Security benefits may be subject to taxation, especially if you are still working while also receiving benefits.

Many people rely on Social Security as part of their retirement income. Take a look at the official Social Security website to learn more about the average social security payment.

Source: Amy Bell. How Social Security Works After Retirement. Investopedia.com. 2023

CHAPTER OVERVIEW

4: Protection Programs and Open Enrollment

PART 1: Protection Programs

Protection programs provide family benefits, promote health, and guard against income loss caused by such catastrophic factors as unemployment, disability, or serious illness. The benefits highlighted below are legally required benefits.

- Social Security
- Disability - Short term and Long term
- Life Insurance
- Unemployment
- Workers' Compensation (covered in more detail in Safety class)
- FMLA (covered in more detail in Employment Law)

PART 2: Open Enrollment

- Eligibility
- Open Enrollment
- Total Rewards

Image: Employee Assistance Programs. AIHR.com.

4.1: Protection Programs- An Overview

Image: Free parent holding child's hand image, public domain CC0. RawPixel.com

Protection Programs: Overview

Protection programs provide family benefits, promote health, and guard against income loss caused by such catastrophic factors as unemployment, disability, or serious illness.

Social Security

The **Social Security Act of 1935** created a system of retirement benefits and established the Social Security Administration. Subsequent amendments to the Act added other forms of protection, such as disability insurance, survivors' benefits, and Medicare.

Social insurance, as conceived by President Roosevelt, would address the permanent problem of economic security for the elderly by creating a work-related, contributory system in which workers would provide for their own future economic security through taxes paid while employed.

Social Security is also known as **OASDI.**

O = Old

A = Age

S = Survivor's

D = Disability

I = Insurance

Social Security is financed through a dedicated payroll tax. Employers and employees each pay 6.2 percent of wages up to the taxable maximum of $168,600 (in 2024), while the self-employed pay 12.4 percent. The payroll tax rates are set by law, and for OASI and DI, apply to earnings up to a certain amount.

The **5 main categories** of Social Security benefits include:

- Retirement
- Disability (SSDI)
- Supplemental (SSI)
- Survivor's & Family
- Medicare

Social Security replaces a percentage of a worker's pre-retirement income based on your lifetime earnings.The amount of your average earnings that Social Security retirement benefits replaces depends on your earnings and when you choose to start benefits.

What is the average monthly retirement benefit? Take a look at the official Social Security website to learn more about the average social security payment. Is this enough for you to live on during retirement?

Social Security Disability

To qualify for Social Security Disability Insurance (SSDI) benefits, you must:

- Have worked in jobs covered by Social Security.
- Have a medical condition that meets Social Security's strict definition of disability.

In general, benefits are paid to people who are unable to work for a year or more because of a disability. Generally, there is a 5-month waiting period to receive this benefit. Consider the average monthly payoment of SSDI, is this enough to live on?

Disability Insurance (short & long term)

Disability insurance protects employees against loss of earnings resulting from injury or illness. Disability insurance is considered insurance for your income in case of unforeseen life events. This private insurance (not part of Social Security) is often offered to employees through their employers.

There are 2 types of Disability Insurance:

- **Short Term Disability:** Typically pays 40-70% of income for a short period of time, based on the terms in the policy. It can range from a few weeks to a full year of income replacement.
- **Long Term Disability:** Typically covers around 60% of income for an extended period of time. It can range from two years or all the way to retirement based on the terms of the policy.

Life insurance

Life insurance provides a cash benefit upon the death of an insured person, designed to protect the employee's family from the loss of a family member's income.

Employers often include a life insurance policy for employees paying 1-2 times their annual salary. They can offer this benefit due to the low cost of a group plan. (Like buying in bulk) This benefit is payable to the employee's designated beneficiary.

There are two common types of Life Insurance:

- **Term life insurance:** provides protection to employees' beneficiaries only during a limited period based on a specified number of years subject to a maximum age. After that, the insurance automatically expires.
- **Whole life insurance**: pays an amount to the designated beneficiaries of the deceased employee, but unlike term life policies, whole life plans do not terminate until payment is made to the beneficiaries.

Consider at what time in your life do you need the most Life Insurance?

Unemployment

Unemployment Insurance is a joint state-federal program that provides cash benefits to eligible workers. Each state administers a separate UI program, but all states follow the same guidelines established by federal law.

Unemployment insurance payments (benefits) are intended to provide temporary financial assistance to unemployed workers who are unemployed through no fault of their own. Generally, benefits are based on a percentage of your earnings over a recent 52-week period, and each state sets a maximum amount.

Unemployment Insurance is paid for solely by the employer. The amount an employer pays for this insurance depends on the industry they work in and their unemployment claims rates.

- Ex. An employer who has a high unemployment rate will pay a higher fee into the state's unemployment fund. Think road construction (cannot work in the winter months).

Compare how much do employees in your state earn while on unemployment with employees in a different state.

Workers Compensation

The **Worker's Compensation Act** provides for payment of reasonable medical expenses and compensation for lost wages resulting from work-related injuries or disabilities.

FMLA

The FMLA entitles eligible employees of covered employers to take **unpaid, job-protected leave** for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to 12 workweeks of leave in a 12-month period.

Twelve workweeks of leave in a 12-month period for:

- the birth of a child and to care for the newborn child within one year of birth;
- the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
- to care for the employee's spouse, child, or parent who has a serious health condition;
- a serious health condition that makes the employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- twenty-six work weeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

What is a life event you could run into where you would need FMLA?

Questions to Ask:

- Why do we need social security?
- Do the social security programs provide enough payment/benefit for you to live on comfortably?
- What are the chances you or someone you know will need this benefit?
- At what time in your life do you need the most life insurance?
- Are the benefits for unemployment different in neighboring states? (I would take a few minutes to look this up.)
- Can you see yourself using or needing FMLA in your lifetime? What type of event would qualify?

NOTE: Review the attached PowerPoint to learn more and answer the above questions.

4.1.1: Social Security

Image: Social Security Card by OpenClipArt via WikimediaCommons

Welcome to Social Security!

Social Security provides financial protection for our nation's people, supporting Americans throughout all of life's journeys. They administer retirement, disability, survivor, and family benefits, and enroll individuals in Medicare. They also provide Social Security Numbers, which are unique identifiers needed to work, handle financial transactions, and determine eligibility for certain government services.

The Social Security website has great information also. Take a few minutes to explore it!

In Retirement

Eligibility is always based on work. Most jobs take Social Security taxes out of your paycheck so you can get a monthly benefit in retirement.

The Social Security Retirement benefit is a monthly check that replaces part of your income when you reduce your hours or stop working altogether. It may not replace all your income so it's best to identify other ways to pay for your monthly expenses as you age.

Estimate your benefit amount, determine when to apply, and explore other factors that may affect your retirement planning.
Use the Social Security Benefit Calculator to do a quick calculation on what you'll earn in Social Security when you retire.

Disability Insurance

Social Security Disability Insurance (SSDI) or “Disability” provides monthly payments to people who have a disability that stops or limits their ability to work.

Survivor Benefits

Survivor benefits provide monthly payments to eligible family members of people who worked and paid Social Security taxes before they died.

Family Benefits

Family benefits provide monthly payments to certain family members of people who are eligible for Retirement or Disability. Family benefits are also commonly called “spousal” or “child” benefits.

4.1.2: READ- The Differences Between Short-Term and Long-Term Disability

Disability Insurance by Nick Youngson CC BY-SA 3.0 Pix4free.org

Short-Term and Long-Term Disability

Disability insurance is a crucial safety net that supports employees who get hurt and can't perform their job requirements. Both short-term and long-term disability insurance serve different purposes depending on the employee's situation.

As a business owner with employees, it's important to familiarize yourself with your legal obligations and your employees' responsibilities regarding both types of disability insurance.

Short-term disability insurance

Short-term disability insurance covers an employee's compensation — supplementing between 40-70% of their salary — for a short period of time in the event that they are unable to perform their job duties due to serious medical conditions, such as an injury or illness. An employee's coverage can last anywhere from a few weeks to a full year in certain circumstances.

To receive coverage, the employee must prove they cannot perform their duties with evidence from medical providers like a therapist or doctor. Qualifying medical conditions include surgery rehabilitation, injury from an accident, or pregnancy. However, unlike workers' compensation coverage, the injury or illness does not have to take place on the job. Because many states are required to offer workers' compensation insurance, on- the-job injuries and illnesses are often covered under that policy instead of disability.

Whether or not employers must provide short-term disability insurance depends on the state in which you are registered to conduct business. Only a few states — like New York, California, and Rhode Island — require employers to provide short-term disability coverage to all employees, whether it's a plan employers purchase through a private carrier or a state-sponsored plan.

Long-term disability insurance

Long-term disability insurance also protects an employee's compensation, covering roughly 60% of their gross monthly income for an extended period of time. In contrast to short-term disability, long-term disability is awarded to those who cannot perform any job — not just their current one. The length of coverage can span from two years all the way to retirement, or when Social Security payments commence.

Qualifying injuries and illnesses include cancer, mental illness, arthritis, back problems, stroke, and other serious conditions that prevent employees from completing normal day-to-day tasks. To receive compensation, employees must provide medical records which show the qualifying injury lasted beyond the elimination period. Then, employees can receive benefits until they have been medically cleared or until their policy benefits have been exhausted.

Oftentimes, an employer will offer both short- and long-term disability benefits; short-term benefits are usually exhausted first, at which point long-term benefits kick in. Employers can, but are not required to, provide long-term disability benefits. Doing so usually yields cheaper rates for employees, but often at the expense of a less comprehensive plan. Furthermore, if an employee leaves the company, they are not able to take their coverage with them, making private policies more appealing to some.

Short-term disability insurance is more suited for situations in which an employee was injured but can ultimately return to work, whereas long-term disability helps those who will be out of work for a long time, or even permanently.

The differences between short-term and long-term disability insurance

While short- and long-term disability insurance have similarities — neither have a deductible or minimum spending threshold and they both cost 1% to 3% of your annual salary — they also have several differences.

The two primarily differ based on the length of the coverage period. Short-term disability insurance is more suited for situations in which an employee was injured but can ultimately return to work, whereas long-term disability helps those who will be out of work for a long time, or even permanently.

In addition to the coverage length, benefits begin at different times for each insurance. For short-term disability, benefits begin after a predetermined amount of time, called an elimination period, ranging from seven to 30 days, with 14 days being the average. The elimination period for long-term disability is longer, lasting anywhere from 30 days to two years, with 90 days being the most common. This range will depend on the policy you purchase — cheaper policies incur longer elimination periods.

Finally, short- and long-term disability insurance each cover a different portion of an employee's income. While the exact amount is determined by their salary and plan coverage, short-term disability insurance typically covers about 80% of one's income, while long-term is closer to 60%.

CO— aims to bring you inspiration from leading respected experts. However, before making any business decision, you should consult a professional who can advise you based on your individual situation.

Published August 25, 2022

A printable copy of this article is attached below.

Source: Short-Term vs. Long-Term Disability: What's the Difference? U.S. Chamber of Commerce. 2024

4.1.3: READ- Everything You Need to Know About Disability Insurance

Disability Insurance by Nick Youngson CC BY-SA 3.0 Pix4free.org

Disability Insurance

For most people, the term “disability insurance” conjures images of accidents and worst-case scenarios, the things that you don’t plan on. One result: the average American probably knows very little about how to qualify for it, the different types available, and the resources designed to help with the application process.

But this Disability Insurance Awareness Month (DIAM), especially as we begin to see the long-term impact of Covid-19, it’s important to remember that hoping for the best can be supplemented by planning for the worst. Disability insurance is an accessible way to protect yourself, your family and your income, for those unforeseen events in life.

Disability insurance isn’t about covering the medical portion of any injury or illness – it's insurance for your income. That’s why many industry experts call it disability income insurance and recommend that most Americans currently earning an income obtain some sort of disability coverage.

Choosing disability insurance involves understanding the different types and the benefits each brings. For example, there are two categories of private disability policies: long-term disability (LTD) and short-term disability (STD) insurance. According to Steve Perrigo, Vice President of Allsup, a nationwide provider of Social Security Disability Insurance (SSDI) representation services, a long-term disability policy may provide coverage for several years after a work-limiting disability occurs. LTD policies typically replace 60% of someone’s income if they can no longer work, while a short-term disability policy typically replaces 40%-70% of income for 13-26 weeks.

Long-term disability policies are most commonly offered as a benefit through an employer, or purchased as an individual policy through a broker or financial advisor. Short-term disability policies are typically obtained as a group policy benefit through someone’s workplace.

SSDI is an additional form of disability insurance available, should you sustain an injury or illness that makes it impossible to work. This federal insurance program is coverage that workers and employers pay for as part of FICA payroll taxes, along with Social Security retirement.

The benefit, or amount you can expect to receive each month while you are unable to work, will vary depending on the plan. It’s important to note that the benefit from an individual disability policy usually isn’t taxed unless it’s paid for from pre-tax dollars. The benefit from a short-term group disability policy offered by an employer, on the other hand, will be taxable.

The next two criteria, the benefit period and the waiting period, will vary depending on the policy and the insurance carrier. The waiting period can be important to research because this let’s you know how soon benefits are likely to begin after experiencing a disability. Also called the elimination period, the typical wait time for short-term coverage is two weeks, while the wait time is 90 days for long-term coverage.

The most critical part of choosing your private disability coverage is the final piece of the policy: the definition of disability. Each policy and carrier has a specific definition of what qualifies as a disability to receive benefits. For example in the case of “own-occupation” and “any-occupation” — the former provides coverage if you are unable to perform the occupation you were trained for, and the latter provides coverage only if you are unable to perform any reasonably suitable occupation. Different levels of disability also may be defined, such as “partial disability,” which could qualify you for a percentage of your total benefit amount.

No matter your occupation or income level, disability insurance is an essential protection for most people against things that are impossible to plan for, such as a life-altering disability, a debilitating illness, or even a global pandemic. We protect our homes, cars, and health with insurance, and safeguarding our income with disability insurance is just as crucial for future security and well-being.

Paula Morgan Paula Morgan has 21 years of public and private experience helping people successfully navigate Social Security Administration (SSA)

Source: Masterson, Les. "Best Disability Insurance Companies Of 2024." *Forbes Advisor.* May 31, 2024.

4.1.4: READ- Chances of Becoming Disabled

Image: Hazard. PxHere. CC0 Public Domain.

What are your chances of becoming disabled?

The acquisition of a disability comes with a host of side consequences. Indeed, outcomes are specific to each individual, but all are playing out against a rising swell of disability claims nationally that is swiftly becoming a crisis. Attorneys can be central players in helping clients navigate an increasingly unforgiving landscape—and be better able to claim the benefits they deserve.

Risks of Becoming Disabled

The likelihood of anyone becoming totally disabled varies depending on age, gender, and occupation. The statistics used in this book are for disabilities lasting 90 days or longer. If some- one is disabled for 90 days, there is a high probability that his or her disability will last much longer, possibly for months or years, or even for the rest of his or her life. (Regrettably, insur- ing shorter-term disabilities such as sprained ankles, rotator cuff repair, or pneumonia would raise the cost of disability insurance by 20% to 30%.)

Some prevalent facts (and perceptions) on disability are as follows:

- Over 36 million Americans today are classified as disabled, which represents 12 percent of the total population. Of those disabled, 50 percent are between the ages of 18 and 64.
- **Perception:** A total of 64 percent of workers say their chance of long-term disability during their career is only 1 or 2 percent.
- **Reality:** Just over one in four (25%) of today's 20-year-olds will become disabled before they retire.
- In total, 8.8 million workers, over 5 percent of the work- force, are receiving Social Security Disability Insurance (SSDI) today.

An article in the *American Journal of Medicine*, reporting on the results of a national study on medical bankruptcy in the United States, found the following:

- A total of 62 percent of personal bankruptcies in 2007 were related to medical conditions.
- Most of the sufferers were well-educated, middle-class homeowners.
- Their mean age was 45 years.
- Three quarters had medical insurance.
- Income loss was the major factor in their bankruptcy.
- Medical bankruptcy rates have risen substantially in recent years.

The Council for Disability Awareness (CDA) provides data from 19 of its member companies representing over 75 percent of the commercial disability insurance marketplace. It reports that:

- Every seven seconds a working-age American will experi- ence the beginnings of a long-term disability.
- Most people are not remotely prepared to experience the consequences of a long-term disability or the financial and psychological impact on their families.

- Eighty-four percent of corporate human resource profes- sionals say the average employee can survive no more than six months without a paycheck, and 77 percent of financial advisors concur.
- The average LTD claim lasts over two-and-a-half years.

As these findings suggest, when people are young and distracted with family and ambition, they understandably give little thought to the likelihood of becoming disabled. However, rein- forcing the data just presented, the Society of Actuaries tells us that the average 40-year-old faces a 20 percent chance of experiencing a long-term disability (i.e., a disability lasting at least 90 days) before reaching age 65, and one worker in seven will be disabled for five years or more sometime before normal retirement age.

Issues and Consequences

The average American, then, does not anticipate becoming disabled. One day your potential client is healthy, pleased to be working, with cares and concerns that center on everyday matters. Like tens of millions of other hardworking Americans, they allow them- selves to remain willfully unaware of the risks and consequences of becoming disabled. And then “it” happens. The “it” might be headaches that won’t go away, followed by an MRI, followed by a visit with a neurologist. Or the “it” might be awakening at 3 a.m. with stabbing chest pains, a spouse calling 911, and waking up a day later in intensive care. There are thousands of causes of long- term disability. Unfortunately, too many people discover the inadequacies of their disability insurance programs only after they are already facing a lifelong disability. Insurance clauses and policy terminology can make it difficult to truly understand the benefits. And then, once disabled, a potential client can struggle mightily to navigate the claims process and successfully collect benefits.

In many ways, the cause of the “it” doesn’t matter—what matters are the issues someone faces when becoming totally disabled. The “it” has been best described as being like walking into a wall—and not at a normal walking speed but rather at 25 miles per hour. After that collision, this person’s life as he or she knew it has effectively ended, so dramatic is the change.

One major consequence of disability can be home loss. For many people, jobs become an important part of identity formation. When health problems prevent potential clients from making a mortgage payment, perhaps the first they have ever missed, the impact can be devastating. The home carries with it enormous psychological value. It is the place where we shelter our families and seek refuge from the world, as well as a source of pride and satisfaction. It is not surprising that the leading cause of mort- gage foreclosure in the United States today is a family member’s health problem (as shown by the statistics on medical bankruptcy published in the *American Journal of Medicine*). We can infer that these statistics typically reflect disabilities experienced by house- hold breadwinners.

As a window into the financial state of many American families, we can look at the mortgage foreclosure disaster that shook the country in 2008. Many households didn’t have enough money to meet the down payment on a home, so a second bank gave them a second mortgage. Or the original bank decided the down payment wasn’t necessary after all, given that houses were then appreciating at 5 percent per year or more. So many adages were proved wrong, notably: “Real estate doesn’t ever go down in value” and “Our house will quickly be worth more than what we owe.” Many homes were purchased with the income of both spouses working full-time jobs, which meant that when one member of the family lost income, many homeowners were unable to meet their mortgage payments. Many families lost their homes because of a disability.

NOTE: A printable copy can be downloaded below.

Source: "What Are Your Chances of Becoming Disabled? ColoradoDisabilityLawyer.com. April 2024

4.1.5: READ- Unemployment Insurance

Image: Muhamed Hassan. Protection. PxHere.com. CCO Public Domain.

What is Unemployment Insurance (UI)?

Unemployment Insurance is a joint state-federal program that provides cash benefits to eligible workers. Each state administers a separate UI program, but all states follow the same guidelines established by federal law.

Unemployment insurance payments (benefits) are intended to provide temporary financial assistance to unemployed workers who are unemployed through no fault of their own. Each state sets its own additional requirements for eligibility, benefit amounts, and length of time benefits can be paid.

Generally, benefits are based on a percentage of your earnings over a recent 52-week period, and each state sets a maximum amount. Benefits are subject to federal and most state income taxes and must be reported on your income tax return. You may choose to have the tax withheld from your payment.

Fun fact:

Wisconsin was the first state to enact an unemployment program. It started in 1932 and was the likely starting point for our current federal program, which is included in the Social Security Act of 1935.

Review the attached fact sheet to learn more about unemployment insurance.

"Unemployment Insurance." FactSheet. U.S. Dept. of Labor

NOTE: A printable PDF is attached below.

4.1.6: WATCH- Unemployment Filing Requirements in Wisconsin

Unemployment Filing Requirements

This Wisconsin unemployment overview provides information on work search and wage reporting requirements. As an HR Professional, you may receive communication from the Wisconsin Workforce Development UI Division to confirm a beneficiary applied for a job at your organization.

Watch this video to learn more!

4.1.7: Wisconsin Workers' Compensation

Wisconsin Workers' Compensation Facts

The Worker's Compensation Act provides for payment of reasonable medical expenses and compensation for lost wages resulting from work-related injuries or disabilities. These benefits are the responsibility of the self-insured employer or the employer's worker's compensation insurance carrier.

Go to the website and video below and to the attachment to learn more about Wisconsin Workers' Compensation. Questions answered include:

- What is Worker's Compensation
- Where did it come from?
- What benefits are payable under a policy?
- When is an employer required to have a policy?
- What about out of state employees?
- What is self-insurance?
- Who pays for this?

Source: "Worker's Compensation Basic Facts." Wisconsin Department of Workforce Development.

NOTE: A printable PDF - Q & A Workers Compnesation - is attached below.

4.2: Open Enrollment

Image: MedicareMall.com. Open Enrollment. Flickr. CC-BY-ND

What is Open Enrollment?

An open enrollment period is a window of time that happens once a year — typically in the fall — when you can sign up for health insurance, adjust your current plan or cancel your plan. It's usually limited to a few weeks. If you miss it, you may have to wait until the next open enrollment period to make any changes.

Qualifying Life Events

As with most things, there are exceptions! In this case, they are called qualifying life events. A qualifying life event is a life-changing situation — sometimes planned, sometimes unexpected — that can impact you and your health insurance. Experiencing a significant life change may allow you to change your health plan outside of the annual enrollment period (also called open enrollment).

Qualifying life events include, but are not limited to:

- Marriage or divorce
- Having or adopting a baby
- Death of someone who shares your health plan
- Moving to a new area
- Earning U.S. citizenship
- Turning 26, or turning 65
- Change of employment status
- Loss of health insurance for other reasons

4.2.1: READ- Open Enrollment Requirements

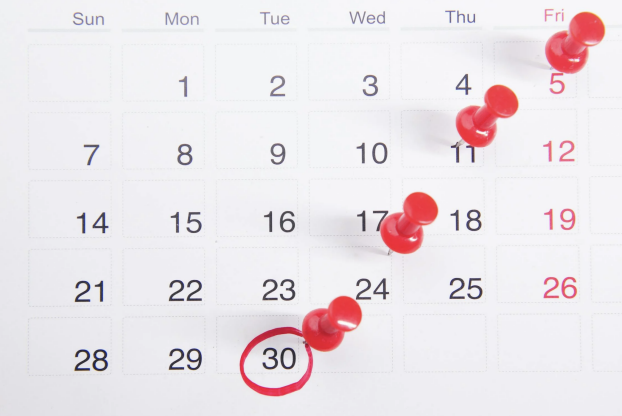

Image. Towfiqu barbhuiya. Calendar. Pexels.com

Open Enrollment: Employer Requirements

Prior to implementation of the Patient Protection and Affordable Care Act (PPACA), open enrollment periods were not required under the Employee Retirement Income Security Act (ERISA) but may have been required by:

- Health insurance contracts.
- Collective bargaining agreements.
- Section 125 cafeteria plans under which participants must be given a reasonable period of time to make elections each year.

Now, under the PPACA, an "applicable large employer," that does not offer an annual open enrollment may be subject to penalties under the health care reform's employer shared responsibility requirements. According to the Internal Revenue Service (IRS), an ALE will not be treated as having "offered" coverage unless employees and dependents are given at least an annual opportunity to accept or decline coverage. For this purpose, "dependent" means an employee's children as defined who are under 26 years of age. This includes sons, daughters, stepsons, stepdaughters, adopted children or eligible foster children. Notably, the dependent definition does not include individuals other than the employee's children, such as the employee's spouse, so a plan may continue to not make an annual offer of coverage to spouses (and, in fact, may entirely exclude non-employee spouses from coverage) without incurring employer penalties.

See Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act.

The PPACA regulations clarify that an employee's election of coverage from a prior year that continues for every succeeding plan year unless the employee affirmatively elects to opt out of the plan constitutes an offer of coverage. "Rolling" or "evergreen" elections would be permissible for purposes of complying with the requirement to make an offer of coverage. Plans with these types of elections would still have an annual open enrollment period and employees wishing to make changes to their elections would do so at that time. Otherwise, their previous elections will rollover to the next plan year. To implement this design, the employer should explain the election process in all the plan materials. Additionally, the employer should disclose any premium increases and whether the participant elections will automatically be changed to reflect the increase. Best practice is for the employer to distribute a copy of the participants' current elections during open enrollment so that they are aware of what elections would carry forward if no action is taken.

Some employers allow employees only one chance to join their employer-sponsored health plan, or only give them what is called "one bite of the apple." Failure to enroll when first eligible results in permanent loss of eligibility under the plan. This approach offers coverage to the employee and dependents only once, which violates the PPACA and could result in penalties for large employers. However, because the PPACA excludes spouses as dependents, the one-bite-of-the-apple approach could still be used for spousal coverage.

Employers that do not employ an average of at least 50 full-time employees are not subject to the PPACA's shared responsibilities requirements and do not have to offer an open enrollment period unless required to do so under one or more of the three circumstances stated above.

Source: Q&A "Is an annual open enrollment period for employee health insurance benefits required?" Society for Human Resource Management (SHRM), 2024.

4.2.2: READ- Open Enrollment Communications

Image: Mohamed Hassan. Workplace Support. PxHere.com. CC0 Public Domain

Open Enrollment Communications

The majority of employees say they are looking for more help and guidance from their employer on benefits offerings, according to data from global insurance provider MetLife. It's a sentiment that's especially felt by Generation Z workers, who are on track to become the largest generation in the workforce. MetLife's 2023 Employee Benefit Trends Study found that 54 percent of all employees said they wish they had personalized benefit recommendations, while half would feel more cared for if their employer improved its benefits communications.

The need for effective open enrollment communications has never been more critical—or more complicated, given the rise of hybrid mixes of remote and onsite work arrangements. This requires a renewed focus on developing communications that meet employees' needs wherever they are and whenever they need to connect. Ideas to help with this include:

- Virtual communications
- Virtual benefit fairs
- Home mailings
- Traditional face to face employee group or individual meetings

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Source: "Employees Seek More Benefits Communications, Personalization", Society for Human Resource Management (SHRM), February 5, 2024.

Source: "Open Enrollment Success Relies on Effective Communications", Society for Human Resource Management (SHRM), August 29, 2022.

NOTE: Printable PDFs are attached below.

4.2.3: WATCH- Technology to assist with open enrollment

Open Enrollment Technology

Helping employees choose the right benefits for them and their family can be difficult. Today, there are lots of technology options to help the employee make the best choices about their benefits. In the below videos, you'll see 2 examples of such technology. Keep in mind as you watch these videos, technology comes at a cost. Many smaller companies do not use this type of technology due to the price to purchase.

Consider: How helpful would you find this technology as an employee? As an HR Professional?

CHAPTER OVERVIEW

5: Paid Time Off- Offering Competitive and Creative Benefits

Paid Time Off (PTO)

Often referred to as PTO, paid time off is personal time that employees take to spend out of the office (and not working) while still receiving pay for regular wages. PTO policies can be structured in many different ways depending on a given company's size, structure, and industry. Consider the following terminology as you work through this module.

Paid Time Off

PTO is the time that employees can take off of work while still getting paid regular wages. This does not include times in which an employee is working remotely or telecommuting. Often, PTO policies combine vacation, sick, and personal days.

Unpaid Time Off

Time off in which an employee is not compensated for the missed days. Types of unpaid time off may include a leave of absence, military leave, unpaid personal time off, vacation beyond paid vacation days, and medical leave.

PTO Banks

A PTO strategy that bundles together multiple PTO types, most commonly sick leave and vacation time, rather than assigning a certain number of days for each type.

PTO Accrual

Time off that an employee has earned over a given amount of time, typically over a certain number of hours, days, weeks, or months worked.

Common reasons to use PTO:

- Holidays
- Floating holidays
- Paid family leave
- Paid sick leave
- Paid bereavement leave
- Jury duty
- Vacation
- Personal appointments

Review the link below for a more thorough listing of types of time off.

Image: Mohamed Hassan. Camping. CC0 Public Domain

Source: "18 Types of Paid Time Off", Days Plan, July 4, 2016.

5.1: READ- Paid Time Off - Costs and Benefits

Image: Worker Burnout. VectorPortal.com. CC-BY 4.0

Why do Employers Offer Paid time off?

Employee burnout is real. Taking time away to refresh can not only improve overall productivity, but can increase overall retention of your employees. A good paid time off policy is essential in business today.

Paid time off, otherwise referred to as PTO, is exactly what it sounds like: It is an employee benefit in which the employer pays the employee for an allotted number of days off of work each year. Employers can choose from a variety of different PTO options like federal holidays, floating holidays, vacation days, sick leave, parental leave, bereavement leave, jury duty and military leave.

When reviewing total compensation, it is important to consider not just the costs of wages and salaries but also the costs of providing various benefits. Paid time off is a necessary benefit to stay competitive in the market. But before offering additional time off, be sure to know what it's going to cost the bottom line.

Employer Costs for Employee Compensation

When observing overall employee compensation, it is important to consider not just the costs of wages and salaries but also the costs of providing various benefits. Aside from wage data, the Employer Costs for Employee Compensation (ECEC) provides detailed benefits cost data for a more comprehensive look at overall compensation. The ECEC provides the employer cost of a specific benefit as well as the percent of total compensation that the benefit represents.

Paid leave benefits cost employers on average $2.94 dollars per hour in September 2022, representing 7.4 percent of total compensation costs. The cost of paid leave is calculated by multiplying the total leave time used by the rate at which the employee was paid during the used leave time.

Paid leave includes a combination of four leave benefits, as shown in Chart 1. Vacation leave (3.8%), holiday leave (2.2%), sick leave (1.0%), and personal leave (0.4%) benefits, as a percentage of total compensation sum to paid leave (7.4%). Paid leave benefits accounted for 25.1 percent of the costs of total benefits.

Among different occupational groups in private industry in September 2022, employer costs for paid leave benefits (per hour worked) varied. Employer costs for paid leave benefits averaged $0.86 for service workers and $7.50 for management, business, and financial workers. The average among all private industry workers was $2.94.

In September 2022, private industry employer costs of paid leave benefits averaged $3.79 for union workers and $2.86 for nonunion workers. Vacation leave accounted for 3.6 percent of total compensation for union workers and 3.8 percent of total compensation for nonunion workers. While paid personal leave accounted for 0.3 percent of total compensation for union workers and 0.4 percent of total compensation for nonunion workers.

Source: Employer Costs for Employee Compensation Fact Sheert. Bureau of Labor Statistics. BLS.gov

Source: "How to create a paid time off policy that reduces employee absences", Business News Daily, December 20, 2023.

NOTE: Printable PDF attached below.

5.2: WATCH- Paid Leave Time and the U.S. Department of Labor

Paid Leave Time and the U.S. Department of Labor

One great resource regarding leave is the U.S. Department of Labor. You can find information on their site about the right to take unpaid leave, FMLA, along with videos and fact sheets about many important topics. As they state on their website, "At some point, we all need time to take care of our own health or to care for a loved one, but access to paid leave is uneven and inequitable. No one should have to choose between taking care of themselves or their loved ones and the job they need."

Watch the below video and review the website link for more information from the Department of Labor.

U.S. Department of Labor Paid Leave.

5.3: WATCH- Paid Time Off - What Happens to It When You Leave the Company?

What happens to your paid time off when you leave the company?

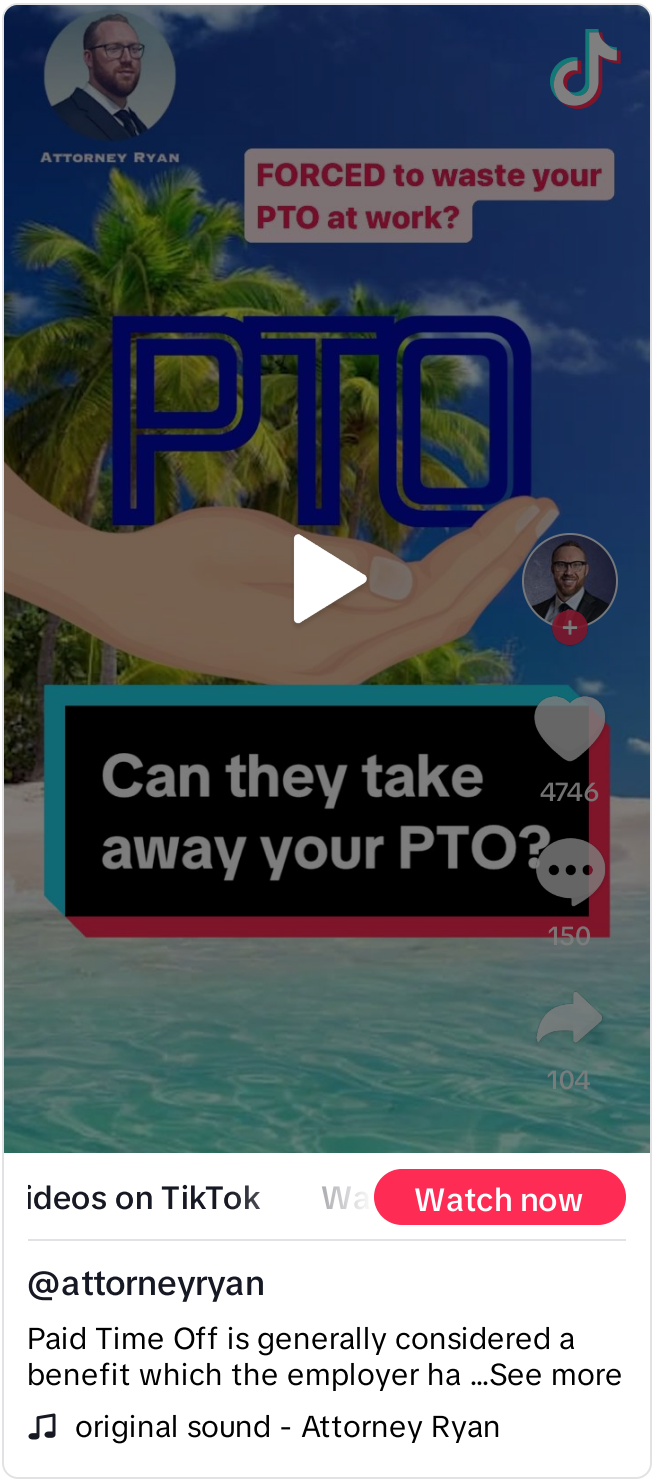
Paid Time Off is generally considered a benefit which the employer has the right to control. It is a Discretionary Benefits. They can place a cap on how much you can accrue, and they can use it when you miss work (even if you don't want to.) But in SOME states (like California), your PTO is considered "wages." So even though they can use it without your express consent, they cannot take it away when you leave the company. Specific rules about PTO vary by state, so be sure to check the rules in your state.

Watch this TikTok for more information.

Paid Time Off is generally considered a benefit which the employer has the right to control. They can place a cap on how much you can accrue, and they can use it when you miss work (even if you don't want to.) But in SOME states (like California), your PTO is considered "wages." So even though they can use it without your express consent, they cannot take it away when you leave the company. Specific rules about PTO vary by state, so check with an employment lawyer about your specific situation.

#vacationmode

♬ original sound - Attorney Ryan



https://www.tiktok.com/@attorneyryan/video/7299884028092566827

5.4: Paid Time Off Policies

Paid Time Off Policies

It can be challenging to balance the needs of the company with the needs of the employee. Your policy should offer something the employees want in order to support recruitment and retention efforts. At the same time you must consider the needs of the business and the bottom line.

Watch this video to learn more about finding a good balance.

5.5: Unlimited PTO

Unlimited PTO

Unlimited PTO is a trend in business today. It sounds great, doesn't it? Is there a downside to offering this benefit?

Watch this video to learn more!

5.6: FMLA and PTO

How do FMLA and PTO work together?

What about FMLA? Is this a paid benefit? Do you have to use PTO when you're on FMLA? What are the state and federal requirements you need to follow? There's so much to consider when working with these 2 benefits at the same time.

Watch this video to learn more!

CHAPTER OVERVIEW

6: Accommodation and Enhancement Benefits

Learning Objectives

This module will discuss the following:

- Employee Assistance Programs (EAP)
- Tuition Reimbursement
- Mental Health benefits
- Wellness programs

Accommodation and enhancement focuses on benefits designed to make your employee's work and home life better. These are discretionary benefits an employer decides to offer to their employees. If a company is not required to offer these benefits, why would they when it will cost them money to pay for them? Consider this question as we work through the materials in this module.

Image: denayune. Business Solutions. FreePik.com

6.1: Mental Health in the Workplace Statistics

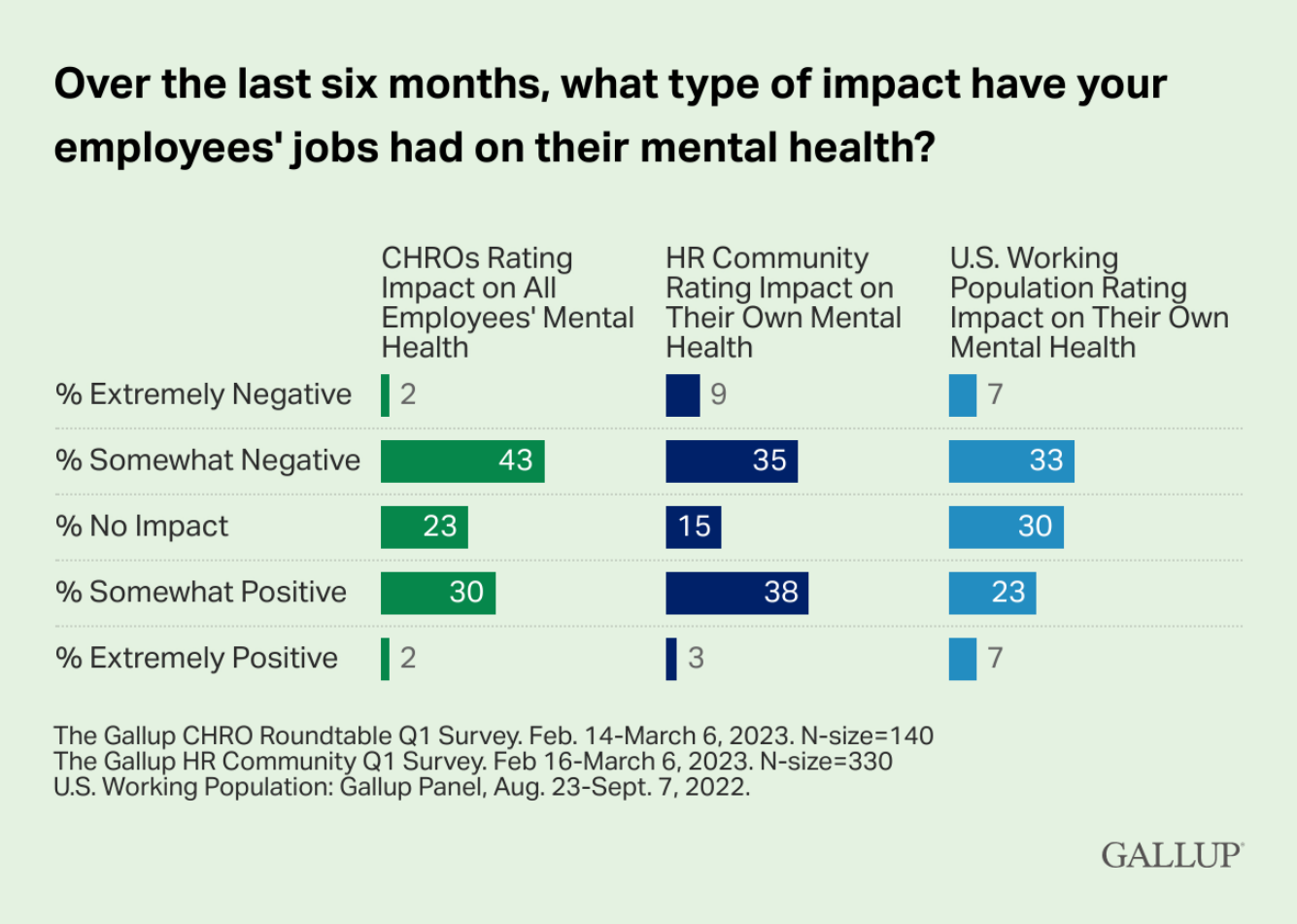
Mental Health in the Workplace

The statistics on the chart below show that 43% of all employees felt their mental health was impacted by their jobs, while 30% felt their jobs had a positive impoact on ther mental health.

- Do these statistics surprise you?
- Can you relate to a rating of somewhat negative due to job impact?

You'll see here, you're not alone. Many employers offer benefits such as **Employee Assistance Programs (EAP)** so their employees can receive free counseling for a period of time, no matter the issue.

Just think - if you have a major issue OUTSIDE of work, that doesn't just go away when you're INSIDE the workplace. Healthy employees are more productive employees!



6.2: WATCH- The Cost of Workplace Stress and How to Reduce It

The cost of workplace stress

By some estimates, work-related stress drains the US economy of nearly 300 billion dollars a year -- and it can hurt your productivity and personal health too, says wellness advocate Rob Cooke. He shares some strategies to help put your mental, physical and emotional well-being back at the forefront.

Watch this video to learn more about the costs of workplace stress and strategies to reduce both.

6.3: How to Establish and Design a Wellness Program

Image: Siti Heyho. Woman Stretching. Unsplash.com

Wellness programs

Designing and managing an employee wellness program is an important step in improving the health and productivity of employees and potentially improving the overall cost of employer-provided health care. Wellness programs can benefit employers by:

- Lowering health care costs.
- Reducing absenteeism.
- Achieving higher employee productivity.
- Reducing workers' compensation and disability-related costs.
- Reducing injuries.
- Improving employee morale and loyalty.

Because of the ever-increasing costs of health insurance and the importance of employee health, employers should consider implementing a well-thought-out wellness program that benefits both the employee's health and the employer's bottom line.

Step 1: Conduct Assessments

Obtaining information about the health of the workforce—and the organization's willingness to make improvements based on this information—is a critical step in developing a workforce wellness program. This information will enable the employer to design programs and services that are most beneficial to both the employer and the employee. Below are suggested steps and tools for obtaining this information:

Conduct employee surveys to evaluate the personal wellness interests and needs of employees.

Surveying employees directly helps assess the current climate as to how a program might be received and what information employees are willing to share. The Centers for Disease Control and Prevention (CDC) provides guidance on how to design an employee survey, including examples of survey topic areas.

Conduct a health risk assessment.

Assessing the health of the workforce will help determine which programs to implement. Several laws affect the use of health risk assessments, therefore, consulting with legal counsel is recommended. For general guidance, see the CDC information on health risk assessments and the Equal Employment Opportunity Commission (EEOC) guidance on wellness programs in relation to the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). The Health Insurance

Portability and Accountability Act (HIPAA) will apply when wellness programs are part of the group health plan (premium incentives, etc.).

Conduct an organizational assessment to determine which types of wellness programs to offer.

Not all programs will be well used or supported by any one organization. Transamerica Center for Health Studies offers a guide, Finding Fit: Implementing Wellness Programs Successfully, with sample assessments for each type of program.

Review group health plan utilization rates, both medical and pharmaceutical.

This information can be obtained in aggregate from the group health insurance carrier or third-party administrator.

Evaluate health culture and conduct environmental audits of the workplace in general.

See the CDC's environmental assessment. Performing an environmental audit will provide information on the workplace culture and its impact on driving employee wellness behavior.

Step 2: Obtain Management Support

Support from management is essential to building a successful wellness program. As with any initiative, management buy-in is critical for funding purposes, for obtaining support throughout the organization, and for approving policies and processes related to the program. Management can provide additional assistance by helping link the health promotion objectives to business outcomes, thereby positioning wellness as a fundamental part of the organization.

The challenge in obtaining management support is communicating the potential value of a wellness program to the organization's bottom line. See Business Case for Employees for ideas on building a business case for wellness programs.

Addressing the three questions below may help in obtaining the required support from senior management:

- What are the organization's short- and long-term strategic priorities?
- Employers should show how wellness programs support these strategic objectives.
- What benefits can be expected from the wellness initiative, and what is the potential value of wellness promotion to the organization?
- What are the leadership styles, pressures, strengths and weaknesses of the organization's senior-level executives? These answers can help determine the method of presentation.

Step 3: Establish a Wellness Committee

After conducting a needs assessment and obtaining management support, an employer can create an internal, employee-driven committee that helps build and sustain a wellness culture in the organization. This committee will help build organizational support and effectiveness for the wellness program. The responsibilities of the wellness committee might include the following:

- Evaluating the current programs, services and policies that are available in the workplace.
- Assessing employee needs and preferences.
- Developing a health promotion operating plan, including a vision statement, goals and objectives.
- Assisting in implementing, monitoring and evaluating wellness activities.

Employers should solicit committee members by invitation or ask for volunteers, ensuring there is cross-sectional representation, such as members from the top management, the HR department, information technology, communications/marketing, and the health and safety department; union representatives; and employees interested in health and wellness.

Employers may want to address these additional considerations for the wellness committee:

- Determine in advance how long wellness committee members will serve and how new members will be selected. Employers may want to alternate committee members annually to avoid burnout and to obtain new perspectives.
- Select committee members who can best represent their peers, motivate others and support the implementation of the wellness program. Employers may want to obtain the support of committee members' supervisors in providing each committee member time to devote to the committee activities.

Step 4: Develop Goals and Objectives

Using the information gathered from the workforce assessment, employers can establish goals and objectives for the program. For many organizations, a key goal is to improve workers' health and thereby reduce health care costs. Other goals may include reducing absenteeism, boosting worker productivity and increasing retention. Wellness program goals and objectives are statements of broad, long-term accomplishments expected from the program. Each goal has one or more objectives to ensure that the goal will be successfully accomplished. Objectives should be clear, time-limited and stated in such a way that it is easy to determine whether they have been achieved. Below are a few examples of goals and objectives:

- Reduce the number of employees who smoke by 5 percent in fiscal year 20XX.
- Increase the number of employees enrolled in smoking cessation classes by 15 percent by the second quarter of 20XX.
- Decrease the number of employees identified as obese by 5 percent in 20XX.
- Increase the level of medication adherence of the employee population by 10 percent.

Step 5: Establish a Budget

Establishing a budget is a critical step in creating the wellness program. Without funding, the program will stall.

When creating a wellness budget, organizations should include the cost of incentives, marketing and program design in the budget. Typical items in a budget would include screening vendor/other provider fees; incentives for participation; promotional materials; meeting provisions; pedometers/fitness trackers; HR representative and committee member time; etc.

Additionally, employers may want to consider taking the following steps to look for hidden funding resources:

1. Conduct surveys to determine if employees would be willing to pay for an aspect of the wellness program such as yoga or exercise classes.
2. Partner with the health insurance carrier to determine wellness components offered by the insurance carrier. Often these program costs are already included in the health insurance premiums.
3. Research the option of participating in clinical studies from universities or hospitals studying the impact of workplace wellness programs.
4. Research free community resources or programs to supplement the wellness program.
5. Consider implementing low- or no-cost internal activities such as a lunch walking group.

Step 6: Design Wellness Program Components

Employers have great latitude in designing the wellness program. There is not one standard program, as each will vary based on organizational needs and resources. The wellness program may range from a very simple program to an elaborate multi-prong program. It is important to include a variety of components that target risk behaviors and the needs and interests of the employees. Organizations can use the resources obtained in previous steps of organizational assessment, in wellness committee data gathering and in budgetary constraints, as well as in the goals and objectives, to determine the types of wellness programs to include in the design. See the sections on "Actions Employers Can Take" in the Transamerica Center for Health Studies report, From Evidence to Practice: Workplace Wellness that Works for ideas and guidance on specific types of programs. The company's level of desired involvement, determined from the organizational assessment in step 1, will be a key consideration in determining the types of programs to include. Examples of common programs are as follows:

- Stress reduction programs.
- Weight loss programs.
- Smoking cessation programs.
- Health risk assessments.
- Health screenings.
- Exercise programs and activities.
- Nutrition education.
- Vaccination clinics.

Although employers do have great latitude in designing wellness programs, like with the health risk assessments discussed earlier, employers still need to consider the legal issues and compliance requirements provided by the ADA, GINA, HIPAA and the Patient Protection and Affordable Care Act (PPACA), such as:

- The ADA prohibits employers from discriminating against individuals on the basis of disability, including an employee's access to wellness programs.
- GINA allows employers to "request, require, or purchase genetic information" in connection with employer-provided health or genetic services only if the services "are reasonably designed to promote health or prevent disease." The ADA has reasonable design requirements as well.
- When part of a group health plan, HIPAA mandates that individually identifiable health information collected from or created by participants in wellness programs is considered PHI and is protected by HIPAA rules.
- The PPACA requires that programs must be reasonably designed to promote health or prevent disease. Programs must be reasonably designed to be available to all similarly situated individuals, and individuals must be given notice of the opportunity to qualify for the same rewards through other means.

Step 7: Select Wellness Program Incentives or Rewards

Incentives or rewards are an effective tool to change unhealthy behaviors, to adhere to healthy behaviors, to increase participation rates or to help individuals complete a program. The argument for rewarding employees for participating in a wellness program pulls from the basic principles of behavioral psychology: People are driven to act by the positive consequences they expect from their actions. Building a rewards system into a wellness program is a great motivator. Rewards can take many forms, including points that can be exchanged for goods, gifts celebrating accomplishments or monetary awards. Over time, the motivation for rewards shifts from an external incentive to intrinsic reinforcement.

Effective incentives will be commensurate with the effort required to practice the desired behavior. For example, incentives attached to smoking cessation or weight loss should be greater than incentives for participating in a lunch-and-learn seminar.

Federal and state regulations may limit incentives, so employers should keep up to date on applicable compliance obligations.

Step 8: Communicate the Wellness Plan

The next step is to write and communicate the organization's wellness policy. This policy statement should include the organization's intent, level of involvement, and rewards and incentives system with respect to employee wellness. In communicating the reward system to employees, presenting a John Doe example may help them see the program in real-life terms.

Communication is important to marketing the program and ensuring participation. It is helpful to use communication to create a social culture where being healthy is valued. This can be done in many ways, using well-established techniques of marketing and changing behavior, such as the following:

- An attention-generating program rollout.
- A wellness program logo and slogans for various components of the program, such as "Every Body Walk Now," "Wellness Wednesday," "Recess" or "Time Out for Tai Chi."
- Visible endorsement and participation by upper management.
- Wellness education based on sound research.
- Persuasion of employees based on anecdotal situations.
- Sustaining the message and the program over several years.
- Multiple avenues of communication, such as e-mail, fliers and presentations.
- Repetition of the message. Keeping the message fresh with new information.
- Ongoing communication and marketing are important for maintaining engagement in the wellness program.

Step 9: Evaluate the Success of the Program

As with any investment or project, evaluating the effectiveness of the wellness program is important in sustaining management and employee support and in revising or implementing new programs. Employers should have established metrics and baselines at the rollout of 6/7any wellness initiative, which will vary depending on the programs implemented. For example, employers may measure participation rates, program completion rates, reduction in health care costs and percentage of employees who stopped smoking or lost weight. Employers may also want to measure the return on investment (ROI). Regardless of the tools or measurements used, evaluating the effectiveness of the wellness program is an important step in the ongoing management of the program.

Source: How-to-guide, "How to Establish and Design a Wellness Program", Society for Human Resource Management (SHRM), 2024.

NOTE: A printable PDF is attached below.

6.4: Tuition Reimbursement

Image: Hartono Creative Studio. Books and Desk. Unsplash.com

How to Offer Employee Tuition Reimbursement

Offering a tuition reimbursement program to your employees can increase employee loyalty, bring your company tax breaks and more.

With tuition soaring, 76% of employees say they're more likely to stay with their employer because of a tuition reimbursement program. Yet, 4.4 million Americans left their jobs in September 2021 — a nod to a trend that has become known as the Great Resignation. Offering a tuition reimbursement program is one win-win strategy employers can implement in their efforts to become more attractive to new applicants and retain current employees.

Here's what you need to know about offering employee tuition reimbursement.

What is tuition reimbursement?

Tuition reimbursement is an arrangement between an employer and employee in which an employer will cover a certain percentage — or all — of an employee's tuition for a study program, college degree or another form of education.

Employees must meet certain requirements before the employer will pay. For example, some employees must pay the full tuition price before they're reimbursed. Employees may also need to take a specific course set that is covered by the tuition reimbursement program. Many companies are already offering tuition reimbursement to their employees including Amazon, Apple, Starbucks, Walmart and Lowes.

How to offer employee tuition reimbursement

Your company's HR team can design an educational assistance program that they will also manage. A considerable amount of effort may go into maintaining this program, enrolling employees and keeping up with current tax laws, so it's important to ensure your HR team is up to the job. Here are a few of the factors to consider when creating your company's tuition reimbursement program:

- Will this benefit be available to everyone within your company or only for certain employees, such as those who have been with the company for a certain amount of time?
- Will your company offer another benefit or cash incentive for employees who choose not to participate in a tuition reimbursement program?
- Are there certain education programs or courses your company will choose to cover?
- What percentage of employee tuition will your company cover, and when will employees receive reimbursement?
- What will happen if an employee is laid off or resigns after enrolling in a tuition reimbursement program?
- Will your organization still offer the program if tax laws change?
- Is your company planning to retain a lawyer, CPA or another third-party resource to administer the program?

Offering tuition reimbursement can help alleviate some recruitment efforts, as this attractive benefit may help retain employees longer.

Tuition reimbursement benefits for employers

Employers can also benefit from a tuition reimbursement program in multiples ways, such as:

- **Earn tax breaks.** An employer can reimburse employees up to $5,250 annually without this amount being taxed. While more can be offered in a tuition reimbursement program, any amount above the allotted amount will be seen as a fringe benefit and will be subjected to taxes. Employers can also deduct the maximum of $5,250 per employee from their taxes each year, making tuition reimbursement cost-effective for all parties involved. For tuition reimbursement to stay tax-free, the money can only go towards tuition, fees and school supplies, such as books. Additionally, graduate courses are tax-exempt only if the employee is in a research or work-study position.
- **Strengthen your company.** A tuition reimbursement program is an attractive benefit to employees searching for companies that will foster their professional development. Offering employees the opportunity to take essentially free coursework in line with your company's industry will strengthen skills that they can bring to their current role. This commitment to your employee development will also further improve your company's reputation.
- **Reduce recruitment costs.** Offering tuition reimbursement can help alleviate some recruitment efforts, as this attractive benefit may help retain employees longer. The more effective benefits your company offers, the greater the chances the employees will stay at a job for a longer period of time, resulting in less time and resources spent recruiting employees to fill positions. Additionally, employees who increase their skills have a greater chance of promotion, so there is more opportunity to promote from within than to hire externally.
- **Promote employee loyalty.** Employees will see your commitment to their professional development through a tuition reimbursement program and may be more likely to stay loyal to your organization. The more emphasis you place on employee growth, the greater chance an employee will choose to stay on your payroll.

Source: "How to Offer Employee Tuition Reimbursement", U.S. Chamber of Commerce, 2024

NOTE: A printable PDF is attached below.

6.5: LISTEN- Tuition Reimbursement - Why to Ask for Help

Tuition Reimbursement

The cost of going to college is high. Some employers will offer to help you pay for your education. As you listen to this interview, what did you learn about why a company would offer to help offset the costs? Are there other benefits you can think of?

6.6: Employee Recognition

Employee Recognition

Image: VectorPortal.com. CC-BY

Story Highlights

- Top performers need to know their efforts are recognized and valued
- Employee recognition isn't one-size-fits-all
- Money isn't the only, or even the top, form of recognition

In today's war for talent, organizations and leaders are looking for strategies to attract and retain their top performers while increasing organic growth and employee productivity. From offering new perks to designing flexible workplaces, company efforts to optimize the workplace are as strong as ever.

But in their search for new ideas and approaches, organizations could be overlooking one of the most easily executed strategies: employee recognition.

According to Gallup's analysis, only one in three workers in the U.S. strongly agree that they received recognition or praise for doing good work in the past seven days. At any given company, it's not uncommon for employees to feel that their best efforts are routinely ignored. Further, employees who do not feel adequately recognized are twice as likely to say they'll quit in the next year.

This element of engagement and performance might be one of the greatest missed opportunities for leaders and managers.

Workplace recognition motivates, provides a sense of accomplishment and makes employees feel valued for their work. Recognition not only boosts individual employee engagement, but it also has been found to increase productivity and loyalty to the company, leading to higher retention.

Beyond communicating appreciation and providing motivation to the recognized employee, the act of recognition also sends messages to other employees about what success looks like. In this way, recognition is both a tool for personal reward and an opportunity to reinforce the desired culture of the organization to other employees.

Acknowledging the Individual

Gallup's data reveal that the most effective recognition is honest, authentic and individualized to how each employee wants to be recognized. Acknowledging employees' best work can be a low-cost endeavor -- it can be as small as a personal note or a thank-you card. But the key is to know what makes it meaningful and memorable for the employee, and who is doing the recognizing. Keep these employee recognition ideas in mind the next time you praise a colleague.

In a recent Gallup workplace survey, employees were asked to recall who gave them their most meaningful and memorable recognition. The data revealed the most memorable recognition comes most often from an employee's manager (28%), followed by a high-level leader or CEO (24%), the manager's manager (12%), a customer (10%) and peers (9%). Worth mentioning, 17% cited "other" as the source of their most memorable recognition.

What's most surprising about these findings? Nearly one-quarter said the most memorable recognition comes from a high-level leader or CEO. Employees will remember personal feedback from the CEO -- even a small amount of time a high-ranking leader takes to show appreciation can yield a positive impression on an employee. In fact, acknowledgment from a CEO could become a career highlight.

When asked what types of recognition were the most memorable, respondents emphasized six methods in particular -- and money isn't the only (or the top) form of recognition:

- public recognition or acknowledgment via an award, certificate or commendation
- private recognition from a boss, peer or customer
- receiving or obtaining a high level of achievement through evaluations or reviews
- promotion or increase in scope of work or responsibility to show trust
- monetary award such as a trip, prize or pay increase
- personal satisfaction or pride in work

It is essential for leaders and managers to keep these employee recognition examples in mind when acknowledging their team members' successes or accomplishments.

Recognition From All Sides

The best managers promote a recognition-rich environment, with praise coming from every direction and everyone aware of how others like to receive appreciation. This type of employee feedback should be frequent -- Gallup recommends every seven days -- and 2/6timely to ensure that the employee knows the significance of the recent achievement and to reinforce company values.

The criteria for recognition should align with the purpose, brand and culture of the company and should reflect its aspirational identity to inspire others. Rewarding employees who are not top performers could adversely affect high performers' motivation. As such, companies need to state specific standards for awards to avoid any backlash. Great managers know that they can never give too much recognition as long as it's honest and deserved. Acknowledging an employee's best work goes a long way toward making him or her feel valued and can lead to other desirable workplace outcomes.

Source: Gallup, "The Importance of Employee Recognition: Low Cost, High Impact", January 12, 2024

6.7: PayPal Case Study- Ensuring Your Workers Are Not Just Surviving

Image: PayPal Logo. CC-BY 4.0

Accommodation and Enhancement in Action

Since 2015, I've been President and CEO at PayPal, a company that focuses on the digital transfer of money and e-commerce. Our business model is driven by our mission: We want everyone — individuals, families, small businesses, retailers of all sizes — to have access to affordable, convenient and secure financial services. As a company, our employees and I have worked hard to deliver on this goal for customers and communities around the world. And we've felt even greater urgency now during the COVID-19 pandemic.

But while we were focused on fulfilling our mission in the larger world, we missed something that was going on inside our company. At PayPal, we make it a point to pay above-market salaries and offer generous benefits, and we assumed this was sufficient. But when we looked more closely, we saw that in some places and for some people, it just wasn't enough.

For example, 65 percent of our customer-service and entry-level employees reported they were frequently running out of money between paydays. As a result, they had to make difficult trade-offs in educating their kids, paying for healthcare, and planning for the long term.

At times, they faced more heartbreaking situations. In 2017, we created an Employee Relief Fund to help people in case of a significant or unforeseen financial shock. One sign of trouble came from a trend that we saw in applications to this fund: We found urgent requests for help were increasingly the result of everyday events, like an unexpectedly steep medical bill, a student-loan payment or a car breaking down.

Knowing that our employees were struggling in this way was simply unacceptable. So, we decided to take some significant steps to shore up their financial security and health. There were four key elements to the Employee Financial Wellness Initiative that we announced at the end of 2019: 1) We reduced the cost of healthcare; 2) we reviewed and raised wages where appropriate; 3) we made everyone a shareholder and long-term beneficiary of our collective success as a company; and 4) we wrapped everything with a long-term financial education and planning program.

At the core of this program was a calculation called Net Disposable Income, or NDI. NDI is the amount of money that a person has left over after paying taxes and necessary living expenses, such as taxes, food, housing and transportation.

We began by reviewing current starting pay for our more than 23,000 global employees by location, taking into account their estimated cost of living and taxes. But we also wanted to go further and understand the impact of other key factors that were within our control as a company — factors like health insurance, long-term savings opportunities, even timing of when people were paid.

We looked at NDI in each of the different geographic locations in which we have employees, and we found that many of our entry-level and hourly employees had an NDI of 4-6 percent. In other words, at the end of every month, they had only this small percentage of their pay that wasn't automatically going toward their essentials. If we want employees to fulfill our company's mission and innovate and effectively deliver services, we simply can't have them worrying how they'll make ends meet every month or how they'll cover the long-term needs of their families.

Ultimately, we decided to target an NDI of at least 20 percent. To drive an increase this significant, we needed to think more holistically and look at both their income and their costs. By far, the biggest cost driver for this portion of our workforce was healthcare. While we offered a generous health plan, it was generally the same price for everyone at the company. But this meant the lower a person's income, the more expensive it was for them — and a higher percentage of their income. So, we lowered the cost of US healthcare benefits for hourly wage earners by an average of nearly 60 percent for employees for whom the cost of healthcare was too high.

After tackling wages and healthcare costs, **a third step was to help employees save more and better prepare for the future.** We chose to make everyone a shareholder and owner of PayPal, irrespective of level or position. We made one-time PayPal stock

grants to anyone who hadn't already received one, and we made everyone eligible to earn PayPal stock awards annually. I fundamentally believe that employee ownership of our company through stock is foundational to our success, because it gives every employee the opportunity to benefit from our performance and puts them all on the path toward building long-term savings.

Finally, we've launched a full suite of financial learning programs and counseling. As we all know, building and maintaining fiscal health requires continual learning, and it's not a linear journey. Financial matters are complex, and we all need support along the way. We now offer coaching services, personalized consultations and other resources for all of our employees, and we're continually exploring, evaluating and introducing new tools. Last but not least, we continue to maintain the Employee Relief Fund for urgent situations.

Of course, it will be a while before we learn the real impact of these changes and whether they're sufficient in meeting people's needs. We announced this program at the end of 2019, and we're monitoring its progress.

But we've already started to see promising results, such as:

- A decrease in the number of employees who report they are running out of funds between pay periods
- An increase in healthcare benefit enrollment and employees upgrading their plans
- A higher rate of 401(k) and employee stock purchase plan enrollment

This has been a major undertaking, but it's something we'd absolutely do again and encourage other companies to do as well. When we began this effort, I certainly didn't expect to discover such a large gap between what we were providing for our employees and what they needed. Closing this gap has required a significant financial investment, but I believe it's worth every dollar and every resource and that it's been essential to making our workforce more resilient in the face of COVID-19.

Capitalism needs an upgrade — while I still think it's the best system to stimulate innovation and commerce, it's not working for a lot of people. The next generation of business leaders has an obligation to take action and do more, and prioritizing and investing in our employees is tangible and doable. If enough leaders and companies can make this difference for their own people, we can start to fix what has been broken.

About the author

Dan Schulman is the CEO of PayPal. He is focused on democratizing and transforming financial services and e-commerce to improve the financial health of billions of people, families and businesses around the world. With extensive experience in payments and mobile technology, Schulman is leading PayPal to reimagine how people move and manage money, and how merchants and consumers interact and transact.

Source: "How can you ensure your workers are not just surviving — but thriving? A CEO shares a new approach", Ideas.ted.com. May 29, 2020.

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