Employee Benefits Report

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Can Healthcare Report Cards Really Help You?

We have ratings for automobiles and dishwashers, why not health plans? That's the rationale, at least, for a slew of organizations, profit and non-profit, now offering report cards that compare the service and cost of healthcare providers. (See sidebar P. 3.) Over the past decade, comparative data on hospitals, health plans, and individual physicians have been increasing. Here's how to use that information to your advantage.

In a typical health care report card, the rating information considers a provider's reputation, mortality rates (for specific procedures), accreditation status, and results of surveys by organizations that evaluate healthcare quality. The better report cards organize the information into a logical framework, since people tend to understand and use information more easily when it is presented in a small number of bits. They also provide interactivity, so users can specify their needs or requirements and find a list of matches.

In order to make the data useful for meaningful comparisons, researchers devise methods to estimate the values for missing data, adjust outcome data for the prior health status of the patients included (a technique known as risk adjustment), and evaluate various aspects of care on similar scales.

The report card on report cards

But who uses report cards and how effective are they? A Rand analysis of report cards found there is now a major industry centered around the collection, analysis and publication of quality data, but attempts to evaluate the effectiveness of these efforts have been sparse and difficult to conduct. Further, because no clear agreement exists about their actual purpose, evaluation of the report cards' effectiveness is difficult.

On the consumer side, evidence from surveys and focus groups suggests that consumers want more information about the performance of their health care providers than report cards offer, and that report card information influences few in their decision-making. According to the surveys, consumers' choice of hospitals relied more on anecdotal press reports of adverse events than on the comparative assessments available.

Purchasers of corporate health plans, meanwhile, have been no more likely than indi-

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This just in

The Department of Labor has issued proposed regulations for civil penalties applicable when a plan administrator fails to comply with disclosure requirements created by the Pension Protection Act. The PPA authorizes the DOL to assess a civil penalty of not more than $1,000 per day for violations of the new disclosure requirements. These include requiring administrators of automatic contribution arrangements to provide notice of the arrangement to participants.

The DOL's proposed regulations explain how the maximum penalty amounts are computed, identify the circumstances under which a penalty may be assessed, describe procedural rules for service and filing and provide for an administrative hearing process to contest a DOL assessment.

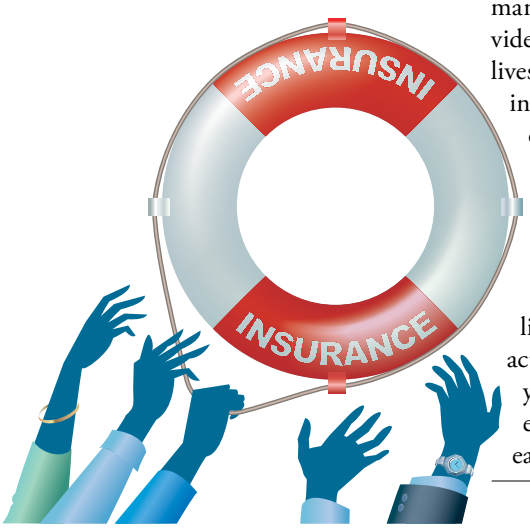
Growing Your Group Life Insurance Offerings

At the end of 2006, 170 million group life insurance certificates were providing $10 trillion of coverage to Americans—most of it employer-sponsored. Today, group coverage accounts for nearly half of the total face value of in-force life insurance in the United States.

The year was 1911, the city was Passaic, New Jersey, and the company was the now-defunct Pantasote Leather Company. That's the when and where of the first group life insurance policy ever issued.

Since then, employment-based life insurance has continued to grow. At the end of 2006, 170 million group life insurance certificates were providing $10 trillion of coverage to Americans—most of it employer-sponsored. This group coverage accounted for 47 percent of the face value all life insurance in force in the United States, according to the American Council of Life Insurers.

As health insurance premiums continue to rise, we see life insurance playing an increasingly important role in employee benefit packages. Employees like life insurance benefits, too — once they have life insurance, they tend to keep it. The voluntary termination rate of group life insurance policies in 2006 was only 8.6 percent. Since many group plans are either contributory or voluntary (employee-paid), that indicates employees think group life insurance is a good value.



The most common form of group life insurance is term life, which provides coverage for a specified period, usually one year or more. Term policies provide no further benefits when the term expires, and no buildup of cash value occurs. If this insurance is not renewed at the end of its term, coverage lapses and no payment is made to the beneficiary in the event of death.

As with individual life policies, group policies can be purchased on either a participating or nonparticipating basis. Most group life policies are nonparticipating—94 percent of those purchased in 2006.*

Here are a few options available for enhancing your life insurance benefits:

Whole Life. Unlike term insurance, permanent life (or whole life) insurance provides protection for as long as the insured lives. Permanent life policies also have a savings component, building cash value that can help families weather financial emergencies, pay for special goals, or provide income for retirement years.

The annual premium for traditional whole life policies remains constant throughout the life of the policy. In earlier years, the premium is higher than the actual cost of the insurance, but in later years it becomes substantially lower. The excess amount of each premium in the early years is held in reserve as the policy's cash value. This cash value grows over time from investment earnings and future premium payments, providing funds the insured can borrow as a policy loan. If a policyholder decides to give up the insurance protection, he or she receives the cash value upon surrendering the policy, less any outstanding policy loans.

Please keep in mind that insurers individually underwrite whole life policies. This means that if you want more than a minimal amount of whole life coverage (such as $25,000), the insurer will require you to complete a standard life insurance application, which is more comprehensive than a group insurance application. If you have poor health, the insurer can decline to cover you for higher amounts.

Portability. Employees often can retain coverage after retirement by paying premiums directly to the insurer. Many policies also offer survivor benefits, usually continuing monthly payments to the spouse of an employee who dies before retirement; payments may extend for life or to the age at which Social Security retirement payments become available, but cease on remarriage.

Contingent Benefits. The policy makes payments to dependent children in the event of a spouse's death. The initial value of these survivor benefits can range from three to 10 times an employee's annual salary.

Accelerated Benefits. To help ease the financial burden that often accompanies a serious illness, accelerated benefits allow terminally ill insureds (employees and spouses) with a life expectancy of six months or less to receive an advance payout of a percentage of their group life insurance face amount. Available to covered individuals with a minimum of $10,000 in coverage, insureds may accelerate up to 50 percent of the face amount of their insurance, to a maximum of $250,000.

Waiver of Premium. Also known as "continued protection," this option waives premium payments for a disabled employee after a specified waiting period. Of group life policies in force in 2006, 94 percent, or 45 million, provided for waiver of premium in case of disability.

Will Preparation. To help insureds protect their assets and secure their families' fi-

*A participating policy pays a dividend to policyholders when premium charged is more than actual losses.

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vidual consumers to use report cards in their decision making, according to Rand. Only a small proportion of purchasers reported even using accreditation data in their purchasing decisions. Those who have used report cards, however, are generally satisfied, according to Rand.

Physicians also are unlikely to use publicly available information as the basis for patient referrals. Although physicians tend to consider the information accurate, they seldom share it with patients. Moreover, many physicians believe that public disclosure of performance information encourages other physicians to refuse to treat those patients in the poorest health.

Too crude or too complex?

Although health insurance companies, government agencies, and employer groups have already spent millions of dollars to develop report cards to rate insurance plans, the report cards published to date have been few and crude, according to an article publish last August in *Consumer Reports.*

The very complexity of providing comparisons between insurance plans makes report cards for these products of little value, according to Kip Sullivan, research director for Minnesota COACT, a citizen healthcare rights organization.

"Health insurance is the ultimate bundled product. There are now approximately 7,500 services for which physicians bill. The count rises if services offered by nonphysician providers are added," says Sullivan. "Thus, the purchaser of a typical health insurance policy is buying, in one bundle, access to thousands of services. A report card simply can't provide detailed information on the quality of thousands of services provided through that company."

At this time, report cards that rate healthcare providers (rather than plans) are more useful for employers and healthcare consumers. These report cards work much like they do for school children—rewarding the ones that earn high marks by increasing their profile, and inspiring the ones with poor marks to do better or risk losing their reputation. ■

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ny) fails to comply with his requests for information? What about Forms 5500? PBGC premiums?

Watch out for…

While there plenty of areas of concern, here are a few major due diligence issues to review:

- **COBRA** – Will the transaction trigger a COBRA notice event? If so, under whose plan are the qualified beneficiaries covered?
- **Defined benefit plans** – What is the funded status of the plan on an ongoing and on a termination basis? What will be the PBGC's interest in the transaction?
- **Defined contribution plans** – Does the plan have a current IRS determination letter and are there operational defects?
- **Executive compensation arrangement** – Will the payout of benefits be accelerated as a result of the transaction?
- **Collective bargaining agreements** – Do they require automatic benefit increases?
- **Multiemployer plan withdrawal liability** – Will it be triggered?
- **Retiree medical benefits** – Who keeps or assumes the liability?
- **Severance benefits** – Will either company owe these benefits as a result of the transaction?
- **Plan loans** – How will they be handled?

Bottom line: Benefit issues in mergers and acquisitions are varied and complicated. They don't typically drive a transaction, but they can bring it to a screeching halt. Companies that support their human resources director and benefits managers — and do their homework on their own plans before a transaction — will be best prepared to avoid unpleasant surprises. ■

Where to Find Healthcare Report Cards

ConsumerHealthRatings.com provides a comprehensive listing of organizations that rate or report performance on specific hospitals, health plans, physicians, nursing homes, home health agencies and other health care providers in the United States. The ratings information is free.

The National Committee for Quality Assurance (www.ncqa.org) is a private, not-for-profit organization offering free interactive report cards. The group is governed by a board of directors that includes employers, consumer and labor representatives, health plans, quality experts, policy makers, and representatives from organized medicine.

The New York State Health Accountability Foundation (www.nyshaf.org) is a public-private partnership dedicated to promoting transparency in the health care system and providing employers and consumers in New York and New Jersey with information on health care pricing and quality.

The state of California's Office of the Patient Advocate (www.opa.ca.gov/report_card/) provides rates on healthcare plans, hospitals and long-term care services, searchable by medical condition, hospital or location. ■

LIFE INSURANCE—continued from Page 2

nancial future, this option covers the legal fees associated with preparing or updating a will, when insureds or their spouses use a participating attorney.

Adding options to your group life program can be a cost-effective way to enhance your benefits package. For more information, please contact us. ■

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What's Your Role in a Merger or Acquisition?

During a corporate merger or acquisition (M&A), it's easy to overlook employee benefit programs. These programs can create hidden liabilities and administrative headaches for the parties involved. In a few cases, employee benefit plans may break a deal. In still other situations, employee benefit plans may tip the scales in favor of the transaction.

In either case, benefits managers, assisted by their employee benefits attorneys, have a role to play in helping merging or acquiring companies avoid unexpected or unwanted liabilities, create a smooth transition for employees, and ease the integration of benefit plans and cultures of the buyer and the seller.

Due diligence

Usually in a merger or acquisition, the parties will start by negotiating the representations and warranties in the sale and purchase transaction agreement and (this is where you come in) conduct due diligence.

Due diligence involves identifying all of the other party's employee benefit plans, determining whether such plans have complied in form and in operation with applicable requirements, their level of funding, whether any benefits are paid solely as a result of the transaction and the impact of any risk on the overall transaction.

If your company is the buyer, it should review all plan documents, determination letters, employee communications, financial and other reports to make sure that they are internally consistent and whether there exists any unidentified potential liability. If any of the benefits are provided pursuant to a collective bargaining agreement, that agreement should be reviewed to determine whether any automatic increases are required.

Naturally, the earlier that due diligence is conducted, the better. This will give your company adequate time to deal with problems and possibly make adjustments to the purchase price if necessary.

Why is due diligence important? Consider all the potential pitfalls of just pension benefit plans. For example, what if one company's plan turns out not to be qualified? This can result in plan disqualification, meaning adverse tax consequences to your company and plan participants.

What if a plan is underfunded or overfunded? Who is going to make up the difference or reap the excess assets? Have all reporting and disclosure requirements been met? What about that pesky participant who keeps asking for information in the hopes of collecting a $100 per-day penalty if the plan administrator (often the compa-

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When to Call a Benefits Attorney

In addition to M&As, here are a few specific examples of instances when it's appropriate to retain an ERISA/employee benefits attorney:

- **Substantial workforce reduction: outsourcing or layoffs**
- **Qualified Domestic Relations Orders ("QDROs")**
- **Designing plan documents, including Summary Plan Descriptions and notices**
- **Analysis/impact of new legislation**
- **Merging an existing money purchase plan with an existing 401(k) plan or profit-sharing plan**
- **Determining fiduciary liability concerns**
- **Sarbanes-Oxley Act planning for blackout periods, company stock and audit oversight.**

The most common mistake that companies make in seeking advice and counsel is waiting until the Internal Revenue Service, Department of Labor or a lawsuit forces the company to hire experienced ERISA/employee benefits counsel, according to Jeff Robertson, an attorney with Barran Liebman LLP in Portland, Ore. ■