

New Guidelines from the IRS on W-2 Reporting of Health Care Costs

On March 29, 2011, the IRS issued Notice 2011-28 to employers regarding the information reporting requirements on each employee's annual Form W-2 of health insurance coverage. This new reporting to employees is

The PPACA (Patient Protection and Affordable Care Act), which was enacted in March of 2010, ensures that employers must report the cost of health care coverage on the Form W-2.



Helpful to Small Employers

With the new guidelines, the IRS provided additional relief for small businesses (filing less than 250 W-2 forms) by making the requirement voluntary for them at least in tax year 2012. The optional treatment for smaller employers will remain in effect until further IRS guidelines are issued.

Opportunity for Benefits Communications

Employers can utilize health care reform as a chance to better communicate with employees regarding their health and wellness benefits. The new requirements will help employees gain a better understanding of the cost, and value, of their coverage. Many employees are going to be surprised at the cost of

for informational purposes only. It is to inform employees of the cost of their health care coverage. Furthermore, the IRS has stressed that employer-provided health care coverage continues to be excludable from an employee's income, and is therefore not taxable.

their health care benefits, and employers can use this opportunity to open a discussion about health care cost containment. They can also emphasize the investment the company makes in each employee in the form of benefits.

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Study Finds That Employees Value Benefits, But Still Don't Understand The Costs

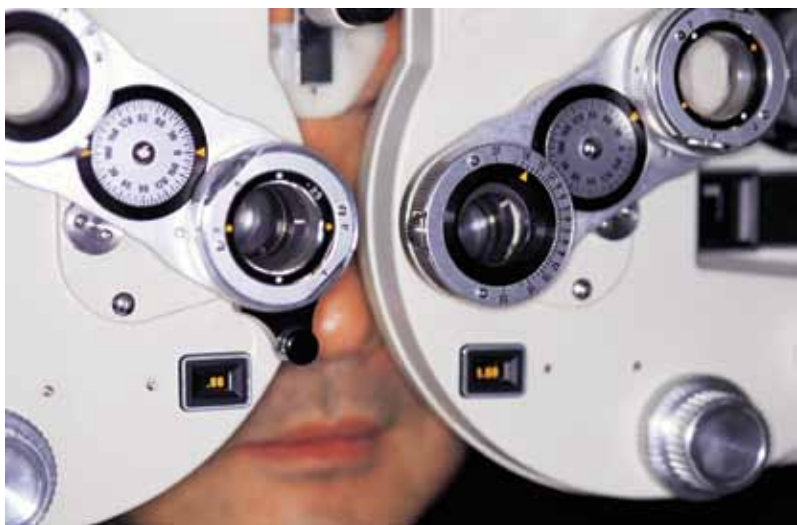
Whether an employee is old, young, male, or female, they most likely already understand the value and importance of benefits like dental insurance, health insurance, and 401(k)s.

That said, the consulting and research firm LIMRA surveyed 1,500 U.S. employees and found that 40% of them didn't know the cost of their health insurance. Furthermore, of the 60% that felt they did know the cost of their health insurance, only 15% could actually state a reasonable cost estimate.

The results of the survey, which were published in LIMRA's What Is \$1 Billion an Hour Worth? Employee Perspectives on Benefits research report, were weighted to be representative of the U.S. labor force, including employer size, private/public company, male/female, and full/part-time employment. Here are some of the key findings:

- While employers frequently have the common misconception that younger employees don't value benefits as much as their older employees, the survey suggests that younger employees actually value benefits almost as much as their older counterparts. It appears that the different values an employee places on benefits has more to do with life experience than it does life stage, education level, or salary level.
- LIMRA's survey showed that U.S. employees generally underestimate the health insurance premium percentage covered by their employer -and- the premium percentage they pay for non-medical benefits.
- Participants were asked what their number one factor would be when considering two similar job offers, each with a comparable salaries. Benefits, such as dental, medical, and retirement plans, were the number one factor for 62% of the participants. Other important factors included: an employer's stability (59%); paid leave (52%); competitive increases in salary (50%); the work environment (42%); an employer's location (38%); fulfilling, rewarding, and challenging work (37%); an opportunity for personal growth (33%); an employer's reputation (32%); a fair balance between personal life and work, such as telecommuting and flex time (31%); the growth potential of the employer (27%); monetary bonuses (26%); and an employer's size (8%).

- While it's clear that most employees value benefits, the research found that the majority didn't understand the costs and didn't know how much their benefits were worth. Such can often make it difficult for employees to make informed, knowledgeable decisions as they decide who to work for and what benefits to select.
- Considering that around 60% of employers have indicated that they plan to continue shifting the skyrocketing costs of benefits toward their employees, employees must know their benefit package's price components and any potential lifestyle or financial changes facing them if any of these price components were to change in the future. The survey found that an employee's decisions about their benefit package as a whole was impacted when they understood how much their benefit was currently costing and any projected cost increases for the future.



- According to the survey, most employees say they're open to paying higher premiums to retain a current benefit plan that they've used regularly, such as their dental, vision, or medical coverages. However, a third of the respondents said that they found it difficult to pay for their benefits. Households with less than \$25,000 in annual income found it particularly difficult to pay for benefits, but households with twice that amount of income also reported struggling to afford their benefits.

Health Plans Tighten Provider Networks to Offer Lower Premiums

A tough economy and ever-climbing health care costs are driving changes to network-based health plans. Employers, seeking more manageable premiums for their health plans, have grown more willing to limit employee provider choice. Insurers have responded with plan options that feature a more limited number of in-network providers, or options that segment in-network providers into tiers, and vary member cost-sharing based on which providers are used.

up paying an extra \$1,000 for a surgery, or an extra \$500 for an imaging service, than if a hospital in the enhanced benefits tier had been chosen.

“Narrow” or “limited” networks leave certain providers out entirely. The inclusion/exclusion determination may be based on quality, cost, geography, or “cultural competence,” or some combination of these factors. An insurer may offer several variations on this concept, with the narrowest networks offering the most limited provider selection-and the lowest premium.

The growth in limited and tiered networks is all about timing. A protracted poor business climate has spurred employers to buck the status quo of maintaining almost unlimited provider selection for employees outside of an HMO plan. Feeling cost pressures of their own, employees may be more willing to consider switching providers, if doing so keeps their premium in check or lowers their out-of-pocket cost at the point of service. And, if these plans go over well with employees now, they’re more likely to maintain their market share, or grow in use, as the economy improves.

Limited and tiered plans also fit nicely with the consumer-directed health plan approach. Consumer-directed health plans urge members to be more conscious about their health care “purchases,” and to “shop around” before making a major health care buying decision, just as they would with any large purchase. In tiered networks especially, members can bring cost-conscious consumerism to every health care decision, by looking at their choice of providers and deciding whether a particular doctor or hospital is worth a larger copayment or higher coinsurance rate.

As with any change in benefits, employers implementing tiered or narrow networks are likely to see them go over better with employees if the change is preceded by effective communications. Though employees know their payroll deduction for health insurance, they might not know the employer’s cost. Employees should know how much the company contributes to their health coverage, how this expense is impacting what the business could do in other areas, and the potential premium savings-to them and to the company-from a tiered or narrow network. Only then, as better-informed consumers, are they likely to understand the true cost of choice.



Tiered networks assess providers according to cost and quality benchmarks, and then place them in groups with different member cost-sharing requirements. (The model for this type of plan structure can be found in health plan prescription drug reimbursement, which commonly divides covered drugs into tiers based on whether they are generic, brand, specialty, lifestyle, etc.) In a tiered network health plan, each time members access care, their deductible, copayment or coinsurance may vary, depending on which tier the selected provider is in. For example, a plan may segment providers into three tiers that pay benefits at basic, standard and enhanced levels, with enhanced benefits paid for providers that have met benchmarks both for quality and for lowest cost. If a member chooses to have a procedure in a hospital in the basic benefits tier, he or she may wind

Five Ways to Avoid OSHA Penalties

In a one-week period in September 2010, the U.S. Occupational Safety and Health Administration announced eight citations against employers; penalties totaled close to one million dollars. The agency fined a picture frame manufacturer for not protecting workers' hearing, allowing combustible dust to accumulate, and blocking exit routes. An excavating contractor is paying a six-figure fine for failing to protect workers against cave-ins. A painting contractor's scaffolding was missing railings, bracing and access ladders. Because OSHA had cited the company for these violations before, it levied a fine exceeding \$200,000.

Clearly, failing to comply with OSHA regulations can be costly for employers. However, by implementing a few new procedures and attitudes, a company can reduce the chances that its name will end up in an OSHA news release.

Improve record keeping. Think of good documentation as your first defense against an OSHA inquiry. Inspectors who find information gaps in the OSHA 300 log (the record of work-related injuries and illnesses) may initiate a full-scale safety audit of the business. If your business has deficiencies in its logs for the past three to five years, devote some time to correcting them. Personnel files and workers' compensation loss records can provide much of the missing information.

Focus on ergonomics. OSHA has announced that it will pay special attention to musculoskeletal problems. Businesses that seek out ways to prevent repetitive motion disorders will avoid citations and penalties. They will also pay lower workers' compensation insurance premiums in the long run. Analyze how workers are performing their tasks and look for ways to reduce the strain on their joints, necks and backs.

Fix the routine violations first. Some safety issues are simple and cost little or nothing to correct. For example:

- Blocked exits
- Lack of protective equipment, such as gloves and safety goggles
- Poor housekeeping
- Improper storage of materials such as flammable liquids

These problems can accumulate over time if management is not paying attention. Operations with large numbers of these violations have paid substantial penalties

to OSHA, so monitoring and correcting them is essential.

Have a plan for disasters. Hurricane Katrina and 9/11 have taught us that all organizations need to have emergency procedures in place for sudden events like storms and terrorist attacks and gradual events like flu pandemics. Disaster plans should include:

- Training for employees on what to do in the event of an emergency
- Procedures for safe evacuation from the building
- Workplace hygiene
- Stockpiling of emergency supplies such as first-aid kits
- Arrangements for operating from remote locations
- Communications with employees, their families, customers and vendors

Although OSHA will not be concerned with some of these aspects of the plan, having them in place will help the business survive the event.

Look at safety as a profit driver, not a cost center. Preventing workplace injuries costs money, but it also saves money and can improve a business's profitability. Some project owners and general contractors will consider bids only from contractors with workers' compensation experience modifications lower than 1.0. Firms with a reputation for safe operations will attract better workers. Also, keep in mind that insurance does not cover many of the costs resulting from workplace accidents, such as time spent on investigating the incident, reduced employee morale, productivity lost because of the disruption and the absence of a worker, reporting costs, and the cost of OSHA penalties. Money saved on accidents that never occur goes straight to the bottom line.

Some workplace injuries may occur despite an employer's best efforts to prevent them. However, taking reasonable steps to improve safety in the workplace will reduce the frequency and severity of those injuries, make the business more competitive, and avoid problems when an OSHA inspector visits.

