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NEWSALERT
May 2024 | Volume 2 | Issue 5

Retention, Recruitment Costs

Study Pegs Group Benefits Return on Investment at 47%

A RECENT STUDY has found that employers who offer health insurance coverage to their staff had an average return on investment (ROI) of 47%, meaning that for every $1 an employer spends, it will receive $1.47 in benefits.

The analysis by Avalere, a wellness plan provider, and commissioned by the U.S. Chamber of Commerce, found that firms with 100 or more workers to whom they offer group health benefits gained from increased productivity, reduced direct medical costs, tax benefits and improved retention and recruitment.

The study confirms that offering health coverage does more than meet a basic need for your staff. Here's how the 47% ROI is generated:

Improved productivity (53% of ROI)

Workplaces where group health benefits are offered have higher productivity thanks to reduced absenteeism and sick days taken, as well as less presenteeism. In addition, workers who maintain their health and have access to a health plan or wellness program when they need one are less sick, and hence more productive at work.

Tax benefits (23% of ROI)

Employers that offer group health benefits receive both federal and state income tax deductions, reducing their overall tax bills.

Reduced direct medical costs (19% of ROI)

Employers who offer group health plans in addition to associated wellness programs, tend to have healthier employee populations and spend less on direct medical costs. The analysis found that this combination of group health and wellness programs boosted overall ROI for employers.

Savings from employee retention (4% of ROI)

Another ROI driver is employee retention thanks to the savings involved in not losing employees to competitors. Providing health insurance reduces staff turnover, lowering how much employers have to spend on recruitment, onboarding and training. Add tens of thousands of dollars if you are paying for a new employee to relocate.

Recruitment costs (0.3% of ROI)

Offering a solid group health plan can also drive down the cost of recruiting as it can positively influence a prospect's interest in accepting an offer.

While the value of recruitment benefits pales in comparison to other benefits, 9% of prospects base their decision to accept an offer on the group health benefits on offer.

See 'Benefits' on page 2

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Growing Risk

Employee Mental Health Leave Requests Skyrocketing

IF YOU'VE noticed a lot of employees asking for time off for a "mental health day," you aren't alone.

A recent study found that the number of mental health leave-of-absence requests has grown by a third since the COVID-19 pandemic. And, data from ComPsych, a provider of employee assistance programs (EAPs), shows that such leave requests have skyrocketed by more than 300% in the past six years.

Roughly seven out of 10 leave requests for mental health reasons are from women — in part but not entirely because of the burden and added stress of childcare.

Poor mental health is a serious problem in the workplace. Stress, anxiety, depression and substance abuse lead to reduced focus and concentration, increased absenteeism and presenteeism, higher turnover costs, and more dangerous workplace accidents.

If you're seeing a broad increase in the number of mental health-related absences, it's a sure sign that something is wrong.

WHAT EMPLOYERS CAN DO

1. **Destigmatize mental health problems.** Create a culture where it's ok to discuss mental health issues, and to seek help.
2. **Establish an EAP.** Workers can use this program to get confidential counseling treatment for a variety of issues.
3. **Invest in mental health training for managers.** Your leaders need training on how to recognize and sensitively deal with workers experiencing mental health problems.
4. **Offer flexible work schedules.** Many minor issues can be dealt with by allowing employees more control over their work-life balance. Working from home, flex hours, job-sharing programs and generous paid-time-off policies can all help.
5. **Create a less stressful workplace.** Work to reduce unrealistic deadlines, spread the workload and maintain adequate staffing levels. Reassign or eliminate "toxic" managers.
6. **Address cost barriers to care.** Many employees can't afford to see a doctor or counselor, even with insurance. Consider adding a direct primary care benefit, which allows workers and covered family members unlimited appointments with their primary care physician with no out-of-pocket costs.
7. **Offer mental health or sick day leave.** Employers nationwide are responding to the employee mental health crisis by expanding their leave programs. In 2024, over 50% of organizations plan to add paid parental leave, paid mental health days and flexible time off programs. Additionally, 49% are adding bereavement leave, and 37% are adding paid caregiver leave as an employee benefit.

The takeaway

Employers have a number of tools they can access to help employees who are dealing with stress and anxiety. Work can also be a cause of stress, so it's important that your staff should feel comfortable approaching their supervisors or managers if they are having trouble coping.

You can't prevent all mental health problems. But you can alleviate work stressors and provide support so that small problems don't metastasize into mental health crises. ❖

Continued from page 1

Benefits Boost Productivity, Retention and Recruitment

The takeaway

While the study focused on health coverage, and to some part wellness programs, employers that go beyond just health insurance by creating and offering a balanced benefit program, have the greatest ROI.

Examples include retirement benefits like 401(k) plans, wellness plans, dental insurance, vision coverage, short- and long-term disability protection, critical illness coverage, accident coverage and employer-funded life insurance.

Before the COVID-19 pandemic, most businesses considered health benefits little more than a cost to be managed. But the value of health benefits is rapidly changing — and employers need to keep up with the changes and new offerings.

.The Avalere study reinforces what many companies know: Employer-provided coverage helps create a stronger workforce and gives businesses valuable benefits to provide to their employees.

We have the expertise to help you transform your health benefits and programs from an expense into an investment that will help both your organization and your staff thrive. ❖

Controversial Coverage

New Rules Clamp Down on Short-Term Health Plans

THE BIDEN administration has rolled back regulations that allow Americans to stay on short-term health insurance plans for up to three years while still satisfying the Affordable Care Act's individual mandate.

The new rules will limit these controversial plans to no more than four months, and they require more disclosure on behalf of the insurers and agents that sell these plans to help consumers understand what they are buying.

These plans are not full-fledged health plans; they offer limited scope of coverage that caps insurance for many services, and they are not subject to ACA consumer protection rules that bar discrimination and guarantee coverage regardless of pre-existing conditions.

The ACA originally limited short-term plans to just three months to fill temporary gaps in coverage when someone is transitioning from one source of coverage to another.

The Trump administration enacted new regulations that allowed people to stay on a plan for 12 months, with the option to renew for three years.

These plans have gotten a lot of bad press citing horror stories of people finding out their policies were virtually useless, leaving one man more than $43,000 in debt after his plan wouldn't pay for his treatment after it deemed his cancer a pre-existing condition.

Critics say the plans are deceptively marketed and consumers are duped into buying health insurance that has stripped-down coverage. Proponents say that these plans serve a valuable purpose in helping people transition from one type of coverage to another.

Many people who have purchased these plans thought they were receiving comprehensive coverage but were surprised later when the insurance wouldn't cover certain procedures or capped coverage.

Some common features of short-term plans are:

- They often use health histories to determine who can get coverage.
- They often exclude key service categories from covered benefits, such as maternity.
- They can decline coverage due to pre-existing conditions.
- They may limit or cap coverage both on a per-service or daily rate basis or in the aggregate (like capping total payments during the year at $100,000).
- They are not required to cover the 10 essential health benefits that the ACA requires compliant plans to cover at no cost to the enrollee.

WHAT THE RULE DOES

Effective date:	Applies only to new plans incepting on or after June 17.
Plan length:	Limited to three months, with renewal for a maximum of four months total, if extended.
Marketing rules:	Plans will now be required to provide consumers with a clear disclaimer that explains the limits of what services they cover and how much they cover.

Please note: the new rule does not affect fixed indemnity plans like critical illness, which pays a lump sum if someone is diagnosed with a covered illness.

Other plans pay a pre-determined amount on a per-period or per-incident basis, regardless of the total charges. Plans might pay $200 upon hospital admission, for example, or $100 per day while a person is hospitalized to help with out-of-pocket costs. ❖

Dental Insurance: DMOs Versus PPOs

WHEN YOU look at the dental options for your employer-sponsored health plan, or if you're just looking at the options available on the market, you may encounter the terms DMO, PPO or indemnity plan in the marketing literature.

Each of these is a different type of dental insurance plan. To pick the best plan for your employees' needs, you'll need to know how each plan is structured, and the advantages and disadvantages of each.

The DMO

A dental maintenance organization is very similar in concept to a health maintenance organization, or HMO.

Essentially, DMOs are designed to reduce premiums and costs, at the expense of a certain amount of freedom when it comes to choosing your own dentist.

Under these plans, you must choose a primary care dentist. If you need to see a specialist, such as an orthodontist or endodontist, you must get a referral from your primary care dentist.

Both HMOs and DMOs attempt to save money and reduce expenses by restricting the number of care providers that the insurance company will allow in the plan.

Negotiators for the insurer approach dentists and clinics in the coverage area and ask them to reduce prices in exchange for a steady flow of referrals from the plan. The fewer providers in the network, of course, the more patients each dentist will receive, and the more valuable the DMO is to the dentist.

They also save money by reducing expenses on specialists. The primary care dentist acts as a "gatekeeper" to more advanced services, and ensures that any referrals to more advanced or specialized levels of care are legitimately medically necessary.

By using restricted networks, leveraging their bargaining power to obtain reduced fees and reducing unnecessary expenses on specialist care, the DMO plan is usually able to realize significant cost savings — and pass those savings along to consumers in the form of reduced, affordable premiums.

These plans are usually best for those who are sensitive to premium costs, and who are indifferent about what dentists they can see under the plan.

The dental PPO

A dental preferred provider organization is much less restrictive than its DMO counterpart. You can normally visit any dentist you want who is willing to accept the insurance, and you don't need a referral to see a specialist.

However, there still may be a network, and your out-of-pocket costs may be lower if you see dentists from within these networks.

You will still have to pay deductibles and copays, but the plan may reduce or waive them for dentists and clinics within the preferred network.

These types of plans may also be referred to as participating dental networks. Their premiums are generally low, but usually not as low as comparable DMO plans.

Indemnity plans

If you have an indemnity plan, you can generally see any dentist who is willing to accept the insurance. You don't have to restrict yourself to dentists in the network. If a dentist doesn't accept direct payment from the insurance company, they may reimburse you directly for covered expenses after the fact.

These plans offer the most flexibility and freedom and the fewest restrictions on care. But they also have the highest premiums.

What's best for your crew?

If it's important for your staff to be able to choose their own dentist or access any specialist they like for covered services, they may want to lean towards the indemnity plan.

Meanwhile, DMOs generally offer the lowest monthly premiums and have low out-of-pocket costs for routine services like cleanings. But, their out-of-pocket costs may rise quite a bit if you need services beyond routine checkups and cleanings.

Dentists may try to upsell additional work, which costs more out of pocket.

If you have staff that anticipates needing more extensive treatment, or access to the services of a specialist, they may wish to select a PPO-type plan.

You can talk to us about which plans are available and which might be the right fit for your workplace. ❖