

A man in a light blue shirt and black pants sits on the left end of a row of black chairs. A woman in a black sweater and tan pants sits on the right end. The chairs are arranged in a straight line against a plain white background.

ATTRACTING AND RETAINING EXCELLENT EMPLOYEES

A HEALTH BENEFITS PRIMER FOR SMALL BUSINESSES

*By Steven D. Strauss
for*

Aflac

A B O U T T H I S B O O K L E T

Any great small business owner knows that the oft-repeated statement, “good employees are your most valuable assets,” is repeated for a very good reason—because it is true. The question really is this: How do you attract and retain the people who will become your most valuable assets?

Offering them great benefits is one important answer.

People work for a variety of reasons: to make money, to feel valuable, to fulfill a need, and these days, nearly topping the list is the need for benefits.

Aflac wants you to have a better understanding of how one of the most important benefits—insurance—can help you attract and keep a great staff. With this goal in mind, we commissioned Steve Strauss, a leading small business expert, to create this booklet, which offers an overview of the many different types of insurance benefits available to you. In it, you will find scores of easy-to-understand and useful tips, strategies, and ideas, which should assist you in creating the right insurance package. The good news is that not only can the right insurance become one of your best recruitment strategies, but it should also be an affordable one as well.

To your success!

A B O U T T H E A U T H O R

Steven D. Strauss is a leading small business expert. An internationally recognized lawyer, business columnist, and speaker, Steve is also the author of 16 books, including the best-selling *The Small Business Bible: Everything You Need to Know to Succeed in Your Small Business*. Steve’s business column, “Ask an Expert,” appears weekly at USATODAY.com and is one of the most widely syndicated small business columns in the world. He is also the small business expert for Microsoft and AllBusiness.com.

If you would like to receive Steve’s free newsletter, *Small Business Success Secrets!* or otherwise get in touch with him, visit his Web site at www.MrAllBiz.com.

The views expressed in this booklet are the views of the author and do not necessarily reflect the views or policies of Aflac. Aflac does not offer all types of coverage outlined in this document and cannot guarantee the accuracy of the data presented.

ATTRACTING AND RETAINING EXCELLENT EMPLOYEES

A HEALTH BENEFITS PRIMER FOR SMALL BUSINESSES

SECTION ONE

THINGS TO CONSIDER BEFORE SELECTING AN EMPLOYEE BENEFITS PACKAGE	1
The Strength and Reputation of the Carrier	2
Servicing Claims	3
Coverage	3
The Policies Inside the Policies	4

SECTION TWO

AN OVERVIEW OF MAJOR MEDICAL INSURANCE OPTIONS	5
Health Insurance	6
Traditional Indemnity Plan/Fee-for-Service	7
Health Maintenance Organizations (HMOs)	8
Preferred Provider Organizations (PPOs)	9
Point-of-Service Plans (POSs)	10
Exclusive Provider Organizations (EPOs)	10

SECTION THREE

AN OVERVIEW OF LIFE INSURANCE PRODUCTS	12
Term	13
Whole	13
Universal	14
Variable	14

SECTION FOUR

AN OVERVIEW OF VOLUNTARY INSURANCE¹ PRODUCTS	15
Protecting Income and Savings	16
Disability Insurance	17
Vision Insurance	17
Dental Insurance	18
Accident Insurance	18
Specified Illness Plans	18

SECTION FIVE

FLEXIBLE SPENDING ACCOUNTS	20
How Medical FSAs Work	21
FSAs in Practice	21
Dependent Day-Care FSAs	23

SECTION SIX

HEALTH SAVINGS ACCOUNTS	24
How They Work	24
Contributions	25

SECTION SEVEN

CONCLUSION	26
-------------------	----



S E C T I O N O N E

THINGS TO CONSIDER BEFORE SELECTING AN EMPLOYEE BENEFITS PACKAGE

It is no secret that we live in an era when employees are only as loyal as the next paycheck. Workers today are more willing to look for new jobs, a fact that makes it more difficult than ever for you, the small business owner, to attract and retain key people.

So how do you do it?

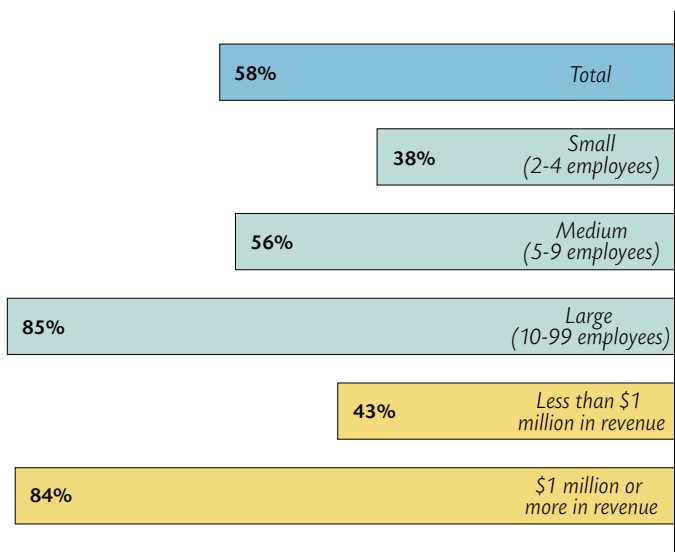
Of course, competitive pay, a friendly culture, and a great benefits package will help. By law, the minimum you must offer is:

- Payment of the prevailing minimum wage and overtime for more than 40 hours a week worked (unless the employee is exempt).
- Workers' Compensation insurance.
- Time off to vote, serve on a jury, or serve in the military.

But the great small business person knows that what you offer above and beyond this bare minimum makes all the difference.

The fact is, a strong insurance package is one of the best things you can offer to attract and retain employees:

Percentage of companies that offer their employees any type of benefit.



- A 2003 survey conducted by the National Federation of Independent Businesses (NFIB) found that 61 percent of small business owners surveyed said that a “major reason” they offer health insurance is because it “helps employee recruitment.”
- In that same survey, 47 percent said they also offer health insurance because it decreases turnover.
- Perhaps more importantly, a 2006 survey of small business decision-makers sponsored by Aflac found that when considering the attraction and retention of good employees, health benefits rank among the top three factors, right behind compensation and workplace environment.
- The same Aflac study found that nearly six in ten small businesses (58 percent) offer some type of health benefits to their employees.

So if you want to attract and keep a great staff, it follows that you should offer great insurance.

Begin by looking at the entire range of options contained in this booklet. A great insurance package—one that will impress employees—is

more than just major medical coverage. You may be surprised to find out just how affordable those “extras,” like life insurance, disability, vision, and so on, really are.

Here, then, are the factors to consider as you start to create your benefits package:

The Strength and Reputation of the Carrier

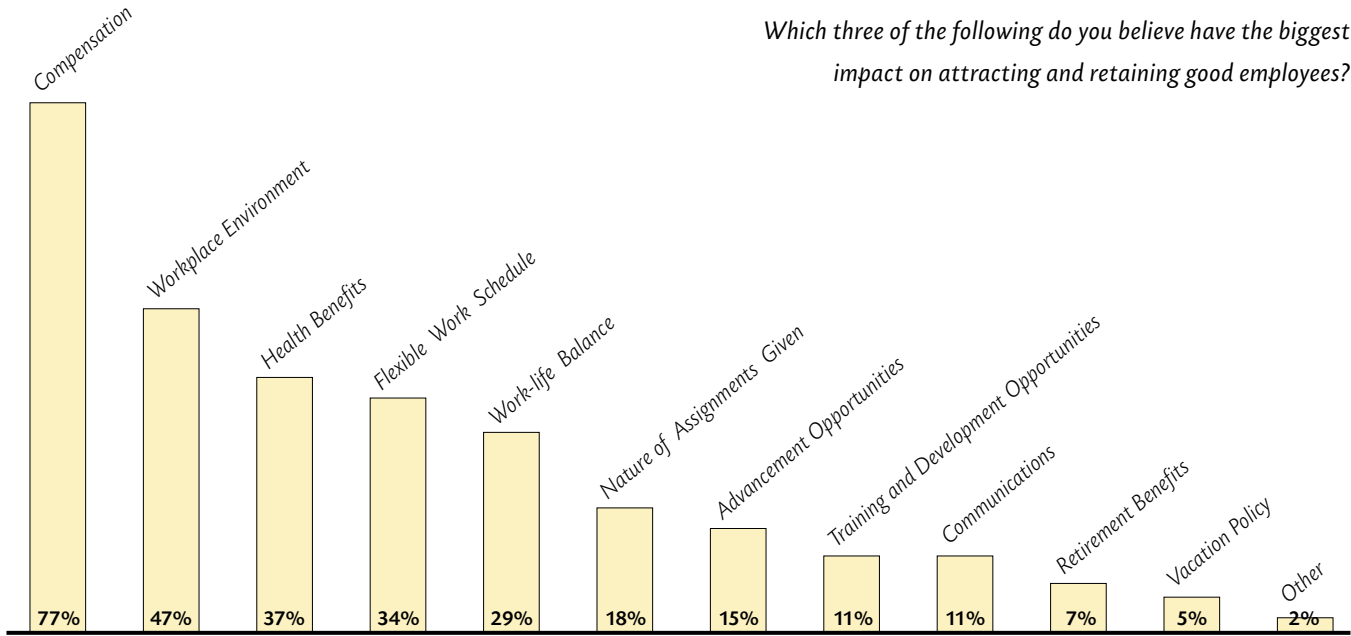
Not all insurance companies are created equal. If you have ever had a carrier take too long to pay a legitimate claim, or maybe worse, to even agree that a claim is legitimate, you know this all too well.

So the first thing to look at when shopping for a benefits package is the strength and reputation of the various companies you may consider using. Sure, you may get a cheaper policy by going with a lesser-known, smaller carrier, but when was the last time you found cheaper to be better?

No, in this critical area, what you want is a reputable, financially strong company. Insurance companies are rated by various independent services, including:

- A.M. Best Company: Like similar companies, A.M. Best grades insurance companies on a scale from AAA (top) to D (bottom.) Because its “Best Rating” is an independent third-party assessment, it is a good place to begin when comparing insurers. A.M. Best’s Web site is www.ambest.com.
- Standard & Poor’s: Like A.M. Best, Standard & Poor’s researches the financials of different businesses and, therefore, is another place to look when analyzing insurance companies. Standard & Poor’s Web site is www.standardandpoors.com.

Which three of the following do you believe have the biggest impact on attracting and retaining good employees?



Begin your research by locating some reputable, financially strong insurance companies.

under a given policy. The claims department is the first to make this call.

Servicing Claims

No one likes filing claims, but in the unfortunate event that you or your staff needs to, having chosen an insurer that is known for being prompt and fair can make all the difference. For this decision alone, your employees will thank you.

What you want is a carrier with a reputation for servicing claims promptly, fairly, and with a minimum of red tape.

This is where word of mouth comes in handy. Ask around. Speak with other entrepreneurs you know and find out with whom they are insured, how well they like their carrier, and how claims are handled.

The magic formula that successful businesses have discovered is to treat customers like guests and employees like people.

TOM PETERS

When a claim is filed, it goes to the carrier's claims department, which determines if your claim is covered under the policy. The claims department will look at two things:

Coverage

1. Whether the person filing the claim is eligible. With regard to health insurance, the employee may not work enough hours to be covered, or there may be a waiting period before the policy goes into effect.

No matter what sort of insurance you want, you should do a cost-benefit analysis of the coverage you are considering: The more you can afford, the more you will be able to purchase. The wise entrepreneur will shop carefully.

Shopping carefully is a three-fold process.

2. Whether the care is covered. Needless to say, not all incidents or illnesses are covered

First, sit down with your staff and find out what they want. Are vision and dental care important

to them? If only some of your employees want these benefits, you can save money by offering that coverage on a voluntary basis. What sort of copayments can they live with? Would using products like health savings accounts and voluntary insurance* help employees deal with higher deductibles? Of course, your employees will want as much as they can get; that's not really the question. Rather, you need to explain to them that, while there is a limit on what you can afford, your commitment is to use that money in a way that helps them the most.

That is how insurance can help you attract and retain a great staff. That is how you build employee loyalty.

Second, as you narrow your choices, consider the types of coverage offered by the various carriers, such as the following:

- Monthly, annual, and lifetime coverage limits
- Whether preventive care is covered
- The company's reputation for customer service

Finally, as you look at the different insurance companies and what they offer, you will want to find a company that can provide benefits with a minimum of cost and bureaucracy.

The Policies Inside the Policies

The last things to review before purchasing an employee benefits package are the standards any particular company uses to make its insurance determinations. For example, you should find out:

- Whether their plans are portable—i.e., can your employees keep their insurance and pay for it themselves after they leave your company?
- How the company defines “disability” and “pre-existing condition.”
- How many previous years the underwriting process will consider.

Often overlooked, how an insurance company administers its policies can make or break an employee when the time comes to file a claim.

* For the purposes of this text, voluntary insurance means insurance sold on a voluntary basis.



S E C T I O N T W O

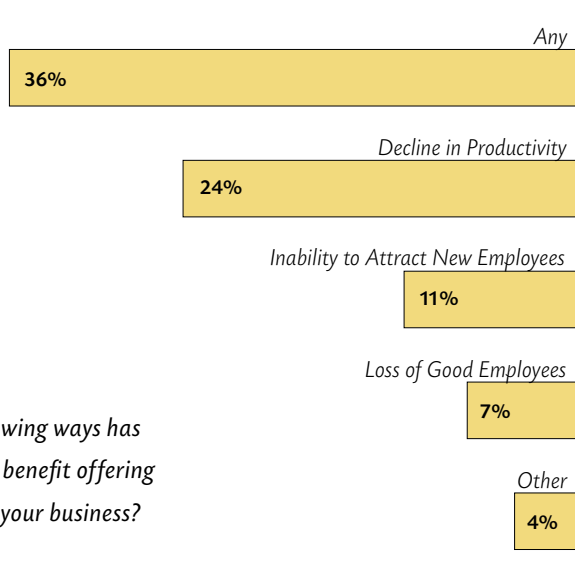
AN OVERVIEW OF MAJOR MEDICAL INSURANCE OPTIONS

Choosing the right health insurance plan can often seem like wading through an alphabet soup of options—is a PPO better than an HMO, and how does it compare to an EPO or an HSA?

But fear not, getting a handle on your health insurance choices need not be a major undertaking (even if you don't spell well!); we have done the heavy lifting for you. What follows is a simple explanation of health insurance in general, your five major health insurance options, the pros and cons of each, and how they compare with one another.

Understanding these options and then making the right choice is critical, both for you and your employees: While employees want and expect health care coverage, providing that benefit is becoming increasingly more expensive for employers. Indeed, a recent Aflac survey found that more than a third of all small business owners surveyed said that their current health plan has negatively affected their business, especially their profitability and employee attraction and retention.

In which of the following ways has your current health benefit offering negatively affected your business?



Health insurance today is not inexpensive, but throughout this booklet, we hope to show you ways to offer it without breaking the bank.

So begin by analyzing the choices below, finding one or two that seem to be a good fit, talking with your staff about these options, and then speaking with your insurance broker to get some quotes.

Health Insurance

Your company’s health insurance plan can be comprehensive and expensive, minimal and economical or, most likely, somewhere in the middle. The first thing to consider when looking at any option is the extent of the coverage. For instance, an inexpensive plan that does not cover hospitalization is not really a bargain at all. So first consider what you need to have covered. Essentials include things such as:

- Doctor visits
- Hospitalization
- Surgery
- Catastrophic injury
- Serious illness
- Prescriptions

In addition, you may want a plan that covers such things as:

- Dental
- Vision
- Mental health
- Maternity
- Obstetrical-gynecological
- Alternative treatments
- Use of specialists

Note, however, that if these additional items are not part of a plan you like, some can easily be added, and often without spending a lot more. Please refer to Section 4, An Overview of Voluntary Insurance Products.

Other coverage issues to consider include:

- Whether the plan allows people to keep their current doctors
- Whether the plan covers employees and their families
- How pre-existing conditions are handled

The flip side to coverage is, of course, cost. While you may be tempted to buy a plan with low premiums, often such plans are a waste of money, because they actually cover so little. When analyzing any plan, be aware of these fees:

- Monthly premiums
- Deductibles
- Copayments

This “coverage versus cost” issue can be a difficult dance to master. A high deductible (that is, the amount you and your employees have to pay out of pocket before the major benefits of the insurance package kick in) will lower your monthly premium, but it will also increase the amount you pay when you get medical treatment.

The sad fact is that it is unlikely in this era of ever-rising health care costs that you will be able to pay for everything your employees would like you to cover. The trick to this dance then is to figure out what they really need, what it really will take to attract and retain key personnel, and then pay for that.

Ten years ago, you might have been able to pay 100 percent of everyone's premiums, but the reality today is that most small business owners have had to pass increased health care expenses on to their staffs, although no one likes that idea. It may be that today you can only afford to pay 75 percent, or even 50 percent, of the premium.

Again, if you see how good insurance can help you attract and retain excellent employees (and you should), then the fact is you will need to pay what you can, let your staff know what it is costing you, and work with them to find a package that affords them enough coverage at a price you both can live with. No, it's not a perfect solution, but those are the steps to take if you want to master the health care shuffle.

Here are the five main options for medical insurance:

Traditional Indemnity Plan/Fee-for-Service

A traditional indemnity insurance plan is also called a fee-for-service plan (and surprisingly, it does not go by the acronym FFS). There are several very nice aspects of a fee-for-service plan, not the least of which are its simplicity and flexibility.

Let's say that you are out playing basketball with the guys one Saturday morning and you

land awkwardly on your ankle. With a fee-for-service plan, you would simply go to the hospital for X-rays and treatment, the hospital would submit a claim to your insurance carrier, and then that carrier would pay the majority of the bill and the hospital would invoice you for your small share. Nice, eh?

There are two basic types of fee-for-service plans:

- 1. Major Medical:** This is essentially catastrophic care. The plan would cover you and your staff in case of a major illness or sudden injury, up to a preset limit. While getting such insurance is inexpensive, most employees would scoff at such minimal coverage.
- 2. Basic Protection:** This is the traditional plan that covers prescriptions, hospitalization, doctor visits, and so on. It is, of course, significantly more expensive. (Because most people, employees and employers alike, generally want the more complete coverage provided by a basic protection plan, that is what we will be referring to as we continue discussing fee-for-service.)

Here's how it works: You pick a plan that offers the coverage you desire, the deductible amount each of your employees would be required to pay, and the coinsurance amount (i.e., the proportion of costs for which the patient is responsible). Of course, the higher the deductible and coinsurance amounts, the less the plan will cost.

When people covered by the plan require health care, they pay out of pocket until their deductible amount is met. Thereafter, when medical service is provided, the insurance

company picks up the majority of the costs (typically 70 or 80 percent), and the insured pays the rest—that is, the coinsurance amount.

The nice thing about a fee-for-service plan is that it is flexible: For the most part, you can pick your own health care providers, you do not need to get a referral to see a specialist, and getting in to see a doctor should be a fairly prompt matter.

But there are several disadvantages to these plans as well:

- There will be yearly limits on the amount of coverage provided.
- Items such as checkups, routine health care, and preventive health care (like vaccinations) may not be covered.
- They are usually fairly expensive.

Health Maintenance Organizations (HMOs)

An HMO is an insurance plan that requires insureds to obtain their medical care from providers within the HMO network. By coordinating all doctors and patients within the same system, costs are kept down. Indeed, in the past 20 years, HMOs (such as Kaiser, Blue Cross, Aetna, and Cigna) have grown in popularity because they have been able to offer quality health care at rates that are, while not inexpensive, at least verging on affordable.

Note that HMOs are a type of managed-care health care system, as are the next three options you will read about: preferred provider organizations (PPOs), point-of-service plans (POSs), and exclusive provider organizations (EPOs). Any type of managed care basically means that three things are in play: (1) Oversight

by the insurer of both the care offered and the fees paid, (2) a contractual relationship between the carrier and the health care providers, and (3) benefits within a certain criteria.

Here's how HMOs work: You select a provider in your area, and your employees pick a primary care physician from a list of doctors in the HMO's network. That physician acts as the gateway between the patient and the system. He or she is the one your employees see first when they have medical issues, and he or she is the one who refers your employees to specialists, hospitals, clinics, and so on. It follows then that selecting the right primary care physician is a critical step in the HMO process.

There are two things your employees will like about almost any managed-care system, but HMOs especially: The first is the coverage. Whereas fee-for-service plans limit care to, essentially, healing rather than preventing illness, a managed-care program typically includes a much wider variety of care, such as:

- Prescriptions.
- Mental health counseling.
- Maternity care.
- Use of specialists.
- Wellness and prevention programs.

In fact, most HMOs (indeed, most managed-care organizations) offer preventive health programs intended to help patients, for instance, stop smoking, lose weight, etc. They are, after all, called health maintenance organizations.

The other thing your employees will probably like about an HMO plan is the fees. Deductibles are minimal. When patients see a doctor, stay in the hospital, get a prescription, or whatever, they pay only a small fee called a "copayment,"

typically \$20 or so. Of course, there is the monthly premium, but it is less than, say, the 30 percent they would pay under a fee-for-service plan.

While there is much to be said in favor of HMOs, there are definite downsides as well, including:

- It is more difficult to see a specialist.
- It usually takes longer to see a doctor.
- Seeing a doctor who is not part of the plan can be very difficult.
- Doctors in the plan are given incentives to keep costs down, so your primary-care physician may not move you through the system as you would like.
- If you get sick out of town, your HMO may not cover the care you receive.
- If the HMO says you are not covered for a treatment, fighting the bureaucracy is difficult.
- It is, in fact, a big bureaucracy.

The key to picking the right HMO is really the key to picking any type of plan discussed herein: Analyze carefully the type of coverage that is and is not offered. Review the reputation of the carrier. And finally, look at the costs as compared to other plans.

Preferred Provider Organizations (PPOs)

Clearly one of the main problems with an HMO plan is that patients are stuck within the system. It is unfortunately very hard, if not impossible, to get treatment outside the virtual walls of the HMO.

Enter PPOs. PPOs prefer, but do not require, that participants get their care from providers within the network. An HMO is a rigid system

that participants must stay within, but a PPO is more like a loose confederation of providers. In that sense, a PPO is like a hybrid. Part HMO, part fee-for-service, the PPO attempts to keep costs down by creating and maintaining a loose HMO-type network, but it offers the flexibility and the possibility of choosing other doctors when necessary.

The catch for your employees is that it costs more to go outside the network.

Another major distinction between an HMO and a PPO is that under the latter, you are not required to choose a primary care physician and, therefore, there will be no gatekeeper between you and your health care. If covered employees want to see a specialist, they can, and they do not need anyone's approval.

This is a major benefit, and something you should consider when choosing a plan and mention when recruiting staff. That a covered employee can see a specialist when he or she wants to is a major selling point.

But there are disadvantages too, such as:

- Copayments are more than other managed-care plans.
- Patients may also have to pay coinsurance.
- There is usually an annual deductible that must be met.
- Treatment outside the network is not inexpensive.
- Generally, because there is more flexibility, there is corresponding higher cost.

If, for whatever reason, flexibility is most important in your workplace, then a PPO would be the way to go, even given the higher associated costs.

Never go to a doctor whose office plants have died.

ERMA BOMBECK

Point-of-Service Plans (POSs)

A POS plan is another hybrid, this time part PPO and part HMO. As with an HMO, in a POS you would have a primary care physician who can refer you to specialists within the network when necessary. Also, just as with an HMO, copayments are minimal and deductibles are practically nonexistent. Patients pay less because they are within a limited, controlled system.

The difference is that with a POS, as with a PPO, patients are allowed to go outside the system as long as they are willing to pay for that privilege. If patients do go to a provider outside the POS, they should expect to pay a deductible as well as a substantial coinsurance payment of, say, 30 percent.

There is, therefore, a lot to be said for the POS plan, and that is why they have become increasingly popular in the past few years. Here is an example: Say that one of your female employees has some medical condition requiring that she see a certain doctor with whom she has some rapport. With a POS plan, she could continue to see her regular doctor, while her kids could be moved into the POS managed-care system. This flexibility is attractive, and it can make employees really appreciate their employer.

Other benefits:

- No deductibles
- Low copayments
- No referral required to see a specialist outside the system

The disadvantages:

- Substantial fees when venturing outside the network
- Required selection of a primary care gatekeeper
- A goal of reducing costs, as with any managed-care program

Because patients will get most of their care within the POS system, the costs are more akin to those one would see in an HMO than in a PPO. That is, POSs are generally more affordable than PPOs, and maybe a tad more expensive than HMOs.

Exclusive Provider Organizations (EPOs)

An EPO is very similar to an HMO. Patients are required to pick a primary care physician who provides the majority of their health care and who helps regulate their access to the system. Also, in the vast majority of cases, patients must stay within the network. In EPO-speak, this is called a “closed panel.” Indeed, any medical expenses incurred when seeing providers outside the network are paid entirely by the patient.

The differences between an EPO and an HMO are that under the former, you have even fewer providers to choose from, but the costs are less, too. A typical EPO coverage plan may look something like this:

- EPO pays 90 percent of most services; patient pays 10 percent coinsurance.
- Coinsurance is applied to the deductible, which might be \$150 per year.

- Copayment for doctor visits is \$20.
- Hospitalization is covered at 90 percent with 10 percent coinsurance.
- Emergency room visits are \$75.
- Well-baby, OB-GYN, chiropractic, and acupuncture services are all covered.

With this option, the key is to make sure that the EPO provides enough different types of care so that your covered employees can get the medical attention they need.

Making the Choice

Your ultimate decision should not be made in a vacuum. Discuss the health care options presented in this section with your staff. With your insurance agent, carefully consider the pros and cons of each choice and weigh them carefully. The good news is that, as you can see in this section, more choices are becoming available all the time.

The Bottom Line

Creating a great place to work is probably the single most important thing you can do to attract and retain great staff, and high on the list of what makes a business a great place to work is a great health benefits package. While benefits are not inexpensive, they need not cripple you financially either. And, as you will see later in this booklet, there are plenty of additional benefits you can offer your employees that will cost you next to nothing.

Intrigued? Read on.



SECTION THREE

AN OVERVIEW OF LIFE INSURANCE PRODUCTS

Why did you go into business for yourself? Maybe you wanted the opportunity to make more money than you could by working a regular job. Maybe you thought you could better provide for yourself and your family by being an entrepreneur.

Well, what would happen if you passed away unexpectedly? Would your spouse and/or children have enough money to see them through growing up and paying for the mortgage, college educations, weddings, and starting their own businesses—you know, all the things you would want for them?

If your answer is no, then you need to consider buying enough life insurance to see things through.

From the perspective of recruiting great employees, the same analysis holds true. Because many life insurance products are very affordable, making a basic life insurance policy a part of your benefits package is not only a very inexpensive way to add value and recruit people, but it also endears you to their families.

Here are your choices:

Term Life Insurance

Term life insurance is the simplest and most popular form of life insurance available today. Why? It is akin to renting a house: Although you do not create any equity when you rent, it is generally less expensive than paying a mortgage.

The same is true when you buy a term life insurance policy. Although it never generates any cash value, it is nevertheless undeniably affordable. With a term policy, you have the insurance for a set period of time, such as 15, 20, or 30 years. During the policy period, the insured cannot cash out the policy because it earns no equity. But if the insured dies during that period, the carrier pays the amount of the policy to the insured's heirs, or in insurance-speak, the beneficiaries.

Conversely, whole life is like buying the house—you eventually create some “equity” (see below).

For the small business owner, term life insurance is most likely what you would buy and offer to your staff for a few reasons:

- **Cost:** Term life insurance is one of the great bargains; rates are at an all-time low right now. How low? Consider: You could insure a healthy 40-year-old male employee with \$500,000 of coverage for about \$30 a month. Now that is a great cost-benefit ratio.
- **Security:** As discussed, term life insurance is available for set amounts of time, and during that period, your premiums are guaranteed not to increase.

You might want to apply for a longer period of coverage (e.g., 30 years) for a young employee (it will cost more, however, to lock in a rate for a longer time), but you must also consider how long you expect an employee to stay with you. If it typically is just a few years, then taking out a shorter, less expensive policy is smart.

Whole Life Insurance

Like term life insurance, whole life insurance also provides a death benefit, but the main difference is that it also has an investment component: Part of your monthly premium goes toward the insurance portion while the remainder builds the policy's cash value. This cash value fund grows tax-free while the policy remains in effect.

But take note: It is not cash that can simply be withdrawn, like a savings account. Rather, the insurance company owns the cash value account and the insured has the right to obtain low-interest loans from the company. If the insured dies before the loan is paid back, the policy will pay out the face value of the policy less the amount owed.

Here is an example: Say that you buy your employee, Brian, a \$500,000 whole life policy, and that he took out a \$25,000 loan against the policy ten years after it was purchased (the cash value amounts of such policies typically do not grow for several years). If Brian passed away before any of the loan was repaid, his beneficiaries would receive \$475,000 (the face amount of the policy less the amount of the loan), minus any interest due.

There are two other differences between a whole life policy and a term life policy:

1. Unlike term life insurance, whole life policies are rather costly. That \$500,000 policy you bought for Brian would cost you probably somewhere around \$4,000 a year.

2. A term policy expires at the end of the term, but a whole life policy can last for someone's "whole life."

While the price may be steep, people like whole life insurance because the premiums are fixed for the duration of the policy, and the cash value builds up over time, creating, in effect, a handy line of credit.

Universal Life Insurance

Universal life insurance takes this idea of creating a cash value account and extends it. With a universal policy, the premium is invested by the insurance company in various funds, mortgages, bonds, and so forth. This investment fund will eventually cover the death benefits the company owes, no matter how well or poorly it does.

When people buy a universal life product, they are guaranteed a basic rate of return on their investment (for instance, 4 percent). The nice thing is that if the insurance company earns more with the investment portfolio than that base amount, it credits the insured with the difference, either through lower premiums or increased cash value. The danger is that if the portfolio earns less than the guaranteed amount, the premiums for the policy may increase.

A main advantage to a universal policy is its flexibility. The insured can choose to invest more or less in the policy, as his or her financial situation warrants. Moreover, the face value of

the death benefit can be increased or decreased, which is not true for term or whole life policies.

Variable Life Insurance

Variable life insurance is very similar to universal, except that there are a wider range of investment choices available with a variable policy. The insurance company will give you a choice of funds in which you can invest your premiums, but unlike a universal policy, there is no guaranteed rate of return or of cash value.

So a variable policy is riskier. If the investments are good ones, the cash value and death benefit amounts will increase. But if the value of the investment dips, so will the cash value and death benefit amounts.

The Bottom Line

Buying life insurance for an employee as a way to add value to a benefits package is different than buying it for yourself to protect your own family. You, personally, may want a whole life or universal life policy because the premiums grow and create cash value over time. But when you are buying insurance for an employee, term is almost always the way to go.

For three days after death, hair and fingernails continue to grow.

But phone calls taper off.

JOHNNY CARSON



S E C T I O N F O U R

AN OVERVIEW OF VOLUNTARY INSURANCE* PRODUCTS

In the previous section we discussed how offering life insurance, especially term life insurance, can be a great way to add value to your benefits package without incurring a lot of cost. In this section you will learn about some additional ways to add value without incurring any cost at all.

How? By offering your employees a variety of voluntary health-related insurance products.

According to a 2005 Aflac study, 79 percent of Americans are concerned about the impact increasing health care costs may have on their financial well-being. The same study found that 66 percent of Americans would be concerned about lost wages from missing work if they became ill or injured.

Employees are aware of the rising cost of health care, yet they perceive the hardships to be greater for them than their employers. Some employers have managed cost increases by providing employees with greater choices. Voluntary benefits, health savings accounts, and flexible

* For the purposes of this text, voluntary insurance means insurance sold on a voluntary basis.

spending accounts are all cost-effective ways to enhance a benefits package.

Why are they so affordable? Because you, the small business owner, do not pay for the policy, yet you reap the rewards of having offered it.

Here is how it works: Voluntary insurance (such as vision, dental, and disability) is, as the name implies, completely voluntary. You make the coverage available to all employees as part of their insurance package, and those who choose to purchase the extra policies pay 100 percent of the premiums through payroll deduction. Another nice thing is that many of these voluntary benefits can be paid with pre-tax or after-tax dollars—your choice.

For the small business owner, the effort (and cost) is minimal indeed:

1. You invite an insurance agent to make a presentation to your staff. (By the way, my friends at Aflac specialize in this sort of insurance, and you would be hard-pressed to find a better company to work with, or better coverage.)
2. Those employees who are interested would apply and agree to payroll deduction of the premium.
3. You then administer the plan by deducting the proper amounts from their paychecks, applying the payments to the carrier's invoice, and forwarding the payments on to the carrier.

Thus, while all it takes for you to make this great benefit available are nominal administrative overhead costs, you nevertheless

look like a hero in the eyes of your employees.

Another nice aspect of voluntary benefits is the wide array of policies available. One employee may want to apply for cancer coverage, and another may want dental. No problem there. That such varied options are available, and available to their families, should make these benefits even more attractive.

Protecting Income and Savings

What is your most valuable financial asset? Your business? Maybe, but probably not. Your pension? Nope. Most people say their house, but that too is incorrect. If you think about it, your most valuable financial asset is your ability to earn an income, which is as true for an employer as it is for an employee.

Consider: A 30-year-old employee who earns \$30,000 a year has an estimated total working-life income stream of more than \$1 million (35 working years at \$30,000 a year = \$1,050,000.)

Here's another fact that indicates that major medical insurance alone won't help your employees protect their financial assets: According to research done by Harvard University and published in 2005, more than 48 percent of all U.S. bankruptcy filings are due to illness or injury. The study also found that more than 75 percent of the people who filed for bankruptcy protection had major medical health care coverage at the time of their unexpected health events.

Many of the people in the study were from middle-class families. They assumed that they would be taken care of by their major medical plans. What they had not anticipated was

the loss of income from missed work or the numerous out-of-pocket expenses that added up during their illnesses—items not covered under major medical insurance plans.

Voluntary benefits pay cash benefits directly to the policyholder (unless otherwise assigned), regardless of any other coverage. That means that the insured may use the money for deductibles, travel expenses, everyday living obligations like the mortgage, and virtually any out-of-pocket expenses or other personal needs.

One of the most important types of voluntary insurance to consider applying for is disability insurance.

Disability Insurance

According to a 2004 study conducted by the Health Insurance Association of America, one of every seven workers will suffer a five-year or longer period of disability before age 65.

In the case of illness or injury, disability insurance helps you maintain your standard of living and pay your bills. The maximum coverage you can get is usually 70 percent of your gross income.

There are two types of disability coverage:

1. Short-Term Disability: This policy pays benefits (i.e., a monthly amount that is a percentage of your gross income) while you are disabled. These benefits are typically payable for two weeks up to two years.

2. Long-Term Disability: This policy replaces income for a significantly longer amount

of time. Typically, you can choose benefits lasting two years, five years, until age 65, until age 67, or for the rest of your life. Most workers prefer the age-65 option since Social Security kicks in after that.

When shopping for disability insurance, keep these pointers in mind:

- As discussed earlier in this booklet, you want to be sure that the insurance company you are dealing with is very strong financially. Check them out at www.ambest.com or www.standardandpoors.com.
- Look for what is called a “noncancelable contract” or policies that are “guaranteed-renewable.” Avoid the “conditionally renewable” policy—the insurer can raise your rates or change conditions at any time.
- Shop for a policy that defines total disability as an “own-occupation disability,” which means that you will be considered disabled if you cannot perform the main duties of the job you currently have.

Disability insurance is fairly expensive—up to three percent of your yearly salary. The amount depends upon the length of time you want to be covered if you become disabled, your age and gender, and your health history, among other factors. While pricey, the premiums will seem like a bargain if the coverage is ever needed.

Vision Insurance

Offering your employees the chance to obtain vision insurance is something they will surely appreciate. Not only is it a benefit most people need, but the fact that it won't cost them much money makes it all the more attractive.

*If I'd known I was
gonna live this long
I'd have taken better
care of myself.*

EUBIE BLAKE, COMPOSER
(AT AGE 100)

Another great aspect of a vision policy is how much it will actually cover. For example, a good vision policy should cover the following:

- Eye exams
- Vision correction
- Specific eye diseases
- Permanent visual impairment

The policy should be guaranteed-renewable for the insured's lifetime and should offer dependent coverage—another aspect that your employees will value. Most plans will allow employees to add spouses and dependents to the policy (in some cases, dependents can stay on until age 25).

Dental Insurance

Needless to say, dental work can be quite expensive, and of course, that is where dental coverage comes in. Whether it is routine dental care, cleanings, checkups, filling cavities, or the dreaded root canal, a good dental policy may help considerably with all of these costs.

A typical plan will offer the following benefits:

- No deductible
- The ability to choose your own dentist
- Ownership of the plan (that is, if you switch jobs or retire, you can take the plan with you, and pay the same rates and receive the same benefits)
- Guaranteed renewal (unless you fail to pay the premium, of course)
- Rate stability
- Additional coverage availability (called “riders”) for orthodontics and cosmetic dentistry

As with vision insurance, the fact that a dental plan can cover an employee's family

as well makes this a benefit that employees truly appreciate.

Accident Insurance

An accident policy may cover everything from a sprained ankle to a major accident, and it may help cover expenses associated with an accidental injury. Benefits are determined by each state but may include the following:

- Emergency treatment
- Follow-up doctor visits
- Intensive care
- Surgical and injury
- Wellness

Specified Illness Plans

For many people, a grave illness like heart disease or cancer is not only a life-altering physical event but a devastating financial one as well. A specified illness policy may make all the difference. These plans can cover conditions like stroke, heart attack, and cancer. Should an employee elect to buy such a policy through your payroll deduction plan and become ill with a covered disease, the carrier would pay benefits in one of two ways:

1. Lump-Sum Payment: The average specified illness policy pays the insured a pre-established amount via a single, lump-sum payment when a covered disease is diagnosed. The insured may use this money to pay for treatment or anything else he or she chooses.

Sound good? Not really. The problem with a lump-sum policy is that after the payment, the insured is uninsurable. Consider this scenario: You have a specified illness policy that covers

heart attacks, then you have a heart attack and receive, say, \$50,000. You spend \$30,000 on care and bills related to the event, and save the rest. That means you have only \$20,000 for the rest of your life to care for your heart disease. What if you have another heart attack? What if you need a stent?

It is for this very reason that the second option is the far better way to go:

2. Indemnity Payments: With an indemnity policy, you will receive a first-occurrence lump-sum payment (though not nearly as large as above) and scheduled benefits throughout the course of your treatment. This can be very useful since treatment can last several years and cost a lot of money, both in terms of unpaid sick days and unreimbursed medical expenses.

For many individuals, the best part of an indemnity policy is that it is guaranteed-renewable; that is, as long as you make your policy payments, you are assured that you will continue to be covered.

The Bottom Line

The voluntary insurance products discussed above are the kinds of benefits that employees truly appreciate. Making them available at your small business means that you can offer many types of coverage to your employees without assuming the cost of premiums.



S E C T I O N F I V E

FLEXIBLE SPENDING ACCOUNTS

The voluntary insurance options discussed in the previous section allow a small business owner to add benefits without incurring cost, and the program discussed in this section—Flexible Spending Accounts (FSAs)—does the same. It is another way to inexpensively beef up your benefits package.

There are two types of FSAs: a Medical FSA and a Dependent Day-Care FSA. Both allow employees to put a specified amount of pre-tax money from each paycheck into an employer-managed account to help pay for out-of-pocket expenses. The funds in a Medical FSA can help pay for medical expenses, while those in a Dependent Day-Care FSA can help pay for, you guessed it, dependent day care. (The Dependent Day-Care FSA is discussed at the end of this section.)

Both Medical and Dependent Day-Care FSAs offer a wide array of covered benefits, but the primary advantage of these accounts is that they allow funds to be set aside and used tax-free.

How Medical FSAs Work

As the name suggests, one of the best aspects of a Medical FSA is the fact that it is so flexible. A traditional medical insurance policy covers some things, but not others, while an FSA can cover most medical expenses—making it a very valuable tool in your benefits arsenal.

Expenses normally covered by an FSA are called “qualified benefits.” The full list of qualified benefits is too long to include here, but to give you some idea, they may include the following:

- Deductibles
- Copayments
- Prescriptions
- Some over-the-counter medicines
- Fertility treatments
- Flu shots
- Chiropractic treatments

An FSA is best used in conjunction with a major medical policy—with the funds from the FSA being used to help pay for eligible expenses the major medical insurance does not cover.

Here is how FSAs work: Once you decide to make the plan available, employees who choose to participate will be asked to specify an amount they want to be deducted from their paycheck every period and put into their FSA account. This amount represents their projected annual spending for “qualified benefits” divided by the number of pay periods in the year. A single FSA account for all employees is controlled by the employer.

Then, when employees receive treatment covered by the FSA, they submit proper

documentation for the expenses incurred. The employee is then reimbursed from the account.

So the process for employees looks like this:

1. Sign up for the plan.
2. Estimate the amount they will spend on out-of-pocket medical expenses for the year.
3. Have the corresponding amount deducted from each paycheck.
4. Obtain medical services, submit paperwork, and get reimbursed with their own tax-free dollars.

FSAs in Practice

Medical FSAs are an excellent way to help your employees pay for their health care, and while the administration of the plan may seem daunting, it need not be. Aflac can partner with you to implement and assist with administration of the plan at almost no cost.

The only trick to FSAs (if it can even be called that) is properly estimating one’s out-of-pocket medical expenses for the year. This is due to what is known as the “use it or lose it” rule, which means participants have a year to use up all the money in the plan. Some participants can have an additional two months and 15 days if their employer adopts a grace period for their FSA plan.

Say, for instance, that an employee, Jim, elects a \$200 monthly deduction (\$2,400 a year). If Jim only incurs and is reimbursed for \$1,800 in covered medical expenses during the plan year, his balance of \$600 would become the property of his employer.

Yes, an employer can refund the money, but not in the way you might think. You cannot simply give the money back to the employee. Instead, unused FSA funds are typically distributed to employees in one of two ways:

1. An equal distribution is made to all plan participants: If Jim leaves \$500 in the plan and there are five employees who participate, each would get \$100, including poor Jim.
2. A proportional distribution: The funds are dispersed pursuant to the amount each participant contributed during the year. If Jim contributed half of all funds in the plan, he would get back \$250. Either way, Jim is not a happy camper.

Now, it may be that halfway through the year an employee like Jim decides that he is paying too much into the plan and wants to reduce his deduction. Unfortunately, he can't do that. Under the law, the amount of the deduction must be decided upon before the start of the plan year and cannot be reduced during that year, except in extraordinary circumstances such as:

- A change in family status, such as a birth, death, adoption, divorce, and so forth.
- A significant increase in health plan cost or coverage.

Although the “use it or lose it” proposition may intimidate some employees, the benefits can far outweigh the risks. The important thing is to help them come up with a realistic estimate of their out-of-pocket medical expenses for the year. For instance, most people know how much they spend in out-of-pocket prescription costs each month, and things like eye exams and dental visits are easily estimated.

At a minimum, employees can start small. That is, they could choose to have less than they probably will need deducted, keep close track of their medical expenses for the year, and then raise their deduction once the enrollment period for the next year comes along—when they have a better idea of how much to deduct.

Properly estimating the costs of the plan is important for the employer too, because once the plan year begins, a small business owner must have available to plan participants the entire amount of reimbursable expenses for the year. This is called the “uniform coverage rule.”

This means that if Jim has a covered expense of \$2,000 in January, he can apply and must get a reimbursement for the entire amount, even if his contribution to date was only, say, \$200. One way to reduce this risk is to set a cap on annual maximum contributions.

Not surprisingly, medical FSAs are popular among both employees and employers alike.

For employees, aside from having a wide range of treatments covered, an FSA is appealing because it enables them to reduce the amount of their taxable income by having pre-tax dollars put into their FSAs. Taxes avoided by doing so include federal income tax, Social Security and Medicare taxes, and state and local taxes. Moreover, because they are able to pay for medical treatments with those pre-tax dollars, they save even more money.

For employers, FSAs can offer significant savings by reducing the gross amount paid to employees. This in turn reduces correlating expenses, such as:

If you would be wealthy, think of saving as well as getting.

BENJAMIN FRANKLIN

- Social Security and Medicare taxes.
- Unemployment insurance.
- Workers' compensation insurance.

In addition, while employee overpayments into the plan can be returned to your employees, there is no requirement to do so. Some employers retain the money and use it to offset any expenses incurred in administering the plan.

Dependent Day-Care FSAs

The Dependent Day-Care Flexible Spending Account is quite similar to the medical FSA. It is designed to help the working parent who has dependent children under age 13, or who has a physically or mentally disabled child, spouse, or other dependent.

As with a medical FSA, the Dependent Day-Care FSA allows employees to put pre-tax

money into a special account and use those funds to help pay for their day-care expenses. As with other FSAs, the amount to be deducted must be decided upon before the plan year begins and costs must be documented. Reimbursements can occur weekly.

The working parent in your office will love this benefit.

The Bottom Line

Flexible Spending Accounts can certainly be a good way for any employer to boost benefit offerings to employees. The accounts allow employees to pay for many day-care and medical expenses with pre-tax dollars.

For you, the small business owner, the accounts can reduce the amount spent on payroll-related taxes while also showing employees that you are doing everything you can to help them.



SECTION SIX

HEALTH SAVINGS ACCOUNTS

In 2003, the Medicare Prescription Drug Improvement and Modernization Act was passed, and one result was the establishment of Health Savings Accounts (HSAs). A Health Savings Account is not a substitute for traditional health insurance. It is in fact a savings account that allows employees and employers to pay for current health expenses and save for qualified future ones, tax-free.

How They Work

It helps to think of a Health Savings Account like an Individual Retirement Account (IRA). Just as you can sock money away in your IRA, tax-free, to help pay for your retirement, so too you can add money to an HSA tax-free to help pay for your medical costs.

There are two things that go into creating a Health Savings Account:

- 1. Creation of the tax-free account:** Employees contribute pre-tax dollars into a special saving account. Employers can choose to match employee contributions.

*Sound health is the
greatest of gifts.*

BUDDHA

2. Implementation of a high deductible health care plan (HDHP): To be legal, the HSA must be created in conjunction with an insurance policy with a yearly deductible of at least \$1,050 for an individual and \$2,100 for a family (these are 2006 numbers, and each year the amount will change a bit).

Once created, HSAs afford employees the chance to save money on their health care costs by paying for “qualified medical expenses” (like deductibles, prescriptions, and doctor visits) with pre-tax dollars from this special account. (In fact, not only are the savings created with pre-tax dollars, but any earnings on the account are tax-free too.)

Aside from tax benefits, HSAs have several other things going for them:

- 1. They lower premiums.** Because these accounts must be created in combination with a high deductible health insurance policy, premiums are less (high-deductible policies cost less than low-deductible policies).
- 2. They pay for many things.** HSA funds can pay for any “qualified medical expense,” even when these expenses are not covered by your insurance policy. For instance, while traditional health insurance does not pay for any over-the-counter medicines, HSAs pay for some.
- 3. They are flexible.** Upon disability, or the age of 65, the money in the HSA can be withdrawn and used for anything, without penalty (although taxes will finally come due). Alternatively, if the account is used toward eligible medical costs (things like prescriptions, health insurance premiums, or COBRA payments), it will never be taxed.

4. They are personal. The accounts belong to your employees and go with them as they change jobs, move, and so forth.

Contributions

Presently, the maximum annual contribution people can make into an HSA is \$2,600 for individuals and \$5,150 for families, although people between the ages of 55 and 65 can make additional contributions of \$1,000 a year above these limits. Again, these numbers will change yearly.

For the small business owner, the good news about HSAs is twofold. First, because you will be implementing a high-deductible health insurance plan in union with the HSA, your contribution to the premiums will be less. Second, there are tax savings for you too, since the money you contribute to HSAs is not taxed.

Although employees may not like the high deductibles of the major medical plan, voluntary insurance policies like those from Aflac can complement the HSA when the deductibles are due.

You can create an HSA health care plan by meeting with an agent of an insurance company that offers HSA-qualified health insurance policies. Not all agents do. Work with the carrier to explain the benefits to your staff and set up the savings accounts.

The Bottom Line

Health Savings Accounts have been developed specifically to help you spend less on your health care-related insurance costs. They are worth checking out.



S E C T I O N S E V E N

CONCLUSION

Throughout this booklet, we have hoped to show you that, while health care costs are an increasing challenge for the small business owner, there are ready solutions and numerous ways to offer your staff the sort of benefits that they want, and that you would like to give them.

Doing so can make all the difference between being a mediocre and a great small business. Although many things distinguish exceptional business owners, how he or she treats employees is high on the list. Says Bob Nelson, author of *1001 Ways to Reward Employees*, “Take time to appreciate employees, and they will reciprocate in a thousand ways.”

Making a real and substantial benefits program available for your employees is a great way to show them just how much you appreciate them. Use this booklet and the four principles below to guide you through the process.

Principle 1: Start With Basic Products. The alphabet soup of health care insurance products discussed in Section 2 are the bread and butter of your benefits package. Whether you go with an HMO, a PPO, or

something else, the important thing is to find a policy, program, and company that will make your employees' lives easier, not harder.

Principle 2: Increase Value Without

Increasing Cost. Whether it is term life insurance, or the voluntary insurance products offered by Aflac (disability, vision, dental, and so on), the important thing to remember is that these employee-selected products may be the key to turning an adequate benefits package into an exceptional one.

*In business for yourself,
but not by yourself.*

*RAY KROC
FOUNDER, MCDONALD'S*

Principle 3: Help Employees Save Tax

Money. Flexible Spending Accounts and Health Savings Accounts can round out your benefits package by helping your staff pay for their health care with pre-tax dollars.

Principle 4: Choose Your Carriers Wisely.

There are many companies out there offering health-related insurance products these days, but only a few that have the history, expertise, and financial wherewithal to deserve a great reputation.

Choose wisely and take good care of your employees. They will take good care of you and your customers.



1932 Wynnton Road · Columbus, GA 31999
Phone: 706.323.3431 Toll-free: 1.800.992.3522
aflacsb.com