

Benefit Insights

Translation Is Only One Issue in Crafting Effective Benefits Communications for Spanish-Speakers

Native Spanish speakers are among the fastest growing segments of the U.S. population—and work force—and represent the largest ethnic minority in this country. As such, it has become increasingly important that communications concerning employee benefits are crafted in such a way that ensures they are understood by this audience. In order to be effective, communications must be an ongoing process that reflects an understanding of native Spanish-language workers. Simply translating English-language versions of written benefits communications is not enough, as surveys show that many Hispanics hold different views concerning insurance and other types of benefits.

For example, research conducted by LIMRA International for Genworth Financial examined Hispanic respondents' perceptions of life insurance. The study broke down respondents into two distinct groups of Hispanic individuals, based on whether they had responded to the survey in English or Spanish. The English-language respondents were likely to have lived in the U.S. their entire lives, while the Spanish-language respondents were more tied to their native culture. Overall, respondents viewed life insurance as more costly than it actually is (some individuals put the price tag on coverage as more than \$100/month for a \$100,000 policy, and the estimated expected median price tag was \$30/month). Twenty-five percent of the English speakers and 46% of the Spanish speakers characterized life insurance as "too expensive."

Along with this cost misconception, many respondents characterized life insurance as an unnecessary product. Close to half of all respondents felt that family members would take care of their burial costs, and 86% of the Spanish speakers said that they expected to take care of their parents' financial needs when they got older.

In the area of financial planning, Hispanic workers are less prepared than the U.S. work force overall. According to the Employee Benefit Research Institute's 2003 Minority Retirement Confidence Survey, half of Hispanic-American workers said they (or a spouse) have saved for retirement, compared with 71% of all workers. The survey cited less familiarity, access and/or trust in savings and retirement planning tools, products and services by non-native-born individuals and those who have difficulty speaking English as one reason for statistical disparity.

Also concerning personal finances, the 2003 Employee Benefits Trends survey from MetLife found that 37% of the Hispanic respondents had done no specific financial planning (compared with 25% of workers overall). This survey also found that only 6% of Hispanic respondents had more than \$60,000 of disability insurance (compared with 16% of workers overall).

While these statistics to some degree no doubt result from a heavy concentration of Hispanics—especially recent immigrants—in low-wage jobs or jobs that do not include insurance coverage, language barriers and cultural differences also need to be considered. In a workplace with native Spanish speakers, steps should be taken to ensure that these differences do not interfere with workers' understanding of the benefits that are available to them and with their willingness to enroll in their benefits of choice.

Prior to the distribution of enrollment materials, bring in speakers knowledgeable in the benefits being offered, who not only are fluent in Spanish but also are familiar with the native culture of the targeted employees. Such speakers might address, for example, differences in the health care systems

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It is with great pleasure that we provide this monthly newsletter to you. In this issue and in coming months, we will discuss pertinent employee benefits topics which may affect your organization and employees. We sincerely hope you will find this newsletter informative and helpful. As always we remain at your service and encourage you to call us with questions or concerns.



Lesa Caputo



With Many Drugs Losing Patent Protection, Savings from Generics Can Be Significant

Generic drugs long have been recognized as a cost-saving alternative to their brand-name counterparts. The Generic Pharmaceutical Association, citing figures from the National Association of Chain Drug Stores, puts the average price of a generic drug at less than one-third the average price of a brand-name drug. With a number of widely used brand-name drugs soon losing patent protection, plan sponsors should be more motivated than ever to seek ways to encourage plan members to make appropriate use of generic drug therapies.

The statistics for encouraging generic drug use are compelling. An analysis from the Pharmaceutical Care Management Association (PCMA) indicates that, over the next five years, more than \$23 billion in savings could be generated as 14 or more major brand-name drugs are expected to become available in generic form. These include medications commonly used to treat depression (Zoloft), high cholesterol (Zocor and Pravachol), prostatitis (Proscar), heart disease (Norvasc and Lotrel), sleep disorders (Ambien), allergies (Zyrtec), hypertension (Coreg), fungal infections (Lamisil) and other infections (the antibiotic Tequin).

Separately, a report from pharmacy benefit manager Express-Scripts estimated that brand-name drugs accountable for more than \$38 billion in sales are expected to lose patent through 2008.

Statistics from AARP on drug price trends also make a persuasive case for generics. AARP looked at 75 widely used generics and 193 widely used brand-name drugs and found that, while the annual rate of increase in manufacturers' prices for brand-name drugs continued to exceed the rate of inflation in 2005, with a 6.0% increase, manufacturers' list prices for generics actually fell, by 0.8%.

Generic medications account for about 56% of all drugs dispensed in the United States, according to the Generic Pharmaceutical Association. Plan sponsors and prescription drug plan vendors that succeed in increasing this rate can realize significant cost savings.

Both benefit plan provisions and patient and physician education play important roles in influencing generic utilization. Educating plan members on the safety, effectiveness and affordability of generics is essential. Many individuals may not realize that a generic drug has the same active ingredient as its brand-name counterpart, but costs less because the generic drug maker does not have the research, development and advertising costs associated with brand-name drugs. Communications should repeatedly make this point, in order to balance the brand-name message that individuals get from the extensive direct-to-consumer advertising that appears in magazines and on television.

Plan provisions that make generics an immediately more cost-effective choice for the members by reducing their out-of-pocket payments can have a great impact on generic utilization. For example, an Express-Scripts study found that use of generic drugs (as defined by the generic fill rate) steadily increased as the difference in the required plan member copayment between generic and brand-name drugs increased. For every \$10 difference in generic versus preferred brand copayments, a plan can expect an increase in its generic fill rate of three to four percentage points, the study found.

Copayment differentials usually are seen in tiered formularies, which assign medications to one of two, three or four different tiers, with each tier having a different copayment (or, in some plans, a different coinsurance requirement). Other plans require that generics be tried as a first step in drug therapy, and coverage of a brand-name alternative is allowed only if the generic does not achieve the desired result (this is called step-therapy).

With a large number of brand-name drugs coming off patent in coming years, now is an excellent time to review your prescription drug plan provisions and communications to take advantage of this cost-saving opportunity.

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of the United States and Mexico and the necessity of having health insurance to help cover the high cost of health care in the U.S. On financial benefits, issues to address include the fact that life insurance coverage is not confined to the wealthy, that banking and financial services providers operate in highly regulated industries in which corruption is not the usual way of doing business, and that a wide range of opportunities with varying degrees of risk are available to small investors.

Of course, provide Spanish-language versions of written communications and enrollment materials. And, during enrollment, make sure employees have access to Spanish-speakers knowledgeable about the benefits and enrollment process to answer questions.

These few steps help ensure that employees who are not native English speakers have full access to the employee benefits programs.

Most Americans Unwilling to Pay More for Better Care

Americans have become more skeptical that fair and reliable ways exist to measure the quality of health care providers' services, and less ready to say that high-quality providers should be paid more. These findings from a Harris Interactive online survey of 2,123 U.S. adults conducted for the Wall Street Journal show shifting opinions on health care quality issues—and on the connection between quality and cost—from 2003 to 2006.

In 2003, 58% of respondents said they believed there were fair and reliable ways to measure and compare the quality of care provided by different hospitals and medical groups, but by 2006 this figure had dropped to 49%. Quality measurement methods identified as fair included patient satisfaction surveys (assessed as fair by 69% of the respondents); medical tests that measure how well doctors are managing patients with chronic medical conditions (61%); assessments by medical boards (58%); assessments by third-party organizations that monitor health care quality (57%); frequency of preventive screening tests (55%); the use of electronic medical records and other information tools (47%); and malpractice suits (41%).



While 33% of the respondents favor health insurance plans paying more to hospitals and physicians that have been shown to provide higher quality care (down from 44% in 2003), only 19% thought that patients should pay more (18% in 2003) and even fewer—14% (16% in 2003)—were personally willing to pay a significantly higher premium for a health care plan that covered access to providers that have been shown to render superior care.

Such data reinforces the importance of health plan members' understanding of the impact that the quality of care can have, on overall health and on costs. A 2003 report from the National Committee for Quality Assurance (NCQA) concluded that quality gaps that hindered best practices lead to more than 57,000 avoidable deaths, 41 million sick days and more than \$11 billion in lost productivity each year. This human and financial toll is a piece of the health care cost equation—along with the member premiums and insurance reimbursements—that should be considered when deciding the price that one is willing to “pay” for quality health care.

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13%. The actual leading cause of long-term disability is musculoskeletal/back problems (24%), followed by circulatory system problems (13%) and nervous system disorders (11%); accidents/injuries/poisonings tie with cancer as accounting for 10% of disabilities.

- People may be expecting income during a disability from unrealistic sources. Employees surveyed expected income from the following sources; this data is juxtaposed with the actual sources from which those in the survey who had actually experienced a disability in the past five years had received income:

Income Source	Expected	Actual
Disability Insurance	49%	37%
Unemployment Comp	27%	6%
Social Security	23%	6%
Medical Insurance	21%	0%
Workers' Comp	18%	12%

- Another misconception about disability insurance concerns is its cost. Close to half—42%—of those surveyed, who had no short-term or long-term disability insurance coverage, gave as their reason the cost of disability insurance being too high. And, these individuals estimated the annual cost of coverage to be about five times higher than it actually would be.

Both employers and employees would be better off if disability insurance coverage rates were more in line with the realities of an actual disability occurrence. Employees without disability coverage may come to work when they shouldn't (known as “presenteeism”), or may fail to return from a disability because no one is managing the return-to-work process, resulting in lower productivity and running up an employer's cost of doing business. Offering disability insurance coverage to employees—whether on a voluntary, employee-pay-all basis or with some employer contribution to the premium cost—helps address these issues, along with helping employees meet their income needs during times when they are not able to work to their full potential.

Misconceptions About Disability Occurrence and Disability Insurance Result in Low Coverage Rates

Although rates for disability insurance coverage are low—fewer employees have the coverage than medical, life, dental or even vision insurance. Yet, the chances of one becoming disabled at some time in a working career are surprisingly high: one estimate finds a one in three chance that an individual will suffer a serious disability between the ages of 35 and 65. The odds may be even higher. Today's longer life spans mean longer working careers, and advances in medical technologies and disease therapies—such as some cancer therapies—may successfully treat an illness but temporarily disable an individual from working during treatment.

In a recent study, *Unintended Exposure: The Surprising "Big Gamble" Employees Take Every Day*, the Hartford undertook to determine why disability coverage statistics seem so out of sync with two realities—the odds of becoming disabled and the impact that a disability of almost any duration can have on one's income. The study found that individuals not only are underestimating their chances of becoming disabled; they're also overestimating the alternative income sources available to them in the event of a disability.

Individuals surveyed had the following insurance coverages:

- Medical—held by 85 %

- Life—72 %
- Dental—69 %
- Defined contribution (e.g., 401(k), 403(b) plan)—50 %
- Vision—47 %
- Short-term disability—42 %
- Long-term disability—34 %
- Pension/profit sharing—32 %
- Health savings accounts/flexible spending accounts—19 %

The study asserted several reasons for so few having disability coverage:

- People have misconceptions about the circumstances that lead to disability. For example, those surveyed thought that accidents, injuries or poisonings were the leading causes of both short-term disabilities (74 %) and long-term disabilities (35 %). People, therefore, may feel they can avoid becoming disabled by being careful and leading safe lives. However, the actual leading causes of short-term disability are pregnancy (21 %) and musculoskeletal/back problems (19 %); accidents/injuries/poisonings account for only

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