Employee Benefits Report

HEALEY & ASSOCIATES
progressive ingenuity. financial security.

10 Free Street, PO Box 599
Portland, Maine, 04112-0599
T: 207.775.6177 | F: 207.775.5688

232 Center St. Suite D, PO Box 3160
Auburn, Maine, 04212-3160
T: 207.784.1535 | F: 207.777.5208

www.healeyassociates.com

Health Benefits | May 2015 | Volume 13 • Number 5

ACA Spurring Interest in Self-Insurance

Self-insurance can create risk exposures that most smaller employers don't want to take. Still, 15 percent of smaller employers (1-199 employees) find the benefits outweigh the risks.

What Is Self-Insurance?

Employers providing health benefits to employees have three basic choices: buying a fully insured plan, self-insuring or offering employees a choice of fully insured and self-insured plans. With an insured plan, the employer pays a flat per-enrollee premium to an insurer that administers the plan and pays claims. Like an insured employer, a self-insured employer has a written plan. However, it pays for its workers' claims directly as incurred and retains the risk of higher-than-expected claims.

continued on next page

This Just In

Workers have mixed opinions on how they want to receive health insurance, according to an analysis by the Employee Benefit Research Institute (EBRI) earlier this year. About equal percentages of workers want their employer to continue to select and pay for their coverage, versus just paying for their coverage (40 and 41 percent, respectively). The remaining 19 percent would prefer their employer to give them money and decide how they want to spend it themselves.

Employers' payments for health insurance are a form of compensation, but unlike cash compensation, they are exempt from income and payroll taxes. In most cases, workers' contributions toward their coverage are also excluded from income and payroll taxes. That favorable tax treatment costs the federal government about $250

continued on next page

So Why Do Employers Self-Insure?

Self-insurance offers a variety of potential advantages to employers, including:

- Autonomy, control and flexibility of plan design, including exemption from state-mandated benefit requirements;
- Lower administrative costs than a commercial carrier would charge;
- More timely and complete access to data on health claims, which can help employers make more informed decisions about plan design;
- Ease of altering their contract with a third-party administrator (TPA) or stop-loss insurer without affecting employees' choice of providers;
- Improved cash flow generated by keeping funds in-house until needed for payment of claims; and
- Avoidance of state insurance premium taxes.

State laws that regulate fully insured group plans usually do not apply to self-insured plans. And some provisions of the federal Patient Protection and Affordable Care Act pertain to fully insured plans but not to self-insured plans.

In addition, several provisions of the Affordable Care Act (ACA) that apply to fully insured small group plans (100 or fewer employees) do not affect self-insured plans:

- Community rating. Insurers can vary premiums only according to actuarial value of the plan, geographic region, age, tobacco use and family size. Your group's health status or actual claims experience will not matter.
- Risk adjustment. The ACA allows the transfer of funds from plans with enrollees having lower than average costs to plans with employees having higher than average costs.
- Plans offered to small groups must cover "essential health benefits" (EHBs). The EHBs include items and services within ten general categories, including prescription drug coverage and mental health and substance-use-disorder services.

Covering the EHBs has made many small group plans more expensive. Large groups, on the other hand, have to meet certain minimum coverage value requirements, but they do not have to cover the essential health benefits. And with community rating and risk adjustment, healthier groups essentially subsidize the cost of covering less-healthy groups. Therefore, if you have a relatively young, healthy group, you may save money by self-insuring.

Self-insurance has potential disadvantages, however. These include:

- Financial risk of unexpectedly large claims;
- Regulatory compliance, which is easier with a fully insured plan;
- Loss of some discounts. Insurers and larger employers have the clout to negotiate discounts with health providers that smaller employers lack.

billion in forgone revenues each year.

Some lawmakers have suggested eliminating tax-preferred treatment of employer-provided benefits as part of a budget overhaul. If that happens (and we aren't holding our breath), small employers would have to decide whether to continue offering benefits. Barring repeal of the Affordable Care Act 's employer mandate, large employers would still have to provide health benefits.

Most self-insured employers outsource plan administration and claim processing to a third-party administrator. They can also mitigate some of their risk by purchasing stop-loss insurance, which will reimburse a covered employer for claims above a specified dollar level.

Provisions under the ACA allow employers that switch to a self-insured plan to switch back to a fully insured plan at a later date without having to worry about the group or specific individuals being denied coverage for pre-existing conditions. This differs from pre-ACA days, when insurers could refuse to cover groups or individuals within a group based on health status. The ACA also prohibits insurers from charging higher premiums based on the health status of your group or the gender of your employees. It also limits how much premiums can vary based on age.

We can help you evaluate your health benefits and claims and help you determine if self-insuring is a viable option for your organization. If so, we can help you structure your plan and also help arrange stop loss coverage to protect your organization from catastrophic claims.

Republicans Introduce Their Own Health Care Reform Law

Republicans in the Senate and House have proposed several bills to repeal President Obama's Patient Protection and Affordable Care Act (ACA). In January, several legislators introduced the Patient Choice, Affordability, Responsibility, and Empowerment Act (Patient CARE Act), which would create a new health insurance reform plan, in addition to repealing the ACA.

The Act's sponsors, Senator Richard Burr (R-NC), Senator Orrin Hatch (R-Utah) and Representative Fred Upton (R-Mich.), introduced an outline of their plan. As this issue went to press, however, none had introduced it as a legislative bill in their respective houses. The following information was current as of early April.

The Patient CARE Act would not require individuals to buy coverage. It also would not require businesses to provide health insurance for their employees. There would be no penalties for failing to have or provide coverage. Although the Patient CARE Act would repeal the Affordable Care Act, it would keep some of the popular changes ushered in by the Affordable Care Act. Affordable Care Act changes the Patient CARE Act would keep include:

- Prohibiting insurers from denying coverage based on a pre-existing medical condition.
- Eliminating lifetime coverage limits on health insurance policies.

The Patient CARE Act would also take the following cost-reduction measures:

- Eliminate "mandated benefits," or a list of benefits that health insurance policies must cover. It would also eliminate the ACA's prohibition on annual coverage limits for health insurance policies. This would lower premium costs, but could increase out-of-pocket costs for less-healthy individuals.
- Make it more difficult to qualify for subsidized coverage. The Affordable Care Act offers "advance premium tax credits" for people whose income is up to four times the federal poverty level. The Patient CARE Act would limit eligibility to people whose income is up to three times the federal poverty level.
- Allow states to opt out of the requirement to offer coverage to dependents up to age 26. The Affordable Care Act requires health insurance plans in all states to offer coverage to dependents until age 26. The Patient CARE Act would continue this requirement for health plans, unless the state opted out of the requirement.
- Eliminate certain taxes created by the Affordable Care Act. These include the 2.3 percent excise tax on the medical device industry and certain taxes and fees on pharmaceutical companies. For individuals, the Act would eliminate the Net Investment Income Tax and Additional Medicare Tax. The Net Investment Income Tax is a tax of 3.8 percent that applies to certain net investment income of individuals, estates and trusts. An individual must have a modified adjusted gross income over $200,000 for the tax to apply. The Additional Medicare Tax of 0.9 percent applies to wages, self-employment income and Railroad Retirement Tax Act compensation over $250,000 for married taxpayers filing jointly, $125,000 for mar-

continued on next page

ried filing separately and $200,000 for all others.

- Lower the tax on so-called "Cadillac plans." These taxes recognize that employer-paid health plans that provide "rich" benefits with few or no out-of-pocket costs give insureds little incentive to control their medical spending. The ACA imposes a 40 percent excise tax on Cadillac plans, paid by health insurers or self-insured employer groups. The Patient CARE Act would instead include the cost of coverage that exceeds a threshold in an employee's income. Employees could receive up to $12,000 in employer-sponsored individual coverage per year tax-free and up to $30,000 for family coverage. Employees would pay taxes at their regular income tax rate on any coverage costs over that amount.
- Allow individuals to use funds in a tax-advantaged medical spending accounts for over-the-counter drugs when prescribed by a licensed healthcare provider. This would apply to flexible spending accounts (FSAs), health savings accounts (HSAs), health reimbursement arrangements (HRAs) and Archer Medical Savings Accounts (MSAs).
- Reform medical malpractice laws to reduce the cost of "defensive medicine." Defensive medicine consists of unnecessary medical tests medical providers do to protect themselves from unwarranted malpractice lawsuits. In a 2014 issue brief, the nonpartisan National Conference of State Legislatures estimated medical liability system costs eat up 2.4 to 10 percent of total health spending. This includes settlements, legal and administrative costs and defensive medicine.

Other changes:

- Would allow Medicaid-eligible individuals the option of using the health tax credit to help buy private insurance. The Affordable Care Act requires Medicaid-eligible people to enroll in Medicaid.
- Would create a "continuous coverage protection." This would prohibit insurers from medically underwriting an individual who moves from one health plan to another (whether an individual, small group or large employer plan) with no significant break in coverage. This means insurers will not be able to deny coverage or require a person to pay higher premiums because of a pre-existing medical condition. The proposal does not define a "significant break" in coverage. The Affordable Care Act prohibits insurers from refusing to cover an individual or charge more because they have a pre-existing condition.

Since the Patient CARE Act is a proposal and not yet a bill, the Congressional Budget Office cannot calculate its cost or effects on the healthcare system. We will keep you informed of this and other legislative or legal changes that could affect your health insurance coverage. ■

Covering the Disability Income Gap

Employer group disability income plans offer tremendous tax advantages to both employer and employee. The employer can deduct premiums as a business expense, and they do not count toward the employee's taxable income. However, group disability plans usually do not provide enough coverage for upper management and highly compensated employees. Here's how to provide for these employees' additional coverage needs.

The basic group disability income policy acts as a safety net for your employees when a disability keeps them out of work. A basic policy probably provides enough coverage for rank-and-file employees, but its structure can create a major coverage gap for higher-income employees.

Most group policies replace 50 to 60 percent of pre-disability income—enough to help cover basic expenses while out of work, but not enough to create a disincentive to returning to work. In addition, policies have

continued on next page

a maximum monthly benefit. Depending on the insurer, your industry, location and the size of your group, that maximum could be as low as $3,000 or $4,000 for smaller groups, and ranging from $7,000 to $15,000 for larger groups. If you have executives, salespeople and others earning more than $300,000 per year, this level of basic group plan won't even replace 60 percent of their pre-disability earnings.

The policy's definition of earnings could create another stumbling block. Most group policies pay a benefit equal to a percentage of the employee's "basic monthly earnings." This usually includes gross salary but may exclude commissions and bonuses. For salespeople and executives with significant commission and bonus income, this could result in a serious income shortfall in the event of a disability.

To remedy this problem, a number of insurers have developed supplemental group disability plans, popularly known as disability buy-ups. These plans allow highly compensated employees to combine the employer's basic group coverage with another plan to receive a higher monthly benefit in event of disability.

You can structure a buy-up plan in several ways:

Employer-paid plans: In an employer-paid plan, the employer pays all premiums, which it can deduct as an ordinary business expense. Premiums do not count toward the employee's taxable income, but he/she will have to pay income tax on any benefits received.

An executive buy-up plan often involves two tiers of coverage: a guaranteed issue policy and a modified guaranteed issue policy. If your group of highly compensated employees is large enough, your insurer might be willing to write a guaranteed issue policy, which means the insurer asks no medical questions and provides a group policy at standard rates. This ensures that even executives with health problems will be able to obtain coverage.

For the second tier of coverage, a modified guaranteed issue plan, the insurer will ask some simple medical questions to make its coverage decision. It may decline to cover an individual, exclude coverage for a pre-existing condition or charge extra premium.

In some buy-up plans, the employer "carves out" coverage for highly compensated employees, providing them with the basic group plan and then supplementing it with individual disability income policies. Insurers typically individually underwrite individual disability income plans, but may make individual policies available on a guaranteed-issue basis for larger groups. Individual plans also offer better rate guarantees and portability than group policies. Unlike with employee-paid individual policies, however, any benefits received under an employer-paid policy will be taxable income.

Employer-sponsored (voluntary) plan: The most popular approach to supplemental disability coverage, voluntary plans, require the employer merely to act as plan sponsor, allowing the insurer to directly solicit employees. Employees who elect coverage pay 100 percent of premium. If the employer has a Section 125 (cafeteria) plan, employees can pay premiums with pre-tax dollars; any benefits received will be taxable. Employees can also opt to pay premiums with after-tax dollars and receive policy benefits tax-free.

Hybrid plan: In a hybrid plan, the employer pays premiums on supplemental coverage for a select group of employees. Employers can deduct premiums as a business expense, but covered employees must pay income taxes on benefits. Other employees can buy the supplemental coverage on a voluntary basis.

Gross-up plans for key employees: Employers can "gross-up" the employee's pay by the amount of the premium, and have the employee pay the premium with after-tax dollars. In this arrangement, the employee pays income tax only on the amount of the pay increase, and the benefits are tax-free.

continued on next page

Negotiating Buy-Up Benefits

If your benefits budget cannot support an employer-paid buy-up plan, a voluntary disability plan could help highly compensated employees by giving them access to a guaranteed issue or modified issue plan with the convenience of payroll deduction payments.

For more assistance in structuring a disability income plan to fit all your employees' needs, please contact us. ■

What You Need to Know About Stop Loss Insurance

Fifty-five percent of plan sponsors surveyed reported having at least one plan participant with claims that exceeded $500,000 in the last two policy years. Twenty-three percent reported a claimant in excess of $1 million, with 9 percent of those in excess of $1.5 million. (Source: 2014 Aegis Risk Medical Stop Loss Premium Survey).

Stop loss insurance, a type of reinsurance, protects self-insured employers by limiting the amount they have to pay out for employee health claims. Two types of stop loss coverage exist: one covers risks on an individual participant level; the other covers them on the group level.

Individual stop loss, or specific deductible stop loss protects you from large claims from an individual. If an individual's claims reach a specific dollar amount, the reinsurer will pay that person's claims for the rest of the plan year.

Aggregate stop loss limits the employers' liability for the entire group to a specified dollar amount during a specified period, usually either a plan year or month. If your claims reach the "attachment point," the reinsurer will pay claims over that amount. More employers buy specific stop loss coverage, since it protects them from unforeseen high-dollar medical claims on an individual.

Unlike other types of policies, where the insurer specifies deductible levels, stop loss insurers allow the insured to select a loss limit, or attachment point, based on its budget. Attachment amounts typically range from 15 to 25 percent above expected claims.

How Much Does It Cost?

Stop loss premiums vary widely due to varying deductible size. Aegis found that premiums in 2014 averaged from $102.52 per employee per month (PEPM) for a $100,000 individual deductible to $13.43 PEPM for a $500,000 individual deductible.

Note that a stop-loss policy is a contract between the carrier and the employer, not a health policy. This means the pre-existing condition and guaranteed renewability requirements that apply to health insurers do not apply to stop-loss insurers. Stop-loss insurers can refuse coverage or drop coverage if a group experiences too many claims. Current Affordable Care Act regulations would allow a group to go back to a fully insured arrangement should this happen. ■

Employee Benefits Report