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 Insurance | November 2013 | Volume 11 • Number 11

Private Exchanges: An Option Worth Exploring

An overwhelming majority of employers, including those that currently offer employee health coverage and those that don't (81 percent and 71 percent, respectively) would prefer a private health insurance exchange to a public one, according to a 2012 survey by Booz & Company. How do private exchanges differ from public ones, and what advantages do they offer employers?

The health insurance marketplaces, or exchanges, created by the Patient Protection and Affordable Care Act (ACA) allow individuals and small employers to fill out an application and see all the health plans available in their area. Through technology, the marketplaces offer individuals and small employers choice among several insurance plans, and an easy way to compare them. But the marketplaces are open only to employers with 50 or fewer employees (although some might expand eligibility to employers with 100 or fewer employees in the future). Private exchanges seek to give other employers these advantages, along with some others.

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This Just In…

Employees give thumbs down to the U.S. healthcare system, but thumbs up to their own health plan.

In a survey by the nonpartisan Employee Benefits Research Institute (EBRI) a majority of workers described the U.S. healthcare system as poor or fair (21 percent and 34 percent, respectively). The percentage of workers who rated the healthcare system as poor nearly doubled between 1998 and 2006 (14 percent to 32 percent) but fell between 2006 and 2012. According to EBRI, "dissatisfaction with the health care system appears to be focused primarily on cost."

While the healthcare system as a whole earns poor grades, employers are doing something

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What Are Private Exchanges?

Private exchanges emerged a few years ago when large employers such as GM and others struggled with the increasing cost of providing retiree health benefits. Instead of buying a specific health plan for retirees, employers instead make an annual contribution to each eligible employee. Employees then use that contribution to buy their preferred Medicare Advantage or Medicare supplement and Part D prescription drug plan in a private exchange. This defined contribution approach to funding retiree health benefits gives employers greater cost control and predictability. Meanwhile, employees can choose the plan that best meets their needs, using the decision support tools offered by the private exchange.

Private exchanges are created by private businesses, rather than government fiat, so many models exist. Some offer the products of only one insurance carrier. Others, typically created by brokers or consultants, offer the products of multiple carriers. Although the market is rapidly expanding and changing, an employer looking for group health plans for active employees will likely find more options among single-carrier exchanges.

Like the ACA's health insurance marketplaces, private exchanges allow individuals to compare and select among various health plans. But in addition to providing major medical plans, private exchanges can offer a range of other products on a voluntary basis, including dental and vision plans, life insurance, hospital indemnity insurance, cancer or critical illness insurance and disability insurance.

Advantages of Private Exchanges

The private exchange model offers advantages to both employers and employees. For employers:

- A defined contribution approach allows employers to set a predictable budget for their healthcare costs.
- Exchanges encourage employees to buy only the benefits they need. Interestingly, employees given a choice of benefit plans on a private exchange tend to choose less-rich benefits than their employer might have offered previously. One private exchange operator says most employers save 10-30 percent in the first year alone.
- Defined contribution plans can control healthcare spending increases by giving employees more transparency and control over their healthcare spending.
- Exchanges can pool risks among many employers. This spreading of risk reduces the impact of a catastrophic claim on any one employer.
- As multi-carrier exchanges emerge, they could foster competition among insurers, making them more efficient.
- Exchanges can offer a variety of benefits on a voluntary basis, eliminating the need for employers to deal with multiple carriers.
- Employers can use their insurance broker to facilitate buying coverage on a private exchange.
- Web-based enrollment tools feed enrollment data directly to the insurance carriers, eliminating paper applications and minimizing billing reconciliation.

right. Among workers with health insurance coverage, the EBRI found half (51 percent) are extremely or very satisfied. Nearly half (46 percent) are also extremely or very confident about their ability to get the treatments they need today. However, they are less certain about the future, with only 28 percent confident they will be able to get needed treatments during the next 10 years.

For Employees:

- Employees who select their own coverage tend to be more satisfied with their plan.
- Employees who have access to voluntary benefits through an exchange can have a one-stop benefits shopping experience. They can use the decision-support tools of the private exchange to select other coverages they want and need.
- Many private exchanges offer web-based enrollment tools that allow employees to instantly see their elections and the costs, then easily make changes to fit their budgets.

Disadvantages

- Employers that buy their coverage on an exchange will not be able to obtain the tax credits available on the public exchanges.
- Lack of uniformity means employers (or their brokers) must do legwork to determine which exchange offers the combination of products and service that meets their needs. However, the variety of models available gives employers more options.

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Administrative Considerations

When the "employer mandate" goes into effect in 2015, employers subject to the Affordable Care Act will need to ensure their health plan complies with the provisions of Affordable Care Act (ACA) or face possible penalties.

Employers that use private exchanges for retiree health benefits typically use health reimbursement arrangements (HRA) to fund retirees' health plan purchases. An HRA, funded solely by the employer, provides tax-free reimbursement of qualified medical expenses, up to a maximum dollar amount per coverage period.

Because HRAs have a maximum dollar amount for a coverage period, they do not comply with the ACA's prohibition on annual dollar limits. The ACA prohibits any group health plan from placing an annual dollar limit on coverage of "essential health benefits," but it specifically exempts standalone HRAs limited to retirees from this prohibition. For active employees, however, the annual dollar limit prohibition means employers cannot use HRAs to fund benefits unless they are integrated with another group health plan. Coverage under that group plan alone must comply with the annual dollar limit prohibition.

Employers turning to private exchanges will also want to ensure they give employees enough money to buy coverage to avoid triggering the ACA's affordability standards. Their plans should also comply with the ACA's preventive care and minimum value coverage requirements to avoid triggering penalties.

Despite the challenges, many experts predict private exchanges will become employers' preferred way of buying coverage in the future. For more information, please contact us.

Life Insurance: The Foundation of a Benefit Program

According to the Bureau of Labor Statistics, 72 percent of all full-time employees in private industry had access to life insurance through their employer. Nearly all eligible employees (98 percent) participated in their employer's program, vouching for the popularity of employer-provided life insurance.

Most employers provide employee life coverage through group term life policies. Under any true group insurance program, one policy, issued to the employer, covers all employees; covered individuals receive a certificate. Term life policies differ from "permanent" life policies, such as whole life or universal life, in that they provide benefits only if the insured dies during the policy term. They do not build any cash value or redemption value. Policy terms under group policies are usually one year; under individual policies, terms are usually five or 10 years.

Unlike many other group policies, coverage under group life policies often is no cheaper than under an individual policy, at least for a healthy individual. However, group life is written on a "guaranteed issue" basis, which means that eligible employees can obtain a minimum "guaranteed issue" amount of coverage without medical underwriting if they sign up during the enrollment period. This means that all your employees can obtain some coverage, even those whose health would make buying individual coverage prohibitively expensive or impossible.

Tax Implications

The IRS allows employees to exclude the cost of the first $50,000 of employer-provided group term life insurance cov-

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erage from income, if the policy is "carried directly or indirectly by the employer." This includes policies for which the employer pays any cost, or policies where the employer arranges for premium payments and premiums paid by at least one employee subsidize those paid by at least one other employee.

Individuals can also exclude the cost of employer-provided group-term life insurance on the life of a spouse or dependent if coverage does not exceed $2,000. This coverage is excluded as a de minimis fringe benefit.* Employers can deduct the cost of group term life premiums, as long as they are not the direct or indirect beneficiary of the policy.

**A "de minimis" fringe benefit is any property or service that you provide to an employee that has so little value (taking into account how frequently you provide similar benefits to your employees) that accounting for it would be unreasonable or administratively impracticable.*

Limits and Features

Employers can tailor a group term life benefit to their needs and budget. According to the Bureau of Labor Statistics, most employees with life insurance benefits (95 percent) do not have to contribute toward this benefit.

Most employees (58 percent) had plans that provide benefits as a multiple of earnings. Among these workers, most (61 percent) have coverage equaling one times earnings, while 22 percent had two times earnings. Typically, management employees receive higher salary multiples than other employees. Thirty-five percent of workers had "flat dollar amount" coverage, which pays the same specified amount for any covered employee.

Group term life policies offer many options, which may vary by insurer or by state. Look for a policy that offers a **conversion option**, which allows employees to convert their group term life coverage to an individual term policy without undergoing a medical exam when either their employment or the benefit plan terminates. To take advantage of this option, insureds must apply and make a premium payment within a period of time specified in the policy. (Some states require policies to be convertible.)

Other valuable options are **waiver of premium**, which waives premium payments for an employee who becomes totally disabled, usually up to retirement age. A **living benefit option** allows employees with a terminal illness to receive a portion of their death benefit in advance, to help cover medical costs.

Although group term life cannot take the place of individual policies in a worker's financial portfolio, employees value their life insurance coverage. You can add to the value by offering additional coverage on a voluntary (employee-paid) basis. In a survey conducted by LIMRA International for Allstate Insurance Company, 25 percent of adults surveyed said they should have more coverage. Voluntary benefits are a cost-effective and convenient way to provide these employees the additional coverage they want.

For more information on setting up a life insurance benefit for your employees, please call us.

How the ACA Affects HRAs and FSAs

In January, when more provisions of the Patient Protection and Affordable Care Act (ACA) go into effect, several could cause HRAs and FSAs to be out of compliance. Here's what employers need to know about administering these popular benefit funding options.

First, the ACA will prohibit group health plans from placing annual limits on coverage of certain "essential health benefits." Second, the ACA will require non-grandfathered health plans to cover certain preventive services without cost-sharing, or with no deductible or copayment. And third, the ACA will change the definition of "benefits" to exclude individual coverage bought on the health insurance exchanges. What do these changes mean for your employees' health reimbursement arrangements (HRAs) and/or flexible spending accounts (FSAs)?

HRAs: An HRA is an arrangement funded solely by an employer that offers employees and eligible dependents tax-free reimbursement for qualified medical care expenses, up to a maximum dollar amount for a coverage

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period. Employees can generally roll over unused account balances to reimburse expenses incurred in later years.

FSAs: Employers establish health flexible spending accounts to allow employees to set aside pre-tax dollars to pay for qualified medical care expenses for themselves and their eligible dependents. Employees make salary reduction contributions, but employers can also contribute additional amounts.

Both these types of plans are considered "group health plans" for purposes of the ACA so they must comply with the ACA's provisions affecting group health plans. Changes you should be aware of include:

- Employers can no longer use HRAs as a standalone medical plan. Because HRAs have annual limits, doing so would violate the annual limits prohibition. Employers can still offer HRAs, but only when integrated with a group health plan that complies with the rules on annual limits. The IRS has issued guidance that outlines how an HRA must "integrate" with a group health plan.
- Employers can use standalone HRAs to reimburse retirees who buy their own health plans. The law specifically exempts plans that cover two or fewer active employees.
- The reforms do not apply to plans that provide "excepted benefits," or those not treated as medical benefits under the law. Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health FSAs. Therefore, an HRA limited to covering these excepted benefits would be permitted.
- The annual dollar limit prohibition does not apply to health FSAs. Contribution limits for FSAs went into effect for plan years beginning on or after January 1, 2013. In 2013, the contribution limit stands at $2,500 per year; limits for future years will be indexed for inflation. The contribution limits apply to employee salary reduction contributions for healthcare expenses alone; they do not apply to employer nonelective contributions.
- Because individual coverage bought on the health insurance exchanges will no longer meet the definition of a "benefit," employees cannot use funds in FSAs to buy individual coverage on the health insurance exchanges. Premium-only plans (POPs) used to buy other individual coverage or employees' share of premiums for an employer-sponsored group plan might still comply with the law; consult a benefits expert for guidance.
- As with HSAs, FSAs must integrate with a qualified group health plan or the market reforms will apply, including the preventive services requirements.

Guidance issued by the IRS and Departments of Labor and Treasury in September also clarifies treatment of employee assistance programs, or EAPs. The guidance states the Departments' intention to amend law to consider benefits provided under an EAP as excepted benefits, if the program does not provide "significant" medical care or treatment benefits. If your EAP focuses primarily on counseling and related benefits, then market reforms likely will not apply.

If you have any concerns over whether your benefit programs comply with the Affordable Care Act, please contact us. ■

Correction: *In our October issue, the article "Plan Now to Avoid the 'Cadillac Tax'" contained an error. In the sentence: "The Kaiser Family Foundation reports that the average annual premium for employer-sponsored family health coverage reached $5,884 this year, a 5 percent increase over 2012 costs," "family health coverage" should have read "individual health coverage." We apologize for the error.*

Help Employees Avoid These Seven Enrollment Mistakes

Last year, Colonial Life & Accident Insurance Company surveyed nearly 400 employee benefits counselors after the 2012 open enrollment period. These experts listed the most common mistakes that employees make during open enrollment.

- Assuming they don't need the benefits offered without first talking with a benefits counselor — cited by 81 percent of respondents.
- Not reading benefits information before enrollment — 69 percent.
- Not knowing what benefits they currently have and what they cost — 69 percent.
- Forgetting to talk with their spouse about their family's needs before enrollment — 67 percent.
- Assuming the cost of a new benefit is unaffordable without seeing any prices — 66 percent.
- Not attending the group informational meeting — 58 percent.
- Not taking time to understand upcoming changes in their benefits plan — 50 percent.

Many of these mistakes stem from poor communication. In another survey, Colonial Life found that only 23 percent of employees think their employers communicate their benefits very effectively, while 9 percent say the benefits communication they receive is not at all effective. To help remedy this problem, consider the following suggestions:

- **Give it time.** Employees need time to digest information and properly evaluate their options. Rather than overwhelming employees just before open enrollment, communicating with employees on a regular basis about their benefits can enhance their understanding and appreciation of their benefits. Among employees surveyed by Colonial Life, 53 percent said it was very important to receive benefits information regularly; 95 percent said it was at least somewhat important.
- **Be available.** Even if you provide the most sophisticated online enrollment and decision-making tools, many employees still like to have an expert accessible for face-to-face communication during open enrollment. Among employees surveyed by Colonial Life, nearly half (46 percent) said having this option was very important, while 90 percent said it was at least somewhat important.

An experienced benefits professional can help guide your employees through open enrollment as painlessly as possible—for more information, please contact us. ■

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