Employee Benefits Report

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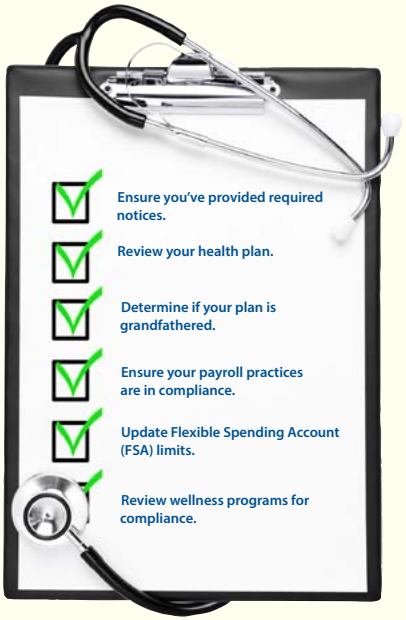
Employer Checklists

Although employers got a yearlong reprieve from the Affordable Care Act's (ACA) coverage mandate, other provisions of the ACA will affect employers in 2014. The following brief checklist will alert you to some important changes to prepare for.



All Employers

1 Ensure you've provided required notices.

- Notice to Employees of the New Health Insurance Marketplace. Beginning on October 1, 2013, employers covered by the Fair Labor Standards Act (generally, firms with at least one employee and at least $500,000 in annual dollar volume of business), must provide this notice to all current employees and to each new employee at the time of hire, regardless of plan enrollment status (if applicable) or of part-time or full-time status. The Department of Labor provides two sample notices,

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This Just In…

The U.S. Department of the Treasury and the IRS recently modified the "use-or-lose" rule for health flexible spending arrangements (FSAs). Employees whose employers modify their plans will be able to carry over up to $500 of funds left in their health FSAs for expenses in the next year.

Under current law, plan sponsors can allow employees a grace period of up to two and a half months following year-end to use remaining FSA balances to pay qualified FSA expenses. The new guidance permits employers to allow employees to carry over up to $500 OR allow employees a grace period after the end of the plan year; a health FSA cannot have both a carryover and a grace period.

Some plan sponsors may be

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one for employers who do not offer a health plan and another for employers who offer a health plan. www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html

- Summary of Benefits and Coverage (SBC). All health plans must provide enrollees with this standard form, which makes it easier to understand and compare benefits by summarizing what the plan covers and what it costs. This requirement went into effect on September 23, 2012; final regulations also require health plans to provide a SBC upon application, upon renewal and if coverage changes; noncompliance could lead to penalties. If your plan is fully insured, your insurer should be providing the form. To see a completed sample form, please go to www.dol.gov/ebsa/pdf/SBCSampleCompleted.pdf.

2 Review your health plan. ALL group health plans, even grandfathered plans:

- Cannot have any pre-existing condition exclusions.
- Cannot impose waiting periods longer than 90 days.
- Cannot apply lifetime dollar limits to key health benefits.
- Cannot cancel coverage solely because of an honest mistake that an individual or employer made on an application.
- Must extend dependent coverage to adult children until they turn 26 years old. In 2014, the exception for young adults who are eligible for coverage outside their parent's plan expires.
- Cannot drop or limit coverage because an individual chooses to participate in a clinical trial that treats cancer or other life-threatening diseases.

3 Determine if your plan is grandfathered. A health plan that existed on March 23, 2010 — and that has covered at least one person continuously from that day forward — may be considered a "grandfathered" plan and not subject to certain provisions of the ACA. Plans may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to members.

Unlike other health plans, job-based plans and grandfathered plans are not required to:

- Provide certain preventive care benefits with no out-of-pocket costs to participants.
- Offer new protections when you are appealing claims and coverage denials.
- Comply with rules that limit payments or require prior approval for out-of-network emergency room services.

Grandfathered plans must include disclosures to members in plan materials, stating that they consider themselves to be grandfathered and including information on how to contact the U.S. Department of Labor or the

eligible to take advantage of the option to adopt a carryover provision as early as plan year 2013. As with the grace period, employers must amend their plan to offer their employees a carryover.

December is a good time to remind employees to check their FSA balances and use remaining funds. Dental exams, eyeglasses, medical supplies, flu shots, prescription refills, and weight loss or smoking cessation programs qualify. For information on FSAs and other low-cost benefits, please contact us.

4 Ensure your payroll practices are in compliance. Beginning on January 1, 2013, the ACA increased the employee portion of Medicare Part A Hospital Insurance (HI) withholdings from 1.45% to 2.35% for employees with incomes of over $200,000 for single filers and $250,000 for married joint filers. Employers must withhold this additional tax, which applies only to wages in excess of these thresholds. The employer portion of the tax will remain unchanged at 1.45%.

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5 Update Flexible Spending Account (FSA) Limits. The ACA limits the amount an employee may elect to contribute to healthcare FSAs for any plan year after January 1, 2013 to $2,500, subject to cost-of-living adjustments. The limit only applies to elective employee contributions and does not extend to employer contributions. To learn more about FSA contributions, as well as what is excluded from the cap, refer to the IRS site, www.irs.gov/publications/p969/ar02.html#en_US_2012_publink1000204180.

In addition, the IRS recently modified the "use-or-lose" rule for health FSAs. Employers can now modify their Section 125 cafeteria plans to allow employees to use up to $500 of unused funds remaining in their health FSA at the end of the plan year in the following year, subject to certain conditions. Employers do not have to allow funds to carry over. For more information, please see the related article on Page 1.

6 Review wellness programs for compliance. Effective January 1, 2014, the maximum rewards available to employees in a health-contingent wellness program will increase. Health-contingent wellness programs generally require individuals to meet a specific standard related to their health to obtain a reward. Employees in a wellness program designed to achieve a specified level or goal can receive rewards up to 30 percent of the cost of health coverage, up from 20 percent. The maximum reward for programs designed to prevent or reduce tobacco use will increase to 50 percent. To view the final rules, visit the Federal Register online and search for "Incentives for Nondiscriminatory Wellness Programs."

7 Determine how to handle any medical loss ratio rebates. The ACA requires large group insurers to spend at least 85 percent of premium dollars on medical claims and activities to improve quality of healthcare, while individual and small group insurers must spend at least 80 percent. Insurers that do not meet this ratio must provide rebates to policyholders, typically an employer in a group health plan. Employers who receive premium rebates must determine whether they constitute plan assets. If treated as a plan asset, employers have discretion to determine a reasonable and fair allocation. For more information on federal tax treatment of rebates, refer to IRS's FAQs at www.irs.gov/uac/Medical-Loss-Ratio-%28MLR%29-FAQs.

Small Employers (up to 50 Employees)

1 Determine whether your organization qualifies for small business healthcare credits. Employers with fewer than 25 full-time equivalent employees making an average of about $50,000 a year or less qualify for employer healthcare tax credits if they pay at least 50 percent of full-time employees' premium costs. You don't need to offer coverage to part-time employees or to dependents. The tax credit is worth up to 50 percent of your contribution toward employees' premium costs (up to 35 percent for tax-exempt employers). You can still deduct from your taxes premium costs not covered by the tax credit.

This is good news for small tax-exempt employers as well. The credit is refundable, so even if your organization has no taxable income, it may be eligible to receive the credit as a refund, as long as it does not exceed your income tax withholding and Medicare tax liability.

Beginning in 2014, the tax credit is available only for plans purchased through SHOP, the Small Business Health Options Program. With the help of an agent or broker, you can compare price, coverage and quality of available in SHOP to plans available in the private insurance market.

2 Understand how rating changes could affect your premiums. In 2014, community rating will apply to non-grandfathered small group and individual policies. In community rating, health insurers cannot vary premiums within a geographic area based on age, gender, health status or other factors. In community rating, younger, healthier individuals and groups effectively subsidize coverage for those who are older and/or less healthy.

For more information on implementing the Affordable Care Act, or assistance with your organization's health benefits, please contact us.

What You Need to Know About Stop Loss Insurance

With uncertainty due to the Affordable Care Act on top of continuing premium increases, more employers are looking into self-insuring their employee health benefits. Although self-insuring involves more risk than buying a fully insured plan, stop loss insurance helps mitigate some of that risk.

In a self-insured health plan, employers directly assume the major cost of health insurance for their employees. Some self-insured employers contract with insurance carriers or third-party administrators for claims processing and other administrative services; other self-insured plans are self-administered.

Employers can finance any type of plan (conventional indemnity, PPO, EPO, HMO, POS and PHOs) on a self-insured basis, and employers may offer both self-insured and fully insured plans to their employees.

Although self-insuring can save money over a fully insured plan, because the employer agrees to pay all claims, it involves some financial risk. How much risk a self-insuring employer assumes varies depending on the level of benefits offered, the size of the group covered under the health plan and cost of medical care in a geographic area. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage.

Stop loss insurance, a type of reinsurance, limits the amount self-insured employers will have to pay for employee health claims. You can buy two types of stop loss reinsurance: 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 insured or dependent. If an individual's claims reach a specific dollar amount, the reinsurance kicks in and the reinsurer will pay that person's claims for the rest of the plan year.

Aggregate stop loss limits the employer's 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.

According to Insurance Administrator of America, Inc., a third-party administrator, individual-level stop loss coverage is more common than group-level coverage, since it protects the employer from the risk of unforeseen high-dollar medical claims on an individual.

Unlike in homeowners policies, where the insurer offers policies at specific deductible levels, the employer can select a stop loss policy's loss limit, or attachment point, based on its budget. Attachment amounts typically range between 5 and 15 percent of annual expected claims. As an example, take a group of 150 with average claim cost per employee of $12,500: 150 x $12,500 = total claims costs of $1,875,000. The specific stop-loss attachment point would be anywhere between $100,000 and $250,000. Certain states, such as New Jersey, have minimum stop-loss amounts.

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How Much Does It Cost?

Stop loss premiums vary widely due to varying deductible size. However, the 2013 Aegis Risk Medical Stop Loss Premium Survey found that the average premium (when normalized), ranges from $97.34 per employee per month (PEPM) for a $100,000 individual deductible to $12.19 PEPM for a $500,000 individual deductible.

Every insurer has its own underwriting criteria. However, policies are typically tied to a health insurance plan, which must meet strict ERISA guidelines. If a plan can't meet ERISA guidelines, the insurer typically will not offer a stop loss policy.

Self-insuring might save some employers money, but it does come with risks. In the Aegis survey, 55 percent of respondents report at least one claimant with medical costs in excess of $500,000 paid in the last two policy years. Fourteen percent report a claimant in excess of $1 million. Stop loss insurance can mitigate some of that risk; however, it's up to the individual employer to determine if potential savings outweigh the additional layer of administration required.

If you would like to discuss self-insuring with us, please call. 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. For more information, please contact us. ■

ERISA and Voluntary Plans

In addition to no costs, voluntary plans can offer employers the advantage of minimal paperwork—if ERISA does not apply.

What's So Bad About ERISA?

One of the primary purposes of ERISA, the federal Employee Retirement Income Security Act, is to protect promised benefits. To help accomplish that goal, the statute and regulations require sponsors of ERISA plans to provide summary plan descriptions (SPDs), adhere to ERISA claims procedures, and to file an annual Form 5500 financial status report. These, and other requirements, make administering an ERISA plan more complex than other plans.

Plans that do not fall under ERISA avoid ERISA's fiduciary provisions and do not require SPDs, ERISA claims procedures or Form 5500 filings. Some, but not all, voluntary plans, fall under ERISA's purview, even if the employer does not contribute a single dollar to them. By understanding ERISA rules, you can structure your plans to ensure compliance and keep your company out of hot water.

To determine whether your voluntary plan falls under ERISA, start with the Department of Labor's rules detailing "safe-harbor exemptions" from ERISA regulations. To fall within the safe harbor:

1. The employer can make no contributions.
2. Employee participation must be voluntary.
3. The employer's function must be limited to collecting premiums through payroll deductions and remitting them to the insurer.
4. The employer cannot receive consideration in connection with the program (other than reasonable compensation for administrative services performed).

If your plan meets all four requirements, it's free of ERISA regulation — maybe. However, additional considerations arise from the fairly generic wording of the original ERISA regulation. In a defining case in the field *(Butero v. Royal Maccabees Life Insurance Co.)*, the Eleventh Circuit Court of Appeals specified seven areas that define whether a plan is "established or maintained by the employer."

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1. Employer representations in internally distributed documents.
2. Employer oral representations regarding the plan.
3. Employer's establishment of a fund to pay benefits.
4. The manner in which benefits are paid.
5. Employer failure to correct known perceptions of a plan's existence.
6. Reasonable understanding of the employees.
7. Employer intent.

Given these factors, you can see how easy it is to unwittingly create an ERISA plan. In a 2006 case similar to *Butero*, a federal appellate court determined in *Moorman v. Unum Provident Corp*. that an ERISA plan had been created. Although the employer had no apparent intent to create an ERISA plan, the court concluded the employer had done enough to lead a reasonable employee to think that the voluntary disability program was employer-sponsored, emphasizing that:

- The plan was referenced in the employee handbook as a benefit for full-time employees.
- The plan was the sole plan of its type available and the employer had selected the waiting period.
- The employer participated in defining who was eligible for coverage.
- The employer maintained claim forms facilitating the payment of benefits.

We're not trying to scare you away from voluntary benefits. In fact, most experts expect voluntary benefits to play a more important role in benefit packages in the future. They help employers round out employee benefit offerings at little to no cost and give employees the option to tailor benefits to their own specific needs. Just don't be fooled into thinking voluntary plans are free from the regulations that govern employer-sponsored benefits.

To learn more about voluntary benefits and their advantages, please contact us.

HIPAA and Employers

The HITECH Act, enacted as part of the American Recovery and Reinvestment Act of 2009, strengthened the health privacy and security protections under HIPAA, the Health Insurance Portability and Accountability Act of 1996. The HIPAA privacy and security rules have focused on "covered entities," or healthcare providers, health plans and other entities that process health insurance claims. The changes expand many of the requirements to business associates of these entities that receive protected health information, such as contractors and subcontractors.

As of September 23, 2013, all "business associates" rules of the HITECH Act became effective. These rules control how business associates secure and disclose protected health information. They do not typically apply to employers, unless an employer self-insures its employees' health benefits.

How the HIPAA Privacy Rule Affects Employers

In general, the HIPAA privacy rule does not protect employment records, even if the information in those records is health-related. The privacy rule does not prevent a supervisor, human resources worker or others from asking an employee for a doctor's note or other health-related information if the employer needs the information to administer sick leave, workers' compensation, wellness programs or health insurance. However, if an employer asks a healthcare provider directly for information about an employee, the provider cannot disclose the information without the employee's authorization, or unless other laws require disclosure.

For more information on HIPAA and other compliance concerns, please contact us.