Employee Benefits Report

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Preventive Benefit Changes and Your Health Plan

The Patient Protection and Affordable Care Act (PPACA) requires most group health plans that are not "grandfathered" to cover certain evidence-based preventive services with no copayments or cost-sharing. This includes screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems.

Covering preventive care services with no cost-sharing sounds like a good idea. Allowing your employees to schedule annual exams or certain screenings without having to pay out-of-pocket could encourage more of them to do so.

In theory, the increase in preventive services will lower healthcare costs in the long term, by catching certain illnesses and conditions early, when treatment costs less. However, nothing is really free. Experts estimate the cost of covering these preventive care services with no cost-sharing—along with the additional treatments and follow-up care likely to result—will add another 1 to 3 percent to your group health premiums.

News stories, healthcare providers and others are telling the public that healthcare reform laws require group and individual insurance plans to cover preventive treatments with no deductible, co-payment or coinsurance. They may fail to explain that this requirement doesn't apply to grandfathered plans, those already in existence when the PPACA was enacted on March 23, 2010. If your organization's plan is grandfathered and does not waive cost-sharing for preventive treatments, you will need to educate your employees.

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This Just In…

The U.S. Department of Labor has increased enforcement against employers that delay or fail to forward employee contributions to benefit plans. ERISA requires employers to remit employees' contributions to pension and health plans "in a timely manner" and gives the Labor Department authority to conduct civil and criminal investigations against employers that fail to do so.

"In a timely manner" means as soon as possible, subject to defined maximums. For pension benefit plans, employers must remit employees' funds: "[no]…later than the 15th business day of the month following the month in which the participant contribution amounts are received by the employer…, or the 15th business day of the month following the

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The PPACA does not address instances when there are changes to the insurance carrier offering the plan (e.g., new corporate owner); it is not clear whether organizational changes would make grandfathered plans into new plans. If any of these changes have occurred to your organization's plan, please check with your carrier or contact us—the preventive care and other provisions of the PPACA might apply. We can also help with employee benefit education—please contact us for more information.

month in which such amounts would otherwise have been payable to the participant in cash (in the case of amounts withheld by an employer from a participant's wages)."

For welfare benefit plans, employers have "…90 days from the date on which the participant contribution amounts are received by the employer (in the case of amounts that a participant or beneficiary pays to an employer) or the date on which such amounts would otherwise have been payable to the participant in cash…" For compliance information, please contact us.

What's Covered

What preventive care services qualify for coverage with no cost-sharing under healthcare reform?

The preventive care provisions of the PPACA give insureds under qualifying group plans "free" access to preventive services such as:

- Blood pressure, diabetes and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use;
- Routine vaccinations against diseases such as measles, polio or meningitis;
- Flu and pneumonia shots;
- Counseling, screening and vaccines to ensure healthy pregnancies;
- Regular well-baby and well-child visits, from birth to age 21.

Availability of benefits might vary depending on age, gender and other risk factors.

401(k) Basics: Nondiscrimination Testing

Test anxiety isn't just for students. The words "nondiscrimination testing" can strike fear into even the bravest of benefit administrators. What is nondiscrimination testing, why is it necessary, and how can you avoid it?

Under a 401(k), employees can elect to have the employer contribute a portion of their wages to the plan. These plans enjoy several tax advantages: the employees' deferred wages (elective deferrals) are not subject to federal income tax withholding at the time of deferral, and they are not reflected as taxable income on the individual income tax return. Employers can also make contributions to employees' accounts. These contributions do not count as taxable income to the employee, and the employer may deduct them as business expenses.

In exchange for tax-favored status, a qualified benefit plan must meet these basic qualifications:

1. Provisions in the plan document must satisfy the requirements of IRS Code.
2. Plan sponsors must follow those plan provisions.
3. The IRS limits the amounts each participating employee can defer per year; plans may have lower limits but not higher. The maximum an employee can contribute to a 401(k) in 2011 will remain at $16,500, the same as in 2010. As in 2010, individuals over the age of 50 can make an additional catch-up contribution of up to $5,500.
4. The plan cannot favor highly compensated employees (HCEs) with respect to contributions, benefits, rights or features of the plan.
5. A "top-heavy" plan must meet additional minimum vesting and allocation requirements to ensure that lower-paid employees receive at least a minimum benefit. A plan is considered top-heavy when, as of the last day of the preceding plan year (the determination date), the aggregate value of the plan accounts of key employees exceeds 60% of the aggregate value of the plan accounts of all employees under the plan. Note that the definition considers aggregate values, not annual contributions!

Types of nondiscrimination testing

If your plan allows employees to make salary deferral contributions, the plan administrator must do an annual nondiscrimination test to ensure that it does not favor highly compensated individuals. There are two types of test: the Actual Deferral Percentage test (ADP) and the Actual Contribution Percentage test (ACP).

Under the ADP test, the plan administrator calculates the average percentage of compensation that has been deferred, pre-tax, to the 401(k) plan by each employee. The deferral percentages of the HCEs and non-highly compensated employees (NHCEs) are then averaged to determine the ADP of each group. To pass the test, the ADP of the HCE group may not exceed the ADP for the NHCE group by 1.25

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percent or 2 percentage points.

Similar to the ADP test, the ACP test applies to matching contributions and/or employee after-tax contributions. The plan satisfies the nondiscrimination requirements of the law if it passes the ADP and ACP tests.

Corrective actions

If the plan fails the ADP and/or ACP tests, the plan sponsor must take corrective action to protect the plan's qualified status. Laws and applicable regulations allow for a 12-month "correction period" after the close of the plan year in which the mistake occurs. "Corrective action" means making qualified non-elective contributions on behalf of the non-highly compensated employees. In simpler terms, the employer (rather than the employees) must make contributions to the accounts of NHCEs.

Smaller employers, or those whose workforce consists of a high proportion of NHCEs, might want to consider a safe harbor 401(k) plan. A safe harbor plan eliminates the need for annual nondiscrimination testing. In exchange, the plan must provide for employer contributions that are fully vested when made. These contributions may be employer matching contributions, limited to employees who defer, or employer contributions made on behalf of all eligible employees, regardless of whether they make elective deferrals. Safe harbor 401(k) plans that do not provide any additional contributions in a year are exempted from the top-heavy rules.

For more information on starting or administering employee retirement plans, please contact us. ■

What is a "key employee"?

During 2011, a key employee is generally one who is either of the following: a) an officer having annual pay of more than $160,000 or b) an employee who for 2011 is either a 5% owner of your business or a 1% owner of your business whose annual pay is more than $150,000. ■

Healthcare Reform Puts Limits on Limited Benefit Plans

Although limited benefit medical plans (also called "mini-medical" plans) have existed for nearly 30 years, healthcare reform is likely to bring about their demise by 2014, unless the law is changed or repealed. If your organization currently offers a limited benefit plan, here's what you need to know now…and what to look for in 2014.

The Patient Protection and Affordable Care Act (PPACA) requires new or existing group health plans to provide minimum annual limits of at least $750,000 for "essential health benefits" in 2011.

The minimum limit increases to $1.25 million in 2012 and $2 million in 2013. For plan years beginning on or after January 1, 2014, group plans will no longer be able to put annual limits on essential health benefits.

By definition, limited benefit plans usually provide annual

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limits of much less than the new $750,000 threshold—sometimes as little as $2,000 per year. This means that limited benefit plans do not comply with the PPACA.

Limited benefit plans often offer lower-cost coverage to part-time workers, seasonal workers and volunteers who otherwise might not be able to afford coverage at all. For this reason, regulations implementing the PPACA allow waivers of the minimum annual limits requirement if compliance would "result in a significant decrease in access to benefits or a significant increase in premiums." Health plans or insurers offering a limited benefit plan must apply to the U.S. Department of Health and Human Services for a waiver. If your organization currently offers an insured limited benefit plan, your insurer has likely applied for a waiver. Waivers are good for one year, but will not be available for plans beginning after January 1, 2014.

When it receives waiver approval, a group health plan or health insurer must notify current and eligible members that their plan does not comply with the provisions of the Affordable Care Act. The Office of Consumer Information and Insurance Oversight (OCIIO) developed a model notice, which reads (in part) as follows:

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by [name of group health plan or health insurance issuer], does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of: [dollar amount] on [all covered benefits] and/or [dollar amount(s)] on [which covered benefits – notice should describe all annual limits that apply].

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members.

Other low-cost health options

Some employers that offered limited benefit plans in the past are switching to fixed indemnity plans on renewal. These plans qualify as a supplemental plan under healthcare reform—therefore, the minimum annual benefit limits under the PPACA do not apply.

For example, a hospital indemnity policy is a supplemental policy that pays cash benefits when the insured is hospitalized for a non-occupational injury or illness.

Unlike medical plans, which pay benefits according to expenses incurred, a hospital indemnity plan pays a flat benefit whenever the insured is hospitalized for a non-occupational injury or illness. Hospital indemnity plans may pay benefits on a per-confinement basis or a per diem basis. The first type pays a flat dollar amount for each hospital confinement, typically ranging from $1,000 to $2,000. Many plan sponsors select limits that correspond with deductibles on their major medical plan. The second type pays a fixed benefit for each day of hospitalization, usually about $100 per day. Each plan type has annual maximums.

Indemnity plans differ from major medical coverage in several ways. First, benefits go directly to the insured rather than the healthcare provider. The insured can use benefits however he chooses. The claim process for these policies is relatively simple—the insured simply provides proof of hospitalization, and the insurer will pay benefits. Under a major medical policy, insured individuals must file a claim with their insurer, which evaluates the claim to make sure it is covered, then makes payment directly to the healthcare provider as reimbursement. (Many providers will file a claim on behalf of the insured.)

Indemnity policies—like all supplemental policies—don't replace major medical plans. They "wrap around" and complement basic health insurance.

If you are interested in providing lower-cost basic health insurance coverage to your employees, a high-deductible health plan linked to a

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health savings account (HSA) could offer a solution. High-deductible plans can provide coverage for catastrophic illness/accident, while workers can use funds in the linked HSA to pay for unreimbursed medical expenses.

Either the employer, the employee or both can make tax-exempt contributions to the HSA. However, the employee owns the HSA, so balances are fully portable. Balances can accumulate year to year indefinitely and tax-free.

You can further tailor your health benefit program by offering supplemental benefits to wrap around the basic health plan. These programs, such as hospital indemnity plans, pharmacy indemnity plans and others, can help bridge the gaps in high-deductible health plans. Many are available on a voluntary (employee-paid) basis. For more information on the many health benefit options available, please contact us. ■

Apply For Retiree Coverage Subsidy Before It's Too Late!

The Affordable Care Act provided $5 billion in financial assistance to employers to help them maintain coverage for early retirees age 55 and older who are not yet eligible for Medicare. The federal Early Retiree Reimbursement Program (ERRP) reimburses participating employment-based plans for a portion of the costs of providing health benefits for early retirees and their spouses, surviving spouses and dependents.

Employers must apply to the U.S. Department of Health & Human Services (HHS) for reimbursement. They can then use the funds to reduce their own healthcare costs, provide premium relief to their workers and families or a combination of both.

The program is available until January 1, 2014 or when funds run out. The Employee Benefit Research Institute (EBRI) has predicted that funds would run out in 2011. Given the current economic and political climate, many experts consider it unlikely that further appropriations will be made. ■

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