Employee Benefits Report

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Long-Term Care Insurance Helps Protect Retirement Funds

The National Retirement Risk Index published by the Center for Retirement Research at Boston College found 44 percent of U.S. households were "at risk" for financial insecurity during retirement. When it considered the effect of projected healthcare costs, that percentage rose to 61 percent…and again to 65 percent when it considered long-term care costs. Many of your baby boomer and Gen-X employees risk a retirement funding crisis. Long-term care insurance (LTCI) can help.

About 70 percent of people over age 65 require some type of long-term care services during their lifetime. Among those aged 85 or older, more than half (about 55 percent) require long-term care—the personal assistance that enables them to perform activities of daily living, such as eating, bathing, toileting and dressing, reports the U.S. Department of Health and Human Services.

The cost of long-term care keeps increasing — currently, the average cost of a year in a nursing home exceeds $70,000. However, only about 8.05 million Americans had private long-term care insurance (LTCI) in 2010.

continued on next page

This Just In…

The Affordable Care Act included several provisions that affect flexible spending accounts (FSAs) for medical expenses. Effective Jan. 1, 2011, distributions from health FSAs can reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This rule does not apply to reimbursements for insulin, even if purchased without a prescription.

The law will also limit the amounts individuals can contribute to their healthcare FSAs to $2,500 for tax years beginning after 2012. For the majority of employers, who run their benefit programs on a calendar-year basis, the change will take effect January 1, 2013. However, em-

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As baby boomers get older, they are more concerned with their long-term financial security—an LTCI plan can help you retain these valued experienced workers. Interested in learning more? You have three basic options:

- **True group plans.** These plans are usually guaranteed issue (no qualifying health questions) for all full-time employees. With guaranteed issue, no employee is discriminated against if he or she has a disabling or potentially disabling condition. As a group plan, a select set of identical benefits can be offered to all employees no matter which state they live in. Benefits other than the select set may be available but usually require medical underwriting. True group plans can often be converted to an individual plan with similar benefits when the employee leaves the group.
- **Modified guaranteed issue.** Modified guaranteed issue means there is no medical underwriting, but employees must answer one or more qualifying questions to eliminate disabled or very sick workers. For groups with low participation, rates for modified guaranteed issue plans are generally less than true group rates. Because modified guaranteed issue programs issue individual policies, the employee can keep the policy and rates when he or she leaves the group.
- **Individual plans with group discounts.** These are identical to plans that are offered to the public but the premiums are discounted from five to 15 percent for members of the group. The employee can choose any of hundreds of benefit options since everything is medically underwritten.

Key components of the LTCI policy include:

- the daily benefit, a maximum dollar amount
- the benefit period — usually two to six years or "lifetime"
- the elimination period — usually 20 or 100 days, during which employees must pay LTC costs out of pocket.

The higher the daily benefit and the longer the benefit period, the more you will pay in premiums. You can control your premium costs by selecting the longest elimination period you can afford.

Other features to look for:

- **an inflation rider (optional).** This increases the daily benefit amount as costs rise, protecting your employees from the effects of inflation.
- **a waiver of premium (optional).** Many policies include this option, which waives an insured's premium payments when he or she is receiving long-term care services, usually after an elimination period of one to several months.
- **pre-existing condition clauses.** If you buy a program that is not guaranteed issue, insurers might put pre-existing condition clauses in the policies of those individuals with pre-existing health conditions. Typically, these clauses eliminate coverage for up to six months AFTER policy inception for long-term care services caused by any condition for which the insured has received medical advice or treatment from a licensed provider within the six months BEFORE the start of the policy. From a practical standpoint, however, insurers use pre-existing condition clauses less frequently in LTCI policies than in other types of health insurance, because the insurer would prefer not to sell a policy to someone who might need long-term care within six months.
- **guaranteed renewability.** A guaranteed renewability provision allows an insured to renew coverage no matter what his/her current health condition. This feature is extremely important, because it ensures that the LTC coverage will be available when needed.

Most LTCI policies exclude coverage for care required due to conditions covered by workers' compensation; drug or alcohol addiction; war-related injuries or illnesses; treatment paid by government; and injuries that are self-inflicted. Employees who pay LTCI premiums receive a tax deduction, while company-paid premiums are deductible for the employer and tax-free for the employee. Individuals can pay LTCI premiums from a health savings account (HSA), up to certain limits.Premiums paid through a cafeteria plan or FSA, however, are taxable.

For more information on how you can provide your employees with this valuable benefit, please call us.

ployers running their benefit plans on a fiscal year basis must take care to ensure that the overlap between fiscal and calendar years does not cause employees to exceed the contribution limit in 2013. If that occurs, the employer's plan would lose its tax-favored status for the plan year. Since deferred salary amounts would then count toward taxable income, it would then result in underreporting of employee wages and under-withholding of FICA, FUTA and income taxes. The employer could also incur penalties.

For more information on FSAs, please see P. 4.

The Next Trend: Consumer-Driven Dental?

No doubt you've heard the buzz about consumer-driven health plans (CDHPs), which seek to control employers' healthcare costs by giving consumers "skin in the game." With the cost of providing dental benefits increasing, can consumer-driven dental plans be far behind?

More than medical plans, dental plan enrollment tends to go up and down with economic conditions, probably because dental plans are more likely than medical plans to be partially or fully employee-paid. There is good news, however—in 2010, the number of people enrolled in dental plans increased 4.5 percent, after dropping in both 2008 and 2009, reported the National Association of Dental Plans (NADP). (2011 figures were not available at publication time.)

Today, most employers that offer dental benefits offer standalone plans. The NADP's 2011 survey found that 98 percent of dental benefits are provided under a separate policy, and PPO plans represent 74 percent of all group dental plans. Although PPO plans aim to control expenses by providing higher reimbursements for care given by network providers, costs are still increasing faster than the general rate of inflation.

To control the costs of an insured dental plan, employers have a couple of options:

1. Switch to a lower-cost plan. Options include decreasing the annual maximum; limiting benefits, such as covering preventive and basic care only; decreasing annual maximum benefits; and switching to a plan that pays benefits according to a schedule, rather than a percentage of "reasonable and customary" charges. **Negatives:** Employees will likely see this as a takeaway; some might not understand the changes in their dental benefit plan until they get a higher-than-expected bill for dental services; and lower (or no) reimbursements for costly services such as root canals and periodontal (gum) treatments might dissuade employees who need these treatments from getting them.
2. Maintain your level of coverage but have employees shoulder a larger portion of costs. Options include increasing employees' share of premiums, increasing copayment percentages and switching to an entirely employee-paid (voluntary) plan. **Negatives:** Cost increases could prompt some employees to drop coverage, bringing your group below the insurer's participation requirements. Most employer-paid fully insured dental plans require a minimum of 75 percent of eligible employees to participate. Voluntary plans typically have much lower participation requirements, as low as 25 percent of eligible employees.

Direct Reimbursement Plans

A direct reimbursement (DR) plan gives employers greater control over their dental benefit program than an insured plan. With a direct reimbursement plan, the employer determines how much it will spend per employee per year. Employees can go to any dentist they choose and pay their bills. They then submit the expense for reimbursement, which they receive free of income taxes for dental expenses that meet the IRS definition of a qualified medical expense. (This generally excludes any treatments made for purely cosmetic reasons.)

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Unlike insured plans, whose rates depend on the claims experience of a group or pooled groups, the employer determines the cost of a DR plan. Employers set a maximum annual benefit for participating individuals at whatever level they choose, often $1,500 or $2,000. They can also tier reimbursement levels—for example, paying 100 percent of the first $100 in expenses and 80 percent of the next $1,750, until reimbursements reach the maximum annual benefit of $1,500. Employers can choose what types of treatments the plan will cover and whether to cover dependents.

DR plans give employees greater control over their dental treatment choices, since DR plans allow them to see any dentist and use their funds for any eligible treatment.

DR plans also give employers greater control over cash flow—rather than paying premiums to an insurer, the employer can invest plan funds and withdraw them as needed for reimbursements. And about 90 percent or more of your costs will go directly to employees' dental care, according to the American Dental Association.

Negatives: Direct reimbursement dental plans require more administration than an insured plan. Someone must educate employees, verify the validity of claims, make reimbursements and track account balances. A benefits expert can help you evaluate whether this is something you can do in-house or whether your firm would benefit from outsourcing this function.

For more information on selecting the best dental plan for your organization, please contact us.

FSAs or HSAs: Which One When?

Health savings accounts (HSAs) and flexible spending accounts (FSAs) let employees or dependents set aside money, before taxes, for qualified healthcare expenses. Employers can use them to incentivize employees to participate in health improvement programs, and they have tax advantages for both the employer and employee. But they have a few key differences—which account should you use and when?

HSAs

An HSA is a savings account available only to people who are enrolled in a qualified high-deductible health plan and who have no other health insurance. As the name implies, high-deductible health plans require higher deductibles and out-of-pocket expenses than other types of health insurance policies, but the premiums generally cost less per month.

The employer, employee or both can contribute to an HSA. Employer contributions do not count as taxable income to the employee; employees can take an above-the-line deduction for any contributions they make. If you offer employees a flexible spending account or cafeteria plan, they can make contributions to their HSA with pre-tax dollars through their FSA. A major advantage to using a health savings account is the money carries over from year to year, so employees don't have to "use it or lose it."

HSAs linked to high-deductible health plans can help control your group medical expenses by giving employees a greater stake in their health expenses. HSA account holders can use money in their HSA for any qualified medical expense, including medical expenses

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in retirement. Employees control the money in their accounts, not the employer. Balances accrue year to year and are fully portable, giving employees incentives to build their accounts rather than spend them down.

FSAs

Employers set up FSAs for employees; FSAs can cover either medical/dental expenses, dependent care expenses or both. A medical flexible spending account will cover any medical expense considered deductible by the IRxS. You can find a list on IRS Publication 502.

Employees elect how much of their pre-tax salary to deposit into their account, reducing their income tax liability. Employees pay no monthly or yearly maintenance fees on their account. However, they need to figure out how much they're going to need for healthcare or dependent care expenses over the year, because they lose whatever is left in the account at the end of the year. This "use it or lose it" feature could encourage employees to make unnecessary expenditures.

Pro and cons for employers

Employers have much to love about FSAs and HSAs. Because funds are pre-tax withdrawals, they decrease employee taxable income, resulting in lower costs for FICA, unemployment insurance, workers' compensation and other wage-based benefits. Payroll tax savings generally offset the cost of administration, and the employer can earn interest on account balances.

On the flip side, the FSA "at risk" provision requires that you reimburse an employee for incurred eligible expenses up to the full amount that he or she has elected to set aside during the plan year — regardless of how much he or she has actually contributed at that point. For example, let's say an employee elects to contribute $2,400 for the plan year and incurs $2,400 of eligible expenses at the end of the second month. At this point, the employee has only contributed $400 to his account, yet is entitled to $2,400 in reimbursement. If the employee remains with your organization, he will contribute the remaining $2,000 by year's end. However, he has no repayment obligation if he leaves his job before the end of the year. The employer may still break even, because an employee who leaves in the course of the year without spending all he has contributed to his account relinquishes the remaining funds, unless he continues participating through COBRA. Employees also forfeit to their employers any unspent amounts left in their accounts at the end of the year.

You can cap your company's liability by limiting the amount that employees set aside. Some employers use a two-tiered limit, limiting first-year participants to $1,000, for example, and then capping future participation at a higher amount. Remember, however, that the Affordable Care Act will limit contributions to medical FSAs to $2,500 for tax years beginning after 2012. ■

Healthcare Reform Update

In late March, the U.S. Supreme Court will hear arguments on several provisions of the Affordable Care Act (ACA) essentially determining its fate. Most attention will center on the minimum coverage provision, the so-called "individual mandate." This provision requires most people to have health coverage for themselves and their dependents starting in January 2014. Employer-sponsored plans will count, as will Medicare and Medicaid. Subsidies will be available for the needy, but those who do not buy coverage will face financial penalties. Although other courts have found the individual mandate constitutional, the 11th Circuit Court said, "Congress cannot...mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die."

The Court will also hear arguments on the ACA's expansion of Medicaid. The ACA will require Medicaid to cover nearly every needy American under age 65 starting in 2014. Although the federal government will pay 100 percent of states' increased costs between 2014 and 2019, and 90 percent starting in 2020, 26 states have brought suit against the U.S. Departments of Health and Human Services, Labor and Treasury and their secretaries over the Medicaid expansion and individual mandate. Finally, the court will listen to arguments on severability, or whether other portions of the ACA will stand if the individual mandate is deemed unconstitutional.

According to the U.S. Department of Justice, "Every insured family pays an average of $1,000 more a year in premiums to cover the care of those who have no insurance," since healthcare providers pass along the costs of treating the uninsured. However, ACA opponents argue that other reforms would do more toward improving health insurance accessibility and affordability than mandated coverage and government-run exchanges. These include extending tax benefits to individually purchased health insurance, making it fully portable and eliminating laws that require policies issued in a state to cover certain procedures, making coverage more expensive. We will keep you informed of important developments; please contact us if you have any questions in the meantime. ■

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