Employee Benefits Report

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Cadillac Tax Reviewed

As this issue went to press, the IRS had just ended a comment period on the so-called Cadillac tax. The tax, part of the Affordable Care Act, is scheduled to go into effect in 2018 unless the law changes. Some Republicans have promised to do just that.

Created by Section 9001 of the Affordable Care Act, the Cadillac tax will apply to "high-cost" health plans. Section 9001 defines a high-cost plan on the basis of total premiums (or costs, for a self-insured plan). Starting in 2018, plan sponsors will have to pay an excise tax on these plans.

The Good

The tax has two purposes. First, it will raise some $80 billion over the next 10 years, estimates the Congressional Budget Office. Funds will help pay for tax credits that will subsidize health insurance coverage for lower- and middle-income Americans.

Second, the tax will discourage high-cost health

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This Just In

The "Angelina effect" has prompted a new wave of cancer testing; patients and insurers are squaring off over payments.

Angelina Jolie underwent a double mastectomy in 2013 for preventive purposes. She had learned she carried mutations in the BRCA1and BRCA2 genes, which give women a higher risk of developing aggressive breast and ovarian cancers. Since her much-publicized decision, interest in genetic testing for cancer risk has soared.

Some 40 genetic mutations have been linked to the risk of developing cancer, but only about 5 percent of cancers in the U.S. have a genetic link. The Affordable Care Act requires insurers to pay for testing to identify BRCA1 and BRCA2 mutations in women with a family history of

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plans. High-cost health plans, which often feature low or no deductibles and copayments, can insulate individuals from the true cost of their healthcare and encourage wasteful spending. And although it's true that rich health plans have become popular benefits for executives, many rank-and-file employees, particularly union workers, also have high-cost health plans. Rather than eliminating or capping the deductibility of high-cost employer-provided health plans, the Cadillac tax does an end-run around them.

So what's a high-cost plan? The law sets the "high-cost" threshold at $10,200 for single-only coverage and $27,500 for families for 2018. The threshold will adjust for cost of living increases in following years. The annual limits increase for retirees not entitled to Medicare benefits and individuals engaged in high-risk professions. For self-only coverage, the limits increase by $1,650. For self and spouse coverage and family coverage, limits go up by $3,450. The tax applies to any premium (or contribution) amount over the threshold, calculated on a monthly basis.

The Bad

Several problems arise with this. First, we don't know what healthcare inflation will look like by 2018, but already it can cost pretty close to five figures per year to buy a good—but not extravagant—health plan in some high-cost geographic regions.

Second, Section 9001 of the Affordable Care Act does not apply only to health insurance premiums. It lumps in all employer-sponsored health coverage that is excludable from the employee's gross income under section 106, whether insured or not. This includes contributions to an employee's HSA (health savings account), health FSA (flexible spending account) or Archer MSA (medical savings account). For insured plans, it applies regardless of a plan's grandfather status. It does not include standalone dental or vision benefits, plans that cover only specified diseases (such as cancer insurance or "dread disease" insurance) or indemnity plans, such as hospital indemnity plans, that pay benefits according to a schedule.

The law specifically states that "coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage" and that "coverage includes [the] employee-paid portion."

The Ugly

When used as an adjective, "Cadillac" has come to mean something luxurious or extravagant. But by these standards, many pretty ordinary plans will meet the definition of a Cadillac plan in 2018. About one-third of employers expect to be hit with the tax, found a 2014 survey by Mercer LLC.

The law allows for cost of living increases to the threshold over time. However, those increases will be less than the rate of healthcare inflation, if current trends hold. The result? More employers will end up paying the tax. Did we mention that it's 40 percent on amounts over the threshold?

The law requires the "coverage provider" to pay the tax. This means…

- For coverage under a group health plan: the health insurance issuer.
- For HSAs and MSAs: If the employer makes contributions, the employer.
- Other applicable coverage: the person that administers the plan's benefits.

In addition, employers will be responsible for determining whether the Cadillac tax will apply. They must "calculate for each taxable period the amount of the excess benefit sub-

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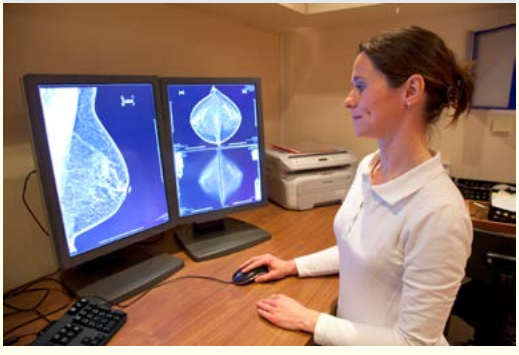
breast cancer. Some insurers refuse to pay for other genetic tests, saying their effectiveness in cancer prevention and detection is unproven.

Researchers say that the refusal to pay creates a Catch 22 situation. Patients who might benefit don't get tested because they can't afford it. That makes the pool of people who have been tested too small to allow researchers to reliably assess testing's effectiveness.

Should your health plan cover genetic testing? Please contact us to discuss this and other preventive care benefits.



ject to the tax" and notify the IRS and "each coverage provider." (In the case of a multi-employer plan, the plan sponsor will handle calculations and reporting.)

Employers can take steps to control employee healthcare spending and keep health plan costs under the threshold. Strategies include:

- **Adopting a high-deductible health plan (HDHP).** High-deductible plans generally cost less than other medical plans. They also make employees more aware of their health expenditures, encouraging them to spend more wisely.
- **Adopting wellness and disease management programs.** Disease management programs can help control the cost of treating chronic disease, while wellness programs might prevent them.

Employers with collective bargaining agreements may need time to negotiate major changes to their health benefits, so they should begin planning now. Please contact us for more information. ■

Why a Little Fee Can Make a Big Difference

No longer can employers select a retirement plan and put it on autopilot. Lately, employee groups have been suing their employers…and winning…over high 401(k) fees.

The Supreme Court heard arguments in a relevant case, *Tibble v. Edison International*, earlier this year.

Plaintiffs claim that administrators of Edison's retirement plan breached their fiduciary duties by offering plan participants retail-class mutual funds, when identical institution-class mutual funds were available at lower cost.

Observers think the Supreme Court will likely rule in favor of the plaintiffs, agreeing that plan fiduciaries have an ongoing responsibility to monitor their plan's performance. If that happens, it could open the door to more fiduciary breach lawsuits.

Properly managing or handling other people's retirement funds is a big responsibility. Actually, it's not just a big responsibility…it's a fiduciary responsibility. Not knowing exactly what that entails could land you in trouble.

What Does a Fiduciary Actually Do?

The Employee Retirement Income Security Act (ERISA), a federal law, governs employee benefit and retirement plans. Every written plan must name at least one fiduciary. This person or entity has control over the plan's operation. A fiduciary differs from a typical manager in that the fiduciary must act solely in the best interest of the plan's participants and their beneficiaries, with the exclusive purpose of providing benefits to them. In other words, fiduciaries must put participants' interests ahead of their own.

ERISA requires a retirement plan fiduciary to have expertise in investments and other areas, such as plan management. Lacking that expertise, the fiduciary should hire someone with that knowledge to handle investment and other functions. Service providers can include investment managers, plan administrators and even investment advisors/educators.

Your responsibilities don't end with hiring pro-

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viders. An employer should establish a formal review process to review providers' performance on a regular basis. One of a fiduciary's most important duties is to monitor management fees and expenses to ensure they are reasonable.

The Importance of Fees

The plaintiffs in the *Tibble* case brought their lawsuit because their plan manager charged retail rates for managing mutual fund investments. However, the same mutual funds were available in the wholesale market, with much lower fees.

Even a one percent difference in fees can make a huge difference in an investment's long-term performance. For example, let's look at an employee who contributes $25,000 and makes no additional contributions over the next 35 years. If returns average 7 percent over that period and fees and expenses reduce average returns by 0.5 percent annually, the employee will end up with $227,000 at the end of the 35 years. At the same rate of return but with fees and expenses of 1.5 percent, that $25,000 will grow to only $163,000—a 28 percent difference.

Limiting Liability

Offering a 401(k) or other retirement plan is a big responsibility. Failing to fulfill those responsibilities could lead to liability, particularly if your negligence causes a financial loss for participants.

Taking certain steps can limit your liability. First, since your responsibilities require you to act prudently, document your decision-making process.

Second, consider setting up your plan to give participants control of the investments in their accounts. For this to work, participants must have a diversified portfolio of funds to choose from and the information they need to make a wise decision.

Finally, you can hire a service provider or providers to handle some or most of the fiduciary functions, setting up the agreement so that the person or entity then assumes liability.

Although it takes work and care, a solid retirement plan can make a powerful recruiting tool. It can make the difference in ensuring employees have a financially secure retirement…as well as helping you hire and retain qualified employees. For more information on setting up or administering a retirement plan, please contact us. ■

The Benefits of Telemedicine

Recently, the state of Washington passed a law requiring employee health plans to reimburse providers for telemedicine services. That made Washington the 24th state to require "telemedicine parity."

Parity laws remove some of the barriers to more widespread adoption of telemedicine. Knowing they will be reimbursed for services makes healthcare providers more willing to offer telemedicine services and to invest in any technology. And the more providers that offer it, the more mainstream it will become. The laws also reduce the compliance requirements on hospitals when granting privileges to telemedicine "visiting physicians."

What Is Telemedicine?

As the name implies, telemedicine encompasses any medical activity involving distance. Today telemedicine uses electronic information and telecommunications, but the practice goes back to the days when sea captains would use ship-to-shore radio to obtain medical advice. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which collect and transmit patient data for monitoring and interpretation.

The Centers for Medicare & Medicaid Services (CMS) says, "…telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site." CMS views telemedicine as "…a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-

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to-face consultations or examinations between provider and patient)…"

What's so Great About Telemedicine?

Telemedicine can help an injured or sick person get proper treatment sooner, particularly in remote or rural areas where medical help or specialists might be far away. In addition, telemedicine technologies deployed in ambulances can help speed diagnosis and the initiation of important, potentially lifesaving interventions.

Telemedicine has the potential to shave $4.28 billion annually from America's healthcare bill, according to a study by the University of Texas Medical Branch. It offers these benefits:

- Providers get greater access to specialized information and diagnoses
- Reduction in hospital admissions from emergency departments
- Reduced wait times for outpatient consultation
- Increased productivity of healthcare staff
- Reduction in patient travel time and expenses

The University of Rochester Medical Center in Rochester, N.Y. has a telemedicine center. Its director, Kenneth McConnochie, MD, MPH, told a forum that telemedicine can handle 85 percent of pediatric primary care visits and 40 percent of emergency room visits. The average telemedicine visit there costs $75, or one-tenth of the cost of a typical ER visit.

Telemedicine also saves patients time and money. The state of Georgia launched a telemedicine partnership in 2005 to provide better health services to the state's large rural population, and to address a shortage of specialists. Paula Guy, CEO of the nonprofit Georgia Partnership for Telehealth, reported that a random sample of Georgia telehealth visits from 2011 saved the average patient travel time of 124 miles per encounter and a total of nearly $762,027 in fuel costs over 40,009 telehealth visits.

The combination of sophisticated videoconferencing, electronic medical records, and telemonitoring can revolutionize medical care for all patients. The challenge lies not in the technology, but the processes and policies that govern healthcare delivery and payment.

There's an App for That

Parity laws help bring telemedicine into the mainstream. Full integration of telemedicine into the medical system will depend on the healthcare industry's ability to address barriers, especially insurance reimbursement models; liability rules; and licensure rules that prevent healthcare providers from offering telemedicine consultations across state lines.

Some of the country's largest health insurers, including Wellpoint/Anthem, United Healthcare and Aetna, are convinced telemedicine is here to stay. They will pay for telemedicine services.

Already, a couple of smartphone apps allow users to connect with a doctor remotely. Doctor on Demand claims to be the largest provider of video physician visits in the country. Doctors connect with patients via smartphone or computer so they can discuss and/or look at a specific problem.

Although telemedicine might never replace a face-to-face doctor's visit, it has its place. It could save money and allow patients in remote areas to see the doctor more often. Does your health plan cover telemedicine? Please call us for a plan review and discussion of your organization's health benefit program. ■

What Are Your Fidicuary Responsibilities?

Every written employee retirement plan must name at least one fiduciary. Responsibilities include, but are not limited to:

Controlling plan operations: A fiduciary differs from a typical manager in that the fiduciary must act solely in the best interest of plan participants and their beneficiaries.

Communicating: Fiduciaries must ensure participants get documents they need to make informed investment decisions. These include:

- **Summary Plan Description.** This plain-language explanation outlines the plan's standards for eligibility, vesting periods, source of contributions (employee with employer match/employer only/employee only), how to claim benefits, and a participant's basic rights and responsibilities.
- **Individual Benefit Statement.** This gives participants information about their own account balances and vested benefits. Plans with participant-directed accounts must furnish statements quarterly. Individual account plans that do not allow participant direction must furnish statements annually. Traditional defined benefit pension plans must furnish statements every three years.
- **Summary Annual Report.** This outlines the financial information in the plan's annual report. Traditional defined benefit plans provide an annual plan funding notice instead.
- Information and education. Fiduciaries should ensure participants have information they need to manage investments wisely. This includes general information about investment types, their relative risks and rewards, and how fees and expenses affect returns.

Some employers offer formal investment education. If a provider gives general information, he/she is not a fiduciary. If you hire an advisor who offers specific investment advice to participants, they will also be fiduciaries who have a responsibility to plan participants.

- **Handling funds.** Employers must make any employee payroll contributions no later than the 15th business day of the month following the payday. For small plans (those with fewer than 100 participants), salary reduction contributions must be contributed no later than the seventh business day following withholding by the employer.
- **Government reporting.** Most plans must file a Form 5500 annual return/report with the federal government.

Sound overwhelming? A plan administrator can relieve you of some or all of these duties, including some of your fiduciary responsibilities. Please contact us for information. ■

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