

Health Benefit Plan Alternatives

‘Saving Your Business Money’

All businesses have concerns with the unpredictable and escalating costs of Health Insurance Premiums. Costs are going up and your employees are resistant to carry the additional burden. These continued increases are disturbing to the employer, who pays the majority of all the costs. Employees are finding benefits dwindling, while sharing the costs of the premiums are escalating. In the past the strategy of dealing with the increases was the IPA's, who controlled all the HMO's. Which now are decreasing in size and popularity, this leaves the business owners looking for other avenues and options to contain their costs.

On our web site: “Consumer Directed Health Care Plans,” links your employees to their personal and financial choices. Our information shows how this can be beneficial to the employee and the employer. Your individual employee has a much greater say in their healthcare decisions, while you the employer lowers your monthly premium costs. With these new options and choices business owners and employees are now making sense of it all. Below I have outlined a few options that I have found useful for many of my clients. Depending on your circumstances they may be beneficial to you and your business as well.

HIGH DEDUCTIBLE HEALTH PLANS – HDHP PLANS: The bases of “Consumer-Directed Health Care” plans are qualified HDHP plans. Essentially these are high-deductible health insurance plans with deductibles of at least \$1,050 for an individual and \$2,100 family coverage.

HEALTH SAVINGS ACCOUNT – HSA: Sometimes called a healthcare “IRA,” is a variation on earlier programs, such as the Medical Savings Account. The accounts work like Flexible Spending Accounts, which let employees set aside pretax dollars to cover out-of-pocket medical expenses, but with a key difference: HSAs do not have the “use it or lose it” feature of FSAs, under which employees forfeit any FSA money that has not drawn down for legitimate health or dependent care expenses during the calendar year. HSAs allow consumers to roll over unused HSA funds and build up tax-free savings that can be used later in life for healthcare costs, or long-term care premiums.

Most businesses can realize cuts in costs of up to 30% or more with an HSA plan. The reduction is from the HDHP Plan premiums, versus traditional lower deductible plans. Additionally businesses have reduced payroll-related taxes, because the employees and employers are contributing to HSA's with pre-tax dollars.

FIRST-DOLLAR COVERAGE PLANS: A “First-Dollar Coverage Plan” is a high-deductible plan that has a foundation with a special benefit feature allowing a limited number of services to be paid prior to the deductible. It offers an affordable alternative

without compromising coverage.

Today you're challenged with providing comprehensive benefits at lower costs with fewer resources. A "First-Dollar Coverage Plan" may be the right balance for your employees. It offers a health care plan that is lower in cost, but still comprehensive in benefits.

Employees take an active participation in their own health care with First-Dollar Coverage Plans. These types of plans give an employee a direct connection to their own personal healthcare, and flexibility in how they use their benefits.

Employees receive a set dollar amount each calendar year, typically for Dr. office visits, check ups, preventive care, and outpatient professional services (x-ray, lab). All covered services are paid out of the "fund" at 100% and not subject to the deductible. Providing a reduced out-of-pocket cost for services employees use most. Typically any unused funds in this account will rollover from year to year.

SECTION 125 – PREMIUM ONLY PLAN: This program enables employers to save money on payroll-related taxes by deducting employee premiums/contributions before taxes. This is a program that allows employees to reduce tax payments by setting pre-tax payroll dollars aside for certain un-reimbursed expenses before tax calculations are applied to their pay. The money is placed in a flexible spending account (FSA) administered by the provider. The flexible spending account under this provision is the employee's, and any unused funds roll over year to year.

Note: There are added tax advantages with these plans for most businesses; you will need to discuss these advantages with your tax consultant.

A more traditional approach to reduce cost, while maintaining or increasing coverage, is to segment either the benefits or those covered. This can be important where "employee retention" becomes an issue for the business.

CARVE-OUT OPTIONS: An arrangement where the employer eliminates coverage for a specific category of services (i.e.; dental, vision care, or prescription drugs) and contracts with a separate set of providers for those services according to a predetermined lower fee schedule.

Carve-Out options recognize situations where a desired coverage is not included or is cost prohibited with the basic "Health Benefit Package." By selecting an overall plan that meets the basic coverage and supplementing it with the add-ons that are desired, a Broker can "shop the market" for the best rates.

GROUP CLASSIFICATION PLANS: This option is to separate "Key Employees" or "Management" from standard plans and offer a 'benefit rich plan' without having to

offer it to all employees. This is an approach to retain key employees and management with a richer benefit package that they may be able to get from another employer. Most business owners believe that what is offered to one group has to be offered to everyone. This little know strategy will allow you to single out specific employees or upper management and provide them with the best coverage necessary to retain ‘key’ employees.

SUMMARY: As you know containing health benefit costs today are challenging. By looking at any of the options I have outlined above, you can see that you, the business owner, have choices. The bottom line is selecting the best benefits for your business. Using this process usually retains and motivates personnel. If you would like to know more about any one of these options and how they could be beneficial to your business – Please contact us for a “Free Assessment”.

‘Glossary of Terms’

I have included this list and hope it proves useful in better understanding the terms used in our industry.

CO-PAYMENT: A pre set amount or percentage that health plan members are required to pay for services along with their healthcare plan.

CO-INSURANCE: An amount or percentage that health plan members are required to pay for health care products or services in conjunction with their employers’ benefits plans.

DEDUCTIBLE: An amount that a health plan member must spend out-of-pocket before the benefits begin to pay for covered medical services.

OUT-OF-POCKET: Co-payments, deductibles or other fees that a member is required to pay along with his or her health benefits plan.

OUT-OF POCKET MAXIMUM: A cap on the amount a health plan member is required to pay along with his or her benefits plan for covered services.

POINT-OF-SERVICE (POS): A health benefits plan that lets members access both participating and nonparticipating providers. Accessing care through a primary care physician (PCP) gives members in-network coverage levels while self referred care is covered at a lower, out-of-network benefit level.

PREVENTIVE CARE: Programs or services that can help maintain good health, such as annual physical exams, or are meant to detect early signs of health problems or disease.

NETWORK: A specific group of health care providers that have contracted with specific Insurance Companies to provide services at a negotiated rate of reimbursement.

PREFERRED PROVIDER ORGANIZATION (PPO): A health benefits plan that lets members choose any provider without designating a primary care physician, but offers benefit incentives to members who choose “preferred” or in-network physicians or hospitals

CONSUMER-DIRECTED HEALTH PLANS: Also referred to as “consumer driven,” or “consumer choice,” this type of health plan gives members more choice and flexibility in making, health benefits decisions which gives more control over their health benefit dollars. These plans often include a health fund or account for covered medical expenses. Depending on the type of fund or account unused dollars may be rolled over on an annual basis to cover medical expenses in subsequent years for the duration of members enrolled in the plan.

FIRST DOLLAR COVERAGE PLAN: A First Dollar Coverage Plan is a high-deductible plan with a special benefit feature allowing a limited number of services to be paid prior to the deductible. Covered services are paid out of the “fund” at 100 percent and not subject to the deductible. Once the available fund is exhausted, the member must satisfy the deductible before receiving coverage under the plan. First Dollar funds may or may not roll-over from year to year depending on the selected plan.

FLEXIBLE SPENDING ACCOUNTS (FSAs): An FSA is an employer-sponsored arrangement under the tax-advantaged cafeteria plan rules, created to cover medical expenses as defined under Section 213(d) of the Internal Revenue Code. While the employer or employee can make contributions to the FSA, the employee typically makes them. Employees pay no federal, Social Security or (in most states) state taxes on FSA contributions. There is no IRS limit on annual FSA contributions, but most employers cap contributions at \$5,000. FSA funds are subject to a “use it or lose it” provision, and must be used in the year in which they are accrued. Unused funds revert to the employer. Funds are not portable, and do not accrue interest.

HEALTH SAVINGS ACCOUNTS (HSAs): An HSA is a tax-advantaged account created for the benefit of an individual covered under a high-deductible health plan. To be eligible, an individual must be covered by a “high-deductible” health plan (as defined by the HSA statute), and not be eligible for other general medical coverage. The employer, the employee or both can make contributions to the HSA. Contributions are deductible if made by the employee, and are excludable from income and wages (for employment tax purposes) if made by an employer. Earnings grow tax-free and distributions for qualified medical expenses (defined under Section 213(d) of the Internal Revenue Code) are tax-free. Unused HSA funds can be carried over from year-to-year, are portable, and can be used into retirement.

MEDICAL SAVINGS ACCOUNTS (MSAs or Archer MSAs): An MSA is a tax-advantaged account created for the benefit of an individual in a high-deductible health plan that is either employed by a small employer (fewer than 50 employees), or is self-employed. Contributions are deductible if made by an eligible individual, and are

excludable from income and wages (for employment tax purposes) if made by an employer. Contributions may be made either by the employee or the employer, but not both. Earnings grow tax-free and distributions for qualified medical expenses under Section 213(d) are tax-free. Rollover of unused funds is permitted from year to year, and funds are portable. Under the new Medicare legislation MSA balances may be rolled over into HSAs as of 1/1/04.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs): An HRA is an employer-funded health benefits account that may be offered to employees and retirees. An HRA may be offered in conjunction with another benefit plan (such as a high-deductible PPO or POS plan) for which an employee contribution is required, but no portion of the HRA can be derived from the employee contribution. Funds must be used for qualified medical expenses permitted under Section 213(d) of the Internal Revenue Code, although the employer can establish more restrictive limits for the use of HRA funds. Unused balances may be carried over from year to year while the employee remains eligible under the plan. Balances may be used after termination of employment, at the sole discretion of the employer. Most HRAs are self-funded obligations of the employer, although HRAs may be established within a fully insured plan as well. While there is no requirement to do so, employers can also choose to credit interest to HRAs.

DEFINED CONTRIBUTION PLAN: A broad term used to encompass a type of benefit plan where the employer gives the employees a set amount of cash to either purchase health insurance from predetermined vendors or from a company of their choosing. A defined contribution plan is often used with “consumer-directed health plans” or “health reimbursement arrangements.” There are distinct differences among the types of plans offered from employer to employer.

ROLL-OVER FEATURE: The ability to carry forward or “roll over” any remaining balance in the health fund, used for covered medical services in subsequent years.

SECTION 213D IRS: Section 213(d) of the Internal Revenue Code outlines what a qualified medical expense is for purposes of FSA, HRA, HSA and MSA spending. Expenditures from an FSA or HRA must be a qualified medical expense under this code section. HSA funds may be withdrawn for other purposes, but non-qualified withdrawals are subject to tax as income and may be subject to an additional tax penalty.