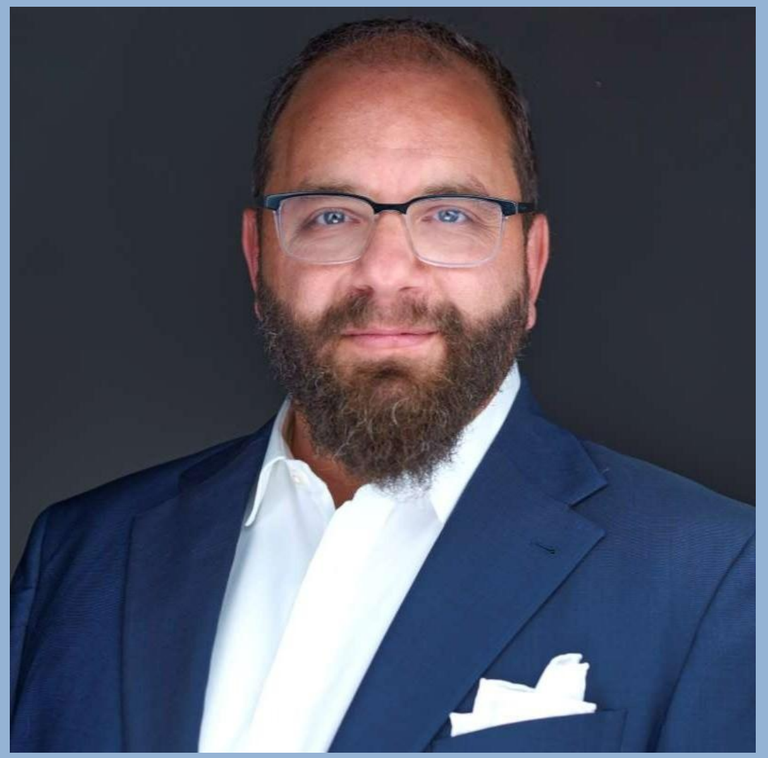
Entrepreneur & Family
BUSINESS COUNCIL

Benefits and Insurance



Marcus Newman

Alera Group

marcus.newman@aleragroup.com

Presenter Intro

Since joining the firm in 1997, Marcus has focused on serving small businesses. He is responsible for more than 200 privately held businesses, medical practices, and physicians. Marcus provides expert and objective guidance with respect to group insurance benefits of all kinds, 401(k) and other salary deferral plans, pension and profit-sharing plans, deferred compensation plans, executive benefits, and a wide variety of investments for closely held business owners.

Before joining the firm, Marcus spent several years working with teenagers as a social worker. Marcus is the Founder and President of Array Education, Inc., an organization committed to the prevention of teenage substance abuse and addiction through a wide variety of programs that help young people make responsible, informed decisions about drugs and alcohol.

Small Business Benefits

What are some reasons small business owners offer insurance benefits?

PSM
TECHNOLOGY | TALENT

Small Business Benefits

Ask any small business owner why they have employee insurance benefits.

They will likely tell you that they hope to **attract and retain quality employees**, and **compete for talent** with other organizations.

Most common insurance benefits (in order of popularity):

1. **Medical**
2. **Dental**
3. **Vision**
4. **Life**
5. **Short-term disability**
6. **Long-term disability**
7. **Volunteer benefits (like AFLAC)**

Small Business Benefits

Our main focus today:

Medical Insurance

- Most popular benefit
- Most difficult to administer

Note: We will spend less time exploring dental, vision, life, and disability insurance programs and their requirements. However, many of the principles and requirements that apply to medical insurance also apply completely, or in part, to the “ancillary” benefits.

Employee Eligibility (W-2)

Administrators must understand:

- Who is eligible?
- What does “full time” actually mean?

✅ **Employees working 30 hours/week:**

If an employee works or is expected to work 30 hours per week, that employee is eligible to participate in the Medical Insurance plan after a waiting period (not more than 90 days). (Affordable Care Act, ACA)

❌ **Employees working fewer than 30 hours/week:**

Employees that work fewer than 30 hours per week are typically classified as PART-TIME and are not eligible to participate in the Medical Insurance plan.

This generally carries through to the ancillary coverages (dental, vision, disability, and life), although larger organizations can petition the insurance companies that provide these lines for expanded eligibility.

Independent Contractor Eligibility (1099)

✅ **Independent Contractors**

All insurance companies in our market allow employers to include independent contractors. These are “employees” that are not paid wages as a W-2, instead are paid by 1099.

In the past, independent contractors were not allowed to participate in group health insurance plans, but this has recently changed.

There may be some restrictions imposed by the insurance companies (e.g., the majority of income must come from the offering company), and these restrictions should be reviewed with a competent broker before making any offers to employees.

Once you know who is eligible for coverage,
you are ready to move on to the next step.

The Census: Creating the perfect census document

What is a census document?

- It is a method used by insurance companies to collect all the necessary information to provide pricing for insurance plans.

- **Note:** The information needed is not always obvious or logical. It is important to know what is needed and why it is needed, so you can avoid delays, or worse, inaccurate numbers that could mislead employees about cost.

All sections, including ATNE, must be completed by employer	**Average Total Number of Employees (ATNE) on payroll the previous year?** An employee is any person for which your company issues a W-2, regardless of full-time, part-time, Union/NonUnion, seasonal or temporary status. **If company is part of a controlled group, all entities should be considered in the ATNE headcount.** Total sum of employees/total number of months = Average Total Number of Employees (ATNE)	0.0	Group Name:	0
			Effective Date:	1/0/1900

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Enter Number of Employees on payroll per month in each cell:												

Total (Sum of) Employees	0
Total Sum of Employees divided by 12 Months	0.0

Census Data for 2-100 Eligible

Include all full-time employees, including waivers (please indicate waiver reason in "notes" column)

****All spouses and/or children being covered on the employee's plan must be included on census**

**Employee or Spouse/Child Last Name	Employee or Spouse/Child First Name	Date of Birth	Relationship: EMP (employee) SP (spouse) CH (Child)	Gender (M/F)	Status A = Active C = Cobra D = Disability L = Leave of Absence	# of Children covered	Medical Coverage (HMO/PPO/HSA) or Plan Name	Medical Election: EE EE+SP EE+CH FAM WAIVER	Dental Coverage: (DHMO/PPO)	Dental Election: EE EE+SP EE+CH FAM WAIVER	Home Zip Code	Occupation	Salary	Notes

The Census: Often Missed Information

Keep in mind:

Birth Dates

- Almost all pricing of insurance plans depends on the age of the insured population. That is the reason that birthdates of the employees and of any potentially covered dependents are of utmost importance.

Home Zip Codes

- Home zip codes are important for the insurance companies because some of the pricing may be dependent on geography. Additionally, zip codes often indicate network suitability for geographically diverse populations.

The Census: Often Missed Information

Salary

- Many administrators object to giving financial information like annual salaries.
- **However** – this information is necessary to quote out disability insurance and sometimes life insurance.
    - **Disability insurance** covers a percentage of earnings, and it is not possible to quote without the underlying numbers.
    - **Life insurance** coverage is often a multiple of salary (e.g., 2x or 5x).
- It is impossible to quote without underlying salaries. Rest assured, no one in the process is interested in what the numbers say; they just want to get you accurate quotes

How The Markets Work

At the top of your handout, there is a data point labeled **ATNE** (average total number of employees). This is an important element of buying insurance.

The Affordable Care Act (ACA)

The ACA established two distinct medical insurance markets for employee benefits:

1. **Regulated Market**
   The first is for companies that insure 2-50 employees (a few states insure 2- 100), and it is referred to by the insurance industry as the Regulated Market.

2. **Pay to Play / Experience Rated Market**
   The second market is for companies that employ more than 50 people, and it is called the Pay to Play or Experience Rated Market.

How The Markets Work

This seems simple and straightforward, but once the insurance companies and their legal teams got a hold of it, complications abound.

The bottom line:
Since the ACA didn't specify which employees it was referring to, the insurance companies decided that it applies to ANY employee regardless of the number of hours worked, eligibility, or participation. So, a company with 51 part-time employees must buy insurance from the Experience Rated market (50+) even though it has 0 eligible employees.

Determining your prior year's ATNE determines which insurance market you are eligible to participate in.

How The Markets Work: Regulated Market

There are three major elements that define the regulated marketplace:

1. **Community Standard Pricing**
    - There is no medical underwriting.
    - All pricing is based on the ages of the employees and the county of the business.
    - The pre-existing medical conditions of the employees DO NOT come into play in any way.
        - This has been the case since 2012, but surprisingly, many business owners, administrators, and employees still experience a great deal of anxiety regarding pre-existing conditions.
        - There is no way that medical conditions can affect pricing in the regulated marketplace.

How The Markets Work: Regulated Market

2. Metallic Plan Design System

- The ACA established levels of quality for coverage based significantly on Maximum out of Pocket risk: Platinum, Gold, Silver, and Bronze
- You will know if the plan is purchased in the regulated marketplace if its name includes one of these metallic monikers.

How The Markets Work: Regulated Market

3. Major change in Participation Requirements

- As you will see in the 50+ market, there is a financial impact to low participation, BUT in the 2-50 world you could have 25 employees eligible and only 2 enrolling in coverage (while highly unlikely), and the plan could still be offered at a standard rate.
- If a small business establishes their plan for a January 1 renewal, there are NO participation requirements at all – other renewal dates may have participation concerns.

These three elements are significant advantages offered to small businesses, but some would argue that they come with a cost. Some believe that larger organizations benefit from lower rates.

That is just not an entirely true statement. Let's look at why.

How The Markets Work: Pay to Play / Experience Rated Market

A Key Difference in Pay to Play:

- Medical underwriting is back in play.
- When buying insurance for a group with more than 50 ATNE, a quote will be offered by insurance companies. THEN, there will be some form of medical underwriting.
- This means the existing medical conditions are now in play for pricing, and the ultimate cost of the insurance will rise, not fall, with the relative health of the group.
- Underwriting can be a process of the employees completing applications, or it can be automated.

IMPORTANT NOTE: Pre-existing medical conditions must be covered by conventional insurance programs, but they can, and will, and do affect pricing. This is why not all larger organizations pay less for health insurance; in fact, some pay a lot more.

How The Markets Work: Pay to Play / Experience Rated Market

Available Choices:

- When choosing a plan design, it is important to know that there are limited choices for Small Groups (2-50) because of the Affordable Care Act.
- Insurance companies offer more plan options to groups in the 50+ market, in other words, more variations. There is a level of customization available in this market.

How The Markets Work: Pay to Play / Experience Rated Market

Participation Rules and Effects on Pricing:

- There are expectations that the insurance companies enforce which can dramatically affect pricing.

- The insurance company expects that **75% of the population will enroll in the coverage** (excluding qualified waivers). If not, the pricing will be raised according to the level of participation achieved.

- **A qualified waiver** is an employee covered elsewhere by a “qualified” plan (e.g., spouse’s group plan, an individual plan bought through the Obama-care market, Medicare, or a military plan).

- **Example:** If a company has 100 eligible full-time employees - 20 of which are qualified waivers, leaving 80 eligible employees - the expectation would be 60 enrollees.

How The Markets Work: Age Rated and Composite Rated

Once you know what market you are shopping in…

- After submitting your census for quotes, you will have to account for one more hurdle in each market before you know what your insurance will cost for the company and for each of the employees.

- In the **Regulated Market** (2-50), we must choose between **Age Rated** and **Composite Rated.**

How The Markets Work: Age Rated and Composite Rated

Age Rated

- Age Rated means that each employee has its own individual rate based on their age.
- This means all employees on the same plan with the same age will have the same rate.
- But as the name implies, as the age of the employee rises, so does their monthly premium.
- The ACA sets the ratio from 20 to 65 at 3:1.

- Here is how it plays out:
    - An employee is 21, and their cost is $350/month.
    - Another employee is 53, and their cost is $700/month.
    - Another employee is 64, and their cost is $1050/month.

How The Markets Work: Age Rated and Composite Rated

Age Rated

- **Is this age discrimination?**
  - ❌ The Federal Government says, “**NO**.”

- The nature of insurance is that the cost is based on the risk.
- As we age, the number of medical claims we experience goes up.
- The insurance industry basically argues, “The more claims that are expected, the higher the premiums will be.”
- Some employers are uncomfortable with the message this arrangement sends to employees.
- Administrators have a different complaint. Every employee with their own rate makes the plan harder to administer. More to deal with, more room for an error.

How The Markets Work: Age Rated and Composite Rated

Composite Rated

- Composite Rating is when the insurance company averages the premiums of the people covered and offers four levels of cost:
    - Employee
    - Employee + Spouse
    - Employee + Child(ren)
    - Family
- The result is that the young people pay more than they would in an age rated policy, and the older people pay less.

How The Markets Work: Age Rated and Composite Rated

Composite Rated

- **Is this reverse age discrimination?**
  - ❌ The Federal Government says, “**NO**.”

- Most people would never even know, see, or understand the difference.
- Trouble ensues when a company has to go back and forth from one to the other method.

- **Note:** Some insurance companies ONLY offer age rated to the Regulated 2-50 Market, and some offer both methods and the employer must choose.

Medical Underwriting

When a company must go through medical underwriting there is a problematic hurdle that often arises, and a good administrator will be ready for it.

The Challenge:

Consider a company that is buying in the 50+ market.

- They submit the census of all employees and get a quote.
- Then medical underwriting must be applied, and the cost can, and often does, change.
- Next, employees must choose whether to be covered or not.
- Low participation can change the price again, which could cause some employees to decide to drop the coverage.
- At this point a change in the census greater than 10% will cause the pricing to change once again, creating a problem for the administrator, disgruntled employees, and angry leadership.

Medical Underwriting

Possible Solutions:

- ✅ **Using automated underwriting**
  - This typically consists of building **a more detailed census document** (including SS#, home address, etc.) versus the traditional method of having every employee complete a health questionnaire.
  - This makes the process a whole lot easier.

- ✅ **Educating employees about cost changes**
  - Coupling an automated approach with an effort to educate the employees regarding potential cost change is very important to allow a potentially positive result.

Timeframes and Expectations

Once the census is complete and sent to a broker, an administrator should expect the following timeframes from the insurance companies:

2-50

- **Medical Quotes:** one week if not sooner
- **Ancillary Coverage Quotes** (dental, vision, etc.): two weeks

50+

- **Medical Quotes:** two to three weeks (if automated underwriting is used the amount of time to achieve FINAL rates will be shorter, if applications are used the process will take more time)
- **Ancillary Quotes**: two to three weeks

Timeframes and Expectations

The best practice for an administrator is to be proactive, have a “living census” document, and get started early.

For 50+ employers this process will require more sensitive information to maximize timeframes and expectations, which some administrators find uncomfortable such as:

- Full copy of the most recent billing statement
- Plan Summaries
- Cost Sharing
- Full last renewal
- Last 5-year carrier history

Paying for Benefits

There are three basic methods of payment:

Contributory

- Employer and the employee share in the premium cost
- Most common payment method
- Most small businesses create their cost-sharing arrangements using a percentage-based approach. They decide what percentage of the cost they are willing to pay and ask the employees to pay the difference.

Employer Paid

- Company pays 100% of the monthly premiums on behalf of the employees
- Rare in medical insurance
- We do, however, see it applied to dental insurance, vision insurance, Life, STD, and LTD regularly.

Voluntary

- In these cases, the employer does NOT contribute to the premiums at all. 100% of the cost is paid by the employees if they choose to be covered by these insurance policies.

Paying for Benefits

- In all of the three basic methods, employee premiums are taken through **PAYROLL DEDUCTION** and usually **pre-tax**.

Pre-Tax Deductions

- To take pre-tax deductions from employee paychecks, the employer must have a Section 125 plan in place. (More on this later.)

- **Not all employee payments should be taken pre-tax though. Rule of thumb:**
  - EXCLUDING MEDICAL INSURANCE, if the employee is paying the full amount (e.g., voluntary disability insurance or life insurance) and they want the benefits, should they become eligible to receive them, to be tax-free – then, and only then, the employee premium payments should be POST tax – otherwise pre-tax is the default.

Paying for Benefits: Cost Sharing

- Once you have picked the insurance plans that you will be offering to employees, the next step is to **determine what the company will pay for and what the employees will be asked to pay**.

- There are many layers to this decision-making. Best practice is to take some time and think it through.

- There are **three major methods of determining cost sharing**, but there is also room to be creative.

- The rules on cost-sharing are relatively simple: **Whatever method you choose must apply equally to all employees.** You cannot, in a compliant manner, have special arrangements for certain people.

- Of course, we know that some employees will elect single coverage and others will add dependents. You don’t have to pay for dependents the same way you pay for employees, but you cannot pay for one employee’s dependents and not others. This will become clearer as we examine the examples.

Paying for Benefits: Cost Sharing

There are three major methods of cost sharing:

Method 1: Percentage Based

- Most common
- Easiest to understand
- Whatever the premium is, the employee pays a predetermined percentage, and the employer pays the rest.
- **Composite Rated:** very simple to administer
- **Age Rated:** a little harder to administer

Paying for Benefits: Cost Sharing

Method 1: Percentage Based

Example 1: Composite Rated

	TOTAL PREMIUM	EMPLOYEE	PERCENT	EMPLOYER	PERCENT
EE	$300	$75	25%	$225	75%
EE + SP	$600	$300	50%	$300	50%
EE + CH	$550	$275	50%	$275	50%
FAM	$1000	$500	50%	$500	50%

- Because each employee is on the same schedule, they are all treated fairly even though one may have dependents, and another may not.
- While this arrangement is the most common, it is not the most equitable.
- An employee may argue that they do more work and are more valuable than the next employee, but because they don't have a family, they are being paid $275 per month less. They aren't wrong, but that's just the way this method works.

Paying for Benefits: Cost Sharing

Method 1: Percentage Based

Example 2: Age Rated

EMPLOYEE	PREMIUM	EMPLOYEE	PERCENT	EMPLOYER	PERCENT
Mike	$425	$106.25	25%	$318.75	75%
Sarah	$532	$133	25%	$399	75%
Steven	$615	$307.5	50%	$307.5	50%
William	$385	$96.25	25%	$288.75	75%
Jane	$362	$181	50%	$181	50%
Billy	$245	$122.5	50%	$122.5	50%

- Often, clients who have a percentage-based cost-sharing arrangement express that they don't know why it is what it is because it has always been that way.
- We recommend that the cost-sharing strategy be a bit more thoughtful and be considered every year at renewal.
- The goal is to make sure that the methodology is in line with the overall objectives of the benefit program and that it is fair and consistent with your company's culture and mission.

Paying for Benefits: Cost Sharing

Method 2: Defined Contribution

- In response to possible “fairness” objections, some employers have changed their cost-sharing to a defined contribution model.
- With this methodology the **employer gives a specific (defined) amount of money** to each employee regardless of their coverage election.
- This methodology allows the employer to budget differently and is less affected by annual renewal increases.

Example 1: $250 Defined Contribution for each employee

EMPLOYEE	TOTAL PREMIUM	EMPLOYEE
EE	$300	$50
SP	$600	$350
CH	$550	$300
FAM	$1,000	$750

Paying for Benefits: Cost Sharing

Method 2: Defined Contribution

Example 2: Defined Contribution – Age Rated

- The defined contribution method can get a little cumbersome in an Age Rated environment.
- Administratively, at the beginning of each year, attention will be given to calculating the payroll deductions, which will be static for the remainder of the year barring a qualifying event.

EMPLOYEE	TOTAL PREMIUM	EMPLOYEE	PERCENT	EMPLOYER
Mike	$425	$175	25%	$250
Sarah	$532	$282	53%	$250
Steven	$615	$615	100%	$0
William	$385	$135	35%	$250
Jane	$362	$362	100%	$0
Billy	$245	$245	100%	$0

COMPLIANCE NOTE: technically, this method, while fair, CANNOT be used by groups with more than 20 employees that are **AGE RATED due to anti- discrimination rules deep in the COBRA laws.**

Paying for Benefits: Cost Sharing

Method 3: Defined Benefit

- To find a fairer approach and to avoid age discrimination concerns, some employers use a defined benefit approach to cost-sharing.
- This is when the employer establishes a "**cost to participate**."
- This will look very much like the percentage approach for a composite rated group if illustrated, but for an age rated group, it levels the playing field across age groups.

- It is true that the employer will pay a different rate for each employee based on age, but that doesn't matter as much to the employer.
- It will allow each employee to pay a standardized amount in order to be covered, which simplifies things from their perspective.

Paying for Benefits: Cost Sharing

Method 3: Defined Benefit

Example 1: Age Rated

	Age	Employee	Total Premium	Employer
Employee 1	21	$150	$325	$175
Employee 2	53	$150	$650	$500
Employee 3	64	$150	$975	$825

- At first glance this method may look a bit skewed from the employer's point of view.
- We have found that an administrator really needs to know the average cost per employee, which in the case of example 3a, is $500 per employee.
- **Is this reverse age discrimination?**
  - ❌ The Federal Government says, "**NO.**"
  - Because the YOUNGER person is paying a HIGHER percentage of the total premium, it is allowed.

Paying for Benefits: Cost Sharing

Summary

- Cost-sharing is a multilevel enterprise for a company.
- It is an opportunity to really establish employee insurance as a benefit to employment.
- It is an opportunity for some level of cost control.
- Most of all, it is one of the biggest challenges that the benefits administrator will face on an annual basis. Nowhere else is the tug-of-war between employees and the financial leadership of the company more in plain sight.

Communication: Employee Cost

- Once you have determined your methodology and set the numbers, you will need **a communication piece for the employees**.
- You do not have to let the employees in on how you arrived at the numbers, but you can. There are benefits to doing so as well as negatives.
- **Ultimately, you should let employees know in an understandable manner what their employee insurance benefits will cost**.
- Don’t forget to solve for Per Paycheck (PPCHK) instead of monthly to increase employee understanding.

NOTE: For groups that have 50+ employees, there are added ACA requirements regarding “affordability.” Basically, you cannot ask your employees to pay more than 9.8% (subject to IRS updates) of their annual compensation to participate as a SINGLE in your lowest cost plan. The actual percentage used to calculate the affordability is subject to change by the IRS. Most employers are already compliant on this front, but it is an element that must be considered and complied with, or there will be a risk of financial consequences in the form of governmental fines.

Communication: Payroll Deductions

- Once the employees choose the benefits and enroll, it is the administrator’s responsibility to communicate the deductions to the payroll provider.

- **Payroll In-House:** You can use your own methods.
- **Payroll Outsources:** You will have to work within the system of the payroll provider.

Communication: Payroll Deductions and Tax Implications

Section 125 Premium Only Plan (POP)

- IRS code Section 125 allows an employer to set up a Premium Only Plan (POP), where **an employee's insurance premium contributions can be deducted from his or her payroll on a pre-tax basis**.
- This can **save employees up to 40%** on income taxes and payroll taxes. The employer also saves on these taxes.
- Many businesses we talk to don't have or don't know if they have a POP, yet they still take employee contributions pre-tax. This could be a mistake upon audit.
- POPs are very inexpensive and simple to set up.

Post-Tax Deductions

- Some employee contributions should be taken post-tax.
- If you offer a VOLUNTARY disability or life insurance program that employees can elect and pay for, these contributions should be taken AFTER tax.
- By doing so any benefits collected will be free of income tax; making a mistake on this issue can cost an employee or their family thousands of dollars.

Presenter Contact Info

Marcus Newman

Alera Group

marcus.newman@aleragroup.com