Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Health Insurance

New Regulations Proposed for Short-Term Plans

AS PROMISED, the Trump administration has issued proposed rules that would allow individuals to skirt Affordable Care Act regulations and buy short-term, low-coverage health plans.

Under the proposal, individuals would be able to purchase short-term plans that last up to 12 months, compared to the three-month maximum under the ACA.

The proposal would also exempt these short-term plans from ACA rules, like covering 10 essential health benefits and barring insurers from rejecting individuals with pre-existing conditions.

The administration said short-term plans are meant for people who:

- Cannot afford ACA coverage purchased on exchanges,
- Are between jobs and need temporary coverage that's cheaper than COBRA, or
- Have doctors who are not included in plans offered on public exchanges.

The Department of Health and Human Services predicted that 100,000 to 200,000 Americans would switch from individual market plans to short-term policies thanks to the new rules.

Short-term health insurance covered 148,118 people in 2015, according to the National Association of Insurance Commissioners.

Under the proposed rules, insurance companies would be required to prominently display in the contract and application materials that the policy is exempt from ACA protections.

Who would buy these plans?

Short-term health insurance is meant to provide temporary coverage for people transitioning between traditional health policies, perhaps because they are changing jobs.

Short-term plans are usually accepted at more doctors' offices and hospitals compared with traditional insurance plans, which are often limited to narrow networks. And they are usually cheaper.

Healthier and young individuals who don't think they need full coverage would likely choose these types of plans, which would pull them from the ACA markets. If that happened, marketplace plans could be left with an older and less healthy pool of covered individuals, which would likely force them to raise rates.

Short-term insurance plans cost an average of 25% less than bronze plans on the individual marketplace, or $65 less per month, according to data from AgileHealthInsurance.

The pricing is low because these plans may not offer all of the 10 essential health benefits as normal ACA-regulated plans do. And they are not required to cover pre-existing conditions.

Currently, there are only a few players in the short-term health plan market, as the ACA allows individuals to carry short-term insurance plans for a maximum of three months. But, since the Trump administration announced in October 2017 that it would propose new regulations for short-term plans, more carriers have been exploring entering the market.

Two major industry lobby groups – America's Health Insurance plans and the Blue Cross Blue Shield Association – have warned that the short-term plans could harm state insurance markets. ❖

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Group Disability Coverage: Is It Right for Your Business?

THE BEST way to guarantee an income is by getting disability coverage. Once someone cannot work due to disability, there are not many options to maintain their current standard of living or to pay for necessary medical expenses due to that disability.

Many people put off purchasing disability coverage because they feel it will not happen to them, at least not right away.

But if it does suddenly happen, cutting off an income stream can be devastating. Some people think that government disability can provide enough income, if one is covered, but in reality it covers a very minimal amount.

Why get group disability?

The last thing an employer wants is an employee hanging on to their job by a thread just to keep their income stream going.

Firing an employee is not always an easy answer and can come with legal consequences.

Group disability can help ease a very painful situation, and is also good management because it reduces any potential disruption and risks that can affect the success of a business.

Lastly, as a great group benefit to offer an employee, it also helps keep the best workers loyal to the business as it can be seen as more important than a higher salary offered by a competitor.

The group underwriting advantage

Group disability underwriting, depending on the size of a group, can either be more lenient or for larger groups medical underwriting may be waived.

Also, in most cases pre-existing conditions are not excluded under a group policy. A group policy may be cancelled as a group, while individual policies may not be cancelled. If a policy is cancelled, there may or may not be replacement options.

Group policies also tend to have more favorable pricing than individual policies.

But, group policy benefits are taxed, while individual policy benefits are not. You may want to consult with your CPA, though, as there may be options to structure a group policy so that the group benefits are not taxable.

Lastly, group policies may not have as rich benefits as individual policies.

The takeaway

Group disability coverage is a management investment decision and is an excellent choice for businesses that want to minimize risk as well as round out their benefits packages to keep and attract the best employees.

In most cases, this costs a fraction of the cost of health insurance and may be the best supplemental benefit a business can offer.

Since each business situation is different, call us to discuss the available options for your organization. ❖

As IRS Sends out Enforcement Letters, Be Prepared

EVEN THOUGH the Trump administration continues taking steps to try to dismantle the Affordable Care Act, the law applies to employers and the IRS is enforcing it by the book.

Businesses are increasingly receiving IRS Letter 226J, which states that they may be in violation of the employer mandate, typically by either not offering coverage when they are legally required to do so or not offering "affordable" coverage to their employees.

Under the law, employers with 50 or more full-time workers must offer coverage to their employees that covers the 10 essential minimum benefits and which will cost each employee no more than 9.56% of their earnings.

Employers are also being targeted for not filing the required ACA-related forms (1094-C and 1095-C), or filing them late. These forms are a crucial part of the equation and you should strive to make sure they are accurate to avoid being surprised by a letter from the IRS demanding you pay a hefty penalty.

The crucial forms

1095-C: Applicable large employers (ALEs) must send this form to all employees eligible for coverage, regardless of whether or not they actually participate in the employer's health plan. The form must also be filed with the IRS.

1094-C: Form 1094-C must accompany the 1095-C forms that you send to the IRS. It is essentially a "cover sheet" for the former.

Advice

In an article in the trade publication Employee Benefit Adviser, Zack Pace – senior vice president, benefits consulting, at CBIZ – recommends the following, should you receive Letter 226J:

You usually have 30 days to respond – The letter will always state how long an employer has to respond, but Pace reminds you to check the response time in the letter as it could be less than 30 days.

If you didn't ask for transition relief, you can't get it – For the 2014 tax year, ALEs could check a box for "Section 4980H Transition Relief" on the 1094-C form, which absolved them of providing coverage to employees for that year only. To qualify for transition relief:

- The employer must have been an ALE that had 50 to 99 full-time employees, including full-time equivalents, on business days in 2014;
- During the period of Feb. 9, 2014 through Dec. 31, 2014, the ALE did not reduce the size of its workforce or reduce the overall hours of service of its employees in order to qualify for the transition relief; and
- During the period of Feb. 9, 2014 through the last day of the 2015 plan year, the ALE did not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014.

But if you qualified but didn't opt for transition relief, you would be required to comply with the employer mandate for that year.

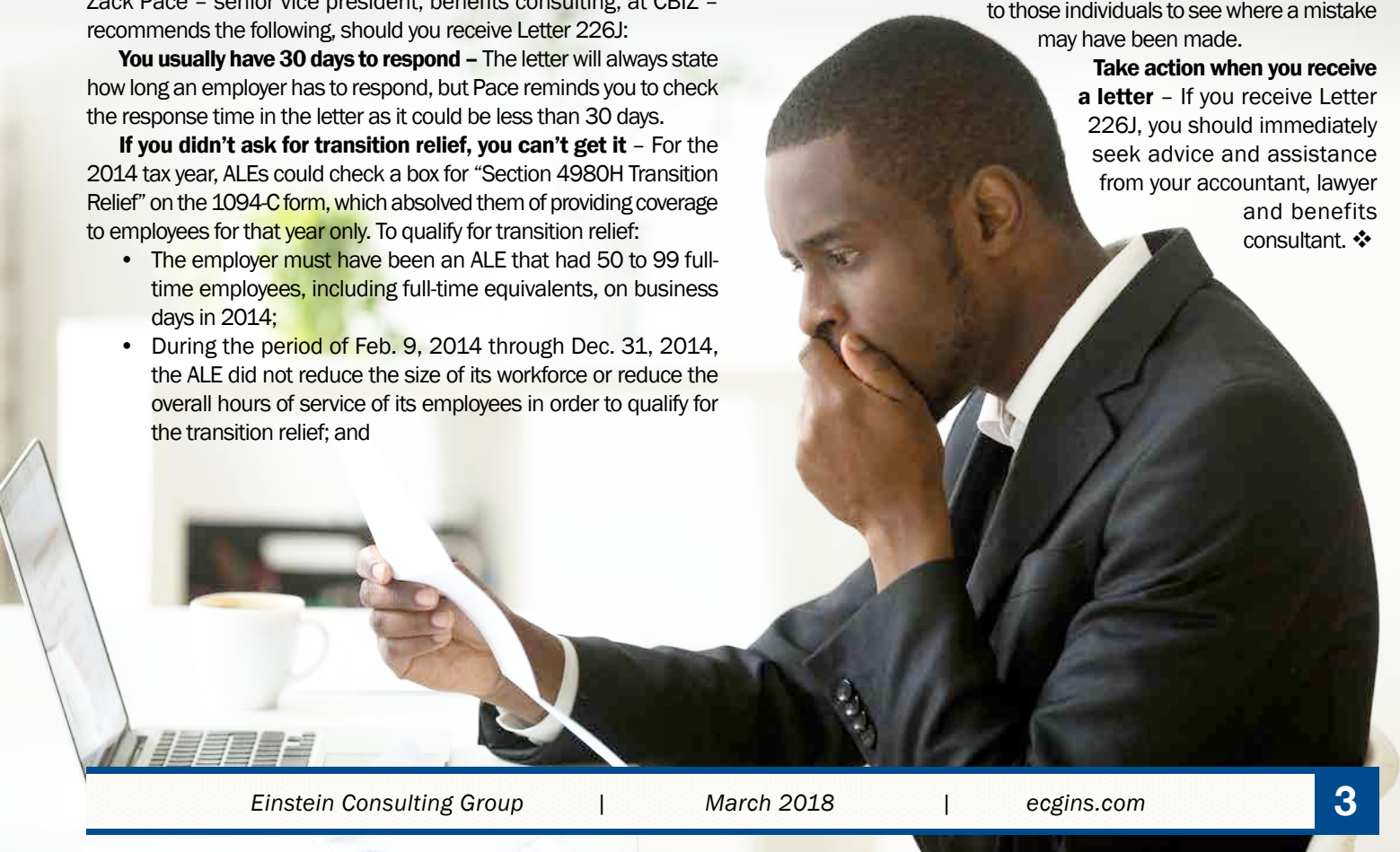
The IRS only has the information on the forms to go by – The IRS only relies on the information the employer provides on the forms, when it comes to assessing compliance and calculating penalties. It won't dig deeper to see if you really were complying or are eligible for a lesser penalty. This is why it's so important to make sure the information on these forms is accurate.

If you use a vendor to populate the forms, verify their work – After all, it's you that the IRS will come after if there are mistakes on the forms. After you receive the forms from your payroll vendor, third party administrator or a similar entity, you should scan through the forms to check that codes and answers are correct. Have a second pair of eyes like your accountant, attorney or benefits consultant to also scroll through them.

No do-overs – After an employer has received Letter 226J, they cannot attempt to refile forms 1094-C and 1095-C if the originals contained mistakes. Instead, recipients should follow the instructions in the letter, including the instruction that they are not to file corrected forms.

You can tie the penalty to specific individual 1095-C forms – Trouble-shooting is made easier, as an accompanying chart to the letter includes notes about which specific individuals any proposed penalties are tied to. With that information, you can pull the forms tied to those individuals to see where a mistake may have been made.

Take action when you receive a letter – If you receive Letter 226J, you should immediately seek advice and assistance from your accountant, lawyer and benefits consultant. ❖



Amazon, JP Morgan, Berkshire

Big Hitter Tie-up Could Shake up Health Care as We Know It

IN A MOVE that could either reshape health care delivery in America or barely register as a blip, three corporate and financial giants have unveiled a new company that they hope will reduce health care costs.

Amazon, Berkshire Hathaway, and JPMorgan Chase, which seem to have had enough with high health insurance costs for their employees, are instead taking the bull by the horns and say they will take a new approach to health care for their workers.

In announcing the venture, Berkshire Hathaway chairman and CEO Warren Buffett said that continuously climbing health care costs are "a hungry tapeworm on the American economy."

The move was greeted with excitement, with hopes that the trio of big hitters could bring an innovative approach to cost-containment that could be replicated for other employers around the country.

Without providing much in terms of details, that said they would leverage their combined scale and expertise to develop technologies that would allow their employees and dependents to enjoy "simplified, high-quality, and transparent healthcare at a reasonable cost."

Many observers are hoping that fresh sets of eyes will be able to take a creative approach to funding insurance coverage and delivering health care for less as cost inflation continues unabated.

The big question is how they will be able to influence pricing, particularly considering that there have been many different approaches to funding reimbursement to providers and none has yielded a method that seriously controls costs and cost inflation.

Tackling costs from the tech angle

The trio of companies, however, seems to be more interested in approaching the cost question from the technology angle. Amazon is already heavily involved in tech and e-commerce, and the banking industry (of which Chase is a member) is light years ahead of the health industry in terms of technology and user-friendly consumer interfaces.

Berkshire Hathaway brings capital to the equation.

Also, the companies have more than 1 million employees combined, which would allow them to wield significant clout in negotiating contracts with hospitals, pharmacies, and doctor networks. They could use this to hold them accountable for billing as well as health outcomes.

The tie-up could also focus on runaway pharmaceutical costs.

During much of 2017, it was rumored that Amazon was considering a move into the pharmacy business and it could be able to use its clout to possibly sway drug prices.

One analyst told the *New York Times* that we could see the new company introduce "an online health care dashboard that connects employees with the closest and best doctor specializing in whatever ailment they select from a drop-down "menu."

Perhaps the companies would strike deals to offer employee discounts with service providers like "medical testing facilities."

The companies said the initiative would be "free from profit-making incentives and constraints."

If the three giants develop a health care organization without a profit motive and instead an aim to shave health care costs, it could bring about serious savings. There are many parts of the health care industry that are high-cost, high-margin sectors that thrive on significant markups.

Jamie Dimon, chief executive of JPMorgan Chase, said in a statement that the effort could eventually be expanded to benefit all Americans.

For now, it's early days and as we learn more about this interesting new venture, we'll keep you abreast of developments. ❖