Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Health Insurance

HDHP Enrollees More Likely to Consider Costs and Quality

A NEW STUDY has found that people enrolled in high-deductible health plans (HDHPs) are more likely to consider costs and quality when looking for non-emergency care.

The 14th annual "Consumer Engagement in Health Care" study by the Employee Benefits Research Institute and market research firm Greenwald & Associates surveyed 2,100 adults, most of whom receive health coverage via their employers.

The survey found that people enrolled in health plans with a deductible of at least $1,350 for self only, and $2,700 for families, were more likely to take costs into account when making health care decisions.

HDHP participants shop around more	HDHP plans	Traditional plans
Enrollees check whether their health plan covers care or medication prior to purchase.	55%	41%
Enrollees check the quality rating of a doctor or hospital before receiving care.	41%	33%
Enrollees ask for generic drugs over a brand name.	41%	32%
Enrollees talk to their doctor about drug options and costs.	40%	29%
Enrollees use online cost-tracking tools provided by their health plans to manage their health expenses.	25%	14%

What you can do

HDHPs should be tied to health savings accounts. HSAs help them pay for services that are not covered until they meet their deductible. Employers can boost participation by matching (fully or in part) employees' HSA contributions.

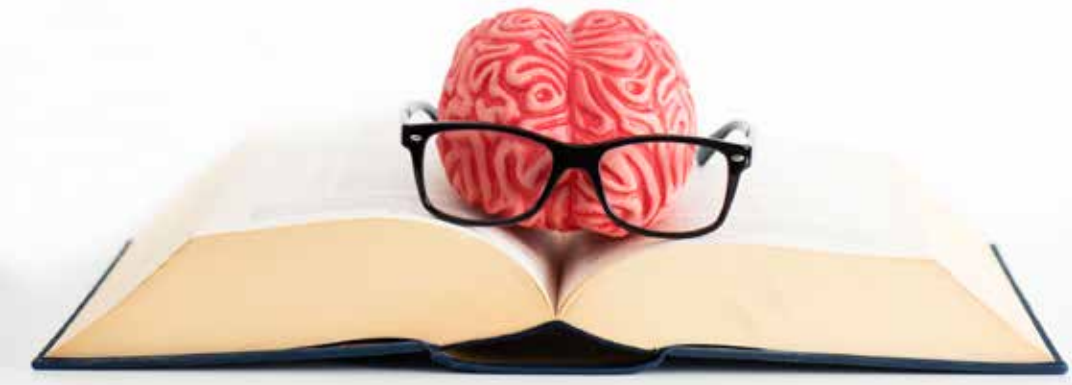
Employers should push the preventative care features of their health plans. The Affordable Care Act requires all plans to cover a set of preventative care services at no cost to the enrollee. Many people don't know that these services must be covered by their plan.

Some employee benefits experts recommend that employers tie the amount of premiums each worker contributes to how well they comply with preventative guidelines.

The key to getting your staff to take advantage of the tax-savings feature of HSAs is education.

You should make sure all of your eligible staff understand how they work.

And if you are not currently contributing some funds to their HSAs, now might be the time to consider doing that. ❖



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Employer Mandate

Proposed Rules Include New Ways to Comply with ACA

THE IRS has proposed new regulations that could let employers avoid Affordable Care Act employer mandate-related penalties by allowing them to reimburse employees for insurance they purchase on health insurance exchanges or the open market.

The regulations are not yet finalized, but the IRS has issued a notice explaining how applicable large employers, instead of purchasing health coverage for their workers, would be able to fund health reimbursement accounts (HRAs) to employees who purchase their own plans.

Under current ACA regulations, employers can be penalized up to $36,500 a year per employee for reimbursing employees for health insurance they purchase on their own.

Employer mandate refresher

Applicable large employers (ALEs), which are organizations with 50 or more full-time employees (including full-time equivalents), must offer health coverage to at least 95% of full-time employees and their dependents that includes:

Minimum essential coverage: The plan must cover 10 essential benefits.

Minimum value: The plan must pay at least 60% of the costs of benefits.

Affordable coverage: A plan is deemed affordable if the employee's required contribution does not exceed 9.56% (this amount is adjusted annually based on the federal poverty line; 9.86% will be the 2019 affordability percentage).

ALEs that fail to offer coverage are subject to paying a fine (called the responsibility payment) to the IRS.

How the new rule would work

The IRS is developing guidance on how HRAs could be used to satisfy the employer mandate. In its recent notice, the agency addressed how the rule would play out:

Requirement that ALEs offer coverage to 95% of their employees – Under the proposed regs and the notice, an employer could satisfy the 95% test by making all of its full-time employees and dependents eligible for the individual coverage HRA plan.

Affordability – The employer would have to contribute an amount into each individual account so that the remaining out-of-pocket premium cost for each employee does not exceed 9.86% (for 2019, as adjusted) of the employee's household income.

This could be a logistical nightmare for employers, and the IRS noted that employers would be able to use current affordability-test safe harbors already in place in regulations.

Minimum value requirement – The notice explains that an HRA that is affordable will be treated as providing minimum value for employer mandate purposes.

What you should do

At this point, employers should stay the course and not make any major changes to their employee health plans.

The IRS is aiming for the regs to take effect on Jan. 1, 2020, but even so, employees and prospects will be looking to work with employers that offer health plans and not HRAs, which add a layer of complication that most workers do not want. ❖

Court Decision

Despite Ruling, ACA Still Stands for Employers

A RULING BY a U.S. District Court judge in December 2018 that the Affordable Care Act is unconstitutional is not expected to stand.

But, if it does, the moves that have been made in the health insurance space to reduce costs, deliver better care outcomes and make the system more efficient would be expected to stay.

For those employers that were offering health coverage to their employees before the ACA and have continued since, the marketplace dynamics would likely not change much if the ruling were not overturned on appeal.

Additionally, since there has been some success in the employer-sponsored health care space in keeping cost inflation relatively tame, there would likely be no incentive for health insurers and providers to abandon those efforts.

The more likely outcome is that a higher court (and eventually likely the U.S. Supreme Court) overturns U.S. District Judge Reed O'Connor's ruling that because Congress eliminated the individual mandate portion of the ACA, the rest of the law is also invalid and cannot stand.

Uphill climb

That means all aspects of the law, including health care exchanges, the employer mandate, and the requirement that policies cover 10 essential benefits, and much more. The individual mandate was repealed at the end of 2017.

Several states such as Massachusetts, New York and California have since intervened to defend the law. They argue that, if Congress wanted to repeal it, it would have done so. The Congressional record makes it clear Congress was voting only to eliminate the individual mandate penalty in 2019; it indicates that they did not intend to strike down the entire ACA.

The original lawsuit against the ACA was brought by 20 attorneys general from Republican states, and now 17 attorneys general have filed a notice of appeal with the 5th U.S. Circuit Court of Appeals in New Orleans.

Interestingly, the Trump administration filed a brief early in 2018 encouraging the court to uphold the ACA but strike down the provisions relating to guaranteed issue and community rating.

There have been more than 70 attempts to invalidate the ACA in courts across the country, and two of those cases made it to the Supreme Court. The last time the ACA was upheld was in 2012 and all five justices who voted at that time to uphold the law are still on the bench today.

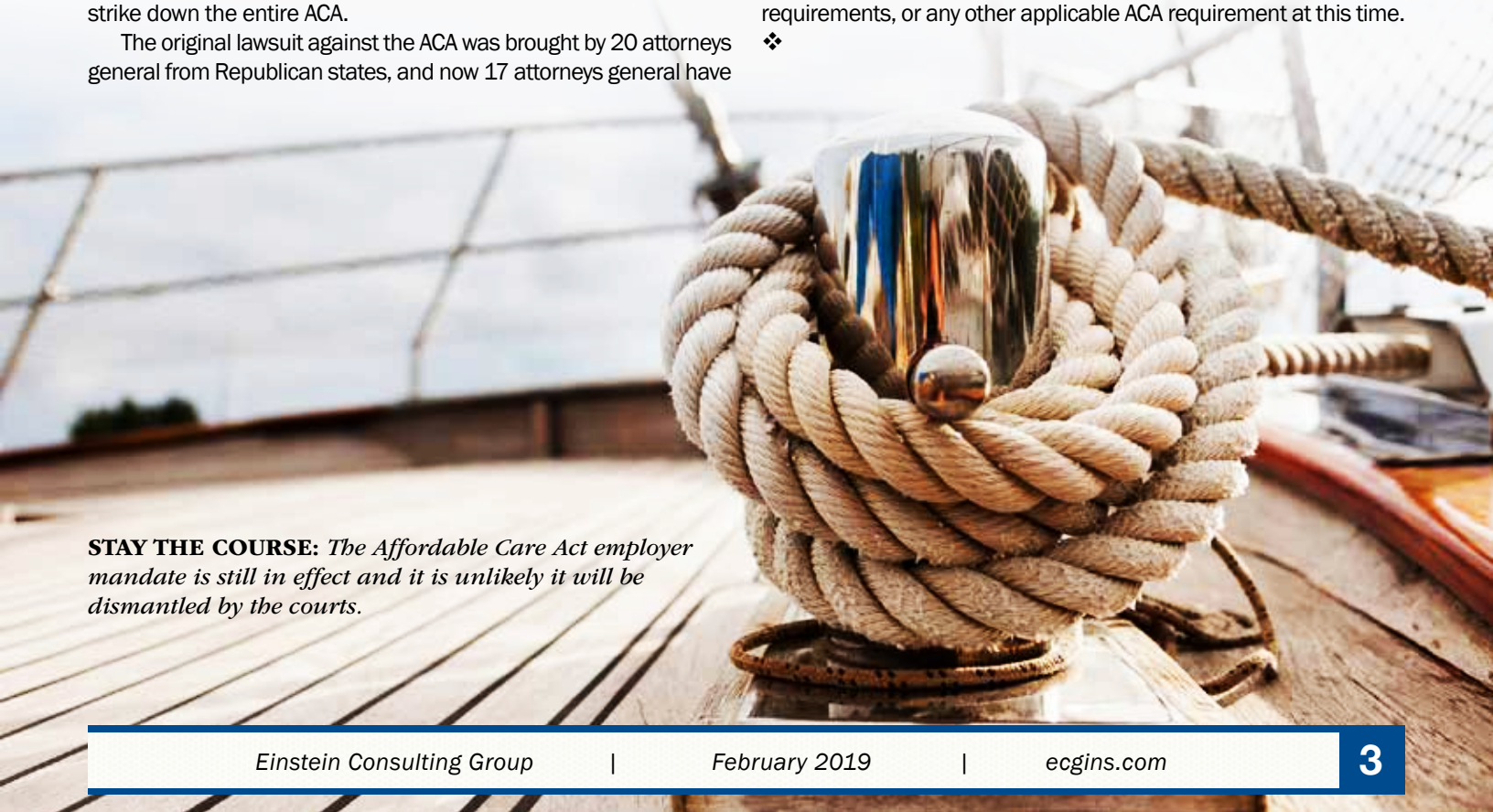
Additionally, the ACA is an extremely expansive piece of legislation, which has been on the books since 2010. Legal pundits say it's unlikely the Supreme Court would want to strike down a law that affects millions of people in the country. In fact, because of this the court may decide not even to take up the case if the 5th Circuit has overturned O'Connor's ruling.

Employer effects

While this case is under appeal the law will stand, meaning that all parts of it, except the individual mandate, will remain. That means all employers who are considered "applicable large employers" under the ACA, will be required to continue offering health insurance to their workers.

If you are one of them, you need to continue complying with the law of the land as it stands. And remember, while Congress eliminated the penalties associated with not complying with the individual mandate, the penalties for not complying with the employer mandate are still very much in place. Fines can be severe for non-compliance.

This ruling is not expected to affect those penalties, reporting requirements, or any other applicable ACA requirement at this time. ❖



STAY THE COURSE: *The Affordable Care Act employer mandate is still in effect and it is unlikely it will be dismantled by the courts.*

Voluntary Benefits

What Your Workers Need to Know About Group Life Insurance

VOLUNTARY LIFE insurance is offered to employees as an optional benefit, and often employers will pay the small premium as an employee retention tool and to provide workers some peace of mind for their families.

There are various avenues for funding these group plans, and different underwriting criteria that can either reduce or increase the premium amounts.

The employer may cover the premium directly, or employees may share in the premium burden through payroll deductions after tax. In most cases, life insurance face amounts will vary from policy to policy and will usually be based in part on each employee's base salary.

Taxation

Employers often provide group term life insurance to their employees at no cost to the employee, usually with a benefit equal to a percentage of base salary.

Internal Revenue Code Section 79 governs the taxation of this employer-provided life insurance. An employee can receive up to $50,000 worth of coverage tax-free.

The cost of any insurance above $50,000, less any amount paid for the insurance by the employee, is taxable income to the employee.

Types of group life insurance

There are three different categories for group life coverage, as follows:

Guaranteed underwriting – Automatic enrollment is granted to all eligible employees who apply. But they must meet eligibility requirements that the employer and insurance company negotiate.

Guaranteed underwriting requires little paperwork, there is no medical exam and it is issued quickly. It is usually only provided for large groups where employees cannot be denied.

To qualify for guaranteed issue, employers usually agree to a minimum percentage enrollment.

Simplified underwriting – There is no blood test, no urine test and no medical exam is required. Each applicant usually answers several health-related questions in addition to agreeing to a medical record background check.

Full underwriting – Medical exams are typically required, and a full examination is taken to satisfy the full records check requirement. Full underwriting is usually required with small groups, with individuals or on larger face amounts.

Because of the more thorough vetting, the application process takes longer to complete and not all people will qualify.

Why offer group life?

Premiums are typically quite low and that's why employers will often offer this benefit at no cost to their employees.

It's a great selling point when attracting new talent and retaining your employees.

It also benefits those employees who otherwise would not purchase life insurance on their own, either because of apathy or they may not be able to afford individual life insurance policies.

Group life also allows higher-risk individuals to be given life insurance coverage where they may have a harder time obtaining coverage on their own.

As a rule, experts recommend people purchase eight to 12 times their yearly wages in life insurance when working full time. If workers are young and have a long career ahead of them, experts recommend they purchase even more coverage. This is especially true for people with multiple dependents. ❖