Health Insurance 101: A Small Business Owner's Guide

Understanding Health Insurance In the Post Affordable Care Act Environment

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Preface

This guide was written to provide business owners with a clear-cut description, in layman's terms, of group medical insurance and benefits. Attempting to decipher the complexities of current medical insurance plans is a daunting task. By thoroughly examining the following pages, this guide will provide relief from contention and stress when dealing with medical insurance and benefit plans overall.

With over 18 years of formulating strategies, plan designs and educating business owners, I have found that most business owners do not understand the basic plan benefits or the complexities of Obamacare. Most employers are befuddled as to what is covered, what is not covered and how much will it cost. The explanations offered in this book are in a clear, concise and succinct format that will make your understanding more clear as to plan benefits and general understanding of medical insurance plans in the post Obamacare environment.

I find that most employers want to continue having a medical insurance plan. Unfortunately, with all the new rules and regulations under Obamacare, they are extremely frustrated and at a loss of understanding of how these plans work and the benefits to their employees. This book provides a rational explanation of how plans work, terminology, definition of acronyms, and a general understanding of medical insurance in the post Patient Protection Affordable Care Act world.

This guide is written exclusively for business owners with companies that have less than 100 employees. The recent changes due to the Obamacare have made it increasingly difficult for small business owners to understand and comprehend what they are providing to their employees and what their employees are responsible for. Utilizing this guide will alleviate a majority of any incomprehensibility. Enjoy this brief summary of medical insurance translated into plain English for everyone to understand.

From this point forward, Obamacare, which is the common name for 'The Patient Protection Affordable Care Act', will be referred to as 'PPACA'. Also, a person insured will be called a 'member'. Lastly, physicians, hospitals, laboratories, etc., will be referred to as 'providers'.

Medical Benefits

Under the Patient Protection Affordable Care Act(PPACA) all Medical insurance plans are required to have what is referred to as the 10 Essential Health Benefits. By requiring insurance plans to contain these ten essential health benefits, PPACA provides standardization across all plans. Standardization makes it somewhat easier for consumers to compare different plans from various insurance companies. Unfortunately, an after effect of the 10 Essential Health Benefits is that plans tend to be convoluted, confusing and downright incomprehensible at times. Often, the only essential health benefit that appears standardized across all plans is one of confusion. Everyone thought health insurance plans were difficult to comprehend prior to PPACA, now many people have thrown up their hands in disgust in trying to interpret and decipher how a plan actually works. Most plans prior to the PPACA covered all the 10 Essential Health Benefits. Now they have to by law.

The ten essential health benefits are;

Ambulatory Patient Services (Outpatient care). Care you receive without being admitted to a hospital, such as at a doctor's office, clinic or same-day ("outpatient") surgery center. Also included in this category are home health services and hospice care (note: some plans may limit coverage to no more than 45 days).

Emergency Services (Trips to the emergency room). Care you receive for conditions that could lead to serious disability or death if not immediately treated, such as accidents or sudden illness. Typically, this is a trip to the emergency room, and includes transport by ambulance. You cannot be penalized for going out-of-network or for not having prior authorization.

Hospitalization (Treatment in the hospital for inpatient care). Care you receive as a hospital patient, including care from doctors, nurses and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly (note: some plans may limit skilled nursing facility coverage to no more than 45 days).

Maternity and newborn care. Care that women receive during pregnancy (prenatal care), throughout labor, delivery and post-delivery, and care for newborn babies.

Mental health services and addiction treatment. Inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse

disorder . This includes behavioral health treatment, counseling, and psychotherapy. (note: some plans may limit coverage to 20 days each year.

Prescription drugs. Medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high cholesterol. At least one prescription drug must be covered for each category and classification of federally approved drugs, however limitations do apply. Some prescription drugs can be excluded. "Over the counter" drugs are usually not covered even if a doctor writes you a prescription for them. Insurers may limit drugs they will cover, covering only generic versions of drugs where generics are available. Some medicines are excluded where a cheaper equally effective medicine is available, or the insurer may impose "Step" requirements (expensive drugs can only be prescribed if doctor has tried a cheaper alternative and found that it was not effective). Some expensive drugs will need special approval.

Rehabilitative services and devices – Rehabilitative services (help recovering skills, like speech therapy after a stroke) and habilitative services (help developing skills, like speech therapy for children) and devices to help you gain or recover mental and physical skills lost to injury, disability or a chronic condition (this also includes devices needed for "habilitative reasons"). Plans have to provide 30 visits each year for either physical or occupational therapy, or visits to the chiropractor. Plans must also cover 30 visits for speech therapy as well as 30 visits for cardiac or pulmonary rehab.

Laboratory services. Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostrate exams, are provided free of charge.

Preventive services, wellness services, and chronic disease treatment. This includes counseling, preventive care, such as physicals, immunizations and screenings, like cancer screenings, designed to prevent or detect certain medical conditions. Also, care for chronic conditions, such as asthma and diabetes.

Pediatric services. Care provided to infants and children, including well-child visits and recommended vaccines and immunizations. Dental and vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam and corrective lenses each year.

When examining different plans, look closely which healthcare services are co-pays and which healthcare services are subject to deductible and any potential

coinsurances. Most often, office visits will be a co-pay and all other services will be subject to a deductible and coinsurance. On the more expensive plans, co-pays will apply for all services. The least expensive plans, all services will be subject to a large deductible. Once that the deductible is met, most services will be covered at 100% or a co-pay schedule will apply. Most times these different levels will determine plan choice.

The 10 Essential Health Benefits are the new building blocks for medical insurance plans under PPACA. A plan may add benefits over and above the 10 EHB's, but may not subtract benefits whatsoever. If so, the plan would become 'non-compliant'.

Prescriptions

Years ago, prescriptions were offered on a two-tiered system; generic and brand-name. Essentially, members enjoyed unrestricted access to all pharmaceuticals. The prescription drug benefit had no maximum and no formulary. A formulary is a listing of prescriptions that the insurance company will cover. Insurance companies would pay for these prescriptions at different levels based upon the discounts that they had negotiated with either the pharmaceutical distributor or manufacturer. Insurance companies now rely heavily on formularies as a way of controlling drug costs and utilize multiple formularies. Find out your plan's, or potential plan's formulary for adequate coverage.

Today's prescription drug benefits are what i refer to as the three 'C's"; complicated, complex and confusing. To illustrate, present plans carry a 4 tiered prescription drug benefit as opposed to two. Prescription drug benefits are similar to the original two-tiered structure, but expanded and more complex.

Here is a listing of what the 4 tiers mean;

Tier 1 Generic

Tier 2 Brand Name Preferred

Tier 3 Brand Name Non-Preferred High cost prescriptions typically referred to as designer drugs. These Pharmaceuticals appear frequently in the media and are usually subject to patent protection.

Tier 4 Specialty Pharmaceuticals. Extremely expensive prescriptions developed within the last few years. These include Slovadi, Humira, Harvoni, etc. Typical annual costs can exceed $85,000 to $130,000.

The actual out-of-pocket expense for the consumer is as follows;

Tier 1 Generic – A specific co-pay

Tier 2 Brand Name Preferred – A specific co-pay

Tier 3 Brand Name Non-Preferred – Either a specific co-pay or a percentage of the prescription drug cost up to some maximum; typically $500 or

the overall plan maximum out of pocket

Tier 4 Specialty – A percentage of the insurance companies cost, typically 30-50% up to a stated maximum, $300-$500 or the plan maximum.

In order to determine your actual prescription drug costs, you will need to access the insurance company's formulary for your specific plan. This can be done on the insurance company's website. The website provides the formulary and will display the specific tier for the member's pharmaceutical. The member pays a fixed copay, the insurance company's cost or a percentage of that cost. If the member pays the cost or a percentage thereof, those amounts will vary by pharmacy.

When choosing a prescription drug benefit, pay close attention to how the benefit is administered. Is the benefit paid on the first dollar basis, or is the benefit subject to a plan deductible or a separate Rx deductible? When a prescription Drug benefit offers first dollar coverage, increased premiums will result. Conversely, when the prescription drug benefit is subject to a plan or separate Rx deductible, decreased premiums will follow.

With the current prescription drug cost escalation and over utilization, insurance companies are attempting to reduce these costs through various means. One such way is to offer extremely low co-pay generics. Also many companies are requiring generic substitution or equivalents for brand-name pharmaceuticals that are high cost. If the member wants the brand name, when a generic is available, the member must pay the cost difference between the generic and brand name pharmaceutical. This Rx benefit is referred to as 'MAC A'. 'MAC' stands for Maximum Allowable Cost.

An alternative to 'MAC A' is MAC C'. 'MAC C' contains no prohibitions against brand name pharmaceuticals if a generic is available. A 'MAC C' rider will generate increased premiums since there is no financial incentive to utilize generics. For simplicity:

MAC A Generics required when available. If m chooses brand name, member
pays cost difference between generic and brand name

MAC C No prohibition against brand name when generic available

One final note on formularies; formularies may and will change. In the post PPACA world, formularies are required to be filed annually. The formulary may change and a

specific drug may be deleted or added. The insurance company is responsible for offering a substitution or equivalent for that pharmaceutical that has been deleted. Sometimes this may cause problems since the consumer is not amenable to the equivalent or substitution pharmaceutical. Check with your consultant to determine which insurance company's formulary provides the best coverage.

Networks

Today, practically all plans have two components: in-network and out of network coverage. We will discuss in network and out of network coverages and what each constitutes for the member (the person insured).

In Network

When we refer to the term in network, what insurance companies actually mean is they have contracted with a provider, at an agreed upon specific dollar reimbursement rate, for a particular healthcare service, for the calendar year. This means the provider will accept members from that insurance company and they will receive some pre-negotiated reimbursement rate for their services. Networks are usually state-based and then expand out into some metropolitan area or tap into a national network; which is usually composed of each individual states network.

When deciding on a network, include office locations, hospitals, ambulatory surgical centers, laboratories, pharmacies, and ancillary providers. Ancillary providers are typically vision providers, chiropractors, naturopathic physicians, etc. Be sure to pick a network that has the greatest percentage of coverage for all your healthcare providers. The network should always include your primary care physician. Also, one should consider whether a local or national network will meet their healthcare requirements. Enrolling in a plan with a national network typically will cost more in premium. When deciding on a network, determine if local or national accessibility to providers are a key component. Do you want the flexibility to visit Dana-Farber Cancer Center in Boston, Sloan memorial Kettering in New York or some other healthcare institution that specializes in your requirements? If you need this flexibility and accessibility, then a national network will meet your needs. If you're confident that the facilities, physicians and ancillary providers in your local network will provide all the care you may require, then an in network only option would be the right fit.

Out of Network Coverage

Out of network coverage is handled in two ways. With an HMO, the out of network providers are not covered at all and the insured will be 100% responsible for payment. With a plan that offers out of network coverage, typically the plan will have a deductible and some coinsurance level for the out of network providers. The out of network deductible and coinsurance amounts combined are the maximum out-of-pocket amounts. These amounts are typically much higher than in network. This is meant to discourage out of network provider utilization and encourage in network visitation. Remember, the out of network providers are what we referred to as non-

participating and do not subscribe to any limitations that in network providers agree to.

Insurance companies typically use a benchmark system for determining the amount that they will cover on an out of network basis. These claim systems are usually Medicare, FAIR or AHIP (American Health Insurance plan). Claims are paid on a percentage basis of these systems; for example an insurance company will use 140% of the Medicare reimbursement amount for office visits and 110% of the Medicare amount for facility (Hospitals, etc.) charges. The insurance company will issue a coverage statement called an EOB – explanation of benefits statement listing a MAA – maximum allowable amount. This designation, MAA, utilizes the benchmark system when determining claim coverage. Essentially the insurance company will only pay up to the MMA – maximum allowed amount. Any balance after that is the insured's responsibility. Most Providers are amenable to negotiate the balance billing over and above the maximum allowable amount. I urged anyone using out of network providers to determine your claim responsibility prior to healthcare services being rendered. Furthermore, be aware of your maximum out-of-pocket exposure when using out of network providers. In the post Obama care environment these amounts can be financially devastating to many people.

Insurance companies have structured their plans to incentivize the consumer to utilize in network providers as much as possible. For in network coverage, the maximum out-of-pocket costs are lower, plus the convenience factor and ease of administration are much higher. It's always best to utilize in-network providers when possible.

Plan Types

In today's post Affordable Care Act environment, plan types have not changed. Although many benefits have either increased or decreased, the basic plan types have remained relatively constant.

HMO (Health Maintenance Organization)

An HMO is a network of physicians, hospitals, laboratories, pharmacies, etc., here after called 'providers'. These Providers have contracted with insurance companies to offer their services in return for an agreed upon reimbursement rate. The insured, or member, utilizes the Provider's healthcare services, pays an applicable copay or deductible and the Provider is reimbursed by the insurance company for any balance. A member can access these providers unfettered.

The insured is limited to the network only; any physician, hospital or other healthcare provider outside the network will not be covered. The member will be responsible for payment. The only exception is an emergency. The member then can access any provider; either in network or out of network. Emergency is defined as any prudent person seeking health care due to potential loss of life or limb.

To illustrate an HMO, think of every healthcare provider in the state of Connecticut as in network. If you cross the state line into Massachusetts, New York or anywhere else, you'll have no coverage.

POS (Point Of Service)

Years ago, many people signed up for an HMO for the convenience. However, some people did not like the 'in network' only coverage option. Insurance companies introduced a plan called the 'Point of Service' or POS. A POS plan functions exactly as an HMO with the added benefit of providing out of network coverage. The out of network coverage typically is a deductible and some level of coinsurance followed by an out-of-pocket maximum amount. This plan enabled members to seek care either in network or out of network. Insurance companies built in some financial disincentives (deductible and coinsurance) to go out of network, thus incentivizing members to remain in network.

PPO (Preferred Provider Organization)

A preferred provider organization, or commonly referred to as a PPO, is typically an expanded HMO with an out-of-network benefit. Like a point of service plan, a PPO

provides an expanded network along with lower deductibles and coinsurance levels out of network. Typically, a PPO plan provides the greatest coverage in network while maintaining lower out-of-pocket cost for any out-of-network coverage. Networks for PPO plans are usually national in scope, thus eliminating a large percentage of out-of-network claims which you would find under a point of service plan. A PPO plan is considered the best coverage and benefit plan available.

EPO (Exclusive Provider Network)

An EPO is essentially a truncated HMO with restrictive and smaller networks. Insurance companies or private physician organizations will construct an EPO to manage healthcare risks more efficiently and generate a larger profit.

Indemnity

If you are over 50, most likely you at one time had an indemnity medical insurance plan. While these plans have gone the way of the dinosaurs, a few still exist today. An indemnity plan contains a deductible and coinsurance level with some out-of-pocket maximum. There is no network involved. The member can visit any provider anywhere at any time. The claims payout from an insurance company in an indemnity plan are based on some benchmark data. Typically insurance companies use Medicare, FAIR or the AHIP (American Health Insurance Plan) systems. Indemnity plans are expensive but provide the greatest accessibility of all plans.

CDHC & HDHP (Consumer Driven Health Care & High Deductible Health Plan)

Basically, there is no difference between these plans; just the nomenclature. Usually all consumer-driven health plans are in fact high deductible health plans. The theory is, if the consumer has to pay out of pocket a large sum initially for their healthcare, this will engage the consumer into learning the true cost of health care and potentially decrease their utilization(frequency). Furthermore, the member will price shop more efficiently when they are subject to a high deductible. HDHP plans contain deductibles between $1,500 up to $12,000 for a family. HDHP plans have proven effective in controlling the healthcare cost rate of increase and actually reducing health insurance premiums overtime.

Plan Design

Plan design – What does it mean? Like anything else, designing a plan of benefits that best suits your employee's needs. Plan design is a function of benefits, networks, demographics and cost structure. Most large companies have the capability of unfettered plan design. They can add and subtract benefits as they wish to accommodate their employee population. They also structure benefits in a way to either incentivize a certain behavior or discourage certain behaviors; ones which typically lead to chronic medical conditions.

Most small employers ask "how can I design a plan when I have to pick and choose a standardized plan that an insurance company offers me?" Before I tackle that question, let's go into basics of plan design.

In considering either designing a plan or choosing the standardize plan, employers should take in to consideration the following;

- Demographics of their employee population
- Networks available to the employees
- Percentage of covered providers that the network would provide
- Physical accessibility
- Employee/employer premium contribution rates or percentages
- Employers cash flow dedicated to healthcare
- Offering one, two or three plans simultaneously.

Once these factors are given careful consideration, the employer may now make an astute judgment as to which plan will best suit their employees' needs.

Venturing further into plan design, the employer may look at varying not only the premium contribution rates between employer and employee but also adding a high deductible health plan (HDHP) in addition to a co-pay based plan. High deductible health plans can vary from a $1,500-$12,000 family deductible. The HDHP may be combined with some type of reimbursement scenario where the employer may offset a portion of the employee's deductible. The employer now has a great degree of flexibility. Offering two plans, (Co-pay and HDHP) the employer may set different employer/employee premium contribution rates for each plan along with a reimbursement program for the HDHP. This allows a large number of combinations for the employer to select from, thus providing greater plan design flexibility.

When implementing a reimbursement scenario, the employer has two options for reimbursing the employee; a health savings account and a health reimbursement arrangement.

The health savings account (HSA) is a tax advantaged account where the employer will provide the employee with a set amount of dollars dedicated to offsetting the high deductible. Once the employer makes the HSA contribution it is the employee's money. If the employee leaves the company, the employer's contribution to the health savings account goes with the employee. The employee may also contribute to the health savings account. All funds in the HSA may be used to offset any out-of-pocket healthcare costs. These dollars are tax-free to the employee. The employer receives a tax adduction for their HSA contribution, making the HSA a win-win situation.

The health reimbursement arrangement (HRA) is where the employer, on an ongoing basis, will reimburse the employee either a fixed dollar amount or some percentage of the deductible. The HRA is the employer's money. The reimbursements are made to the employee as claims are processed by the insurance company. For simplicity, the HSA is the employee's money and the HRA is the employer's money. In order for the employer to receive a tax deduction, both the HSA and HRA must be set up in conjunction with a group health insurance plan and meet certain IRS guidelines.

Now that small employers actually have a plethora of options, permutations and combinations of benefits, they can custom tailor a medical insurance plan that will efficiently fit their employee's needs, while minimizing their cost structure.

Don't think your choices are limited. Remember to procure an experienced broker or consultant when designing your plan to fit your and your employees' requirements.

Ancillary Coverages

The ancillary coverages discussed include dental, vision, long-term and short-term disability and life insurance.

Dental

Today, dental plans are becoming overly complex and confusing. I recommend a simple dental plan that covers both in and out of network services. As in medical plans this is called a PPO; preferred provider organization. Dental plans are structured into four basic benefit levels; Preventive, Basic, Major, and Orthodontia services. I recommend plan benefits of 100/80/50. This means that services are covered according to the following schedule;

Preventive services – 100%
Basic services – 80%
Major services – 50%
Orthodontia – Deductible, then 50% up to a Maximum

These benefit levels apply to both in and out of network coverage and typically incorporate a small deductible. In network coverage provides convenience and less out of pocket since the cost for all services are pre-negotiated between the dentist and insurance company.

With out-of-network coverage, ensure the plan pays for what is referred to as 'the 90th percentile of UCR'. This means the insurance company will pay an amount that is 90% of the usual, customary and reasonable charge for a service in a given geographic area. The 90th Percentile of UCR will result in lower out of pocket costs and reduce any potential balance billing.

Orthodontia is offered to companies with 10 or more employees enrolling. The benefit is usually 50% up to a predetermined maximum. If you decide on implementing orthodontic coverage, be sure to include adult coverage.

Depending on the number of employees enrolled or prior coverage, most plans have waiting periods for Major services. Major services include crowns, bridges, and denture work and will usually have a waiting period of 12 months from the plan inception date.

For plan maximums I recommend either a $1,500 or $2,000 annual benefit maximum. With dental procedures becoming more costly, it is a wise investment to pay a little

more in premium to gain 50% to 100% more coverage per year. I also recommend considering a rollover account. The rollover account deposits unused benefits from the current year and can be used to pay for the following year's claims. These funds can be accumulated up to a pre-determined maximum. This is a nice benefit to have when unexpected basic or major services pop up.

Vision

Typical vision plans are co-pay-based and utilize a national vision provider network. These plans provide both in and out of network coverage; with out-of-network coverage being limited to a certain dollar amount. In network coverage is typically the co-pay for the service or material.

Vision plans usually have a three tiered structure of benefits;

Exam Frequency / Material Frequency / Frame Frequency.

For example a 12/24/24 plan will provide an exam once every 12 months, lenses every 24 months and frames every 24 months. Contacts are considered materials and subject to a dollar maximum. Contacts are paid out "in lieu of frames". This means the member can use glasses but opts for contacts. Therefore the insurance company will only pay for a limited amount of contacts, since they are not medically necessary. Medically necessary contacts require a prescription from an ophthalmologist and are needed for clear vision. They usually are covered in full with no maximum. For simplicity;

12/24/24 Plan

Exam	Every 12 Months
Materials	Every 24 Months
Frames	Every 24 Months

Short-term and Long-term Disability Plans

Short-term disability plans usually will cover 60% or 66 2/3 of an employee's salary, up to some weekly maximum; typically $1,000. The short-term disability plan or STD, is structured on a two tiered benefit level. Those benefits determine when the plan starts and the length of coverage. The start of coverage is typically first day for

accident and eighth day for sickness. Coverage can run 13 weeks or 26 weeks. Typically a plan will look like this; 0/8/26. This means the plan benefits will start first day for an accident and eighth day for illness, followed by 26 weeks of coverage. Also, the insurance company may put a 3/12 clause in the policy. This clause means that any medical condition which an employee visited our consulted with a provider for in the last three months prior to the inception date and will be excluded for 12 months when considering a claim. This prevents an employee from enrolling in a STD plan for the sole purpose of entering an immediate claim. For simplicity;

0/8/26 Plan

0 Days	Coverage begins immediately for accident
8 Days	Coverage begins 8th day due to sickness
26 Weeks	Length of time benefits are paid

3/12 Pre-existing Clause

3 Months	Time period before plan inception date that a physician or Healthcare provider consulted with for a specific condition
12 Months	Amount of time 'pre-existing' condition is excluded from Coverage

Long term disability plans are structured relatively the same as STD plans; two tiered benefits scenario, waiting and benefit periods. You have a waiting period, typically 180 days. This coincides with the 26 weeks of STD coverage. The benefits for LTD coverage range from two year, five-year, ten year, age 65 and SSNRA (social security normal retirement age). Since the Social Security retirement system is in financial trouble, the government has extended the full retirement age in excess of 65 years. Insurance companies have followed this change and extended the benefit accordingly. When considering premiums for LTD plans pay close attention to the occupation definition. Most plans that seem extremely competitive in premium will have an "any occupation" definition. That means the benefit will be payable as long as the employee cannot perform any occupation for which they are qualified by reason of age, education and experience. So, as long as the disabled employee can't operate a

high tech machine (his regular occupation) but is able to sweep a factory floor, that employee is consider not disabled and thus will not qualify for benefits.

A good LTD plan will have an own occupation definition, meaning the employee will be paid the benefit if they cannot work at their own occupation. This plan is a bit more expensive but the benefit is much more generous and advantageous to the employee.

Life insurance

Life insurance plans are typically a multiple of $10,000 or a multiple of an employee's annual salary. The most common amounts of life insurance are $10,000 or $20,000 along with one times the employee's annual salary. On group life insurance make sure the employee designate a beneficiary on their enrollment form or the probate court will decide where the life insurance proceeds are to be paid.

Employee Benefit Websites

Over the last few years, employee benefit websites have gained popularity. Employers, consultants, and brokers are relying more heavily on these websites and portals for day-to-day administrative tasks and ease of access for employees to benefit information and web links. These websites are a welcome change to both employers and employees alike.

For employers, the websites have reduced dramatically the employer's administrative cost by incorporating web-based and cloud-based technologies. Employers are able to enroll, terminate and track employees with ease. Most employee benefit portals contain administrative functions for human resource information systems along with all pertinent contact, salary, wage and tax information for the employee. Human resource manager efficiencies have increased dramatically since the inception and introduction of benefit portals. Not only do these portals contain the day-to-day administrative functions for a human resource manager and employer but some incorporate links to HR services for each state and the federal level. This allows companies with offices throughout the country and internationally to maintain a high level of employee benefit communications and oversight.

Over the last few years, employers have reduced administrative costs by shifting their time to brokers and consultants; and also to employees by means of self service. What once took perhaps a few hours to complete, an administrative assistant can now access information in literally a minute to complete the desired task.

Further compounding an employer's cost savings are reduced liability costs. Most websites contain an automatic electronic feed to a COBRA vendor. Typically these COBRA vendors will supply on boarding packages for new employees and the required COBRA paperwork for terminated employees, all with the click of a mouse. Employers enjoy greater efficiencies, reduced overhead and liability costs when implementing these employee website portals.

For employees, the benefits are just as great. Years ago, employees would have to retain website addresses, plan descriptions and ID card numbers in their physical possession in order to access information. Now, with a username and password, the employee has the ability to access all their information along with any pertinent forms, plan descriptions, telephone numbers, email addresses and links for frequently asked questions and confidentiality issues. Even though the trend is towards employee self service, the access to information is efficient and accurate. I have found many employees enjoy these websites and utilize them quite frequently.

Overall, I would highly recommend companies implement an employee benefits web portal. Not only will it save money but it makes everyone's life easier and less stressful. One note of caution; many websites are what I deem as overkill. There are too many functions and may cause confusion amongst the employees and the HR department. I recommend a website that will replace the day to day administrative functions of your HR department and increase the ability for employee communications. Also, the site should provide, via electronic feeds, any COBRA, enrollment or termination functions.

Medicare

This discussion of Medicare is based on group or business based medical insurance plans. Individual plans will not be discussed. Knowledge of Medicare Parts A, B and D is assumed.

There are three areas of Medicare to be concerned with. First, the Medicare eligible person has to decide whether they should remain on the group plan or enroll in an individual plan. Secondly, determine whether Medicare will be the primary or secondary payer on claims. Lastly, how ownership across multiple companies may affect whether Medicare will be the secondary or primary payer.

When an employee turns 65 and is eligible for Medicare, a calculation must be made to determine whether that employee remains on the group plan or enrolls in an individual plan. The calculation consists of determining the part B premium plus the part D premium. Excess premium may be required by Medicare. The Part B and D excess premiums are based on prior year's adjusted gross income from the employee's IRS Form 1040. Medicare publishes both tables every year (Medicare.gov) The excess amount is typically referred to as 'IRMAA' or the income related monthly adjusted amount. Once the 'IRMAA' amounts are determined, those amounts plus the individual Medicare plan premium plus any prescription drug program premium must all be added together to determine total monthly cost for an individual plan. To illustrate:

Part B Premium + IRMAA
Part D Premium + IRMAA
Individual Medicare Medical Plan Premium
Individual Medicare Prescription Drug Plan Premium

Total Cost for Individual Medicare Medical and Prescription Drug Plans = X

Cost for Group Plan = Y

Cost for Group Medicare Plan (if available)+ Part B Premium = Z

These costs can be compared (X>Y>Z) and a determination made as to plan choice. Please note, an employer cannot financially induce a Medicare eligible employee to enroll in an individual plan; it is against the law.

Regarding Medicare primary and secondary payer of claims; this is determined by the total number of full-time and part-time employees that a company employed during

the previous year. If a company employs less than 20 part and full-time employees, Medicare will be the primary payer of claims. This means if the employee remains on the group plan, Medicare will pay any claims first. The group plan will pick up the claim balance, if any, according to its claim schedule. This is not to be confused with a group Medicare supplement plan that the company may provide the employee. A group Medicare supplement plan functions like an individual plan but usually has increased benefit levels. The primary payer situation is only if an employee remains on the regular group plan.

For secondary payer, a company must employ more than 20 full and part time employees in the previous year. Now, Medicare will be the secondary payer of claims. The group plan will pay claims first followed by Medicare paying any balance of claims according to their schedule. Again this assumes the individual is enrolled in the regular group plan.

Lastly, the ownership provision is one that is not commonly known but may have devastating financial consequences if not properly addressed. For example, an individual may own, or have incidence of ownership across two companies. One company, Company A, may have 7 full-time employees. The other company, company B, may have 35 Employees full and part time. In order to save costs the owner may enroll in a group Medicare supplement plan under company A. This action would appear commonsensical. Unfortunately that is not the case.

For Medicare purposes, ownership, or incidence of ownership will be across two companies; A & B. Both companies would be considered one company for the purposes of counting the number of employees, full and part time. Since this number will be over 20 employees full and part time, Medicare would be considered the secondary payer. The owner would literally be forced into enrolling in the regular group plan of Company B. The only other option is to enroll in an individual Medicare plan. This may not make sense depending upon the owner's income, which will determine part B premium along with part D premium and any excess (IRMAA). This amount can be compared against the company's group plan premium plus any deductibility of that premium. To illustrate:

Company A 7 Full Time Employees
Company B 35 Full and Part Time Employees

Both Companies 42 Full and Part Time Employees
Medicare will be the Secondary Payer

Cost Determination:

Company B Group Medical Premium = X

Actual Cost = Employee Benefit Expense Deduction (assume 30%)= .7X

Individual Plan Premium (including all Part B & D premiums) = Z

Again, a determination can be made (X<Z) as to which plan the owner will enroll in. Note, individual plans must be paid out of personal accounts.

If the owner does not enroll in an individual Medicare plan or Company B's group plan, but enrolls in Company A's group plan or Medicare supplement plan, the owner will be responsible for any Medicare primary payer claims from that point going forward.

This can result in disastrous financial consequences down the road. For example the owner enrolls in company A's group Medicare Supplement plan or the regular group plan. Over the next two years he has over $150,000 of claims due to multiple hospitalizations and high cost diagnostic testing. If Medicare discovers he should be in Company B's group plan, Medicare will enforce the regulation of Medicare secondary payer and request reimbursement of the $150,000. This is why it's imperative for an individual who has ownership or any incidence of ownership across multiple companies to be keenly and astutely aware of choosing the correct Medicare plan.

Government Regulations

While there are many government regulations, we will focus on three that are pertinent to small companies.

ERISA
SBC
COBRA /Continuation

ERISA was a law passed back in 1974. Its technical name is the Employee Retirement Income Security Act. One provision under ERISA is that any company, regardless of size, is required to have a summary plan description for any welfare benefit plan. Now what does that mean? A welfare benefit plan refers to a company-sponsored group plan encompassing medical, dental, long-term and short-term disability, vision plans, etc. A summary plan description is a document requiring specific language which outlines the employees rights, contact information and plan specifics. The department of labor requires each company that offers their employees a general welfare benefit plan also provide a summary plan description to each employee. If an employer does not meet these criteria, they may be fined not only for one time incidents but on a daily basis.

Next, a SBC, or Summary Of Benefits and Coverages is a document that employers are again, required to distribute to their employees once a year. The SBC contains a description of co-pay levels, coinsurance levels, maximum out-of-pocket expense, number of visits per healthcare item, etc. The SBC has taken the place of the plan description. Under the Patient Protection Affordable Care Act (PPACA), the SBC provides uniformity and standardization across all insurance plans. The SBC must accompany the summary plan description for the employer to be in compliance with ERISA and PPACA.

Finally, COBRA / Continuation. COBRA/Continuation is not a separate plan. COBRA/Continuation are both federal and state statutes dedicated to former employees and their beneficiaries; enabling them to continue coverage at their own expense when they are no longer eligible to participate in their employer's plan(s). The former employee's status (termination of employment, either voluntary or involuntary, disability or death) will determine the length of coverage and premium amount. Former employees are not eligible to participate in COBRA / Continuation if employment termination was due to 'Gross Negligence'.

If a company employs more than 20 full-time and part-time employees, that company is subject to COBRA provisions which are regulated by the Federal govt.; less than 20

full and part-time employees the company is subject to Continuation. Continuation is regulated by each individual state. Provisions mirror COBRA with a few minor differences and may differ from state to state.

COBRA provisions are complex and often times confusing. I recommend that any company subject to COBRA, contract with an outside service specifically designed to maintain compliance. The fines for COBRA violations can be quite high. Typically violations result in $100 a day fine and sometimes these violations are not uncovered for 1 to 2 years. Hiring an outside service will avoid any potential fines. It is a worthwhile cost to incur.

For continuation, typically the costs are prohibitive for an outside service. Moreover, depending upon the state, it is difficult to find a service for continuation. Usually an association plan will pick up the cost of administering continuation rights, if you belong to one. Other than that situation you will have to rely on your broker or consultant to assist you in administering continuation rights to any former employee.

A note on COBRA / Continuation; often times COBRA / Continuation violations may result in a review through the insurance commissioner's office or a lawsuit. Just remember, the insurance commissioner's office and the courts always assume the employee is right. Unless you have valid paperwork signed and delivered according to the time provisions, you may be subject to fines. Assume the employee is always correct and that will help you in determining what type of service to contract with.

Summation

PPACA has presented challenges for many small companies. Navigating and understanding the rules, regulations and complexities of PPACA should now be clearer and more concrete for business owners. Although PPACA changed the 'game', many former statutes have remained the same, continuing a modicum of stability in the health insurance markets.

PPACA has added an administrative layer and cost burden for companies.
Companies now have to rely on astute brokers and consultants for two important items; remaining compliant and reducing their overall cost burden.

Hopefully, this guide has provided adequate answers to your PPACA questions and a greater understanding of medical insurance terms and plan functionality. Going forward, I highly recommend securing the services of a credentialed broker or consultant. By doing so, business owners will alleviate much of the stress and angst associated with complying with PPACA along with strategic guidance and the formulation of a benefits portfolio that meets your company's requirements. Best of luck in your future benefit endeavors.

Bio

David E. Wilgan is an insurance professional with over 20 years of experience benefits consulting to small and mid-sized companies. David holds the designation of 'Registered Health Underwriter' and 'Certified Insurance Consultant'.

Through his extraordinary effort, vast knowledge base and effective communications, David's client companies have saved millions of dollars in costs over the years and enjoyed peace of mind knowing that David provided astute counsel and strategic guidance. Moreover, by instituting small but effective changes, David's client companies have enjoyed reduced liability exposure, expanded benefits and continued compliance.

David enjoys cross country skiing, volunteers for environmental groups and is an avid fly fisherman. He resides in CT with his 3 sons.

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