

Risk Monitor



A Look at Healthcare Reform's Impact on Employers

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Along with the Health Care and Education Reconciliation Act of 2010, this legislation will make significant changes to our current health care system.

The Act adds new responsibilities for employers and insurance carriers. While most of the provisions will start in 2014 or later, some provisions are effective right away or within a short period of time after enactment.

Effective 2010

- **Small-Business Tax Credit.** A tax credit of up to 35 percent of the employer's health care contribution is available for qualified small employers (any employer with no more than 25 full-time employees and average wages of less than \$50,000). This tax credit will increase to 50% starting in 2014 once exchanges are operational.
- **Early Retirees.** A temporary reinsurance program is provided to employers that offer coverage to early retirees between the ages of 55 and 64.
- **Health Plan Changes.** 1) Plans must offer unlimited lifetime benefits and annual benefit limits will be restricted. 2) Pre-ex conditions will be prohibited for children under 19. 3) Re-cissions are prohibited except in the case of fraud. 4) Plans must cover certain preventive health services at no cost to the insured. 5) Dependent coverage age limit extended to 26.
- **Federal High Risk Pool.** Temporary establishment of a high risk health insurance pool for individuals unable to find insurance elsewhere.

Effective 2011

- **W-2 Reporting.** Employers must report value of health care benefits provided on employee w-2s, but not as taxable income.
- **Higher Penalty Tax on Non-Qualified Health Savings Account (HSA) Withdrawals.** Non-qualified withdrawals will be taxed at 20% versus the current 10% penalty.
- **Cafeteria Plans.** A new Simple Cafeteria Plan is created through which small employers (less than 100 employees) can easily provide tax-free benefits to their employees without the administrative burden of sponsoring a cafeteria plan.
- **Standardized Definition of Qualified Medical Expenses.** Costs for over-the-counter medications obtained without a prescription will no longer be considered a qualified medical expense.

Effective 2013

- **Flexible Spending Account Limits.** Annual contribution limits are reduced to \$2,500 per year, with CPI increases available in future years.
- **Itemized Deduction for Medical Expenses.** The Act increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals over age 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- **Higher Payroll Taxes for High Income Earners.** The hospital insurance tax rate will be increased 0.9 percentage points for wages over \$200,000 for individuals and \$250,000 for those filing jointly.

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Welcome to The Chadler Group's Newsletter!

It is with great satisfaction that we bring our newsletter to you. In this issue and the coming quarterly newsletters, we will discuss pertinent insurance topics which affect your business and personal insurance needs. We hope you find this information both informative and useful in your overall risk management practices.



the
ChadlerGroup

The Chadler Group, Inc.
PO Box 11115
330 Passaic Ave, Ste. 200
Fairfield, NJ 07004

Phone: (800) 706-2478
Fax: (973) 227-4026



What Factors Determine Small Group Health Renewal Rates?

Determining renewal rates for small groups (2-50 employees) is not an arbitrary process. There is definitely a method to the madness. But what exactly comes into play in calculating the rates? Despite the fact that there are various criteria to consider, generally insurers use the following factors to formulate your renewal rates:

Trends in General Healthcare

This is a baseline factor applied to all group health insurance renewals. The word “trend” refers to two things: the change in cost of healthcare products and services, and how consumers utilize these products and services. New technologies, procedures, and even facilities encourage more people to seek advanced treatments. And all these extra goods and services are not available for free. They are expensive and increasing rapidly!

The “prescription drug trend” is another factor that influences healthcare trends. More and more drugs are being introduced, and the pharmaceutical companies market them aggressively. The costs of research, development and advertising of these drugs are significant. These rising expenditures, in combination with increasing utilization, all affect the baseline factor.

Another factor in this “trend” has much to do with your group’s geographic location. Similar to housing costs, healthcare costs differ significantly upon location. Healthcare premiums in some areas reflect the higher cost of more people using state-of-the-art, expensive, treatments and services.

Group-Specific Medical/Health Factor

A carrier may adjust renewal rates based on the overall health of the individuals covered under your health plan, depending on state regulations. The premiums can be adjusted to cover the cost of expected future claims. Based on your state regulations, some rate caps may exist that limit the amount an insurer can raise premiums based on your group’s health status alone.

More often than not, carriers use a “prospective” system where they look at medical conditions and diagnoses, which may affect the group’s amount of claims in the coming year. Under this system, resolved claims from the past year are not taken into account.

The renewal adjustment can also be positively impacted by the overall good health of the group being evaluated.

Group-Specific Characteristic/ Demographic Profile

This component includes:

1. Changes in age brackets (For example, an employee or spouse turns 50, moving them from the 45-49 bracket to the 50-54 bracket.)
2. Gender and coverage composition changes (This reflects changes in the percentage of females versus males; or changes in the mix of single and family contracts.)
3. Changes in the group’s geographical location (Rates may change if the company moves to a new locale.)

Group-Specific Administrative Expenses

This factor involves the fixed costs that are necessary to administer the plan. The smaller the group, the higher the expense load. To clarify, a three-person group would have a larger expense load, as a percentage of premiums, than a 30-person group.

Given all of these factors, is there anything you can do to reduce the costs? Consider adjusting your plan design and/or premium contribution to support the most efficient utilization of health care options. Also, encourage employees to become smarter health-care consumers. Communicate with your employees so they understand their benefits, and spend some time promoting prevention and wellness programs.

Help Your Employees Gain a Healthy Understanding of HSAs

As more and more employers offer HSAs as part of their health plan mix, they need to make certain that employees understand how to use the plans. Additionally, the goal should be to help employees form a positive perception of HSAs.

Some of the reasons to consider an HSA that an employer may want to highlight are:

- health care costs continue to rise rapidly;
- the increasing share of company funds allocated to health care represents funds not spent on product innovation, capital investment, and other corporate and employee needs; and
- increased employee involvement in how health care dollars are

spent can lead to better health care decision-making by employees, along with improved overall cost containment.

Complementing such educational messages should be communications that describe the direct advantages of an HSA to the employee:

- HSAs provide flexibility. They allow the employee to decide how to spend their health care dollars. Health care expenses typically not covered by the primary health plan—such as vision, dental, and orthodontic expenses—can be paid from the HSA.
- HSAs allow employees to control their health care dollars. So, provided that the IRS has defined an expense as payable from an HSA (and the employer sponsoring the HSA has not decided

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We All Need to Fight the Epidemic of Health Care Fraud

In 2007, health care expenditures in the United States hit approximately \$2.6 trillion, according to the Centers for Medicare and Medicaid Services. Estimates put the portion of this outlay that is attributable to health care fraud—payment for nonexistent, exaggerated, or ineligible services—at anywhere from 3% to 10%, according to the National Health Care Anti-Fraud Association (NHCAA).

Health care fraud comes in many different shapes and sizes. Perpetrators include patients, providers, as well as individuals or groups with no connection to the health care system.

Organizations such as the NHCAA emphasize that, while the vast majority of doctors, hospitals, therapists, etc., are honest and submit valid billings, most cases of health care fraud do originate with providers. The types of health care fraud seen from providers include:

- Billing for services that were never actually provided to the patient;
- Falsifying a diagnosis;
- Upcoding, or billing for a more expensive service, treatment, or procedure than the one that was actually performed;
- Recoding, or billing for a different treatment or procedure than the one actually provided (for example, the service actually provided is a nose job, which is considered a cosmetic procedure and not covered under the plan; but the provider codes it as a repair to the septum, which would be covered);
- Performing unnecessary tests and/or procedures (e.g., diagnostic tests);
- Unbundling services that are part of one procedure and billing for each separately; and
- Billing for the entire cost of a service when partial payment (such as a copayment) has been collected from the patient.

Patients commit health care fraud by listing and filing claims for ineligible dependents; sharing health plan identification cards; filing claims for services they never received; altering or forging bills and receipts; and buying and re-selling prescription medications.

Health care fraud can also be perpetrated by individuals or groups posing as providers who, using stolen or “purchased” patient

insurance information and provider billing numbers, submit bills for services from a fictional clinic. Or, they may pose as providers in order to obtain other individuals’ legitimate health insurance information, and then use the information for themselves, or even sell it.

While health care fraud adds to costs, it also carries a price tag that is not financial. Patients undergoing unnecessary procedures, testing, or drug therapies face risks to their health. Phony or inflated diagnoses result in inaccurate patient medical records, which can complicate later treatment. Amounts paid on fraudulent claims may result in an insured reaching a dollar-amount or number-of-visits maximum under a policy when seeking coverage for later, legitimate claims.

Industry groups, insurance companies, and state and federal governments have become increasingly proactive in their efforts to prevent, detect, and punish instances of health care fraud. The Health Insurance Portability and Accountability Act (HIPAA) established health care fraud as a federal criminal offense. HIPAA provides for financial penalties as well as imprisonment for up to ten years for health care fraud convictions, with longer sentences if the fraud results in patient injury or death. Many state insurance departments require anti-fraud efforts by the insurers or HMOs that operate in their states. Insurers and HMOs staff dedicated investigative units that use computer technology, patient education, and solid communications with other insurers and law enforcement to battle health care fraud. The NHCAA offers a professional certification—the Accredited Health Care Fraud Investigator—to those that complete a training course.

It is in the best interest of every business and individual to do what it can to prevent health care fraud. Not only does fraud contribute to the overall rate of health care cost increases, it affects your rates at renewal. Talk with your health insurance provider about their anti-fraud efforts, and help your employees become attuned to what they can do to avoid becoming an unwitting participant in a health care fraud scheme (e.g., safeguarding their health insurance ID cards and insurance information; being wary of offers for “free” services; examining explanation of benefits (EOB) statements for accuracy).

These efforts, at a grassroots level, do make a difference.

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to narrow this definition by plan design), employees can opt to use the HSA to pay for the expense, without regard to health plan authorization requirements or other limitations.

- Unused dollars contributed to the HSA roll over into subsequent years, and the account earns interest. In other words, there are no “use it or lose it” rules for HSAs. These features increase the opportunity for the account to grow, generating a nestegg for future health care expenses, even into retirement.
- HSAs are portable, meaning that employees continue to enjoy their coverage even if they leave the sponsoring employer, change medical coverage, change their marital status, or move to another state.

- HSAs offer considerable tax savings: employer contributions are not considered part of the employee’s gross income, employee contributions can be made on a pre-tax basis (or are deductible if made with after-tax dollars), and withdrawals used for permitted health care expenses are tax-free.

Taking the time to explain HSA options—through a thoughtful consideration of the overall health plan design and through clear and concise communications to employees—enhances the likelihood that the plan will meet employer goals and be accepted, enthusiastically, by employees.

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Effective 2014

- **Employer Coverage Mandates.** Employers with 50 or more employees who do not offer employee health coverage will pay \$2,000 annually for each full-time employee, excluding the first 30 full-time employees. The penalty is increased to \$3,000 for any full-time employee receiving a federal tax credit for coverage, because his or her employer health coverage is considered "unaffordable." Coverage is considered "unaffordable" where the employee contributes more than 9.8 percent of his or her income, or the employer contributes less than 60 percent of the actuarial value of the plan.
- **Insurance Exchanges.** Exchanges are created at the state level starting in 2014, where individuals and small employers can shop for health coverage. Initially, the exchanges would be available to individuals and small groups (less than 100 employees), unless the state opts to cover only groups with up to 50 employees. Starting in 2017, states could open the exchanges to larger groups.
- **Wellness Programs.** Employers can offer larger rewards, up to 30% of the cost of coverage, to employees for participation in a wellness program or for meeting certain health-related goals.

- **Individual Tax Credits.** Credits are available for people with incomes up to 400 percent of the poverty level for insurance purchased through an exchange.
- **Health Plan Changes.** 1) Insurers cannot refuse to issue coverage on any individual due to pre-existing conditions. 2) Higher rates cannot be charged to any individual based on health status, gender or other demographic factors. 3) Coverage cannot be non-renewed or dropped because an individual participates in a clinical trial.

Effective 2018

- **High Value Plan Excise Tax.** A nondeductible excise tax of 40 percent is imposed on any health insurance plan with combined annual employer/employee premiums exceeding \$10,200 for individual coverage and \$27,500 for family coverage. The tax would only apply to premiums in excess of the threshold.



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330 Passaic Ave, Ste. 200
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