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This Just In

A group of large retailers has filed suit in federal court to stop implementation of Maryland's "Wal-Mart Law." The Maryland legislature passed a bill to require all employers with more than 10,000 employees in the state to spend at least 8 percent of their payroll on healthcare for employees or put the money directly into the state's health program for the poor. A similar measure was passed in Suffolk County, New York. The Retail Industry Leaders Association has filed suit in both locations, arguing the laws illegally pre-empt ERISA, the federal law that governs qualified benefit plans.

Vermont has become the second state to mandate near-universal health coverage. Gov. James Douglas signed a bill in late May that would extend coverage to as many as 96 percent of the state's residents by 2010. The new plan, called Catamount Health, will be offered by private insurers beginning on July 1, 2007. State subsidies will be available for the previously uninsured, paid in part by cigarette taxes and a fee on employers that do not provide employee health coverage.

Between January 2005 and January 2006, the number of enrollees and dependents covered by a consumer-directed health plan nearly doubled, according to a report by the Government Accountability Office. Consumer-directed health plans usually link a high-deductible health plan (HDHP) with a health reimbursement or health savings account. Which is right for your firm? See the article on this page for more information.

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Health Benefits

HSAs, HRAs, MSAs & FSAs–Which is Best for YOU?

Is your business considering moving toward a consumer-directed healthcare plan to control employee healthcare costs? You are not alone. Thirty-eight percent of employers want to offer consumer-directed health plans during 2006, according to the Employee Benefit News/ Forrester Research 2005 Benefits Strategy and Technology Study. Only 25 percent had offered these plans by the end of 2004. At that time, the plans were most popular among smaller employers (with fewer than 250 employees) and retailers—two industry sectors that are less likely to provide health benefits than others.

In general, a consumer-directed plan gives employees greater incentive to control their medical costs by providing them with a special account to pay healthcare costs. The types of consumer-directed accounts available include:

HSAs – Health Savings Accounts are tax-sheltered accounts from which consumers may pay HSA-specific qualified medical expenses. In order to enroll in an HSA, an individual must have a qualified high-deductible health plan, or HDHP. An employer can buy HDHPs for employees, or employees may buy coverage on an individual basis. HSAs may be funded by contributions from employers, employees or both. An HSA must be held at a qualified financial institution. Employees retain control of their HSA accounts. Unspent balances roll over from year to year and follow the employee to subsequent employers.

If you elect to contribute to employees' HSAs, you may contribute an amount up to the HDHP deductible, subject to certain restrictions. For employees age 55 or older, you may contribute an additional "catch up contribution" of $700 in 2006. The IRS considers employers' contributions to an HSA qualified medical benefits, so they are excluded from employees' gross income.

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Benefits Administration

How the Uninsured Cost Us All

The Kaiser Family Foundation tells us that 18 percent of non-elderly Americans, or 45.5 million people, lack health insurance. If you include people who lack coverage for short periods, the number goes even higher—the Kaiser Commission recently found that some 30 percent of Americans lacked health insurance for at least one month during a three-year period.

The costs to employers

There are two types of uninsured Americans, those who want to be and those who must be. Often, young, healthy Americans don't see the need to pay health insurance premiums and opt not to participate in an employer's plan. This distorts the system, leaving only older, often sicker individuals to carry the load. And having a higher percentage of older, sicker individuals in your plan drives up claims…and eventually premiums.

Even the uninsured require medical services, however. The Kaiser Family Foundation estimated the cost of unpaid care among the uninsured at almost $125 billion in 2004. And who pays for these services? Insured employers end up footing the bill, as providers pass along their unreimbursed costs to those with insurance, forcing premiums still higher.

The costs to individuals

Lack of health insurance has the greatest impact on the uninsured themselves. The Kaiser Family Foundation reports that 18,000 Americans die prematurely each year because they lack health coverage. Several factors account for this. First, the uninsured receive fewer preventive services that can detect serious conditions, such as cancer. The uninsured are therefore more likely to receive a diagnosis when the disease has progressed and become more difficult to treat. For example, uninsured women are 40 to 50 percent more likely to die of breast cancer than the insured.

One-third of the uninsured have a serious problem paying medical bills. As a result, they often delay treatment or neglect to take care of chronic conditions, such as diabetes.

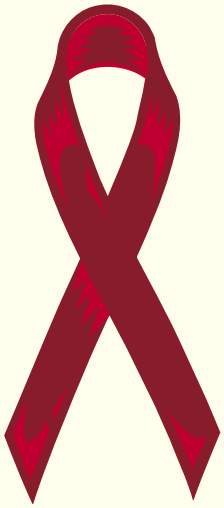
Being uninsured can cause a lot of stress as well. A 2003 study found that more than one-third (34 percent) of the uninsured ranked medical bills as a major source of stress in their lives, versus 13 percent among the insured. Although it would be nearly impossible to quantify the cost of this stress, research has long proven the link between stress and poorer health.

Lacking health insurance impacts other areas of life for the uninsured. Although even 25 percent of those with insurance have either delayed or decided not to get care due to costs, that number increased to 53 percent among those who lacked insurance for part of the year.

The bottom line is that lack of health insurance costs more than dollars and cents. Lowered and lost productivity due to poor health is difficult to identify, and often goes unseen. The uninsured pay more for each individual health service they receive, so the costs quickly outstrip their ability to pay. In serious cases, their heath deteriorates, removing them from the workplace and productive life. ❑

Wellness

Workplace Cancer Campaigns



Several leading pharmaceutical companies are helping their employees avoid and fight cancer, and they want other employers to do the same. Johnson & Johnson, AstraZeneca, OSI Pharmaceuticals, Novartis AG and GlaxoSmithKlinePLC have joined forces to form the CEO Cancer Gold Standard.

The program establishes strict guidelines for certification. Employers must promote healthy lifestyles among their employees and lower barriers to diagnostic and therapeutic tests.

Participating companies offer free smoking cessation classes and medicine to employees while banning smoking on company worksites. Menus in company cafeterias are overhauled with weight reduction and nutrition in mind. Employees are encouraged and aided in getting exercise. Should an employee be diagnosed with cancer, the companies subsidize the employee's participation in clinical trials.

Employees are offered a free health assessment, and those who take advantage of the offer receive a discount on benefits. Employers benefit by having a healthier workforce, resulting in lower healthcare costs. Employers can find details about the program at www.cancergoldstandard.org. ❑

Retirement

Phased Retirement: Inching Your Way Out the Door

The AARP recently published a study of phased retirement, and its findings may point to some interesting opportunities for employers. Phased retirement is when a worker slowly cuts back on work time and obligations in preparation for full retirement.

The study found that current phased retirees were largely well-educated, financially secure workers in management positions. Since phased retirement is not an official program, but seems to evolve on a case-by-case basis, this is not surprising.

Interest in phased retirement is likely to increase over the next decade or so. Most employers will face a demographic shift as baby-boomers retire and the next generation moves into management. Because many companies downsized during the '80s and '90s, those who would have become the next generation of leaders were exiled to other fields. Many employers are now expecting gaps of 15 to 20 years between the time the boomer generation leaves and younger workers are ready to enter senior management positions.

The large gap means a whole generation of institutional memory will be out fishing when the relatively young manager needs to ask a question. Phased retirement will allow companies to ease into a well-planned succession program.

Benefit implications

Although employers have many reasons for wanting to keep productive older employees in the workforce, phased retirement can raise some administrative hurdles. These include:

Pension distributions. IRS regulations prohibit defined benefit plans from making inservice distributions to participants younger than normal retirement age. This could discourage many employees who would otherwise be interested in phased retirement from pursuing it. Regulations proposed in late 2004 would establish requirements for a bona fide phased retirement program and permit employees to receive distributions from a qualified pension plan under a phased retirement program. Although the IRS Web site says these regulations remain a "high priority" for IRS and Treasury, final regulations had not been implemented at press time.

Defined contribution plans, such as 401(k)s, also generally prohibit early withdrawals. Employees who withdraw money from a 401(k) plan before turning 59½ will owe income taxes on the amount of the withdrawal and (usually) an early withdrawal penalty of 10 percent on the amount of the withdrawal. Some 401(k)s do allow active employees to borrow from their plan or to make hardship withdrawals. If you're considering offering employees a phased retirement, have them discuss the retirement plan implications with their financial advisor.

Healthcare benefits. Healthcare benefits can be another stumbling block to phased retirement. Those who retire at the "traditional" age of 65 become eligible for Medicare. But what happens to younger workers who cut back on hours and no longer qualify for coverage under your group health plan? Health Savings Accounts (HSAs) or other plans that allow employees to save for retirement health costs could make phased retirement a more attractive option for some of these workers.

For more information on structuring retirement benefits appropriate for your workforce, please call us. ❑

Benefits Administration

DeMinimis Benefits: Little Perks that are not Taxing

Want to give your employees something to smile about? A little section of the IRS code allows for something called de minimis fringe benefits. De minimis benefits are occasional small gestures, such as buying the office lunch, bringing a birthday cake in for an employee's birthday, or the occasional dozen doughnuts. The key is that the value of such benefits is small—so small in fact, that determining the fair market value of the benefit is more trouble than its worth, to you or the IRS. De minimis benefits do not count towards an employee's taxable income.

The de minimis rule exists for "administrative convenience," but should not be abused. IRS regulations make it clear that season tickets to the local ball team or providing a company vehicle more than one day a month exceed the de minimis limit. The IRS would consider this type of benefit includible in the employee's taxable income.

Psychologically, the occasional perk can be more effective than an everyday benefit. Employees are surprised, feel that the perk is special and appreciate it more. ❑

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HRAs – Health reimbursement arrangements are employer-funded accounts from which employees can receive reimbursement for qualified medical expenses, as specified in the plan documents. Employers can use HRAs to reimburse a variety of expenses not covered by a group health plan, including employee contributions toward premiums, dependent coverage, long-term care, policy deductibles or co-pays. HRAs will work with any health plan, not just HDHPs, and give employers more control over employee health spending than do HSAs. For example, employers can specify what types of expenses an HRA will reimburse. They can also opt to limit the amount of unspent funds employees can roll over from one year to another. And any unused balances revert to the employer when an employee leaves the company.

Only employers may contribute to an HRA. These contributions are tax-free, with no maximum, although employers usually set their contributions below the annual deductible of the accompanying health insurance.

MSAs – Medical Savings Accounts—or more precisely Archer Medical Savings Accounts—are HSAs for small employers and the self-employed. Only individuals enrolled prior to December 31, 2005 can participate in an MSA. Employers or employees may make contributions to MSAs, but not both during the same year. Individuals enrolled in an MSA must have an HDHP.

The legislation enabling the Archer MSA program expired on December 31, 2005. Individuals eligible prior to that date may continue with their Archer MSA or roll funds from their Archer MSA into an HSA.

FSAs – Flexible Spending Accounts are also known as Section 125 plans after the part of the Internal Revenue Code that authorizes them. Employees generally fund FSAs through a salary reduction agreement, but employers may also make contributions. Employees can use funds in their FSAs for specified expenses, such as health expenses or dependent care expenses. Unlike HRAs, FSAs are "use it or lose it" plans. This means that although employees determine how much of their salary to defer into an FSA, anything left at the end of the year goes to the employer to cover administrative costs. Self-employed people are not eligible for FSAs.

Employers can use FSAs and HRAs in conjunction with any health plan. But HSAs and MSAs require participating individuals to be covered by an HDHP. To determine which type of consumer-directed plan is right for your company, determine whether you want to offer employees an HDHP or a more traditional health insurance plan, such as an indemnity or preferred provider organization (PPO) plan. Generally, HDHP premiums are lower, but they also offer more limited coverage. And some employers worry that consumers often don't have access to the information they need to make informed healthcare choices. In response, some insurers are starting to provide more information on the prices they negotiate with healthcare providers, or price ranges for certain procedures in a geographical area.

For more information on HDHPs, please see the text box below. ❑

What is a High-Deductible Health Plan?

To participate in a Health Savings Account, an individual or family must have a high-deductible health plan (HDHP) that meets certain requirements. Archer Medical Savings Accounts have different requirements for HDHPs. For specifics on HDHPs for MSAs, please call us.

For individuals, a health plan qualifies as an HSA-eligible HDHP if it has a deductible of at least $1,050 and it has a maximum annual out of pocket in-network expense of $5,250. For family coverage, those figures are $2,100 and $10,500. Employers and employees covered by HDHPs can contribute up to the annual deductible amount, to a maximum of $2,700 for individuals or $5,450 for families, into an HSA.

Optional items. Ordinarily, an HDHP requires participants to meet the plan's deductible before it begins paying benefits. However, HDHP plans may cover specific preventive treatments with low or no deductible to encourage insureds not to postpone preventive care. When participants receive specified preventive care services, such as an annual physical, they will pay a small deductible or a co-payment rather than having the cost apply toward the deductible.

A maximum dollar amount can also apply to preventive services. This means that once an insured pays the out-of-pocket maximum—say $500—for preventive services, he or she will no longer have to pay when receiving preventive care. Applicable preventive treatments include screening for cancer, heart and vascular diseases; infectious diseases; mental health conditions; substance abuse; metabolic, nutritional and endocrine conditions; muscoloskeletal disorders; OB-GYN conditions; pediatric conditions; and hearing and vision disorders.

Other insurance. Generally, HDHPs do not play well with other health plans. Insureds may not have a PPO or other major medical-type plan along with an HDHP. Having a medical FSA may also disqualify you from having an HSA, unless the FSA is strictly limited to covering expenses permitted by the HSA. HDHPs do not interfere with workers' compensation, tort liabilities or medical payments from automobile insurance and similar property coverages. Additionally, policies covering specific diseases, such as cancer insurance or "dread disease" coverage, or those that provide a per diem benefit for hospital stays, create no conflicts. Similarly, accident, disability, dental, vision and long-term care insurances do not affect an employee's eligibility for an HDHP.

Generally, young healthy people will fare better under HDHP/HSA programs. After all, they are geared toward healthy people to encourage them to contribute premium dollars to the system. Older, not-so-healthy individuals will not benefit as much from an HDHP/HSA. However, premium hikes could increase these plans' appeal to older workers, particularly since they can use HSA funds to pay post-retirement medical expenses. ❑