Employee Benefits Report

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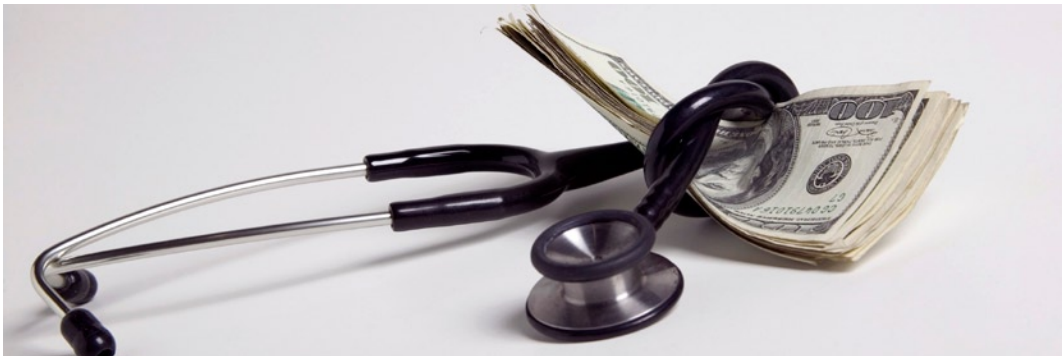
The Pros and Cons of Flexible Spending Accounts



At first glance, healthcare Flexible Spending Accounts (FSAs) sound great: employees can fund accounts through salary reduction and can withdraw funds at will to pay for medical bills. There is no statutory maximum contribution, and funds set aside escape both income and Social Security taxes. Some flexible spending accounts even cover childcare expenses.

About 85 percent of large companies (with 500 or more employees) offer flexible spending accounts, but only 22 percent of eligible employees took advantage of the benefit, according to a recent Mercer Survey.

Why so low? Many employees are wary of the one big FSA drawback: If they deposit more than they spend on qualified expenses in these accounts, they forfeit the unused funds. Although the number of times this actually happens is small — only about four percent of employees lose money, the rule is still a deterrent, according to an article in *The New York Times*.

To soften the blow, some companies and employees are taking advantage of a two-and-a-half month grace period that the IRS has implemented for end-of-year expenses.

This use-it-or-lose-it aspect makes FSAs a gamble but not a bad bet. It simply means that employees have to be vigilant on account balances and employers must be better at communicating the rules of FSAs.

If your company doesn't provide health care insurance or if you do provide coverage but you're faced with increasing deductibles, co-pays or out-of-pocket expenses, flexible spending accounts can help you increase the value of your benefits program.

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This Just In

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), signed in February, reauthorizes the CHIP program through Fiscal Year 2013. It will affect employer group plans by giving CHIP and Medicaid-eligible dependents special enrollment rights and expanding employers' notice requirements.

Beginning April 1, CHIPRA requires group health plans to allow eligible employees and/or dependents to enroll for coverage if (1) they lost eligibility for Medicaid or CHIP coverage and request coverage under the group health plan within 60 days after such termination; or (2) they become eligible for Medicaid or CHIP assistance and request coverage within 60 days after the eligibility determination date.

CHIPRA allows states to subsidize premiums for CHIP or Medicaid-eligible children enrolled in their parent's employer group plan. The child or parent must elect to receive the subsidy. Employers can opt out of receiving subsidies directly, in which event the state shall pay the employee.

Employers must provide employees notice of their enrollment rights after the Departments of Labor and Health and Human Services develop a model notice. The Act imposes a deadline of Feb. 4, 2010 for the creation of this notice.

Employers Look at On-Site & Retail Healthcare Clinics to Keep Costs Down

Visit any major corporation these days and chances are you'll find an on-site primary care and occupational health facility staffed with any number of physicians, nurse practitioners, medical assistants, physical therapists, practice administrators, case managers and administrative personnel.

A recent study by the Washington Business Group of 120 organizations with more than 1,000 employees found that of companies with on-site medical clinics:

- 68 percent say that the facilities effectively improve employee health;
- 59 percent say that the facilities manage costs effectively;
- 56 percent say that the facilities effectively improve employee satisfaction;
- 54 percent say that the facilities effectively increase employee productivity.

On-site healthcare facilities will likely continue to increase in popularity as firms run out of short-term options for cutting health care costs, such as restructuring benefit plans and shifting costs to employees. And while on-site facilities might make sense for larger employers, what can the smaller ones do?

Retail healthcare

Smaller businesses, particularly those in major metropolitan areas, now have an alternative to hosting their own medical clinic: the local retail clinic around the corner, and increasingly, inside big box stores like Wal-Mart, CVS and Target.

Retail-based medical clinics have attracted a lot of attention since they emerged a few years ago. The clinical care and business models vary by operator and location, but all have a common value proposition: They offer consumers a limited menu of simple health services within a walk-in retail environment. The journal *Health Affairs* reported last year that there were about 1,000 clinics in 37 states, which accounted for almost 3 million office visits.

In addition to increased access (convenient locations, expanded hours and no appointments required), retail medical clinics offered medical services at lower prices than other outlets. A study in *Health Affairs* examined office visits for the five conditions most frequently treated at a chain of retail clinics in the Minneapolis/St. Paul area, versus cost of treatment at other outlets. The study found that getting treatment at a MinuteClinic cost an average of $104, a savings of $51 from the cost of urgent care, $55 less than visiting a physician's office, and a whopping $279 less than treatment in an emergency room. (Interestingly, in contrast to what you might expect, the study also found that other medical providers in the area did not lower their rates in response to competition from MinuteClinic. In fact, cost of treating the five conditions studied rose 14.1 percent during the four-year study period. The study's author attributed this to other providers raising their charges to make up for lost revenue.)

The first retail clinics asked consumers to pay 100 percent of the cost of their visits, so insurers were not involved in the equation. As attracted as insurers were by the potential cost savings, many were nervous that clinics would increase their subscribers' total health care visits, rather than acting as a cheaper substitute for care they would have received elsewhere, according to a report by the California HealthCare Foundation.

Once it was clear from initial usage patterns that the clinics did not appear to increase overall demand for medical services, insurers were sufficiently encouraged to begin covering retail clinic services.

Clinic operators, however, didn't initially accept insurance because the claims process is expensive for the provider. Billings-related expenses account for about 30 percent of the operating costs of a physician's practice (this includes staffing, documentation, IT, delays in accounts receivable and unpaid claims). The economics of in-store clinics cannot support such overhead.

But in 2004, a retail clinic in Minneapolis began working with certain plans to find an approach that made sense for the retail clinic model. The plans changed their pa-

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Pro and cons for employers

Employers have much to love about FSAs. Because employees fund their accounts with the decreased employee taxable income lowers employers' expenditures for FICA, unemployment insurance, workers' compensation and other wage-based benefits. The savings on payroll taxes typically offsets the cost for administration, and you can earn interest on account balances. And while employers may contribute to employees' accounts, they don't have to.

On the flip side, the FSA "at risk" provision requires that you reimburse an employee for incurred eligible expenses up to the full amount that he or she has elected to set aside during the plan year — regardless of how much he or she has actually contributed up to that point. For example, let's say an employee has elected to contribute $2,400 for the plan year and incurs $2,400 of eligible expenses at the end of the second month. At this point, the employee has only contributed $400 to his account, yet he is entitled to $2,400 in reimbursement. If the employee remains with your organization, he will contribute the remaining $2,000 by year's end. However, he has no repayment obligation if he leaves his job before the end of the year.

It all may break even because an employee who leaves in the course of the year without having spent all of what he has contributed to his account relinquishes the balance, unless he continues participating through COBRA. Employees also forfeit to their employers any unspent amounts left in their accounts at the end of the year.

Apart from the offsetting tax savings, you can cap your company's liability by limiting the amount that employees set aside. Some employers use a two-tiered limit: Limiting first-year participants to $1,000, for example, while they become accustomed to the program, and then capping future participation at a higher amount, say $3,000.

What about smaller employers?

The U.S. Bureau of Labor Statistics reported that as of 2006, about 8 percent of those employed by smaller employers were eligible for FSAs. (More professional and technical employees at smaller employees had access to these plans, about 14 percent.) Despite their advantages, many small employers fear the administrative burdens of an FSA will outweigh any benefits.

The IRS requirement that FSAs "substantiate" expenses before reimbursing them poses an administrative challenge to smaller employers. New developments, such as debit cards linked to employees' FSAs that employees can use at specific health care providers, can make administration a bit easier. In addition, some health insurers will provide FSA administration services for employer groups of at least 200. You can also contract with third-party administrators that can administer your program and pay claims.

Still, for some smaller employers, the Health Savings Account linked to a high-deductible health plan (HDHP) might offer similar tax advantages with fewer administrative hassles for employee health benefits. You may want to reserve FSAs for transportation or dependent care costs.

Bottom line

If you decide to implement an FSA plan, be prepared to engage in active administration or outsource these functions, and to educate employees for maximum participation and fewer disappointments.

For more information on FSAs, HSAs and other healthcare arrangements, please contact us. ■

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per- and people-intensive process (including multiple claims rejections and negotiated fees) to a radically simplified system: 100 percent payment for 100 percent of claims within 10 to 14 days.

About 40 percent of retail medical clinics now accept insurance. Check with your insurer to see if you can work with a retail clinic in your area. If you can, be sure to educate employees on this new benefit. Many clinics offer preventive services, such as vaccinations, at less cost than a physician's office. And encouraging employees to visit their local clinic for urgent, non-emergency care rather than going to the emergency room can save your health plan a lot of money, while employees get the care they need faster and with less hassle. ■

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responsibility of influencing treatment decisions due to plan selection or sponsorship.

Benefit gap

Dental insurance benefits under many plans have remained at the same level for more than two decades, leaving patients to pick up any remaining costs out-of-pocket. In recent years, payment options have emerged to help patients bridge the gap between what their insurance covers and the total cost of care. Some plans now offer features similar to cell phone payment plans, allowing members to roll over unused benefits or to share benefits with other insured family members. With many plans having annual benefit limits as low as $1,000 per individual or $3,000 per family, benefit-sharing features help employees and dependents who need extensive dental care get the care they need.

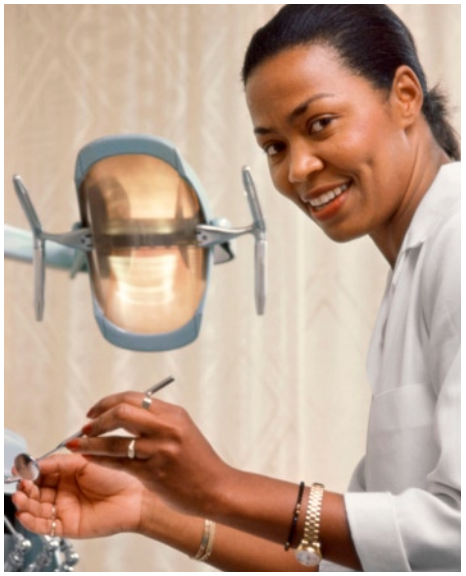
Welcome changes

Many dental insurers have also incorporated consumer-directed health features into their benefit designs, such as tiered networks or consumer decision-support tools. Look for online tools that allow enrollees to calculate how much they spend on dental benefits each year in order to estimate needed contributions into a health savings account.

Employers that provide dental coverage have found it to be a very popular benefit – one people actually use. It's visible, it's valued, and the price is right. ■

Flexibility Makes Dental Benefits a Worthy Option

Dental health coverage is the second most requested benefit — right behind medical insurance. Yet many companies have been canceling dental plans to cut costs, even though dental health insurance costs about one-tenth of what medical insurance does. Before canceling a dental plan, consider selecting another model that may keep your costs down and your employees satisfied.



According to the National Association of Dental Plans (NADP), about 20 percent of dental enrollees are covered by a voluntary plan, in which the participating employees pay all the premiums or fees, not the employer. Voluntary dental plans allow companies to offer benefits at group rates, with reduced (or no) employer contribution.

Dental Plans Galore

There are a number of models of dental plans, generally divided into two categories: managed care and fee-for-service. *Managed care* dental plans are cost-containment programs that generally restrict the type, level and frequency of treatment. They provide limited access to care and control the level of reimbursement for services. *Fee-for-service* dental plans are typically freedom-of-choice arrangements under which a dentist is paid for each service rendered according to the fees established by the dentist. Here are some more details:

Preferred Provider Organization (PPO) programs are managed care plans that allow patients to select a dentist from a network of providers who have agreed, by contract, to discount their fees. If patients go outside the network they may face higher deductibles and co-payments. The good news for employers is that PPOs can be fully insured or self-insured, so you have full funding flexibility. PPOs are usually less expensive than comparable fee-for-service plans and are regulated under the appropriate insurance statutes in the company's state of domicile and operation.

Dental Health Maintenance Organizations (DHMOs) pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless of how much dental care they provide. In return, the dentists agree to provide specific types of treatment to the patient at no charge (for other treatments, a co-payment is required). Theoretically, the DHMO rewards dentists who keep patients in good health, thereby keeping costs low. DHMO models typically offer the least expensive dental plans.

Direct Reimbursement (DR) is a self-funded dental benefits plan that reimburses patients according to *dollars spent* on dental care, not type of treatment received. It allows the patient complete freedom to choose any dentist. Instead of paying monthly insurance premiums, even for employees who don't use a dentist, employers pay a percentage of actual treatments received. Moreover, employers are removed from the potential

DENTAL—continued on Page 3

COBRA Expansion Effective March 1

The federal stimulus package signed in February, the American Recovery and Reinvestment Act of 2009 (ARRA), will affect COBRA benefits. Changes went into effect on March 1 for most plans.

First, the bill will subsidize 65 percent of the cost of COBRA continuation coverage for up to nine months for "assistance eligible individuals." These are people who lost their jobs between September 1, 2008 and December 31, 2009 for reasons other than gross misconduct, and who have a modified gross adjustable income of less than $125,000 if single, or $250,000 if married, for each year in which the subsidy is received. Eligible individuals already receiving COBRA coverage will not get a rebate; however, they will begin receiving the subsidy in March.

Second, the bill gives eligible individuals who did not enroll in COBRA when they first qualified another 60 days in which to apply. Employers, or their health plan providers, must notify eligible individuals by March 1.

Third, employers can offer assistance-eligible individuals the option to enroll in any other health plan they offer their active employees, as long as premiums are less than the COBRA coverage. The provision applies to health plans only and specifically excludes health care FSAs, most HRAs and on-site medical clinics.

Finally, the bill would extend the maximum COBRA coverage period to 24 months for individuals receiving a health care tax credit (HCTC) because they lost their job due to foreign competition and are eligible for trade adjustment assistance (TAA).

Under the subsidy arrangement, employers will pay the 65 percent share of COBRA premiums and receive an offset in their employment tax deposits. They will report the amount of the subsidy and number of recipients on a revised IRS Form 941.

Many employers fear the COBRA expansion will increase their healthcare costs, since less-healthy individuals are more likely to elect coverage, driving up utilization rates. Others are more likely to use their benefits to the maximum, knowing that their coverage is limited. It also increases plan sponsors' administrative duties. For more information, please call us. ■