

Employee Benefits Report

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Health Benefits

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How Do Your Company's Benefits Compare?

The Patient Protection and Affordable Care Act requires the Secretary of Labor to “conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers.” The first report, published in April 2011, provides employers with a valuable tool for benchmarking their employee health benefits.



Following are some of the most relevant statistics from the report, which used data from 2008 and 2009.

Most common plan types, among employees covered by an employer health plan:

- ★ 79 percent covered by a fee-for-service arrangement.
- ★ 21 percent covered by health maintenance organization (HMO)

This Just In...

Starting in 2014, § 4980H of the Patient Protection and Affordable Care Act will require an “applicable large employer” to offer its full-time employees (and their dependents) the opportunity to enroll in an affordable employer-sponsored health plan providing minimum essential coverage (MEC). Employers that fail to enroll full-time employees in a plan, or fail to offer a plan that’s affordable, will have to pay an annual assessment.

The definition of full-time employee is key in determining whether and, if so, to what extent, an employer may incur liability for providing healthcare. The IRS has invited the public to submit comments on a number of pos-

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Most of those in fee-for-service plans were in the sub-category of preferred provider organizations (PPOs), where enrollees are provided medical services at a higher level of reimbursement if they receive care from designated providers.

Cost-sharing features:

- ★ Deductibles: 93 percent of employees covered by a fee-for-service plan had services subject to a deductible.
- ★ Median annual deductible: \$500 per person, for plans not having or not specifying varying deductibles.
- ★ Median annual deductible, for plans specifying varying deductibles: \$1,000 per person for out-of-network care; \$500 per person for in-network care.
- ★ Coinsurance, for in-network services: 80 percent.
- ★ Coinsurance, for out-of-network services: 60 percent.
- ★ Out-of-pocket maximum: \$1,900 per individual.

Hospital/surgical/medical benefits:

- ★ Hospital room and board: 99 percent of participants covered. Only 7 percent of fee-for-service and 29 percent of HMO plans covered in full; most plans had a copayment with a median amount of \$250 per admission.
- ★ Surgical procedures: 99 percent of participants covered. Among fee-for-service plans, 90 percent of participants had limits on this coverage, while the remainder had charges covered in full for inpatient and outpatient surgery. Among HMO participants, 54 percent had full coverage for inpatient surgery, with the remainder subject to limits such as copayments. In contrast, one-third of HMO participants had full coverage for outpatient surgery. When plans subjected outpatient surgery to a copayment, the median was \$50 per visit in fee-for-service plans and \$75 per visit in HMOs.
- ★ Physician office visits: 100 percent of participants had coverage; however, 97 percent had limits on their coverage, most often a copayment. The median copayment for a physician office visit was

sible rules, definitions and approaches for interpreting and applying § 4980H. Section III of the notice, Notice 2011-36, addresses potential definitions of employer, employee and hours of service.

The law defines a large employer as one who employed an average of at least 50 full-time employees on business days during the preceding calendar year. § 4980H(c)(4) provides that a full-time employee with respect to any month is an employee who is employed on average at least 30 hours of service per week.

\$20 in a fee-for-service plan and \$15 in an HMO.

Hospital alternatives:

- ★ Skilled nursing facility: 70 percent of participants had coverage, with a median day limit of 90 days per admission.
- ★ Home healthcare: 73 percent, with a median day limit of 100 days per year.
- ★ Hospice care: 67 percent had coverage.

Preventive care services:

- ★ Adult physical exams: 80 percent of participants had coverage.
- ★ Well baby care: 77 percent had coverage.
- ★ Adult immunizations and inoculations: 56 percent had coverage.

Prescription drugs (outpatient):

- ★ 79 percent of plan participants could receive ongoing maintenance drugs through a mail-order program. The median copayment for generic drugs was \$10 per prescription; the median copayment for brand-name drugs was \$25 per prescription.

Mental health/substance abuse treatment:

- ★ Inpatient mental health and substance abuse detoxification: 99 percent of fee-for-service plan participants and 98 percent of HMO participants had coverage.

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- ✦ Inpatient substance abuse rehabilitation: 78 percent of participants had coverage.
- ✦ Outpatient mental health care: 85 percent of participants had coverage; outpatient substance abuse rehabilitation is covered for 79 percent of participants.

This coverage is nearly always subject to limits, including overall plan limits. There is also frequently a limit imposed on the number of days of mental health and substance abuse coverage; the median limit was 30 days per year.

Other benefits:

- ✦ Emergency room visits: 91 percent of participants had coverage; 89 percent of these had some limitation on their coverage.
- ✦ Ambulance services: 64 percent of participants had coverage; 90 percent of those with coverage had some limits on that coverage.
- ✦ Diabetes care management: 27 percent of participants had plans that specifically included some form of coverage in plan documents; remainder did not mention coverage.
- ✦ Dialysis: 27 percent of participants had plans that specifically included some form of coverage in plan documents; remainder did not mention coverage.
- ✦ Physical therapy: 69 percent of participants in fee-for-service plans had coverage; 72 percent in HMOs did. In 68 and 69 percent of cases, respectively, plans limited the number of covered visits.

This report used national averages; if you are competing for employees, it helps to have data more specific to your region or industry. We can help you develop a health plan that helps you attract and retain employees. ■

Stringent Tax Rules Govern Dependent Care Reimbursement Accounts

Many employees take care of their children, parents or both. This “sandwich generation” can benefit from dependent care reimbursement accounts, which allow employees to pay for eligible dependent care expenses on a pretax, salary reduction basis.



By setting aside pre-tax money into a dependent care account, employees can later be reimbursed for eligible expenses incurred in the plan year. They save on taxes because their contributions are deducted from their pay before federal income, state income, and Social Security taxes have been withheld.

But tax rules that govern these accounts are stringent and require

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vigilance on the employee's part. You may want to help employees keep these regulations in mind if they decide to contribute to a dependent care account.

- ✱ Total contributions cannot be greater than the employee's earned income or spouse's earned income, whichever is lower. This means if a spouse's salary is \$4,000 and the employee's salary is \$30,000, the contribution ceiling is \$4,000. If both the employee and spouse have dependent care reimbursement accounts, the total combined contribution limit is \$5,000. Likewise, if employee and spouse file separate federal income tax returns, the individual dependent care reimbursement account limit is \$2,500. Single filers with an eligible dependent, however, can contribute up to the full \$5,000. A spouse who is a full-time student, or incapacitated, has imputed income of \$200 per month for one qualifying dependent, or \$400 per month for two or more qualifying dependents.
- ✱ Employees can use a combination of the dependent care reimbursement account and the dependent care tax credit. However, participation in a dependent care reimbursement account offsets on a dollar-for-dollar basis the allowable expenses used to calculate the dependent care tax credits on income taxes.
- ✱ Employees must also report the name, address and Social Security number or taxpayer identification number of each dependent care provider when they submit a dependent care reimbursement account claim.
- ✱ Eligible dependents include:
 - ✓ A child under age 13 whom the employee claims as a dependent on their tax return;
 - ✓ A legal spouse who is physically or mentally incapable of self-care;
 - ✓ A dependent who lives with the employee—such as a child age 13 or older, same-sex domestic partner, parent, sibling or in-law—who is physically or mentally incapable of self-care, and whom you claim as a dependent on your tax return.
 - ✓ If care is provided outside of the employee's home for a spouse or a dependent age 13 or older, either of whom is incapable of

self-care, the spouse or dependent must live in the employee's home at least eight hours each day.

- ✱ Eligible expenses include:
 - ✓ Day care facility fees for qualified dependents
 - ✓ Before- or after-school, or extended day programs
 - ✓ Local day camp fees if custodial in nature, not educational
 - ✓ Baby-sitting fees for at-home care while you and your spouse are working (care cannot be provided by you, your spouse or other dependent).
- ✱ Ineligible expenses include:
 - ✓ Child support payments or child care if the employee is a non-custodial parent
 - ✓ Payments for dependent care services provided by the dependent, the spouse's dependent, or a child who is under age 19
 - ✓ Healthcare costs or educational tuition
 - ✓ Overnight care for dependents (unless it allows the employee and spouse to work during that time)
 - ✓ Nursing home fees
 - ✓ Diaper service
 - ✓ Books and supplies
 - ✓ Activity fees
 - ✓ Kindergarten expenses

Before employees open accounts, they should determine whether they could save more income tax through the dependent care reimbursement account or through dependent care tax credits. The best approach will depend upon eligibility for the earned income tax credit, dependent care expenses, marital status and adjusted gross income. You may want to suggest consultation with a tax attorney or accountant.

To participate in a dependent care reimbursement account, employees must complete IRS Form 2241, "Child and Dependent Care Expenses," along with your IRS Form 1040, "U.S. Income Tax Return."

Dependent care accounts can offer your employees significant tax savings — if they are managed correctly. ■

Why Everyone Needs Long-Term Disability Insurance

What would your employees do if they became injured or ill and couldn't work for an extended period? How does this affect morale?

By the time people reach age 35, they have a one in three chance of being disabled for more than 90 days during the rest of their working life, according to America's Health Insurance Plans, a trade organization. A recent MetLife survey indicated that an increasing number of employees are more concerned with having financial security in the event of a disability than they are with premature death.

Group long-term disability income (LTD) insurance provides your employees funds to help them meet daily expenses when they cannot work. This security can enhance recruiting, retention and productivity.

Employers can cover the entire cost of LTD, cost-share with the employee or offer coverage as an employee-paid, voluntary benefit. You can also offer group or individual coverage.

Studies show that almost half of mid-size to large employers provide coverage that pays benefits for at least five years. Typical group policies replace 50 to 60 percent of income, which balances disabled employees' need to meet expenses with the employer's need to provide incentives to return to the job. Many employers fund a basic plan to protect employees, who can then add supplemental coverage to meet their individual financial needs.

Most individual disability policies are non-cancelable, so the insurance company cannot cancel the policy (except for nonpayment of premiums, of course). This gives employees the right to renew the policy every year without an increase in premium or a reduction in benefits, regardless of their health. Group disability income insurance policies differ: they are usually "guaranteed renewable." If a policy is guaranteed renewable, the insurance company cannot change your benefits if you pay your premiums on time, but it can increase your



premium on a policy anniversary as long as it makes a similar premium increase for your entire class of policyholders. You typically pay more for a non-cancelable policy because you are paying for the protection against a premium increase.

What to look for

As with all benefit programs, employers have many options when selecting a group LTD plan:

- ✦ **Ease of use.** Employees and employers should have easy, timely access to information. Many employers like having online access to plan information and usage data, including the number of people on leave, average length of leave, and at which locations. For employees, plans often work best when they offer multiple ways to get information, whether mail, phone or online.
- ✦ **Rehabilitation.** Evaluate the insurer's capabilities in rehabilitation and case management. How successful has the carrier been in helping employees return to productive work?
- ✦ **Guaranteed issue.** Employees can get coverage up to a specific limit regardless of health conditions. This means the insurer might place a limitation on pre-existing conditions in the first 12 months, for example. But the insurer issues coverage rather than

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denying it, so the insured can get immediate coverage for disabilities resulting from accidents or non-pre-existing conditions.

Group long-term disability coverage provides a valuable addition to a well-rounded benefits program. If you'd like to learn more, please contact us and we'll help find you a policy that's right for you. ■

Smart Phones and Overtime

A survey of employed email users finds:
 22% are expected to respond to work email when they're not at work.
 50% check work email on the weekends.
 46% check work email on sick days.
 34% check work email while on vacation.
Source: Mother Jones

In several recent cases, non-exempt employees have sued their employers for unpaid overtime compensation because the employer required them to check communications on their smart phone when not on duty. The cases revolve around the question of whether the act of checking communications constitutes compensable work.

The Fair Labor Standards Act (FLSA) governs minimum wage and overtime. It entitles employees to whom the law applies to receive overtime compensation for "time spent working" beyond the 40-hour workweek. Both the minimum wage and overtime provisions of FLSA generally do not apply to workers in executive, administrative, professional and outside sales employees who are paid on a salary basis.

Requiring these "exempt" employees to check their smart phones would not subject employers to overtime claims.

As phone records are easily accessible, employees who use them off hours can provide solid evidence for their overtime claims. To avoid claims for unpaid overtime, employers can limit use of company cell phones to exempt employees only, or limit their use by non-exempt employees to work hours only.

The U.S. Department of Labor has launched a timesheet application for smart phones to allow employees to track their work hours and wages. Users can add comments related to their work hours; view a summary of work hours in a daily, weekly and monthly format; and email the summary of work hours and gross pay as an attachment.

The free app is currently compatible with the iPhone and iPod Touch. The Labor Department will explore updates for other smartphone platforms, such as Android and BlackBerry, and other pay features. Both the app and the calendar can be downloaded from the Wage and Hour Division's home Web page at <http://www.dol.gov/whd>. ■

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