

DREGGORS, RIGSBY & TEAL, P.A.

CERTIFIED PUBLIC ACCOUNTANTS

Group Health Insurance: A Valued Employee Benefit

Two of the main reasons why employers offer group health insurance are to attract new employees and to retain existing employees. Unfortunately, many employees overlook the value of group health insurance until they have to find health coverage on their own. Almost without exception, group coverage usually offers better, more comprehensive benefits at lower cost than individual policies.

There is no federal or state law that requires employers to offer health insurance. Your choice is often simply a cost/benefit business decision. But if you do decide to offer group health, you must understand some government rules. Many states now have laws that cover the design of plans (e.g., whether all full-time employees have to be covered).

Rules and regulations

To begin with, you must file an information return with the IRS about your group health plan. The IRS wants to know how many employees you have in your company, how many employees are eligible for health-plan benefits, and so on.

If you have over 20 full-time employees, you will be required to offer extended health-care coverage to an employee who leaves your business (except in cases of gross misconduct). Usually referred to as COBRA coverage (which came from the Consolidated Omnibus Budget Reconciliation Act of 1985), this requirement allows employees to maintain their group health coverage at their expense--they pay the full premium. Also, you may charge an administrative fee (paid to you) of between 1 and 2 percent of their full premium.

For new employees, you can impose a waiting period before they are eligible to enroll. However, since one of the main purposes of group health insurance is to attract new employees, many employers choose a very short waiting period, such as 15 to 30 days.

As with other kinds of employee benefits, you may be able to pick and choose (within limits) which employees receive group health coverage. If your health plan is fully insured, you have almost complete discretion. Otherwise, when you choose the classes of employees to cover, you must be fair in offering the same coverage to all employees within that class. For instance, you can cover management personnel (just make sure to include all of them) and exclude your front-line employees.

If your plan is "discriminatory" toward certain classes of employees, the costs that your business pays for the plan may be considered taxable income to the covered employees. Normally, group health premiums can be deducted as a business expense, so having a discriminatory plan can hurt your business by increasing your taxes. Many employers avoid this situation by simply offering coverage to all employees.

Plan costs and considerations

In general, the process of establishing health premiums varies from state to state. Most insurers use one of two methods. One method is based on the medical underwriting of each employee. Factors like the employee's age, gender, and medical history can all affect the premium.

The other method, known as a modified community rating, bases the premium on the employer's ZIP code. This method assumes that most employees live within a reasonable distance of the employer. The insurer can then research typical medical claims and costs for the area and use that information to establish a reasonable premium.

In practice, employers often pay between 50 and 90 percent of the group health premium. The more the employer pays, the higher the income tax deduction generated for the business. The employer may permit employees to pay their portion of the premiums with pretax dollars. This means that each employee may choose to reduce his or her salary by the amount equal to that employee's share of the premium; the employer uses this amount to pay each employee's share of the premium. Since this amount isn't salary to the employee, both the employee and the employer benefit. The employee pays less income tax, and the employer pays less payroll taxes.

Other cost variables include the size of the deductible for the plan. In general, the higher the deductible, the lower the premium. Many plans include a provision for co-payments by the employee, which can also lower premium costs. Medical costs vary among providers, so your costs may be affected by the hospitals and doctors who are part of the plan.

In making these decisions about benefits and providers, it's important to pay attention to your employee demographics and business patterns. For instance, if you have mostly middle-aged and older employees, offering a maternity benefit may not be cost effective. On the other hand, if your employees travel a lot, offering a plan with out-of-state facilities may make sense.

In addition to medical coverage, you may have the option of providing vision and dental coverage for your employees. There are other options as well, such as skilled nursing care and prescription drug cards. Again, you can identify your employees' needs and weigh the costs against the benefits of providing these options. An experienced group benefits specialist can help you sort through these different factors and priorities.

Types of health plans

There are a few main types of group health plans to consider. You can offer more than one type and let your employees choose the plan that best fits their needs. With all of these plans, there is usually a financial incentive for an employee to stay within a particular network of providers and facilities.

Health maintenance organization

A health maintenance organization (HMO) is usually the least expensive of the group health plans but is also the least flexible regarding employee choices. Employees can only use doctors and medical facilities that are part of the HMO. A primary care physician (PCP) (chosen by the employee) serves as a gatekeeper to specialists within the HMO. Employees must have a referral from their PCP to see other medical personnel in the HMO. Employees pay a small co-payment for each visit and prescription (such as \$10), but there are no deductibles to satisfy or claim forms to submit.

Preferred provider organization

A preferred provider organization (PPO) usually costs more than an HMO, but employees enjoy more flexibility. They can see a specialist at any time; there is no gatekeeper as with an HMO. The PPO keeps a list of doctors, labs, and hospitals that the PPO prefers to use; this is known as the PPO's network. If an employee chooses to use doctors and facilities that are part of the network, the employee makes a small co-payment. Unlike an HMO, employees can go outside the network for medical care, but they pay more. A typical out-of-network charge might be paid 60/40, where the plan pays 60 percent of the costs, and the employee pays 40 percent as coinsurance. If the employee had seen in-network providers, he or she would be covered at 80 percent. PPOs typically have deductibles and coinsurance payments.

Point of service plan

A point of service (POS) plan also has a network of medical personnel and facilities, and employees have a PCP. To see specialists within the network, employees need a referral from their PCP. But employees can go outside the network (with a referral from their PCP) and still be covered. The freedom to go outside the network comes at a price--the employee pays more in deductibles and coinsurance to use providers outside the network.

Traditional indemnity plans (also known as fee for service)

These plans offer the most flexibility and coverage for your employees, but also have the highest cost. An employee can see any doctor and use any medical facility, without restriction. These plans have a deductible and some type of coinsurance (a typical coinsurance split is 80/20). After the employee pays the deductible, the plan pays 80 percent of a charge, and the employee pays the other 20 percent. Employees in this plan are more likely to encounter insurance paperwork, such as claim forms and keeping track of their deductible.

Self-funded (also known as self-insured)

Employers can also choose to self-insure medical costs. In this case, the employer is liable for any and all medical costs. This option generally works better for companies with a large number of employees. If you choose to self-insure, you can still add a policy to protect against catastrophic medical expenses, so that one large claim won't harm your business financially. Ideally, an employer would set aside money in the beginning to pay the anticipated claims. You save money on premiums, but have to create your own administrative system.