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MICHIGAN'S AUTO INSURANCE REFORM – WHAT EMPLOYEES NEED TO KNOW

In May 2019, Governor Gretchen Whitmer signed two laws making sweeping changes to Michigan's no-fault auto insurance law. This may save consumers money on their auto insurance premiums, which are currently the highest in the nation. While premiums will not be reduced until next summer, when the laws takes effect, employees may have questions now. Employers, who know their group health plan far better than employees' auto insurance agents, should be prepared to take the lead on providing information and clarification on how employees' auto insurance intersects with the employer-sponsored medical coverage. This will be critical to employees' decision-making process when their auto insurance renews after July 1, 2020.

PIP AND THE GROUP HEALTH PLAN

The chief driver for Michigan's high premiums is the requirement that auto insurance policies include wage loss benefits and unlimited lifetime coverage for reasonable medical expenses incurred by individuals who suffer catastrophic injuries in an auto accident. This is called Personal Injury Protection (PIP), and benefits are paid by the claimant's insurer regardless of which driver is ultimately found to have caused the accident. PIP is thus a critical component of Michigan's "no-fault" insurance system.

Beginning in July 2020, drivers will have new options for PIP. They may continue to have unlimited PIP benefits, or they can elect coverage that caps PIP at $250,000 or $500,000 for medical expenses. In addition, drivers with Medicaid can elect a lower cap of $50,000.

Employees should be aware of the following:

- **PIP covers reasonable medical expenses related to the auto accident, which are generally not covered by the employ-**

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We welcome your comments and suggestions regarding this issue of our Viewsletter. For more information, please contact your Account Manager or visit our website at www.mma-mi.com.

er's health plan to the same level. Services like office visits and hospitalization may be covered by both PIP and the employer's health plan. However, keep in mind that PIP benefits are currently unlimited for Michigan drivers, with little cost sharing. If, for example, an injured employee is prescribed ongoing physical therapy to maintain limited function but is not expected to recover further, PIP will still pay for it, for as long as it is medically recommended. But the employer's health plan may have an annual visit limit for physical therapy, and may not cover treatment if it is not expected to restore function to the employee.

- **PIP is more comprehensive than the employer's health plan, as it pays for certain treatment and expenses of daily living that are not covered by any medical plan.** PIP covers services which are never included in a group health plan, such as home and vehicle modifications, and attendant care. (In fact, attendant care could be provided in the individual's home by a family member who is paid to provide such service.) This is significant, as an individual may sometimes have to enter a nursing home, potentially draining the family's financial assets until the injured person qualifies for Medicaid. PIP can therefore protect the individual and his or her family from financial catastrophe in the event the individual needs nursing services to assist with the functions of daily living.

  In addition, PIP pays for replacement services to handle the cost of household tasks that the individual performed prior to the accident. This may include payment for housekeeping, landscaping, and babysitting, among other tasks.

COORDINATION OF BENEFITS WITH THE GROUP HEALTH PLAN

In view of this legislation, employers with self-funded health plans should take a closer look at how they pay for medical claims resulting from an auto accident. When self-funded plans are governed by ERISA, a federal law, instead of state insurance law, they can choose to take a primary, secondary or exclusionary stance with regard to these claims. (Non-ERISA plans must either pay auto-related claims on a primary basis, or exclude them from coverage entirely.) However, regardless of plan funding, employers should explain the difference between "coordinated" and "uncoordinated" coverage in their benefit materials, if they are not doing so already.

When coverage is coordinated between the individual's auto insurance policy and the group health plan, the health plan pays claims on a primary basis. PIP would still pay the individual for lost wages, and would cover any services not paid by the health plan. Under Michigan law, insured plans must pay primary for such claims, and that will not change after July 1, 2020. If an employer's plan is insured, the employee can therefore elect coordinated coverage, and save some money on the PIP portion of the auto insurance premium.

However, unless the individual requests coordinated coverage (and provides proof that the group health plan will pay primary, such as a letter from the employer or insurer), the default is for PIP to be uncoordinated with the health plan. In that case, PIP would pay primary, regardless of any other health coverage the claimant may have. If a self-funded health plan is taking a secondary or exclusionary stance on medical claims related to an auto accident, this should be clearly communicated

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DID YOU KNOW

- Of employers with 500 or more employees, 55 percent were covering applied behavioral analysis or intensive behavioral therapy for autism spectrum disorder in 2018, a 10 percent increase from 2017.
- Sixty-three percent of these employers provide some type of infertility coverage, a seven percent increase from 2017. However, this coverage is largerly limited to evaluation by an infertility specialist. (In-vitro fertilization is only covered by 28 percent of these employers.)
- Thirty-five percent of these employers cover gender reassignment surgery, just a slight increase from 2017. However, it is a 21 percent increase from 2016.
- Only 58 percent of these employers cover bariatric surgery for weight loss.

Source: 2018 Mercer National Survey of Employer-Sponsored Health Plans

YOUR QUESTIONS

Q. An employee is covering her spouse and children on our HSA-qualified high deductible health plan (HDHP) His adult child is working full-time and living on his own, and is no longer the employee's tax dependent. However, the child is under age 26 and therefore eligible for coverage in our medical plan. Can the employee continue using his HSA to pay for this child's qualifying health expenses?

A. No. Keep in mind that eligibility for the health plan is not based on the dependent's tax dependency status – the child simply cannot be older than age 26. But the rules surrounding health savings accounts (HSAs) are different. You cannot use your HSA to pay for health expenses incurred by someone who is not your tax dependent. In addition, a "qualifying child," for the purposes of the parent's HSA, must also reside with the parent for at least half the tax year and have not provided more than half of his or her own support during that year. The child must be under age 19, or under age 24 if a full-time student by the end of the tax year (unless permanently and totally disabled).

In this case, the employee's child is likely eligible to open and contribute to his own HSA, assuming he meets the criteria established by the IRS. That includes being covered by a qualifying HDHP, not being enrolled for non-qualifying health coverage, and not being claimed as another's tax dependent. For example, if the child is also covered by his own employer's "traditional' PPO plan, then he would be ineligible to make HSA contributions.

Finally, because the child is enrolled for family HDHP coverage, he could contribute up to $7,000, the maximum HSA contribution for family HDHP coverage, in 2019. That may seem odd, but he is not limited to the single HSA contribution.

to employees, as they must elect uncoordinated PIP in order to have sufficient medical coverage available for any such claims.

Beginning in July 2020, a driver can elect to reduce PIP benefits to a lifetime maximum of $250,000 or $500,000 (or $50,000, if covered by Medicaid). While a reduced benefit may lower the auto insurance premium, it is risky in the event the individual suffers a catastrophic injury that necessitates lifetime care in excess of the maximum. While this is a decision the driver must make, the employer can explain that the health plan is unlikely to pay for the excess medical claims, particularly if the individual's employment terminated and COBRA was exhausted or not elected. If a self-funded employer takes a secondary payment stance, employees should consider unlimited PIP to potentially cover expenses the health plan will not cover. If the plan takes an exclusionary stance, the employee should consider unlimited PIP because the health plan will not pay any expenses related to an auto accident.

While this change to Michigan's no-fault auto insurance law may provide welcome premium relief for drivers, it is important for individuals to fully understand what they are giving up if they elect a reduced amount of PIP in 2020. They may have unreasonable expectations with regard to their employer-sponsored plan, especially if it is insured and they currently have coordinated PIP benefits. Employers should consider providing some basic information to employees about this change, prior to the July 1, 2020 effective date. In order to make this information stand out, do not include it with the annual enrollment materials, as that could be overwhelming to employee. In addition, everyone's auto insurance renews at different times, so it would be helpful to provide a memo to employees which they can keep for future reference.

Many employees look to their employers for guidance on all matters affecting their benefits, so offering clear and concise communication on this change, and its potential impact on employees, is a good way to strengthen or build this trust.MMA

ANNUAL BENEFITS ENROLLMENT – ARE YOUR SYSTEMS READY TO GO?

Many groups, with renewal dates on or around January 1, are beginning to prepare for annual enrollment activities. You may be concentrating on obvious concerns like carrier and vendor

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implementations and drafting communications to employees. But don't forget about your benefit administration and payroll systems! Getting the "back office" ready is key to ensuring an efficient and successful process for all parties, from the first day of enrollment to the first pay date of the new plan year. Here are some recommended steps to take after confirming your plan design, rates and employee contributions for the next plan year.

BENEFIT ADMINISTRATION SYSTEM

Your benefit administration system is critical, as it's generally the chief repository of employee elections. It may be used to transmit regular enrollment data, via electronic files, to your various carriers and payroll vendor. Keeping benefit and cost data correct and up to date in the system should be a top priority.

- **Review and update your monthly rates.** Even if some of your benefit plans are in a rate lock for the coming year, double-check all rates, including age-banded rates for voluntary life and disability coverage. This is especially important for any plans that are self-billed, where you calculate the premium and volume yourself, rather than relying on a detailed invoice from the carrier. You want to be sure you're not overpaying or underpaying the carrier, based on reporting generated by the benefits administration system.
- **Update employee contributions.** It's likely that at least some employee contributions will change for the coming plan year. Don't forget to make those updates in the system. In addition, you may add or remove a contribution tier, which will require your vendor to make a programming change. Give them advance notice of any structural modifications, including changes to the pay schedule, so they have sufficient time to complete the work before the system opens to employees.
- **Confirm the programming for benefit reductions and rate changes based on age.** Your life and AD&D policies likely include age reductions after the insured person attains a certain age. Voluntary life and disability coverage may also be age-banded, which means the cost goes up as the insured gets older. Is your system programmed to apply the benefit reduction and age band changes at the correct time?

  Reach out to your insurance carrier and benefits consultant to ensure your system administers the life rates according to the terms of your polices. For example, do age reductions and age band changes happen at the point the employee attains a specific age, or do they instead take effect on the policy anniversary date (which is typically be the first day of the next plan year)? If the change should occur at the time of the

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TREND TIDBITS

$ The larger the employer, the more likely it is to have carved out pharmacy benefits from the medical plan, and contracted with a pharmacy benefits manager (PBM) to administer the pharmacy benefit. Only 14 percent of employers with 500 to 999 employees have contracted with a PBM, while 33 percent of employees with 1,000 to 4,999 employees have done so.

$ Larger employers are assessing coinsurance, rather than a flat-dollar copayment, for at least some drug categories. For employers with 500 to 999 employees, 36 percent charge coinsurance at the retail level, and 26% charge coinsurance for the mail order pharmacy.

$ Spending on specialty drugs continues to grow at a faster pace than overall spending on pharmacy benefits. About 32 percent of employers with 500 or more employees exclude some specialty medications from retail drug plan or medical benefit, thus driving plan participants to the specialty pharmacy to fill their scripts.

$ Employers continue to implement cost-savings strategies for non-specialty drugs. In particular, 38 percent of employers with over 500 employees allow plan participants to fill a 90-day supply of "maintenance" medication at a specific retail pharmacy. This is up from 24 percent of employers in 2017.

Source: 2018 Mercer National Survey of Employer-Sponsored Health Plans

employee's birthday, make sure the benefits administration system doesn't apply the change on the policy anniversary date.

Similarly, make sure your policies and benefits administration system are in accordance with regard to age banding for new hires and other new enrollees on the plan. For example, assume an employee is age 39 during annual enrollment and the first day of the plan year, but will turn age 40 six months later, which is a new age band for voluntary life coverage. Will the employee be placed in the age 40-44 age band upon enrollment, or on the first day of the subsequent plan year? Even if you implemented your plan several years ago, you may still find discrepancies between the policy and your benefits administration system when it comes to these subtle nuances. Plan administration is not just about rates and contributions!

- **Check your resources.** You may be loading various benefit and carrier documents in your benefits administration system, such as summary plan descriptions, benefit summaries and carrier brochures. Make sure these are current for the plan year. For example, materials regarding flexible spending accounts or health savings accounts may still be accurate, except they show an annual benefit maximum that is out of date. Ensure you have the latest editions on hand for employees. Remove any materials that reference prior carriers or benefits no longer in force.

  Further, you may prefer to electronically distribute documents like summary plan descriptions and summaries of benefits and coverage, among others. You may do this, as long as employees have regular access to your benefits administration system (such as via their own work computer). Because employees should understand the importance of these documents, and be aware that they may request free paper copies at any time, include language to this effect at the point employees log into the system. This could be done via a "splash page," where employees are presented with this information and must click a button acknowledging their consent to receive documents electronically before proceeding with enrollment.

PAYROLL SYSTEM

You may have some additional time to make updates to your payroll system, as the new plans and contributions will not take effect until the new plan year begins. Therefore, address changes in your payroll system after ensuring the accuracy of all updates in your benefits administration system.

- **Make sure all payroll codes are up-to-date.** If you have changed carriers, added new benefits or modified contribution tiers, you likely need to establish new payroll codes and eliminate old ones that are no longer valid.
- **Know when to enter the new price tags.** Can you enter the new contributions prior to the beginning of the new plan year, to take effect at a future date? Or must you wait until after the last pay period of the prior plan year, and before the first pay period of the new plan year?
- **Audit all election data.** Your payroll records should sync with employees' elections in the benefits administration system. In addition, make sure all member detail on the carrier invoices matches both the payroll system and the benefits administration system. It's best to perform these audits at the beginning of the plan year, when it may be easier to identify and resolve any discrepancies.
- **Account for state-mandated benefit deductions.** This is important, especially if your company operates in states where there are mandated disability and/or family leave laws that permit or require employee contributions for coverage. Make sure these contributions are being taken, and that they are updated as necessary.

There are many tasks associated with a successful annual enrollment, and it can be difficult to keep everything in focus. Don't lose sight of what is happening behind the scenes from a programming perspective. Making sure your benefit administration and payroll systems accurately reflect your decisions for the new plan year will go a long way toward keeping the process running smoothly.MMA

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Technical Corner

Most employers are familiar with the Section 125 regulations governing employees' pre-tax contributions for employee benefits. You are aware that plan participants can make changes to their elections during annual enrollment for the coming plan year, or within a specific window of time for a qualifying life event during the year. But do you know how to handle these situations?

- **An employee asks to terminate his employee-paid voluntary life or disability coverage a few months into the plan year.** The employee's ability to drop this coverage mid-year, outside of a qualifying life event, is based on how he pays his premium. Generally, such coverage is paid with after-tax dollars. The Section 125 rules govern pre-tax contributions only, so the IRS is not concerned with individuals making changes to their after-tax elections during the year. You could allow the employee to terminate his coverage.

  However, when voluntary coverage is paid with pre-tax dollars, the Section 125 regulations will apply. The employee can only change his election mid-year if he experiences a qualifying life event that permits the change, and he requests the change in the time frame mandated by your plan (typically within 30 days of the event).

- **An employee asks to drop her children from her medical plan, because they were enrolled for Medicaid. But it's been more than 30 days since their Medicaid coverage became effective.** The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) added two HIPAA special enrollment events, allowing the employee or their dependent to terminate or enroll for coverage in the employer's plan, if they enroll or lose coverage for Medicaid or CHIP. Unlike other qualifying life events, the employee must request the change to employer-sponsored coverage within 60 days of enrollment or termination of Medicaid or CHIP.

  In this case, if it's been no more than 60 days since the employee's children enrolled for Medicaid, then the employee can make a corresponding change to her election, and drop them from her medical plan.

- **So you've allowed this employee to cancel her children's coverage since they enrolled for Medicaid within the last 60 days. But what is the effective date for their termination from the employer's plan?** Great question! Generally, it should be the date the request was made or the first day of the month following the day the employee requested the change. This is because, in most cases, the Section 125 regulations require changes to be made prospectively, for a future effective date. The regulations permit retroactive changes only in the event of the birth, adoption or placement of adoption of a child, where the effective date must be the date the child was born, adopted, or placed for adoption. A retroactive election is also allowed for new hires making their initial benefit elections during the specified enrollment window.

  Frequently, however, employers do allow retroactive changes, and also take back premium with pre-tax dollars. The problem is that, except in the limited situations indicated above, retroactive elections cannot be paid with pre-tax dollars per the regulations. If an employer wants to allow this, then the employee's contributions for such coverage must be waived for the retroactive premium, or taken with after-tax dollars. For example, if an employee marries on August 5 and requests to add the spouse on September 3, the employer should make the effective date no earlier than September 3 (October 1 may be more administratively feasible). If the employer goes back to August 5 to add the spouse, then the employee should pay with after-tax dollars for the spouse's first month of coverage, or the employer should waive premium for the spouse during that time.

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LIABILITY LESSONS

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We need a certificate showing we are additional insured on your Commercial General Liability policy – can you send that to us? You get this request from, for example, a client and send it to your insurance agent. The certificate is produced and everyone is happy… for now. Here are two things to consider when you agree to give someone additional insured status on your Commercial General Liability policy.

First, understand that giving someone additional insured status on your Commercial General Liability policy means they become an insured under your policy and share in the coverage that is available for a claim. If you have a $1 million per occurrence limit, that limit is shared between you and the additional insured.

Second, do you have a contractual requirement to do this? Have you agreed in a contract or agreement to provide additional insured status? Why is this important? If there is no contractual requirement, do you truly want to share your coverage? Also, many people opt to carry a blanket additional insured endorsement on their policy rather than endorsing each additional insured separately.

Such endorsements require that there be a contract or agreement requiring additional insured status in order for coverage to apply. If there is no contract or agreement in place, then there is no additional insured status and thus no coverage. Someone is not going to be happy if they thought they were an additional insured but in fact are not, because there is no contractual responsibility to extend coverage.

There are many nuances to contractual risk transfer. We have touched on just two of the important things to think about when it comes to granting someone additional insured status on your Commercial General Liability policy. There are other aspects to consider, and your risk management techniques should be an ongoing discussion with your business insurance professional.

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