MARSH & McLENNAN AGENCY

ViewsLetter

Volume Twenty-Three, Issue One

February 2020

# MEDICARE FOR ALL – WHAT DOES IT MEAN FOR EMPLOYERS?

As we move closer to the 2020 presidential election, there are myriad issues capturing the attention of voters. One of the most pressing is how to remedy the significant challenges facing our current healthcare delivery system, including inequities in coverage and the high cost of premiums, medical services and prescription drugs.

Two of the leading Democratic contenders for their party's nomination, Senator Bernie Sanders of Vermont and Senator Elizabeth Warren of Massachusetts, have become the standard-bearers for a plan termed "Medicare for All." Currently, Medicare covers individuals aged 65 and older, as well as younger people who are disabled or were diagnosed with End Stage Renal Disease. Medicare for All would expand this coverage to all Americans, regardless of age, health status or income, effectively establishing a universal health plan administered by the federal government. Should this actually become law as proposed by the candidates, what would it mean for employer-sponsored health plans and the people they cover?

## WHEN WOULD IT TAKE EFFECT?

Ultimately, employer-sponsored medical coverage would be phased out during an implementation period lasting several years. Private insurance and self-funded employer plans would not be permitted to offer duplicative coverage and compete against the government-run health plan. Under Sanders' proposal, the Medicare eligibility age would be lowered to age 55 in the first year of his administration, and then to age 45 in the second year and to age 35 in the third year. The transitional period would last a total of four years, and younger individuals would have the option to buy into Medicare during that time.

Warren has indicated that she would begin her presidency by extending Medicare for free to children under age 18 and to families earning up to 200 percent of the Federal Poverty Level. In addition, individuals over age 50 could enroll in an expanded version of Medicare. All others could buy into Medicare during the first three years of a Warren administration.

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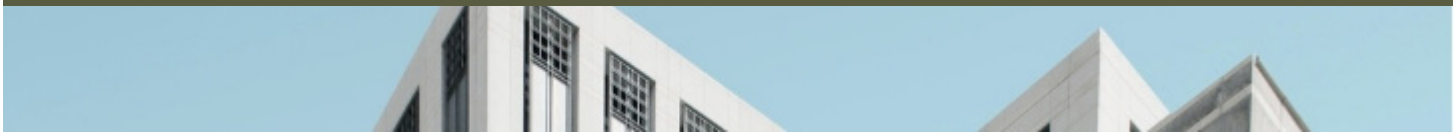

It is likely that many employees would decline their employer-sponsored health plan during the transitional period, especially older workers and those with lower incomes. However, as both Sanders and Warren are promising comprehensive coverage with little out-of-pocket spending, even those with higher incomes may find the offer tempting. It is important to note that this would not eliminate the current responsibilities of employers with 50 or more eligible employees under the employer mandate of the Affordable Care Act (ACA). Such employers must still offer affordable, minimum-value coverage to at least 95 percent of their employees, and continue to abide by the annual reporting requirement, during the Medicare transitional period.

## WHAT DOES IT COVER?

The ACA requires individual health policies and small employer insured plans to cover ten essential health benefits, which include preventive care, emergency services, prescription drugs and hospitalization, among others. The Medicare proposals of both Sanders and Warren would cover the same benefits, but go even further. For example, dental, vision and hearing services, which are not covered by Medicare today, would be included. Long-term care would also be covered under both proposals.

All deductibles, coinsurance and copayments for medical services would be eliminated. Under Sanders' plan, charges for certain non-preventive prescription drugs would be capped at $200 annually per individual.

No employer-sponsored plan could offer benefits as rich as these, especially with no premium contributions from employees. Certainly such coverage is not available today in the health insurance marketplace established by the ACA. Even the current Medicare program does not offer such comprehensive coverage at no cost to beneficiaries.

## DID YOU KNOW

- 26 percent of U.S. adults aged 18 to 64 said they or someone in their household had problems paying, or an inability to pay, a medical bill in the past 12 months.
- For uninsured individuals, the largest source of their medical bill problem involved the emergency room (35 percent). For insured individuals, the largest source of their medical bill problem involved diagnostic tests (14 percent).
- 24 percent of the insured and 22 percent of the uninsured reported struggling with bills of less than $1,000.
- 64 percent of those enrolled in high-deductible health plans said their bills totaled $2,500 or more, compared to only 40 percent of those enrolled in lower-deductible plans. (In this study, a high-deductible plan was defined as one with deductibles of at least a $1,500 for an individual and $3,000 for a family.)

*Source: The Burden of Medical Debt; Results from the Kaiser Family Foundation/ New York Times Medical Bills Survey, January 2016*

## WHAT PROVIDERS CAN YOU SEE?

Many people have established close relationships with their doctors, especially specialists, and are loathe to lose access to them. When an employer is looking to change insurance carriers (or third-party administrators for a self-funded plan) it is standard to perform a network analysis to ascertain the likelihood of network disruption for employees.

Under the Medicare for All proposals, there would be no networks, and thus no network restrictions. Theoretically, individuals could see any providers they choose, and would not require referrals to specialists. However, not all providers participate with Medicare today, with the number of participating providers varying by geographic location. In many cases this is due to the amount of Medicare reimbursement received. Providers may consider themselves insufficiently compensated for the care given to patients.

One of the main concerns Americans have with universal health coverage involves long wait times for both medical procedures and office visits. It is possible these fears would become reality, as providers could refuse to participate with Medicare or stop practicing altogether. There is already a strong demand for primary care providers, and that need would increase as more people become covered and expect to pay nothing out-of-pocket for care. That puts increasing pressure on the providers and facilities that participate in the program, who will find it difficult to stay in business without private insurance making up the difference for Medicare reimbursement. Rural areas in particular could find their access to health care in jeopardy.

During the transitional period to Medicare for All, some employees may opt to maintain their employer-sponsored group coverage specifically to keep their current providers. This could increase the risk for adverse selection, as healthier individuals may move to Medicare, leaving the individuals who require

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more specialized, expensive treatment on the group plan. This could drive up the employer's insurance premiums or claims experience.

## WHO PAYS FOR IT?

There is much discussion regarding the actual funding of Medicare for All, and its potential impact on the U.S. economy. But our interest here is the direct cost to employers and employees.

During the four-year transitional period in Sanders' proposal, as employees opt into Medicare, employers would have to pay a 7.5 percent payroll tax or 75 percent of the health care costs they are currently paying for the employees enrolling in Medicare, whichever is higher. After the transitional period, employers would pay the 7.5 percent payroll tax for all employees. However, the first $2 million in payroll would be exempt.

Individuals, after taking the standard income tax deduction, would pay a four percent income-based premium. Sanders' proposal indicates that a family of four earning less than $29,000 annually would not pay the premium.

Under Warren's proposal, the employer's Medicare contribution would be 98 percent of their average current health care costs. This essentially penalizes employers who offer generous benefits, which necessarily cost more. In addition, small businesses with under 50 employees, who do offer coverage to their employees, would also have to pay this contribution. This means they are penalized for extending coverage to their workers, when they are not actually required to do so by the ACA.

Critically, in Warren's plan, an employer is paying the same for their less-compensated employees as for their executive staff, because the cost is based not on payroll but on the cost of health coverage, which is unlikely to vary amongst the employee population. This eats into a larger share of low wage-earners' total compensation, and also makes them more expensive to hire. This is far less equitable than Sanders' more progressive proposal.

In addition, independent contractors are exempt from the employer's Medicare contribution under Warren's proposal, which means an employer wishing to avoid paying the fee could reclassify employees as independent contractors. That is certainly not a worker-friendly strategy.

## IN SUMMATION

It is important to keep in mind that a lot of variables are in play with regard to Medicare for All. First, either Sanders or Warren would have to win the 2020 presidential election, and also have a Democratic House and Senate to further their legislative agenda. Next, compromise on various details is a certainty, and much could change during the multiyear transitional period. The harsh light of reality eventually throws quite a shadow on the dreamy proposals of politicians looking to lure voters. But employers should be aware of the potential changes that could be on the horizon, as the conversation regarding universal health care continues. MMA

## TREND TIDBITS

- $ An employer's average annual premium contribution for family PPO coverage in 2019 was $15,045. The employee's portion of the premium was $6,638.
- $ An employer's average annual premium contribution for family HMO coverage in 2019 was $14,688. The employee's portion of the premium was $6,009.
- $ An employer's average annual premium for family high deductible health plan coverage in 2019 was $14,114. The employee's portion of the premium was $4,866.
- $ For all types of medical plans, the total premium for family coverage has increased by 22 percent from 2014 to 2019. The employee's contribution has risen by 25 percent during that time.

*Source: The Kaiser Family Foundation, Employer Health Benefits 2019 Annual Survey*

# TRAVEL MEDICAL INSURANCE DURING A HEALTH EPIDEMIC

Many employers protect their workforce with some form of travel medical insurance, to cover them when they are traveling on company business outside their home countries for a limited period of time (e.g., for less than six months). While employees may be covered by the group health plan back home, that plan may offer little or no international coverage in the event they experience a health emergency. In addition, navigating a foreign health care system presents unique challenges, such as finding quality providers and facilities, language translation, and claims payment. A travel medical plan removes much of the guesswork, by providing assistance with all aspects of obtaining health care abroad.

Employees will use this plan only if they're accidentally injured, or exhibit symptoms of a serious health condition that require medical

attention. This could include acute respiratory distress, which is frequently seen with the novel coronavirus outbreak that began in Wuhan, China in December 2019, and has since spread to several other countries. As of the end of January 2020, China had quarantined around 50 million people in numerous cities, and several airlines have suspended or cancelled flights to the Chinese mainland.

This situation is developing rapidly, as more cases are diagnosed throughout the world. Public health officials are still working on how best to address what could become a global pandemic. If you have employees conducting company business outside the United States, who are covered by employer-paid travel medical insurance, here are some questions to ask your insurer. They are applicable not just to the Wuhan coronavirus, but to any potential epidemic:

- **What is our plan's medical evacuation benefit?** This is a good time to closely review the terms of your policy. Medical evacuation is a critical component of a travel medical insurance plan, with a maximum benefit per trip that can vary widely, from just $50,000 to over $1 million. If your employees are traveling to remote or underdeveloped areas, it's wise to have a maximum benefit of at least $250,000 per trip.

  In addition, confirm if dependents traveling with the employee are also eligible for benefits under the travel medical policy. For example, if the employee is healthy but a dependent suffers an accident, is medical evacuation covered for the dependent? Employees should be made familiar with the provisions of their coverage, especially if they want family members to join them on their trip. If dependents are not eligible for this plan, then the employee may want to pursue individual travel medical coverage for them.

- **Under what circumstances is medical evacuation approved?** If a covered individual is accidentally injured, or becomes suddenly ill, would medical evacuation be covered, and to what extent? Generally, evacuation will be approved only if emergency treatment is necessary, per the terms of the policy, and adequate medical care is not available locally. For example, if an employee is seriously injured in an auto accident in London or Tokyo, medical evacuation will probably not be needed nor approved. But if the accident instead occurs in a rural area, and the local medical facility cannot provide sufficient care, then it is more likely the patient will be transported to another hospital elsewhere that can better meet his or her needs.

- **Can an employee be evacuated from an area suffering an epidemic?** You cannot use the medical evacuation benefit to transport seemingly healthy people to a "safer" area. However, this situation may fall under the trip interruption benefit that's generally included with a standard travel insurance policy, assuming the employer has such coverage.

  Further, even an employee who falls ill from the epidemic illness may not be evacuated if sufficient medical care can be accessed from local providers.

- **Can an employee be medically evacuated from an area under a government-imposed quarantine, if adequate medical care is not available there?** This will not be addressed by your policy, but should be discussed with your insurer on a case-by-case basis. The circumstances will play a critical role in what can be done, including the timing and destination of the patient's transport. The insurer may have to work closely with government authorities when movement is highly restricted or prohibited within a given area.

  In addition, it may be challenging to find a place to which to evacuate the patient, if other areas are trying to restrict the spread of an epidemic by keeping infected individuals out. It is wise to circumvent the issue entirely by taking a proactive approach, and removing all employees from an area shortly after an epidemic becomes obvious. Take your cues from government and the airlines. If governments are evacuating their own citizens, and airlines are suspending or canceling flights, it is time to bring your employees home (and not to initiate travel to certain areas at all). Even a medically necessary evacuation will be impossible if transportation options become unavailable.

The Wuhan coronavirus is just the latest epidemic to capture the news cycle and create concern about the possibility of a global pandemic. While that may not actually occur in this case, the threat of highly infectious disease will continue to exist. If you are sending employees on international assignments, make sure you have the right travel coverage in place to protect their health and peace of mind before they pack their bags. MMA

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# YOUR QUESTIONS

**Q.** In February, after several payrolls in our 2020 plan year, an employee advised that he mistakenly elected the dependent care flexible spending account (FSA) during annual enrollment last fall. His children are not in day-care, and he actually intended to use that money for his dependents' health care expenses. Is there any way to fix this for him now, without violating the terms of our Section 125 plan?

**A.** Section 125 of the Internal Revenue Code permits employees to convert their taxable wages into certain non-taxable benefits. The Section 125 plan document and summary plan description (SPD) provide precise details on how this plan works, including which benefits are eligible for pre-tax deduction and when and how those elections may be made and changed during annual enrollment and mid-year.

Flexible spending accounts are a component of the Section 125 plan. There are two versions of the FSA: health care and dependent care. The health care FSA is used to pay for eligible health care expenses incurred by the employee and his or her tax dependents under the Internal Revenue Code. The dependent care FSA is used to pay for the day care expenses of a qualifying child or qualifying relative, which allows the employee (and the employee's spouse, if applicable) to work or attend school full-time.

Employers generally try to explain the difference between these accounts to employees, in the annual enrollment materials and via distribution of the SPD to plan participants. Unfortunately, employees may still assume that a dependent care FSA pays for the health expenses of their spouse and children. Often, they fail to realize their error until after pre-tax deductions for this benefit have begun.

Technically, the employee should not be permitted to change a pre-tax election on a retroactive basis, and without experiencing an IRS-defined qualifying change in status that allows such an adjustment. An employer who does not rigorously uphold the provisions of their Section 125 plan puts its existence in jeopardy for all participants, in the event of an IRS audit.

However, informal guidance from the IRS has indicated that an employee's pre-tax election can be changed, outside of a qualifying change in status, if there is "clear and convincing" evidence that a mistake was made. If the mistake arose on the employer's part (such as a data entry error), it is much easier to prove. But if this employee does have dependents who could potentially be enrolled for day care, despite present circumstances, it is more difficult to prove clear evidence of an employee error. He may simply have changed his mind, and is now saying the election was made by mistake to improve his chances for getting it changed. Thus, the safest response in this situation is to disallow an election change outside of an actual qualified change in status.

Although this is the correct approach, it may not sit well with employers who want to be empathetic and helpful. Employers may want to allow the change, but should not do so without first documenting the decision thoroughly. Don't simply wipe the election from your benefits administration system or destroy the FSA enrollment form. Make a note of what is being requested, with the pertinent dates, and why the employer has decided to allow the change. Have the employee sign off on the note, indicating agreement with the stated facts.

At this point, change the election in your benefits administration system, notify the administrator, and refund any deductions taken for the dependent care FSA as taxable wages. You should not allow the employee to transfer any funds to a health care FSA, even if that was, allegedly, his original intent. It is sufficient to fix the error, not to re-do his elections for the plan year.

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# TECHNICAL CORNER

When is the last time you conducted nondiscrimination testing for your Section 125 (or cafeteria) plan? The IRS regulations require plans to perform annual testing by the last day of the plan year. But nothing precludes an employer from testing early in the year, and testing multiple times. In fact, it is advisable.

The Section 125 plan allows participants to choose between taxable benefits (i.e., wages) and non-taxable benefits, which may include medical, dental and vision coverage and health care and dependent care flexible spending accounts (FSAs). Some of the tests will determine if the plan is treating all employees equally with regard to eligibility and access to benefits. A plan can easily pass these tests as long as non-highly-compensated employees are offered the same benefits, on the same basis, as highly-compensated employees (HCEs).

However, an issue often arises with the 55 percent average benefits test applicable to the dependent care FSA. This particular benefit is infrequently elected, as many people fare better by instead taking the dependent care tax credit. Thus, the dependent care FSA tends to be more popular with individuals earning higher incomes, including those defined as HCEs (i.e., employees earning greater than $130,000, or a five percent shareholder in the company). The plan will fail the 55 percent average benefits test if the benefit provided to non-HCEs is not at least 55 percent of the benefit given to HCEs. For example, if several HCEs elect the maximum benefit of $5,000, and a handful of non-HCEs elect a lesser amount, it may be found that the dependent care FSA is discriminatory in favor of HCEs.

If your Section 125 plan fails one or more tests, then adjustments must be swiftly made to bring it into compliance. In the case of the 55 percent average benefits test, that means changing the elections of the HCEs so they don't receive a greater benefit, on average, than the non-HCEs. If they've already received reimbursement for expenses, they may have to repay a portion to the plan. This is why it's wise to test early, preferably during the first quarter of the plan year. If the plan fails this test after only a few payroll deductions, it's much easier to adjust the HCEs' elections and corresponding contributions. In addition, they are unlikely to have received excess reimbursement. There is significantly less frustration in making the changes early, for the HCEs, human resources and payroll.

Your Section 125 plan administrator will likely perform the basic required tests for you at no charge after you provide them with the necessary information. Take advantage of this, and test your plan at least twice per year, during the first quarter and again during the fourth quarter. But testing on a quarterly basis, especially if you are doing a lot of hiring, is the optimal choice.

# LIABILITY LESSONS

## TO REPORT OR NOT TO REPORT - THAT IS THE QUESTION

When exactly do you need to report an accident to your insurance carrier? Does someone need to be hurt? What happens if there is a "near miss" where it appears no one was injured? Should you report those cases as well? This article examines those questions in the context of a general liability policy.

For the sake of this discussion, let's assume the following fact pattern. A visitor at your facility or office trips and falls in the lobby. Your staff saw the fall and immediately provided assistance. The individual was able to stand on his own and walk without assistance. Your staff observes him closely to make sure he is well and then writes an incident report to create a record of the fall and their response. The "near miss" incident report was placed in your risk management file. Two years later, the individual files a lawsuit against your company, alleging injuries from the fall. Your company immediately reports the lawsuit to your general liability insurance carrier, and they in turn deny coverage.

The insurance carrier's denial letter points to language in the policy that says "you must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim."

To the extent possible, notice should include:

1. How, when and where the "occurrence" or offense took place;
2. The names and addresses of any injured persons and witnesses; and

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3. The nature and location of any injury or damage arising out of the "occurrence" or offense.

An “occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

The insurance carrier argues that because your staff was aware of the fall but didn’t report it to the insurance carrier, you did not comply with the policy notice requirements and therefore coverage is denied.

If you are aware of an accident or occurrence which may result in a claim, it would be in your company’s best interest to provide notice to the insurance carrier in order to preserve your rights to coverage. Accidents that are reported as a matter of “record only” generally don’t result in premium increases unless there is a significant frequency of accidents that give rise to concern.

Another option is for companies to revise their insurance policy’s notice requirements so that company executives or the risk manager (as opposed to general staff) must have knowledge of the incident in order to trigger the notice requirement.

As the insurance market continues to harden, insurance carriers might find more reasons to resist paying claims where policy conditions have not been met. Notice requirements vary widely between policy types, so insureds should be mindful of when they need to report an incident to their insurance carrier. When in doubt, check with your insurance agent or just report it to the carrier to be on the safe side.


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