

# 3

## *Group Insurance*

### **Overview and Learning Objectives**

Chapter 3 discusses the general concepts of group insurance, the keystone of employee benefit packages. This discussion is followed by an in-depth look at the four major types of group insurance. The chapter closes with one new planning approach to medical expense coverage, the Health Savings Account (HSA). An understanding of the material in this chapter should enable the student to

- 3-1. Explain the general concepts, legal requirements, tax aspects, prospects, and information to gather within the group insurance market
- 3-2. Discuss the types, legal requirements, tax aspects, and planning considerations of group medical expense coverage.
- 3-3. Describe the types, legal requirements, tax aspects, and planning considerations of group life insurance coverage.
- 3-4. Describe the types, legal requirements, tax aspects, and planning considerations of group disability insurance coverage.
- 3-5. Discuss the concept, types, legal requirements, tax aspects, and planning considerations for group long-term care insurance coverage.
- 3-6. Explain the concept, legal requirements, tax aspects, and planning considerations for HSAs.

## **Chapter Outline**

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# Group Insurance

The most common employee benefit is *group insurance*. This section gives an overview of some general group insurance concepts. It goes on to describe some of the more popular group insurance products: medical expense coverage, life insurance, disability insurance, and long-term care insurance (LTCI). Then it examines them in terms of legal requirements, tax aspects, and planning considerations.

## Basics of Group Insurance

It is helpful to review the basics of group insurance in order to lay the foundation for discussing its various types. There are some concepts, legal requirements, and tax aspects that are common to all of the types. In addition, group insurance products also share commonalities in terms of prospects and the information to gather during the fact-finding process.

### Concept of Group Insurance

Group insurance is distinct from individual insurance because of the nature of the group contract and group underwriting. For larger groups, an additional distinguishing characteristic is experience rating.

**Group Contract**—Group insurance provides coverage to multiple persons under one contract, the *master contract*, that is issued to an entity other than the persons insured. The insured group of individuals is considered to be a group because of their specific relationship to the policyowner. This is, typically, an employee-employer relationship. Instead of a policy contract, each employee receives a certificate of insurance that describes the coverage provided.

**Group Underwriting**—In addition, the insurance company utilizes *group underwriting*, which differs from individual underwriting in that it focuses on the characteristics of the overall group rather than any one

**“My entrée into small closely held businesses is group insurance. Group insurance opens the doors for pensions, nonqualified plans, and estate planning for the business owner.”**

**—Advisor in the group insurance market**

individual. Typically, individuals are not asked to provide evidence of insurability when initially enrolling into a group plan.

**Experience Rating**—Finally, larger groups utilize *experience rating*, a practice by which the actual claims experience of the group is a factor in determining future premiums.

<b>Opportunities and Challenges in the Group Insurance Market</b>	
<b>Opportunities</b>	<b>Challenges</b>
<ul style="list-style-type: none"> <li>• There is access to blocks of new prospects who are familiar with your expertise and professionalism.</li> <li>• Commissions are higher and generally increase substantially due to the growing number of employees, aging of the employees, and increased costs of coverage.</li> <li>• Business owners are willing to talk about group insurance—especially medical expense coverage.</li> <li>• If you do not offer it, another advisor will offer it and may seize other nongroup opportunities as well.</li> <li>• It opens the door to other business and personal insurance for the business owners.</li> </ul>	<ul style="list-style-type: none"> <li>• Most business owners shop around for group insurance.</li> <li>• Group medical expense coverage rates tend to be volatile and increase sharply every so often.</li> <li>• Group insurance is very service intensive, especially when you first implement a plan.</li> <li>• The learning curve is challenging and there is much to learn in order to become competent in the group insurance field.</li> </ul>

### **Legal Requirements**

Various state and federal laws regulate group insurance. State laws may apply to group insurance in general or specifically to one type of group insurance. For example, state laws may limit

- the minimum number of covered employees
- the minimum percentage participation
- the conditions for conversion to individual policies upon termination of employment
- the maximum amount of group life insurance allowed on any one person

Check with your company or state insurance department for the specific rules that apply in your situation.

In addition, the following federal regulations apply to group insurance in general. Specific federal regulations are discussed within the context of the type of insurance to which they apply.

**Employee Retirement Income Security Act (ERISA)**—The *Employment Retirement Income Security Act (ERISA)* is a federal act designed to protect employee benefit plan participants and their beneficiaries. ERISA mainly focuses on pension plans. However, employee welfare benefit plans are addressed in specific sections of the act. Employee welfare benefit plans include benefits such as medical expenses, sickness, disability, death, dependent care, and prepaid legal services. Thus, it governs group insurance plans and other employee benefits.

ERISA requires that every employee welfare benefit plan subject to the act's regulations be established and maintained pursuant to a written document. The document must

- specify the plan fiduciaries who will have the authority to control and manage the plan's operation and administration
- describe how the funding of the plan will be established and carried out
- describe how the plan will make amendments and who is authorized to make them
- specify how payments are made to and from the plan

In addition, ERISA requires reporting and disclosure to plan participants, the Department of Labor, and the Internal Revenue Service (IRS). Examples of the information required include a summary plan description, a summary of material modifications, and an annual return/report (IRS Form 5500 or a variation of this form). However, employee welfare plans with fewer than 100 participants at the beginning of a plan year may be exempt from some of the reporting and disclosure requirements, if they meet certain conditions. Financial advisors should advise employers to consult an accountant or attorney for details.

**Nondiscrimination Requirements**—In general, Congress does not want to give tax advantages to group insurance plans that discriminate in favor of highly compensated employees. Thus, the purpose of *nondiscrimination requirements* is to encourage business owners to

provide coverage for rank-and-file employees and not simply for themselves and/or their executives and key employees.

Nondiscrimination requirements vary from one benefit type to another and are discussed within the context of the specific benefits to which they apply.

## **Tax Aspects**

Financial advisors must not give specific tax advice unless they are licensed to do so. However, they should develop a solid understanding of the tax aspects of group insurance because

- taxation of group insurance is a major concern for business owners
- knowledge of tax aspects is essential for being recognized as a competent advisor
- tax aspects of group insurance influence plan design

The tax aspects that are discussed for each type of group insurance are the tax deductibility of the premium for the employer, the taxation of employer-paid coverage to employees, and the taxation of the benefits to the employee.

**Tax Deductibility for the Employer**—Premiums paid for group insurance on employees, including the owner-employee (sometimes referred to in this text as shareholder-employee or just shareholder) of a C corporation, are tax deductible to the employer. (By *owner-employee*, we mean that the owner is a full-time employee of the corporation. An owner who is not active in the day-to-day management of the business is not considered to be an employee.) The exceptions to the deductibility that normally applies to group insurance premiums include that

- no deduction is allowed for group plans that fail to comply with the various federal requirements previously discussed
- no deduction is allowed if the business itself is the beneficiary of the policy
- no deduction is allowed for premiums paid on behalf of any owner-employee whose total compensation, including employee benefits, violates the IRS principle of reasonable compensation

Other exceptions apply, depending on the type of group insurance. These exceptions are described in the discussion of each type of group insurance.

**Taxation of Employer-Paid Coverage to Employees**—Generally, the cost of employer-paid coverage is not taxable to the employee. Details and exceptions are described in the discussion of each type of group insurance.

**Taxation of Benefits to the Employee**—Generally, the benefits are not taxable to the employee. Details and exceptions are described in the discussion of each type of group insurance.

## Prospects

If an employer has employees, there is a possible need for group insurance. Here are a few ways to segment the market.

**Employers with No Group Coverage**—Obviously, if an employer does not offer group insurance, it can be a prospect. The key in working with such employers is to determine why they do not have group insurance. Some of the common reasons and their implications include the following:

*Hazardous Industry*—If the employer is in a hazardous industry, group insurance may not be available. Unless you know coverage can be obtained from a specialized carrier or that part of the group can be “carved out” and covered, you probably would be wasting your time pursuing the matter.

*Employees Cannot Afford It*—Employees in minimum-wage-type jobs cannot afford or, typically, are unwilling to pay their portion of the premium. In these situations, you do not have a prospect.

*High Employee Turnover*—Some employers prefer not to offer coverage because of high turnover among employees. Sometimes you can

### Cold-Canvass Approach

One of the best approaches for group prospecting is cold-canvassing. Your approach can be very simple, for example:

*“Hello! Are you the owner?”* (Wait for a response. If he or she is not the owner, you might say, “May I speak to the owner?”)

*“Business owner, do you have group insurance on yourself and your employees?”* (Wait for a response.)

Once you obtain the answer to this question, you can follow up by finding out why they do not have coverage or what coverage they have and how satisfied they are with it.

suggest plan features, such as extended waiting periods, which may eliminate the high-turnover category. On the other hand, it is possible that installing a quality group program could reduce turnover. Use sound judgment here, not wishful thinking. Some key factors to determine:

- How much of a concern is employee turnover? If it is a high concern, you may have a prospect.
- Why do employees leave? If employees are leaving to go to employers with better benefits packages, you may have a prospect.

*Too Few Employees*—Some employers have been misinformed or feel they are too small for group insurance. If you have a small-group product, chances are you have a good prospect.

### **Working with Employers That Have Existing Group Coverage**

When you encounter employers with existing group insurance, ask questions such as the following:

- *“What kinds of coverage do you have?”*
- *“Are you satisfied with your current coverage and with the service you are receiving?”*
- *“When does your health coverage come up for renewal?”*
- *“At your next renewal, would you be interested in looking at ways to save money and/or upgrade your service?”*

If your prospect has recently had a premium increase, try the following:

*“Prospect, if I can be cost competitive with your current group insurance, would you be interested?”*

If the answer is *no*, you do not have a prospect. If the answer is *yes*, continue this way:

*“If the cost is favorable, are you willing and able to do business with me, or are you obligated to someone else?”*

Wait for a response. If you have unbeatable competition, it is best to find that out now. At this point, if the response is favorable, get as much additional information as possible. At a minimum, obtain a copy of the present employees' plan booklet or a copy of the master contract itself. Try also to secure a copy of the most recent billing statement and a census of the employees. If you cannot obtain a census, you probably do not have a prospect.

Then, ask for an appointment. If the prospect is reluctant to schedule an appointment at this time, ask when the group insurance comes up for renewal. Plan to contact the prospect again 45 to 60 days before the renewal.

*New Businesses*—You may find a new business that has not yet adopted a plan. Frequently, the owners will have left another employer to start their own, and in doing so, will have given up their group coverage. These are often good prospects.

**Employers with Existing Group Insurance**—According to the NFIB Education Foundation survey cited earlier, the number one concern for small-business owners is the cost of health insurance. If an employer offers health insurance to its employees, there is a good chance it will be a prospect.

There are two things you want to look for when qualifying these prospects. First, look for warning signs that the employer demands unreasonable service or has poor claims experience. If they express dissatisfaction with their current coverage, ask the reason. Second, assess whether or not the employer is interested in changing carriers. If you have “unbeatable” competition, it is best to find that out in the beginning.

**Business Owners Who Need Coverage**—In many cases, business owners need coverage for themselves. Group insurance can provide coverage at a price generally lower than that of individual insurance. Also, if the business owner or a family member would be uninsurable or rated through an individual policy, group insurance is an opportunity to provide otherwise unavailable or cost-prohibitive coverage.

**Businesses Competing for Talented Employees**—Competition for talented employees ebbs and flows with the economy. In economic-boom times, such as in the 1990s, companies compete aggressively for good employees. The more competitive the industry, the greater the pressure for a company to offer excellent group insurance benefit packages.

## **Information to Gather**

The information-gathering process is fairly involved. The following is a list of things that may be needed before you prepare a group insurance proposal for a prospect. The exact requirements will depend on your carrier and your state. You may need

- an employee data or census sheet that typically includes the following information for each employee: name (or employee number), sex, date of birth or age, earnings, length of time with the company, occupation or duties, whether the employee has a

spouse and/or number of dependent children, and the age of spouse

- the name and address of the business organization
- the type of business
- a proposed effective date for the insurance
- to know whether or not the plan is to be contributory. If so, you will need information about how the premium will be prorated between the employer and the employees.
- the name of the current carrier, if the business already has group insurance. (Information about the employer's recent history with group insurance may also be required. For example, you may need details about the rates, benefits, and claims for each of the past few years.)
- the renewal date of the present plan
- a copy of the booklet or master contract that describes the current plan. (This may not be needed by your carrier until the plan is sold, but a copy will help ensure that you are providing comparable benefits.)
- the various forms and checklists your company may require
- a recent billing statement
- a current health history

## **Group Medical Expense Coverage**

Group medical expense coverage is the most popular type of group coverage. It is also the most expensive.

### **Types of Group Medical Expense Coverage**

Medical expense coverage in the United States has been evolving since the emergence of the earliest forms of health insurance plans in the 1930s. The traditional product, *medical expense insurance*, dominated the market until the 1990s. Under these traditional plans, the covered person had complete freedom in choosing a doctor or a hospital. Medical bills were paid by the plan. No attempt was made to control costs or to limit services. It is estimated that in the mid-1980s, about 75 percent of all insured workers were covered under such medical expense plans. This number is dropping rapidly. Today, these plans represent a small percentage of all coverage. In addition, many traditional reimbursement plans have been redesigned to include varying degrees of cost control.

The plans that have overtaken the traditional medical expense plans are *managed care* plans. Managed care is a generic term that refers to a variety of requirements imposed by the plan to keep costs down. It includes such concepts as controlling the person's access to specialists by requiring referrals from the person's primary care physician. Reviews are made automatically to decide if a planned operation is really necessary or advisable. Doctors and hospitals are rewarded for keeping costs down. In addition, preventive care is encouraged as a way of keeping costs down.

**Traditional Medical Expense Insurance**—Traditional medical expense plans are structured in one of two ways. Some plans offer basic coverages along with a major medical supplementary contract. Others offer the basic coverages as part of a major medical comprehensive contract. More information follows.

*Basic Coverage*—Basic coverage typically includes the following:

- hospital expense benefit
- surgical expense benefit
- physicians' visit expense benefit

The *hospital expense benefit* pays for expenses related to inpatient hospitalization, although some outpatient procedures are covered as well. These expenses include the cost of the room, meals, routine nursing care, and so forth. The hospital expense benefit also includes services and supplies ordered by a physician during the hospital stay, for example, drugs, laboratory expenses, diagnostic X-ray expenses, and so on. However, one notable exception is that the charges associated with the physicians' services are generally not covered.

The *surgical expense benefit* pays for the cost of a physician's service related to surgical procedures, including outpatient surgery. The definition of surgery includes procedures other than those that require cutting. For example, the treatment of fractures or dislocation are classified as surgery.

#### **Example of Deductible and Coinsurance**

John's major medical policy has a 20-percent coinsurance and a \$500 deductible. John requires treatment that costs \$250. He would pay the full \$250 because his \$500 deductible has not been satisfied.

John requires treatment again in the same calendar year. The total cost is \$500. He would pay

\$250	(to satisfy the rest of his deductible)
<u>\$ 50</u>	(20 percent x the remaining \$250)
\$300	

Any further claims during this calendar year would result in an out-of-pocket payment for John of 20 percent of the total costs.

The *physicians' visit expense benefit* pays for the fees related to an attending physician (other than a surgeon) whose services are required during a hospital stay. In some policies, the coverage extends to office and home visits.

Many of these traditional plans provide 100-percent coverage and, thus, they contain maximums to limit the amount of the insurance company's liability. In recent years, however, newer plans have been written to use coinsurance and deductibles.

*Major Medical Coverage*—There are two types of major medical coverage: supplemental and comprehensive. Supplemental plans are designed to coordinate with basic plans to provide coverage once an insured's basic coverage exceeds the basic plan's maximums or scope of coverage. In contrast, comprehensive plans provide full coverage of basic and supplemental medical coverage needs under one plan.

Supplemental coverage is designed to fill in the gaps left by the basic plan. For example, it covers items such as radiation therapy, ambulance services, and prescription drugs. However, there are few plans that cover all of the gaps. Most notably, routine physicals, dental, vision, and hearing care are typically excluded. The comprehensive coverage includes the basic plan but it also has these gaps in coverage.

Both supplemental and comprehensive major medical plans differ from basic plans in that they require the insureds to pay a deductible, usually within a \$100 to \$500 range. Major medical plans pay nothing until the deductible is met. Once the deductible is met, the plans pay a percentage of the medical expenses, typically 80 percent. The insured pays the remaining 20 percent.

Many major medical plans begin to pick up 100 percent of all expenses (in contrast to the 80/20 split just mentioned) after a certain amount of out-of-pocket expenses have been incurred by the insured. This provision is known as a *stop-loss limit* or *coinsurance cap*. The stop-loss provision limits the liability of the insured in the event of a major medical situation.

*Other Coverages*—There are other coverages that can be offered, such as vision care, prescription drugs, dental, and hospice care.

**Managed Care Plans**—Managed care plans have grown dominant because they were seen as a solution to the rampant increase in health

care costs. In general, managed care plans have the following characteristics.

First, managed care plans limit access to medical care providers by using a referral process. Insureds must obtain approval from their primary care physician before they can see a specialist. The logic is that unrestricted access to medical care causes increased and indiscriminate use because the person assessing the medical necessity of a surgery or a procedure is, in most cases, someone who does not know much about medicine. In contrast, managed care places the decision for further treatment into the hands of the primary care physician.

Second, managed care plans emphasize preventive care. For example, a comprehensive major medical plan may not cover preventive care, such as routine physicals, pap smears, immunizations, eye exams, and so forth. In contrast, these are covered by managed care plans.

Third, managed care plans contract with medical care providers and include incentives to reduce unnecessary diagnostic tests.

Finally, as the name implies, managed care plans provide comprehensive utilization case reviews. These reviews include the monitoring of ongoing care and the assessment of a case once treatment has concluded.

These characteristics are true in varying degrees of all managed care plans.

As you probably already know, there are several variations of managed care, each with its own set of nuances. The most common are the *Health Maintenance Organization (HMO)*, the *Preferred Provider Organization (PPO)*, and the *Point-of-Service (POS) Plan*.

*Health Maintenance Organizations (HMOs)*—HMOs were authorized by Congress in 1973 in an attempt to establish quality health care in communities with limited or inadequate services and to pioneer cost-containment concepts. The number of HMOs in operation grew dramatically in the 1980s, and peaked in the mid-1990s. Recently, the numbers have been declining.

HMOs hire or contract physicians to provide its subscribers medical treatment, perform surgery, and provide all other medical services. Subscribers pay a fixed monthly amount and little or nothing additional for services received. The HMO itself may be for profit or nonprofit.

HMOs use a variety of models. Currently, the most popular one is the *individual practice association (IPA) model*, which enables an HMO to contract a large number of individual and group physician practices

through a single entity known as an *individual practice association (IPA)*. The HMO subscribers that a physician sees through an IPA are usually in addition to non-HMO patients. The IPA model is popular because it typically provides the greatest number of physicians from which subscribers can choose.

In contrast to the IPA model, the next three models are ones in which physicians generally treat HMO subscribers only. In the *staff model*, the HMO owns a facility and hires physicians as salaried employees. In the *group model*, instead of hiring the physicians as employees, the HMO contracts with one group of physicians. A variation of the group model is the *network model*, in which the HMO contracts with two or more physician groups.

As HMOs increase in the number of subscribers, they tend to adopt a *mixed model*, which is a combination of two or more of the previously described models. Mixed model HMOs represent over 30 percent of all HMOs.

*Preferred Provider Organizations (PPOs)*—Preferred provider organizations are groups of physicians and hospitals that contract with employers, insurance companies or third-party administrators to provide health care services at reduced fees. PPOs are similar in concept to HMOs. They differ in that they provide service on a fee basis that is scheduled, not by prepaid agreement, and it is the same for all participants. Also, enrollees do not have to use the PPO physicians or facilities. They can make a choice each time health care is necessary, but using the PPO usually means a lower deductible (if at all) and copayment.

*Point-of-Service (POS) Plans*—Point-of-service plans combine qualities of HMOs and PPOs. If you go to a doctor within the POS network, the plan acts like an HMO. That is, you pay only a small copay and no deductible. If you choose a physician outside the network, the insurer pays a portion of the cost, usually 70 or 80 percent, and you pay the rest, as well as an annual deductible amount. The cost of a POS plan generally falls between that of an HMO and a PPO.

**Defined-Contribution Medical Expense Plans**—The *defined-contribution medical expense plan* is a new concept in medical expense coverage and it is gaining considerable attention. The term is very difficult to define because it has been used in so many ways. However,

the main theme is that employees have increased choices and responsibilities associated with their medical expense coverage. The theory is that employees will make more cost-effective choices in selecting coverage and seeking treatment when they have a financial stake in the matter. Thus, defined-contribution medical expense plans increase employee responsibility and choice in selecting coverage, seeking treatment, or sometimes in both.

*Selecting Coverage*—The first defined-contribution strategy is for the employer to make a fixed contribution with which the employees can choose to “purchase” their own coverage. The employees can choose from any of the available coverages, but they pay for any cost in excess of the employer-provided amount.

One such model has been around for quite some time. For example, many employers make several medical expense plans available to their employees, such as an HMO, a POS, and a traditional medical expense plan. The employer’s contribution toward the cost of each plan may be a dollar amount that is a fixed percentage of the plan with the lowest cost. Therefore, an employee who elects a more expensive plan will need to make a greater out-of-pocket contribution for his or her coverage.

A second model is emerging, albeit slowly, in which the employee can use an employer’s contribution along with his or her own monies to purchase a medical expense plan from a “health care supermarket.” An insurer or a broker via the Internet may offer these plans, and the employer may or may not be involved in the selection of the supermarket that an employee uses.

*Seeking Medical Treatment*—The second defined-contribution strategy is often referred to as *consumer-directed health care*, in which employees must factor in the costs associated with seeking medical treatment.

This strategy uses a health plan that has a very high deductible (such as \$5,000 per year), in combination with an account from which the employee can make withdrawals to pay medical expenses that are not covered because of the deductible. One such account is the *health reimbursement arrangement (HRA)*. Only the employer can fund an HRA. Typically, with an HRA, the employer contributes an amount less than the deductible, such as \$2,500 per year. Any unused amount in the account can be carried over and added to the employer’s contribution for the next year. Such a plan gives the employee an immediate incentive to purchase medical care wisely, because the employee will have to pay

**“Nobody spends  
other people's  
money the way they  
spend their own  
money.”**

**—Maureen Cotter  
Watson Wyatt  
Worldwide**

medical expenses out of his or her own pocket if the amount in the HRA is exceeded. Note that self-employed are not considered employees and HRAs cannot be set up for them.

A new type of account that can be used, the *health savings account (HSA)*, was available as of January 1, 2004. (The HSA is discussed later in this chapter.)

Another type of account, the *Archer Medical Savings Account (MSA)*, can also be used. However, new Archer MSAs are no longer available as of December 31, 2003.

**Self-Funding**—In general, *self-funding* or *self-insuring* in the context of employee benefits means that an employer finances the cost of an employee benefit plan. In the method's purest sense, the employer pays the benefits from current revenue, administers all aspects of the plan, and bears the risk that benefit payments will exceed those expected. As it relates to health insurance, it can mean that a business organization provides everything for itself that an insurance company normally provides, including all actuarial, administrative, and claims work.

Although self-funding holds a potential for cost savings, it is such a huge undertaking that very few corporations give it serious consideration. On the other hand, there are many organizations large enough and interested enough in the concept of self-funding that they self-fund some of their insurance liabilities. In a typical arrangement, a business self-funds a certain portion of the employee health care exposure, buys excess coverage, and contracts out most or all of the administrative, legal, and claims work to an insurance company or to a third-party administrator.

## **Legal Requirements**

In addition to the legal requirements that govern all group insurance, there are a few additional ones that apply to group medical expense insurance.

**Pregnancy Discrimination Act**—The *Pregnancy Discrimination Act* was passed in 1978 as an amendment to the federal Civil Rights Act. It requires that health care and sick-pay plans of most employers with 15 or more employees treat pregnancy the same as an illness. The employer must provide this coverage either through an insurance plan or by self-insuring the costs.

**Health Maintenance Organization Act of 1973**—The *Health Maintenance Organization Act of 1973* requires that employers with 25 or more

employees and subject to minimum wage laws offer a dual option between an insured health care plan and a qualified health maintenance organization, if a federally qualified HMO requests inclusion.

**Consolidated Omnibus Budget Reconciliation Act (COBRA)**—Passed in 1985, the *Consolidated Omnibus Budget Reconciliation Act (COBRA)* requires that employers with 20 or more full-time employees on at least half of its previous calendar year’s regular business days offer employees, spouses, and dependents a continuation of group health coverage for up to 36 months.

An offer of continued coverage must be made to employees who would lose coverage because their work hours are reduced or they are terminated for reasons other than gross misconduct. Coverage for this class of employees must be continued for up to 18 months. It is extended to 29 months for a person who was disabled at the time of the qualifying event.

Continued coverage for at least 36 months must be offered

- to divorced, legally separated, or widowed spouses and their dependent children
- to dependent children who would lose coverage as dependents when they attain the limiting age under the health plan
- to spouses and dependents who are ineligible for Medicare when the covered employee elects Medicare coverage and loses or refuses group plan coverage

Employers are permitted to charge the employee or family member for this continued coverage. The premium cannot be more than 102 percent of the cost of the plan for insuring similarly situated plan members. The one exception to this rule is for the extension of benefits for disability. For months 19 through 29, the premium can be as high as 150 percent.

Core health benefits under Section 125 flexible spending accounts are included under COBRA if they had been elected prior to the qualifying event. In contrast, voluntary benefits purchased through voluntary payroll deduction plans are not subject to COBRA.

Some states have laws that pertain to continuation of benefits coverage. Check with your state’s insurance department.

**Health Insurance Portability and Accountability Act (HIPAA)**—The *Health Insurance Portability and Accountability Act (HIPAA)* was

passed in 1996. It requires group health insurance to have a degree of portability. That is, employees can change jobs without losing health coverage while they are between jobs.

HIPAA also places limits on the exclusions an insurance company might otherwise impose on a new enrollee due to the employee's pre-existing health condition. Furthermore, any pre-existing condition exclusions that are allowed cannot extend for more than 12 months.

Some of the other provisions of HIPAA that impact the medical expense coverage include:

- a pilot for Archer Medical Savings Accounts (MSAs)
- a change in the tax-deductibility of medical expense premiums for self-employeds
- an expansion of the definition of "child" for COBRA purposes to include any child who is born to, or adopted by, the employee during the period of COBRA coverage

**Nondiscrimination Rules for Self-Funded Plans**—Only self-funded plans, referred to by the Internal Revenue Code as self-insured medical reimbursement plans, are subject to nondiscrimination requirements. If a self-funded plan discriminates in favor of a *highly compensated employee (HCE)* in the way it determines eligibility or pays benefits, a portion or all of the benefits that the highly compensated employee receives is considered taxable income.

A highly compensated employee is a person who meets at least one of the following:

- is one of the five highest-paid officers of the employer
- is a shareholder who owns more than 10 percent of the employer's stock
- is one of the highest-paid 25 percent of all the employer's employees

A self-insured plan does not discriminate as to eligibility if it passes any one of these tests:

- the plan benefits 70 percent of all employees
- the plan benefits 80 percent of all employees eligible to participate if 70 percent or more of all employees are eligible
- the plan benefits an IRS-approved classification of employees

With regard to the benefits test, the same benefits must be available to all employees. Benefits may not be in proportion to compensation.

## **Tax Aspects**

**Deductibility of Premiums by Employer**—The rules for tax deductibility are slightly different for coverage through an insurance company, a Blue Cross-Blue Shield plan, an HMO, a PPO, or POS than they are for self-funded plans. In the case of the former, the employer’s portion of the premium for an employee is tax deductible for federal income tax purposes as long as the employee’s overall compensation meets the federal guidelines of reasonable compensation.

For self-funded plans, tax deductibility depends on the plan meeting the nondiscrimination rules described earlier in the “Legal Requirements” section.

Unlike other group insurance benefits (except for long-term care insurance), self-employed can deduct the premium for medical expense coverage on themselves. (Self-employed include a sole proprietor, partner, member, or the owner of an S corporation that has more than a 2-percent ownership interest). In fact, beginning in 2003 (thanks to HIPAA), they can deduct 100 percent of the premium. In previous years, they were only able to deduct a percentage.

**Taxation of Employer-Paid Coverage to Employees**—For group medical expense coverage, the employer-paid portion is not deemed to be a taxable economic value. For this reason, group medical expense coverage is a financially attractive fringe benefit to employees.

**Taxation of Benefits to Employees**—Medical/hospital/surgical benefits are generally received tax free. However, if the benefits paid exceed actual expenses incurred, the excess is reportable as ordinary income.

In addition, if the IRS deems that a self-funded medical expense plan is discriminatory in either benefits or eligibility, all or a portion of the benefits will be taxable to the highly compensated individual as defined earlier in the “Legal Requirements” section. Again, this applies to self-funded plans only.

## **Planning Considerations**

Medical expense coverage is the most expensive benefit an employer can offer. Yet, it is the one benefit employees covet the most. In your

planning sessions with business owners, consider the following possibilities.

**Traditional Medical Expense Plan versus Managed Care**—The main decision will be the type of plan the employer ought to select. The traditional medical plans provide much more freedom in choice but less in cost-controlling tools. Use table 3-1 to help you evaluate the differences between each type of plan. The degree of managed care increases as you move left to right.

**Traditional Medical Expense Plan Options**—There are a few planning considerations to note when working with traditional medical expense plans.

*Basic/Supplemental versus Comprehensive*—If your prospect's situation and preference is for a traditional medical expense plan, you want to weigh the benefits of a combination basic and supplemental major medical plan, and those of a comprehensive major medical plan. All things being equal, the comprehensive plan is better than a combination arrangement, because it provides greater communication and administrative ease. However, you should consider the following possibilities.

In some situations, the basic plan may cover more expenses than the corresponding coverage of a comprehensive plan. For example, the basic plan may provide coverage without a deductible or coinsurance, while the comprehensive plan requires the insureds to pay a deductible and coinsurance.

One other possibility is if the employer would like to pay for the cost of basic coverage but offer the supplemental coverage as a contributory benefit. Obviously, the same arrangement could be made with one policy; however, the employer may feel more comfortable with a two-policy arrangement.

*Stop-Loss Limit*—The stop-loss limit, as mentioned earlier, limits the exposure an insured has to incurred medical expenses. It is important for the employer to set an appropriate limit—one that his or her employees can afford.

<b>TABLE 3-1 Comparison of Health Insurance Plans <sup>1</sup></b>				
	<b>Traditional Major Medical Contracts</b>	<b>Managed Care Plans</b>		
		<b>PPOs</b>	<b>POS Plans</b>	<b>HMOs</b>
Provider Choice	Unlimited	Unlimited but benefits are greater if network provider is used	Unlimited but benefits are greater if network provider is used	Network of providers must be used; care from non-network providers covered only in emergencies
Use of Gatekeeper	None	None	Used for care of network specialists	Used for access to specialists
Out-of-Pocket Costs	Deductibles and percentage participation	Deductibles and percentage participation, which are lower if network providers are used; may have small copayment for network services	Small copayments for network services; deductibles and percentage participation for non-network services	Small copayments for some services
Utilization Review	Traditionally little, but a few techniques are likely to be used now	More than traditional plans, but less than HMOs; network provider may be subject to some controls	Like HMOs for network services; like PPOs for non-network services	Highest degree of review, including financial incentives and disincentives for providers
Preventive Care	Little covered other than that required by law	Usually more coverage than traditional major medical plan, but less coverage than HMOs and POS plans	Covered	Covered
Responsibility for Claims Filings	Covered person	Plan provider for network services; the covered person for non-network services	Plan provider for network services; the covered person for non-network services	Plan providers

1. Burton T. Beam, Jr., *Group Benefits: Basic Concepts and Alternatives*, 9th ed. pp. 288–289

**Managed Care Options**—The main consideration with managed care options is access to physicians and specialists of choice. Employees prefer that coverage does not impact their current physician. This is especially true in replacement situations. Such changes could create friction for the prospect, so proceed carefully.

**Defined-Contribution Health Care Options**—The skyrocketing cost of medical expense coverage is causing many businesses without coverage, especially small businesses, to not include it in their benefits. And it has caused those who currently have such coverage to consider its elimination. In these situations, defined-contribution health care may be an appropriate solution. For example, a high-deductible health plan with an HRA or HSA can enable an employer to provide some medical expense coverage at an affordable cost to the company. The presence of an HRA or HSA softens the blow of the high-deductible plan. Furthermore, the HSA has the potential of financially benefiting a healthier employee in the long run. (The HSA is discussed later in this chapter.)

## Group Life Insurance

The second most common group insurance benefit is life insurance.

### Types of Group Life

Several forms of group life insurance are available. Group term life and group accidental death and dismemberment coverage are the most popular types.

**Group Term Life**—*Group term life* is the most common form of group life, comprising 95 percent of all group life insurance coverage in force.

Group term life promises to pay a benefit to a named beneficiary in the event the insured dies during the contract period. In the past, coverage was provided only during an employee's working years. Today, the majority of employees have coverage in their retirement years, provided they retired from the company.

Waiver of premium is often included automatically. It becomes operable if the insured becomes totally and permanently disabled prior to a stipulated age.

<b>TABLE 3-2 Sample Dollar-Amount-By-Earnings Schedule</b>	
<b>Annual Earnings</b>	<b>Amount of Life Insurance</b>
Less than \$20,000	\$ 20,000
\$20,000 to \$29,999	40,000
\$30,000 to \$39,999	75,000
\$40,000 to \$49,999	100,000
\$50,000 and over	150,000

Group term life utilizes benefit schedules to determine how much coverage is provided. Benefit schedules can be simple or complex. They can be as simple as a specification that every employee receives a single amount of life insurance. Or, they can be as complex as categorizing employees into employer-defined classes and providing different amounts of coverage for each of those classes. A typical benefit schedule specifies the available benefit as a multiple of earnings or a specified dollar amount. Regardless of the method, predetermined coverage amounts minimize adverse selection. (See tables 3-2 and 3-3 for examples.)

**Group Accidental Death and Dismemberment**—Traditionally, *group accidental death and dismemberment (AD&D)* coverage was written in conjunction with group term life. It is now common for AD&D to be written as a separate contract and paid for by the employee as a voluntary benefit.

<b>TABLE 3-3 Sample Position Schedule</b>	
<b>Position</b>	<b>Amount of Life Insurance</b>
President	\$300,000
Vice presidents	150,000
Managers	90,000
Salespersons	60,000
Other employees	30,000

AD&D provides lump-sum benefits in the event of death or dismemberment (such as the loss of a hand or a foot) that are the result of an accident. The amounts are provided in a benefit schedule that lists the type of injury or loss and the corresponding benefit amount. For example, death may provide twice the principal sum or coverage amount. Whereas the loss of either both hands or both feet would result in payment of the principal sum.

Group accidental death and dismemberment often covers accidents on or off the job, but it may be written to cover nonoccupational accidents only. Usually, when the employee selects AD&D as a voluntary benefit, both occupational and nonoccupational coverage is provided.

**Dependent Life**—Most states permit group term insurance to be written on the lives of dependent spouses and children. Some states stipulate a maximum coverage amount. *Dependent life* coverage amounts tend to be quite modest.

**Group Universal Life**—*Group universal life* plans combine group term insurance with cash accumulation. They enable employees to buy individual universal life policies through a group underwriting process and at group rates. An employer sponsors the plan, but employees pay the full premium and their participation is voluntary. The plan is portable and has the general characteristics of a universal life policy.

One variation of group universal life occurred in the 1990s with the introduction of a group variable universal life insurance product. The two share the same basic characteristics except that the cash value is invested in a series of separate accounts. Group variable universal life plans account for a very small portion of all new group life insurance plans implemented.

**Group Creditor Life**—*Group creditor life* is a form of group life insurance that covers all of the debtors of a particular creditor (often a lending institution). If an insured debtor dies, the insurance company pays the outstanding loan balance to the creditor (up to the maximum provided by the contract).

**Group Survivor Income Benefit**—Unlike other forms of group life insurance that typically pay lump-sum benefits, *group survivor income*

*benefit* coverage pays monthly benefits to the surviving spouse of a deceased employee.

## **Legal Requirements**

There are some legal requirements with regard to group life insurance that must be complied with, mainly nondiscrimination requirements.

**State Legal Requirements**—Each state might have different requirements for minimum enrollment percentages, maximum coverage amounts, and required contract provisions of group life insurance. Verify any regulations specific to the state(s) in which you conduct business.

**Nondiscrimination Requirements**—Group life insurance must satisfy certain nondiscrimination requirements in order to maintain its favorable tax status.

If a group term life insurance plan includes participants who are defined as key employees, the plan must not discriminate in their favor as far as benefits or eligibility to participate. It is not discriminatory to set up classes of employees and to give different benefits to different classes.

If the plan is discriminatory, key employees do not receive the same favorable tax treatment as the rank-and-file employees. The cost of all of the key employees' group coverage must be included as income. (See the section on "Tax Aspects" on the next page for more information.)

A *key employee* is one who meets one or more of the following definitions:

- an officer of the employer who received more than \$130,000 (as indexed for inflation in \$5,000 increments) in compensation from the employer
- a 5-percent owner of the employer (without regard to compensation)
- a one-percent owner of the employer who received more than \$150,000 in compensation from the employer

The plan must be nondiscriminatory regarding eligibility for participation. The plan does not discriminate in favor of key employees if it passes any one of the following tests:

- The plan benefits 70 percent or more of all employees.
- At least 85 percent of all participants are not key employees.

- The plan benefits a class of employees that the IRS determines is nondiscriminatory.
- The plan satisfies Section 125 (cafeteria plan) requirements, if it is part of a Section 125 plan.

In applying these tests, an employer may exclude employees who are part time, seasonal, subject to a collectively bargained agreement, or have fewer than 3 years of service.

The plan must also be nondiscriminatory regarding benefits. The plan cannot discriminate in favor of key employees, if the benefits are available to all participants. Multiples of compensation can be used to determine the amount of insurance, as long as the same multiple is used for all participants belonging to the same class of employees—for example, two times compensation for all.

## **Tax Aspects**

The tax considerations for group life insurance include the tax implications for the employer and the employee.

**Deductibility of Premiums by Employer**—The employer can deduct group life insurance premiums for all employees. Many employers think they can only deduct the cost of the first \$50,000 of group life insurance coverage. This is not so. They can deduct as much as they pay. The only limits on the employer are that the reasonable compensation requirements are met.

Owner-employees of C corporations are considered employees, and the corporation can, therefore, deduct the entire premium for group life insurance.

There are some situations in which premiums are not deductible for group insurance.

- No tax deduction is allowed for that portion of group life insurance covering a sole proprietor, a partner, or an S corporation owner with more than a 2-percent interest of ownership.
- If group life insurance is to be used to fund a corporate buy-sell agreement among stockholders, the Internal Revenue Service may deny the corporation a business expense deduction for the premiums. (It is also significant to note that the proceeds of group life insurance may be taxable under the transfer-for-value

rule if the stockholders name each other as beneficiaries and if they agree to use the group insurance proceeds to purchase each other's stock.)

**Taxation of Employer-Paid Coverage to Employees**—While the tax situation for group term life insurance is also favorable, it is neither as simple nor as all-encompassing as it is for group health and disability income insurance.

*Premium for Employee Coverage*—Section 79 of the Internal Revenue Code stipulates that the cost of the first \$50,000 of group term insurance is not considered to be a taxable economic benefit to the employee. However, the cost of any amounts above \$50,000 is a taxable economic benefit to the employee. The amount of taxable income is the cost of the insurance as determined by using rates from the IRS table known as the *Uniform Premium Table I*, or simply Table I (see table 3-4). These rates are subject to occasional revision by the Internal Revenue Service. The rules governing taxability of group life insurance apply equally to both active and retired employees.

<b>TABLE 3-4 IRS Uniform Premium Table I: Uniform Premiums per \$1,000 of Group Term Life Insurance</b>	
<b>Age Range*</b>	<b>Monthly Premium Rate</b>
Under 25	\$ .05
25–29	.06
30–34	.08
35–39	.09
40–44	.10
45–49	.15
50–54	.23
55–59	.43
60–64	.66
65–69	1.27
70 & above	2.06

\*For purposes of the Uniform Premium Table, an employee's age is his or her attained age on the last day of the taxable year.

### Computing the Federal Income Tax Using Table I

Jane is a 49-year-old employee for ABC Company. ABC pays for \$150,000 in group term life insurance coverage. For federal income tax purposes, the following is true:

- ABC Company can deduct its entire cost
- Jane receives the first \$50,000 in coverage tax free
- Jane must report only the cost of \$100,000, or \$180 ( $\$0.15 \times 12 \text{ months} \times 100$ )

Assuming Jane has the same amount of coverage, in the following year she would report \$276 ( $\$0.23 \times 12 \times 100$ ).

Note: The calculation of taxable income is somewhat more complex, because it must take into account the possibility that age and/or amount of insurance changed during the taxable year.

If the employee contributes toward the cost of the group insurance, all of his or her contributions are allocable to coverage in excess of \$50,000. In other words, the employee's full contribution is subtracted from the amount that would otherwise be taxable income. Thus, if Jane contributed \$120 per year toward the group life insurance premiums, she would have a taxable income of \$60 ( $\$180$  minus  $\$120$ ). At age 50, assuming the same amount of coverage and employee contribution, she would report \$156 of income ( $\$276$  minus  $\$120$ ).

In contributory plans, it is possible that the employee's share of the premiums could exceed the Table I cost. When this happens, the employee's excess contributions cannot be carried over from one tax year to the next.

As noted previously, if a group term life plan is discriminatory, the full cost of the coverage will be taxable to the key employee. The taxable amount is the greater of the actual cost of the coverage or the cost of insurance calculated using Table I rates.

*Premium for Dependent Coverage*—Under current tax law, there is no taxation on group life insurance coverage on an employee's spouse and dependent children, if the protection is no more than \$2,000. If the amount does exceed \$2,000, then the entire cost of such dependent and spouse coverage is includible in the employee's gross income. The cost is calculated by using the Table I rates.

*More than One Employer*—If an employee works for more than one employer, the employee can *exclude* the cost of no more than \$50,000 of group term life insurance.

**Taxation of Benefits to Employees**—Group life insurance benefits received by the beneficiary are received tax free for federal income tax purposes.

Federal estate taxes apply to virtually all property owned by a decedent at the time of his or her death. The face amount of group life insurance owned by an employee is treated as a part of the employee's estate for federal estate tax purposes, just as any other property owned by the decedent.

Certain provisions in the tax law, such as the marital deduction and the unified credit, allow large exemptions from federal estate taxes. Nonetheless, some insureds can benefit from removing group life insurance proceeds from their estates. An employee can do this as long as both the master policy and state law permit absolute assignments. Most insurance companies have assignment forms and provide specific instructions on the steps to follow when executing an absolute assignment.

The following three conditions must be met in order to remove group insurance from an insured's estate:

- The employee must give away (an absolute assignment) all of the ownership rights in the policy.
- The proceeds must not be payable to the insured's estate or for the benefit of the insured's estate.
- The transfer of ownership (the assignment) must be executed at least 3 years before the insured's death.

Meeting these three conditions can keep any life insurance proceeds out of an insured's estate, not just group term life insurance.

Before this action is taken, however, the potential tax advantages of removing life insurance from the estate should be weighed against the potential disadvantages—especially that of giving up all ownership of the life insurance and the accompanying loss of control, particularly in designating the beneficiary.

The assignment of group life insurance can be an important estate-planning tool for your prospects and clients, but it must be done with caution and care.

## **Planning Considerations**

Group life insurance is fairly straightforward because it has fewer options than group medical expense coverage. The main considerations

involve selecting the type of group life, adding supplemental life coverage, and considering carve-outs for key employees.

**Selecting the Type of Group Life**—Mainly, the decision regarding the type of group life insurance to offer comes down to an employer’s ability to fund the benefit. If the employer can fund the benefit, group term life is the benefit of choice because it is the least expensive option. Employees tend to prefer any extra monies that may have gone to fund cash value group life insurance to be spent on reducing costs for medical expense insurance.

If the employer wants to offer group term life as a voluntary benefit, you want to help the employer choose an option that will be selected by the employees. An optional benefit is not appreciated if it is not selected. Thus, group term life offered as a voluntary benefit is probably the best option unless you are dealing with employees who have the disposable income to make cash-value-type options, such as group universal life insurance, viable.

**Adding Supplemental Life Coverage**—Most group life insurance plans give employees the ability to purchase additional coverage. Typically, the employer pays for a basic benefit amount for all eligible employees. The employees are then responsible for paying for the coverage over and above that basic amount.

Supplemental life coverage can be a part of the basic group life insurance contract or a separate contract. The separate contract is often selected when supplemental coverage is offered only to a select group of employees. A benefit schedule is used to determine the benefit amount to help reduce adverse selection.

Should the employees desire cash value and flexibility, group universal life is a viable supplemental life insurance option. However, a group universal life plan can only flourish in situations in which the employees are able to afford the higher premiums.

**Carve-out**—Many times, as alluded to in the discussion of supplemental life insurance, the life insurance program for key employees is carved out. This becomes a cost-savings strategy if group life insurance coverage is extended into a key employee’s retirement.

Notice how the Table I rates (see table 3-4) jump dramatically at age 65, and then again at age 70. Someone aged 70 with \$150,000 of group

term life would have to report \$2,472 of income each year based on Table I rates (\$2.06 per month per \$1,000 x 12 months x 100 = \$2,472).

Buying permanent insurance on the executive at a younger age results in paying a lesser premium for the coverage over the long haul. In addition, it could be added to the existing \$150,000 of group coverage.

## Group Disability Insurance

### Types of Group Disability

A discussion of group disability is usually divided into two major topics: short-term disability and long-term disability. Short-term disability typically involves two types of plans: sick-pay plans and short-term disability plans. Sick-pay plans are generally uninsured and usually cover 100 percent of lost salary or wages for a short period of illness or disability. Because they are uninsured, we will not discuss them further. Instead, we focus our discussion on the short-term and long-term disability plans funded by insurance.

**Group Short-Term Disability Insurance**—As the name implies, *group short-term disability insurance* provides income benefits to a disabled worker for a limited period of time. Depending on the plan, benefits may be paid for 13, 26, or 52 weeks. A typical plan might pay weekly benefits starting with the first day of an accident or with the eighth day for an illness. The date payment of benefits for illness commences is coordinated with any sick-pay plan in place.

Benefits are usually limited by a schedule published by the insurance company. Group short-term disability plans are generally renewable at the option of the insurance company, so neither the rates nor the benefits are guaranteed.

**Group Long-Term Disability Insurance**—*Group long-term disability insurance* pays monthly benefits for an extended period of time for a prolonged disability. A typical group long-term disability plan might provide benefits to retirement age, with waiting periods ranging from 30 days to 360 days.

#### Group Representatives

Many companies have group offices or group insurance representatives. Typically, the group representative is an employee of the insurance company who assists advisors.

Find out what the group representative will do. For example, he or she may assist in gathering data, developing proposal specifications, assist in the selling process, and help service the case.

If the representative is willing to accompany you on interviews, find out how much advanced notice is required.

The group representative can be a powerful asset to you.

The duration of the waiting period often depends on what short-term coverage exists, or on the period the employer will carry the employee on the full-time payroll.

Benefits are usually limited to a stipulated percent of pay as well as to a stipulated maximum dollar amount and may be reduced by any payments from Social Security, workers' compensation, other group disability income benefits, state sick-pay plans, and disability pension benefits.

Long-term group disability income contracts are renewable each year at the option of the insurance company and can be terminated or changed upon short notice.

## **Legal Requirements**

Other than the requirements discussed earlier that apply to all employee benefits, only the Pregnancy Discrimination Act has a great impact on disability plans.

**Pregnancy Discrimination Act**—This act impacts disability plans as it does health care plans. The act requires that employers with 15 or more employees treat pregnancy and any related medical conditions the same as any other disability.

## **Tax Aspects**

**Deductibility of Premiums by Employer**—An employer is able to deduct its cost for group disability insurance premiums on an employee as long as the employee's overall compensation meets the federal guidelines of reasonable compensation.

There are some notable exceptions to this rule.

- Self-employed (sole proprietor, partner, member, or owner of an S corporation that has more than a 2-percent ownership interest) cannot deduct the premium for disability insurance on themselves.
- If the proceeds are used to fund a corporate disability buyout agreement among stockholders, the IRS may deny the corporation a business expense deduction for the premiums.

**Taxation of Employer-Paid Coverage to Employees**—For group disability coverage, the employer-paid portion is not deemed to be a taxable economic value. For this reason, this coverage is a financially attractive fringe benefit to employees.

**Taxation of Benefits to Employees**—Any and all disability income benefits attributable to the employee’s own contributions to the plan are received federal income tax free. One exception is if the disability income plan is a part of a Section 125 plan. In this case, if the premium is paid with pre-tax monies, the benefit is fully taxable.

In most cases, disability income benefits attributable to the employer-paid premiums are fully taxable to the employee as ordinary income.

In some cases, an employee might be eligible for a disability income tax credit. To be eligible, however, the employee must meet the stringent Social Security definition of disability. As a result, the percentage of disabled employees who qualify for this credit is extremely low.

### **Planning Considerations**

Three planning considerations are the coordination of disability plans, supplemental benefits, and carve-out plans.

**Coordination of Disability Plans**—Essentially, there are three different disability plans that require coordination: sick-pay plans, short-term-disability plans, and long-term disability plans. It is important to minimize any overlap between plans in order to maximize savings.

**Supplemental Benefits**—As with group life insurance, many newer plans offer additional coverage to the employee at his or her own expense. Such an arrangement helps employers manage the cost of benefits by shifting some of the cost to the employees.

**Carve-out Plans**—Some employers may want to carve out disability benefits for owners and key employees. The carve-out can be accomplished by offering separate plans or supplemental plans for employees, and owners and key employees. In either situation, individual disability income policies might be appropriate.

#### **Social Security Definition of Disability**

A person must be unable to do any kind of substantial, gainful work because of a physical or mental impairment (or a combination of impairments), which is expected either

- to last at least 12 months, or
- to end in death

If, because of a medical condition, a person cannot do the work that they performed in the past, then age, education, and past work experience must be considered in determining whether the person can do other work. If the evidence shows that the person can do other work, even if it involves different skills or pays less than their previous work, they cannot be considered disabled for Social Security purposes.

Source: *Social Security Administration*

Chapter 7 explores salary continuation plans that are used primarily for owners and key employees.

## Group Long-Term Care Insurance

Long-term care (LTC) is a growing need that could potentially cause major societal disruptions in the near future. The need is primarily the result of two demographic trends: a growing, aging population that will require LTC and a decreasing ability of families to provide it. These trends are major reasons for the anticipated rising costs for LTC that some experts are describing as a looming crisis.

General awareness of the LTC crisis is increasing, as is the acceptance of long-term care insurance (LTCI) as a desirable solution. The establishment of such programs as the federal LTCI program (FLTCIP) for federal employees, as well as state-sponsored long-term care partnership programs, has undoubtedly aided the publicity.

Greater awareness has resulted in employees asking for LTCI as an employee benefit. Consequently, many employers are including group LTCI as an employee benefit, but mainly on a voluntary basis. However, in some cases, employers contribute toward the premium.

In addition to offering group LTCI to their employees, many employers also enroll a spouse, parents, siblings, and children. One reason to include parents is to combat the potential increased absences, greater emotional stress, and lower productivity of employees who might face the pressure of caring for elderly relatives. In fact, many business owners have these concerns as well and are searching for cost-effective ways to pay for their parents' LTC needs in addition to their own. Group LTCI gives them the opportunity to address these concerns for their employees and themselves.

### Concept of Group LTCI

LTCI and, consequently, *group LTCI*, is aimed primarily at the problems associated with aging. It provides coverage for the broad range of medical, custodial, and other care services needed due to a chronic illness, physical disability, or cognitive impairment and provided over an extended period of time in various care settings.

**Types of Care**—LTCI covers three broad areas of care: custodial, medical, and other types.

*Custodial Care*—*Custodial care*, often referred to as personal care, is the most common type of LTC. Custodial care is assistance with routine daily activities because of deficiencies in physical and/or cognitive functions.

Physical functions are known as activities of daily living (ADLs). The standard ADLs are bathing, dressing, eating, transferring (such as from a bed to a chair), toileting, and continence.

Cognitive functions are known as instrumental activities of daily living (IADLs). They pertain to the mental processes of comprehension, judgment, memory, and reasoning. Examples include shopping for personal items, managing money, using the telephone, preparing meals, managing medication, and doing housework.

*Medical Care*—In addition to custodial care, LTCI also covers *skilled-nursing care*, which involves medical personnel on an around-the-clock basis. An intermittent level of medical care—intermediate care—is also covered. LTCI does not cover *acute care*, which is the type of care a person receives for a relatively brief period of time for an illness, accident or trauma, or recovery from surgery.

*Other Types of Care*—Furthermore, most LTCI policies also cover respite and hospice care. *Respite care* is the term used to describe the care provided to relieve a primary caregiver from the physical and emotional stress of providing care over a long period of time and/or to allow some period of personal time. *Hospice care* is the type of care that is designed to relieve the discomfort of terminally ill individuals and to maintain quality of life to the extent possible throughout the phases of dying.

In addition, many LTCI policies also cover the cost of support services and equipment that modify a living arrangement to meet a care recipient's LTC needs. Such services and equipment include ramps, medical response systems, stairway elevator seats, bathroom balance bars, and so forth.

**Care Settings**—These levels of care can be provided in many different care settings, including in any of the following locations:

- home
- adult day care center
- independent living facility
- assisted living facility
- nursing home
- hospice

The settings that are covered varies from policy to policy. In general, policies tend to cover facility-care, home-care, or both.

**Benefit Trigger**—LTCI benefits are triggered in one of two ways. First, benefits can be triggered if a person requires substantial assistance (the definition of substantial assistance varies from policy to policy) to perform a specified number of ADLs (two out of five or six for tax-qualified policies). Second, if severe cognitive impairment causes a person to require substantial supervision in order to ensure his or her personal health and safety, benefits can also be triggered.

**Benefit Options**—In general, group LTCI products mirror the individual LTCI policies that are sold. Depending on the policy, the employee may have options regarding

- type of coverage. Most employer-sponsored plans provide comprehensive coverage, covering both home- and facility-based care.
- benefit duration. Most plans offer two or three options expressed in terms of years. Some plans may offer lifetime benefits.
- benefit amount. Most plans offer at least two or three daily benefit amounts.
- inflation protection. Options include a compound, simple, or automatic increase option.
- elimination period. Many plans offer only one elimination period, most commonly 90 days. A few plans offer additional choices.
- nonforfeiture benefits

**Underwriting**—One major difference between group and individual LTCI is found in the area of underwriting. Group LTCI underwriting is much more flexible. Policies may be issued on a guaranteed, modified guaranteed, simplified, or full individual underwriting basis.

The most liberal underwriting standard is guaranteed issue, which means coverage is provided for all employees who apply for it. Guaranteed issue is usually used only when an employer group meets certain criteria that minimizes adverse selection. Such criteria include a large group, a minimum number of applicants, and so forth.

With modified guaranteed issue underwriting, the insurer accepts most applicants. However, the application does ask some medical questions that can result in the declination of an applicant.

Simplified issue is more stringent than modified guaranteed issue. The insurer asks more medically related questions. Further medical information is only requested if the answers to these questions indicate such a need.

The most stringent underwriting is full individual underwriting, which is the same standard used in the individual market. Generally, this stringent form of underwriting is reserved for small groups or for applicants other than the employees.

## **Types of Group LTCI**

Currently, there are two main products that are sold under the auspices of group LTCI. The first is “true” group insurance and the second is a mass marketed individual version of LTCI. For the most part, there is very little differentiation between the two products.

**“True” Group Insurance**—The “true” group version of group LTCI is characterized by a group contract. A master contract is issued to the employer, association, or other legitimate group. The participating employee or association member receives a certificate of insurance.

Portability for the “true” group LTCI policy is provided for under one of two provisions. Under a *continuation of coverage*, the insured retains coverage under the group contract but pays premiums directly to the insurer. Under a *conversion of coverage*, the insured is issued an individual policy that must be identical or equivalent to the group coverage. The premium for the converted policy is based on the rates for the individual policy at the insured’s attained age when the original coverage was obtained.

**Mass Marketed Individual LTCI**—*Mass marketed individual LTCI* is an individual policy sold through a sponsoring organization, such as an employer or association. While not a group policy, an employee can often receive a discount from the insurance company, if the employer meets a specified minimum-participation rate. In addition, underwriting procedures are somewhat less stringent than LTCI that is sold in the individual market.

Portability for the mass marketed individual policy is not an issue because the policy is already an individual one. The only change is that the insured must make arrangements to pay the premium directly to the insurer.

## Legal Requirements

**HIPAA**—HIPAA was introduced earlier in this section during the discussion of group medical expense insurance. It provides a more favorable tax treatment of long-term care insurance by creating a qualified or tax-qualified class of policies. *Tax qualified* policies have important tax benefits for employees and employers, if they meet specific requirements, such as being guaranteed renewable or not reimbursing Medicare-covered expenses. Group LTCI (both “true” group and mass marketed individual LTCI) are generally tax-qualified plans. The actual tax benefits of a tax-qualified plan are discussed next.

## Tax Aspects

**Deductibility of Employer-Paid Premiums by Employer**—In general, tax-qualified LTCI policies are treated as health insurance for federal income tax purposes. Thus, employer-paid premiums on behalf of employees are deductible by employers as long as the employee’s overall compensation meets the federal guidelines of reasonable compensation.

In addition, self-employed (sole proprietor, partner, member, or owner of an S corporation that has more than a 2-percent ownership interest) can deduct the premium for LTCI on themselves, their spouses, and their dependents up to the annual deductible limit shown in table 3-5. A self-employed person may count premiums in excess of the annual deductible limit toward deductible medical and dental expenses on Schedule A (Form 1040). Taxpayers can deduct the amount of medical expenses that exceeds 7.5 percent of their adjusted gross income (AGI).

**EXAMPLE:** Marita is 45 years old, self-employed, and pays a LTCI premium of \$600. She will be able to deduct \$490 of that premium on the appropriate line of Form 1040. The remaining \$110 can be counted as an unreimbursed medical and dental expense itemized on Schedule A.

**Taxation of Employer-Paid Coverage to Employees**—The employer-paid tax-qualified LTCI premiums do not count as taxable income to employees.

**Deductibility of Employee-Paid Premiums for Employees**—Employee-paid portions of qualified LTCI premiums follow the same rules that govern policies purchased in the individual market. A portion of the employee’s premium can be itemized along with other medical

**TABLE 3-5****LTC Annual Deductible Limit Per Covered Individual**

Age	2004	200__
40 or younger	\$ 260	\$ _____
41–50	\$ 490	\$ _____
51–60	\$ 980	\$ _____
61–70	\$2,600	\$ _____
Older than 70	\$3,250	\$ _____

**LTC Per Diem Contract Benefit  
Excludable from Income**

2004	\$ 230/day
200__	\$_____/day

Note: These limits are indexed for inflation, and the current year's limits may be obtained from your company or the IRS website.

expenses on Schedule A. The portion is based on age and is adjusted for inflation (see table 3-5). The employee's total medical expenses in excess of 7.5 percent of adjusted gross income (AGI) are deductible, including the eligible amount of LTCI premiums. (See IRS Publication 502 for more information.)

**Taxation of Benefits to Employees**—Benefits received from a tax-qualified LTCI contract, regardless of who paid the premium, may be excluded from taxable income up to a specified maximum amount that also increases with inflation as illustrated in table 3-5. Benefits that exceed this amount are excludable only to the extent they reflect the actual cost of the expense incurred.

**EXAMPLE:** In 2004, Pat's LTCI policy paid (on an indemnity basis) \$265/day in benefits and her expenses were \$265/day. She can exclude the full amount of benefits from her income even though it is more than the \$230/day limit. However, if her expenses were \$200/day, she would only be able to exclude \$230/day. The additional \$35/day in benefits is taxable income.

**Understanding Your Products**

If you are planning to write group insurance, you should understand the products available to you. For each product, find out the following:

- What size group is it designed to insure?
- Are there preferred industries?
- Are there prohibited industries?
- What are your contractual obligations to the carrier?

### Know Your Carriers

If you are planning to write group insurance, take the time to know the following about any carriers you represent:

- What are the underwriting rules?
- What is the minimum number of employees acceptable to the carrier?
- What are the requirements on the split of premiums for contributory plans?
- What are the minimum and maximum coverage amounts?
- What forms of coverage are available to groups of different sizes?
- How much and what kind of support will the company provide to you?
- What services are available to you and to your prospects or clients?
- How do you access those services?

## Planning Considerations

Some of the decisions that you will help the prospect make include selecting whom to cover, deciding on whether to contribute to the plan, and selecting the right product.

**Selecting a Class**—Unlike other benefits, LTCI as described by HIPAA, does not have a requirement regarding nondiscrimination for employer-provided plans. Many insurers interpret this liberally and market owner-only or key employee plans for which the employer contributes a portion, if not all, of the premium. For C corporations, the employer may deduct the full amount of the premium on all owners and key employees. For unincorporated businesses and S corporations, the employer can only deduct the full premium for non-owner employees. Owner-employees can deduct a portion as described earlier.

**Employer-Paid or Voluntary Benefit**—Once the class of employees for which LTCI will be offered is decided, the employer needs to decide whether or not to contribute to the plan. A common option for employers who pay only a

portion of the premium is to fund a minimum-benefit plan and allow the employees to purchase additional coverage.

The employee-paid portion of the premium cannot be funded by a cafeteria plan or flexible spending account (FSA). However, the employee can use funds from an Archer MSA or an HSA to pay LTCI premiums.

**Selecting a Product**—For many advisors, there is a decision about the type of product to use. Price will most definitely be a factor, however, consider some of the other possible needs the client may have

- Is there a need for customizable products?
- Are spousal discount and preferred ratings important?
- Is the employer contributing to the plan? (Some plans require an employer contribution.)
- Is guaranteed issue desired by the prospect?

- Is there a need to cover employees located in another state? (Individual LTCI policies require multi-state licensing; “true” group plans typically do not.)

## **Summary**

Group insurance is an area almost any employer will want to discuss. Thus, your knowledge of group insurance can help you market employee benefits, even if you do not sell group products. For example, a conversation about group insurance can open the door to a discussion about voluntary benefits.



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## Health Savings Accounts (HSAs)

The movement toward consumer-directed health care continues. As of January 1, 2004, there is a new option for paying medical expenses—the Health Savings Account (HSA). Actually, the HSA is simply a more liberal version of the Archer Medical Savings Account (MSA) in that more people are eligible and the benefits are more generous. This section discusses the concept, the legal requirements, tax aspects, and planning considerations of the HSA.

### Concept of the HSA

The HSA was an add-on to the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*. It is an augmented version of the Archer MSA. Thus, we begin our discussion with a review of the Archer MSA. Then we will look at the key components of the HSA.

### The Archer MSA

The Archer MSA is a trust account that the account owner uses to pay for qualified medical expenses. In other words, it is like an IRA that pays medical expenses. In conjunction with the Archer MSA, there must be a *high-deductible health plan (HDHP)*. An HDHP does not pay a benefit until the insured has paid a substantial cumulative deductible for the year.

The Archer MSA was created by HIPAA as a pilot program. The program ran from 1997 through the end of 2003, and the number of Archer MSAs never exceeded 100,000 during that time period. Supporters of the Archer MSA say the poor showing was due to the strict eligibility requirements. It was limited to self-employed persons, the employees of a small employer (less than a daily average of 50 employees) with an HDHP, or the spouses of either of the first two groups.

The HSA attempts to correct the shortcomings of the Archer MSA. Although the HSA technically replaces the Archer MSA, current account owners can continue to use an existing Archer MSA.

## **HSA and HDHP**

Like the Archer MSA, an HSA is a trust created or organized as a tax-advantaged savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary. In addition, the HSA must also be issued with an HDHP. However, as we will see, there are some key differences between the Archer MSA and the HSA. Regardless of the differences, the idea of both plans is that pretax dollars can be put aside to pay for routine medical care, while the high deductible medical expense plan pays for major medical expenses once the plan deductible is met.

## **Legal Requirements**

There are three main legal requirements that govern HSAs. First, only certain people are currently eligible. Second, the HSA must be set up as a trust account. Third, the HDHP must meet certain requirements put forth by the federal government. If an employer is contributing to the HSA for its employees, then a fourth legal requirement—comparability—applies.

### **Eligibility**

The eligibility requirements of the HSA are much more inclusive than those of the Archer MSA. A person is eligible for an HSA if he or she is covered under an HDHP purchased in the individual market or sponsored by an employer. In addition, he or she cannot be covered under any other health plan that is not an HDHP and that duplicates benefits provided under the HDHP. Exceptions to this rule include coverage for specified disease or illness, a fixed payment for a period of hospitalization, accidents, disability, dental care, vision care, and long-term care insurance. Finally, the person must not be eligible for Medicare.

**EXAMPLE:** Pat is covered by an HDHP provided by her employer and is also covered by a managed care plan by her spouse, Pat is not eligible for an HSA. However, if her spouse's plan were another HDHP, Pat would be eligible for one.

### **Trust or Custodial Account**

The HSA is a tax-exempt trust or custodial account that can be set up with a bank, insurance company, or other IRS-approved entity.

**Contributions**—Contributions can be made by the employer, the employee, or both. They cannot exceed the lesser of the annual deductible of the HDHP or

- \$2,600 in 2004 for an individual who has self-only coverage
- \$5,150 in 2004 for an individual who has family coverage

One notable exception to these contribution limits is for those individuals who have attained age 55 before the close of the taxable year. These individuals can contribute an additional \$500 in 2004. The amount of the additional contributions increases through 2009. (See table 3-6.)

Contributions for a tax year can be made up until April 15 of the following year, which is the same rule that applies to IRAs.

**Earnings**—The account value does not have to be used up each year. Unused account value grows tax deferred and can be withdrawn tax free, if used to pay qualified medical expenses (as later described).

### High-Deductible Health Plan (HDHP)

The government provides the limits a plan must meet to qualify as an HDHP. In general, this means a health plan that has an annual deductible not less than \$1,000 for self-only coverage and twice the dollar amount of the self-only coverage for family coverage. In addition, the sum of the annual deductible and the annual out-of-pocket expenses required to be

<b>TABLE 3-6 Additional Contribution Amounts for Individuals 55 or Older</b>	
<b>Tax Year</b>	<b>Additional Contribution Amount</b>
2004	\$ 500
2005	\$ 600
2006	\$ 700
2007	\$ 800
2008	\$ 900
2009 and thereafter	\$1,000

paid under the plan cannot exceed \$5,000 for self-only coverage and twice the dollar amount of the self-only coverage for family coverage. These amounts are subject to an annual inflation adjustment.

## **Employer Contributions**

The IRS requires that if the employer makes contributions to its employees' HSAs, it must follow the "comparability rules" that also apply to Archer MSAs. These rules require an employer to contribute comparably to participating employees who have the same category of coverage (individual or family) and the same category of employment (part-time or full-time). Specifically, the employer must contribute to each participating employee either

- the same amount
- the same percentage of the annual deductible limit of the employees' HDHP

## **Tax Aspects**

There are income tax aspects for contributions and distributions as well as estate tax implications on unused balances.

### **Contributions**

**Tax Implications for Employer**—HSAs are considered to be health plans under Section 106 and, thus, contributions made by the employer are tax deductible. Furthermore, they are not subject to FICA or other employment taxes.

However, if the employer's contributions fail to comply with the comparability rules described earlier, an excise tax is levied against the employer and is equal to 35 percent of all employer contributions made during the period of noncompliance.

**Tax Implications for Employees**—Any employer contributions are excluded from income. Also, the employee may deduct his or her contributions from income for federal income tax purposes. Furthermore, if the employee contributions are made through a cafeteria plan, their contributions are excluded from taxable income and are not subject to FICA taxes.

In addition, account owners are subject to a 6 percent excise tax on any excess employer or employee contributions. The excise tax can be

<b>TABLE 3-7 Tax Implications for HSA Contribution</b>		
<b>Contributor</b>	<b>Impact on Employer</b>	<b>Impact on Employee</b>
Employer	<ul style="list-style-type: none"> <li>• Tax deductible</li> <li>• Not subject to FICA</li> </ul>	<ul style="list-style-type: none"> <li>• Excluded from income</li> <li>• Not subject to FICA</li> </ul>
Employee	N/A	<ul style="list-style-type: none"> <li>• Deductible from income</li> <li>• Excluded from income and not subject to FICA if contributions made through a cafeteria plan</li> </ul>

avoided if the excess contributions are detected and corrected before the due date of the employee's federal income tax return. (Note: These rules apply only to contributions to the HSA and not to the premiums for the HDHP.)

**EXAMPLE:** Douglas and Jane have an HDHP with a \$3,000 deductible. They are able to contribute \$3,000 to their HSA. If they contributed \$4,000 to the HSA, they would have an excess contribution of \$1,000 that would be subject to the 6 percent excise tax, if it is not withdrawn before or on the last day prescribed by law (including extensions) for filing income tax.

## **Distributions**

There are two types of distributions: qualified and unqualified.

**Qualified Distributions**—The HSA, like the Archer MSA, is one of the few times when tax-deductible dollars purchase a tax-free benefit. Distributions are received tax free as long as they represent a reimbursement for the qualified medical expenses of the individual or the individual's family. Qualified medical expenses are generally the same type of expenses that qualify for the medical and dental expenses deduction (see IRS Publication 502, *Medical and Dental Expenses*). (Note: Qualified medical expenses paid from an HSA are not eligible for itemization on Form 1040 Schedule A.)

In general, insurance premiums are excluded. Thus, the premiums for an HDHP could not be paid from an HSA. Two notable exceptions to this rule are long-term care insurance and COBRA coverage.

A further plus is that qualified distributions can still be withdrawn from an HSA, even if the account holder is no longer eligible to contribute to one.

**Nonqualified Distributions**—For distributions that do not qualify as qualified medical expenses, the withdrawal is includible as income and subject to a 10-percent penalty tax. The 10-percent penalty tax does not apply if the distributions are received in the following situations:

- at the death of the account owner
- at the disability of the account owner
- after the account owner turns age 65
- in connection with a rollover to a new HSA within 60 days

### **Estate Tax Treatment**

The unused balance in an HSA is includible in the account owner's estate. Fortunately, if the spouse is the beneficiary, the account can keep its status as an HSA and be used for the spouse's qualified medical expenses. For all other beneficiaries, the account loses its tax-advantaged status and is taxable to the beneficiary at the fair market value of the HSA.

## **Planning Considerations**

When determining whether or not an HSA is appropriate for a prospect, consider the following:

- the characteristics of the account holder
- the HSA versus other defined-benefit health plans
- the coordination of the HSA and FSA
- the potential increase in paperwork for the account holder

### **The Characteristics of the Account Holder**

When you are evaluating the HSA as a possible solution, consider the anticipated medical needs, financial situation, and current medical expense coverage of the prospective account holder or holders.

**Anticipated Medical Needs**—The anticipated medical needs of the account holder and his or her covered dependents determines whether or

not this is a good solution for medical expense coverage. For example, persons with young children would probably not find an HSA to be cost-effective because of the higher number of visits to the doctor for both illness, routine checkups, and shots that young children often require. In addition, HSAs would not be as advantageous for persons with health problems. In both of these cases, the HSA would be used up and could mean out-of-pocket and, thus, after-tax monies to meet the deductible.

**Financial Situation**—The HSA is not the solution for those who are unable to fund it well. An inability to fund it can indicate that the person may have difficulty paying toward the deductible of the HDHP, should he or she use up the monies in the HSA.

**Current Medical Expense Coverage**—For any individual or employer that has a high-deductible health plan, the HSA is worth considering. For the individual, being able to pay many unreimbursed medical expenses with pretax dollars is quite attractive. For the employer, even if it does not fund the HSA, giving employees this option will enhance its benefits package at minimal cost.

### **The HSA versus Other Defined-Benefit Health Plans**

As discussed earlier, the HSA is one of two possible accounts that can be used with HDHPs. If the prospect already has an Archer MSA in place, then there are three alternatives. Your recommendation to the prospect should take into account the differences between the plans. As you can see from table 3-8, the HRA gives more flexibility than the HSA and the Archer MSA. There are neither size limitations nor any requirements to be used in conjunction with an insurance plan. However, the HSA and Archer MSA involve less expense because only the employer can contribute to an HRA. Thus, HSAs and Archer MSAs are usually more appropriate for small businesses.

Note that an Archer MSA can be rolled over into an HSA. In addition, one can participate in an Archer MSA and an HSA. However, the amount that can be contributed to the HSA is reduced by the amount contributed to an Archer MSA.

### **Coordination of HSA and FSA**

The HSA enables a person to roll over the unused account balance to the next year. The rollover feature gives it an advantage over the FSA. Also, unlike the FSA, the HSA earns interest on the unused account value.

<b>TABLE 3-8 Key Differences Between HSAs, HRAs, and Archer MSAs</b>			
	<b>HSA</b>	<b>HRA</b>	<b>Archer MSA</b>
Eligibility	individuals or employers in conjunction with an HDHP	any employer	employers with 50 employees or fewer and in conjunction with an HDHP, self-employed
Deductible limits (self-only coverage) for HDHP	not less than \$1,000	n/a	not less than: \$ 1,700 no more than: \$ 2,600
Total annual out-of-pocket expenses (self-only coverage) for HDHP	no more than \$5,000	n/a	no more than: \$3,450
Deductible limits (family coverage) for HDHP	not less than \$2,000	n/a	not less than \$ 3,450 no more than \$ 5,150
Total annual out-of-pocket expenses (family coverage) for HDHP	no more than \$10,000	n/a	no more than: \$6,300
Contribution limits	self-only: lesser of 100% of deductible or \$2,600 family: lesser of 100% of deductible or \$5,150	none	self-only: 65% of deductible family: 75% of deductible
Additional contributions for account holders aged 55 or older	yes	no	no
Contributions in any plan year can be made by	both employee and employer	employer only	either the employee or employer, but not both
Inclusion in a cafeteria plan	yes	no	no
ERISA applies	only if employer makes contributions	yes	only if employer makes contributions

In spite of these advantages, the FSA will not become obsolete, although the numbers of FSAs will probably diminish. However, FSAs allow the purchase of routine health care items not now covered by HSAs.

## **Potential for Increased Paperwork**

The HSA tax reporting requirements are the same as the Archer MSA. Thus, the account holder must be willing to deal with additional paperwork.

All contributions and distributions must be recorded on Form 8853 and attached to Form 1040. In addition, the account holder must also keep a record of the name and address of the payee, the amount, and the date of payment for each qualified medical expense paid with funds from the HSA. While they are not to be sent with the tax return, these records need to be retained.

## **Summary**

The HSA provides another alternative for providing or obtaining medical expense coverage. For those currently covered by HDHPs, an HSA makes a lot of sense. These arrangements also make sense for those who are healthy and have the financial means to fully fund the HSA.



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## Chapter Three Review

*Key terms and concepts are explained in the Glossary. Answers to the Review Questions and Self-Test Questions are found in the back of the book following the Glossary.*

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### Key Terms and Concepts

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group insurance	self-insuring
master contract	Pregnancy Discrimination Act
group underwriting	Health Maintenance Organization Act
experience rating	Consolidated Omnibus Budget Reconciliation Act (COBRA)
Employee Retirement Income Security Act (ERISA)	Health Insurance Portability and Accountability Act (HIPAA)
nondiscrimination requirements	highly compensated employee (HCE)
owner-employee	group term life
medical expense insurance	group accidental death and dismemberment (AD&D)
managed care	dependent life
hospital expense benefit	group universal life
surgical expense benefit	group creditor life
physicians' visit expense benefit	group survivor income benefit
stop-loss limit	key employee
coinsurance cap	Uniform Premium Table I
Health Maintenance Organization (HMO)	group short-term disability insurance
individual practice association (IPA) model	group long-term disability insurance
individual practice association (IPA)	group long-term care insurance (LTCI)
staff model	custodial care
group model	acute care
network model	skilled-nursing care
mixed model	respite care
Preferred Provider Organization (PPO)	hospice care
Point-of-Service (POS) Plan	continuation of coverage
defined-contribution medical expense plan	conversion of coverage
consumer-directed health care	mass-marketed individual LTCI
health reimbursement arrangement (HRA)	
self-funding	

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## Review Questions

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- 3-1. What is the purpose of nondiscrimination requirements?
- 3-2. List five common reasons employers do not have group coverage.
- 3-3. What are the exceptions to the deductibility that generally applies to all group insurance premiums?
- 3-4. List and briefly describe the five different models of HMOs.
- 3-5. Describe the requirements that the Pregnancy Discrimination Act places on medical expense coverage.
- 3-6. List and describe the six types of group life insurance.
- 3-7. Other than the situations that apply to all forms of group insurance, describe two additional situations in which group life insurance premiums are not deductible.
- 3-8. List and describe the two types of group disability discussed in this chapter.
- 3-9. List four care settings in which long-term care can be provided.
- 3-10. Who can set up an HSA?
- 3-11. How much can André, who is 45 years old and single, contribute to his HSA if he has an HDHP with a \$2,000 deductible?

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## Self-Test Questions

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*Instructions: Read chapter 3 first, then answer the following questions to test your knowledge. There are 10 questions; circle the correct answer, then check your answers with the answer key in the back of the book.*

- 3-1. Which of the following is an ERISA requirement that applies to all group insurance plans?
  - (A) All employees must be covered by the plan.
  - (B) The plan must be in writing.
  - (C) The plan is permanent.
  - (D) The plan must exclude highly compensated employees.

- 3-2. Blue Light HMO hires and pays its physician staff a salary. The physicians work out of a central location. Blue Light HMO is most likely using the
- (A) group model
  - (B) staff model
  - (C) individual practice association
  - (D) PPO model
- 3-3. Anthony has a group plan at work that pays twice the coverage amount if he dies in accident either on or off the job. Most likely, Anthony has
- (A) group term life coverage
  - (B) group medical expense coverage
  - (C) group accidental death and dismemberment (AD&D) coverage
  - (D) group disability coverage
- 3-4. Jasmine has a group insurance benefit at work that will pay a benefit for up to 26 weeks if she is ill. Most likely, Jasmine has
- (A) group short-term disability coverage
  - (B) group long-term disability coverage
  - (C) group accidental death and dismemberment (AD&D) coverage
  - (D) group term life coverage
- 3-5. Which of the following statements regarding an employer's ability to set up Health Savings Accounts (HSAs) for its employees is (are) correct?
- I. Eligible employees must be covered by a high-deductible health plan.
  - II. The employer and employees may not contribute to the plan in the same year.
- (A) I only
  - (B) II only
  - (C) Both I and II
  - (D) Neither I nor II

- 3-6. Which of the following statements regarding the written plan document required by ERISA for employee welfare benefit plans is (are) correct?
- I. It must specify how payments are made to and from the plan.
  - II. It must describe how funding of the plan will be established and carried out.
- (A) I only
  - (B) II only
  - (C) Both I and II
  - (D) Neither I nor II
- 3-7. Which of the following statements regarding group life insurance is (are) correct?
- I. Group survivor income-benefit plans always pay benefits in a lump sum.
  - II. Most states permit group term coverage on the lives of a dependent spouse.
- (A) I only
  - (B) II only
  - (C) Both I and II
  - (D) Neither I nor II
- 3-8. All of the following are considered activities of daily living (ADLs) for long-term care insurance purposes EXCEPT
- (A) getting dressed
  - (B) taking a bath
  - (C) eating
  - (D) managing money
- 3-9. All of the following statements regarding the Health Savings Account (HSA) are correct EXCEPT
- (A) Contributions are tax deferred and qualified distributions are made tax free.
  - (B) The premiums for the high-deductible health plan (HDHP) can be paid from the HSA.
  - (C) An individual can be covered by a disability income policy and qualify for an HSA.
  - (D) Contributions made by the employer are not subject to FICA taxes.

3-10. All of the following statements regarding group life insurance are correct EXCEPT

- (A) Any taxable amount is figured using Table 2001 rates.
- (B) Group life insurance must satisfy certain nondiscrimination requirements.
- (C) Employer-paid premiums are generally tax deductible to the employer.
- (D) The first \$50,000 of group term is generally not taxable to the employee.

