HEFFERNAN INSURANCE BROKERS
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News You Can Use

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AFFORDABLE CARE ACT

How to Disburse Medical Loss Ratio Rebate

IF YOUR company received a medical loss ratio (MLR) rebate check from its health insurer this year, you may be wondering how you can spend it.

Under the Affordable Care Act, health plans are required to pay back a portion of premium if they fail to spend a certain amount of the collected premium on medical benefits. For large group plans that minimum is 85%, and for small group plans the minimum is 80%. The MLR rebates were due by Aug. 1.

If a plan spends less than that on treatment, drugs and other covered services, they are required to send out rebate checks to plan sponsors. In turn, employers have certain requirements on how they can spend the rebate checks and if you receive one, you need to know the regulations.

Your plan should have language dictating how rebates received may be used. If not, make sure that you get it clearly stated. This may require an amendment to the plan, which should be done in accordance with the plan's amendment process.

Four steps for disbursing rebates

If your company receives a rebate, the Department of Labor has outlined the steps you need to take.

- **Determine the plan to which the rebate applies** – Typically, rebates apply only to a specific plan option. So the only ones benefiting from the rebate would be those that participated in the specific plan. If there are checks for two plan options, you need to apply the rebate separately based on the separate calculations of the insurer.
- **Determine what portion of the rebate applies respectively to the employer and employee contributions** – If your company contributed 80% of the premium and the employees 20%, then typically, your company can keep 80% of the rebate, while the rest must be used for the benefit of participants.
- **Determine to whom you will distribute the rebate** – You can chose to use an allocation method, as long as it is fair. It does not have to reflect the actual contribution amount of each employee. You can choose to provide a flat amount to each participant, or a percentage of their actual contribution.
- **Determine the method for distributing the rebate** – Regulations on the MLR include four possible methods for distributing rebates to enrollees:

– Premium contribution reductions for enrollees,

See 'Rebates' on page 2

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Rebates Should Be Applied within 3 Months of Receipt

– Enhancing plan benefits or services,
– A refund back to plan participants, either through cash or check, or
– A premium holiday (essentially using the rebate to pay the employees' portion of the premium).

If the cost of distributing the refund by cash or check is not cost-effective, you should consider the other options available.

Although it's not stated in the regulations, the consensus is that rebates must be applied within three months of receipt.

Tax treatment

The tax consequences of receiving an MLR rebate depend on whether the employees paid premiums on a pre- or post-tax basis. According to IRS guidance, in cases when the employee portion was paid for using pre-tax dollars:

- If the rebate is distributed as cash, it will be taxable.
- If the rebate is used to reduce current-year contributions, it will be "effectively" taxable – since the participants' pre-tax contribution toward current year benefits will decrease, their taxable income will increase by a like amount.

When employees pay their portion of a premium post-tax, the rebate will generally not be subject to federal income tax.

Don't forget!

You are not required to send a notice regarding the rebate to your employees. That's the insurance company's job. The notices sent by carriers will not include the amount of the rebate, but will state that the rebate was sent to the employer.

If you receive an MLR rebate, you may want to send a memo to your staff informing them if and how they may receive a portion of it.

You may also want to point out that the rebate will usually be a relatively small amount on a per participant basis. That will counter an expectation of a huge windfall. ❖

Notices of Insurance Exchanges Due by Oct. 1

THE AFFORDABLE Care Act requires that most employers notify all their employees of the availability of health insurance exchanges and that government subsidies are available to qualified individuals.

Under the law, employers must provide these notices to their workers no later than Oct. 1. In addition, after that date they will be required to send the notices to new employees within 14 days of their start date.

The Department of Labor has issued model notices for the so-called health insurance marketplaces.

The model notice for employers that currently offer coverage to their employees is available here:

http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf

The model notice for employers that do not offer their employees coverage can be found here:

http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf

You must send these notices to all of your current employees – that includes full-time, part-time and seasonal workers, regardless of if they are eligible to participate in your current employee benefits plan.

Also, if you do not offer health insurance coverage in 2014, but plan to do so for 2015, you will likely be required to send an updated notice of exchanges to employees in 2014 to reflect their status change.

Under the regulations, you have a few options for distributing the notices:

- Hand delivery at work
- First-class mail, or
- Electronically

The law does not require you to obtain a proof of receipt, but it's not a bad idea to have your employee acknowledge receipt in writing so that you protect yourself should you be accused of not providing notices.

Also, these model notices expire on Nov. 30 of this year, so after that you will need to use updated ones. We'll notify you in a later newsletter about the updated notices.

Exempt employers

Small employers that are not subject to the Fair Labor Standards Act are exempt from the rules, meaning those that have less than $500,000 in annual revenues.

Also, common ownership rules set out by the IRS apply, so an employer with several small businesses may be considered as one concern under the law. ❖

WORKERS' COMP

Costs Rise Quickly the Longer Claims Stay Open

NEW DATA and studies show just how quickly costs can spiral out of control the longer a workers' comp claim stays open.

Recent data indicates that claims that close within 30 days of an injury incur an average cost of $287 (with 90% of those cases being medical only – meaning they required no lost time from work).

However, between 31 and 90 days, the average claims cost jumps 150% to $722 (and the number of medical-only cases drops to 81%), according to information released by Sedgwick Claims Management Services Inc. on its book of workers' comp claims that closed during 2011.

For claims that close between 91 and 180 days after an injury, the average cost jumps to $2,150 and, if it goes beyond that, the average cost leaps to $6,875 when such cases stay open 181 days to one year – that's about 3.5 times more than the $2,150 cost when they remain unresolved for 91 to 180 days, according to Sedgwick's book of claims.

The percentage of medical-only claims drops to a minority of all claims when they are unresolved from 181 days to one year, with only 37% in that category.

When comp claims close between one and two years, Sedgwick's data shows their average cost jumps to $19,888, when only 21% are medical-only claims.

Claims that close between two and three years incur average expenses of $36,792, when the medical-only proportion drops to 13%.

After three years, when fewer than 10% of cases are medical-only claims, the average cost soars to $63,087.

Among other factors also blamed for average claims remaining open longer than expected while their costs balloon, are the growing incidence of worker obesity and related co-morbidities, Medicare set-aside mandates that complicate settlements, as well as litigation, observers say.

Pharmaceutical costs

Another factor driving costs in claims that stay open longer is pharmaceuticals.

The "2011 Workers' Compensation Drug Trend Report", released by Express Scripts Inc. in April 2013, found that the average cost per prescription in the third year of a claim is twice the average $48.20 cost per script in the first year.

If a claim is still open in the ninth year, the average prescription cost has tripled.

Also, Healthcare Solutions' "2012 Workers' Compensation Drug Trends Report" found large increases in the number and prices of prescriptions in the first three years of a claim.

"The most significant increase occurs between the first and second service year, when a 65% increase in the number of prescriptions and a 76% increase in the average price per prescription is observed," the report states.

"Claims that have progressed to the second and third service years have likely found initial treatment unsuccessful and are utilizing second- and third-line medications," which are often single-source drugs that are more expensive.

In year four, claims often stabilize, with the number of prescriptions and their price not rising as rapidly as the first three years, Healthcare Solutions found.

The increases that do occur often are the result of additional medications being used either as adjunct treatment or prophylaxis for the side effects of other medications.

Closing claims early

So how can you ensure that your workers' comp claim does not languish and end up costing more than it should?

Veteran risk managers say that to get claims closed early, the injured worker needs aggressive up-front treatment and attention.

Delays in treatment can result in further complications down the road, and what was once a medical-only claim can then turn into one that also includes lost time from work – which means indemnity payments.

Interestingly, these long-term claims often start out as injuries expected to require only limited medical attention without the employer having to pay indemnity benefits since the injured worker remains on the job while recuperating.

In fact, more than half of all workers' compensation claims are medical-only claims, meaning they require no time off from work.

You as an employer also have a role to play, and that's being there for your injured worker.

Claims specialists say that claims for workers who are left in the dark can easily take a turn for the worst.

After they file a claim, you should contact the employee immediately and let them know that their treatment will be paid for.

Most workers have never filed a workers' compensation claim, and they don't know what to do or what to expect.

And, if they are unsure of what's going to happen, they'll often start by consulting friends, and then searching online. Before you know it they've hired an attorney who may try to move them to a new doctor of the lawyer's choosing.

At that point the chances of closing the claim diminish substantially. ❖

INSURANCE ISSUES

How to Handle a Premium Audit Without Panicking

WHILE PREMIUM audits are not the highlight of anyone's week, they do serve a useful purpose and are actually just as important to you as they are to your insurance carrier.

When you were first issued your policy, the carrier looked at the estimated sales figures or payroll data that you provided to them. The insurance company calculated your premiums based on this information.

Now that you have actual numbers and accounting of your operations, the information needs to be reassessed to determine the correct premium amount. The audit is designed to ensure your are properly covered.

Depending on how your business operates and the size of your policy, there are several different methods your insurance carrier can use to conduct your premium audit, including:

1. Mail – Your carrier will mail you an audit form and the instructions to complete it. Once completed, you will return the form by mail to your carrier.

2. Phone – Your carrier will hire an independent audit company to conduct your audit over the phone.

3. Physical – Your carrier will usually conduct the audit at your business, but it could be conducted at an alternative location, such as your certified public accountant's office.

Regardless of the method, the auditor will typically want to see your payment and payroll records, ledgers, tax and Social Security reports, state unemployment forms and other accounting records.

Depending on the audit, other documents could be involved.

The most commonly audited policies are liability and workers' comp. The insurer will compare actual numbers from the audit to the exposure estimates made when the policy was written.

This data is then used for determining and adjusting premium amounts (either higher or lower). Information typically (though not exclusively) required includes the following:

Liability policies

- Company sales data
- Payments made to independent contractors (insured and uninsured)
- Payroll records

Workers' compensation policies

- Actual employee payroll records
- Cost of independent contractors if no certificate or proof of other coverage is provided

If you are notified that you will be audited, you can make the whole process easier and less stressful and hopefully end on a positive note if you follow these tips:

Before the auditor arrives

- Find out what the auditor will be reviewing by looking at their auditor's work sheets and past audit billing statements.
- Determine which of your employees would be best suited to work with the auditor. Try to choose someone who is knowledgeable about the accounting records that will be used in the audit and about what work is done by various employees and departments.
- Collect all the accounting records that will be used during the audit.
- If you use subcontractors, make sure that you have their certificates of insurance on hand. Make sure that your documentation shows all the contractors have their own general liability insurance and workers' compensation.
- Check that your payroll documents include a breakdown of wages according to class code, department and employee.

The day of the audit

- Make sure you have all the applicable records easily available to the auditor. You might request the audit be conducted at your business if you are concerned about having all the records accessible.
- Ask the auditor to explain any points that aren't perfectly clear to you.
- Request a hard copy of the auditor's findings.

After the audit

- Carefully assess the audit billing statement, comparing it to your original policy. Discuss the findings with your broker for assistance and advice.
- Don't agree to pay any additional premium dollars until after you've made a list of all changes and discussed any problematic areas with the auditor.❖