White Paper:

Cost Avoidance Strategies

Enhancing People and Profit

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Cost Avoidance Strategies

The growth in health care spending continues to plague American employers. Plan sponsors have become accustomed to annually reviewing their health care plans to identify cost containment opportunities in the following areas:

- Benefits Provisions— Are plan deductibles, coinsurance, and copayments set at appropriate levels? What services should be covered and what services should be limited or excluded?
- Employee Contributions— How much of the premium cost should be borne by plan participants? How should annual premium increases be allocated between the plan sponsor and the plan participants?
- Carrier/Administrator and Network— Is the carrier/administrator a good business partner for the plan sponsor? Do networks provide adequate access with a competitive level discount level?

One area that has received less scrutiny historically is eligibility—who is actually enrolled and receiving benefits from the plan? Typically, a plan provides coverage for full-time employees, their spouses and their dependent children. Plan sponsors may want to review their eligibility requirements and consider whether there are opportunities to move individuals off of their plans. In the following sections, we explore some potential ways to accomplish this goal, with a focus on dependent spouses.
Most plans make coverage available to an eligible employee's spouse. Absent a very specific definition of "spouse," this may encompass individuals the plan sponsor did not intend to cover, including:

- Spouses who are separated from the employee.
- Same-sex spouses in jurisdictions that recognize same sex-marriage.
- Common-law spouses in jurisdictions that recognize common-law marriage.

Plan sponsors should be very clear in defining who is considered to be an eligible spouse. For example, a plan sponsor might add language stating the spouse must actually reside with the employee or be of the opposite gender in order to be covered under the plan. In addition, plan sponsors may want to consider requiring that employees who wish to enroll a newly-acquired spouse provide proof of the marriage.

Working Spouses

Two-income households have become the standard in this country. Although some individuals are not eligible for employer-sponsored health care benefits, many working couples have access to coverage through both of their employers. In some cases, each spouse enrolls in the health care plan offered by his/her own employer. In other cases, both spouses enroll under one health care plan (one as the employee and one as the dependent spouse). This tends to happen when one of the health care plans offers richer benefits or requires a lower payroll contribution than the other.

Over the last several years, plan sponsors that offer these generous health care plans have picked up a disproportionate number of dependent spouses who could be enrolled in another plan, but are not. In an effort to direct these spouses back to their own employer-sponsored plans, some plan sponsors have adopted special spousal access or spousal surcharge rules.

Spousal Access

This special eligibility rule states that if an employee's working spouse has coverage available through his/ her own employer, that spouse must enroll in his/her own plan as a condition of enrolling in the employee's plan. The spouse's own plan thus becomes the primary payer for the spouse's claims and the employee's plan becomes secondary. Some plans take this a step further and state that if an employee's working spouse has coverage available through his/ her own employer, that spouse is not eligible at all for coverage under the employee's plan.

Spousal Surcharge

This provision imposes an additional premium contribution on an employee with a working spouse who has access to health care coverage through another employer, but continues to enroll as the employee's dependent spouse. The employer remains the primary payer for these working spouses, but is able to partially offset its financial exposure through the higher premium contribution. Among employers requiring a spousal surcharge, the typical monthly amount ranges from $50 to $150.

While definitely advantageous to plan sponsors, spousal access and spousal surcharge provisions are not necessarily popular with employees. Employees may complain that their spouses' plans are not as rich as their plans or that those plans require much higher payroll contributions. Some plan sponsors have responded by waiving the spousal access or surcharge provision in certain circumstances (for example, when the working spouse's plan requires a contribution in excess of a certain amount). Making exceptions like these can become administratively challenging, as the plan sponsor would have to verify information about each working spouse's health care plan.

Monitoring Compliance

Most plan sponsors have historically relied on the "honor system" to monitor compliance with spousal access or spousal surcharge programs. Increasingly, however, plan sponsors are requiring a written statement from each employee, attesting to the employment and coverage status of his/her spouse (this is usually incorporated into annual enrollment material). A few employers have even adopted a method whereby spousal coverage is assumed to be in place for all employees and it is up to the employee to request a waiver (if the spouse does not have other coverage available). These are relatively rare, though.

Summary

Reviewing and amending the eligibility provisions in their health care plans may provide plan sponsors an opportunity to reduce enrollment in these plans. If you would like to discuss this issue in more detail to determine if it is appropriate for your plan, please contact CPI-HR at 440-542-7800.

Most plan sponsors offer medical, dental and vision coverage for the spouses and child dependents of their eligible employees. Other coverage options are also sometimes extended to these family members. To ensure those individuals covered under your plan meet the eligibility definitions upon enrollment and continue to meet the eligibility definitions as established in your plan documents, there are several processes we encourage. This article provides a brief overview of:

- Clear and consistent Eligibility Definitions
- Initial Eligibility Verification
- Ongoing Eligibility Verification
- Periodic Audit

Clear and Consistent Eligibility Definitions

Eligibility definitions should be consistent across plans in booklet language and in the ERISA plan document. Eligibility terms should also be as clear as possible. For example, if a dependent child can be covered as a full-time student to age 23, the plan language should also note whether the child will be covered until his/her birthday, at end of the month in which she/he turns 23, or the end of the calendar year in which she/he turns 23.

Initial Eligibility Verification

There are three periods during which an employee can add a dependent to his/her plan(s): during their initial enrollment period, annual open enrollment, or within 30 days of experiencing a qualifying life event as defined by Section 125 or HIPAA.

During the initial enrollment period, dependent eligibility should be verified. If an employee is enrolling their spouse, s/he should provide a copy of their marriage certificate. If an employee is enrolling their child(ren), s/he should provide a copy of each child's birth certificate (or adoption or legal guardianship papers). Finally, a dependent child enrolling in the Family Continuation or College Rider must provide proof of student status and/or support and income to meet the eligibility definition requirements.

Ongoing Eligibility Verification

Certain eligibility verification should also be performed annually, usually as part of the regular open enrollment process. During open enrollment, employees may make changes to their covered plan members. Any employee who newly enrolls a dependent should be required to provide the same documentation as listed in the previous paragraph. Dependent children in the Family Continuation or College Rider should also be required to provide documentation they meet the criteria. For example, if the plan eligibility language requires full-time students

to take a minimum number of credits for at least two semesters of the year, appropriate documentation from their educational institution should be provided at least annually.

Periodic Audit

For those employers who have not consistently required such eligibility documentation, you may wish to consider a one-time audit to help "clean up the books." You can then implement regular eligibility documentation practices to keep the eligibility "clean" going forward.

Summary

Diligent documentation of dependent eligibility should be a consistent part of the enrollment process. Employers may be reluctant to ask for this information for fear that it is intrusive or too time consuming. Remember, however, that enrollment in an employer sponsored plan is a benefit. As the plan sponsor, your organization is legally required to offer and administer the plans consistently under the requirements posed by ERISA law. By regularly requiring this data of all eligible employees, you help protect your organization from claims of unfair application of the plan standards. It also helps protect you as the plan sponsor – and the plan itself – from paying premium or claims for ineligible individuals.

The Working Families Tax Relief Act (WFTRA) made several changes to the tax code, beginning in 2005. One of these changes was in the definition of "dependent" for purposes of health care plans. Under the tax code, employees generally are not taxed on the value of health care benefits or coverage provided to the employee, his or her spouse and his or her dependent children, assuming these children meet the tax code's definition "dependents." If health care coverage is extended to children who do not meet the tax code definition of dependent, the value of the benefits (under a self-funded plan) or the cost of coverage (under an insured plan) are taxable to the employee. As we head into open enrollment season, it's a good time to review all your plans' eligibility language to make sure it accurately reflects your enrollment processes and is not, inadvertently, creating a taxable event for any of your employees.

Under the WFTRA, a child is considered to be "dependent" if he or she meets either of the following two criteria:

1. **Age Test:** The child must be the son or daughter of the employee (this can include adopted children, step-children and foster children if otherwise eligible), have the same principal address as the employee for at least half the year and not have provided more than half of his or her own support for the year. Such children can be covered until the end of the calendar year in which they attain age 18 (age 23 if a student).
2. **Support Test:** The child must be the son or daughter of the employee (again, this can include adopted children, step-children and foster children if otherwise eligible) and be dependent upon the employee for more than half or his or her own support for the year.

Some health care plans allow dependent children to be covered until the end of the year in which they reach age 19 (or 25 for students). These children would not pass the age test, but

could still qualify under the support test. The plan's eligibility language should make clear that the child must rely on the parent for at least one half of his or her annual support in order to be covered under the plan.

This same dependency requirement applies to other individuals who might be covered as dependents on the employee's plan, such as domestic partners or sponsored dependents. In order for the benefits or coverage to be considered non-taxable income to the employee, such dependents must meet the support test outlined above.

As you review your plans' eligibility requirements, you might consider using the same definition of dependency for all health care plans, including flexible spending accounts. CPI-HR is ready to assist you in the review and in facilitating any necessary changes as a result of the review.

Cafeteria plan regulations allow plan participants a choice between taxable compensation (e.g., cash) and non-taxable compensation (i.e., qualified benefits such as health care). For some plan sponsors, the cash component is simply the payroll deduction that employees avoid if they choose not to participate in the employer-sponsored health care plan. Other plan sponsors offer additional compensation as an incentive for employees to take coverage through a source other than the employer's plan (e.g., a spouse's plan). Plan sponsors should consider which approach is more appropriate to their culture and workforce.

Avoidance of Payroll Deduction

The majority of plan sponsors in America require some type of premium contribution from employees participating in their health care plans. Over the last several years, plan participants have seen a steady increase in these required contribution amounts. According to a 2005 national survey, required monthly contributions for PPO plans in the U.S. averaged $96 for single coverage and $398 for family coverage.

As an alternative to simply raising required premium contributions, some plan sponsors have adopted a tiered contribution schedule, heavily weighted for employees who choose to enroll their dependents. For example, some plan sponsors contribute an amount equal to the single rate for all employees and require employees enrolling dependents to pay the full differential between the single and family premium rates.

This large contribution requirement effectively deters employees from enrolling family members who have access to other coverage. Some plan sponsors don't require the full premium differential as a contribution, but still have a fairly high contribution for family coverage. Either way, this approach provides enough incentive for some employees to seek coverage for family members through another source.

Cash Opt-Out Incentives

Other plan sponsors have found payment of a cash opt-out incentive to be an effective tool in reducing the overall plan enrollment. This approach involves paying additional compensation to employees who do not participate in their employer-sponsored health care plans. Some

plan sponsors offer a two-tier incentive: one amount if the employee does not enroll eligible dependents and a higher amount if the employee declines to enroll himself/ herself and all eligible dependents. Other plan sponsors require a full family opt-out to qualify for the incentive.

Most plan sponsors pay the incentives per pay period, rather than as a lump sum at one time during the year. This is treated as additional income and is subject to normal income taxation.

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The way in which a plan sponsor structures its premium contribution requirements can greatly impact the ultimate enrollment in the plan. CPI-HR recommends you review this issue annually to determine how it fits into your overall employee benefit strategy.

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