2 Hours of Self-Study CE

"Health Savings Accounts: Another Step Forward in Health Insurance"

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Health Savings Accounts: Another Step Forward in Health Insurance

Background

Many agents today specialize in employee benefits and executive benefits, which means there are a lot of agents selling a lot of group health insurance. The purpose of this article is to review what may be one of the biggest changes to come our way related to health insurance and the healthcare industry. In any event, health savings accounts (HSA) were created by the Medicare Reform Act of 2003, signed into law by President Bush in December 2003, and became law on January 1, 2004.

So what we're going to try to do in this article is to try to understand exactly what health savings accounts are and how agents can better educate the public, specifically employers and employees about this product. So the first question that comes to mind is: Why HSAs? The creation of HSAs was designed to help provide greater access to affordable health care. There is no mystery — it's a known fact that this country has a problem with rapidly rising costs of both health care and health insurance.

Depending on whose figures you look at, there are somewhere between 43 and 45 million people in America who don't have health insurance, and that number continues to increase each year. Candidates for national elected office need to get it straight, because there are a lot of elected officials and candidates for public office, stating that there are 45 million people who don't *have* health care, and that's simply not true. *Everybody* in America has health care. It's just that the rest of us who *have* health insurance pay for it. But that is a problem, and so we need to take a minute and just analyze who those 43 or 45 million people are.

The population of the United States is approximately 300 million and with 45 million people uninsured, that means that 85 percent of us do have health insurance. Now, that's not as good as we'd like it to be. We would like 100 percent of the people to have health insurance. But it's not bad. So the problem is not as big as perhaps we might think when we look at a number of 45 million. But let's analyze that 45 million. Who are they?

First of all, it needs to be pointed out that -- even though we may not know the exact number of people -- a number of those folks are people who are *voluntarily* uninsured. Many agents who specialize in health insurance receive phone calls from people all the time who are looking for health insurance, and that doesn't

necessarily mean young people. Some of these people are in their thirties and forties and even fifties who are looking for health insurance who have never before had health insurance. Usually it's because they now have a problem and probably have difficulty in getting health insurance, but there are a lot of people who are voluntarily uninsured. A lot of them *are* young people. Most young people think they are never going to get sick, and they would rather spend five or six hundred dollars a month on a new car payment than to pay for a health insurance policy. That's understandable. We've all been there.

There's also the chronically unemployable in this country, and, again we don't know exactly what that number is, but it's a fairly large number. There are a large number of people in any society, including ours, who are chronically unemployed, and as a result do not have health insurance. They can't afford it, and no one is providing it for them.

And then there are somewhere between 12 and 15 million illegal immigrants in this country, and they are counted in that number. So HSAs were designed by the Congress to help alleviate a big portion of this problem, and that's what we're going to talk about. Here's a quote from Chairman Bill Thomas. He says, "HSAs help put individuals in control of their own health care while helping manage health care's rising costs." So that's addressing the rising costs of health care.

HSAs Address Rising Costs of Health Care

Estimates show that premium savings on a health saving plan can be 25 percent or more compared to a typical low deductible plan. And to give you a couple of examples from one agent's experience: They had a client who the agent recommended an HSA to a few months ago, who has a fully insured low-deductible plan, has the very best plan their carrier offered, and wanted to maintain that level of benefits. However, he was disturbed by the fact that he had had three consecutive 30 percent rate increases over the last three years, which was not untypical, unfortunately, in their market. The agent showed him an HSA using the largest deductible allowed under an HSA, which is $2600 this year (2004), for a person with single coverage and $5150 for a person with family coverage. Now, those numbers are going to be indexed for inflation. So these numbers are the 2004 figures. But anyway, that's the plan that the agent showed him which resulted in a 52 percent decrease in the premium for the health insurance component.

Now, the agent then calculated if he fully funded the Health Savings Account. That is to say, he put in $2600 for each one of his employees who have single coverage and $5150 for each one of his employees who had family coverage. This is a firm with 18 employees, and by fully funding the health savings account, he was able to save about $21,000 a year in total costs for health insurance. That's pretty significant and what that means is that he can continue to provide good health insurance benefits for his employees, instead of just getting out of the providing of health insurance altogether.

Consumer awareness of the actual costs of health care services will lead to more patient involvement. And this is a good concept. And very often concepts are difficult to explain to your clients who are not in the business that we are in. They are consuming, they're not manufacturing or selling the product as we are. But this is a concept that's so important that we need to get it across. We have in the last 40 or 50 years in this country convinced the consumer, as well as most employers, that they should have health insurance as an entitlement, and that it should pay for everything; that they should be able to go to the doctor, pay $10 or $15 or $20, not have to fill out a claim form, and have everything else taken care of, regardless of whether they spend $100 a year or $100,000 in a year. And that's our fault. We have done that. Our industry has done that over the last 40 or 50 years.

Here's the scenario: A young man graduates college 40 years ago and begins his career with a big employer and doesn't have any health insurance for the first six months. That college graduate wasn't eligible for his company's health insurance plan for the first six months. He now has a pregnant wife, and when they go to the hospital, they asked him a series of questions, one of which was: Do you have insurance? "No"; Do you have money? "Yes"; What do you do, Mr. Smith? "I'm a Certified Public Accountant." So anyway, after six months when the young college grad was eligible to go on their health plan, he had a $250 deductible, and then the plan paid 80 percent of everything over and above that. Now, if

you index that $250 deductible for inflation from 1964 to 2004, that deductible today would have to be about $2600 or $2700 dollars. Yet we are selling plans which either have no deductibles, or which have a minor co-pays like $10 or $15 or $20.

So we have helped to create this problem, folks, and now we have an opportunity to turn that around by educating the public, our public, our consumers, our clients, on why we should be doing something different than what we have done for the last 30, 40, or 50 years. So consumer awareness of the actual costs, we feel, will begin to mitigate the cost of health insurance, and the cost of health care. Here's why we say this: If you put some money in a savings account – either you personally or your employer – put some money in a savings account and it's your money, once the money goes in the savings account, no matter who puts it in — employer or employee — it's the employee's (your) money. Now, we're going to give you, the employee, a debit card which you can use to pay for your health care. Unlike a FSA (Flexible Spending Account), which we're all used to under Section 125, if you don't spend the money, you get to keep it. So under the old flexible spending accounts that we're all used to, it was either spend it or lose it. Under an HSA, it is spend it or *keep* it. And so if people understand that concept, they are going to begin, we think, are going to begin to be judicious in how they spend that money.

Let's take a look at another scenario, using you as an example. When your oldest daughter is ready to have braces put in, your spouse takes her to the orthodontist, and then that evening when you come home from work, they said, "We went to the orthodontist today and it's going to cost us $3,500." You say, "How many estimates did you get?" Your spouse looks at you like you are from another planet. They say, "What do you mean?" You say, "Well, this is not an emergency procedure. We can afford to shop around for the best price." Well, your spouse is very uncomfortable with that. You say, "Okay, I'll tell you what you do. Call the orthodontist and tell him you're going to shop around and see what he says." The next evening you come home and your spouse says, "I did what you said. I called the orthodontist. I told him we were going to shop around. He said, 'I'll do it for $2,750.'" Well, that's just an example, but it's a good example because we can negotiate the price of everything, folks. We negotiate the prices of cars, TV sets, and kitchen stoves. We negotiate everything. And why shouldn't we negotiate the cost of health care?

If it's my money instead of some entitlement that's setting out here in some first dollar benefit plan, then I'm more likely to do that. And we think if people do that, the cost of health care may not come down, but it won't go up quite as fast as it has been in the last three, four, five years. Patients will inquire about the cost associated with their health care and consider the options.

<u>Comparing HSAs with MSAs</u>

HSAs are an improvement over MSAs (Medical Savings Accounts). Some of you may remember that up until December 31, 2003, we were able to sell medical savings accounts. Now, unfortunately, as a group, we as agents didn't do a very good job at that. Congress created MSAs as an experiment and said okay, we will allow insurance agents to sell a certain number of MSAs and we'll see if they work, and then we'll decide whether or not to extend the program or to make it permanent. Now, in the time that was allotted for that, we didn't come anywhere close to selling 750,000 plans. We're not sure who was counting, or even if anyone was counting, but we're also pretty certain we didn't reach that number. But anyway, agents didn't sell a lot of MSAs, and Congress even extended the program, and agents still didn't reach the 750,000 number. And so, MSAs really went out of business on December 31, 2003.

But HSAs became available the next day, and they are a vast improvement over MSAs, and a lot of that was because a lot of us looked at MSAs, and a lot of people are going to look at HSAs, unfortunately, the same way and say, "Well, if I sell an MSA or an HSA as opposed to a fully assured plan, the premium is going to be lower, and as an agent I'm going to make less money." Hopefully, you won't do that. Let's compare the old MSAs with the new HSAs.

First of all, under HSAs you have a *lower "high deductible"*. The "high deductible" plan under an MSA had to be at least $1700 for individuals, and at least $3450 for families, compared to $1,000 for HSAs for single coverage and $2,000 for families. So under an HSA you can have a much lower "high deductible."

It's not just for small employers. MSAs were only available to self-employed people and small employers. HSAs are open to everyone. Anyone can buy an HSA. Anyone can buy a qualified, "high deductible" major medical plan and set up a health savings account, whether they're just an individual looking for coverage and buying into the concept of the savings account, or a person who is self-employed or a small business, or for that matter a large business. They're available to anyone.

Flexible Funding

HSAs may be funded by employers and employees. The old MSAs could be funded by either, but not by both. So under an MSA arrangement, the employer could put in the money in the savings account, or the employee could put in the money in the savings account, but it couldn't be co-mingled. You couldn't have both employer and employee money going in. In an HSA you can. And here's another example: Assume you have a small chiropractic firm for which you have provided an HSA. The employer, the chiropractor in this particular case, is putting $600 in the savings account for each of his employees who have single coverage and $2200 in the savings account for each of his employees who have family coverage. And if the employees want to add additional money, they can -- up to the limits that we'll discuss in a few minutes.

Some of you also probably remember HRAs (Health Reimbursement Account), which are still available. You can still sell a Health Reimbursement Account, and under an HRA arrangement, it can only be employer money. Employees cannot put money in an HRA. So you have much more flexible funding. HSAs are similar, but more flexible. First of all, there's no sunset. MSAs were established, as explained earlier, as a pilot project, and new MSA accounts could not be established after December 31, 2003. The HSA legislation is permanent legislation. There's no sunset provision. Also, the tax penalties are lower under an HSA than they are under MSAs. Remember, when we give this employee, whether it's his money or the employer's money, when we give this employee a debit card, we can't force him or her to not spend it on things that are not allowed. Now, safeguards can be built into the debit card so it will be rejected if he or she goes to Toys R Us to buy some toys for the kids with it, but that only works as good as the system works. And we know there are going to be breakdowns in that. When that happens, if you spend that money and the IRS knows that you spent that money for things that are not allowed, that are not medically-related expenses, then under MSAs there was a 15 percent tax plus a 15 percent penalty. That penalty is only 10 percent under HSAs. So that's an improvement. Annual deductible on the insurance policy must be at least $1,000 for individuals and at least $2,000 for families.

Now, you're going to hear the term "qualified high deductible health plan," and let's elaborate just a little bit on that, because when this first became available and before the Department of the Treasury issued its final regulations on it, it wasn't clear what was meant by a qualified "high deductible" health plan. And a lot of us thought that you could just go to any insurance company and buy a "high deductible" plan, and that would be okay. It's not so, and now the final regulations are in place and have been issued, and we know that there can be no first-dollar benefits in that high deductible plan.

So if we went to XYZ Insurance Company and bought a $1,000 deductible major medical plan which had a prescription drug benefit, then it would not qualify. There cannot be any first-dollar benefits other than for preventative care, which is a temporary measure, in order for it to be a "high deductible major medical plan." Out of pocket maximums are limited to $5,000 for individuals and $10,000 for families for in-network expenses. Translation: If you buy a $1,000 deductible plan and then the plan pays 80 percent, when your total out of pocket expenses reach $5,000 if you have single coverage, or $10,000 if you have family coverage, then the plan must then begin to pay 100 percent of the in-network expenses. If people go out of network, obviously, they can have more out of pocket, but this discussion is about in-network expenses.

Preventative care services may be covered on a first-dollar basis, currently. It's possible that might change. It's possible that once HSAs are up and running and the public begins to understand them, then that provision will be removed. But nobody's sure of that. Right now you can put preventative care in.

HSAs are portable and are owned by the individual.

Now, this is both a positive and a negative. It's a positive from the employee's point of view; it's a negative perhaps from the employer's point of view. Let's explain. If the employer is putting money in the savings account on behalf of the employee, and the employee leaves, it's the employee's money. Some employers may not like that. Obviously, the employee will like that, so it's a positive from the employee's point of view, not so much a positive, perhaps a negative, from the employer's point of view. However, we need to explain to the employer first of all and it's very possible that many employers are not going to fully fund the savings account.

There was a report issued in 2003 from a specific health insurance carrier which stated the following: It said that 91 percent of us spend less than $600 a year on health care. Ninety-one percent of us! So what that means is that 9 percent of us are spending a lot more than $600 a year, which is what brings that average cost per person per year for health care up. There are a lot of people, and, we're all in the business and some of us have seen some very large claims. A few years ago, several years ago actually now, there was a company which paid a $750,000 claim for a premature baby who eventually died. But when you add that to all the people who are spending two, three, four hundred dollars, or nothing, and average it out, then the average number comes way up. But 91 percent of us spend less than $600 a year on health care.

So what we're suggesting to our employers is that they fund $600 in the savings account for employees, or if they want to be a little safe because there is some inflation since that report was issued, maybe $650 or $700 in the savings account for their employees with single coverage, $1500-1600 for people who have two people covered, like a husband and spouse, or employee and a child, and $2400 for people who have family coverage, not fully funding it.

Obviously, you've got to have a higher deductible in order to be able to do that, reducing the premium to the employer so he can afford to do that. What's being suggested here to most of our clients is that they buy a plan with the highest deductible allowed, which is $2650 for single coverage and $5150 for family coverage. And if they do that, it's going to reduce their insurance premiums by anywhere from 40-55 percent, depending on the case. So then the employer can afford to put some money in the savings account. And then if the employee wants to add money to that, they can do that. But they don't *have* to do that. And frankly, most employees are not putting additional money in the account. Some are, but most are not. So that sort of takes away from the negative impact of an employer having to put money in the account and then losing control of it.

Okay, for family coverage, a "high deductible" plan has an annual deductible of at least $2,000 while self-coverage allows for an annual deductible of at least $1,000. This amount cannot be used in family coverage. This is an example: Bob and family have a plan which provides payment of covered expenses for any member of Bob's family in excess of $1,000 even if the family has not incurred covered medical expenses in excess of $2,000. This is not a qualified "high deductible" plan. Remember, the deductible has to be at least $1,000 if you have single coverage, and at least $2,000 if you have family coverage. Office visits and co-pays are not permitted. Prescriptions must be covered under the deductible, but not under a drug card.

Prescription Drugs

So the employee who, in the past, is used to going to the pharmacy and presenting his or her drug card and getting the drugs for $10 or $15 or $20 or whatever the co-pay is on the drug, would no longer have that. But what he or she will have is their debit card. And so when they go to the pharmacy, instead of presenting a drug card, they'll present their debit card. And by the way, they will get the discounts that the network has negotiated, and whatever the cost of the drug is will be taken then directly by way of the debit card from their savings account. So there really is very little change. In fact, the change is a positive change from the employee's point of view because there is no co-pay. They may have been paying $20 for a generic drug in the past, now they will pay nothing except that all of the money comes out of their savings account. But at that point they're paying nothing.

Out of pocket maximums include deductibles, co-insurance, and co-pays if any. As mentioned before, preventative care can be covered without application of a deductible. For network plans, the deductibles and maximum out of pocket apply to in-network services. If an out of network deductible or out of pocket maximum is more than allowed under the law, the plan will still qualify, as long as the in-network benefits meet the requirements.

Contributions

HSA contributions must be made in cash. They can equal the amount of the insurance policy deductible, between $1000 and $2600 for people with individual coverage, or up to $5150 for those folks who have family coverage. Individuals 55 years of age or older can make extra contributions to their accounts. Once fully phased in, a married couple could save an additional $2000 annually. The amount allowed in 2004 for individuals 55 and over, and younger than age 65, is $500. So that's going to ratchet up over the next three years to an additional $2000 in addition to the $5150 maximum. Catch-up contributions are only allowable for the months during a year that a person is younger than age 65. If the person is age 64 for only four months of the year, then one-twelfth of the $500 annual allowance, multiplied by four months, is the amount of catch-up provision that they can put in.

You probably see a lot of similarities between the rules that they've set up for HSAs and the pension rules that we're all used to. Please be sure to note that you cannot make any contributions to an HSA after age 65. So once you reach age 65, you can't make any additional contributions. But let's take a moment to elaborate a little bit on that because this is a great opportunity, especially for young people.

Assume, just for a moment, that you're a young family person just getting started in life and buy into this concept of a health savings account. There's a good chance, if you fully fund that savings account every year, you are not going to spend all of the money. There is a lot of money that is going to carry over. Interest is going to be credited to it on a tax-deferred basis, and the money is going to grow. And it's not inconceivable that a person could end up at age 65 with a few hundred thousand dollars accumulated in their HSA.

A lot of people are calling these "health IRAs" because it's another opportunity, in addition to what you can put in your IRA or your 401k plan on a tax-deferred basis. And we bring this point up because if you start this at 30 or 35 and have a couple of hundred thousand dollars in the account when you reach age 65, what happens at that point? You go on Medicare. But most of us at that point would probably buy a Medicare supplement policy. If you've got a couple of hundred thousand dollars, you can still spend money on your health care from the savings account. You just can't contribute to it after age 65. And so the money is sitting there, and as long as you spend it on health-related expenses, then perhaps you don't need to buy a Medicare supplement policy. So that could be additional savings, you know. And a Medicare supplement policy today is a couple of hundred dollars a month for the best supplement, which could be saved because the money is there in the health savings account.

Both employers and employees can contribute to the account portion of the plan. Contributions by an employer are not taxable income to the employee — very important point — and are also not subject to FICA taxes. Individuals own their HSAs. Contributions by an eligible individual or family member of the eligible individual are tax-deductible by the eligible individual on an above-the-line basis. No more of this listing this with all of your medical expenses on the Schedule 1040A and then subtracting from the total 7.5 percent of your adjusted gross income and ending up with no deduction. This is an above-the-line deduction. That's at least a double play in tax planning.

Contributions by an eligible individual — just to repeat — or a family member of the eligible individual are tax deductible by the eligible individual on an above-the-line basis. Contributions made by an employer are not deductible by the individual. That's fair. They weren't taxable to the individual either. Individuals can take a deduction on their tax return for medical expenses if the expenses were reimbursed under the HSA. Individuals cannot take a tax deduction if they paid for it using their MSA because they are using money which has already escaped taxes.

Interest and investment earnings on contributions are not taxable while they're in the HSA. Just like an IRA or 401k plan, the money is going to earn interest and it's not going to be currently taxed. Contributions from all sources are counted equally to calculate the contribution maximum. If a person already has an MSA and opens an HSA in 2004, or if the person has more than one HSA, the maximum contribution is limited to the combined amounts. Any contributions made under an MSA will be subtracted from the amount allowed for 2004 under the HSA. That only makes sense.

The contribution limit is calculated on a monthly basis; i.e., if a person bought a policy on January 1 but opened the HSA account in May, the contribution limit would be based on eight months versus the entire year. So it's important that they open the savings account and purchase the qualified "high deductible" health plan at the same time.

Contributions may be made at any time of the year in one or more payments. So that seems to contradict what was just said, so it may need further explanation. Just like in a pension plan, if you set up a 401k plan or an IRA or a small company pension plan before December 31, you've got until April 15 of the following year to fund it. And the same thing is true here. We said it's important to open the HSA at the same time you purchase the insurance policy, but you don't necessarily have to fund it at that time. The deadline for contributions is April 15 of the year following the year in which the contribution is made.

Contributions in excess of the maximum allowable amount, or contributions made on behalf of an employee who is not an eligible individual, will be included in the employee's income regardless of who made the contribution, and a 6 percent excise tax will be imposed. What's that all about? All we're saying is that if the person, for whatever reason, is not eligible – and there are any number of reasons why you may not be eligible such as you're covered under another health plan. Let's say you work for XYZ Company, your spouse works for ABC Company, and ABC provides free health insurance for your spouse and her family, and so you're covered under that plan. You're not eligible for an HSA because you're covered under another health plan. In this example, if your employer put money in a health savings account in your behalf, you're going to have to pay tax on that, and a 6 percent excise tax, and the rationale for the 6 percent excise tax is because it's an HSA it's going to grow on a tax deferred basis. So that's the government's way of recouping some of that money up front. If the excess contributions are returned to the employee before the end of the employee's time for filing a tax return for the year the excess contributions were made, including any extensions, the employee will only be liable for actual income tax on the excess and not the excise tax.

Multiple "High Deductible" Health Plans

If one or both spouses have a qualified "high deductible" health plan with family coverage, both are treated as having family coverage. Example one: Bob has a high deductible policy with a $4000 deductible. His wife, Karen, has a high deductible policy with a $2000 deductible, also with family coverage. Between the two of them, they can contribute $2000 to their HSAs, divided equally between them, unless they agree to some other arrangement. If one of them were age 55 or older, that amount could be increased by $500 in 2004. So it's the lower — in the case of multiple plans -- it's the lower deductible which governs the amount that you can contribute. Example two: Paul and Mary both have "high deductible" policies with single coverage and a $1000 deductible. In this case, they have single coverage, not family coverage so each of them can contribute $1000 to his or her HSA.

Distributions

Let's talk about distributions from an HSA. Balances remain in an HSA at the end of a year roll to the next year. So as we said earlier in this article, unlike FSAs where it was "use it or lose it", this is "use it or keep it". This is a very important distinction. Distributions may be made using a debit or other stored value card. If a person is no longer an eligible individual, for example, they turn age 65 or no longer have a qualified "high deductible" health plan, the funds remaining in the HSA can still be used, but only for qualified medical expenses. And when we say only for qualified medical expenses, you could use it for other things, but you'd have to pay tax and penalties. So what we should say is, only for medical expenses without taxes and penalties. Amounts distributed which are not used to pay for qualified medical expenses

will be taxable, plus an additional 10 percent tax unless they are made after an individual's death or disability or the attaining of age 65. After age 65 you can take money out of the account with no penalty, but, of course, you would pay ordinary income tax on it.

Death of the Account Holder

When an account holder dies, if the beneficiary listed on the account is his or her surviving spouse, the spouse may use the funds in the account for qualified medical expenses. If the beneficiary is someone other than a surviving spouse, the amount of funds in the HSA is taxable income to the beneficiary, except for medical expenses of the account holder paid within one year of death.

Employer Contributions and Discrimination Rules

If an employer makes contributions to an HSA, they must make comparable contributions for all comparable participating employees during the same period. This is right out of the regulations, and it's important that you understand what was just stated. This doesn't mean that you couldn't set up a plan in a company and cover only one class of employees. You could, if you really read that sentence carefully, you could go into a company and the employer could say, "I have some union employees, they're covered under a collective bargaining agreement. I only want to cover the non-union employees." That's fine, and you're not discriminating by putting money in an HSA for those folks and not for the union employees.

Likewise, take a construction company as an example. This is very typical in that industry, where the employer might be willing to provide health coverage for all of his internal staff, management, and field supervisory people, but not for the laborers. That's not unusual, and as long as you classify them by class, then you can do that and you're not discriminating. A comparable contribution means the same dollar amount or the same percentage of the deductible under the "high deductible plan". Part-time employees are considered separately when calculating comparable contributions. If an employer does not meet the comparability rule, they are subject to a 35 percent excise tax on aggregate contributions made to the HSA during that period. So there are some real teeth in these nondiscriminatory rules. The comparability rule does not apply to contributions made under a cafeteria plan, or to rollovers from an MSA or another HSA.

Employer contributions must be reported on the employee's W-2 in the place designated. As most of you know, on a form W-2 there's a place which says "other income". It doesn't mean you've got to pay tax on it, but the IRS wants to know where this money is going and why they're not getting the taxes. And so there is a place on the W-2 to put that in there. Both the "high deductible" health plan and the HSA account may be offered under a Section 125 cafeteria plan.

HAS accounts are not subject to COBRA continuation. Those of you who have sold HRAs know that money left in a health reimbursement account, if a person elects COBRA, are subject to COBRA. In an HSA they are not. HSAs are not subject to Section 419, and are not considered welfare benefit funds.

Qualified Expenses

What are qualified expenses? Now we've set this up, we've got all this money accumulating in this account, we've given debit cards to each of the employees so that they can access the account, what can they spend it on? Well, they can spend it on prescription drugs. They can spend it on funds paid for the diagnosis, cure, mitigation, treatment, or prevention of disease. They can also pay COBRA premiums from the Health Savings Account.

Now, there are some limits on how much premium you can pay for long-term care, and those are basically the same limits that you have now on how much you can deduct. Health insurance for those on unemployment compensation can be paid for. That's a qualified expense. Premiums for Medicare Part A and B are also qualified expenses as are Medicare HMOs or Medicare Advantage premiums, but not Medigap.

So you can pay your premiums for Medicare Part B. Right now it's about $67 a month for Medicare Part B, and that number is going to keep going up. That can be paid. Retiree health expenses for individuals age 65 and older, but retiree health plans would not have to meet the $1000 and $2000 minimum deductible

because you can’t contribute to it anymore. So the money that’s in there can be used for your expenses after age 65.

Custodians of accounts are not responsible for insuring that the expenses paid under the account are qualified medical expenses. It’s important that we know that because a lot of our client employers are going to be concerned that they have some legal responsibility in seeing to it that this money is used only for medically related expenses. They will not be. The law says clearly that they will not be held responsible, and if they have hired an administrative firm, which in all likelihood they will do, to manage those accounts, they also will not be held responsible for how the employee spends the money.

Employers who make contributions and/or assist with the administration of HSAs are also not responsible for insuring the expenses paid out of the account are qualified medical expenses. Insuring that expenses paid from the account are qualified medical expenses is the responsibility of the account holder, the employee. Remember, they own the money and they are responsible for the money. The account holder must keep adequate records concerning the use of HSA funds. The account holder – again, that’s the employee. That’s not the employer, it’s not the administrator, it’s not the custodian, it’s not the third party administrator, rather it is the account owner who is responsible.

Designing a HSA

Many carriers are either planning or are already selling a package HSA product which will provide a turnkey approach to setting up HSAs. If you go back to January, February, March of 2004, there were very few companies which had a qualified “high deductible” major medical plan. And mostly they were small companies. Not that there’s anything wrong with small companies, but mostly they were small companies. The larger companies did not have a qualified “high deductible” major medical plan. That’s beginning to change. Most of the large companies now either have a “high deductible” health plan which will qualify for HSAs, or they are in the process of developing one. Virtually all of the companies had qualified plans in place by September or October of this past year. Other “high deductible” plans may be used in conjunction with an account. They don’t need to be provided by the same insurer. So you can have an insurance company over here that provides the “high deductible” health plan and a completely different entity over here who handles and manages the savings account. They do not have to be the same.

Most of the insurance companies, of course, are going to make deals with administrators so that they can all be handled in one nice, neat package, which makes it simpler for the employer and the employee, but it does not have to be that way. In fact, a person who already has an existing “high deductible” plan which meets the requirements of the law could open an HSA account at a bank or other institution. So if you have an individual who already has a plan which meets the requirements, they can go down to the local bank or to a third party administrator and set up a savings account.

A qualified plan can be either a group plan or an individual plan. So this goes back to what was said earlier — everybody qualifies. If a person has group coverage which meets the requirements of the law, that individual could establish an HSA on his own, even though his employer might not provide any structure for the account. So the employer doesn’t have to provide the savings account. They can simply say, “I’m going to give you a “high deductible” major medical plan which qualifies under the HAS regulations. You go out and set up your own account – or don’t set up your own account. It’s your choice.”

Alternatively, an employer of the plan who meets the requirements of the law might make some arrangement with an administrator to provide a convenient means for employees to establish accounts to use in conjunction with other group health policies, whether or not the employer actually contributes to the account.

It’s important to remember that qualifications regarding the deductible, when establishing an account under either of these scenarios, “high deductible” plans cannot have office visit co-pays, they cannot have prescription co-pays, and individuals electing family coverage must have a minimum deductible of at least $2000.

Now let's digress just a little bit here. Some agents in the past have sold, maybe still are selling, partially self-insured plans. There was one firm which started selling partially self-insured plans about 30 years ago, and they were told then that the only companies which should partially self-insure were companies with over 200 employees. That firm has been doing it successfully for 30 years with companies as few as 25 employees. They were all told when they started doing that that they had rocks in their head, that they were subjecting their clients to unnecessary risks. Most clients saved a great deal of money. Now, that's changed in the last four or five years. About four or five years ago, the reinsurance market for stop loss coverage began to encounter a great deal of trouble, difficulty, and the product, reinsurance, became very hard to get and very expensive. And so most of the clients who had fewer than 75 to 100 employees had to take back the fully-insured plans. Now, they loved the self-funding, but they couldn't afford what was going on in the partial self-funding market, so they had to go back to fully-insured plans. And if they have any way of going back to self-insurance of some form, they would do that, and this is an opportunity for them to do that. Think about it. Isn't this partial self-funding for small employers? Isn't that really what this is? The stop-loss policy is that qualified high-deductible plan.

This discussion of Medical Savings Plan was intended to take you into the "nuts & bolts" of how this products works and to explain the advantages, as intended by Congress, to both the health insurance consumer and their employer. As you can see, HSAs are truly a step forward in providing health insurance to Florida's consumers.

Unauthorized Entities

Introduction and Overview

Unauthorized entities engaging in insurance are a serious and growing problem in Florida for consumers and agents. Consumers are being substantially harmed with these entities failing to pay claims and defrauding through deception. Agents are unwittingly (sometimes knowingly) representing these entities and placing clients and themselves at risk. Florida law is being violated under the guise of these unauthorized entities claiming to be ERISA exempt or some type of association plan that claims to not be insurance or to be exempt from Florida regulation. All of this is simply not true! This is a problem in the state of Florida and other states.

In the fall of 2001, FAIFA (Florida Association of Insurance and Financial Advisors) by way of former FAIFA CEO Herb Morgan, received communications from officials at the Department of Financial Services regarding a problem whereby certain health insurance entities were not paying health insurance claims. The Department became aware of the problem because insurance consumers were contacting the Department to complain. The Department's Fraud Division looked into the problem and discovered that the entities selling the insurance were not authorized or approved or licensed, if you will, by the Department to sell insurance in Florida. And of course, neither were the products that they were selling. (Remember, any insurance entity which wants to sell life or health insurance products in Florida are required by law to submit the appropriate applications, including rates & forms, to the Department and must receive the Department's approval before the entities are permitted to sell their products here.)

Furthermore, Department investigators discovered that, not only had the entities failed to apply for or receive authorization to sell their products in Florida, but the products they were selling were bogus. Investigations by the Department later revealed that the actual entities themselves were also bogus, that they did not truly exist in any form except in the scam artists' minds and in beautifully printed marketing materials, applications, and agent contracts.

The problem of unauthorized entities selling unauthorized products originated in the health insurance arena. These unauthorized entities promised low health insurance premiums, a promise fueled by skyrocketing health insurance premiums with legitimate health insurance carriers. In the current market, low health insurance rates just do not exist. The public and certain agents, apparently, were ripe for the picking by these scam artists.

The scenario involving consumers played out this way: Representatives (sometimes they were licensed agents, sometimes they were simply unlicensed people hired by the entity, or sometimes it was the actual scam artist and his/her cohorts) would contact consumers, either directly (which is illegal) or indirectly. Florida law says that licensed agents must be used by carriers to sell life and health insurance products in the state. The unauthorized entities would use unlicensed people to sell the bogus products. Even if a licensed agent is used, it is illegal for a licensed agent (or anyone else for that matter) to sell insurance products sold by an unauthorized entity. It is against the law to represent an unauthorized entity. Obviously, selling bogus insurance products, whether sold by a licensed agent or an unlicensed individual, is illegal and is considered fraud.

Consumers are vulnerable to this type of scam because they are anxious to find relief from rising health insurance premiums. Several of these unauthorized entities were cunning in that some of them actually paid some of the smaller claims before they were caught by the Department. They paid the smaller claims to give the impression of legitimacy and to maintain their image of credibility. But when the larger claims (bypasses, transplants, strokes, etc.) started to roll in, the entity was nowhere to be found and certainly had no intention of paying the large claims. Remember, these are scams and the intent is to collect as much premium as possible without having to pay claims, or very few claims.

Unsuspecting licensed insurance agents are also vulnerable to this type of scam because representatives of the unauthorized entity will contact the licensed agents and send them (or give them in person) printed marketing materials touting the unauthorized entity and their bogus products which, again, gives the impression of legitimacy and credibility. The representatives will ask the agents to represent them and sell their products and will offer them contracts. It's at this point that the agent may decide to represent the entity because they offer low health insurance premiums and the agents knows LOTS of clients who would be interested in saving money on their health insurance. Who wouldn't? The agent signs the contract and he or she has just broken the law because that entity exists only on paper –it has not been authorized by Florida's Department of Financial Services.

Maybe the agent is asking too many questions of the representative – is just a little too inquisitive – about who they are, where they're located, how long they've been in business, etc. The agent may even question the legitimacy of the product. Some of the scam artists are telling agents that their products do not have to be authorized by the Department because the plan is an ERISA plan, or that the plan is part of a MEWA (multiple employer welfare arrangement) or it's to be sold to labor unions – all the while stating that under any of these previously-mention circumstances, the products do not have to be approved or authorized by the Department.

The representative of the unauthorized entity might say, "It doesn't have to have approval, because this is an ERISA plan." Or "It doesn't have to have approval because this is plan is part of a MEWA plan." Or "This plan doesn't require approval of the DFS because it's for labor unions." None of this is correct! Any employee benefit plan which contains an insurance component is required, by law, to receive authorization of that component by the Department before it can be sold in Florida. Any legitimate company representative who approaches you about selling and representing their products should not mind the scrutiny you put them under by verifying their status with the Department. (More on this later.).

It should be pointed out that the problem of representing unauthorized entities is no longer just a problem in the health insurance arena. The problem now seems to be spreading into property-casualty and general lines licensed agents are to be cautioned.

Let's review some of the key concepts we've just discussed regarding unauthorized entities:

<u>Employee Retirement Income Security Act (ERISA)</u>

The Employee Retirement Income Security Act of 1974 (ERISA) is a complicated and comprehensive federal law dealing with employee pension plans and employee welfare benefit plans. Employee welfare benefit plans is very broad and includes employer-sponsored and union-sponsored health plans. This

includes “medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment”.

ERISA Preemption and Relationship to State Insurance Law

ERISA does not preempt state insurance law. This results in a dual regulation. If an ERISA plan pays directly out of plan assets, that is, it is self-funded; it is exempt from state regulation. If a plan purchases insurance to cover some or all of its benefits, then state regulatory authority over the insurance therefore provides state regulation of aspects of the plan. ERISA specifically provides for states to enforce all state laws that regulate insurance. If an ERISA plan is insured, a state may regulate the plan indirectly under its power to regulate the insurer, the insurance contract and those who transact the insurance.

General Characteristics of an ERISA Plan

The ERISA law requires employee welfare benefit plans include four elements. The plan must include each of the following: a) established or maintained; b) by an employer or by an employee organization, or by both; c) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits; d) to participants or their beneficiaries.

Arrangements which do not meet each of these elements and whose activities are subject to state laws regarding the business of insurance must secure a state certificate of authority as an insurer. Those arrangements not complying with state law are then subject to the unauthorized insurer laws of the state.

Single-Employer Plans

A single-employer plan is sponsored by one employer for its employees. Two or more employers under common ownership or control may also be treated as a single-employer plan for purposes of ERISA. State regulation is very limited, unless the plan is insured.

Multi-Employer Plans

A multi-employer plan has more than one employer contribute and it is maintained pursuant to a bona fide collective bargaining agreement between one of more employee organizations and more than one employer. Multi-employer plans accept contributions from unrelated employers for their employees who are union members. These plans are administered by a board consisting of employer and union trustees. State regulation is very limited, unless the plan is insured. Not all plans which ostensibly involve collective bargaining agreements are covered by ERISA. Arrangements that do not involve bona fide collective bargaining agreements are MEWAs and are regulated by state insurance law.

Multiple Employer Welfare Arrangements (MEWAs)

A MEWA is an employee welfare benefit plan or arrangement maintained for the benefit of employees of two or more employers to provide health care or other welfare benefits to those employees and their dependents. Most MEWAs are not ERISA plans because they are usually not established or maintained by an employer or employee organization. Plans established through ostensible collective bargaining may also be MEWAs, if there is not a bona fide bargaining agreement. So-called “unions” are formed consisting of employees of unrelated employers in order to establish a health plan, but no legitimate bargaining takes place between employers and employees over wages, hours, and conditions of work or benefits. Such a “union” usually is not part of a recognizable trade or industry, but may use terms that sound similar to such organizations.

States have authority to regulate MEWAs whether covered by ERISA or not. States may enforce minimum standards for operation of MEWAs, including requiring them to qualify for and obtain a certificate of authority. Purchasing reinsurance or “stop-loss” coverage does not reduce or negate state insurance regulatory requirements. The Department of Financial Services has complete regulatory authority over MEWAs and a valid Certificate of Authority is required in order to operate. There are requirements for operations, rates, solvency, sales and assessments.

Let's now look at a just a few unauthorized entities which have been shut down by Florida's Department of Financial Services:

<u>N.A.P.T. Case</u>

Also operated and known under other names: NAPT, National Association of Physical Therapists, National Association of Professionals & Technicians, National Association of Professional Technical, National Association of Professional Truckers, National Association of Professional Traders, National Association of Chiropractic Professionals, National Association of Dental Professionals (Dental Division), National Tourism & Hospitality Association (Division), National Veterinarian Association, National Real Estate Association (Division), collectively referred to as "N.A.P.T." Also, known as Physician's Choice Limited a/k/a Physician's Choice LTD.

David Weinstein is the principal involved in this entity as an individual and as "Group Administrator" of N.A.P.T. He is not licensed nor has ever been licensed to engage in the insurance business in Florida in any capacity, including the operation, management or administration of a MEWA. He has engaged in the business of insurance in violation of the Florida Insurance Code (624.401(2), 624.437, 626.901 F.S.).

N.A.P.T. is not licensed nor has ever been licensed or authorized to transact insurance, or to operate as a MEWA. N.A.P.T. has engaged in the unlicensed, unauthorized and therefore illegal business of insurance, including as an illegal MEWA in violation of the Florida Insurance Code (624.401(2), 624.437(2), 626.901 F.S.).

<u>T.R.G. of Greenwood, Indiana Case</u>

Also operated and known under other names: T.R.G. Marketing, LLC; T.R.G. Administration, LLC; The Redwood Group, LLC. The principals involved are Carmelo Zanfei and William Paul Crouse working through a multitude of Florida-licensed insurance agents. T.R.G. nor the individual principals are licensed or authorized to transact insurance or to operate as a MEWA in Florida. They have engaged in the unlicensed, unauthorized, and therefore illegal business of insurance, including as an illegal MEWA in violation of the Florida Insurance Code (624.401(2), 624.437(2), 626.901 F.S.).

<u>American Benefit Plans</u>

Also operated and known under other names: National Association for Working Americans, National Association of Working Americans, American Association of Agriculture, Forestry and Fishing Workers, American Association of Transportation, Communication, Electrical, Gas and Sanitary Workers, American Association of Wholesale Trade Workers, American Association of Manufacturer Workers, American Association of Service Workers, American Association of Professional Workers, United Employers Voluntary Employees Beneficiary Association, United Employers Voluntary Employees Beneficiary Association I, Enhanced Health Management, Inc., The Four Corners Company, LLC, Four Corners Co., LLC, The 4 Corners Company, LLC, Electronic Benefits Group, Inc.

The principals involved are Robert David Neal, Robert Neal Pointer, Jose Michael Mangawang, John Baptist Ramirez a/k/a Johnny Rhondo and a network of Florida-licensed insurance agents, third-party administrators and supposed affinity and business organizations. American Benefit Plans nor any of the other entities are licensed or authorized to transact insurance or to operate as a MEWA in Florida.

Representing or Aiding an Unauthorized Insurer Is Prohibited

626.901 Representing or aiding unauthorized insurer prohibited.—(1) No person shall, from offices or by personnel or facilities located in this state, or in any other state or country, directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, any insurer not then authorized to transact such insurance in this state in:

(a) The solicitation, negotiation, procurement, or effectuation of insurance or annuity contracts, or renewals thereof;

(b) The dissemination of information as to coverage or rates;

(c) The forwarding of applications;

(d) The delivery of policies or contracts;

(e) The inspection of risks;

(f) The fixing of rates;
(g) The investigation or adjustment of claims or losses; or
(h) The collection or forwarding of premiums; or in any other manner represent or assist such an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state. If the property or risk is located in any other state, then, subject to the provisions of subsection (4), insurance may only be written with or placed in an insurer authorized to do such business in such state or in an insurer with which a licensed insurance broker of such state may lawfully place such insurance. (2) If an unauthorized insurer fails to pay in full or in part any claim or loss within the provisions of any insurance contract which is entered into in violation of this section, any person who knew or reasonably should have known that such contract was entered into in violation of this section and who solicited, negotiated, took application for, or effectuated such insurance contract is liable to the insured for the full amount of the claim or loss not paid. (3) No insurance contract entered into in violation of this section shall be deemed to have been rendered invalid thereby.

626.902 Penalty for representing unauthorized insurer.—
(1) In addition to any other penalties provided in the insurance code:
(a) Any insurance agent licensed in this state who in this state represents or aids an unauthorized insurer in violation of s. 626.901 commits a **felony of the third degree**, punishable as provided in s. 775.082 or s. 775.083.
(b) Any person other than an insurance agent licensed in this state who in this state represents or aids an unauthorized insurer in violation of s. 626.901 commits a **felony of the third degree**, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.(2) In addition to the penalties provided for in subsection (1), such violator shall be liable, personally, jointly and severally with any other person or persons liable therefore, for payment of taxes payable on account of such insurance under s. 626.938.

Agents or any other persons are prohibited from representing or aiding an unauthorized insurer. If an agent or any other person represents an unauthorized insurer, they are subject to severe penalties, including possible civil and criminal action. Agents are subject to **suspension or revocation of their licenses** and/or monetary penalties for violation of the unauthorized insurer law. Agents can be held liable for claims and losses not paid by unauthorized insurers. Agents who represent or aid an unauthorized insurer commit a **felony of the third degree**.

Don't let yourself be fooled by phony health plans that sound too good to be true – they probably are not true! Your career and personal financial security are at risk. Investigate before you sell or buy these plans. Check to determine if an entity or plan is an authorized insurer by calling the Department of Financial Services at 800-342-2762 for calls in Florida. Call 850-413-3131 for out-of-state calls.