To Group or Not To Group

What You Need to Know Before Switching to Individual Policies

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There has been a lot of recent interest in selling individual policies to groups on what has been termed a "list-bill" basis. This packaged policy is being marketed as a smart option for employers; however, it is important to be aware of the legal intricacies of the plan and the potential dangers that it generates.

In theory, the idea of a voluntary individual health benefits program sounds like a smart one. In order to help employers address the rising costs of employee health care insurance, agents are exploring these programs, believing that their customers will benefit from the plans. The program allows employers to offer their employees individual health insurance plans through payroll deduction.

The premium is run on a pretax basis in accord with Section 125 of the Internal Revenue Code. An employee who wishes to purchase insurance makes the application, is accepted or rejected by the carrier as an individual, and notifies the employer, which then handles the payroll deduction and the remittance to the carrier.

From the carrier's perspective, it's attractive because underwriting is individual and the carrier can simply decline a high-risk individual or

increase the price of coverage according to risk. For employers, no contribution is required and there are no participation requirements. Employers are happy because they are spending less money, not operating in a controlled system, have control over their own plan design and contributions, and are not "penalized" financially for their co-workers' health ailments. Agents are happy because their clients are happy. However, place this theory into reality and some problems can surface.

First, individual health policies and list-bill programs have been available to employers from many sources, including our firm, for a long time. The plans can be a good solution—as long as the sponsoring company fits some tight parameters:

- The company is a certain, constant size and anticipates no increase in the number of employees.
- All company employees are in good health and approximately the same age: that is, there are unlikely to be variations in the costs and quality of insurance available to anyone employed.
- The company is family-owned and primarily employs family. Here, the ownership assumes that disputes about insurance matters can be handled without subjecting the company to litigation and the involvement of regulators.
- The company employs part-time or seasonal people. The health plan is non-existent or it is a participation-challenged group, or the company wants to initiate a virgin plan on a non-contributory basis.

For any of these, the list-bill option would work and could be viewed as an appropriate solution. But the employer still runs into the potential public relations problem of only a percentage of the employees who desire coverage being approved, as opposed to declined or ridered, and questions about HIPAA and ERISA may then come into play.

For companies that fall outside those parameters, the payroll-deduction program of voluntary, individual insurance can be troublesome and a very difficult way of accomplishing the savings and simplicity sought by the employer.

The carrier intentions/expectations are both noble and practical, but a more serious question is: What will the real applications be in the marketplace? If you are a group broker, you need to be aware that competition may be going in to your present group clients and presenting these new concepts! If the savings are promised, your clients may be listening—especially if the pitfalls are not understood or taken to heart.

The risk is great that an employer's plan will become subject to ERISA regulations.

Michael Paton, a partner in the Indianapolis office of law firm Barnes & Thornburg, advises that a program of individual coverage can work very well when the company has universally healthy employees of like age and when the employer maintains a limited role. However, management and design of a program can expose an employer to the burden of compliance with regulations that include ERISA.

Says Paton, "Normally, health insurance arrangements are ERISA plans; however, there are specific Department of Labor regulations under ERISA that exclude from the definition of an employee welfare benefit plan insurance arrangement where the employer does not contribute to the cost of coverage, the participation of the employee is voluntary, the only function the employer has is to withhold contributions and forward them to the insurance company, and the employer receives no compensation from the insurance company. In that case, the arrangement is not a plan and is not subject to ERISA.

"If there are employer contributions or if the employer provides funds to the employee that could be used, for example, in a cafeteria plan setting to pay for the benefit, then the arrangement would become a plan under ERISA. This, in turn, could require the employer to file an annual 5500, could subject the arrangement to COBRA, and could require compliance with a number of HIPAA requirements."

In his advice to Barnes & Thornburg clients, Paton warns that use of the Internal Revenue Code's Section 125 provision governing pretax payroll deduction for insurance purchases can lead to ERISA regulation: "If you run any type of premium on a pretax basis through a Section 125 plan, Section 125 treats those, for tax purposes, as employer contributions. Therefore, an argument can be made that because they are employer contributions, the employer is paying for the cost of the benefits, which would mean that ERISA applies."

Even if the employer maintains limited involvement, a plan that was attractive for its simplicity can become burdensome. For example, how many employers will remember that the plan is not a "company health insurance plan" but a voluntary program dependent on an employee's own wishes and state of health? Begin telling job candidates that "Yes, we have a company health plan" and an employer will have a company health plan—one subject to ERISA.

How many employers will be comfortable with the resentment that can fester in a workplace if an employee in perfect health pays a certain rate while others can not obtain insurance at all, must pay an increased premium for any insurance made available to them, or have conditions for which they badly need coverage excluded (ridered)?

And suppose a new hire expecting access to insurance learns that none is available, or is not affordable? Won't that diminish the enthusiasm of the new employee, and perhaps cause trouble for an employer that can't deliver on a promise, real or implied?

Maybe the underlying problem is that companies are collections of people who come together because the group is able to accomplish something individuals can not. When people are hired and managed with that expectation, they may not be ready for the "you're on your own" quality of an individual list-bill program, no matter how enthused the employer is about the same program.

As agents well know, insurance varies. The difference between individual insurance and a group plan can be very significant. A great many individual contracts treat preexisting conditions more stringently than group plans do. In addition, the individual coverage may not provide for benefits such as maternity and infertility, or there may be waiting periods or caps that group policies do not require.

To give good advice, agents need to consider the circumstances of their clients. Being educated on the advantages and potential dangers involved with voluntary individual health benefits programs will make the agent a good advisor to employers seeking answers that work. Knowing the facts and considering the consequences are valuable tools that will help agents provide the best possible program, specific to the client's needs and situations. And that makes for a group of satisfied customers. ■

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