MARTIN INSURANCE GROUP, LLP

CLIENT NEWS & ADVISORY

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"Really?!" – Top 5 Most Common Questions Answered

Hello Everyone,

Summer is winding down and the school year is about to start again. For some working parents, this could be a bittersweet relief for getting the kids back out of the house again. For others, it is the living nightmare of your morning and afternoon commute being extended by school traffic once again!

In this issue of our client news and advisory letter, we have compiled the top 5 most common questions that our answers receive a "really?!" reaction from business owners and individuals.

#1: "Is it true that Medicare is free once I reach age 65?"

This is probably the biggest misconception about the US Healthcare system. The facts are that "Part A" is pre-paid via tax deductions during your working years and covers in-patient hospitalizations. However, "Part B", which covers outpatient services such as doctor's visits, has a monthly cost of $175 and this cost increases based on your household income (*can increase anywhere between $75-$420 a month*). Additionally, the fee can also increase year to year based on inflation. So no, since there is a premium paid, the coverage is not "free". Medicare also has "cost sharing" once you are enrolled.

- For example, you have an annual hospital deductible of $1,600 that covers day 1-60 of in patient stays, then you have per day copays for serious health conditions that require longer stays day 61-90 is a $400 copay per day, and 91+ require a $800 copay a day. For office visits and outpatient services, Medicare generally pays 80% of the bill while you pay 20%.

Most individuals circumvent the large portions of the cost sharing that Medicare requires by purchasing private "Supplements" backed by private insurance companies.

#2: "Should my company implement a 401K?"

Although this is a hard question to blanketly answer, we generally say not to implement a 401K until your company is financially able to contribute to all participants' accounts. The most common contribution is a "Safe Harbor Match" which is generally where the employer matches "3% of the first 100% and 2% of the next 50%."

- EX: Employee elects to contribute 4% of his 50K annual salary into the 401K every year. This comes out to $2,000. The Employer must match 3.5%, or $1,750. If you have 50 employees that fall into this category, then the company costs will amount to approximately $87,500 annually.

"Why do I as an employer need to contribute?" – because the IRS has a very strict "non-discrimination test" that must be performed on an annual basis. This test measures the amount of funds in a 401K from "highly compensated" employees versus "non-highly compensated" employees, and historically speaking the lower income earners only participate in a 401K if there is some sort of employer matching involved. Thus, without a company contribution, it is very unlikely the company will pass the non-discrimination test and the plan will fail.

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#3: "In your professional opinion, what would happen if the Government implemented Universal Healthcare?"

Another huge misconception is that Universal Healthcare would mean no more bills for Medical insurance or Medical related expenses for every US citizen. That is just not the case. Universal Healthcare is just a catchy term to describe "Medicare for all." So, what we would get is a mass expansion of the existing Medicare Part A and B system, but instead of requiring participants to be age 65+ or disabled to qualify, everyone would qualify.

- You would see taxes increase in lieu of premiums (*savings for some and a wash for others*).
- Private insurance companies would pivot and expand their Medicare supplement coverages to cover the high cost sharing of Medicare. In some cases, this would be more profitable for the insurance carriers, (*i.e. Humana Insurance Company's recent departure of the group medical industry in favor of the Medicare space.)*
- You would also see Employers go from sponsoring "Medical" plans to sponsoring "Medicare Supplement" plans in their employee benefits packages.
- You will see a natural rise in cost by hospital systems and pharmaceutical companies as the market would go from dozens and dozens of private insurers negotiating reimbursements to one single entity (*Medicare*).
- You will see a boom in the "concierge doctor" model by private physicians (*patients pay monthly 'membership' fee in lieu of per visit copays*), as most private practices currently do not accept pure Medicare reimbursement.

#4: "My Doctor says they accept my insurance, but I always get balance billed?"

We always tell clients if calling a provider's office directly ask, "*are you a contracted in-network provider*" versus "*do you accept X insurance?*" The reason being is that PPO policies will reimburse for both "*In*" and "*Out*" of network providers, so an out of network provider will say "*yes, we accept all PPO insurance*" as they know they can submit a claim. However, only an "*in-network*" provider is bound by a contract to accept a set reimbursement rate and not "*balance bill*." Whereas an out of network provider can accept the reimbursement from the insurance carrier and ask for additional monies from the patient directly.

#5: "It is always the same employees who enroll and waive in the group health plan. Do we really need to do a yearly company wide open enrollment?"

YES! This is often the area that we see prospective clients struggle with when first evaluating their company. Your company needs to document that every eligible employee receives the equal opportunity to add, drop or change coverage in the company's employee benefits offering every year. This will keep the company in compliance with the IRS and DOL and avoid individual discrimination lawsuits.

Thank you for reading, let us know what questions that you might have about the insurance industry!

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