



**Reviewing Your Practice's Healthcare Benefit Plans for 2012/2013©**  
(Getting Behind the Numbers to Manage the Costs and Keep Employees Healthy)

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As you examine your 2012/2013 healthcare options for your staff, not only do you have to focus on managing the rising costs, while staying competitive with a fair health benefit offering and motivating employees to be better health care consumers but also keeping in mind what other changes and reforms from the Patient Protection and Affordable Care Act ("PPACA"), signed into law by President Barack Obama on March 23, 2010 need to be analyzed as options and developed into strategies for implementation and compliance. As the economy is still sputtering, you as a practice owner or manager have to balance business and employee needs while keeping PPACA in focus (especially with state-run health insurance exchanges scheduled to open in 2014).

Why offer a health care benefit? As part of your overall compensation package to attract and retain employees, keeping your staff healthy to be productive and potential financial advantages of offering the plans on a tax-free basis. Plus, PPACA provisions may provide your practice with some tax credits if the practice meets the eligibility requirements.

As you prepare for your meeting with your insurance broker, have some numbers in mind. What have been the practice's health care costs in the prior years – some trending is very eye opening (not only total costs but the annual increases) and what have you budgeted to spend towards these costs for 2012/2013? It is suggested that health benefits costs will rise an average of 5.4% in 2012 (Mercer survey) if employers are managing the overall costs. Without changes to health care plans, estimated costs would be increased by 7.1%. On average over the past five years, health care costs have risen 9% annually. Cost of medical coverage in 2010 for an active single was \$5,184 (Tower Watson Survey). Being smaller employers, practices have a harder time achieving these smaller annual increases – less clout with the insurance carriers to negotiate rates in preparation for when open enrollment begins.

What tactics will you discuss with your insurance broker on managing these costs to keep or implement a viable health care benefit instead of dropping coverage outright?

- If you are currently subsidizing individual employee coverage at 100%, can you afford to continue? On average, practices split the cost 50/50 with employees for individual coverage. DVMs may have a contractual agreement but that can also be negotiated with a dollar amount instead of 100% subsidized for individual coverage.
- Should your practice be turning to cost-shifting and increasing employee contributions to health care premiums? If your employees contribute to the costs of the premiums, consider IRS section 125 plans for health insurance to offset insurance premiums

increase— the eligible employee’s taxable income is reduced which increases take-home pay and as the eligible employer, the practice gets a reduction in payroll tax liability.

- What about consumer-directed health plans (‘CDHP’)? These are high-deductible plans with tax-advantaged spending accounts like Health Savings Accounts (HSA) attached to it. These are less expensive than traditional health care plans (approximately 15% according to Mercer). Many of these CDHP plans give employees an incentive to take cost into consideration when seeking health care services. The practice is providing more value to employees while managing costs.
- Are limited provider network plans an option for your practice? These health insurance plans restrict members to certain providers and require them to pay higher rates for out-of-network care in an effort to stem the rising cost of health insurance by directing patients to lower-cost hospitals.
- What elements of the plan design should you tweak to minimize the premium increases? Raising deductibles, co-pays and out-of-pocket maximums would be some but this places the burden now on the employee – so consider carefully (balancing practice’s and employee’s needs).
- How do employee-paid, group rate voluntary insurance policies (such as accident, short-term disability, life, vision) help your practice’s ability to control costs? The addition of voluntary plans to augment your existing benefit offerings enables you to offer more robust benefits while staying within cost constraints.
- What about wellness programs? More intensive employee education and engagement to encourage employees to be healthier helps your practice to control health care costs. The practice may even be able to get aid to offset any costs associated with these wellness programs or would your pharmaceutical vendor be willing to sponsor a wellness fair for your employees?
- Should you offer incentives as wellness initiatives to motivate sustained health care behavioral change by your employees? Will it be advantageous to reward or penalize employees based on biometric outcomes – for example, having your employee accountable for weight or cholesterol? The incentives are given to those employees who are doing the most to maintain or improve their health.

Thinking ahead on PPACA’s mandates:

- Practices with more than 50 employees may pay a \$2,000 fee for each full time employee without health coverage in 2014.
- Practices with fewer than 25 full-time employees may be eligible for a tax credit if average annual wages paid are below \$50,000 and the practice contributes at least 50% of total premium costs for individual coverage.
- For practices with fewer than 100 full-time employees; grants may be available for workplace wellness programs for employers with fewer than 100 employees working 25 or more hours per week.
- Reporting the cost of employer-provided health care coverage on their employees' Form W-2 for small employers (those filing fewer than 250 W-2 forms): this requirement remains optional for tax year 2012 and later, until further guidance is issued.
- In November 2011, federal agencies announced that compliance with the Summary of Benefits and Coverage (‘SBC’) requirement, originally set for March 23, 2012 under the

proposed rule, will not be required until the agencies publish a final rule with a new applicability date providing sufficient time for group health plans to comply.

- Health flexible spending arrangement contributions are capped at \$2,500 in 2013.
- States must create Small Business Health Options Programs, or “SHOP exchanges,” that will “assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market of the state.” What will this mean for your practice?

Preparation is key – be an educated consumer when it comes to health care benefits and implementing a strategic health care plan for your practice while focusing on PPACA requirements.