The BottomsLine | SPRING 2019

A MANAGEABLE ASSET

BY GARY BOTTOMS, CLU, CHFC
CHIEF EXECUTIVE OFFICER
gbottoms@thebottomsgroup.com

One of our physician clients recently asked us to take a look at an insurance policy insuring the life of his father. After 20 years of level premiums, the premium had recently increased and there was confusion about the future viability of the coverage and the ongoing premium commitment. As it turns out, the policy was not a 20 year term policy, but it was a universal life policy with a 20 year guaranteed premium and death benefit. Even 20 years ago, life insurance was available in many different designs and these variations can be confusing. *(Continued on page 4)*

CALIBRATING EMPLOYEE PREMIUMS TO ENSURE AFFORDABLE CARE ACT COMPLIANCE

BY DAVID BOTTOMS

When the compliance aspects of the Affordable Care Act (ACA) became enforceable in 2014, most large employers subject to the ACA's Employer Shared Responsibility provisions were keen to ensure that the benefit plans they offered to employees met the ACA's requirements regarding both coverage "minimum value" and premium "affordability."

While maintaining "minimum value" compliance has been relatively easy, since insurance carriers tend to only offer qualifying plans, managing the "affordability" side of the process has proven more difficult, especially as health plan premiums have continued to increase and focus on compliance has somewhat diminished.

Nonetheless, given that employer mandate penalties of up to $3,750 per employee per year are still in effect, it is best that employers be proactive in calibrating their health plan premium rates each year to ensure compliance. *(Continued on page 3)*

ABOUT TBG

The Bottoms Group, LLC, has for decades been listening to clients and developing employee benefits, insurance and estate planning solutions customized to their unique and changing needs. For more information about TBG, visit **www.thebottomsgroup.com**.

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BY **KELLY THOMPSON,**
SENIOR ACCOUNT EXECUTIVE, BENEFITS
kthompson@thebottomsgroup.com

BUNDLING ANCILLARY COVERAGE WITH MEDICAL

As the cost of employee benefits continues to rise, carriers are offering some additional discounts to the medical coverage that we can uncover for our clients. In addition to a discount on medical coverage, carriers can typically offer discounts on the dental, vision, life, and disability lines as well, assuming they would be a package discount. There are many benefits to bundling ancillary lines of coverage with medical. The most common advantage would be the potential for discounts on the medical rates, usually ranging from 1% to 4% based upon the types of coverage and number of lines that are bundled. Every case is different depending on the size of the group, the type of underwriting, the specific insurance carrier's offering, and these options do change throughout the year based on the effective date. The medical discount typically offers the most savings even if another line of coverage is not as competitive. Many times the rates on the dental, vision, life or disability are competitive and adding a medical discount of 1% to 4% allows for even more savings. Sometimes carriers will offer two year guarantees on certain lines that are bundled with the medical, or even a medical rate cap for the second year.

Another incentive employers would receive for bundling different lines of coverage in addition to the discount on the medical plan, is that carriers usually offer to include the bundled lines of coverage on the same invoice and administration platform. This allows clients to streamline their process and minimize the number of steps needed to administer their plans. Many clients also prefer having a single carrier to administer their billing and enrollment needs in one point of access. Bundling these coverages can sometimes allow the medical claims process to integrate with the carrier's system and generate any necessary communication to the members. For example, if there is a specific claim that may be related to a disability or injury, the claims department may reach out to the employee regarding the next steps.

Integrating benefits with a single carrier can also allow ease of access to care for the participants. In most cases, bundling the dental or vision allows the members to use just one ID card instead of having to keep up with multiple ID cards from various carriers. Many carriers also offer a smart phone app which would allow easier access to all lines of coverage in a single place rather than accessing various carrier websites. It is most important to remember that each carrier may offer various discounts or incentives that can change based upon the effective date or other factors. Staying on top of each carrier's current special offers allows us to provide the most competitive options for our clients each year. Above all, each case will be different based on each client's unique situation.

CALIBRATING EMPLOYEE PREMIUMS TO ENSURE AFFORDABLE CARE ACT COMPLIANCE

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To that end, and given the complexity of the ACA's regulatory wording tying affordability to the employee's household income which employers typically do not know, most employers have elected to rely on "safe harbor" provisions to ensure their plans are deemed "affordable."

The safe harbor affordability calculations are driven by a requirement that employees be provided with a minimum value health plan option (i.e., a base plan) that costs them no more than a specific percentage of their income and, since the affordability percentages change each year, it is very important for employers to annually review their calculations as what was affordable one year may not be affordable the next.

For 2019, the most commonly used W-2 safe harbor calculation is satisfied if the employee's premium for employee-only coverage under the employer's minimum value plan is no more than 9.86% of the employee's W2 income as reported in Box 1.

So, as a basic example, if a full-time active employee earns $10,000 in 2019, that employee would have been deemed to have had access to affordable coverage if their cost to enroll in employee-only coverage on the employer's base medical plan option cost them no more than $82.17 per month ($986 over the course of the year).

Of course, for most full-time employees annual income is a good bit higher than the amount in the example, but nonetheless, the moral of the story is that, as employee income goes up, the employer can pass more health plan premium costs to the employee and still maintain ACA compliance.

A common question from employers relates to whether they can pay more toward the health plan premiums for their lower paid employees in order to ensure that all employees have access to affordable coverage? The short answer is "yes." If an employer decides to pay a higher percentage of health care costs for lower paid employees, that is okay as long as they do not distribute the premium reductions in a manner that is deemed to be discriminatory to a protected class of employees, i.e., on the basis of gender, ethnicity, etc.

Regardless of whether premium amounts are the same for all employees or not, it is important for employers to carefully document both their offer of coverage and the employee's acceptance (or declination) of it as documentation must be provided to reverse any proposed penalties in the event that the IRS contends the affordability requirements were not met for a specific employee.

It is also important for employers to remember that it is their responsibility to offer minimum value, affordable coverage to employees. It is not the employer's responsibility to ensure that employees enroll in coverage. As such, if an approved coverage offer is made to employees and they decline to enroll, the employer is off the proverbial hook as long as they have a documentation trail to validate the offer of coverage.

In closing, ACA compliance is no simpler now than it was 5 years ago. As such, employers should be diligent to ensure that the coverage they offer meets the requirements of the law because it is most certainly true that an ounce of ACA penalty prevention is worth a pound of IRS cure.

> *Given that employer mandate penalties of up to $3,750 per employee per year are still in effect, it is best that employers be proactive in calibrating their health plan premium rates each year to ensure compliance.*

BY **DAVID BOTTOMS, REBC, RHU, CLU, CHFC,**
PRESIDENT
dbottoms@thebottomsgroup.com

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BY **GARY BOTTOMS, CLU, CHFC,** CHIEF EXECUTIVE OFFICER
gbottoms@thebottomsgroup.com

Therefore, after 20 years the premiums have increased and will continue to escalate each year so it's important to understand what the future schedule of premiums might look like. Reliance on term life insurance, or an underfunded universal life policy, may prove unduly costly with respect to the intended return and may be unaffordable, non-renewable or non-convertible to a different type of coverage designed to be permanent. With a signed authorization from our physician client who is now the owner and premium payer for the policy on his father's life, we were able to ascertain the facts related to the future and make some recommendations.

Some version of the above scenario happens a lot in our practice. We believe life insurance is a financial asset that should be managed just as any other financial asset would be. This means whatever coverage placed into effect needs to be suitable to the needs that are present, and then be managed and reviewed periodically after it is implemented.

Suitability, by definition, requires a process to determine if a life insurance product is appropriate for a given client, based upon the client's goals and financial situation. In short, this means that our goal is to help the client accomplish whatever it is he or she wants to accomplish. It's all about the client. The role of life insurance as a financial asset is to create capital when it's needed on a tax efficient basis. This can mean the creation of cash during the lifetime or upon the insured's death. Life insurance is somewhat unique among financial assets because permission is needed, under most circumstances, prior to being approved to purchase. A change in health can make one uninsurable for any new coverage.

Financial stability of the insurance carrier is also a major consideration. We have access to the rating services and use the data regularly. On the softer side of the carrier selection equation is their reputation for administrative efficiency. About 20 years ago there were 2,400 insurance carriers. Today there are around 800. Much consolidation has taken place and there has been consolidation of information technology systems on which the policy administration depends. Some of the transitions have gone smoothly and some have not. We work with a lot of different insurance carriers and factor the future service into the carrier selection process.

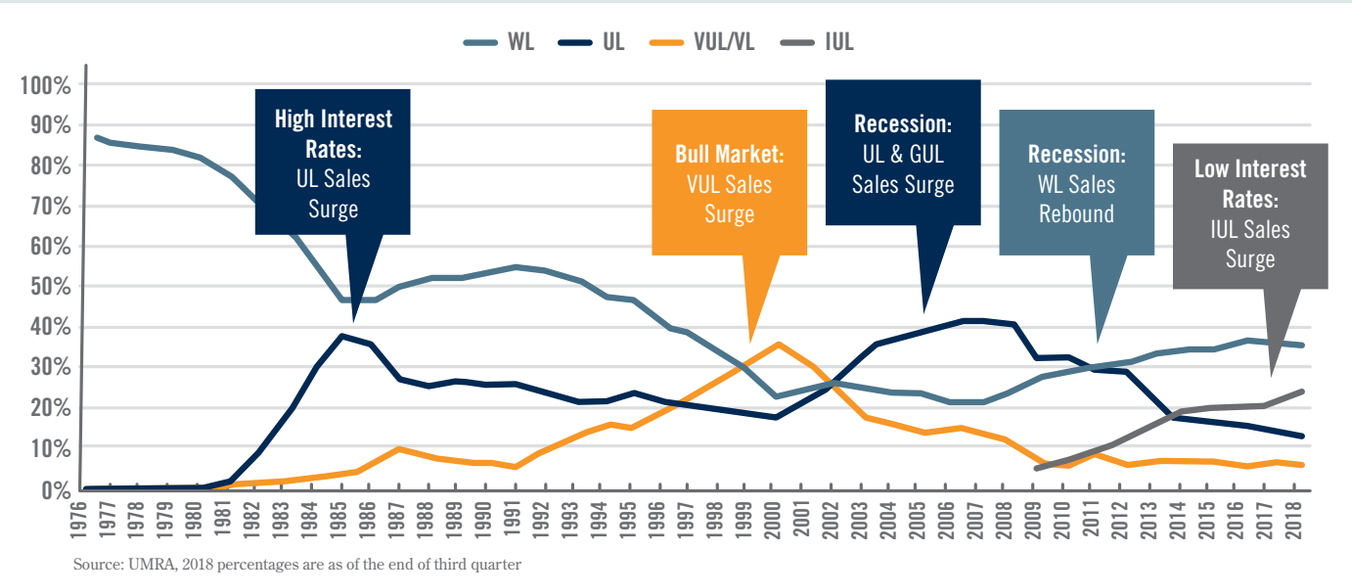
Cost efficiency is naturally a major factor. The financial stability ratings referenced earlier do not indicate the relative cost of the product. The insurance industry traditionally provides illustrations of the policy which include future projections based upon guarantees as well as projections based upon assumed mortality, expenses, and rates of return. We are in a prolonged period of relatively low interest rates which means that it is likely that additional premium outlay is required in order to compensate for the lower than expected returns. Otherwise, the future outlook may vary dramatically when compared to the earlier projections.

We believe life insurance should be a member of the conservative asset class and therefore recommend strong guarantees by the insurance carrier which will help us avoid surprises down the road. One advantage of being in the business for a while is the perspective derived from passing through several cycles. For example, in the 1980s, when interest rates were near all-time highs, prevailing industry practices were focused upon the sale of the new universal life and other interest sensitive type products. As the accompanying chart indicates, we then progressed through the period of strong stock market returns and then as

VALUED CLIENT
INTERNAL RATE OF RETURN (IRR)

END OF CALENDAR YEAR	DEATH BENEFIT	ANNUALIZED PREMIUM	IRR
1	$2,000,000	$20,385	9711.14%
2	$2,000,000	$27,180	825.09%
3	$2,000,000	$27,180	312.08%
4	$2,000,000	$27,180	174.54%
5	$2,000,000	$27,180	115.75%
6	$2,000,000	$27,180	84.24%
7	$2,000,000	$27,180	64.97%
8	$2,000,000	$27,180	52.11%
9	$2,000,000	$27,180	43.00%
10	$2,000,000	$13,590	36.41%
11	$2,000,000	$13,590	31.39%
12	$2,000,000	$13,590	27.45%
13	$1,000,000	$18,000	15.53%
14	$1,000,000	$18,000	13.66%
15	$1,000,000	$18,000	12.10%

INDIVIDUAL LIFE INSURANCE INDUSTRY MARKET SHARE BY PRODUCT TYPE (ANNUALIZED PREMIUM)



Source: UMRA, 2018 percentages are as of the end of third quarter

interest rates dropped we moved toward products with stronger guarantees. Today's offering provides the opportunity to combine the appropriate desired factors so that the product can be suitable to meet a particular client's stated goals.

We believe that in addition to being suitable, the plan needs to be managed and reviewed regularly. Life insurance products and the mechanisms for owning them, such as trusts, are becoming increasingly popular and in some cases, quite sophisticated.

Two primary factors related to the policy management process are the review of the needs the coverage is designed to meet, and the performance of the product when compared to the original projections. Unless the original illustration was based upon totally guaranteed results, which is rare, the illustration is guaranteed to be off the original course, either positive or negative. It's important that we monitor this to make sure we make changes along the way so that our objectives are accomplished.

The chart to the left shows the results of an actual client case. The client passed away recently. When the policy was initiated about 15 years ago, the plan was to have $2 million of coverage for 10 years, then reduce the amount to $1 million from that point forward and maintain the premium constantly at $27,180. Based upon this configuration, the prescribed death benefit would remain in effect for life.

However, at the 10th year, he decided to delay the reduction in the coverage amount and reduce the premium by 50%. We produced financial projections based upon this scenario and he realized that the higher death benefit and the lower premium could not work long-term. We reviewed his plan annually. All of the coverage was projected to end soon if we left the coverage at $2 million and reduced the premium. Therefore in the 13th year he reduced face amount to $1 million and increased the premium to $18,000 per year.

He died suddenly in year 15. Based upon the premium paid and the death proceeds delivered, the internal rate of return on the life insurance asset was 12.1% income and estate tax free. A comparable taxable investment would have needed to create an annual return of over 14% in order to match what the life insurance policy delivered. Without proper management and adjustments along the way, the coverage would have ended prior to his death.

BY **LAURA BOTTOMS HIGGINBOTHAM,**
VICE PRESIDENT, INSURANCE SERVICES
lbottoms@thebottomsgroup.com

FIVE COMMON BENEFICIARY MISTAKES

Life insurance is a selfless investment. When someone makes a step in obtaining a life insurance policy, they are not doing it for their own personal gain but to protect their loved ones once they pass away. Therefore, it is very important that the beneficiaries are properly designated in order to fulfill the intent of the insured. Designating a beneficiary should not be an overly complicated process and can be quite simple if your wishes are clearly and thoughtfully communicated. The owner of the life insurance policy can change the beneficiary as often as he or she would like and is recommended after life-changing events. Beneficiaries can be one or multiple people, a trust, business, or even a charity. However, if a beneficiary is not named or is written incorrectly, your loved ones could find themselves at the mercy of the court to decide who receives the proceeds.

AVOIDABLE MISTAKES:

1. NOT UPDATING

Lives are busy and ever evolving with births, marriages, deaths, and divorce. Whenever your relationships change, for better or for worse, do not forget to change your beneficiaries. Did you get divorced and your ex-spouse was your beneficiary? Change it (unless life insurance is required by divorce decree). Did you get married or re-married? Change it. The insurance company will only pay the proceeds to who is listed as beneficiary, even if it is an ex-spouse and the insured's new spouse wasn't designated.

2. NOT NAMING A CONTINGENT

While the primary beneficiary will most likely be the recipient of the funds, as with anything, a back-up plan is always necessary. It can happen, however, that a primary beneficiary predeceases the insured and the contingent beneficiary is needed. If only a primary beneficiary is listed and they are no longer living, the court will decide who receives the proceeds. Even if you believe you are diligent in making updates, it is possible that an insured passes away at the same time as their primary beneficiary in a tragic accident.

3. NAMING A MINOR CHILD

Life insurance companies will not pay proceeds to a minor child. Therefore, it is important to avoid a lengthy court process by creating a trust for the benefit of the child or if a minor child must be named, indicating who the adult trustee is to handle the proceeds until the minor turns 18 or 21, depending on the state. It is not enough to indicate how the money will be handled in your will because insurance companies follow what is on their forms rather than the will. So if you have a trust within the will or financial guardians named in the will, those need to be indicated on the beneficiary designation form to ensure a smooth claim process for your minor child.

4. NOT COMMUNICATING

No one likes talking about death. We get it. But while you are going through the life insurance planning process and thoughtfully naming beneficiaries, it is in the best interest of your loved ones to at least tell them you have named them as a beneficiary and where they can find policy information. It is often the case that a loved one happens upon a long lost life insurance policy while sorting through the deceased's belongings. The first step is communicating where to find policy details and the insurance company. As your insurance relationship, we welcome the opportunity to meet your loved ones before we are needed at claim time. We are involved in the claim process from the start until we hand deliver the check. Having a pre-established relationship makes an already difficult time a little easier on your loved one.

5. ASSUMING A WILL TRUMPS BENEFICIARY DESIGNATION

Stating your wishes in your will is not enough to ensure your life insurance proceeds get to the right person. If you have a particular designation on file with the life insurer and another indicated in your will, the will's wishes do not trump what is on file with the insurer.

BY **BETTY MCGINNIS,**
SENIOR CLIENT ADVOCATE
bmcginnis@thebottomsgroup.com

HRA, FSA, OR HSA: WHAT DO YOU HAVE?

Do you offer your employees a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) and/or Health Savings Account (HSA)? Accounts such as these are beneficial and can make a difference to employees when they are able to elect and enroll in benefits. Depending on whether or not your company offers these significant accounts, or will possibly have them available in the future, it is important for employees to be aware of how each are uniquely designed.

An HRA is a notable option in allowing employees and/or family members to receive a reimbursement after accumulating or satisfying their medical deductible. A group may use a Third Party Administrator (TPA) to set up specific guidelines and requirements for an HRA. The reimbursement process typically requires a participant to submit an HRA claim form along with proof of the eligible expenses such as an Explanation of Benefits (EOB) provided by the insurance carrier.

FSA accounts are also advantageous to employees who decide to elect this type of funding account. A FSA participant may accumulate funds that are deducted out of his or her paycheck to use on eligible expenses. Typically, a participant may receive a FSA card they may use for the account, however, a group may decide not to have cards issued based on how the program is implemented. Claims may also be submitted for reimbursement with a FSA. Funds are only available for a certain amount of time and will eventually expire, unlike an HSA.

An HSA is a separate benefit opportunity. This type of account allows employees of a group to collect funds that are withdrawn as a payroll deduction, which is similar to a FSA account. One major difference is that the funds do not expire, and an employee must be enrolled in a High Deductible Health Plan (HDHP) for medical insurance coverage rather than a Traditional co-payment plan. A participant may not elect or utilize funds within a FSA and HSA simultaneously.

Double dipping is also not permitted. The International Revenue Service (IRS) has established detailed guidelines involving HSA and HRA submissions. Admin America, a Third Party Administrator, provided the two examples shown below.

If ever in doubt about questions from you or your employees, please reach out to The Bottoms Group HelpDesk for assistance. We are wlling and available to provide guidance to you and your team.

EXAMPLE 1:

"Employee A is on a family medical insurance plan. S/he has incurred $6,000.00 in deductible expenses. This amount has NOT been paid to the medical provider. Employee A is responsible for the first $5,500.00 of their deductible expenses prior to HRA reimbursement. Employee A can use his or her HSA funds to pay for the first $5,500.00 in deductible expenses. Employee A can submit all Explanation of Benefits from the medical insurance company to Admin America showing that $6,000.00 was incurred. Employee A is then reimbursed the last $500.00 of the deductible."

EXAMPLE 2:

"Employee B is on a family medical insurance plan. S/he has incurred $6,000.00 in deductible expenses. This amount has been paid to the medical provider. Employee B is responsible for the first $5,500.00 of their deductible expenses prior to HRA reimbursement. Employee B used his or her HSA funds to pay for the full $6,000.00 in deductible expenses, which is $500.00 greater than the required $5,500.00 responsibility. Employee A can submit all Explanation of Benefits from the medical insurance company to Admin America showing that $6,000.00 was incurred, however, s/he cannot be reimbursed the last $500.00 of the deductible because it was already paid with the HSA funds."

the bottoms group
SINCE 1947 BENEFITS · INSURANCE · COMMUNICATION
180 CHEROKEE STREET NE, SUITE 200
MARIETTA, GA 30060-1610
770-425-9989

BY **JAMIE MOODY,**
SENIOR ACCOUNT EXECUTIVE, BENEFITS
jmoody@thebottomsgroup.com

EMPLOYER ONSITE HEALTH SCREENING BENEFITS

As healthcare costs steadily increase, employers are finding new and improved ways to combat those costs by incorporating wellness initiatives into the workplace. Adding in additional resources, such as wellness programs coupled with onsite health screenings, have been a common trend in supporting organizational needs in addition to maintaining a competitive benefits package. By implementing onsite health screenings employers are able to show a level of commitment and concern for their employee's health while increasing awareness around wellness matters.

A healthier and more knowledgeable workforce benefits employers in many ways, and it's been discovered that offering onsite health screenings is not only a common and effective health strategy for employers to promote wellness internally, but it also proactively impacts employer spending. The added mindfulness helps employees reduce their health risks and improve their health status. It gives flexibility to those who would rather see their doctor at a time that's convenient for them, and it improves access if there are worksites where onsite events are not being offered. Bringing the tests and screenings directly to employees at work provides convenience to them and encourages them that employers are concerned with their preventive care in hopes they will seek additional medical attention for existing conditions. Being onsite also saves valuable time so employees do not have to leave the workplace for annual routine testing.

It is common for insurance carriers to include wellness packages within group policies to help offset the employer's financial responsibility spend while engaging and supporting workforce participation. Wellness programs and incentives are designed to reward employees for making healthy choices and implementing onsite health screenings provides the added advantage of increasing engagement within the corporate wellness program, providing health education resources, and giving employees access to the use of in-network providers to help save on costs.

During onsite health screenings employees can expect to receive educational materials showing the benefits related to the different types of screenings so that they are more engaged in their health, which in turn reduces health care costs and improves productivity in the workplace. There are a variety of screening options available onsite, but the most common options range from flu shots, health risk assessments, cancer screenings, mobile mammography units and biometric screenings. The biometric screening is a set of quick checks including cholesterol, blood glucose, body mass index, blood pressure, waist circumference and height and weight. These screenings and tests are all led by professional, certified, and licensed staff members that provide accurate results to help employees better understand their health.

Wellness is a critical part of staying healthy and empowering employees with health information and tools can lead to reduced healthcare costs, increased morale, less absenteeism and improved employee retention.