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Self-Insured Group Medical Plans and Their Effect on the Corporate Tax Return

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The escalating cost of providing group medical benefits has forced many employers to dedicate more time and energy toward gaining control over increasing premiums.

During the past several years companies have seen their premiums increase anywhere from 10 to 30 percent on annual basis. Many employers that have been content to purchase coverage from traditional carriers have begun to consider moving to a self-insured plan.

Self-insured group medical plans can allow companies to better manage their health care costs and improve cash flow while still providing health coverage for their employees. In a self-funded plan, the employer takes on the financial risk of funding their health plan and becomes responsible for managing and administering the benefit plan. Many CPAs are increasingly asked to weigh in on matters relating to financial services and insurance for their clients, including self-funded plans and the corresponding tax considerations.

Rules for establishing and running a self-funded group medical plan are governed by the Employer Retirement Income Security Act. ERISA allows employers a greater level of flexibility to tailor a plan according to their needs by avoiding many state-mandated requirements with which commercial insurers are forced to comply. Additionally, the employer is not subject to state health insurance premium taxes, which typically comprise 2 to 3 percent of the total premium charge.

While employers take on the financial risk, they are able to limit their risk through the purchase of stop-loss insurance policies. The stop-loss policy is one of the most crucial elements of a self-insured plan. There are two forms of stop-loss coverage: individual (or specific) stop loss and aggregate stop loss.

Individual (specific): This coverage protects against large, catastrophic claims incurred by a single individual. Individual stop loss reimburses the employer when claims for an individual exceed a specific deductible. Deductibles typically range from as low as \$40,000 to as high as \$500,000, depending on several factors, including group size and risk tolerance.

Under the Patient Protection and Affordable Care Act, after September of 2010 employers will be prohibited from capping the lifetime limits for "essential health benefits." Therefore, it will be important for employers to insure with carriers that also provide unlimited lifetime benefits to the extent they want their stop-loss coverage to mirror their obligations under the new law.

Aggregate: This coverage protects against higher than anticipated claim activity for the plan as a whole. Once the total paid claims exceed the threshold for the plan, the carrier reimburses the employer for the overage.

The aggregate stop-loss threshold fluctuates throughout the year based on enrollment and is established based on something known as the "aggregate attachment factor." The attachment factor is determined as follows:

The stop-loss carrier determines the average expected monthly claims per employee per month based on the employer's loss history. For example, with \$250 per employee per month, that figure is then multiplied by a percentage ranging from 110 to 150 percent (typically 125%). For example, $\$250 \times 125\% = \312.50 , which is then established as the aggregate attachment factor.

The factor is then multiplied by the enrollment on a monthly basis to establish the aggregate deductible (attachment point). For example, if we assume that between individuals, individuals +1 and families the employer has 500 employees enrolled in his plan the initial month, then $\$312.50 \times 500 = \$156,250$. Thus, \$156,250 is the aggregate deductible for the month.

If we assume the enrollment stays the same for the year we can project the annual aggregate by multiplying the monthly product by 12: $\$156,250 \times 12 = \$1,875,000$.

Assuming enrollment stays level, the maximum out-of-pocket claims for this employer would be \$1,875,000. However, the actual aggregate deductible would fluctuate monthly based on enrollment.

Aggregate policies are typically issued with \$1,000,000 annual limits, or less frequently \$2,000,000-plus or unlimited.

While it is possible to self-administer a self-funded group health plan, nearly every employer contracts with a third-party administrator to manage and pay claims. TPAs also coordinate access with preferred provider networks, prescription benefit managers and wellness programs.

Tax Considerations

Most employers establish a self-insurance reserve or sinking fund to pay claims on an ongoing basis. A typical strategy is for the employer to fund on a monthly basis an amount equal to what the premium would be in the traditional market. The primary benefit of this approach is to smooth out cash flow. By funding the same amount every month, the employer avoids the unpredictable swings of having several months with low claims and then being hit with several months where claims run higher than expected.

With traditional, fully insured health plans, the employer is able to take a deduction for premiums paid to the carrier. Health insurance premiums are treated as an ordinary and necessary business expense and are reported on line 24 of Form 1120.

In a self-insured plan, an employer is only afforded a deduction for stop-loss premiums, administrative expenses and actual claims paid during the year. Amounts paid into the reserve fund are not deductible. This can create a challenge for firms attempting to accumulate sufficient reserves, as they will have to pay federal and state tax on any money not paid out in claims.

Captive Alternative

One strategy that can be implemented is to establish a captive insurance company. In a properly structured captive arrangement, premiums paid to the captive would be tax deductible and the captive would be able to establish loss reserves to defer taxation on a majority of the plan savings.

When evaluating the feasibility of a captive, advisors and their clients should look closely to make sure the costs associated with running the captive do not offset the resulting tax benefits. Special care should also be taken to ensure that the captive complies with IRS guidelines to qualify as an insurance company for tax purposes. Depending on the client's corporate structure and the design of the medical plan, advisors will want to review Rev. Rul 92-93, Rev. Rul 2002-89, Rev. Rul 2002-90 and Rev. Rul 2005-40.

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