focus

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It's time to go SHOPping

How to navigate Small Business Health Options Program Marketplaces

Small companies have another option for providing workers with health insurance: the Small Business Health Options Program (SHOP) Marketplace. Marketplaces, which are run by individual states or the federal government, were created through the Affordable Care Act (ACA).

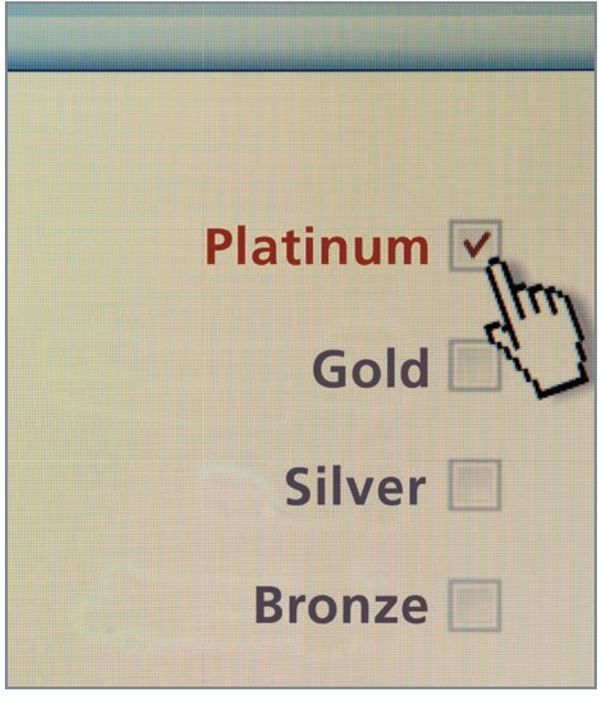
For 2014, most businesses with fewer than 50 full-time employees or the equivalent (as defined by the ACA's play-or-pay provision) can take advantage of the SHOP Marketplaces with limited application until 2015. By Jan. 1, 2016, the Marketplaces will be available to most employers with fewer than 100 full-time employees or the equivalent.

Research required

While the Marketplaces will offer eligible employers another choice, employers need to understand how the Marketplaces work in each state. The Marketplaces offer four levels of plans, but it's important to note that plans in each level offer similar benefits and quality of care. For instance, all offer "essential health benefits," such as emergency services, maternity and newborn care, and prescription drugs.

Employers must work with an insurance agent, broker or company to determine their eligibility for a SHOP Marketplace and to compare available SHOP plans.

The differences between the plans lie in the ways in which employees share in the costs of their health insurance. This includes the monthly premiums, and costs such as deductibles and copayments. The levels are:



Platinum: Plans cover 90% of the total average costs of care. They typically will have the highest monthly premiums, but lower out-of-pocket costs for each service.

Gold: Plans cover 80% of the total average costs of care.

Silver: Plans cover 70% of the total average costs of care.

Bronze: Plans cover 60% of total average costs of care.

Be sure to review all costs before deciding on a plan to offer, as the plan with the lowest premium may not provide the best value. For instance, employees on a bronze plan may pay a lower monthly premium, but also pay more each time they visit a doctor. In general, plans with lower premiums have higher out-of-pocket costs and vice versa.

In addition, employers who aren't happy with their plans will have to wait until the annual enrollment period to choose new offerings. (They can still add or remove eligible employees and dependents throughout the year.)

In some states, companies can offer just one health plan, and possibly a dental plan, while in other states an employer can offer multiple plans. Dental plans generally cover between 70% and 85% of the total average cost of care. Employers who aren't satisfied with a Marketplace's offerings may still want to keep tabs on it, as each state's offerings may change in 2015.

Eligibility criteria

In addition to the employee limit, employers must meet other criteria to use a SHOP Marketplace. For instance:

- The company must have a business address or employee work site within a particular SHOP's service area.
- The business must offer coverage to all full-time employees. Employees generally are considered full-time if they work at least 30 hours per week.
- In some states, at least 70% of eligible employees must enroll in the program. However, this figure can exclude those who have coverage elsewhere, either through another job or person, or a program such as Medicare or the U.S. Department of Veterans Affairs. Employers who apply for SHOP coverage between November 15 and December 15 each year may be able to enroll without meeting this requirement.
- Eligible companies must have at least one common-law employee, other than the owner or spouse, on their payrolls. (Self-employed individuals can look for coverage in the individual marketplaces.)

In addition, employers must work with an insurance agent, broker or company to determine their eligibility for a SHOP Marketplace and to compare available SHOP plans. Most agents or brokers will have a National Producer Number (NPN). They also must agree to safeguard the privacy and security of the personal information provided by employees during the application process. Of course, employers can browse the plans and estimate costs on their own using healthcare.gov.

Enrollment dates

Employers can begin SHOP plan coverage at any time; enrolling by the 15th of the month typically means they'll have coverage beginning the first of the following month. Be aware that employers are responsible for letting their employees know about SHOP coverage and providing information on enrolling.

Tax credits available

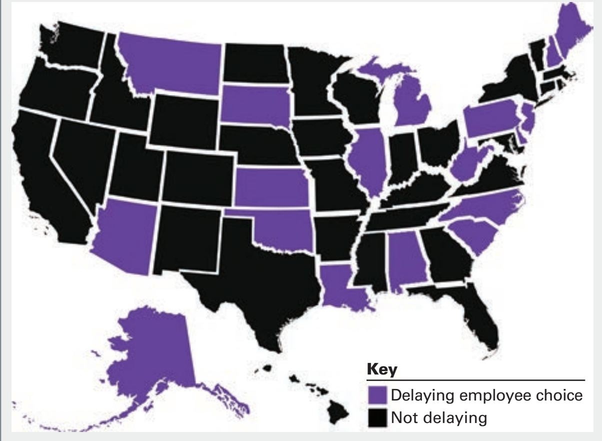
Employers with fewer than 25 full-time equivalent employees (as defined under the ACA's provision for the credit) who purchase insurance through a SHOP Marketplace may qualify for a tax credit. For more information, contact your financial advisor. He or she can help explain the new law and how it might affect your business. ◈

Some states delay employee choice in SHOP marketplaces

In May, the Department of Health and Human Services allowed some states to delay implementation of "employee choice" in their SHOP Marketplaces until 2016. So, for now, those states can offer a single medical and dental plan.

The delays were granted if they were determined to be in the best interests of participants in the small group insurance market in those states, according to the Centers for Medicare and Medicaid Services.

As of this writing, the list of states delaying implementation of employee choice includes Alabama, Alaska, Arizona, Delaware, Illinois, Kansas, Louisiana, Maine, Michigan, Montana, New Hampshire, New Jersey, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota and West Virginia.



Putting the brakes on employee fraud

Business owners and executives are concerned about the damage that a cybercriminal could wreak if he or she hacked into their organizations' information systems. At the same time, occupational or employee fraud is a significant and real danger. The average business loses about 5% of its annual revenue to fraudulent actions by employees, according to estimates provided by the Association of Certified Fraud Examiners (ACFE). The median loss? A hefty $145,000.

The most common type of fraud, accounting for about 85% of the incidents in the ACFE report, is asset misappropriation. This crime might involve an employee who creates and pays a fictitious vendor, submits an inflated expense report, steals inventory or intercepts cash collections.

No business is exempt

While all organizations are at risk for fraud, companies with fewer than 100 employees tend to suffer disproportionately. Why?

They're more likely to have weaker internal controls due to a limited number of personnel and less management oversight. However, by taking proactive steps, business owners and managers not only can slash the risk that their organizations will be hit by fraudulent activity, but also uncover any wrongdoing more quickly. The sooner a perpetrator is caught, the less harm he or she might cause.

The more difficult it is for a single employee — acting alone — to commit a crime, the less likely it is to happen.

Here are six tips for avoiding fraud:

1. Remain vigilant. Look for common warning signs of fraudulent activity, such as an employee who's living well beyond his or her means or a worker who refuses to take time off. While the latter might be a sign of dedication, it also can signal the individual's concern that a replacement will discover his or her criminal activities. An employee who insists on working odd hours, when he or she is most likely to be alone, also may be trying to get away with something.

2. Separate duties. The more difficult it is for a single employee — acting alone — to commit a crime, the less likely it is to happen. That's why many companies require multiple individuals to authorize disbursements over certain amounts, or assign one employee to add vendors to the payables system and another to pay them. Separating duties also makes sense when reconciling bank accounts and other statements. The employee charged with making deposits or disbursements shouldn't also reconcile the bank accounts, as doing so offers an opportunity to hide any wrongdoing. In small companies, having the bank statement delivered unopened to the owner for

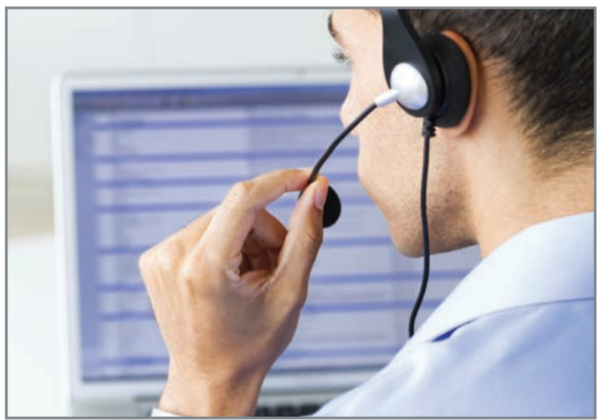
his or her review is an effective way to deter unauthorized activities.

3. Use physical controls. Locking away checks and financial statements and allowing access only to employees who require them for their jobs not only makes it more difficult for other workers to misuse these instruments, but also sends a signal that management takes seriously the need to safeguard the company's assets.

4. Train employees. Educate staff members to know what fraud is and how it can occur, as well as how it can hurt the business and ultimately their livelihoods. Armed with this information, employees will be better able to identify fraudulent actions. And, by simply discussing the issue, management emphasizes the fact that it's on guard against potential wrongdoing.

5. Understand the cost of fraud. As a business owner, it's critical that you install antifraud processes, such as segregation of duties.

6. Implement a tips hotline. Tips from employees or vendors accounted for more than 40% of all fraud detections in the ACFE report, making it the most common detection method. It pays to establish a means for employees to securely let the appropriate manager know if they have reason to suspect fraudulent behavior.



Don't become a victim

No organization is completely immune to employee fraud. But, by implementing these steps in your business, you can reduce the risk that it'll become a victim. And, if any fraudulent activity does occur, it's more likely that it'll be uncovered. Either way, potential losses can be reduced. Discuss what fraud prevention strategies might work best for your company with your business advisor. ◈

Long-term care insurance: Good or bad?

As the baby boomers reach their 60s and 70s, many might wonder what their future holds. Will they be as sharp as a tack and robust in their strength? One would hope so. But the reality is that many boomers will require some type of long-term care (LTC). If you or a loved one is among them, here are some Q&As on how to navigate the future.

Is it really needed?

LTC insurance policies help pay for the cost of long-term nursing care or assistance with activities of daily living (ADLs), such as eating or bathing. Many policies cover care provided in the home, an assisted living facility or a nursing home, although some policies restrict coverage to only licensed facilities. Without this coverage, you'd likely need to pay these bills out of pocket.

Medicare or health insurance policies generally cover such expenses only if they're temporary — that is, during a period over which you're continuing to improve, such

as recovering from surgery or a stroke. Once you've plateaued and are unlikely to improve further, health insurance or Medicare coverage typically ends.

That's when LTC insurance may take over. But you need to balance the value of LTC insurance benefits with the cost of premiums, which can run several thousand dollars annually.

Should you buy now or later?

The younger you are when you purchase a policy, the lower the premiums typically will be. And, the chance of being declined for a policy increases with age. Having certain health conditions, such as Parkinson's disease, can also make it more difficult, or impossible, for you to obtain an LTC policy. If you can still get coverage, it likely will be much more expensive.

Many policies cover care provided in the home, an assisted living facility or a nursing home, although some policies restrict coverage to only licensed facilities.

So buying earlier in life may make sense. But, you must keep in mind that you'll potentially be paying premiums over a much longer period. You can often trim premium costs by choosing a shorter benefit period or a longer elimination period.

Do you understand the terms?

It helps to understand a few terms when considering an LTC policy. One is the *benefit trigger*. This is the criterion the insurer uses to determine when your need for LTC begins. Examples include cognitive impairment or the inability to perform several ADLs on your own.

The *elimination period* is the period of time between the start of the benefit trigger and the time that the policy begins paying benefits. This can range from 30 days to several months. The longer the elimination period, the less expensive the premiums typically are.

The *benefit period* is the period of time over which the policy pays for care. This can range from a year or two to an unlimited amount of time.

Another term is *inflation protection*. This boosts the dollar value of the benefit for each year of the policy. It becomes more important if it's likely you won't begin to receive benefits for a decade or more.

Exclusions are conditions not covered by a policy. For instance, some policies won't cover treatment for addictions or self-inflicted injuries.

Many policies are classified as either *reimbursement* or *indemnity*. With a reimbursement policy (which is the most common type), you're paid for the costs you incur up to a set daily or weekly limit. The policy may require that care be provided in a licensed facility.

Under an indemnity policy, you receive a set amount of money to use against your expenses, even if your bill is less than the amount allowed in the policy. For example, if your caregiver sends you a bill for $150, but your policy is for $200, you would receive the full $200. Not surprisingly, indemnity policies tend to be more expensive.

Work with your financial advisor

Purchasing LTC insurance can be a boon or a bust. That's why you need to work with your financial advisor. He or she can help you determine the amount of coverage you or your loved one might require. ◈

Be sure to run the numbers

Reverse mortgages have been both touted as a solution for older homeowners who are struggling financially and criticized for the fees associated with them. Both observations carry some truth. But reverse mortgages *can* play a role in the financial plans of seniors who are relatively well off.

How it works

Reverse mortgages allow homeowners age 62 or older to convert some of the equity in their homes into cash. The payments, which typically are tax-free and unlikely to affect Social Security or Medicare benefits, are repaid only when the last borrower passes away or sells or leaves the home. However, because the homeowners retain title to the home, they remain responsible for taxes, upkeep and other expenses.

Research suggests that reverse mortgages may make financial sense even for some homeowners who aren't struggling to pay the bills.

While reverse mortgages are one way to free up cash that otherwise would remain tied up in a house, they're not right for everyone. And because reverse mortgages carry origination, servicing and other fees, they may not be the best solution for homeowners who plan to remain in their house for just a few years. In this case, a home equity line of credit may be a better alternative.

Why they might make sense

Research suggests that reverse mortgages may make financial sense even for some homeowners who aren't struggling to pay the bills. A 2012 study in the *Journal of Financial Planning* examined the financial impact of three strategies an individual might use to generate income. They include:

1. Exhausting a securities portfolio and then turning to a reverse mortgage,
2. Using the proceeds from a reverse mortgage while simultaneously taking cash from an investment portfolio, and
3. Drawing on the reverse mortgage credit line first.

Researchers found that the second and third options can, in many cases, increase the "cash flow survival probability" over a 30-year period. The reason for this counterintuitive conclusion? The investment portfolio continues to grow while the individual is drawing down the reverse mortgage.

Still another strategy that homeowners might benefit from is to use a reverse mortgage to delay the start of Social Security benefits.

What you need to do next

If a reverse mortgage appeals to you, make sure you thoroughly run the numbers. Reverse mortgages are complicated financial instruments. And while they can be a sensible option for some homeowners, making the determination requires an honest assessment of one's financial situation and the pros and cons of reverse mortgages. ◈

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THE RIGHT IDEAS

THE RIGHT RESULTS

ACHIEVED WITH THE RIGHT FIRM.

Has a Recent Occurrence Altered Your Path?

You may need to review your financial plans prior to moving forward.

Change happens. Marriage, divorce, birth, death and other such events may force you to alter your financial plans before continuing down your path.

The financial planning experts at Zinner & Co. can help you review your current estate and financial planning documents to determine what may need to be updated in order to set your course straight.

The professionals at Zinner & Co. know that every major financial decision a client makes, personally or in business, carries with it long-term implications. We are available to each of our clients, at all times, to offer smart tax & financial advice.

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