

FOR YOUR BENEFIT

IN WAKE OF HEALTH CARE REFORM, OPEN ENROLLMENT PRESENTS OPPORTUNITIES FOR EMPLOYERS

By: Peggy Bomberger, SHRM
 Date: July 29, 2010

The fall 2010 open enrollment period provides employers with an opportunity to explain benefit changes, many of which are required as a result of the health care reform legislation enacted in March 2010 (the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act), and to allay any fears that employees have regarding their employers' group health plans.

Open enrollment also is the perfect time for employers to review their group health plan documents and employee communications—including summary plan descriptions and other notices—to ensure that such documents are distributed timely and in compliance with recent law changes.

Explanation of Benefit Changes

Most employers are required to amend their group health plans to include new benefits as a result of the health care reform legislation for plan years beginning on or after Sept. 23, 2010. For calendar year plans, these benefit changes are effective Jan. 1, 2011. For non-calendar year plans, the provisions of the reform act might be effective earlier. Some employers might want to implement optional plan design changes for the upcoming plan year. Open enrollment provides an excellent opportunity for employers to communicate and explain these benefit changes.

Employers that wish to use their open enrollment materials to satisfy their benefit change notification requirements might need to rethink this practice. Certain provisions of the reform act might make it prudent for employers to communicate such benefit changes well in advance of their open enrollment periods or schedule earlier open enrollment periods. For instance, the reform act includes a requirement that plan administrators of group health plans provide a notice of material modifications of benefits to participants by 60 days prior to the date the changes are effective.

It is unclear whether this new requirement is effective Jan. 1, 2011, (for calendar year plans) or March 23, 2012. Cautious employers will want to notify employees at least 60 days prior to the effective date of the benefit changes for the upcoming plan year. For calendar year plans, this means that employees will need to be notified of benefit changes prior to Nov. 1, 2010. This date is earlier than open enrollment periods scheduled in November and December for calendar year plans.

(Continued on page 3)

Inside this issue:

In Wake of Health Care Reform, Open Enrollment Presents Opportunities for Employers	1
Survey Notes Most Health Plans to Lose Grandfathered Status	2
Accident and Critical Illness Insurance: The Financial Problem Solvers	2
It's As Easy As Falling Off A Bike	4

DID YOU KNOW?

Beginning January 1, 2011, over-the-counter (OTC) drugs will no longer be considered qualified medical expenses for FSAs, HRAs, and HSAs. Insulin is the one exception to this rule. For other OTC drugs, employees cannot use funds from any of these accounts, unless it is prescribed by a physician.

For the most recent news on Healthcare Reform, please contact your Benefit Controls representative.

SURVEY NOTES MOST HEALTH PLANS TO LOSE GRANDFATHERED STATUS

By: Jerry Geisel, Workforce Management
Date: July 2010

Ninety percent of employers expect their health care plans to lose their grandfathered status by 2014 under the health care reform law because of changes they expect to make, according to a survey released Tuesday, August 10. Under the Patient Protection and Affordable Care Act, employer plans are shielded from certain requirements, such as providing full coverage of preventive services, if they meet certain requirements. For example, employers must maintain current co-insurance requirements and cannot raise employees' premiums by more than five percentage points. Changing insurers also

invalidates a plan's grandfathered status. According to the Hewitt Associates Inc. survey of 466 employers representing 6.9 million workers, 90 percent of respondents expect their plan to lose its grandfathered status by 2014—the majority in the next two years. "Most large employers would rather have the flexibility to change their benefit programs than be tied down to the limited modifications allowed under the new law," Ken Spering, leader of Hewitt's health management practice in Norwalk, Connecticut, said in a statement.

Seventy-two percent of employers expect their health care plans to lose their grandfathered status because of design changes. Changing premium subsidy levels, changing insurers and consolidating plans are among other actions employers expect to result in their plans losing grandfathered status. Fifty-one percent of employers with self-funded plans expect their plans to lose grandfathered status in 2011, and 21 percent expect that to happen in 2012. Forty-six percent of employers with fully insured plans expect to lose grandfathered status in 2011, and 18 percent expect that in 2012.

ACCIDENT AND CRITICAL ILLNESS INSURANCE: THE FINANCIAL PROBLEM SOLVERS

By: Jim Foley and Gary Harger, Employee Benefit Advisor
Date: August 2, 2010

For the last several years, employers have struggled to control rising benefit costs amid very difficult economic and competitive pressures. Escalating medical claims costs have been particularly tough on bottom lines. Employers have responded by redesigning their medical plans to keep them affordable - usually by removing more expensive plan options, raising deductibles and co-payments, or limiting eligibility. One major trend has been to replace traditional major medical plans with high-deductible plans, which have shown promise in managing rising medical cost trends for employers.

The consequences of these trends are not surprising. From 1999 to 2008, the average annual employee contribution for family health insurance coverage went up 81%, according to the Robert Wood Johnson Foundation. Meanwhile, a 2009 study by the National Opinion Research Center and Watson Wyatt Worldwide reported that adults with employer coverage shouldered an average of \$729 annually in out-of-pocket medical costs in 2007 - which represented a 34% increase from just three years earlier. The bottom line: Employees pay higher premiums and out-of-pocket medical expenses. Among other things, this means they are exposed to potentially significant financial strain if they or their family members are involved in an accident or suffer a life-threatening medical problem.

Two voluntary group insurance products are ideally equipped to address this benefits gap - accident and critical illness - yet many employers either don't know about them or simply haven't taken a close enough look. As an adviser, now might be a great time to bring these products forward with clients for consideration since they are timely, relevant and help the employer add new company benefits without a bottom-line impact in an era of continual benefits erosion. They can also be positioned as a way to soften the impact of a transition to high-deductible (HSA or HRA) plans.

Taken together, accident and critical illness insurance perform much like an extended warranty that supplements medical coverage in important and attractive ways. When discussing these policies with a client, you will want to reinforce these key features:

* Payment, not reimbursement. With these two products, the insured does not have to spend money up front, in terms of a deductible, in order to get the benefit. Having an accident or being diagnosed with a specific illness, such as cancer, triggers the pay-

(Continued on page 5)

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(CONTINUED FROM PAGE 1)

Summary Plan Descriptions

Open enrollment is also a good opportunity for employers to ensure that their summary plan descriptions (SPDs) are timely distributed to plan participants and revised to comply with recent law changes. A plan administrator for a group health plan must provide a SPD to new participants within 90 days after enrollment and to other participants at least every 10 years, provided that the plan terms do not change materially. The plan administrator is required to notify plan participants of changes to the group health plan. This can be accomplished by providing plan participants with an updated SPD or a summary of material modifications.

There has been a surge in federal and state legislation impacting group health plans over the past few years. Employers should verify that their SPDs have been updated for these recent law changes, including, but not limited to, Michelle's Law, the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act (GINA), and the Children's Health Insurance Program Reauthorization Act (CHIPRA).

Required Notices

Open enrollment provides a convenient opportunity for employers to provide notices required by various federal laws to group health plan participants. Employers are encouraged to use open enrollment as an opportunity to audit their group health plans to ensure that the required notices are up to date and timely provided. The following is a list of notices that are required to be provided to participants of group health plans:

- **Notice of special HIPAA enrollment rights** must be provided at or before the time an employee is initially offered the opportunity to enroll in a group health plan. This notice must include the new CHIPRA special enrollment rights.
- **Notice of special CHIPRA enrollment rights** for eligible employees and dependents to enroll in employer group health plans must be provided annually (and can be combined with notice of special HIPAA enrollment rights). The U.S. Department of Labor recently published a model notice that can be used to satisfy this requirement and can be found at www.dol.gov/ebsa/chipmodelnotice.doc.
- **Notice of enrollment opportunity attributable to extension of coverage to adult children** up to age 26 must be provided no later than the first day of the first plan year beginning after Sept. 23, 2010, and the adult child must be given 30 days to enroll.
- **Notice of HIPAA pre-existing condition exclusions**, if applicable to the group health plan, must be given to participants prior to enrollment or prior to the date the group health plan imposes a pre-existing condition exclusion.
- **Notice of HIPAA privacy rights** (updated for GINA) must be provided to new enrollees and to other participants at least once every three years by the plan administrator if the group health plan is self-funded, or by the insurer if the plan is fully insured.
- **Notice of Women's Health and Cancer Rights Act rights** must be given to participants upon enrollment and annually thereafter.
- **A statement of state and federal law regarding minimum length of stays** for mothers and newborns, as required by the Newborns' and Mothers' Health Protection Act, must be included in the plan's SPD.
- **Notice of creditable/non-creditable prescription drug coverage** must be given to Medicare Part D eligible individuals annually prior to eligible individuals' annual coordinated election period, prior to enrollment in the group health plan, and prior to the date prescription drug coverage ceases.
- **COBRA notice to new enrollees** must be provided to all covered individuals. This notice should be addressed and sent to the most recent address for the employee and spouse and should not be included in open enrollment materials.

A Unique Opportunity

The fall 2010 open enrollment period, perhaps more so than in previous years, presents employers with a unique opportunity. Because of the many recent law changes affecting group health plans, employers' plan documents and communication materials will need to be reviewed and updated. Employers should seize this opportunity and conduct an in-depth audit of their plan documents and communication materials to ensure that they reflect current law accurately.

Employers should not assume that their third-party administrators or insurers have completed these updates for them. Maybe more importantly, though, employees will be relying on employers to explain effectively changes made to group health plans as a result of health care reform. Employers can use open enrollment materials to provide information to reassure employees and address their concerns.

IT'S AS EASY AS FALLING OFF A BIKE

By: Jim Foley and Gary Harger, Employee Benefit Adviser

Date: August 2, 2010

Imagine that a 35-year-old employee takes a tumble and is injured - with a fractured wrist and torn knee ligament - while bicycling on a family outing. Here's how quickly costs might accumulate, and how an accident policy might theoretically respond to cover those costs*.

Out-of-pocket expenses incurred:

\$100 emergency room copay

\$250 deductible

\$750 copay for knee surgery (\$3,750 x 20%)

\$150 copay for eight physical therapy visits

Total out-of-pocket expenses: \$1,250

\$150 emergency room co-pay

\$50 appliance (knee brace)

\$300 fractured wrist

\$400 surgical ligament tear repair

\$50 follow-up appointment

\$150 for six physical therapy sessions

Benefits paid by typical accident insurance policy:

Total benefit paid: \$1,100

*Cost of treatment and benefit amounts are representative only; amounts will vary by cost of care in various locations and richness of benefits offered by carrier.



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(CONTINUED FROM PAGE 2)

out. The employee doesn't have to incur an expense and then wait for reimbursement. This is important because employees may be facing high deductibles in their medical plan coverage, so having the ready cash is a major help.

* Not tied to medical plan. A common point of confusion with both accident and critical illness products is that their benefits are somehow "offset" by medical plan benefits. It's important that the employee and the employer alike understand that these limited benefit policies perform as supplements to medical coverage, but are not in any way linked to them and their benefits are delivered with no offsets or reductions once policy requirements are met.

* Use money in any way. The nature of medical plans is that insureds only get reimbursed for "qualified expenses," which the insurer details within the program. With both accident and critical illness, since insureds receive a lump sum for particular injuries or diseases, they have no such restrictions on how they use the money. For example, a person who loses the use of a limb might use the accident policy's payout to make home modifications that make life easier. Someone with a cancer diagnosis might wish to consult with a specialist across the country, and can use the critical illness policy's payout for travel and lodging expenses. If an experimental treatment is not covered by a medical plan, the insured can use the critical illness policy's payout to spend the \$10,000 or more to pay for the treatment.

* Direct and transparent. For most people, a glance at the list of potential injuries on an accident policy, or taking on the topic of dread diseases, can generate queasiness. Who really wants to think about winding up in a coma or fighting cancer? But the policy benefits are clear and transparent, unlike the sometimes-mystifying coverage rules in medical policies. Employees will get the message that, by offering these voluntary benefits, the employer is raising important financial-security issues and providing affordable solutions to address them.

* Simplified claims. In most cases, to receive a benefit the insured simply provides the insurer with a claim form and applicable paperwork from a care provider that documents the injury or diagnosis of disease. With accident insurance, additional paperwork might be required to determine whether the claim stems from the insured taking part in certain inherently dangerous activities, such as bungee jumping or car racing, in which case benefits might be denied. Such restrictions will be clearly stated in the policy.

* Ready availability. Generally, accident insurance payments are issued to employees without any pre-existing condition limitations. Critical illness insurance might require the employee to fill out questions on an application for coverage, although under certain conditions, employees may be eligible for a guaranteed issue offer without requiring answers to health questions. Regardless, employees would have a hard time finding either of these coverage options at such affordable prices outside of the group voluntary benefits context. Premiums of only \$20 or \$30 a month for each insured are common in these worksite products.

* Family coverage. Depending on the carrier, the employee can opt to get coverage for a spouse and dependent children (up to a certain age) as well. This is a real advantage if a working spouse does not have coverage through his or her employer. But, this is equally important for spouses who work in the home, because household finances might be more constrained and thus make the additional policy benefits even more critical. In the case of children, the accident coverage usually pays benefits for non-professional sports injuries, a common occurrence. Depending on the injury, the out-of-pocket costs for emergency room services, copays and deductibles for medical care and follow-up physical therapy can quickly exceed \$1,000. An accident policy typically would provide benefits to cover the lion's share of those costs.

* Portability. In most cases, accident insurance allows employees and dependents to continue the coverage after leaving the employer or retiring. For critical illness, there may be certain conditions involved, but the key is that most policies allow employees and dependents to continue enjoying these coverage options at group rates wherever life might lead them next. In presenting accident and critical illness insurance options to the client, ensure that you read the fine print in the carriers' offerings. In the descriptions above, you see many uses of "typically" or "in some cases" or similar phrases. This is because rules, payout amounts and exclusions can vary from carrier to carrier.

For example, some carriers' critical illness policies may make multiple partial or full payments for certain diagnoses while others may not. Similarly, riders for spouses and children might have specific rules that make one more desirable than another.



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