Benefit Plan Administrators

UpFront

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SPECIAL ENROLLMENT PERIOD TO COVER ADULT CHILDREN

The Patient Protection and Affordable Care Act (PPACA) requires group health plans to make dependent coverage available to all adult children up to age 26. This requirement is effective the first plan year after September 23, 2010. These adult children may be married, do not need to reside with the employee, do not need to be a student and do not need to be financially dependent on the employee.

Group health plans must provide a 30-day special enrollment period to allow adult children to enroll. This special enrollment opportunity may be provided to the employee and it may be combined with other open enrollment materials as long as it is prominently displayed. Please plan for this 30-day special enrollment period prior to your plan year renewal.

Please contact our office with questions.

HOW PPACA WILL AFFECT FLEX SPENDING ACCOUNTS

Starting January 1, 2011, PPACA will require people who have medical flexible spending accounts (FSAs) to get a prescription for some over-the-counter (OTC) medications, such as pain relievers, to get reimbursed. Right now, eligible OTC products are automatically reimbursed when participants use their benefits debit card, according to Discovery Benefits, Inc. (DBI).

When the new requirement goes into effect, participants will have to pay out-of-pocket for some medications and then file a claim that includes the prescription as documentation to get reimbursed. DBI is still waiting for guidance from the IRS on how exactly this will work. It is still unclear if you will need a doctor's prescription like you do now for prescription medicines, or if you will only need a written note of medical necessity.

Employees can visit www.discoverybenefits.com for a list of OTC items.

Employees may want to consider these questions when they choose how much to flex for 2011:

1. Are you willing to call or visit your doctor to get a prescription for things like cold medicine or sleeping pills? Can you anticipate what items you will need and ask for OTC prescriptions during an annual physical or some other required office visit? If you can plan ahead, the savings will be worth it.
2. How will your out-of-pocket costs for the office visit compare to savings from your medical FSA? For every dollar you put into an FSA, you save up to 40 percent because the contribution is made before federal, state and FICA taxes are deducted from your wages.

In three years, medical FSAs will undergo more changes when the government regulates annual flex elections. Right now, employers are free to choose any amount as the limit for employee flex elections, which are written into the plan design. On January 1, 2013, the salary reduction limit cannot exceed $2,500 per year, regardless of whether the participant is single or married. However, a husband and wife who participate in separate FSA plans, each with a $2,500 limit, will be able to elect up to $5,000 per year. Employers may contribute to an FSA over and above the $2,500 salary reduction maximum if they choose to do so.

If you have questions regarding the new health care FSA requirements, please contact the benefit administrator for your Flexible Benefit Plan.

NAIC PRESERVES ROLE OF HEALTH INSURANCE PRODUCERS

The National Association of Insurance Commissioners (NAIC) adopted a resolution to protect the ability of licensed insurance professionals to continue to serve the public. The resolution affirms the important role of health care insurance agents in providing services to consumers and businesses while the standards for implementing PPACA are developed.

"State insurance regulators recognize the important service that agents provide to all consumers as they make critical health care decisions for their families," said Jane Cline, NAIC president and West Virginia insurance commissioner, in a news release. "Significant changes for health plans under the PPACA precipitate the need for clarity and guidance by licensed, specially trained insurance professionals. The continuing role of producers in the health insurance transaction is an essential part of protecting consumers during this transition."

Licensed insurance agents assist consumers in numerous financial planning decisions, including benefit and contribution arrangements to ensure compliance with applicable state and federal laws/regulations; assist with establishing Section 125 plans, HRA, FSA and other programs to maximize tax advantages; and ensure compliance with applicable IRS guidelines.

Producers are required to complete continuing education to maintain appropriate licenses, which helps ensure that agents remain current in the evolving insurance marketplace.

The resolution was sponsored by Illinois, Maine, Florida, Kansas, Oklahoma, Louisiana, Alaska, New Hampshire, Utah, South Carolina, North Carolina, Nevada, Montana, Ohio, New Jersey, Kentucky, Missouri, Michigan, Connecticut, Tennessee, Washington, Delaware, California, New York and North Dakota.

MOST LARGE EMPLOYERS WILL CHANGE HEALTH PLANS

Fifty-three percent of large employers plan to make health plan design changes for 2011 in spite of the threat of losing grandfathered plan status under health reform, according to a survey from the National Business Group on Health (NBGH).

- Another 19 percent of large employers have decided to scale back plan design changes for 2011.
- 19 percent have decided to make no changes.
- 9 percent are waiting for federal regulations before they make any decisions.

The NBGH survey was conducted before the June 17 release of interim final regulations, according to *Spencer's Benefits Reports*. The final regulations detailed the changes that will cause health plans to lose grandfathered status under PPACA. Grandfathered plans are any group health plans that were in effect on March 23, 2010, the date the Affordable Care Act was enacted. Grandfathered plans are exempt from some, but not all, of the provisions of health reform.

HEALTH CARE REFORM CHANGES THAT AFFECT EMPLOYERS

Many provisions of health care reform act will go into effect in 2011. Here are some changes that all medical plans, including grandfathered plans, will need to implement:

- Dependent coverage for children up to age 26
- Elimination of lifetime benefit limits
- Restriction of annual benefit limits
- Elimination of pre-existing condition exclusions for enrollees younger than age 19
- Limits on ability to rescind coverage

If you have a non-grandfathered plan, you will need to implement additional changes:

- New claims and appeals procedures
- Required coverage of preventive services
- New nondiscrimination rules for fully insured plans
- Other patient protections

Employers must distribute new notices to employees regarding these requirements of health care reform.

- Grandfathered plan notice
- Age 26 dependent coverage notice
- Lifetime limit notice

MORE HEALTH CARE COSTS WILL SHIFT TO EMPLOYEES

An Aon Consulting survey found that 65 percent of respondents plan to increase cost-sharing through actions such as boosting deductibles, copayments, coinsurance or out-of-pocket limits, according to the Workforce Management website.

What's more, 57 percent said they expect to boost health care plan premiums paid by employees. Those changes come amid major increases in health care plan costs.

Another area of concern is how expensive COBRA health care continuation coverage has become. For example, this year the median monthly COBRA premium charged for single coverage in a preferred provider organization plan was $449, while the median monthly premium for family coverage was $1,310.

A total of 1,079 individuals participated in the survey, including 44 percent at employers with 500 to 5,000 employees, 38 percent at employers with fewer than 500 employees and 18 percent at employers with more than 5,000 employees.

ER COSTS VERSUS OFFICE VISIT

You should certainly seek care when you need it, but seeking the appropriate type of care can help keep health care costs in line. In 2009, acute otitis media, or ear infection, was the most common non-emergency to show up in the emergency room. The average allowed cost of an ER visit was $226, while the average cost for an office visit and the same care was $92.