MUTUAL ASSURANCE ADMINISTRATORS, INC.

BenefitWise

Important news and updates from your benefits professional

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Is It Time for Scheduled Benefits?

A scheduled benefit plan is exactly what the name suggests – a health plan with limits to what will be paid for each covered expense. Similar to a comprehensive major medical plan, members typically have a deductible with the plan paying up to each respective limit for covered expenses. In order to determine what will be paid for a covered benefit, many plans base their scheduled payments on Medicare, since it is the most widely accepted index. It is fairly common for the plan and area hospitals to agree on Medicare plus 20%. In other instances, hospitals agree to accept a payment equal to their cost plus a pre-determined margin – perhaps 10% to 15%.

The biggest difference between a scheduled benefit plan, sometimes referred to as a "cost plus" plan and more common PPO plans is that no provider network is involved. While cost plus plans eliminate hospital networks, some may still contract with physician networks.

Years ago, PPO networks offered a real advantage because many providers participated in only one network. Today, it is not uncommon for providers to belong to every provider network in a market, diminishing the real value of a network discount.

Transparency is another factor driving the trend to scheduled benefits. The absence of reliable price information, especially among smaller groups, makes it very hard to identify the real savings in a PPO environment – especially when hospital costs continue to rise.

Beware of Balance Billing

While a scheduled benefit plan can produce significant cost savings, some providers will accept the scheduled payment and then turn around and "balance bill" the patient in an effort to collect the difference between the agreed amount and what they wanted to charge initially. All "cost plus" plans caution members about balance billing and some engage attorneys to negotiate with hospitals on the member's behalf. This is a great service since few plan participants feel comfortable negotiating with providers.

As studies have long shown, the price for an identical health care procedure performed in the same city can vary greatly, with no difference in quality. As long as these conditions persist, interest in "scheduled benefit" or "cost plus" plans will continue to grow as employers look for ways to better manage the costs and future risks of health care.

What Is Affordable Coverage?

For organizations that are determined to be "large" employers under PPACA, it will be necessary to determine if the coverage being offered is "affordable." Coverage is affordable if the required employee contribution does not exceed 9.5% of their annual household income. The coverage to which this rule applies is the employee portion of the self-only premium for the employer's lowest cost coverage that provides minimum value. The employer can charge more for spouse or dependent coverage and IRS regulations offer a number of methods for determining the employee's household income. When coverage is not affordable and an employee obtains coverage from an exchange and receives a premium tax credit or cost sharing benefit, the employer will be liable for an assessable payment for that employee.

An employer is "large" if, on average, at least 50 full-time employees were employed on business days in the preceding calendar year. Parent-subsidiary and brother-sister controlled group rules within the tax code apply in making this determination, meaning that all subsidiaries that are at least 80% owned directly or indirectly by the parent corporation will be treated as a single employer. In addition, an employer must take part-time employees into account and include the number of "full-time equivalents" when determining whether it is a large employer.

Self-Funding Continues to Grow

As employers and their agents search for ways to manage costs in a more regulated post-reform environment, many are moving to partial self-funding. While some employers are interested in avoiding new regulations that will impact traditional fully-insured plans, most are looking for a way to control costs and maintain flexibility in plan design.

Self-Funding enables a health benefit plan to meet the specific needs of a covered group and stop loss insurance protects the plan against claims that exceed anticipated levels. When claims are lower than anticipated, the savings remain in the plan, rather than insurance carrier reserves.

As independent benefits administration specialists, we handle all the administrative concerns associated with self-funded plans, including enrollment, claims administration and management reporting. Predictive modeling helps identify factors driving cost increases and disease management strategies can help plan participants and dependents receive the personalized care they need. When symptoms can be identified early, costly claims can often be avoided.

Is the Stick Gaining Strength in Wellness?

While incentives are often a part of wellness programs, disincentives are being talked about with increasing frequency. Experts say that incentives often produce high levels of enthusiasm and engagement in the early stages of a wellness program, with diminishing results going forward. For that reason, some organizations are beginning to consider what may be described as "low impact" disincentives.

An example might be giving an employee the opportunity to avoid a cost increase by taking a recommended wellness action, rather than giving a monetary reward for taking the action. Those who make the decision to not engage themselves in the activity will see a cost increase, while those who participate avoid the increase. While this option would not be considered a big stick, it is an approach that some employers are considering.

Trends Latest Happenings in Today's World

Electronic Health Records Gaining

According to data recently released by the Department of Health and Human Services, more than half of U.S. doctors are managing basic patient information with electronic health records. This transition has been required in order to qualify for federal payments under an incentive program established in 2009.

At a minimum, patient records must include notes on blood pressure, weight, height and medications and prescriptions must be written electronically. While some physicians say that typing into a computer is a distraction while talking with a patient, making it harder to focus on the patient, some 55% of office-based providers have made the transition.

Start-Ups Help Patients Get Meds

To boost the number of patients taking prescribed medications as directed, new companies are testing a variety of technologies, from digital, digestible sensors placed in pills to software that offers rewards to patients who adhere to the prescribed routine. One California-based company has released a smart phone app that lets users earn

Health Care Reform Update

Moving Forward to Full Implementation

Small Businesses to Wait a Year

The Small Business Health Options Program, or SHOP, the part of the health care reform law intended to create a marketplace where small businesses (those with less than 100 employees) could choose from a variety of health plans, has been delayed until at least January of 2015.

The Small Business Health Options Program, included in regulations released by the U.S. Department of Health and Human Services, has been delayed until at least January of 2015. This is the part of the health care reform law intended to create a marketplace where small businesses (those with less than 100 employees) could choose from a variety of health plans.

This delay will impact some 33 states that will have an exchange operated by the federal government. As part of the regulation, these exchanges will be able to offer only one plan that employers can offer to their workers. The National Federation of Independent Business, a small-business lobbying group that opposed the reform law, believes that the delay stemmed from the government underestimating the logistics involved in getting the exchanges up and running.

Employers Gaining Confidence

According to the 2013 survey by the International Foundation of Employee Benefit Plans (IFEBP), a vast majority of employers have abandoned the "wait and see" attitude and are taking steps to comply with the law. Our experience is consistent with these findings, as we help clients with predictive modeling of plan design changes, consumer directed options and ways to use wellness incentives to encourage healthier behavior.

The IFEBP results are being described as encouraging by many who have been quick to predict a drop in employer-sponsored health benefits. It may also suggest an interesting resemblance to the State of Massachusetts, where today, more people have employer sponsored coverage than seven years ago when their universal health care law was enacted – a trend recently reported in a two-part research study conducted by the PwC Health Research Institute.

Another indication of increased confidence on the part of employers is the interest in self-funding we've seen this year. Agents and employers are considering partial self-funding as a way to contain costs and maintain flexibility in plan design.

retail gift cards. Others are making pill bottles that do everything from measuring how many pills remain inside to displaying bright colors when it's time to take a prescribed dose or when a dosage is missed. To those who may think these ideas are a little over the top, the New England Health Care Institute estimates that $300 billion in doctor and hospital visits could be avoided annually if folks complied with medication schedules.

Health Spending Down

While the reasons for the slow-down in health care spending may long be debated, the numbers show that the growth rate in spending has leveled off at about 3.9% in the past 3 years. This rate of increase is down from a range of 6% to 10% experienced during the previous decade.

While plenty of politicians want to take credit for the positive trend, others say that this is the obvious lull before the storm of health care reform. Others believe the drop in health care spending is nothing more than a by-product of a tough economy and the higher unemployment and lower disposable incomes that accompany it.

DOL Issues Guidance on Exchange Notice

The U.S. Department of Labor and its Employee Benefits Security Administration have issued new direction on section 18B – the ACA requirement that employers must provide employees with a notice of the health insurance coverage options that will be available through future health insurance exchanges. These notices must be sent to all current employees by October 1, 2013 and within 14 days of a start date for any new employees who are hired beginning October 1, 2013.

The guidance announced in mid-May notes the availability of three different model notices, including a notice for employers who offer a health plan to some or all employees; a model for employers who do not offer a health plan; and one for employers who do not offer a health plan COBRA Model Election Notice. All employees must receive a notice, regardless of their status as full-time or part-time or their plan enrollment status.

The purpose is to inform employees that the new marketplace exists, along with contact information and a description of services. Employees must also be told that they may be eligible for a premium tax credit if they purchase a qualified health plan from the marketplace and that such a purchase may cause them to lose any employer contribution that may be offered by their employer.

Notice to Employees of Coverage Options *(Visit www.dol.gov/ebsa)*

- Technical Release 2013-02 – Guidance on the notice to employees of coverage options under FLSA 18B
- Model Notice for employers who offer a health plan to some or all employees (en español)
- Model Notice for employers who do not offer a health plan (en español)
- COBRA Model Election Notice Redline Version

Did You Know? New Ideas for Healthy Consumers

Don't Let the Sun Get Under Your Skin

For generations, Americans poured on the baby oil and basked in the hot sun for hours at a time, committed to getting that perfect tan. Now, years of research have taught us that we need to respect the sun and all the dangers that come from exposure to its harmful rays.

The Skin Cancer Foundation reports that skin cancer is the most common form of cancer in our nation, with more than 3.5 million cancers found annually. In fact, more people are diagnosed with skin cancer each year than with breast, prostate, lung and colon cancers combined. One fact that many folks overlook is that sun exposure is cumulative, meaning that the more exposure you have, the more the risk of developing skin cancer increases.

To help prevent skin cancer, the Skin Cancer Foundation recommends:

- Get in the shade between 10am and 4pm and do not let yourself burn
- Avoid tanning and UV tanning booths
- When in the sun, cover up with clothing, a broad-brimmed hat and UV-blocking glasses
- Use a broad spectrum (UVA/UVB) sunscreen with an SPF of 15 or higher and 30 or higher when swimming
- Examine your skin every month and see your physician for a professional skin exam annually

Smoking May Be Hazardous to Your Employment

The National Business Group on Health and the Center for Disease Control report that the number of Americans smoking continues to drop. There are several reasons for the trend – rising costs, increased health concerns and a growing number of employers imposing penalties being the most common.

While many businesses have, for years, rewarded workers for quitting, a growing number are now penalizing smokers instead. More companies, in fact, are imposing hiring bans, which are legal in 21 states. Most firms ask job candidates if they smoke, but some are requiring urine tests to screen for nicotine. Some employers see these practices as discriminatory since they often penalize less educated and low income workers who are more inclined to smoke. Others, such as the Cleveland Clinic, which imposed a hiring ban on smokers several years ago, say that rewards and free smoking cessation treatment have failed and that hiring bans is the only way to achieve their desired result.

Navigating Allergy Season

For those who suffer from seasonal allergies, keeping your windows closed, both at home and while riding in your car, is a good place to start. If you play outdoor sports or exercise outdoors, it might be wise to avoid early morning since pollen counts are usually higher then. Changing your clothes once you enter your home can help and wearing sunglasses can keep pollen out of your eyes.

For Midwesterners, the concern over tree pollen usually ends by June 1st or so, just in time for grass pollen in June and July. This is followed by ragweed in August and September and of course, mold counts tend to remain high until the first frost.

Milder winters in recent years seem to result in earlier starts to allergy season – something allergy sufferers always hope to avoid. Antihistamines, especially those that do not cause drowsiness, are helpful to many allergy sufferers, but those who need more help may want to talk with their doctor about a stronger prescription or a consultation with an allergist.

Please Contact Us: This newsletter is not intended as a substitute for personal medical or employee benefits advice. Please consult your physician before making decisions that may impact your personal health. Talk to your benefits administrator before implementing strategies that may impact your organization's employee benefit objectives.

MUTUAL ASSURANCE ADMINISTRATORS, INC.
www.maa-tpa.com
[P] 800.825.3540
[F] 405.607.2626