Tikia Consulting Group, Inc.
Employee Benefits

Newsletter

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With a new year comes new opportunities, new resolutions...and new federal laws. Our newsletter this month addresses and highlights some of the mandates and healthcare information that may directly impact your business and employees. Happy New Year!

In This Issue:

"The ladder of success is best climbed by stepping on the rungs of opportunity."
– Ayn Rand

Health Reform Online Assistance

The Obama Administration has developed a number of official websites that provide access to information, regulations, guidance, and more on the provisions of the health reform law. *Healthcare.gov* is the official site of the new Health Insurance Marketplace and the entry point for consumers who wish to shop for exchange-based coverage. For compliance resources regarding Marketplace coverage and consumer assistance, Centers for Medicare & Medicaid Services (CMS) has set up the *marketplace.gov* site. Most of the insurance market reform provisions of the new law fall under the jurisdiction of the Department of Health & Human Services' (HHS) *Center for Consumer Information and Insurance Oversight* (CCIIO). The Department of Labor (DOL) also has jurisdiction over many PPACA provisions. The Department's *overview page* contains a wealth of information and their *Frequently Asked Questions* pages give detailed answers to very specific PPACA implementation scenarios. The Internal Revenue Service (IRS) has a *site* dedicated to the tax-related provisions of the health reform law. In addition, they have a separate *site* with news releases, multimedia, and legal guidance. Finally, the *White House Office of Health Reform* also is a comprehensive source of information.

Preventive Medicines for Women with High Risk of Breast Cancer

HHS Secretary Kathleen Sebelius announced that "women at increased risk for breast cancer may now get preventive medications without out-of-pocket costs." HHS "issued guidance stating that drugs like tamoxifen and raloxifene be covered as a preventive medication under the ACA, which means women will not have to pay co-pays or coinsurance for them." Sebelius wrote, "We are making significant advancements in combating this disease — and for women who are shown to be at a higher relative risk for breast cancer, today, access to early treatments can improve their health."

It's noted that the move comes after the US Preventive Services Task Force (USPSTF) "recommended last September that clinicians give medications such as tamoxifen or raloxifene to such women to reduce their risk of the disease."

Under the ACA, "items or services rated A or B by the independent review board of physicians and academics must be covered by insurers without a co-pay or deductible." Insurers have a year to make the change.

The American Cancer Society Cancer Action Network "praised the announcement," saying, "This policy means millions of women at high risk for breast cancer will know they can access proven risk-reducing medications at no cost to them... By making prevention more accessible and affordable, the health care law is helping people stay healthy and avoid the high costs of treatment after diagnosis."

Parity Law Broadens Coverage for Mental Health Disorders

The Affordable Care Act (ACA) and rules to fully implement the Mental Health Parity and Addiction Equity Act of 2008 are expected to provide improvements and greater availability of "insurance coverage for mental conditions and addictions." The ACA "includes mental health care and substance abuse treatment among its 10 'essential' benefits, which means plans sold on the public health care exchanges must include coverage." What's more, "the parity law says that when health insurance plans provide coverage for mental ailments, it must be comparable to coverage for physical ailments."

Did You Know?

Thirty-six percent (36%) of those who make a resolution to begin a fitness regimen in the New Year have, unfortunately, given up before the end of January.

As an employer, you can provide workplace perks such as discounted memberships to fitness centers or a company sponsored wellness program. These incentives may encourage employees to adhere to their goals and commitment, which could lead to happier and healthier employees as well as lower healthcare costs across the board.

January is Cervical Health Awareness Month

About 79 million Americans are diagnosed with the most common sexually transmitted disease, human papillomavirus (HPV), which is a major cause of cervical cancer.

Click here for 10 Things To Know.

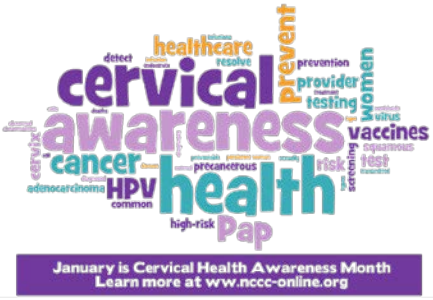
Rest assured there's plenty you can do to prevent cervical cancer:

- Talk to your physician about the HPV vaccine;
- Get regular screening tests (called Pap tests) as well as follow-up care;
- Under PPACA, these screening tests (if considered preventive) are covered at 100%.

To help increase awareness this month, you should encourage:

- Women to start getting regular screenings at age 21;
- Women to get the HPV vaccine before age 27;
- Parents to make sure their children get the HPV vaccine at age 11 or 12;
- Men to get the HPV vaccine if under age 22.

For more information, please visit the *National Cervical Cancer Coalition (NCCC)* or *American Sexual Health Association*.



Enroll America Increases Staff As Survey Shows Many Unaware Of Key ACA Provisions

Enroll America, "the nonprofit group with ties to the White House" that is helping to promote the ACA in 11 states, is increasing its field staff by 30%. The influx is aimed to help the group better "educate uninsured people about the financial assistance available under the law."

It's reported that Enroll America is adding staff in response to a survey it released Thursday, which showed nearly 70% of uninsured Americans were unaware of key provisions of the ACA, namely the financial incentives available to encourage enrollment. Moreover, a similar share had yet to log onto the online insurance marketplace available in their state. In the survey's press release, Enroll America said, "Large proportions of the uninsured are also still in the dark about deadlines and that brand new plans are available. A lack of facts about costs and coverage may be the greatest barriers to enrollment."

Another study that was released by the Commonwealth Fund showed "people who were eligible for coverage at HealthCare.gov and who visited the site in December tended to report good health."

The combined impact of these studies shows that they "paint [a] mixed picture of marketplace success so far."

14 States Announce Minimum Wage Increases

With Colorado's confirmation of its new rate bringing up the rear, every state has now set its 2014 minimum wage rate. January 1, 2014 will see minimum wage increases in twelve states including Arizona, Colorado, Connecticut, Florida, Missouri, Montana, New Jersey, Ohio, Oregon, Rhode Island, Vermont and Washington. New York is getting in ahead of the game and raised its minimum wage on December 31, 2013 and California's minimum wage will be increasing on July 1, 2014.

Washington State will continue to have the nation's highest minimum wage ($9.32 per hour) followed by Oregon ($9.10 per hour) and California ($9.00 per hour after July 1, 2014).

Click here for a full chart detailing the increases.

Waiting Period Compliance

When you amend your waiting period to comply with ACA, any existing employees in their waiting period are also subject to the same provisions. If your ERISA Plan Year is January 1st, any employees hired prior to 01/01/2014 cannot have more than a 90 day waiting period either as of 01/01/2014.

For example, if you change your waiting period to 1st of the month following 60 days and an employee was hired on 10/15/2013, this employee would become effective 01/01/2014 because they have satisfied the new 60 day waiting period (60 days from hire date would be 12/14/2013, so the following 1st of the month falls on 01/01/2014).

This Month's Holidays

January 1
New Year's Day

January 20
Martin Luther King Jr. Day

Prescriptions: Step Therapy vs. Prior Authorization

How are they similar and different?

	Step Therapy	Prior Authorization
Program Description	• Members must use a preferred alternative first or have clinical documentation for why they cannot take the alternative	• Clinical criteria must be met before a drug will be covered • A preferred formulary product may be required first
Goals of Program	• Lower cost to plan • Lower cost to member • Encourage use of generics	• Evaluate drug for medical necessity (for example: FDA approved indication, proper dose, frequency, monitoring, and duration of therapy) • Control cost to plan
Target Medications	• Brand medications that have generic, equally safe and effective alternatives available	• Medications with complex dosing or monitoring parameters • Costly, new medications • Drugs with potential for misuse
Examples	• Cholesterol medications • Nasal steroids • Acid reflux medications	• Multiple sclerosis medications • Hepatitis medications • Cancer medications

Step therapy and prior authorization programs are commonly used mechanisms to control plan cost.

Source: LDIRx 2013

2014 COLA Updates – Defined Contribution/Retirement Plans

Although some plan limits will remain unchanged from the 2013 limits, some have been indexed as shown below.

For 401(k), 403(b), and most 457 plans, the Cost of Living Adjustment (COLA) increases for some dollar limits on benefits / contributions are as follows:

Defined Contribution Plan Limits	2013	2014
Maximum elective deferral by employee	$17,500	$17,500
Catch-up contribution (age 50 and older during year)	$5,500	$5,500
Defined contribution maximum deferral (employer and employee combined)	$51,000	$52,000
Employee annual compensation limit for calculating contributions	$255,000	$260,000
Annual compensation of "key employees" in a top-heavy plan	$165,000	$170,000
Annual compensation of "highly compensated employee" in a top-heavy plan ("HCE threshold")	$115,000	$115,000

As you can see, the Maximum Elective Deferral and Catch-up Contribution amounts have not increased for 2014. According to the IRS, these contribution amounts were not increased since the Consumer Price Index did not meet the statutory thresholds for their adjustment.

W-2 Reporting of Employer-Provided Health Coverage

One of the provisions of health reform included in PPACA is the requirement that employers report the value of employee health coverage on the annual W-2 form (document used to report taxable wages and payroll deductions).

Many questions have arisen regarding the use of a tax-reporting document to report health premiums that are, generally, not taxable income for an employee. The IRS has offered numerous assurances that this new collection of data is intended to be for employee informational purposes only. It is not intended to be a precursor to taxing health benefits.

Initially, this reporting requirement was to be effective for the 2011 tax year, but regulators deferred the compliance requirement and issued guidance that reporting for 2011 would be voluntary.

For years after 2011, however, employers are required to report the cost of health benefits when they issue W-2s, unless they fall under the "transitional" relief for smaller employers, which continues the voluntary reporting. An employer "is not subject to the reporting requirement for any calendar year if the employer was required to file fewer than 250 W-2 Forms for the preceding calendar year." It's important to note that the relief is based on the number of forms filed, not the number of employees.

Many provisions of PPACA require the application of "controlled group" rules for compliance purposes. These rules require consideration of multiple companies that have high joint ownership or similar aggregations. However, for the W-2 reporting obligation and the transitional relief, the employer is determined without the application of any aggregation rules.

The transition relief also applies to:

- Multi-employer plans
- Health Reimbursement Arrangements
- Dental and Vision plans that either are not integrated into another group health plan or give participants the choice of declining the coverage or electing it and paying an additional premium
- Self-insured plans of employers not subject to COBRA continuation coverage or similar requirements
- Employee assistance programs, on-site medical clinics, or wellness programs for which the employer does not charge a premium under COBRA continuation coverage or similar requirements
- Employers furnishing W-2 Forms to employees who terminate before the end of a calendar year and request a W-2 Form before the end of that year.

The value of health care coverage is reported on the W-2 Form in Box 12. Generally, the amount reported is the actual premium paid by both the employer and the employee during the year. Employers may also use the COBRA premium, less any administrative fee.

If an employee changes coverage or if there is an increase or decrease in premium costs during the year, the W-2 reporting should reflect any resulting change in health plan costs. When a change occurs mid-month, an employer can prorate the amount or use another reasonable method.

The amount reported should not include the amount of salary reduction contributions to an FSA; however, HRA amounts can be included, but they are not required. Also, specialized coverage is excluded if it is paid on an "after-tax" basis.

Employers may have situations where it is unclear if a W-2 Form should be provided**.** A rule of thumb is that employers only have to report health plan costs if they would otherwise provide a W-2 Form for that individual. For example, an employer that reimburses the cost of Medicare premiums for a retiree would not have to report this information on a W-2 unless the retiree was due a W-2 Form for other reasons, such as deferred compensation.

The W-2 Form reporting should include both taxable and non-taxable health benefits if the benefits are reportable. An example of taxable benefits that would be included would be the premiums paid for a domestic partner.

Employers are not required to include the cost of coverage under an employee assistance program (EAP),

wellness program, or on-site medical clinic if the employer does not charge a premium for any of these programs.

IRS guidance emphasizes that employers should be consistent in applying any reasonable reporting methods they use. For example, an employer may report only the cost of coverage for an active employee, excluding COBRA coverage costs after the employee terminates. Alternatively, the employer may, in this same situation, report premiums that include COBRA payment. The importance is that the employer should treat all cases of this kind in the same manner.

Many employers will have payroll and coverage periods that overlap from one calendar year to the next. In that case, employers can allocate all of the costs to one year -- the year ending or the year beginning. Or the employer can allocate the cost of coverage between the two calendar years based on the number of days in the period of coverage that fall in each year. Again, once an employer has determined which method to use, the method should be applied consistently to all employees.

We hope that you find the information presented helpful, and we welcome any feedback. We want to ensure that all of your healthcare questions are addressed.

Please feel free to visit our website at www.tikiaconsultinggroup.com and provide us with comments.

Thank you!