Tikia Consulting Group, Inc.
Employee Benefits

Newsletter

Volume 03
Issue 02
February 2014

The year is well under way and as you "puddle" through the challenges of the weather, we will continue to help clarify the health care world of 2014.
Have you checked out our website recently? We've added a Resources page which links to several helpful sites and will soon be adding a Glossary and FAQs page.
Please let us know what else we can do to assist!

In This Issue:

"I really believe that everyone has a talent, ability, or skill that he can mine to support himself and to succeed in life."
- Dean Koontz

HHS Again Extends PCIP Program

It has been reported that the Obama Administration has again pushed back the deadline for the Affordable Care Act's *Pre-Existing Condition Insurance Plan* (PCIP), the temporary program that was "supposed to disappear January 1." Now, because of technical problems with health care.gov, the program "will continue to run through the remainder of the health care law's first open enrollment season, which ends March 31."

"Congress had assumed that it would no longer be needed because private insurers would have to accept all applicants and could not charge higher premiums due to a medical condition or history."

Discontinued Plans to Hit Small Businesses

Although many have already been notified of insurance policy cancellations, the majority of such terminations are expected to be sent out in October, in advance of the start of the next enrollment period. This 2nd round of cancellations is expected to be particularly painful for small businesses. The reasons for policy cancellations within this class are two-fold: (1) many plans will continue to be canceled simply because they do not meet the coverage requirements stipulated by the new legislation and (2) a number of plans will also be subject to cancellation as insurance companies attempt to grapple with increased administrative burdens and financial risks associated with health care reform. They will do so by merging and eliminating plans. In effect, the landscape of small-business insurance coverage will be considerably reshaped as a side-effect of the health care overhaul. A company with sick workers may enjoy the benefit of lowered premiums since insurance companies cannot bill higher premiums for preexisting conditions. On the other hand, small businesses with good risk will experience a rate hike. Small business may also be surprised to find that these new plans often have increased provider, hospital, and prescription limitations. For e.g., in Pennsylvania, West Virginia, and Delaware, Highmark BlueCross BlueShield will be discontinuing all plans that failed to renew early. The company estimated that 99.5% of individual and small-businesses covered by its plans will be affected. In summary, small businesses should expect changes and challenges on the horizon.

Concern Grows Over Limited Exchange Networks

Among the numerous doubts surrounding the implementation of the Affordable Care Act is the network access for exchange plans. Physicians grow increasingly concerned as many states do not yet have their provider databases up and running. There is also fear that many networks will be far too limited and insufficient for patient care. An NYC plan, for e.g., was found to have no gynecologists in the entire network. Another plan in San Bernardino, CA showed that accessing the nearest urologist would require an 80 mile drive. Even in the most well developed networks, provider directories are still quite small. These limitations are likely to complicate the prospect for comprehensive care for those insured within the exchange(s).

2014 Health Care Reform Provisions

You may be wondering what, if any, impacts Health Care Reform will have on employers over the course of this year. Below is a summary of the major 2014 provisions that may impact you:

1. **Maximum Waiting Period** – For health plans renewing on or after January 1, 2014, employers may no longer impose a waiting period that exceeds 90 calendar days (60 calendar days in California). The maximum waiting period provision applies to employers of all sizes. This means that if your current health insurance waiting period is "the first of the month following 90 days of employment," you will need to adjust this duration once your plan renews in 2014. Many employers have opted to switch to a "first day of the month, following 60 days".
2. **Consumer Protections** - Two major protections effective in 2014:
   - *Pre-existing Conditions* – Health insurance plans may no longer refuse to cover an individual or charge a higher premium based on a pre-existing health condition. In addition, once a health insurance consumer secures a health plan, the plan may not refuse to cover treatment for pre-existing conditions. *Exception*: grandfathered individual plans.
   - *Annual Limits* – For plans renewing on or after January 1, 2014, no yearly dollar limits on essential health benefits are permitted. However, it is important to note that insurance companies can still place a yearly dollar limit and a lifetime dollar maximum on spending for health care services that are not considered essential health benefits. *Exception*: grandfathered individual plans and some group health plans that have received a temporary waiver from the annual limit rules.
3. **Expanded Small Business Tax Credit** – The maximum amount of the health care tax credit for small businesses in 2014 has increased to 50%. To be eligible for this credit, the company must have less than 25 full-time equivalent employees (excluding owners), pay average annual wages of less than $50,000, pay for at least 50% of the cost of employee only health coverage, and purchase coverage in the SHOP Exchange.
4. **State Health Care Exchanges**
   - *Marketplace* – The State Exchanges (or "Marketplace") has opened and individuals can log in and shop for health insurance coverage from a variety of carriers. Additionally, individuals who earn an annual salary of up to 400% of the federal poverty level (approximately $46,000 for an individual and $94,000 for a family of four) may be eligible for a federal premium subsidy if the cost of their health care coverage in the Marketplace exceeds 9.5% of household income. Open enrollment in the Marketplace closes on March 31, 2014. Remember, if an employee opts out of the company-sponsored health plan in favor of securing coverage through the Marketplace, the employee will lose any employer contribution to the plan and will no longer enjoy pre-tax deductions for health insurance premiums through the company's Section 125 plan.
   - *Small Business Health Options Program (SHOP)* – The SHOP Exchanges are also open for small employers; however, the online shopping tool for small employers is not yet available in states that default to the federally-run Exchanges. At this time, the SHOPs in these states are only available through a health insurance broker, agent, or insurer. It is important to note that no business is required to use the SHOP Exchange, it is simply an option.
5. **State Medicaid Expansions –** The ACA intended to expand Medicaid for most low-income Americans earning up to 138% of the federal poverty level (approximately $16,000 for an individual or $32,500 for a family of four). However, a Supreme Court decision has left the decision whether to adopt this Medicaid expansion up to each state. Currently, 26 states and DC have opted to adopt this expansion.
6. **Individual Mandate** – The Individual Mandate is the requirement for all Americans to secure health insurance coverage or face a penalty. Americans will be subject to fines if they are not covered by health insurance for a period of three (3) or more months. Therefore, any uninsured individuals must secure coverage on or before March 31, 2014 in order to avoid the penalty. In 2014, the Individual Mandate penalty is $95 or 1% percent of taxable income, whichever is greater.
7. **Employer Mandate** – Requires large employers (those with 50+ full-time equivalent employees) to offer health insurance to all full-time employees working 30 hours or more per week or face a penalty. Although the Employer Mandate has been delayed until January 1, 2015, the look-back period for determining which employers are subject to the employer mandate encompasses the 2014 calendar year. Before the delay of the Employer Mandate, the IRS had issued transitional relief allowing the employer to use any consecutive six-month period in 2013 to assess whether the company would be categorized as a large or small employer and subject to the employer mandate in 2014. It is still unclear as to whether this transitional relief will apply in 2015. Thus, borderline employers must begin averaging their monthly full-time equivalent employees now.
8. **Non-Discrimination** – Prohibits the employer from offering more generous benefits or higher contributions to highly compensated individuals (HCIs). The IRS code defines a HCI as: (1) one of the five highest paid officers; (2) a shareholder who owns more than 10% of the employer stock; or (3) among the highest paid 25% of all employees. Some examples that may cause a plan to fail the non-discrimination testing requirements are offering a management carve-out health plan, a richer health plan for managers/owners, shorter health insurance eligibility waiting periods for managers/owners, and/or offering higher contributions to managers/owners than to other employees. This provision has been indefinitely delayed, and we are still awaiting detailed guidance from the IRS regarding the specific parameters of this rule.

Improving Your Biometric Screening Program

Biometric screening is a way to educate and motivate your employees to take charge of their health and, by doing so, effectively reduce your plan costs. Below are some tips to make your biometric screening program successful in its goals to have healthy employees and create the possibility for reduction in health care costs.

1) **Make it easy on the employees.** Schedule screenings at the employees' convenience. If fasting is required, schedule it during the morning and provide refreshments for them to enjoy afterwards. Aim to have around five people to one screener to limit wait times.

2) **Protect their privacy.** Consider scheduling the screenings in a space that allows for privacy, such as in small offices or private rooms. If none are available and larger rooms have to be used, create "visual privacy" by dividing the room into separate screening sections. Also, screeners should refrain from verbalizing any results aloud and, instead, point to the recorded results.

3) **Limit the number of stations.** If you have one screener for measurement-taking, another screener to draw blood, and another screener that provides coaching, it can make it feel like an assembly line. Decide if all can be accomplished in a one-stop screening station.

4) **Accommodate dispersed workers.** Some employers have workers in remote locations and must provide accommodations to those workers unable to attend on-site screenings. Ways to have their screenings and results accounted for are to provide the use of at-home self-collection kits, physician kits, or arrange screenings to be conducted at urgent care centers, so long as they can report the collected data.

5) **Select qualified screeners.** Get references, background information, experience, and success rate with previous programs for companies in similar industries or size.

6) **Cover all your bases.** Remember to select your vendor diligently. Check their:

- experience and references
- quality in staffing and service-level standard guarantees
- compliance with regulatory guidelines and laws
- competitive cost for the requested services
- geographic availability
- versatility in blood draw methods
- availability of desired tests
- support services made available to you for scheduling, reporting, and participant support

FMLA Violations Cause Employer to Pay Former Employee Back Wages

A Bradenton, Florida retail store paid a former employee $8,787 following an investigation by the U.S. Department of Labor's Wage and Hour Division that found the company violated the Family and Medical Leave Act. The Columbus, Ohio-based company terminated the worker's employment for absences from work that should have been protected as FMLA leave because the employee was taking time off to care for a seriously ill child.

The investigation found that the retailer failed to properly provide the employee with the required FMLA eligibility and designation notices. The firm then disciplined the employee by writing her up for tardiness and absences. It ultimately fired her for violating the company's attendance policy, although the time off met the qualifying criteria for FMLA.

The Wage and Hour Division is responsible for the administration and enforcement of a wide range of laws, which collectively cover virtually all private, state, and local government employment—over 135 million workers in more than 7.3 million establishments throughout the United States. Approximately 65% (4.7 million) of these private and public sector employers are subject to FMLA.

Source TASC

Are You Prepared for an ERISA Audit?

Department of Labor (DOL) audits are on the rise.

In each audit, the company is required to provide many documents including signed Plan documents, IRS Form 5500, adoption agreements, trust agreements, wrap documents, amendments to date, a Summary Plan Description, Summary Annual Reports, financial documents, medical loss ratio rebates, and more. Such an audit is stressful and time-consuming.

As 2014 progresses, we expect additional legislative requirements will come into play with both ERISA and ACA disclosure requirements. This means we can expect more and more audits with more and more information required from employers.

Medicare Members May Lose Prescription Cost Protection

The Obama administration is considering new legislation that would eliminate the current prescription cost protections in place for Medicare recipients. Presently, a federal guarantee limits the costs of drugs in three classes: antidepressants, antipsychotics, and immune suppressant drugs needed for organ transplant patients. Medicare representatives argue that these prescription protections are no longer needed to guarantee access to the drugs. Further, it is reported that the change could save $1.3 billion by 2019. These savings are significant considering Medicare's projected funding challenges.

Putting the prescription protections on the chopping block is not without its opponents, however. A number of advocacy groups worry that prices for poor and elderly patients will be drastically increased. The required drug regimen for organ transplant patients can cost as much as $2,000.00 a month, for example. In the absence of cost protections measures, these individuals will be forced to pay out of pocket. In addition, the range of drug options is likely to narrow considerably for these patients.

The Center for Medicare and Medicaid Services has responded to these claims by saying that the increasing availability of generic drugs will allow the current protections to be eased back safely. The agency also argues that it would be better able to combat fraud, waste, and abuse under the new legislation. Another problem they hope to address is the over prescription of antipsychotic drugs in nursing homes.

Lastly, while costs would be up for individuals requiring prescriptions in the affected three classes, the agency touts more wide-spread cost saving that will be felt by the majority of participants.

Clearly, there are many and varied views on the proposed legislation. The Obama Administration will be listening to public comments on the issue until March 7, 2014.

Dates To Remember …

February 14
Valentine's Day

February 17
President's Day

Be Aware of Upcoming 401(k) Deadlines

Now that we are heavy into 401(k) non-discrimination testing, there are a few upcoming deadlines that you should keep in mind to be sure that penalties and fees are avoided:

- March 15th – ADP/ACP Corrective Distributions for failed testing must be processed no later than March 15th to avoid a 10% penalty on the principal amount of the distribution.
- March 15th – Corporations must make their contributions unless the corporation has filed for an extension of time to file their tax return.
- April 15th – 402(g) corrective distributions for excess deferrals must be made by April 15th to avoid plan compliance issues.
- April 15th – Sole Proprietors and Partnerships must make their contributions unless they have filed for a time extension to file their tax return.

We hope that you find the information presented helpful, and we welcome any feedback.

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

Thank you!