Tikia Consulting Group, Inc.
Employee Benefits

Newsletter

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Recent healthcare rulings have addressed various controversial topics and ongoing sources of contention. In addition to remaining informed about continuing ACA developments, please note that the Insurance Exchange will be held from November 15, 2014 through February 15, 2015. You can use the Exchange to compare plans and healthcare costs.

In This Issue:

"There are no secrets to success. It is the result of preparation, hard work, and learning from failure."
- Colin Powell

Burwell v. Hobby Lobby

On June 30, 2014, the Supreme Court announced its 5-4 decision in *Burwell v. Hobby Lobby*, holding that closely-held, for-profit corporations ("Corporations") are protected by the Religious Freedom Restoration Act of 1993. Under the Supreme Court's reasoning, Corporations that sponsor non-grandfathered group health plans are not required to comply with the Affordable Care Act's mandate to offer FDA-approved contraception benefits with no cost sharing to women.

Under the exemption for religiously-affiliated nonprofits, the employer is not required to provide or pay for coverage, but employees can obtain separate contraceptive coverage by the insurer or, in the case of self-funded group health plans, the third party administrator.
To view the *Burwell v. Hobby Lobby* ruling in its entirety, please visit:
http://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf

Administration Developing Work-Around For Nonprofits To Ensure Contraception Coverage

The *Washington Post* reports that in a legal brief filed with the US Court of Appeals for the 10th Circuit in Denver, the Obama Administration said it is developing "a work-around to ensure that employees of certain charities, hospitals and colleges whose leaders have religious objections to contraceptives can still get birth control through their employee health insurance plans." The move comes "in response to a recent Supreme Court order questioning the government's current process for allowing nonprofit organizations to opt out of a requirement that their health plans cover all contraceptives that have been approved by the Food and Drug Administration."

The *AP* reports that Wheaton College, the Christian institution at the center of the Supreme Court decision in question, claims even filling out the Form 700, which "lets faith-affiliated groups transfer responsibility for paying for birth control to insurers or third-party administrators" and makes the group "complicit by forcing it to participate in a system that subsidizes coverage they oppose." It is unclear what form the opt-out will take so it remains to be seen if the alternative will be "any less objectionable."

The Administration's willingness to take up this issue is a departure from the opinion of the Justice Department, which according to The *Hill* had argued that "the college falls under the 'accommodation' category cited in the recent Hobby Lobby case which exempts it from directly paying for worker's contraception." As part of the accommodation, The Justice Department felt that the college "should be required to fill out the form so third-party insurers can use it to get tax credits."

Also reporting on this "work-around" are the *Wall Street Journal*, the *Los Angeles Times*, *Politico*, the *Huffington Post*, and *Reuters*.

Q: What if an employee works full-time (40 hours) two weeks of the month and only part-time (30 hours) other weeks of the month? Does the employer classify the employee as full-time or part-time status?

A: The response to this question partially depends upon the Summary Plan Description (SPD) for your organization's health insurance plan. For example, if the SPD defines full-time employment as working 35 or more hours per week and does not include a specific look back period for eligibility, an employee's status is generally based upon his or her average hours worked in a week over a period of four weeks. In this case, the best approach would be to classify the employee as a full-time employee and invite them to participate in the benefits plan, as the average weekly hours worked will be very close to the SPD minimum requirement.

When provisions of the Affordable Care Act (ACA) go into effect on January 1, 2015, affected large employers will be required to extend benefits to all employees who regularly work more than 29 hours in a workweek.

President Obama to Sign Executive Order Prohibiting Sexual Orientation and Gender Identity Discrimination by Federal Contractors

This week, the White House announced that the President will issue an executive order that will forbid federal government contracted companies from discriminating against employees based on sexual orientation or gender identity.

This executive order will add to the current state-specific patchwork of prohibitions on sexual orientation and gender identity discrimination in employment. Currently, twenty-one states and the District of Columbia prohibit discrimination based on sexual orientation, and eighteen states and the District of Columbia ban discrimination based on gender identity.

While similar federal legislation that would apply to all employers (not just those with federal contracts) has been passed in the U.S. Senate, it has stalled in the U.S. House of Representatives. Administration officials state that the President decided to act unilaterally in the absence of Congressional action.

The exact details of this executive order, including whether there will be exemptions for certain religious organizations, have not yet been finalized, and no date for finalization or signature has been announced.

IRS Reiterates Prohibition of and Penalty for Pre-Tax Employer Reimbursement for Health Premiums

Recently, the IRS issued a Frequently Asked Questions (FAQ) list that reiterates earlier guidance disallowing pre-tax employer reimbursements for employee health care premiums. The FAQ also calls attention to the $100 per day, per employee penalty for non-compliance.

The initial guidance from last fall indicated that pre-tax employer reimbursements for healthcare premiums would be categorized as group health plans and, thus, would not be permissible as they would not comply with the requirements for group health plans under the Affordable Care Act. Since that time, however, many people have attempted to find alternate solutions in order to continue the practice of reimbursing employee premiums in lieu of providing a full health plan.

This latest FAQ and penalty announcement clarifies that the IRS is serious about disallowing this arrangement. We recommend that employers who still utilize a pre-tax health care premium reimbursement benefit discontinue this practice. Any advice that employers have received suggesting these benefits are still allowed, should be carefully reexamined in light of this most recent guidance and penalty reminder.

HHS Stays Silent On ACA Data, States More Transparent

In a piece titled "Tale Of Two Obamacares: States Open With Info, Feds Not Much," CNBC reports that almost four months after the close of ACA's first open enrollment, "the federal government remains mum on several key questions about that online marketplace," and "in sharp contrast to HealthCare.gov, the 15 health insurance exchanges run by individual states and the District of Columbia are, as a group, much more forthcoming with answers when asked those same kinds of questions."

CNBC details questions that HHS would not answer, and "in an email response to CNBC, HHS spokesman Aaron Albright suggested that all of the information requested would be disclosed in the future, but he would not specify a date." Albright said, "HHS issued monthly enrollment reports during the first marketplace open enrollment period in order to provide the best understanding of enrollment activities as it was taking place. Now that this time period has ended, we are looking at future opportunities to share information about the marketplace that is reliable and accurate."

The Daily Caller reports that "ten of 15 state exchanges CNBC surveyed have released at least once how many people paid their first month's premiums," while the Obama Administration "has held that it doesn't have the ability to get that kind of information." Meanwhile, "eleven state-run exchanges have either regularly released numbers on special enrollment outside of the open enrollment period, or provided the information when asked; and 12 states have made their 2015 premium rate proposals from insurance companies public."

Did You Know?

Studies Show Uninsured Rates Are Falling

Three new surveys found that the United States has a substantial number of newly insured adults. They show that the number of Americans with access to health coverage is growing significantly.

The first survey was the monthly tracking survey by the Commonwealth Fund. This survey showed that the uninsured rate among working-age Americans dropped from 20% at the end of last summer to 15% at the end of this spring. It found that 78% of self-identified Republicans who had gotten covered were somewhat to very optimistic that it would improve their ability to get needed healthcare. By their count, there are 9.5 million newly insured Americans.

Meanwhile, the Urban Institute estimated that 8 million Americans have gained coverage since September.

The Gallup-Healthways Well-Being index says that only 13.4% of American adults claimed to be uninsured in the second quarter of 2014. This is the lowest number since Gallup started tracking the uninsured rate in 2008, and a drop from 17.1% at the end of 2013.

At a Glance: HMO, PPO, EPO, POS

With the myriad of plan options in the healthcare world, choosing the right health plan can often be a confusing and daunting task. Generally, the basics to look for when evaluating a plan include whether the plan requires a primary care physician (PCP) gatekeeper (such as in an HMO), what the out of network coverages are, as well as whether out of network spending is applied towards your out of pocket maximum. HMOs and PPOs are among the most popular plans, with POS plans being a hybrid of the two, and EPOs being the most unclear amongst healthcare consumers. The list below provides some general information about these four types of plans.

Health Maintenance Organizations (HMOs): Provide both patient care as well as financing, and offer services to members living within a specified geographic area. Certain physicians provide care at a prenegotiated price, and members of these plans receive hospital as well as physician services. While members are free to choose their PCP, when seeing a specialist, the PCP acts as a "gatekeeper" and refers the patient to a specialist of their choice.

Preferred Provider Organizations (PPOs): Members in a PPO are free to choose any physician they like; however, benefits are richer when utilizing physicians within the preferred network. Physicians in the PPO network practice on a fee for service basis, versus the HMO prepaid basis.

Exclusive Provider Organization (EPOs): EPOs use an exclusive network of providers; that is, if a member accesses a provider outside of that network, no benefits will be paid. However, using a gatekeeper is not required to see a specialist.

Point of Service Plan (POS): Cost sharing is generally higher with Point of Service plans. Though gatekeepers may be involved in a POS, any time a medical need arises, members are free to choose their physician and facility, whether they are in network or out of network. Out of network benefits, however, may be reduced.

Medicare Section 111 Reporting - Medicare Part D Notices

The Medicare Modernization Act (MMA) requires entities (whose policies include prescription drug coverage) to notify Medicare eligible policyholders whether or whether not their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. For these entities, there are two disclosure requirements:

1. The first disclosure requirement is to provide a written disclosure notice to all Medicare eligible individuals who are covered under its prescription drug plan, prior to October 15th every year and at various times as stated in the regulations, including to a Medicare eligible individual when he/she joins the plan. This disclosure must be provided to Medicare eligible active working individuals and their dependents, Medicare eligible COBRA individuals and their dependents, Medicare eligible disabled individuals covered under your prescription drug plan and any retirees and their dependents. The MMA imposes a late enrollment penalty on individuals who do not maintain creditable coverage for a period of 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit. Accordingly, this information is essential to an individual's decision whether or not to enroll in a Medicare Part D prescription drug plan. For more information go to the "Creditable Coverage Guidance and Model Disclosure Notices to be used after January 1, 2009" Section on the left hand side of this page.
2. The second disclosure requirement is for entities to complete the Online Disclosure to CMS Form to report the creditable coverage status of their prescription drug plan. The Disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status. For more information go to the "Disclosure to CMS Form" Section on the left hand side of this page. -- This requirement does not pertain to the Medicare beneficiaries for whom entities are receiving the Retiree Drug Subsidy (RDS).

CMS.gov provides guidance documents relating to Creditable Coverage requirements for employer and union-sponsored plans and model notice documents.

Source: cms.gov

USPSTF Recommends New Preventive Service for High Risk Women

New recommendations by the United States Preventive Services Task Force ("USPSTF") regarding medications for risk reduction of primary breast cancer in women have recently been released. For nongrandfathered plans that begin on or after September 24, 2014, these preventive services are to be covered by at 100%.

For women with an increased risk for breast cancer, clinicians are advised to share information about medications to reduce their risk, thereby ensuring informed decisions. Another advisory is for clinicians to offer to prescribe risk reducing medications (e.g. raloxifene, tamoxifen) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

Upcoming Dates To Remember ...

October 13
Columbus Day

October 15
Medicare Part D Notice Deadline

October 31
Halloween

November 11
Veterans Day

November 15
Health Insurance Marketplace 2015 Open Enrollment Begins

Planning For Retirement

As we know, saving for retirement is essential. In the current economic times, it is difficult to save for something so many of us see as an event in the very distant future. We think, "There's always tomorrow, next month, or even next year to begin saving."

A 401(k) is an employer-sponsored plan and is an easy way to begin working toward a comfortable retirement. Another common option is an individual retirement account (IRA): which can be opened through a financial institution, including banks.

The best way to start saving is to set up an automatic deposit into whichever retirement account vehicle you prefer. If you participate in your employer's 401(k) plan or choose an IRA, you can start your contributions on a budget friendly, small scale. You may increase your contributions over time as you receive salary increases, pay off existing balances, etc. because every little bit helps towards your goals.

If you want to live comfortably in your golden years, you need to start planning now. Here are some hints to help you avoid common mistakes:

- ❖ If you are not saving right now—start! Even a little now is worth much more in the future. Your contributions, if invested wisely, will grow simply by compounding interest.
- ❖ Know how much you need to retire. There are various websites that can be used to estimate how much you should plan on needing at retirement. Depending on age and other demographics, it could be as much as $2 million.
- ❖ Do not take a withdrawal from your retirement account—you will be hit with penalties, fees and taxes.
- ❖ Be diligent in following fees that are being charged for your retirement account. Ignoring high fees will definitely hurt your account in the future.
- ❖ Make sure you take advantage of an employer match 401(k) plan—if your employer offers to match a portion of your 401(k) contributions, save enough to get that match.

Take a Deep Breath. Repeat.

Most people take around 17,000 breaths a day, but few ever think about it. That is because most breathing is controlled by the brainstem and involuntary.

With some basic training, shallow chest breaths can be replaced with deep abdominal breathing to improve sleep, posture, stress tension, and mental clarity.

Use this technique daily to increase energy and manage stress:

- Sit comfortably in a chair with feet on the floor;
- Place one hand on your chest and the other on your abdomen;
- Slowly inhale through your nose, holding your breath for a count of seven, then exhale through your mouth for a count of eight.
- The hand on your abdomen should rise higher than the hand on your chest to ensure your diaphragm is filling the lungs with air.
- Repeat this process for a total of 5 deep breathing cycles.

Source: Sterling

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!