Benefit Bullets

Jennifer Geesey | Central Penn Benefits | 717-718-5687 | jgeesey@centralpennbenefits.com

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Health Care Reform

Growing Marketplace Awareness But Poor User Experiences

A recent survey conducted by the Commonwealth Fund indicates sixty percent of Americans are now aware of the newly established Health Insurance Marketplace, up significantly from a survey conducted earlier this year by the Commonwealth Fund. However, according to the survey conducted between October 9th and 27th, only seventeen percent of eligible enrollees visited the health insurance marketplaces. Even worse, only twenty one percent of those visitors actually enrolled in a health plan. This is no surprise as the marketplace websites have been inoperable for many since the October 1st opening.

Those individuals who gained access to the Marketplace found it difficult to shop and identify an appropriate plan. Seventy percent of users indicated a fair or poor experience while over half of users found it impossible, very difficult, or somewhat difficult to compare benefits and costs of plans offered. Not all Americans have given up hope yet as the survey indicates fifty eight percent of individuals potentially eligible, that is those currently without insurance or enrolled in an individual plan today, will likely try to enroll by the close of open enrollment period on March 31, 2014. “The initial rollout of the Health Insurance Marketplace has been challenging, but as the website problems are addressed we expect people’s experiences to improve” said David Blumenthal, President of the Commonwealth Fund.

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Narrow Networks A Hit in Health Insurance Marketplaces

A new trend is emerging within the public health insurance marketplaces, known as narrow network health plans. These plans limit the number of providers a plan participant may receive services from and were initially designed as a means to minimize premiums within the health insurance marketplaces. A recent survey conducted by Booz & Co. found that in addition to lower costs consumers prefer a narrow network of high-quality providers opposed to the broad network plans that's dominated the market in recent years. The results of the 20,000 consumer survey found that consumers are more interested in a quality hospital network rather than having a primary care physician as more and more individual are beginning to utilize retail clinics for primary care. Additionally, some consumers are willing to bypass upper-tier hospitals and health systems. Contrary to popular belief that a larger network is better, many consumers are starting to find comfort in knowing that future services will be provided by a hospital or health system they are familiar with. Researchers at Booz & Co. believe that as these plans gain traction with the marketplaces, there is the potential for network innovation and redesign both in and out of the public health insurance marketplaces.

Grace Period Granted For Late Enrollees

The individual mandate provision of the health care reform law is scheduled to take effect January 1, 2014 requiring all citizens to obtain health insurance or face a tax penalty. Public health insurance marketplaces have been established to provide citizens with an alternative method of obtaining health insurance or, for the current uninsured, a means of obtaining health insurance coverage. The health insurance marketplaces allow individuals to enroll between October 1, 2013 and March 31, 2014 however the law requires penalties be enforced beginning January 1, 2014 for those who do not have coverage for greater than a 3 month period of time. As a result of the fifteen day application processing time and coverage only becoming effective on the first of a month, one would have to enroll by February 14 th 2014 with an effective date of March 1st to avoid the individual mandate penalty.

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On October 23rd the Obama administration addressed this issue by relieving any individual who purchases health insurance within the health insurance marketplaces prior to the March 31st deadline of any penalties. The Obama administration states it would be unfair to penalize individuals that purchase health insurance after mid-February and will allow a one-time hardship exemption for those who obtain coverage on or before March 31st. Additionally, the Obama administrations notes that this grace period is not related to the recent problems users are experiencing with the marketplace websites but as a resolution to the timing confusion associated with the health care reform law.

Compliance Corner

Feds loosen 'use-it-or-lose-it' rule on health accounts

The Treasury Department is changing the rules on flexible health spending accounts to allow taxpayers to carry over $500 at the end of the year. The new Internal Revenue Service rule ends the 30-year-old use-it-or-lose-it policy, which forced taxpayers to forfeit whatever unspent amount they had set aside for medical expenses at the end of the year.

Treasury Secretary Jacob Lew called the rule change "a step forward for hardworking Americans who wisely plan for health care expenses for the coming year." Flexible Spending Accounts are employer-sponsored accounts that allow employees to pay for out-of-pocket health expenses before taxes -- expenses like copays, deductibles, prescriptions and eyeglasses. But under a 30-year-old tax rule, employees lose whatever money they didn't spend by the end of the year. The employer gets to keep that money.

"Historically that has been a road block to getting more folks to take advantage of a flexible spending account to pay for their health expenses," said Tom Torre, CEO of Alegeus Technologies, a benefits administration company that helps companies run the accounts. "We just think it makes a lot of sense."

An estimated 14 million American families use the accounts, though only about 20 percent of those whose employers provide the benefit take advantage of it, according to Alegeus. Estimating out-of-pocket expenses a year ahead of time can be a hassle for taxpayers. The IRS formerly allowed taxpayers to go on an end-of-year spend-down by stocking up on aspirin, bandages and other over-the-counter medications.

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But the Affordable Care Act disqualified any purchase that didn't have a doctor's prescription, and limited the annual contribution to $2,500.

It's still up to employers to decide whether to allow a carryover. Some employers could begin allowing a carryover as early as this year. Many employers already allow a grace period at the end of the year to give employees more time to spend down their accounts, but the Treasury Department said an employer cannot allow both a carryover and a grace period.

Source for Compliance Corner - Gregory Korte, USA TODAY

New CHIP Notice Released

Employers are required to distribute annually the government provided CHIP notice. A revised model notice has been released and employers my want to use the new notice for any new hire distribution. Employers are not required to redistribute the new notice if they have already met the annual distribution requirement. The new notice is available here www.dol.gov/ebsa/chipmodelnotice.doc?

Product Spotlight

Hospital Confinement Insurance

The average cost of a one day inpatient hospital stay is over $1,800.*

Hospital Confinement Insurance is designed to provide benefits that supplement existing major medical or comprehensive health insurance plans. These additional benefits help cover out-of-pocket expenses related to coinsurance, co-pays and deductibles for inpatient and outpatient services.

Employers today are faced with the dilemma of how to contain rising health care costs while continuing to offer affordable coverage to their employees. Many are looking to higher deductibles and co-pays as a way to manage plan expenses, but are concerned about the additional financial burden on their employees. Hospital Confinement Insurance plans can help employees adjust to a change in the health plan.

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Covered services typically include: inpatient hospital stays, inpatient surgeries, physician's in-hospital charges, emergency room treatment, outpatient treatment including surgeries and diagnostic exams.

Hospital Confinement Insurance can help employees reduce out-of-pocket expenses and the financial impact related to a surgery or hospital stay.

*Kaiser State Health Facts for 2009; Health Costs & Budgets

*Discover*Health ®

Pre-Diabetes: Are you at Risk?

Type 2 diabetes can start at any age. It can put you at risk for a number of health issues such as kidney disease, vision problems, heart disease and stroke. But, it can be managed. And, research has found it's almost always preceded by a condition called pre-diabetes.

In pre-diabetes, blood glucose levels are higher than normal, but not quite high enough for a diabetes diagnosis. There is good news. If pre-diabetes is detected early enough, you can take steps to prevent or delay the start of Type 2 diabetes.

Who Gets Pre-Diabetes?

There are factors that may put some people at a greater risk for pre-diabetes. These include being age 45 or older, having a family history of diabetes, having undesirable cholesterol levels or high blood pressure or being overweight or inactive. Some ethnic groups seem to have an increased risk, as well. But, anyone can develop pre-diabetes. Your doctor can help judge your risk.

How is it Diagnosed?

There are two different tests that doctors commonly use to diagnose pre-diabetes. Both normally need to have you fast—or not eat—for a period of time. Then, your doctor will check your glucose levels either before you eat or after you drink a sugary substance on an empty stomach.

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What Can You Do?

Being diagnosed with pre-diabetes gives you the chance to take action now to help delay or prevent Type 2 diabetes. Many people can get great results through lifestyle changes. If you've been diagnosed with pre-diabetes, your doctor may suggest the following:

- **Exercise.** Staying active is a great way to prevent diabetes. Just 30 minutes a day of moderate physical activity can make a difference. Work with your doctor to create a healthy exercise program for you.
- **Weight loss.** If needed, losing five percent to 10 percent of your body weight may help. Your doctor can work with you to set a realistic weight loss goal. You also can ask your doctor for tips on how to reach and stay at your target weight.
- **Regular screenings.** Routine blood sugar testing allows your doctor to monitor your diabetes risk. If the condition does develop, you'll have the benefit of early detection.

Should You Be Tested for Diabetes?

Nearly three out of 10 people who have diabetes don't even know they have the disease. Find out if you should get tested.

Diabetes is the sixth leading cause of death in the U.S. It is also the leading cause of blindness, kidney failure and lower limb amputations in adults. Having diabetes raises your risk for heart disease, stroke, nerve damage and gum disease.

About 24 million people in the U.S. have diabetes. One fourth of them don't know they have the disease. And 57 million more people have pre-diabetes. Studies show that many people with pre-diabetes will develop type 2 diabetes within the next 10 years.

The message is clear: diabetes is a dangerous disease that affects a lot of people. And, you can have diabetes or pre-diabetes and not know it.

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Risk factors for diabetes

You are at an increased risk for type 2 diabetes if you:

- Are overweight
- Are not physically active
- Have a family history of diabetes
- Are African-American, Hispanic, American-Indian or Pacific Islander
- Are older than 45
- Have high blood pressure or high cholesterol
- Have a history of heart disease or stroke
- Had abnormal results on a previous diabetes test
- Had gestational diabetes (diabetes during pregnancy)
- Gave birth to a baby who weighed 9 pounds or more
- Have another condition that affects how your body uses insulin, such as polycystic ovarian syndrome (PCOS)

Who should get tested?

- If you are 45 years of age or older.
- If you are younger than 45, overweight and have one of the above risk factors - such as a family history of the disease - get tested now.
- If results come back normal, you should get tested for diabetes again once every three years. Your doctor may suggest more frequent screening if you have certain risk factors.
- Children who are overweight and have other risk factors for diabetes are at high risk for diabetes. They should be tested every two years starting at age 10 or at the onset of puberty, whichever comes first.

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Question of the Month:

Question: An employer is located in a State that does not recognize same sex marriage and the employer does not currently offer coverage for same sex spouses. If the employer has an employee who is legally married in another state to a same-sex spouse, does the employer have to allow the same sex spouse coverage under their self-funded medical insurance plan?

Answer: No direct guidance has been received on this question. However, it is our attorney's position that nothing in the Windsor decision or the IRS or DOL guidance released to date would require the self-insured employer to offer benefits to the same-sex spouse. The plan, however, must be reviewed to determine whether it provides for the benefit. A plan that simply says that "spouse" is covered without defining the spouse, may lead to an argument that if it is not defined, then it is defined under federal law, which would track back to the state of celebration rule taken by the government after the Windsor decision (i.e., coverage would be offered). The plan might specifically say that "spouse is defined under federal law." Again, current guidance would lead to coverage being available. In either case, the employer would have to amend the plan to state specifically that same-sex spouses are not covered, regardless of state of ceremony. Any employer considering this should speak directly with competent ERISA counsel who will advise them of the risks of litigation, either under ERISA (section 510, to the extent applicable) or under state (or even federal law). Sometimes just offering a benefit is easier and cheaper than getting sued, even if the merits of the suit are not necessarily rock solid under applicable law.

Source for Question of the Month: Benefit Advisors Network

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