Insurance Specialists Newsletter

INSURANCE SPECIALISTS

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New Tax to Become Effective for All Health Plans

The healthcare law imposes an additional tax on all group health plans to fund a new organization named the Patient-Centered Outcomes Research Institute. Although the Treasury Department has not yet provided guidance regarding the timing and manner of payment of this tax, this information is available at this time:

- The amount payable will be based on the average number of lives covered under the plan and will be effective for plan years ending after September 30, 2012.
- The fee will not apply to plan years ending after September 30, 2019.
- Fees would be assessed based on the average number of covered lives under the plan.
- Fees will be treated as taxes.
- According to IRS Notice 2011-35:
  - ⇒ Proposed regulations could require the plan sponsor to report and pay the fees annually as opposed to quarterly.
  - ⇒ Proposed regulations might also require the reporting and payments to occur on the same calendar date regardless of the plan year.
- The initial annual fee is $1.00 per covered life. It increases to $2.00 after October 1, 2013. For plan years beginning after September 30, 2014, it will be based on an amount indexed to national health expenditures until 2019, when it phases out.

To review the IRS notice 2011-35, go to: http://www.irs.gov/pub/irs-drop/n-11-35pdf

MLR Rebates Tax-Free Under New CMS Rule

Consumers won't have to pay taxes on rebates they receive when health insurers exceed medical loss ratio (MLR) standards governing the percentage of premium revenue they must spend on medical care and improvement activities, under interim final regulations issued by the Centers for Medicare and Medicaid Services (CMS).

The regulations also propose that insurers will have to send notices to consumers showing not just the amount of any rebate but also what the medical loss ratio, or MLR, means and how it has improved under the health care law. And the regulations remind insurers that they can't exclude broker and agents fees when adding up administrative expenses.

The final MLR regulations took effect at the start of 2011. But the recent announcement addressed such previously unresolved issues as the way insurers report MLRs and the mechanism for distributing rebates. It also disclosed progressively tougher MLR standards for so-called mini-med plans, which offer very limited benefits—typically to low-wage workers—and for "expatriate" health plans sold to Americans living abroad.

The news release announcing the changes quotes Marilyn Tavenner for the first time in her new position as acting CMS administrator. "If your insurance company doesn't spend enough of your premium dollars on medical care or quality improvement this year, they'll have to give you rebates next year," Tavenner said.

According to the CMS, early estimates were that starting in 2012 up to 9 million Americans could get rebates totaling $600 million to $1.4 billion. But "early reports suggest insurers

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Agencies Delay Deadline for Health Benefit Summaries

The U.S. Departments of Labor, Treasury and Health and Human Services—the federal agencies responsible for implementing the Patient Protection and Affordable Care Act (PPACA) - announced via an online frequently asked questions response that they will not require sponsors of group health plans to comply with the requirement to create and distribute to employees a standardized "summary of benefits and coverage" (SBC) and uniform glossary by March 23, 2012, as they had originally proposed.

The agencies said that compliance with the SBC requirement will not be required until the agencies publish a final rule with a new applicability date providing sufficient time for group health plans to comply.

Background

The PPACA amended the Public Health Services Act (PHS Act), adding section 2715 to require health insurers and group health plans to provide consumers with "clear, consistent and comparable information" about their health plan benefits and coverage. On August 22, 2011, the departments issued a proposed rule and template in connection with implementation of the SBC and uniform glossary requirements. An applicability date "beginning March 23, 2012" was proposed. At the same time, the departments invited comments on a range of issues, including the timing of the application of the SBC requirement.

The departments received many critical comments on the proposed regulations and template. The departments said they intend to issue, "as soon as possible, a final rule that takes into account these comments and other stakeholder feedback."

"Many plan sponsors expressed concern that the SBC was not appropriate for self-insured group health plans," according to a Sibson Consulting alert on the department's announcement. "Plan sponsors requested revisions to the form or a customized version for self-insured plans. Sponsors also commented that the SBC effective date should be delayed until some period of time after the final rules are published," the alert said.

According to the departments' announcement, **"until final regulations are issued and applicable, plans and issuers are not required to comply with PHS Act section 2715."** The announcement added, "It is anticipated that the departments' final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply."
Source: SHRM

Compliance Corner

Q. We are cleaning out our files for the new year. How long should we keep employee-benefits-related forms, claims, bills and booklets?

A. ERISA provides guidelines for certain record retention requirements for plan sponsors and employers. ERISA §§ 107 & 209 impose the time frames that must be maintained for employee benefits plan records. In the event an employer or sponsor is unable to furnish such records during that time frame, applicable fines and penalties may be levied. ERISA has conveniently determined that an electronic copy of a form is as good as a paper one as long as certain requirements are met. The electronic recordkeeping system must maintain the integrity of the original document, be properly backed up, and be able to print legible copies.

Generally, ERISA requires that plan records must be kept "for a period of not less than six years after the filing date of the document. "Since the Form 5500 is not due until seven months after the end of the plan year and many plans file a 2 1/2 month extension, it is generally recommended that such records be kept for eight years. Records that fall in this category include: plan documents; summary plan descriptions; certificates of coverage; Form 5500s; COBRA notices; claim approvals, denials and appeals; election materials, forms and changes; participant contributions; and administrative expenses. Records regarding selection, monitoring correspondence and contracts of service providers, as well as most HIPAA-related documents, must be maintained for a period of at least six years.

Additionally, IRC § 6039D presents different record retention time frames, as it mostly affects records relating to eligibility rules, discrimination testing and election records for cafeteria plan components, such as dependent care FSAs and HSAs. These records must be maintained for at least five years. Cafeteria plan components that are subject to ERISA, such as health plans or health FSAs, would continue to follow the eight-year retention use.

Finally, some states may have longer retention periods, not included within the time frames above, which may require longer retention periods of plan-related documents and enrollment materials.

Source: National Financial Partners

The Smokers' Surcharge

More and more employers are demanding that workers who smoke, are overweight or have high cholesterol shoulder a greater share of their healthcare costs, a shift toward penalizing employees with unhealthy lifestyles rather than rewarding good habits.

Policies that impose financial penalties on employees have doubled in the last two years to 19% of 248 major American employers with at least 1,000 workers—was expected to double again.

In addition, another survey released by Mercer, which advises companies, showed that about a third of employers with 500 or more workers were trying to coax them into wellness programs by offering financial incentives, like discounts on their insurance. So far, companies including **Home Depot, PepsiCo, Safeway, Lowe's and General Mills** have defended decisions to seek higher premiums from some workers, like Wal-Mart's recent addition of a $2,000-a-year surcharge for some smokers. Many point to the higher health care costs associated with smoking or obesity. Some even describe the charges and discounts as a "more stick, less carrot" approach to get workers to take more responsibility for their well-being. No matter the characterizations, it means that smokers and others pay more than co-workers who meet a company's health goals.

But some benefits specialists and health experts say programs billed as incentives for wellness, by offering discounted health insurance, can become punitive for people who suffer from health problems that are not completely under their control. Nicotine addiction, for example, may impede smokers from quitting, and severe obesity may not be easily overcome.

Earlier this year, the American Cancer Society and the American Heart Association were among groups that warned federal officials about giving companies too much latitude. They argued in a letter sent in March that the leeway afforded employers could provide "a back door" to policies that discriminate against unhealthy workers.

And the only way for Wal-Mart employees to avoid the surcharges was to attest that their doctor said it would be medically inadvisable or impossible to quit smoking. Other employers accept enrollment in tobacco cessation programs as an automatic waiver for surcharges.

"This is another example of where it's not trying to create healthier options for people," said Dan Schlademan, Director of Making Change at Wal-Mart, a union-backed campaign that is sharply critical of the company's benefits. "It looks a lot more like cost-shifting."

Wal-Mart declined to make an official available for an interview and provided limited answers to questions through an e-mail response. "**The increase in premiums in tobacco users is directly related to the fact that tobacco users generally consume about 25% more health care services than non-tobacco users,"** said Greg Rossiter, a company spokesman.

Wal-Mart requires an employee to have stopped smoking to qualify for lower premiums. <u>The company, which has more than one million employees, started offering an anti-smoking program this year, and says more than 13,000 workers have enrolled.</u>

Some labor experts contend that employers can charge workers higher fees only if they are tied to a broader wellness program, although federal rules do not define wellness programs.

Employers cannot discriminate against smokers by asking them to pay more for their insurance unless the surcharge is part of a broader effort to help them quit, said Karen L. Handorf, a lawyer who specializes in employee benefits for Cohen Milstein Sellers & Toll in Washington.

Many programs that ask employees to meet certain health targets offer rewards in the form of lower premiums. At Indiana University, a large health system, employees who do not smoke and achieve a certain B.M.I., can receive up to $720 a year off the cost of their insurance. "It's all about the results," said Sheriee Ladd, a senior VP in HR at the system.

Initially the system also rewarded employees who met cholesterol and blood glucose goals, but after workers complained that those hurdles seemed punitive, Indiana shifted its emphasis a bit.

Workers who do not meet the weight targets can be eligible for lower premiums if a doctor indicates they have a medical condition that makes the goal unreasonable, Ms. Ladd said. <u>"There are not many of those who come forward, but it's available,"</u> she said, adding that workers must be nonsmoking to get the other discount. About 65% of roughly 16,000 workers receive a discount.

Wal-Mart's decision to start charging smokers more for insurance came abruptly, according to some employees who say they had no chance to quit or consult a doctor. Jerome Allen, who works for Wal-Mart in Texas, says he realized he was paying $40 a month more as a smoking surcharge only when he saw a printout of his insurance coverage.

"Forty dollars is a lot of money," said Mr. Allen, 63, who works part time. He says he has now quit smoking.

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Smoker Surcharge Cont'd from Page 3

Wal-Mart says it mailed information about benefits changes weeks in advance .

Under Wal-Mart's programs, employees who want to enroll in some of the company's more generous plans, which offer lower deductibles and out-of-pocket maximums, can pay as much as $178 a month, or more than $2,000, a year more if they smoke.

Many other companies charge smokers a smaller, flat amount, and have kept any financial penalties under the 20 percent threshold set by the federal rules, according to benefits experts.

Target, a Wal-Mart competitor, does not charge smokers more for insurance, while Home Depot charges a smoker $20 a month. PepsiCo requires smokers to pay $600 a year more than nonsmokers unless they complete an anti-smoking program.

Some critics say Wal-Mart's surcharge may have the effect of forcing people to opt for less expensive plans or persuade them to drop coverage altogether. Dr. Kevin Volpp, the director of the Center for Health Incentives and Behavioral Economics at the Leonard Davis Institute at the University of Pennsylvania, pointed out that surcharges and stringent health targets might wind up endangering those whose health was already at high risk. "There is this potentially very significant set of unintended consequences", he said.

Source: The New York Times

MLR Rebates Cont'd from Page 1

lowered premium growth rather than face the prospect of providing rebates—a win-win for consumers," the CMS news release said. **Rebates under the MLR will be paid for the first time in 2012 and must be paid by August of next year.**

Insurers must pay any rebate they owe to the group policyholder, which is usually the employer. The employer would keep part of the rebate and would have different options for distributing the rest to employees

If the insurer owed the policy holder–say an employer– a rebate of $20, 000 for example, and the employees paid 40% of premium costs, they would get 40% of the rebate, or $8,000. The employer could pay the $8,000 by lowering premiums by that amount the following year or by paying a cash refund to workers.

Rebates paid in 2012 will go to plan enrollees that year, not to enrollees in 2011, even though the data on medical and administrative outlays used to determine MLRs is from 2011. "We believe that this results in administrative simplicity, as it does not require tracking former enrollees," CMS says in the rule.

The MLR standards require that individual and small group plans pay out at least 80 percent of premium revenue for medical care or quality improvement and not more than 20% for administrative costs (including profits). In the case of large groups, the MLR standard is 85%.

MLRs are calculated by dividing a numerator—total medical and quality improvement expenses—by a denominator—total premium revenues. In the case of mini-med plans and "expatriate" plans sold to Americans living abroad, CMS has permitted sponsors to have a far lower total of medical and quality improvement expenses, which recognizes the heavy administrative costs involved in offering the plans.

But those standards will get tougher. For 2011, CMS is allowing a multiplier of two for the numerator in order to meet the MLR standard (thus if combined medical and quality improvement expenses of a mini-med plan totaled 40 percent of the premium dollar and the MLR requirement is 80 percent, the plan would meet the requirement, because it could multiply the 40 percent by two).

In the case of mini-med plans, the multiplier will drop to 1.75 in 2012, 1.5 in 2013, and 1.25 for 2014. "In 2014, the use of annual dollar limits on coverage will be banned and we expect that these mini-med policies will cease to exist," a CMS fact sheet says. In the case of expatriate policies, the 2.0 multiplier will continue.

CMS said that mini-med MLRs will be posted publicly in the spring of 2012 "to further enhance transparency to consumers." The MLR requirements also allow insurers to consider certain costs involved in converting to the ICD-10 billing system as quality improvement expenses and to deduct certain taxes from total premium revenues.

The National Association of Insurance and Financial Advisers (NAIFA), a group representing insurance agents, expressed disappointment that the latest MLR regulations do not permit insurers to exclude agent and broker fees for administrative expenses. The National Association of Insurance Commissioners (NAIC) adopted a resolution last week urging Congress to quickly consider legislation that would ensure consumer access to broker services. "NAIFA is disappointed that the administration rejected the NAIC recommendation to take action that would ensure continued consumer access to professional health insurance agents in its Final MLR rule," said NAIFA President Robert Miller.

Source:

The Commonwealth Fund