Employee Benefits Report

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Dental Benefits and the Affordable Care Act

Of the 45 percent of employees who had access to a dental benefit plan through their employer, 78 percent participated, making dental benefits a very popular offering. Will the Affordable Care Act change all that?

The vast majority of Americans with dental insurance (98 percent) have coverage through a standalone dental plan, or a plan sold separately from medical coverage. Whether written on a group or individual basis, the Affordable Care Act (ACA) does not apply to this type of "excepted health plan."

Although the ACA might not apply to your employee dental plan, it could affect dental benefits under your group health plan.

The ACA and Dental Benefits

Starting in 2014, all health plans offered on the individual and small group markets must offer a comprehensive package of items and services known as essential health benefits (EHB). These EHBs must include pediatric oral care.

This means medical plans for small groups and individuals, whether sold on an exchange or not, must include benefits for

oral health risk assessments and screenings and treatment for dental cavities (caries) with no cost-sharing. Medical plans do not have to cover these services for adults.

In November 2012, the U.S. Department of Health and Human Services (HHS) provided states with two benchmarking options for supplementing

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This Just In…

The Affordable Care Act (ACA) contains a provision that protects whistleblowers, Section 1558. Section 1558 prohibits private and public sector employers from retaliating against employees who receive a federal health insurance income tax credit or a cost-sharing reduction when enrolling in a qualified health plan or who provide information relating to violations of Title 1 of the ACA.

Title I includes a range of insurance company accountability requirements, such as the prohibition of lifetime limits on coverage or exclusions due to pre-existing conditions. Title I also includes the "financial responsibility" requirements that apply to employers with 50 or more full-time employees.

An employer may be found to have violated Section 1558 if the

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coverage in plans that do not include coverage for pediatric dental benefits. The first option is to add benefits included in the FEDVIP (Federal Employees Dental and Vision Insurance Program) dental plan with the highest national enrollment. The second option is to supplement with the benefits available under that state's CHIP program of health benefits for low-income children, if applicable.

The problem with this approach is that these plans provide "richer" benefits than the typical small group dental plan. The National Association of Dental Plans (NADP) estimates the cost of covering a child under a small group dental plan at about $21 per child per month without orthodontia benefits, and at about $23.80 per month with orthodontia benefits at 50 percent coinsurance (the insured pays half and the insurer pays half of covered charges). This compares to a monthly cost of $27.90 for benefits under the FEDVIP plan or $32.05 per month under the CHIP standard.

Evelyn Ireland, NADP's executive director, told *Medscape Medical News* (November 29, 2012) that the price difference due to benefits required by the ACA could cause about half of the adults who pay toward dental benefits through small employer plans to drop their own coverage , since their children will have dental benefits through the group medical plan. If your organization requires employees to share premium costs for dental coverage (and the majority of employers do, with 54 percent requiring employees with single coverage to share costs, and 67 percent requiring employees with family coverage to do so), be prepared for changes in dental plan takeup rates in plan years 2014 and later.

The Importance of Dental Insurance

Lower dental plan participation rates could cause more health problems in the long term. More than one-third of adults surveyed for the Surgeon General's study on oral health (2000) had not visited a dentist in the past 12 months. Fewer adults with dental benefits could mean that number will increase. Laurence R. Weissbrot, FSA, MAAA, director of actuarial and underwriting at Northeast Delta Dental in Concord, N.H., says that "75 percent or more of the people who have dental coverage see their dentists on a regular basis. Fewer than 50 percent of people without dental coverage do so."

Unfortunately, oral health conditions can progress rapidly without treatment. Most adults show signs of periodontal or gingival (gum) diseases, with about 14 percent of those aged 45 to 54 having "severe" periodontal disease.

The Surgeon General's report points out that oral health is integral to general health. "You cannot be healthy without oral health.... Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job."

Employees who drop their employer-based coverage will be able to buy standalone dental insurance on an individual basis. However, Weissbrot points out that individuals buying coverage on insurance exchanges will lack the double tax advantages employer-provided benefits enjoy: employers can deduct premiums as a business expense, and employees do not have to report their value as income.

Many employers, even some smaller employers, self-insure dental benefits. Even when they add the cost of using a third-party administrator to manage their plans, some employers may save money on dental benefits this way. Although standalone health reimbursement arrangements (HRAs) will not meet the ACA's "no annual limit" requirement, a dental HRA might fall under the "excepted health plan" exemption from ACA requirements.

Please contact us to discuss ways your organization can provide valuable dental benefits to your employees at reasonable cost. ■

employee's protected activity was a contributing factor in the employer's decision to take unfavorable employment action against the employee. Such actions may include:

- **Firing or laying off**
- **Blacklisting**
- **Demoting**
- **Denying overtime or promotion**
- **Disciplining**
- **Denying benefits**
- **Failure to hire or rehire**
- **Intimidation**
- **Making threats**
- **Reassignment affecting prospects for promotion**
- **Reducing pay or hours.**

Employees alleging a violation of Section 1558 must file a complaint with OSHA within 180 days after the violation occurred.

Using Communications to Sell Your Benefits Plan

April 2 is Employee Benefits Day, a day to recognize benefit administrators and to remind your employees of the importance of their benefit program.

Are you getting maximum return on investment on your employee benefit plans? If your employees do not fully understand their benefits, probably not. The following step-by-step guide will help you structure a benefits communication program to the particular needs of your employees to guide them through this year's open enrollment.

Step 1: Show Them the Money

Employers that file 250 or more W-2 forms have begun reporting their contributions toward health insurance on employees' W-2s. Although these contributions do not count toward employees' taxable income, the move was intended to make Americans with employer-paid coverage more aware of the cost of healthcare.

Some employees, at least, have taken notice. Still, many are not aware of just how much their total benefits package costs.

In 2012, the average private industry employer spent nearly 30 percent of total compensation dollars on employee benefits, reported the Bureau of Labor Statistics. Only 8.2 percent went toward legally required benefits, such as workers' compensation, FICA contributions and state unemployment. This means more than 20 percent of your compensation dollars (on average) go toward optional benefits, such as paid leave, health and other insurance plans, and retirement and savings benefits.

Where do the average private industry employer's compensation dollars go?

Compensation component	Percent of total compensation
Wages and salaries	70.3
Benefits	29.7
Paid leave	6.8
Supplemental pay	2.8
Health benefits	7.7
Other insurance	0.5
Retirement and savings plans	3.6
Legally required benefits*	8.2

*Includes workers' compensation, FICA and Medicare contributions, unemployment and state disability insurance, where required.

Your employee benefit costs will likely vary. Many employers provide their employees with an annual "benefit statement" showing the total costs of their compensation.

Step 2: Solicit Opinions

Only about half of employers survey their employees to understand how workers perceive their benefits, found research by the International Foundation of Employee Benefit Plans (IFEBP). In 2005, the IFEBP found that employers listed their top three reasons for conducting an employee benefit survey as gauging satisfaction, identifying problems and determining how well employees understand their benefits.

A survey can help you determine whether you are spending your benefits dollars as effectively as possible. Conducting an anonymous survey is easier than ever with online tools such as Survey Monkey and Zoomerang, to name just a couple. Some (such as Survey Monkey) offer their basic services for free and offer templates employers can use to set up their own employee surveys.

Step 3: Tell Them What to Expect

Each new plan year usually brings some changes to an employer's benefit programs, whether it's a premium increase, change in deductible, change in covered benefits or

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even change in type of plan.

The Affordable Care Act (ACA) will bring a whole new set of questions to this year's open enrollment period. The insurance exchanges created by the ACA are supposed to be ready to begin enrolling people in October for coverage that will begin in January 2014.

With more than 900 pages, the ACA is complicated and confusing. It's no wonder that researchers from Stanford University found in 2012 "…nobody, literally nobody in the country" who could answer a list of questions on the law's provisions correctly. However, expert assistance is available!

Some of the questions your employees might have include:

- Will the employer continue to offer health coverage in the future? If your organization plans to continue to offer coverage for 2014, tell employees so. Circumstances can change, however, so avoid making promises for the longer term.
- Will my health insurance premiums increase or decrease? In the short term, health premiums are likely to increase under the ACA, due to expanded coverage for preventive care and other mandated benefits, expanded coverage for adult children and those with pre-existing health conditions, and elimination of annual and lifetime benefit caps.
- Will healthcare be rationed under the ACA? As mentioned earlier, the ACA requires insurance to cover a broader range of services and benefits, rather than narrowing them.
- Will everyone be covered by the same standard plan or plans after 2014? Although the ACA imposes specific requirements on health plans, insurers and self-insured employers will continue to offer a wide variety of health insurance plans that will vary greatly in terms of structure, cost and covered benefits.
- Will part-timers and temp workers be eligible for coverage under the employer's plan now? The ACA's "pay or play" requirement applies only to employees who work 30 or more hours per week. It applies to workers hired on a temporary basis only after they have worked full-time for 90 days. An employer may opt to cover part-timers, but the ACA does not require it. These employees will be able to obtain individual coverage on an insurance exchange.
- If my employer provides health benefits, will I be able to opt out and buy coverage on an exchange? Yes, employees can opt out of an employer's plan and buy coverage on an exchange. Those who qualify for a subsidy might save money by doing so. Newly promulgated "whistleblower" rules prevent an employer from retaliating against an employee who applies for a subsidy.

Step 4: Follow Up

After open enrollment, survey employees again. How did their opinion of their total benefits package change? Did they find pre-enrollment materials useful and understandable? Do they have any further questions, gripes or suggestions? These responses can help you fine-tune your benefits offerings and communications for the following year.

For assistance in communicating your benefit programs to your employees, please contact us. ■

Employee Assistance Programs Deliver

Wellness programs might be getting all the buzz lately. But employee assistance programs (EAPs) can also help employers control their employee health costs, while reducing absenteeism and other productivity problems as well.

In fact, more private-industry workers in the U.S. have access to an EAP than access to a wellness plan, 48 percent versus 34 percent in the most recent National Compensation Survey. These programs provide structured plans, closely related to employee wellness programs, that typically deal with more serious personal problems than the essentially medical problems covered by wellness programs.

An employee assistance program, properly implemented, can provide a significant return on investment by helping employees identify and resolve personal problems that can adversely affect their work performance and/or conduct.

EAPs can offer referral services, or referral services in combination with counseling services. Both the referral services and the counseling services may be supplied by company personnel, by an outside organization under contract, or by a combination of both. An EAP may include a full suite of services or just a few. The National Compensation Survey defines an EAP as a program that provides referral services or counseling concerning any of the following:

- Alcoholism
- Drug abuse
- Marital difficulties
- Financial problems
- Emotional problems
- Legal problems

Some of the things to look for when considering an EAP include:

- **24-Hour crisis telephone response.** Professional EAP counselors provide live, immediate telephone crisis counseling 24 hours/day, seven days a week.
- **Confidential assessment and counseling services.** Licensed, professional counselors — experienced in providing EAP services — deliver assessment and brief, solution-focused counseling in safe, private, confidential offices.
- **Referral support, tracking and follow-up.** The EAP should assist with referrals for long-term or specialized care based on assessed client need, recommended treatment, client preferences, financial and other resources.
- **Emergency intervention/critical incident stress management.** A full-service EAP can provide onsite assistance for emergencies, including critical incident stress management (CISM) defusing and debriefing, and other crisis response needs.
- **Substance abuse expertise.** Given its disproportionately significant impact on the workplace, EAP providers should have specific knowledge, training and experience in the assessment and treatment of chemical dependency and other addictions.

Many plans base costs on utilization, while others charge a flat per-employee fee. The exact cost of an EAP varies with your location and the type of services offered; charges of around $25 per employee per month are typical.

Are EAPs worth the cost? Consider the following facts:

- An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. Mental Health

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America estimates that untreated and mistreated mental illness cost U.S. businesses up to $44 billion per year.

- Eleven percent of American workers have a problem with alcohol. In a 2006 study, about 15 percent admitted to using or being impaired by alcohol at work during the preceding year. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) estimates employers' savings from investing in alcohol and substance abuse programs can exceed costs by a ratio of 12 to 1.
- Twenty-six percent of respondents to a Families and Work Institute survey said they were often or frequently very stressed or burned out by their work. Workers who report high levels of stress have healthcare costs that are nearly 50 more than other workers.

For more information on EAPs, please contact us.

HIPAA Health Privacy Rules Strengthened

A stronger medical privacy protection rule became effective on March 26. In January, the U.S. Department of Health and Human Services (HHS) released a new rule to strengthen the privacy and security protections for health information as required by the so-called HITECH Act. The rule modifies protections established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It also revises the HIPAA privacy rule to increase privacy protections for genetic information as required by the Genetic Information Nondiscrimination Act of 2008 (GINA). According to HHS, "The final omnibus rule greatly enhances a patient's privacy protections, provides individuals new rights to their health information, and strengthens the government's ability to enforce the law."

In the past, HIPAA privacy and security rules have focused on healthcare providers, health plans and other entities that process health insurance claims. The rules control how a health plan or covered health provider discloses protected health information.

The new rule will expand many of the privacy requirements to "business associates" of these entities that receive protected health information, making them directly liable for compliance with certain privacy and security requirements. The HIPAA rules define "business associate" generally to mean a person who performs functions or activities on behalf of, or certain services for, a covered entity that involve the use or disclosure of protected health information.

An employer might be subject to HIPAA privacy requirements if it:

- ✔ **maintains an on-site clinic to provide health care to one or more employees**
- ✔ **self-insures health benefits for employees.**

If either of these applies to your organization, a compliance expert can help you ensure your policies and procedures comply with the new rule.

Most employers will be relieved to know that the law explicitly excludes individually identifiable health information in employment records from coverage. The Privacy Rule does not prevent an employer from asking an employee for a doctor's note or other health-related information needed to administer sick leave, workers' compensation, wellness programs or health insurance. For more information, please contact us.