Employee Benefits Report

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Insurance Exchanges: More Interstate Options, More Competition?

The Patient Protection and Affordable Care Act (PPACA) has several provisions that give small businesses more options to pool risks and buy coverage across state lines, with the goal of increasing competition.

The PPACA mandated creation of "Affordable Insurance Exchanges." These exchanges must be ready to enroll consumers by October 1, 2013 and fully operational by January 1, 2014.

Exchanges will allow individuals and small employers to compare and buy "qualified health plans" that meet minimum coverage standards set by the PPACA. Historically, individuals and small groups have paid more for their health insurance than large employers due to adverse selection and high administrative costs. Exchanges will allow individuals and small businesses to benefit from the pooling of risk, market leverage and economies of scale that large businesses currently enjoy.

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This Just In…

As of March 1, 2013, employers must provide current employees (and new employees at the time of hiring) with information about the existence of an "affordable insurance exchange," as created by the Patient Protection and Affordable Care Act (PPACA). The notice must include information about the services the exchange provides and how employees can contact the exchange for assistance.

It must also outline subsidies available and how to qualify for them, and the effects of buying coverage with employer contributions through the exchange.

The U.S. Department of Health and Human Services (HHS) announced plans to create a model notice for employers to

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Exchanges Will Vary State to State

The PPACA gives the states choices regarding the structure and governance of their exchanges. States electing to establish an exchange had until January 1, 2013 to submit their plans to the Department of Health and Human Services (HHS) and receive approval or conditional approval. States that do not elect to establish an exchange or receive approval or conditional approval by that date can participate in a "partnership" exchange, in which the state performs some functions of an exchange and HHS performs others. For example, the state could manage the participation of health insurance plans in the exchange, oversee consumer assistance and conduct outreach and education, while HHS manages eligibility determinations and enrollment.

States that do not have their own or a partnership exchange will have a federally facilitated exchange. HHS will work with the state to ensure coordination with the state's ongoing role in managing the private insurance market, Medicaid and CHIP, the insurance program for children.

State exchanges may operate as a state agency or as a nonprofit organization. An exchange may act as a clearinghouse where private insurers can offer their policies, or as an active buyer of plans from private insurers. A state may also choose to partner with other states to form a regional exchange, or may establish one or more subsidiary exchanges within the state. Since states already handle health plan licensure, rate review and consumer complaint, state-based exchanges should have the flexibility to respond to local market conditions.

PPACA Will Create More Interstate Buying Options

The state-based system of insurance regulation has allowed states to ensure health plans meet the needs of their populations. However, it prohibits the sale of health insurance plans across state lines. Certain provisions of the PPACA will allow exchanges to operate across state lines, giving small businesses greater opportunities to pool their risks and access to more plan options.

Section 1334 of the PPACA requires health benefit exchanges to offer two multi-state plans, one a nonprofit. These plans would be established under federal charter through the Office of Personnel Management (OPM) and licensed in all states.

use. This notice was not available at time of publication, however.

If you have questions on the model notice or the PPACA and how it will affect your employee health benefits, please contact us.

Section 1333 will allow health insurers to sell across state lines via "health care choice compacts" starting in January 2016. "Two or more states would agree to allow health plans to be sold in each state, but subject to regulation only by the state in which the plan was written or issued. Plans sold outside their state of domicile would still be subject to licensure and rules in the state in which the purchaser resides…" The PPACA requires HHS to issue regulations governing health care choice compacts by July 1, 2013.

"Finally, the PPACA allows the exchanges themselves to operate across state lines. Section 1311(f) provides for 'Regional or Other Interstate Exchanges' operating in more than one state if the involved states and the federal HHS approve." (Source: "Health Insurance Crisis" blog, Frederick L. Pilot, author and consultant. Reprinted with permission. http://healthinsurancecrisis.net)

Funding of Exchanges

States setting up their own exchanges can choose how they want to pay infrastructure costs. Options include charging participant fees on insurance carriers, fees on participants and appropriations from state funds. States that participate in the federal exchange will be billed by the federal government for their share of costs; how the government determines that remains to be seen.

In future issues, we'll discuss other aspects of the PPACA, including the employer mandate, mandated benefits and the role of agents and brokers in exchanges. If you should have any questions on the Affordable Care Act and how it will affect your employee benefits, please contact us.

New Rules Would Encourage Tobacco Cessation Programs

Tobacco use causes one in five deaths in the U.S. It also contributes to an extensive list of serious diseases, including cardiovascular and cerebrovascular diseases, multiple cancers, emphysema and bronchitis. Recently proposed rules could allow employers to increase financial incentives for smokers who participate in a smoking cessation program.

Despite warning labels on cigarette packages and decades of anti-smoking ads, 19 percent of U.S. adults still smoke. In addition to the death and suffering tobacco use causes, it costs at least $96 billion per year in direct medical expenses and $96.8 billion per year in lost productivity due to sickness and premature death. On the employer level, a smoker's healthcare costs employers approximately $1,300 more per year than care for a nonsmoker, according to Mayo Clinic estimates.

Smoking cessation programs can provide a higher payoff than almost any other workplace wellness initiative. However, quitting smoking can challenge even the most strong-willed individual. Cigarettes are essentially a delivery system for nicotine, which research suggests is as addictive as heroin, cocaine or alcohol. Tobacco users may require multiple quit attempts (8 to 11) before they can quit permanently.

To start a smoking cessation program, look at your health plan. Structuring your health benefits to not only cover smoking cessation programs, but to provide support for multiple quit attempts, can encourage more employees to quit. And ensuring your prescription drug benefits cover medications (such as nicotine patches) that have demonstrated effectiveness in cessation programs can also help.

To be successful, the Centers for Disease Control suggests tobacco cessation programs include coverage for

- Four to six face-to-face counseling sessions of at least 30 minutes each;
- Both prescription and over-the-counter medications;
- At least two quit attempts each year.

Employers should also communicate the availability of support programs.

Wellness Incentives

Premium incentives can increase participation in wellness programs. Currently, employers can offer incentives of up to 20 percent of their health plan's total premium (both employer and employee share) to employees who participate in wellness programs. Beginning in 2014, the Affordable

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Care Act will increase allowable incentives to 30 percent of total premiums. Rules recently proposed by the Departments of Health and Human Services (HHS), Labor and the Treasury would increase the maximum permissible reward for programs designed specifically to prevent or reduce tobacco use to as much as 50 percent.

The proposed rules continue to support workplace wellness programs, including "participatory wellness programs," which are generally available regardless of health status. These include programs that reimburse employees for gym memberships; that reward employees for attending a monthly, no-cost health education seminar; or that reward employees who complete a health risk assessment without requiring them to take further action.

The rules also outline amended standards for nondiscriminatory "health-contingent wellness programs." These programs require individuals to meet a specific health-related standard to obtain a reward. This includes programs that reward those who do not use or decrease their use of tobacco, or programs that reward those who achieve a specified cholesterol level or other biometric target. To be considered nondiscriminatory, these programs must also provide alternative qualification standards (and rewards) for those who fail to meet the biometric target but take certain additional required actions.

To protect consumers from unfair practices, the proposed regulations would require health-contingent programs to:

- Have a reasonable chance of improving health or preventing disease.
- Be available to all similarly situated individuals.
- Create no unreasonable burdens for individuals. If an individual's medical condition(s) make qualifying for the reward unreasonably difficult or medically inadvisable, the plan must offer a different, reasonable means of qualifying for the reward.
- Provide eligible individuals a simple-language notice of the opportunity to qualify for the same reward through other means.

For more information on wellness programs and other options to control group medical costs, please contact us. ■

AD&D Insurance: Big Benefits at Little Cost

With its low cost, accidental death and dismemberment (AD&D) coverage makes a valuable addition to any employer's benefits package, particularly for the vast majority of workers who do not have individual disability insurance.

Unintentional injury ranks as the fifth leading cause of death among all Americans. AD&D policies provide a set payment, typically $100,000, to beneficiaries when an insured dies from injuries suffered in an accident.

AD&D coverage doesn't help just the family of a deceased, however. The "dismemberment" part of the policy's name comes from the fact the policy also pays if an insured loses a limb or its use in an accident. The benefits payable depend on the loss. For example, a policy might pay half of the death benefit for the accidental loss of one hand or arm or one foot or leg. If the insured lost two or more limbs (a combination of arms and legs), the policy would pay the entire face value (death benefit) to the insured.

AD&D policies may also cover the sudden loss of vision or hearing. The same principles apply. If an insured loses one eye (or its use), the policy would pay one half the benefit. If he/she loses both eyes, then the insured will

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receive the entire face value of the policy.

AD&D is particularly attractive for young workers, who statistically are more likely to die from accident than illness. For these workers, AD&D is substantially cheaper than regular life insurance and may be an attractive alternative to individual term life if your organization offers AD&D on a voluntary basis.

If your organization plans to pay for AD&D benefits, the low cost of AD&D premiums might come as a pleasant surprise. This is because accidental death and other covered losses occur rarely, so insurance companies do not pay out very often. Hence, AD&D insurance is among the least expensive benefits you can offer. However, for the families of an employee who suffers an accidental death or dismemberment, the benefit will prove valuable indeed.

You can provide coverage in a separate AD&D policy, or by simply adding coverage to term life policies you already have in place through an accidental death and dismemberment rider. With an AD&D rider, the insurance company will pay a "double indemnity." This means if a covered accident causes an insured's accidental death, the beneficiary will receive the life policy's death benefit, plus a benefit under the AD&D rider.

Coverage Questions

Before offering AD&D coverage, it's important to understand—and to convey to employees—what AD&D covers and what it doesn't. "Accidental death" under the policy means that an unforeseen circumstance

caused a death unrelated to a malfunction of the body. An example of "malfunction of the body" would be someone suffering a stroke or heart attack while driving. If the heart attack or stroke occurred before the accident and the accident resulted from that bodily malfunction, the policy would not cover the accident.

If an accident leads to death, many policies require the death to occur within 90 days of the accident for benefits to be paid. In addition, policies usually stipulate that the cause of death must be directly related to the injuries incurred from the accident.

As with most insurance policies, AD&D policies do not cover death by any form of illegal or crime-related activities. Policies also don't cover death by suicide. And because they don't cover death from illness, an AD&D policy is no substitute for life insurance coverage. Nevertheless, AD&D policies provide a valuable benefit for employees who use their bodies to earn their livelihood.

Companies that pay for AD&D coverage for their employees can offer dependent coverage on a voluntary basis so employees' dependents can get coverage at competitive group rates. We can help you analyze your current benefit program and employee needs. ■

Employee Death and Your Benefits Programs

Dealing with the death of a co-worker is never easy. Human resource and benefits managers should be prepared to deal with these events, though. An employee death can affect the following personnel functions:

Payroll: Assess any final and outstanding pay due. State labor laws may require you to issue payment within a certain time period once you've received notice of the death. Typically, wages and compensation are paid to either the employee's legal representative, such as an executor, or to the employee's estate — not directly to a relative. If state laws require that you direct the payment to the employee's estate, you may need the estate's federal tax ID number.

EAP: If you have an employee assistance program (EAP), inform your employees that they can seek free counseling through the program to help them absorb the news. Depending on the EAP program, family members of the deceased employee may also be eligible for this service.

Benefits: If your business provides life insurance, retirement benefits, health insurance, or other benefits to employees, contact your providers as soon as possible.

If COBRA (the Consolidated Omnibus Budget Reconciliation Act) applies to your business, a deceased employee's spouse and dependants will likely qualify for continuing benefits. COBRA allows eligible employees and dependents to continue their group health coverage temporarily after certain "qualifying events," such as termination of employment, death and divorce. COBRA generally applies to all private-sector group health plans that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. To enable a deceased employee's spouse and dependents to continue coverage, you will need to contact your healthcare provider and file necessary paperwork. ■

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