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U.S. Supreme court announced it will consider for the upcoming 2012 term whether Congress exceeded its authority by requiring all Americans to either acquire health insurance by 2014 or pay a penalty.

A Scramble to Shape the New Health Insurance Exchanges

From insurance companies to drug stores to doctors, just about any industry that touches the health care system has a different opinion on how the Obama administration should shape the new insurance markets at the heart of health-care reform law.

But they all agree on one thing: now is the time to weigh in. Health and Human Services has received thousands of comments on preliminary exchange regulations issued earlier this year, which laid some ground rules for what the new marketplace would look like.

Under the health overhaul, every state will have a new health insurance marketplace called an “exchange”, which launch in 2014. Often described as state-based “Expeditas” for health insurance, the exchanges will serve as online hubs for individuals and small businesses to compare and purchase health insurance plans. Low-and-middle-income Americans will also be able to use new tax subsidies on the exchange, meant to make health coverage more affordable.

Approximately 24 million Americans will eventually purchase their health insurance through these new exchanges, according to estimates from the non-partisan Congressional Budget Office. If a state

does not set up its own exchange, the federal government will step in and do the job, ensuring each state has its own market.

The Affordable Care Act, passed last March, laid out some basic exchange guidelines, which detailed who would be eligible to use the marketplace and what type of coverage insurance companies would be required to sell.

But it also left many questions: who will be authorized to sell health insurance on the exchange? What benefits will health plans have to cover? And, if states don’t set up their own marketplace, what would a federally run exchange look like?

“If we don’t get this right, we could mess up the insurance market rather than improve it,” said Judy Waxman vice-president for health at the National Women’s Law Center, a consumer advocacy group. “We really feel like this is so new to most people, it’s worth laying the right ground rules.”

America’s Health Insurance Plans, which lobbies for the insurance industry, has pushed the Obama administration to leave much of the regulation to the states, which have traditionally overseen insurance market functions. More than anything though, AHIP wants more final rules

from the administration, so its members can know what to plan for.

“We need to understand what the rules are,” AHIP President Karen Ignagni said in a recent interview. “It takes a great deal to make sure you’re ready. That’s one of the reasons we’ve telegraphed such a sense of urgency in our comments.”

Less obvious health industry groups also have a big interest in how the Obama administration sets the rules.

That includes pharmacy chain CVS Caremark, which has 7,200 drug stores across the country. The company has petitioned the Obama administration for rules that would allow its employees, such as pharmacists and nurse practitioners, help consumers navigate the exchange and purchase health insurance.

Part of it, the company explains, has to do with its history: when Medicare’s prescription drug benefit came online in 2006, CVS assisted seniors with enrollment through a program called “Medicare Tuesdays.” Pharmacists would set up laptops and, using a senior’s prescription history, help them pick the appropriate plan.

But it’s not just goodwill that has gotten CVS interested:

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With Economic Uncertainty, Perceived Value of Benefits Rises

Benefits play an increasingly pivotal role in the employer-employee relationship in the U.S., according to the 2011 Mercer Workplace Survey. The latest annual survey of employee attitudes was fielded in June 2011 by Mercer's U.S. outsourcing business.

Nearly eight out of 10 employees in the U.S. said their benefits are one of the reasons they work where they do, and almost as many (76%) said that benefits make them feel appreciated by their company. Both of these results represent significant increases from the 2010 survey.

Higher Health Care Costs

According to the findings, employer-sponsored health care continues to be a critical component of the overall benefits offering. Even as health care costs continue to rise, employees appear ready to accept changes to the employer-employee cost-sharing model. In 2011, almost half (44%) of the employees surveyed reported that they were asked to pay more out of pocket for health benefits in the past 12 months. Nevertheless, 46% responded that their health benefits are "definitely worth" the cost (up from 38% in 2010).

In addition, participation increased in programs that encourage healthy behaviors. Nearly a third of employees said they take advantage of their employer's wellness program 'a great deal,' up from 15 percent.

Impact of Health Care Reform

Contributing to the growing importance of employer-sponsored benefits was the still-uncertain impact of health care reform; which continued to received mixed reviews among insured employees.

Perceived Value of Benefits

Percentage of employees that agree with these statements:

	2011	2010	2008
Getting health benefits through work is just as important to me as getting a salary.	91%	90%	88%
My benefit are one of the reasons I work where I do.	79%	74%	73%
My benefits make me feel appreciated by my company.	76%	72%	67%
As health care costs rise, I would rather pay more out of pocket than have my health benefits reduced.	75%	67%	69%
My company should offer better benefits.	73%	67%	69%
Source: 2011 Mercer Workplace Survey			

Perceptions of Health Care Reform

How do you expect health care reform to affect you personally when it comes to:

	2011		2010	
	Better off	Worse off	Better off	Worse off
My access to care	32%	28%	19%	35%
My choice of doctors and hospitals	32%	30%	16%	36%
What I pay for care	31%	40%	17%	49%
The quality of care I receive	30%	29%	16%	36%
My health benefits at work	29%	36%	16%	40%
The federal income taxes I pay	27%	43%	11%	59%
My situation overall	31%	33%	18%	43%
Source: 2011 Mercer Workplace Survey				

More than a third (36%) of surveyed employees—double the 2010 level (18%) - reported that their employer had indicated that changes in their health plan will occur as a result of health care reform. As employees ponder exactly how those changes will affect them, 75% said they would rather pay more out of pocket than have their health benefits reduced. Employees seem to be turning their uncertainty about the future—both in terms of health care reform and their own job security—into greater appreciation for their benefits and a desire to become more involved in their health care decisions," said Nolan. "Employers can build on this momentum by providing the education and programs to encourage informed decision making and health-conscious behaviors."

Spousal Exclusions on the Rise

Pressed between a hammer of rising healthcare costs and an anvil of mandatory health insurance rules, employers are renewing interest in adding “working spouse” provisions to their health care plans. These provisions limit access to a plan when an employee’s spouse works for another employer that offers health insurance.

But before adopting such policies, employers should examine whether the savings will be sufficient to offset the administrative burdens and possible adverse employee reactions. Employers also must pay attention to the nuances of spousal exclusions, as these details can determine whether they are effective –and legal.

Gregg Bott, SPHR, an attorney and consultant at Associated Financial Group, a Kimberly, WI based insurance agency and human resources consulting company, says working-spouse provisions-also termed “spousal carve-out” or “spousal exclusion” policies-generally take one of three forms:

A requirement that a working spouse pay a premium surcharge for coverage through the employer’s plan if the spouse’s employer offers health insurance.

A requirement that the spouse purchase health insurance through the spouse’s employer’s plan before also purchasing it through the employer’s plan.

An outright exclusion from coverage under the employer’s plan if similar coverage is available from the spouse’s employer.

The third option is not common: Only 3 percent of companies do not cover spouses at all if they are eligible to be covered by their own employers, according to an online survey of HR

professionals conducted by the Society for Human Resource Management in 2005.

Many employers are receptive to working-spouse provisions because spouses can still obtain health insurance under their own employers’ plans.

Members of the National Business Group on Health, a consortium of large employers, view the policies favorably. “We recommend that employers (use these provisions) as a way to control costs,” says Helen Darling, president and chief executive officer of the group.

Trending Upward

A Towers Watson survey report, 2011 Employer Survey on Purchasing Value in Health Care, found that in 2010, 19% of nearly 600 employers surveyed used spousal surcharges or waivers when other coverage was available for spouse.

Three percent of employers said they intended to implement such provisions in 2011 and 13 percent intended to implement them in 2012 or later.

Health care reform has likely spurred adoption of these provisions. “Health care reform, by placing more focus and attention on medical plans, has caused employers to explore their options more than they did in the past to determine what they can do to save money,” Bott says.

“More companies are putting these provisions in,” adds Tom Billet, a New York based senior consultant for benefits with Towers Watson. At the same time, Billet and others say surcharges or plan exclusions are only one way and not the most common way of addressing the costs of spousal coverage. Instead, more plans

simply charge more to cover spouses than they charge to cover employees.

“Many companies are becoming sophisticated in applying actuarial data to reflect the higher per capita costs for spouses compared to employees,” notes Bernard Knobbe, senior director of global benefits for Yahoo. Spouses cost 10 percent more on average than employees, he says.

Savings

Are working-spouse provisions likely to result in significant savings? In some cases, there is no question they have.

Indianapolis-based Ivy Tech Community College will save an estimated \$1.3 million in 2011 on \$27 million in health and dental care costs after instituting a working spouse policy at the beginning of the year, says Susan Farren, executive director of employee benefits.

Under Ivy Tech’s policy, employees’ spouses who have access to coverage through their own employers must obtain primary coverage through their employers’ plans before enrolling in the Ivy Tech plan for secondary coverage to supplement the primary plan. If spouses elect not to enroll in their employers’ plans, they may not have primary coverage through Ivy Tech.

The size of the spousal surcharge helps determine whether the surcharge is effective—both by increasing premium revenue and by giving spouses an incentive to use their own employers’ plans. Towers Watson’s Billet says that to influence employee behavior, such charges must be significant, with various studies indicating that \$600 to \$1200

in annual costs on top of premiums will influence employee behavior.

In 2012, Xerox Corp. plans to institute a supplemental working-spouse surcharge of \$1,000 for spouses and domestic partners of employees who can obtain coverage from another employer but opt into the Xerox plan. “This is one of our cost savings actions for 2012 specifically aimed at reducing the number of adult dependents covered under our plan,” says Peter Dowd, vice president of compensation, benefits and global mobility at Xerox.

Legal Questions

Generally, working-spouse provisions are legal under the Employee Retirement Income Security Act (ERISA) and other federal laws, Bott says. He notes, however, that many states have marital discrimination laws that could allow challenges to working-spouse provisions. Such state prohibitions are pre-empted by federal law if the employer’s plan is subject to ERISA, Bott says. That is not the case, however, for church plans, school districts, and state and local government plans not subject to ERISA.

When instituting a working-spouse policy, consider how it will affect corporate culture, morale and recruiting. For example, the policies may be less attractive to employers in industries such as retail, insurance and hospitals, where health benefits are a major recruitment and retention tool.

Source: SHRM, Stephen Miller

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the pharmacy chain believes it will increase consumer trust, leading to stronger sales in drug stores.

“We very much see ourselves playing in that space,” said Helena Foulkes, CVS’ chief health care strategy and marketing officer. “There’s a business value to it: If we’re seen as a helpful partner, we can drive more business to our stores.”

Other groups have focused on making the health exchange accessible to specific populations. Young Invincibles, which advocates for young adults, is pushing the administration to allow individuals to access the exchange through mobile devices, like smartphones and iPads. Nearly half of 18-to-29 year-olds use a smartphone as a primary source for Internet access, according to the Pew Research Center.

“Young people are obviously much more uninsured than older people,” said Jen Mishory, deputy director for Young Invincibles. “They have less access to employer-sponsored insurance. It’s important that the exchanges meet them where they are, and that’s often with a smartphone.”

The National Association of Insurance commissioners, a group that represents each state’s top insurance regulator, discussed the

issue at their fall meeting, at the National Harbor in Maryland. While the Obama administration will write the regulations for exchanges, these regulators will use those rules to set up the new marketplaces.

A half-dozen groups testified before the insurance commissioners, each running through a regulatory wish list. They ranged from the Center on Budget Policies and Priorities, a Washington-based think tank to the Illinois Chamber of Commerce.

Laura Minzer, speaking on behalf of the Illinois Chamber of Commerce, described herself as a “relative newcomer” to the world of insurance regulations. But with exchanges online, she said it’s more important than ever for groups such as hers to get involved.

Even “small players want to be engaged in this process,” she told the group.

Source: The Washington Post

Compliance Corner

Is the new \$2,500 limit on health FSA contributions, effective in 2013, plan-year or calendar-year specific?

The requirement under PPACA is that a health FSA participant’s contributions cannot be greater than \$2,500 in a calendar year effective January 1, 2013. Section 10902 of PPACA states:

“Limitation on Health Flexible Spending Arrangements— in general—for purposed of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement...Effective Date—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.”

Section 1403 of the reconciliation bill (The Health Care and Education Reconciliation Act) amended this effective date to January 1, 2013. It states, “Section 10902(b) of the Patient Protection and Affordable Care Act is amended by striking ‘December 31, 2010’ and inserting December 31, 2012.

As you can see, there is no mention of plan years.

Thus, it is effective January 1, 2013, regardless of plan year. This limit will be hard to administer for plan years that straddle two calendar years. For example, if a plan runs from June 2012 to May 2013, the employee will be making their election in 2012 for the 2013 calendar year. The contributions would not be limited in 2012, but they would be in 2013. Because of this difficulty, and to simplify administration, some sponsors of non-calendar-year plans may wish to consider implementing the limit as of the first day of the plan year that includes the January 1, 2013, effective date, as opposed to waiting until midyear. All plan sponsors will likely need to adopt a plan amendment before the January 1, 2013, effective date, incorporating the revised maximum. Further guidance from the IRS on how the \$2,500 limit applies would be welcomed.

Source: National Financial Planners