



“Benefit Briefs”

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Turning 65

In the past 10 years, the number of people working past age 65 has climbed 52 percent, according to U.S. Bureau of Labor Statistics data. For some, employer coverage is the primary payer of benefits, with Medicare paying costs not covered by the employer plan. For other employees, the reverse is true. If you continue to work, you may be able to keep your employer's existing group health plan (GHP). You should confirm that your employer will continue covering you.

If your company has more than 20 employees, the GHP is the primary payer in most instances and Medicare acts as the secondary payer. Traditional Medicare has two parts, Part A is hospital coverage and Part B is medical services. Generally, everyone should take Part A when they become eligible since it is free. You have the option of enrolling and paying the monthly premiums for Part B coverage. If you don't enroll in Medicare Part B, you need to get a deferral from Medicare so that you are not subject to penalties when you enroll in the future.

If your employer has fewer than 20 employees, Medicare becomes the primary payer and your employer's plan is the secondary payer. In this instance, it's essential to enroll in Medicare Parts A and B. If you don't enroll, then generally, you will have to pay from your own pocket anything that Medicare would have covered.

You may be able to move to your spouse's healthcare plan if it would provide you with equal or better coverage than Medicare. Again, determine how the plan would coordinate with Medicare (for example, as primary or secondary payer).

If you have coverage as good or better than Medicare under your retiree benefits and your retiree healthcare plan allows, you may be able to defer Medicare Part B. However, some retiree plans stipulate that Medicare is the primary payer and the retiree plan is the secondary payer. Therefore, you need to understand how much coverage is provided under your retiree health plan to determine if you need additional Medicare coverage.

Veteran healthcare benefits, in general, are covered when provided at U.S. Department of Veteran Affairs (VA) facilities or for services authorized by the VA. Depending upon the level of VA benefits you receive, you may be adequately covered and don't need Medicare coverage. But, some people find that Medicare offers more flexibility and choose to use a Medicare plan as well. VA benefits and Medicare do not coordinate.

If you are turning 65 and your spouse or your children are covered under your employer's healthcare plan, you need to consider how their coverage may change if you choose to switch to Medicare. For example, will they be eligible for COBRA or need to secure private coverage? This is becoming increasingly important as children up to age 26 can now remain on their parent's healthcare plan.

Whether seeking a deferral or enrolling in Medicare, it is important to understand options provided under the federal healthcare program. This includes the alphabet of Medicare programs: Part A-hospital, Part B-medical, Part C-Medicare Advantage and Part D-prescription drug, and Medigap. In most instances, regardless of the path you take, it's generally a good idea to enroll in Part A, as it's available at no cost. Enrollment in the other parts depends on several factors, including those outlined above. Consumers also need to evaluate the options under each type. For example, most people can choose from dozens of Medicare Part D, Medicare Advantage and Medigap plans.

Healthcare needs can be different for everyone, so it is important to research which plan best meets your needs. Most people find this a confusing process because they have always had a GHP and someone else was making coverage decisions for them.

Transitioning to Retirement

Recent survey results showed that only 7% of those surveyed used employer-provided information to make investment decisions. Also, member contributions had declined from 7.3% in 2007 to 4.9% in 2010. Plan sponsors need to be thinking about transition to retirement and the fact that up until now, the focus has been on the accumulation phase of retirement assets. Tools (online calculators, booklets, in-person sessions, etc.), communications and balanced communications are all important parts of the retirement arsenal. An accurate estimate of retirement income is only as good as the information put in by the plan members themselves. Please note that the downside of most of these tools, is that tools help members understand what the ultimate benefit they will receive from the retirement plan will be, not what they might need. Employers should also try to provide information to employees on the other two pillars of retirement—personal savings and federal programs. However, this has to come long before employees are considering their retirement date so they can include this in their long range planning. The other issue is that most employees have no emotional involvement in retirement planning. They don't answer the question, “what's in it for me” until later in life, when the window of time to accumulate has shrunk down considerably.

As retirement time comes closer, Employee Assistance programs and even phased-in retirement are two areas that make it somewhat easier for members to ease into retirement. In other words, programs that allow plan members to emotionally prepare for retirement, either by talking their issues through or easing into the retirement phase by not doing it in one fell sweep. This can provide employees with the lead time to address their retirement concerns in a way that will suit their needs when the time arrives.

Notes:

The World Health Organization defines a healthcare system as something that has a primary purpose to promote, restore or maintain health. We can probably agree that most healthcare systems spend more on restoring health than on promoting and maintaining it in the first place. Is the purpose of healthcare to make sick people well, or keep more people from getting sick. Or both?

ADAAA expands scope of disability

The Equal Employment Opportunity Commission (EEOC) has finally put the finishing touches on regulations pertaining to the ADA Amendments Act of 2008 ("the ADAAA").

The ADAAA expanded the scope of the term "disability" to include more major life activities, which caused increased responsibilities for employers. However, the new regulations represent a dramatic departure from proposed regulations issued by the EEOC in 2009. (The departure was based on comments submitted to the agency.) Generally, the interpretations in the final regulations are favorable to employers.

Who must comply with these regulations? These regulations apply to all private and state and local government employers with 15 or more employees, employment agencies, labor organizations (unions), and joint labor-management committees.

Here is a brief description of the key points of the new rules:

Categorical disabilities: The final regulations reject the concept in the proposed regs listing certain impairments that would consistently qualify as disabilities under the ADA. These impairments are often referred to as "categorical disabilities." The proposed regulations were publicly criticized because they eliminated the traditional method of assessing a specific impairment based on its effect on the individual, rather than a mere diagnosis. Despite this critical change, the final regulations still include a strong presumption that certain impairments will consistently be treated as disabilities as defined by the ADA.

The regulations list several such impairments including the following:

- Deafness; Blindness; Intellectual disabilities; Autism; Partially or completely missing limbs; Mobility problems requiring use of a wheelchair; Cancer; Diabetes; HIV; Multiple sclerosis; Muscular dystrophy; Cerebral palsy; Epilepsy; and serious mental disorders.

The impairments on this list usually impose a substantial limitation on a major life activity and require a "simple and straightforward" individual assessment.

Substantial limitations: Although the proposed regulations did not definitively define the term "substantial limitations," they did state what would *not* be substantial. The new final regulations now provide additional guidance. In determining if an individual is substantially limited in a major life activity, employers may compare him or her to other people in the general population as to:

- The condition and manner in which they perform the major life activity.
- The length of time it takes to perform the major life activity.
- The difficulty and effort required to perform the major life activity;
- Any pain experienced when performing the major life activity.
- Any adverse effects or mitigating measures (such as side effects of medicine).

Conversely, employers are instructed to focus on the extent to which an impairment limits a major life activity – not on the results the individual can achieve. For example, the fact that someone performs adequately in school doesn't negate the possibility of an intellectual disability.

"Transitory and minor" impairments: The only type of impairment that cannot form the basis of a claim is one that is both "transitory and minor." Regarding the definition of "transitory and minor" impairments, the final regulations establish the following guidelines:

1. This defense must be proved by the employer.
2. A condition is considered transitory if it lasts, or is expected to last, less than six months.
3. The defense applies only if the impairment was actually "transitory and minor" -- whether or not the employer believed it was so.
4. The transitory nature of an impairment is not relevant as to whether someone suffers from an actual disability.

Please note: Each situation is analyzed on its own merits. Consult with your legal advisers concerning the application of the new final ADAAA regulations at your organization.

Preventive Care under PPACA

Under the Patient Protection and Affordable Care Act, all plans must cover certain preventive care services with no member cost-sharing - with an exception for grandfathered plans - as of plan years beginning on or after Sept. 23, 2010. Complying with this provision is much more complicated than simply not charging members for certain preventive care services. The list of services is extensive, health plan and administrators' claims payment systems must be reconfigured and provider office policies must be revised. This, coupled with the grandfathered plan provision, has caused confusion for employers, employees, administrators, advisers and providers. Adding to the uncertainty is the fact that the definition of "routine care" or "preventive care" historically has caused disagreements between members and administrators, since each member can have a different understanding of what is "routine" or "preventive."

The theory behind offering preventive care services with no cost-sharing is that members will schedule annual exams and chronic or catastrophic conditions can be detected earlier, thus improving health and lowering costs over time. However, there are some unintended consequences of this provision in the law:

* **The grandfather provision.** Most employees and dependents do not understand the provision, nor the reasons an employer might want to retain grandfathered status. Although the media and government PR efforts have told members that preventive services are available with no cost sharing, this may not be the case if their employer is grandfathered. When employees in a grandfathered plan talk to employees at other companies that are not grandfathered, they may feel that their employer is penalizing them.

* **Medical management.** A member may think a service or procedure is "routine" or "preventive" for him or her because of an existing medical condition, but services are classified as preventive based on certain criteria in the law. Additionally, if a condition is discovered as part of the preventive care examinations, there is no requirement the treatment for that particular condition be covered, or be covered with no cost sharing.

* **Provider reactions.** Providers which collect co-pays will have additional responsibilities. The relatively simple procedure of collecting co-payments is complicated by several factors: Is the plan grandfathered? Is the service preventive care? What if the initial reason for the visit is preventive, but follow up tests and services are related to a particular condition?

* **Follow-up care.** Although PPACA requires that preventive care services be covered with no cost sharing, follow-up tests, care and procedures (that are covered by the plan) will increase claim costs for both members and employers. Most plans have a deductible or some member cost sharing, so members' cost will increase for these tests.

Employers, in the short run, will see claims cost increases as members who did not previously seek preventive care do so because the services are now "free." The claims cost will increase in both more preventive claims, and in the more expensive follow up lab tests, MRIs, scans, etc.

- Administrator reactions. Claims payers, self-insured administrators and health plans which have to administer this provision are also experiencing challenges. They need to reconfigure their claims payment and adjudication systems to recognize grandfathered and non-grandfathered plans, preventive care services vs. non-preventive care services and the related follow-up care. Some plans are restricting employers as to whether they can grandfather or not, whether by only allowing grandfathered plans to be a certain employee size, or limiting the number of plan design choices offered.
- Although many employers have already implemented robust wellness programs, or have plan designs that cover some preventive care services with no co-payment, the preventive care provisions in PPACA have more far-reaching implications for employers than simply improving health and access to preventive care services.