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Health Care Auto Enrollment Expected to Present Challenges

Since the March 2010 passage of the Patient Protection and Affordable Care Act (PPACA), U.S. employers have felt its effects, with an average 2 percent increase in enrollment as of July 2011, attributable largely to the extended eligibility for dependent coverage to employees' children up to age 26, according to a survey by HR consultancy Mercer released in August 2011. (See figure 1)

Impact of Auto-Enrollment

According to the survey of nearly 900 U.S. employers, PPACA's rule requiring employers to enroll newly hired, or newly eligible, full-time employees automatically into a health plan will cause enrollment to grow by another 2 percent on average in 2014, when the provision is slated to go into effect.

"Employers have already been facing average increases in per-employee health benefit cost of about 6 percent annually for the past six years," said Tracy Watts, a consultant in Mercer's Washington, D.C., office. Adding enrollment growth on top of that puts a real strain on their budgets."

Cost of Mandates

More than a fourth of respondents (28%) said that compliance with PPACA mandates slated to go into effect in 2014—most significantly, extending coverage to all employees working on average 30 or more hours per week, auto-enrolling new full-time employees and ensuring that plans pay for at least 60 percent of covered services—will add another 3 percent to their projected 2014 plan costs, with 15 percent

FIGURE 1
Most employers say enrollment grew in 2011 due to extending dependent coverage to employees' children up to age 26

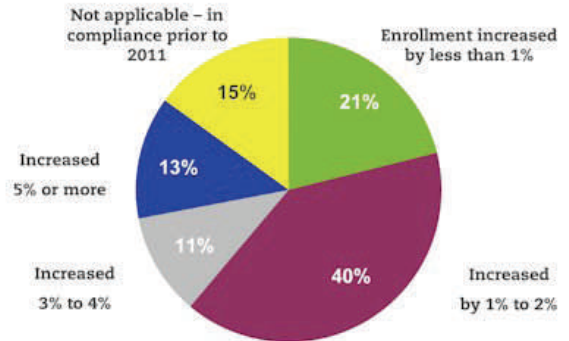


FIGURE 2
Anticipated cost increase in 2014 due to PPACA requirements

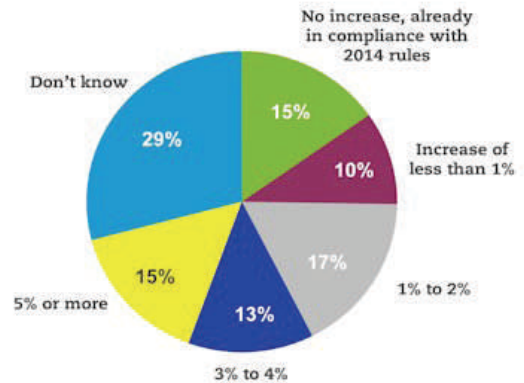
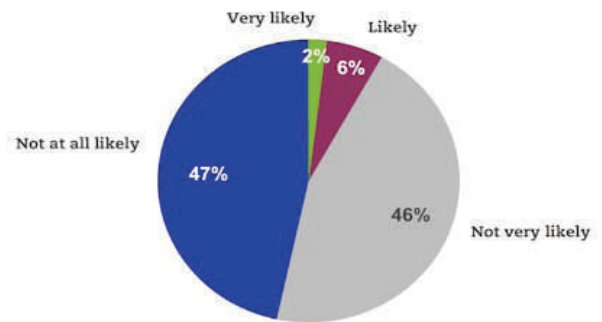


FIGURE 3
Likelihood of terminating medical plans and having employees seek coverage in an exchange or the individual market



expecting an additional cost increase of 5 percent or more. (See figure 2)

Despite concerns about cost, employers remained committed to offering medical coverage to their employees. **Just 2 percent of survey respondents say that are "very likely" to terminate medical**

plans after the insurance exchanges are operational, with 6 percent "likely" to do so. (See figure 3)

Mercer asked the same question in a survey of U.S. employers conducted a year earlier, just a few months after health (Continued on page 3)



NLRB Mandates Notification of Union Organizing Rights

The National Labor Relations Board (NLRB) has issued a final rule that will require most private-sector employers to notify workers of their rights guaranteed under the National Labor Relations Act (NLRA). According to NLRB officials, the rule appeared in the *Federal Register* on August 30, 2011, and **will take effect 75 days after that publication, on November 14, 2011.**

Under the new rule, most private-sector employers (including labor unions) will be required to post a notice of employee rights where other workplace notices are normally displayed. The new notification requirement applies to all businesses that are subject to the NLRA, which excludes agricultural, railroad and airline employers.

In response to comments received after the proposed rule was published, the NLRB agreed

to exempt the U.S. Postal Service because of the postal service's unique set of compliance rules under the NLRA. In addition, the notification rule will not apply to small employers with less than \$50,000 worth of business across state lines.

The NLRB based the rule on other requirements for notifications of workplace rights. The NLRB has developed an 11" x 17" poster similar to a notice of NLRA rights that federal contractors must now display. Before the rule takes effect, the NLRB says, copies of the poster will be available from the NLRB regional offices or may be downloaded from the NLRB website. www.nlrb.gov

In addition, employers who usually notify employees about employment rules and policies on a company Internet or intranet site will be required to post the NLRA rights notice online.

Employers that fail to comply with the notification rule could be subject to a complaint of unfair labor practice and face legal action by the NLRB. Officials said employers that aren't aware of the rule change and who fail to post the notice will receive a written warning. If the employer responds promptly and posts the notice, then according to an NLRB fact sheet on the final rule, the unfair labor practice case will typically be closed without further action.

The NLRB received more than 7,000 comments on the proposed rule change. After reviewing the comments, the NLRB made some changes when finalizing the rule. Most notably, the board removed a provision that would have required employers to notify employees through email, voice mail, text messaging or other electronic communications. **Source: Healthcare Finance News**

More Detail Needed on New Health Care Benefit Summaries

A proposed regulation that would implement a requirement that employers issue a health care benefit statement to employees raises more questions than it answers, experts say.

The heart of the proposed regulation involves a multipage summary of health care benefits and coverage that is mandated by the federal health care reform law. The IRS and the Health & Human Services and Labor Departments proposed the rule. The statement, which employers and plan administrators would have to follow assuming the regulation is not altered, would have to be provided for every plan that an employer offers by March 23, 2012. That is two years after enactment of the PPACA.

One part of the Summary of Benefits and Coverage would be divided into three columns. One column, "Important Questions," would include:

- What is the premium?
- What is the overall deductible?
- Are there other deductibles for specific services?
- Is there an out-of-pocket limit on my expenses?
- What is not included in the out-of-pocket limit?

In an adjacent column, "Answers," responses to the questions would have to be provided. A third column, with the heading "Why this Matters," would include required additional detail.

In another section of the statement, employers would have to give examples of how coverage would apply in three specific situations: having a baby, treating breast cancer and managing diabetes. The government is considering adding three more unspecified examples.

For each example, employers

would have to use a dollar figure dictated by the government on the amount that would be owed to providers. In the case of having a baby, the figure in the regulation is \$10,000.

Benefit experts say the proposed regulations raise numerous questions. "There is just not enough here to tell us what to do," said Rich Stover, a principal at Buck Consultants L.L.C. in Secaucus, NJ. For instance, the examples make no distinction between costs employees would pay depending on whether the service was delivered in or out of network, said Gretchen Young, Senior V.P. health policy with the ERISA Industry Committee in Washington.

Regulators had made it very clear that they want public comment, said Kelly Traw, a principal with Mercer L.L.C. in Washington.

Source: Business Insurance.com

Kentucky Workers Tout Benefits of Exercise on the Clock

Some state agencies in Kentucky allow their workers to have paid exercise breaks.

Department of Financial Institutions' employee Lisa Clark said being able to extend her lunch break to work out has been so beneficial she hasn't had to visit her doctor for low back pain and fibromyalgia, which causes body-wide pain, in a year.

"Nothing has helped me like exercise has," said Clark, an administrative coordinator. "For me to be able to incorporate it into my lunch hour, motivates me to go to the gym."

At least three other agencies also allow employees to exercise on the clock—the Dept. of Military Affairs, the Dept. of Veterans Affairs and the Personnel Cabinet, according to the Lexington Herald-Leader.

Personnel Cabinet spokeswoman Crystal Pryor says

the "wellness breaks" are cost effective because they result in "reduced absenteeism, increased productivity, higher employee morale and lower health care costs for the Kentucky Employees' Health Plan, the state's self-funded insurance program."

Pryor noted a Harvard University study published last year that found that "medical costs fall about \$3.27 for every dollar spent on wellness programs, and absentee day costs fall by about \$2.73 for every dollar spent."

Different state agencies have different rules for using the program. Some employees can exercise up to five hours a week; others are limited to 90 minutes each week. Employees can participate only if their workload on a given day allows and only with approval from a supervisor.

Pryor said centralized records aren't kept on the number of

workers who use the program, but she estimated that less than 20 employees in the Personnel Cabinet participate—and none use the full 90 minutes each week that's allowed under the policy.

At the Dept. of Financial Institutions, Clark is one of three employees who use the exercise program. Participants have 150 minutes each week, including travel time, to work out and must sign in and sign out before and after exercising

"Often these employees are discussing work issues while they are exercising so we really don't see this as cutting back on productivity," said Brown. "There are no hard facts around the impact of the program on reduction of sick leave, but certainly that is one of the benefits and trade-offs we hope to see over time."

Dept. of Veterans Affairs spokeswoman Lisa Aug said 161 out of 165 employees at

the Eastern Kentucky Veterans Center in Hazard have participated in the exercise program at least once. In warmer months, up to 74 employees at any given time will use the policy that allows three hours of exercise a week, she said. But the department's policy is that "serving veterans through all of our programs shall always take priority."

The most liberal exercise policy is at the Dept. of Military Affairs, which allows employees to exercise up to an hour a day or five hours a week.

Spokesman David Altom said civilians and military personnel work side by side and are expected to be equally physically fit. "The key to our physical fitness program is found in the nature of our mission: The Department of Military Affairs is supporting the Kentucky National Guard in a time of war," Altom said.

Source: Fox News

Continued from Page One (Mercer Survey)

care reform was signed into law, and employers' opinions on this question are essentially unchanged. "Employers have spent the past year studying the new law and developing strategies to deal with the increased costs and administrative burdens," said Beth Umland, director of research for health and benefits for Mercer. "But they don't seem to have changed their minds about the value of continuing to offer their employees health coverage."

Default Plan Section

Of the employer-related reform provision slated to go into effect in 2014, auto-enrolling new full-time employees seems to be causing the most headaches. Auto-enrollment is

seen as a "very significant" or "significant" concern by about a fifth of respondents (21%) and by 28 % of those with at least 5000 employees.

Employers are already considering how to manage the cost of the auto-enrollment requirement. Among survey respondents that currently offer only one medical plan, most will simply use their current plan as the default plan for auto-enrolling new full-time employees. However, 10 percent say they will add a new, lower-cost plan to use as the default plan, and 3 percent will change to a new, lower-cost plan for all employees.

Among respondents that offer a choice of medical plans, 65 percent will use their current

lowest-cost plan as the default plan, 29 percent will use their standard plan (the plan with the highest enrollment) and 7 percent will add a plan as the default for auto-enrollment.

The largest employers—those with 5,000 or more employees—are the most likely to add a plan (11 percent).

"Adding health plan enrollees has such a significant impact on cost that it's easy to see why employers accustomed to about a 15 percent opt-out rate are concerned about auto-enrollment," said Watts.

Covering Part-Time Workers

The rule that employers must offer "affordable" coverage to all employees working an average of 30 hours or more a

week in the month (or else be subject to penalties) is a very significant or significant concern for 17 percent of all respondents but for 37 percent of those in the wholesale/retail industry, which relies heavily on part-time labor.

Among respondents that have part-time employees but currently do not offer coverage to all employees working 30 or more hours per week, one-half say that they are most likely to change their workforce strategy so that fewer employees work 30 hours or more a week.

Source: SHRM

IRS to Issue New Health Care Reform Law Affordability Test

The Internal Revenue Service said it will develop new rules that will make it easier for employers to determine if their health care plans are “affordable” and exempt from a stiff financial penalty mandated by the health care reform law.

Under the law, starting in 2014, employers are liable for an annual \$3,000 penalty for those employees whose required health insurance premium contribution for single coverage exceeds 9.5 percent of family income and the employees are eligible for federal premium subsidies to buy coverage through state insurance exchanges.

In rules proposed August 12, 2011 that were welcomed by employers, the IRS said it will develop a safe harbor in which coverage would be considered affordable so long as the premium contribution for single coverage did not exceed 9.5 percent of employees’ W-2 wages.

The IRS said it is developing the new safe harbor to give employers more certainty on whether their plans will pass the affordability test.

“Giving employers the ability to base their affordability calculations on their employees’ wages (which employers know) instead of employees’ household income (which employers generally do not know is

intended to provide a more workable and predictable method of facilitating affordable employer-sponsored coverage for the benefit of both employers and employees.” the IRS said in its notice of proposed rule-making.

Employers had complained that it would be difficult—if not—impossible—for them to know employees’ household income, creating a big obstacle to determine whether their plans would be considered affordable, said Anne Waidmann, a director with PricewaterhouseCoopers in Washington, D.C.

The IRS safe harbor “would provide more certainty and effective planning,” said Frank McArdle, a principal with Aon Hewitt Inc. in Washington, D.C.

“This will make it easier for employers to do the necessary calculations,” said Chantel Sheaks, a principal with Buck Consultants, also in the District.

The IRS also affirmed that the 9.5 percent affordability test is to be applied only on single coverage, allowing employers to charge higher amounts for family coverage.

“While we think that was clear in the law, employers will welcome the additional clarity,” said James Klein, president of the American Benefits Council in Washington, D.C.

Source: Workforce Management

Compliance Corner



Q. How Does COBRA apply to health flexible spending arrangements?

A health flexible spending arrangement (FSA) is a benefit that allows for the reimbursement of certain medical expenses incurred by employees, their spouses and their tax dependents. In most instances, FSAs are offered to employees under IRS Code 125 cafeteria plans. Under the cafeteria plan, employees make salary reduction elections and pay for unreimbursed medical expenses with pre-tax dollars.

Generally, a health FSA is considered an ERISA-covered health plan, whether offered under or outside of a cafeteria plan. Similarly, unless an exception applies an employer subject to COBRA provisions may be required to offer COBRA to qualified beneficiaries (QB) who experience a loss in coverage due to a qualifying event for up to 18 months, including new elections during the open enrollment period. However, the FSA qualifies for limited COBRA obligations to a qualified beneficiary if all of the following conditions are met:

- The health FSA benefits provided are expected benefits and therefore not subject to HIPAA’s portability provisions (this provision is generally met if a health insurance plan was available to the FSA participant and the employer has the same eligibility guidelines for both)
- The maximum COBRA premium (102% for the remaining months in the year) equals or exceeds the maximum benefit available

year in which the qualifying event occurs.

- The annual FSA election amount cannot exceed two times the amount contributed by the employees (this provision is generally met if the employer does not fund any portion of the FSA).

For those who have ‘underspent’ accounts, COBRA must be offered, but it may be terminated at the end of the plan year in which the qualifying event occurs. COBRA coverage does not need to be offered to QBs who have ‘overspent’ their accounts at the time of the qualifying event.

Employees who elect COBRA continuation coverage may only make after-tax contributions to the FSA account once they have ceased receiving a paycheck. In addition, employers may require a QB to pay an additional 2% administrative fee. As an example, an employee who makes an annual FSA election of \$2400 and terminates employment on June 20 will have contributed \$1200 (\$200 per month) at the time of termination. For each month of continued coverage, the QB should send \$204 (102% of the applicable premium/contribution) to the employer. Under the limited COBRA obligations scenario, a QB’s participation ceases at the end of the plan year in which the qualifying event occurred or when he or she fails to submit premium payment.

Source: NFP