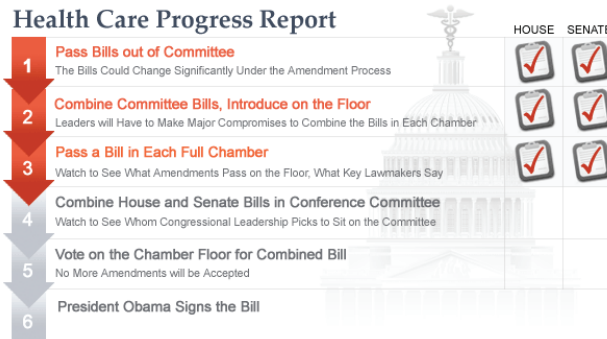




EMPLOYEE BENEFITS NEWSLETTER ~ FEBRUARY 2010

Update: Health Care Reform - What Will Change for You



Source: Kiplinger Magazine
by Kimberly Lankford

The Similarities

The key concepts in the Senate and House bills are the same: people who already have insurance can keep their current coverage, and people with health problems will have an easier time finding affordable insurance.

Both bills prohibit insurance from rejecting anyone because of a pre-existing condition (called guaranteed issue) or charging them more because of their health status. They also eliminate dollar-amount caps on coverage, expand Medicaid and provide subsidies to help more people pay for coverage. For example, a family of three earning up to about \$73,000 would be eligible for a subsidy.

Each bill mandates that most Americans have health insurance and creates exchanges to make it easier to buy coverage. Large companies must provide insurance to employees or pay a fine (specific requirements are still being negotiated).

The Sticking Points

The House and Senate structure the insurance exchanges differently (they're state created in the Senate bill versus a single, national exchange in the House version), and the Senate bill would allow insurers to sell policies outside of the exchanges. Rules to make sure that policies in the exchanges aren't competing against less-regulated ones outside the exchanges are still up in the air. If outside policies have lower premiums and less coverage than required in the

exchanges, they could siphon off healthy people and leave the exchanges with the less than healthy and boost prices.

Enforcing a mandate to require insurance is also tricky, aside from possible constitutional issues: the rules prohibiting insurers from rejecting applicants because of pre-existing conditions or basing premiums on health status will work only if a broad enough group of people buy insurance. Both the House and Senate bill impose penalties on people who don't have coverage, but the penalties are pretty low. Politically, it's difficult to increase the penalties. But Cori Uccello, senior health fellow at the American Academy of Actuaries, says lawmakers could find other ways to encourage people to buy coverage, such as offering health insurance only during an annual open-enrollment period so that people don't wait until they're sick to get insurance.

The Congressional Budget Office estimates that the cost would be \$871 billion over ten years for the Senate version and \$894 billion for the House bill. The House bill proposes a 5.4% tax on individuals with annual incomes in excess of \$500,000 and families with incomes above \$1 million. The Senate bill relies on a 40% excise tax on plans costing more than \$8,500 per year for individuals and \$23,000 for families. The thinking is that this would encourage insurers to keep costs down. The White House supports this tack. Considering that the Senate passed its bill with no

votes to spare, odds favor the excise tax over the income tax, although labor unions may cut a deal to change some of the details.

The Timetable

Most major changes won't take effect until 2013 (in the house bill) or 2014 (Senate). But a few provisions would become effective sooner.

Both versions would prohibit insurers from placing lifetime limits on coverage and from rescinding coverage except in cases of fraud—two protections that would take effect six months after the law is signed. Also on the fast track: a provision in both bills that requires policies to provide dependent coverage for children up to age 26 (Senate) or 27 (House). And both versions expand funding for high-risk pools, which can help people with medical conditions find coverage until the guaranteed-issue law takes effect. Also, the House bill would immediately extend eligibility for insurance under COBRA until insurance exchanges are established (COBRA eligibility now lasts for only 18 months if you lose your job).

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DOT Announces Federal Ban on Texting for Commercial Truck Drivers

Source: SHRM, Allen Smith, J.D.

U.S. Dept. of Transportation (DOT) Secretary Ray LaHood announced federal guidance on January 26, 2010, to expressly prohibit texting by drivers of commercial vehicles such as large trucks, buses and vans. The prohibition is effective immediately and applies to interstate truck drivers and commercial bus and van drivers who carry more than eight passengers. Truck and bus drivers who text while driving commercial vehicles may be subject to civil or criminal penalties of up to \$2,750.

“Today we’re sending a strong message: We don’t merely expect you to share the road responsibly with other travelers—we require you to do so: said LaHood. “This is an important safety step, and we will be taking more to eliminate the threat of distracted driving.”

“We want to make it crystal clear to operators and their employers that texting while driving is the type of unsafe activity that these regulations are intended to prohibit,” stated Anne Ferro, administrator for the Federal Motor Carrier Safety Administration (FMCSA).

FMCSA research shows that drivers who send and receive text messages take their eyes off the road for an average of 4.6 seconds out of every 6 seconds while texting. At 55 miles per hour, this means that the driver is traveling the length of a football field, including the end zones, without looking at the road.

President Barack Obama signed an executive order directing federal employees not to engage in text messaging while driving government-owned equipment. Federal employees were required to comply with the ban starting on 12/30/09.

Medicare Reporting Rules

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) added new mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plans as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers’ compensation. The purpose of the new reporting rules is to enable Medicare to correctly pay for the health insurance benefits of Medicare beneficiaries by determining whether Medicare or other insurance is required to pay first.

In general, employers will not have any reporting obligations if they have an insurer or third-party administrator to assume the role of responsible reporting entity (“RRE”). Employers with self-insured benefit programs will have to register as an RRE and will remain responsible for reporting. Reporting for group health plans was scheduled to begin October 1, 2009. Reporting for self-insured liability arrangements such as workers’ compensation is scheduled to begin July 1, 2010.

OSHA Publishes Illness-Injury Database

Data from 1996-2007 on workplace-related illnesses and injuries have been posted online in a searchable database from the U.S. Occupational Safety and Health Administration (OSHA). The database, part of the U.S. Dept. of Labor’s efforts to comply with the Obama administration’s Open Government Directive, includes information from more than 80,000 employers. This is the first time the information has been made available in an online database. The public can search establishment or industry-specific injury and illness data at www.data.gov.

According to an OSHA news release, OSHA uses this information to calculate injury and illness incidence rates to guide its planning and focus its Site Specific Targeting Program, which the agency uses to target its inspections. “Making injury and illness information available to the public is part of OSHA’s response to the administration’s commitment to make government more transparent to the American people,” said David Michaels, Assistant Secretary of Labor for OSHA. “This effort will improve the public’s accessibility to workplace safety and health data and ensure the agency can function more effectively for American workers.”

The databases gives the following information for companies that provided OSHA with valid data through the end of 2007: name, address, industry, associated Total Case Rate; Days Away, Restricted, Transfer case rate; and Days Away From Work case rate.

Reminder: all employers with 10 or more employees are required to post their OSHA 300A log from February 1, 2010 through April 30, 2010.

Wellness At Work For You

Participants in Wellness Programs Had Lower Health Care Costs

Health plan members who participated in fitness-related activities within an incentive-based wellness program had significantly lower medical costs, according to a study published in the January/February 2010 issue of the *American Journal of Health Promotion*.

The study examined the medical claims data over one year of 948,974 adult members of South Africa's largest private insurer, Discovery Health. Of these members, more than 62 percent (591,134) registered for "Vitality," an incentive and reward-based health promotion program offered by the insurer to its members.

"Employers continue to struggle with increasing health care costs and the growing prevalence of chronic diseases, but more and more are turning to population health management programs as a solution," said Arthur C. Carlos, CEO of The Vitality Group, as U.S. provider of wellness programs and a member of Discovery Holdings Ltd. "Incentive based wellness programs are designed to change behaviors and improve the health of their members. By improving health in a sustainable way, it is possible to reduce costs over the long-term."

Hospital Cost Savings and Short Stays

The adult insured members were grouped based on registration and their level of engagement in the Vitality program: not registered (37.5 %), registered but not active in any health promotion activity (21.9 %), low engagement (30.9 %) and participated in enough activities to be considered highly engaged (9.5 %). Most activities (i.e., fitness-related activities, assessment and screening, healthy choices, and health knowledge) and outcomes were validated.

Hospitalization costs were analyzed per member in the various groups, and the research indicates that not only costs per member decreased based on activity level, but the same pattern was demonstrated for admission rates. For those admitted to a hospital, the length of stay and frequency of admission was significantly less for participants who were active in fitness-related activities.

This most engaged group had lower annual medical costs, admission rates and cost per admission than any of the other groups. Costs for medical conditions related to lifestyle factors were also lower, including:

- ◇ 21.38% lower for endocrine and metabolic disease.
- ◇ 17.44% lower for musculoskeletal disease.
- ◇ 15.09 % lower for cancers
- ◇ 7.17% lower for cardiovascular disease.

"The rise in incidence of chronic disease and associated health care costs is unsustainable," said study leader Dr. Deepak N. Patel, a senior clinical specialist at Discovery Health. "As researchers, it is critical we evaluate and identify solutions to mitigate this trend. Although more research will need to be done, this study is encouraging as it shows a positive correlation between engagement in health promotion and lower health care costs."

ROI Quantified

Rigorously conducted case studies indicate a positive return on investment (ROI) from employer-sponsored wellness programs, according to a report in the February 2010 issue of the journal *Health Affairs*. In "Workplace Wellness Can Generate Savings," researchers at Harvard University conducted an analysis of the literature on costs and savings associated with wellness promotion policies. "The evidence suggests that large employers adopting wellness programs see substantial positive returns, even within the first few years of adoption," they found. "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."

Among the findings: Citibank's health management program reported an estimated savings of \$4.50 in medical expenditures per dollar spent on the program, and studies from the California Public Employee Retirement System, Bank of America and Johnson & Johnson similarly estimated sizable health care savings from wellness efforts.

Aside from savings on health care costs, wellness programs were likely to result in lower replacement costs for absent workers. Researchers concluded: **"all of this suggests that the wider adoption of such programs could prove beneficial for budgets as well as health."**

Controlling Health Care Costs in 2010

1. Conduct a dependent eligibility audit. Begin with an amnesty period to allow employees to voluntarily remove ineligible dependents without penalty.
2. If you have retirees on your health plan, make sure your claims administrator is correctly integrating with Medicare.
3. Audit your claims administrator to ensure that all claims eligible for stop-loss reimbursement have been accurately reported to your excess risk carrier.
4. If self-insured, negotiate changes in your ASO fees to reflect probable changes in your company's wages and salaries next year.
5. Consider offering a Consumer-Driven Health Plan (CDHP). This often comes in the form of a high-deductible health plan paired with a health savings account (HSA).
6. Examine your prescription drug plan and consider adding alternative drug plans, such as a CDHP option. Or, if you have a three-tier RX plan, redesign the tiers to encourage lower-cost generics. Consider adding a 4th tier for pricey "lifestyle" drugs.
7. Analyze carrier data to identify common chronic diseases and implement a disease management program.
8. Routinely educate employees on smart consumerism strategies, the importance of preventive care and low cost medical or RX options.
9. Raise your employee deductibles, copayments and/or out-of-pocket maximums. This will encourage employees to think twice about their health care expenditures, plus will save you money.
10. Increase your use of health and wellness incentives. Offer incentives for behaviors such as taking a health risk assessment or participating in a smoking cessation, weight management or fitness program. Incentives may include gift cards, cash or discounted premiums.

Interested in learning what a Wellness Program can do for your Company? Call our Wellness Manager at:

Phone: 270-793-0367

Supreme Court to Clarify When Attorney’s Fees Are Available in ERISA Disputes

The U.S. Supreme Court announced on January 15, 2010, that it will review a decision that involves the question of when attorney’s fees are available in litigation under Section 502(g)(1) of the Employee Retirement Income Security Act (ERISA). The court will decide whether attorney’s fees may be awarded at a district court’s discretion to either party or only to a “prevailing party.”

Long Term Disability Benefit Dispute

The case that the court will review arose from a dispute over long-term disability benefits.

Bridget Hardt, an executive assistant to the president of textile manufacturer Dan River Inc., began experiencing pain in her neck and shoulders in 2000. After she was diagnosed with carpal tunnel syndrome, she underwent surgery on both of her wrists, but continued experiencing pain and stopped working on January 23, 2003.

In August 2003, Hardt asked that Reliance pay her long-term disability benefits under Dan River’s group Long-Term Disability Insurance Plan. Under the terms of the plan, Dan River administered the plan, but Reliance Standard Life Insurance Co. underwrote it and decided whether a particular individual was entitled to benefits. Reliance notified Hardt that she must submit to a functional capacities evaluation and granted her a provisional approval.

Hand Rehabilitation of Hampton Roads, VA, administered the functional capacities evaluation in October 2003. The evaluator concluded that Hardt had major limitations, including neck and upper extremity pain, decreased right hand dexterity and strength, restricted overhead reach, a restricted ability to squat and kneel, the inability to crawl or to climb ladders, and decreased lift, carrying and abilities to push and pull.

In December 2003, Reliance denied Hardt’s claim, concluding she did not meet the plan’s definition of total disability. Under the terms of the plan, Hardt appealed. Reliance then reversed its decision and granted Hardt 24 months of temporary disability benefits.

Meanwhile, Hardt also was diagnosed with hereditary small-fiber neuropathy, a disorder involving small sensory cutaneous nerves and whose symptoms include tingling, numbness, burning pain or extreme coldness as well as brief, painful sensations and loss of temperature sensation.

Hardt applied to the Social Security Administration (SSA) for disability insurance completed by her treating physicians that concluded she could not return to her prior

position or other sedentary positions because of her neuropathy and other maladies. The SSA found that Hardt was disabled under the Social Security Act.

A few months later, Reliance notified Hardt that her benefits would expire at the end of the 24-month period. The plan provided benefits after 24 months only to individuals who were totally disabled from *all* occupations. Reliance found that she had several employment opportunities still available and concluded that she was not totally disabled.

Hardt appealed this denial of her claim, but her appeal was denied after review of her functional capacity examinations, a review by a doctor who Reliance hired to see some of Hardt’s medical records and a labor market study prepared by a vocational rehabilitation counselor who Reliance also hired.

Hardt filed a complaint in federal district court alleging that Reliance violated ERISA by wrongfully denying her long-term disability benefits. The district court remanded Hardt’s claim to Reliance for reconsideration. In sending the claim back to Reliance, the district court stated that if Reliance did not adequately consider all of the evidence discussed in its opinion within 30 days of the date the opinion was issued, judgment would be issued in favor of Hardt.

On remand, Hardt provided additional medical records for Reliance’s consideration, and Reliance reversed its earlier decision. It awarded Hardt full long-term disability benefits until her 66th birthday, as well as retroactive benefits for the time elapsed. Hardt then filed a motion for attorney’s fees and costs, which the district court awarded on August 7, 2008, concluding that Hardt was a prevailing party. The court awarded \$39,149 in fees.

Tactical Mooting

Reliance appealed, and the 4th U.S. Circuit Court of Appeals reversed, determining that only a prevailing party is entitled to consideration for attorney’s fees in ERISA actions, and that Hardt was not a prevailing party because there was no enforceable judgment on the merits or judicially sanctioned relief. The 4th Circuit stated that “there is no exception for ‘tactical mooting’ - the situation where a defendant chooses to settle rather than risk an award of attorney’s fees.”

Hardt asked the Supreme Court to review the case, arguing that the circuits are split over whether attorney’s fees may be awarded in ERISA cases at the district court’s discretion to either party or only to a prevailing party. “Review by this court plainly is warranted to provide needed uniformity on these issues that



have profound implications for this comprehensive statute affecting millions of workers across the United States,” her brief for review stated.

“The reach of ERISA is staggering,” noting that the U.S. Dept. of Labor’s Employee Benefits Security Administration has oversight authority for nearly 700,000 retirement plans, approximately 2.5 million health plans and a similar number of other welfare benefit plans such as those providing life or disability insurance, covering about 150 million workers and their dependents. “Ensuring an effective private enforcement provision for ERISA therefore is critical,” her brief stated. Approximately 9,000 to 11,000 ERISA cases were filed in federal court each year from 2004 ~ 2008. “Whether attorney’s fees should be awarded there arises in a significant number of cases and is frequently recurring in the lower courts.” Hardt also asked the court to decide whether a claimant is entitled to attorney’s fees under ERISA where she secures a remand to her plan administrator for reconsideration of her benefits claim, saying there was a split in the lower courts on this issue as well.

In its brief opposing review of the case, Reliance asserted that the Supreme Court already has addressed fee awards under the ERISA statute in *Kaiser Steel Corp. v. Mullins*, 455 U.S. 72 (1982), where the court said that in an ERISA action, “attorney’s fees are normally awarded only to prevailing parties.” Reliance also asserted that Hardt “has not identified a single case in which a court actually awarded attorney’s fees to a nonprevailing party under ERISA.”

Hardt stated “plan administrators in the 4th Circuit are now incited to vigorously oppose claims in violation of ERISA, for if the claimant elects to pursue the matter in court and is able to secure a remand, the plan can simply pay the claim and tactically moot the case at that later point, thereby avoiding liability for attorney’s fees. If this result is allowed to stand, most claimants, especially those with small claims or limited means, effectively will have been denied their rights in contravention of the clear purpose of ERISA.”