

# Benefit Insights

## **CHIP Reauthorization Act Creates New Special Enrollment Rights, Notice and Disclosure Obligations for Employers**

New special enrollment rights, along with notice and disclosure requirements for employers, are among the provisions in the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, signed into law by President Obama on February 4, 2009. CHIP is the federal program that gives matching funds to states in order to provide health insurance to low income families with children. The Reauthorization Act expands the program, but is also including new special enrollment rights and notice and disclosure requirements for employers.

The law creates special enrollment rights for employees and their dependents who are "eligible but not enrolled for coverage" under an employer's group health plan in two situations: the employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, or the employee or dependent becomes eligible for a subsidy (see next paragraph) under Medicaid or CHIP. An employee exercising one of these special enrollment rights must do so within 60 days of Medicaid/CHIP termination or becoming subsidy-eligible. (Note that this special enrollment rights period is twice as long as that under the HIPAA special enrollment rights situations.) These special enrollment rights become effective April 1, 2009.

States can provide health care coverage directly to CHIP-eligible individuals, but the law also allows them the option of paying a premium assistance subsidy so that low-income employees can cover CHIP-eligible children under an employ-

er group plan. The subsidy can be provided to the employee as a reimbursement for premiums paid to the group plan, or to the employer sponsoring the plan. Employers can opt out of receiving the subsidy payment, in which case it will be paid to the employee. The subsidy can only be offered for what the law refers to as "qualified employer-sponsored coverage"—a plan for which the employer contributes at least 40% of the cost, and not including health care flexible spending accounts and high deductible health plans.

In states that provide a premium assistance subsidy, employers will be required to give employees notice of the potential opportunity for the subsidy. Such a notice will need to be provided when notifying the employee of plan eligibility, when open enrollment materials are distributed, or when providing the summary plan description (SPD). The Department of Health and Human Services (HHS) is to develop a model notice by February 4, 2010; this notice requirement will become effective for employers beginning with the plan year after issuance of the HHS model notice.

The law also creates a disclosure requirement for group health plans. The purpose of disclosure will be to help states determine eligibility for the subsidy and its cost-effectiveness. HHS and the Department of Labor (DOL) will form a working group to develop a model disclosure form, and employers will be required to disclose information upon request beginning with the plan year following issuance of the model disclosure form.

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## Employers Need to Review FMLA Procedures and Notices

The Department of Labor (DOL) has published final regulations on the 15-year-old Family and Medical Leave Act (FMLA). According to the DOL, these final regulations provide “clarity” about FMLA rights and obligations for both employers and employees. More than 200 pages long, the regulations address numerous FMLA issues. Some of the significant provisions include the following—

- The regulations provide guidance on FMLA’s application to military families. The 2008 National Defense Authorization Act, enacted in early 2008, expanded FMLA to include provisions particular to military families in cases of leaves required by the injury/illness of a service member or by an exigency caused by the active duty/call to duty of a service member. For exigency leave, the new regulations define eight “qualifying exigencies”: short-notice deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities, and additional activities where the employer and employee agree to the leave. For military caregiver leave, the regulations clarify that this leave is available on a per-service-member, per-injury basis for up to a total of 26 weeks in a 12-month period, for a caregiving employee who is the spouse, child, parent or next of kin of the service member.
- The final regulations consolidate all employer notice requirements into one section of the regulations and within this consolidation make substantial changes. Employers now have five business days (up from two) from when the employee requests FMLA leave, or from when the employer knows that an employee’s leave may be for FMLA purposes, to notify the employee of his or her eligibility for FMLA leave and to provide the employee with a FMLA designation notice. The notice required at this time has been separated into two new notices, an “Eligibility/Rights and Responsibilities” notice and a “Designation” notice. Most of the other forms and notices associated with FMLA also have been changed. Sample notices, forms and required postings will be available through the agency’s Web site.
- With regard to an employee’s notification to the employer of the need for FMLA leave, in the case of a foreseeable leave when advance notice is not practical, the employee must provide notice the same day of the absence or the next business day (this tightens the timing from what had previously been interpreted, and is intended to minimize workplace interruption).
- The regulations revise the medical certification form, enabling a more complete statement of the information relevant to a leave-taking employee’s condition. The

employer now may directly contact the employee’s medical provider for authentication or clarification of the information on the certification, but the employer representative who makes this contact cannot be the employee’s direct supervisor.



- With regard to employee recognitions such as perfect attendance awards, days missed because of FMLA leave can now be counted against an employee, so long as other leave takers are treated in the same way.
- While employees cannot waive FMLA rights prospectively, the regulations clarify that employees can settle or release FMLA claims based on past employer conduct.

This is just a brief sampling of some of the provisions of the final FMLA regulations. The bottom line is this: These final FMLA regulations include significant changes, meaning that any employer subject to the law should review its existing leave policies and notice procedures to ensure that it is in compliance. The regulations are effective January 16, 2009.

## What Goes into Determining the Cost of a Prescription Drug?

Prescription drug costs continue to be one of the fastest growing components of total health care costs. According to a 2008 report from the Kaiser Family Foundation, spending in the United States for prescription drugs in 2006 was \$216.7 billion, more than five times what it was in 1990. Though spending for prescription drugs was one-third of that for hospitals and half of that for doctors' services, the annual rate of increase for spending on prescription drugs has exceeded that for these other services in all but one of the last 11 years.

Nearly half (44%) of spending for prescription drugs is paid for by private insurance, and since employers are the principal source of health insurance coverage in the United States, they fund a major portion of the spending for prescription drugs. Therefore, it's worthwhile for employers to understand the factors that go into the ultimate cost of the prescription drugs that are paid for, in part, by employee benefit plans.

When a new drug is first brought to market, the company that developed it enjoys some patent protection for the drug, which gives that company the exclusive right to sell that drug in the market for a certain period of time. This protection is intended to help pharmaceutical companies recover some of the cost of drug research and development, which can be substantial. By providing patent protection for a period of time, companies are encouraged to take the financial risk associated with new drug development. Only after the patent protection has expired can competitors bring lower-cost generic versions of the same drug to market.

When a company develops a new drug, it decides what price to charge for it, taking into account factors such as the research and development costs associated with the drug; whether other, different drugs with similar therapeutic effects are available; market demand; the current economic and competitive climate; and advertising costs and marketing strategy. While in some other countries governments play an active role in setting the prices for prescription drugs, this is not the case in the United States.

The price a drug manufacturer sets for its product is just the first piece of the equation that determines what the drug

ultimately costs at the time it is dispensed to the consumer. Health plans and pharmacy benefits managers (PBMs) will negotiate with pharmaceutical manufacturers for discounts and rebates on their prescription drug products. The success of such negotiations and size of incentives achieved can vary significantly depending on a number of factors, including the utilization volume of the plan/PBM for the manufacturer's products, placement of the manufacturer's products on a plan formulary or preferred drug list, etc. Health plans and PBMs also can save costs by trying to achieve savings at the pharmacy level of the prescription drug distribution chain. This can be done by establishing networks of preferred pharmacies that agree to accept an established reimbursement rate in exchange for being included in the network, and by setting up or working with mail-order pharmacies.

Though these factors that establish the price of a prescription drug are out of an employer's hands, there are things that any company with a prescription drug benefit can do to have some impact on what prescription drugs will ultimately cost the plan. Effective plan designs that encourage the use of generics and other preferred medications and that succeed in getting employees to use preferred and mail-order pharmacies can dramatically lower plan spending on prescription drugs. Working with a PBM or health plan that is proven effective with these strategies can be key in getting the most for your prescription drug dollar.



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The law provides for penalties of up to \$100 a day for failure to comply with either the notice or disclosure requirements.

So what should employers be doing now to get up to speed on this new law?

- Identify all states where employees reside and determine whether the state provides a premium assistance subsidy.
- Review health plan documents and amend them as necessary to provide for the new special enrollment rights.

As noted above, employees are able to exercise these special enrollment rights effective April 1, 2009.

- Review any health insurance contracts' coordination of benefits (COB) provisions, because states will be the secondary payer for services provided under employer group health plans for which a premium assistance subsidy is provided.
- Stay alert to developments from the DOL and HHS concerning this law, and be prepared to take compliance steps as soon as the model notice and disclosure forms are released.

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## **Voluntary Benefits Provide Value in Tough Economy**

Tough economic times can take a toll on all aspects of a company's operations, including the employee benefits department. As companies look for ways to keep a cap on employee benefits costs—while still offering an attractive, competitive benefits package—consider the value of voluntary benefits.

Voluntary benefits can help meet individual employee needs and fill gaps in the regular employee benefits program, at little or no cost to the employer. Employees pay for voluntary benefits with their own money, but at a sometimes substantial savings of both time and money: group discounts generally are available; marketing is brought into the workplace, instead of employees having to shop for these products on their own; and payment can be conveniently made through payroll deduction. Furthermore, employees may have access to products that would not be available to them on an individual basis, as underwriting may be relaxed when the product is offered to a group.

When considering voluntary benefits, it's important to offer those products that are most likely to be well-received by your employee group. Therefore, have a strategic plan for implementation, just as you do with your core benefits program. Consider first what coverage gaps employees may have. For example, if your core program lacks dental or vision options, these are ideal voluntary benefits offerings. If you limit life insurance coverage to a set multiple of salary, supplemental life or life insurance options with a cash accumulation feature could be offered. If your workforce includes part-time employees who are not eligible for the core plan, voluntary benefits offerings could include limited medical, along with dental and vision. And if your benefit plan is comprehensive, and has few gaps, bring in options that give employees alternatives to purchasing insurance products in the individual market—long-term care, group home and auto, cancer and/or critical illness insurance, legal services plans, even pet insurance.

In addition to coverage gaps, examine employee demographics to determine which voluntary benefits offerings would be appropriate. Employee focus groups and surveys can also be useful information-gathering tools in selecting voluntary benefits products that are likely to be well-received by your workers.



In addition to expanding your employee benefits options, voluntary benefits can enhance your communications opportunities with employees. Choose a vendor that is armed with communications vehicles that ensure program success: a combination of paper, online and in-person outreach designed to promote the opportunities of the voluntary benefits offerings, but without the kind of hard sell that can turn employees off.

Today's technologies make the administration of voluntary benefits programs easier than ever. Online enrollment and claims inquiries/processing direct to the vendor can, in many cases, limit the burden on the employer's human resources and benefits staff to the set-up of payroll deduction. This is a small investment when the return is a more comprehensive benefits program at little or no additional cost, and employees who are more satisfied with their employee benefits package.



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