k&p benefits insider

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Kibble & Prentice

In our continued efforts to keep you informed of recent changes in health and welfare plans and administration, this issue of the *k&p benefits insider* addresses recent federal and state legislative changes. Also included are important carrier information and changes that may affect current plans. And as a reminder, our Benefit Resource Center at Kibble & Prentice is here to assist participants with elevated claims needs.

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Proposed Legislation Surrounding Long-Term Care

Most Americans do not plan for an unexpected medical crisis or future medical expenses. As the population lives longer, more people will require long-term care. Many believe Medicaid will cover their long-term care needs. However, the Medicaid program requires those in need to spend down assets before receiving public assistance. The following legislation is pending in Congress, which would encourage more Americans (including younger individuals who can take advantage of lower premiums) to purchase long-term care insurance.

Long-Term Care and Retirement Security Act of 2005 (H.R. 2682/ S. 1244)

- Allows individuals to take tax deductions on long-term care insurance premiums, without the need to itemize. (HIPAA regulations have allowed a portion of certain types of long-term care insurance premiums to be tax deductible since 1996 on an itemized basis).
- Allows employers to offer long-term care policies which can be run through Section 125 plans with pre-tax dollars.
- Provides financial assistance for those already ill and/or their caregivers who require long-term care services, by means of a tax credit of up to $3,000.

Medicaid State Long-Term Care Partnership Program Act of 2005 – (H.R. 3511/S.1569)

Long-term care (LTC) partnership programs have been operating in four states for years (California/March 92, Connecticut/April 93, Indiana/April 93, and New York/August 94). The Omnibus Reconciliation Act of 1993 (OBRA '93) impedes all other states from implementing LTC partnership programs because of its recovery rules, which allow the states to recover amounts paid by Medicaid after the death of the recipient, rather than protecting the assets for the surviving beneficiaries. Current legislation proposes to remove this impediment, so that other states are encouraged to establish partnership programs.

The goal of partnership programs has been to:

- Provide an incentive for insurers to offer high quality long-term care products.
- Protect consumers from the high cost of long-term care.
- Coordinate between private long-term care insurers and Medicaid.
- Reduce Medicaid expenditures at both the state and federal levels.

In a partnership program, a consumer purchases a private Long-Term Care (LTC) insurance policy,

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Proposed Legislation Surrounding Long-Term Care

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which is the initial payer for long-term care costs. If the private insurance benefits are exhausted, Medicaid becomes the secondary payer. The policyholder is able to keep personal assets equal to the benefits paid by the policy, rather than having to spend down to qualify for Medicaid.

The legislation would allow individuals to bequeath a portion of their assets to their loved ones instead of leaving a burden to their surviving spouse or children, offer consumers more care options while protecting assets from Medicaid recovery, and provide reciprocity between the states.

For more information regarding the current laws regulating Long-term Care, please see the following website: http://www.nahu.org/government/issues/long_term_care/LawsRelatingtoLongTermCare-revised%208-2005.pdf.

Contact the Kibble & Prentice Employee Benefits Tech Team

Would you like to obtain future copies of this newsletter by e-mail? If so, send us your name, phone number and e-mail address and we will add you to our e-mail list in time for the next mailing!

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Proposed Legislation: Association of Health Plans for Small Businesses

On July 26, 2005, the House passed the Small Business Health Fairness Act of 2005 (H.R. 525). Known as the AHP Bill, this legislation would allow small businesses across the country to form Association Health Plans (AHP). While thousands of association plans exist today, these are state regulated and thus may include state-mandated benefit requirements. The proposed AHP plans would be exempt from costly state-mandated benefit laws since they would be federally regulated by the U.S. Department of Labor. Federal health insurance requirements such as COBRA, ERISA and HIPAA would still apply.

Overview

AHPs allow small businesses to purchase health coverage through a national association of small businesses under a uniform set of rules that apply across state lines. The intention of this federal legislation is to create a level playing field for small businesses, enabling them to increase bargaining power and administrative efficiencies. Ideally, these efficiencies will allow insurance companies to better serve small businesses by offering health insurance at reduced costs.

Insurance premiums would be based on the claims experience of the entire AHP plan – not by individual employer. However, rate variations would be allowed if they are permitted by the state for other bonafide associations. Fiduciaries of the plan, under ERISA, act solely in the interest of participants and in both self-funded and fully insured AHPs, all profits and savings would go to plan participants.

Requirements

The proposed legislation would require, in part:

- The association be in business for at least three years for purposes other than providing health insurance coverage,
- Board members must be principals in participating employers,
- The AHP be certified by the Secretary (some exceptions to the certification requirement apply),
- Specific diseases not be excluded.

To offer a self-funded plan under the proposed AHP arrangement, the AHP must:

- Have at least 1,000 or more covered employees and dependents; or
- Already have an established self-funded plan before the date of enactment; or
- Membership not be restricted to specific trades or businesses; or
- Include employers that have an average or above average health insurance risk.

What's in Store for AHP Legislation?

The House has passed similar legislation numerous times in past years. To date, the Senate has never passed such legislation and current companion legislation S. 545 is not expected to pass the Senate. However, Senator Mike Enzi (R-WY), chairman of the Health, Education, Labor and Pensions (HELP) Committee, plans to introduce a bill in September 2005 that would bridge the gaps between the House and Senate versions of the AHP Bills.

Too Good to Be True: Fraudulent Insurance Scams

Employers, individuals and families continue to seek creative solutions to reduce health care costs. Unfortunately, there are options in the market place that are too good to be true.

Fraudulent health insurance plans resemble authentic health insurance plans, except for one important detail — they do not actually pay the benefits as promised. Often fraudulent companies avoid early detection by covering small claims and recruiting licensed agents to sell the product. When large claims occur, the company vanishes. Victims of these scams are ultimately responsible for large unpaid medical claims. In addition, once a victim realizes they are uninsured and attempts to purchase other insurance coverage, they may not be eligible for new coverage on their pre-existing medical condition.

Employers who purchase fraudulent health insurance may also be liable for unpaid medical bills. Fraud affects everyone because the cost is passed on to consumers through higher healthcare premiums.

How to Avoid the Scam

Be wary of:

- Individuals who tell you they are not required to have an insurance agent license to sell their product.
- Health insurance premiums that are significantly lower for a similar product in the market.
- Health insurance plans that offer to provide coverage for all, regardless of pre-existing conditions.
- A health insurance plan that does not use the word "insurance" anywhere in its materials.
- Companies that ask you to pay for premiums in cash, pay a year's premium in advance or request that you sign a blank insurance form.
- Companies that use names that imply they are connected with the government, Medicare or other well-known companies. Fraudulent companies often choose familiar names in an attempt to mislead consumers into thinking they are purchasing insurance from a reputable company.

Also:

- Check with your state insurance department to confirm the insurance company is licensed.
- Ask for references from clients of the insurance agent.
- Remember not to jump at a deal just because the rates are extremely low.

Our Mission

Kibble & Prentice is dedicated to assisting clients in making sound decisions that create value and manage risk.

Kibble & Prentice Benefit Resource Center

Having problems getting a claim processed?
Concerned that a claim didn't process the way you thought it should?
Not sure what your preventive care maximum is?
Call the Benefit Resource Center.

The Benefit Resource Center is here to help our clients! Our experienced staff will work with your insurance carrier to address any escalated claim issues or benefit question. Feel free to contact us anytime. We are available Monday through Friday, 7:30 am to 5:30 pm Pacific Time. Should you need assistance outside our normal business hours, you may leave a message or send an email. We will respond to your inquiry by the end of the next business day.

Call us today!

Kibble & Prentice Benefit Resource Center
1.866.4ourBRC (1.866.468.7272)
4ourBRC@kpcom.com

First Choice EAP

First Choice EAP is utilizing a new vendor, Work Life Benefits, for Elder Care, Child Care, Childhood Education and consultation services. This change allows First Choice to offer financial planning, consultation services, a broader range of legal consultation services, and ID theft/fraud protection.

In order to ensure a seamless transition, members will continue to access First Choice's central 800 number and/or website for all services provided by the vendor, rather than go directly to Work Life Benefits.

For Work Life information and resources, visit www.1stchoiceeap.com.

Group Health

Effective September 30, 2005, Group Health Cooperative and its subsidiary Group Health Options, Inc., will cease their business relations with BENU Washington. BENU provided a platform for administering a multi-carrier arrangement between Group Health, Kaiser Permanente and CIGNA since 2002. However, with the ever changing health care market, Group Health is focusing on more cost-effective single carrier arrangements to meet the needs of their customers.

Group Health will honor all current BENU contracts through their expiration date, maintaining coverages and services. However, any contracts that renew in 2006 will not be offered as part of any BENU plan. Through September 2005, Group Health will continue to provide BENU quotes to prospective groups and any group sold will be covered for the remainder of the contract year.

Group Health's affiliate, Kaiser Permanente, continues to operate under the BENU arrangement in Oregon and the Mid-Atlantic.

KPS Health Plans

The members of the Kitsap County Medical Society established KPS Health Plans, formerly Kitsap Physicians Service, in 1946. Today, KPS is a non-profit corporation licensed as a Washington state healthcare service contractor.

In 1999, KPS was placed under the control of the Office of Insurance Commissioner just as it was on the brink of insolvency, running an $8 million operating deficit.

Despite making steady improvements, increasing enrollment and consistently paying claims on time during the past six years, the company remains far below minimum requirements to successfully emerge from receivership. Insurance Commissioner Mike Kreidler has agreed to sell KPS Health Plans to Group Health Cooperative.

Some of the terms of the proposed sale include:

- Group Health will invest $19 million into KPS to meet the minimum capital reserves standards.
- Group Health Cooperative will allow KPS to continue to serve its 55,000 members.
- KPS will maintain a separate corporate identity and remain as a non-profit company.

Kreidler must now ask the court to lift the receivership order to approve the sale. The first hearing on this issue was scheduled for August 19.

To view the Notice of Hearing on the sale of KPS to Group Health Cooperative, please go online to http://www.kpshealthplans.com/brokers/linkedpdfs/noticeofhearing.pdf. If you would like to view news releases or see "Questions & Answers", you may go to the OIC Website at http://www.insurance.wa.gov.

KPS to Assign Unique Member ID Numbers

KPS Health Plans will be assigning new member Identification (ID) numbers instead of using Social Security Numbers (SSN) to ensure the privacy of members. In August, KPS sent new ID cards to all members. Along with a new ID card, members will receive a letter explaining the reason for this change. Going forward, all new enrollees will also be assigned a unique ID number. For seamless claims processing, KPS will cross-reference the member's SSN to their new member ID number. This will allow KPS phone representatives to access member information using either the new member ID number or their SSN.

For more information, please visit the KPS website at www.kpshealthplans.com.

Great West Makes Changes to Preferred Drug List

Great West announced changes to their preferred drug list effective July 2005. Great West has a three tier prescription drug structure, outlined below:

Tier 1— Generic medications on the Great West formulary

Tier 2— Brand-name medications without a generic equivalent that are on the formulary

Tier 3— Non-preferred/ Non-formulary medications

The drug list change added some medications to Tiers 1 and 2 while other medications were moved from the preferred brand (Tier 2) to the non-preferred level (Tier 3). Some of the preferred brand-name medications that were moved from Tier 2 to Tier 3 now have generic equivalents. Below is a list of changes for some of the most commonly used medications. Please note, this is not a complete list of medications. The entire drug list is available at www.mygreatwest.com.

Generic Additions (Tier 1)

Ergotamine
Fentanyl patch
Gabapentin
Mirtazapine
Mometasone Furoate
Quinapril
Terconazole cream

Brand Additions (Tier 2)

Spiriva (Spiriva was previously covered at tier level 3)

Brand Deletions (Tier 3)

The following medications have been moved from Tier 2 to Tier 3 (non-preferred):

Bactrim
Betaseron
Betapace 80, 120, 160, 240mg
Betatrex
Neurontin
Nitro-Dur
Nizoral
Clomid
Compazine
Depo-Provera
Diflucan
Dilantin
Diprosone
Flexeril
Levothroid
Lotrimin
Soma Compound Tablet
Flexeril 10mg tablet
Levothroid 75, 125 mcg tablet
Lotrimin 1% cream
Topicort
Valium 2, 5, 10mg tablet
Xanax
Zantac 300
Zyban

If you are currently taking a brand-name medication that now has a generic equivalent, you may wish to speak with your doctor about the possibilities of changing your brand-name prescription to the generic equivalent. It is important to discuss any changes in medications with the prescribing physician.

Premera Selects American Healthways to Deliver Disease Management Solutions

On August 25, 2005, Premera announced a three-year agreement with American Healthways. Beginning December 1, 2005, American Healthways, a provider of disease and care management services, will provide enhanced disease management programs to all Premera groups.

Fully insured customers will have access to congestive heart failure, coronary heart disease and diabetes disease management programs. Self-Insured customers will also have access to these programs. In addition, self-insured clients will have the option to create a tailored package by choosing from 18 other disease management programs (i.e., for back pain or depression). Premera will analyze each company's claims experience and offer employer customized packages that provide the greatest potential value to their employees.

American Healthways has a Washington based care enhancement 24-hour call center with nurses available to offer support to members in managing their chronic illness, following their doctor's plan of care and setting personal goals.

For members who are currently participating in existing disease management programs, Premera is working closely with American Healthways to ensure a seamless transition. Additional information will be provided to employers and members in October and November.

American Healthways also offers online educational tools and a confidential health-risk management program.

For additional information and resources, visit Premera's website at www.premera.com, or visit American Healthways website at www.americanhealthways.com.

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Carrier Updates

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UnitedHealth Group Buys PacifiCare

On July 6, 2005, UnitedHealth Group acquired PacifiCare, creating the nation's largest health insurance company. The acquisition of PacifiCare is UnitedHealth Group's seventh acquisition in the last 12 months. Combined, the two companies' plans cover 68 million people.

Company officials say the merger will allow current PacifiCare customers access to UnitedHealth's nation-wide network and will reduce costs by combining technology and eliminating duplicated services.

The deal would improve upon UnitedHealth's force in the California market, where it currently serves fewer than one million clients. It also gives the company new operations in Nevada, Oregon and Washington. Further, the merger would improve Medicare coverage for seniors.

Much of the companies' shared focus has been on providing health care plans for seniors, especially those that use Medicare and, beginning next year, a new federal prescription drug plan (Medicare Part D). Both companies have said they will participate in the government-financed program.

For more information, contact your Account Manager at Kibble & Prentice, or visit UnitedHealth Group's web site: http://www.unitedhealthgroup.com or PacifiCare's web site: http://www.pacificare.com.

WSA Employee Benefits Trust

The Washington State Software Alliance (WSA) Employee Benefits Trust has chosen to partner with the third party administrations services of Benefit Solutions, Inc. (BSI) effective September 1, 2005. In this partnership, WSA Trust participants will still be able to utilize the internet-based Employease system and maintain current eligibility connectivity. BSI will coordinate with Employease to obtain all current eligibility updates. This change will in no way affect participants' premiums.

As a result of WSA's partnership with BSI, WSA Trust participants receive a consolidated billing statement beginning September 2005. September billing statements were generated around August 15, 2005. Future billings will continue to be generated and mailed on or near the 15th of each month. Multiple coverages with the WSA (i.e., medical, dental, vision, life, EAP) will be itemized on one billing statement from BSI.

The implementation process is currently in progress to ensure a seamless transition to the WSA Trust participants. The WSA Trust will be sending frequent status updates.

AB 1825: A California Training Mandate for Supervisors

For years, some employers have trained supervisors and employees in preventing unlawful workplace harassment and discrimination. Yet, sexual harassment remains a major workplace issue and the risks to you as an employer are significant.

To help combat this growing problem, Governor Arnold Schwarzenegger signed into law California Assembly Bill 1825 which became effective September 30, 2004.

California's AB 1825 requires that California employers with 50 or more employees provide a minimum of two hours of sexual harassment training and education to all supervisory employees. This law increases the training obligations of all employers who have employees within the State of California (regardless of domicile), and extends their obligations beyond current Federal regulations.

The initial supervisor training must be completed by January 1, 2006. An exemption exists if a covered employer has provided two hours of training and education to supervisory employees since January 1, 2003.

After January 1, 2006, AB 1825 requires that all eligible employers provide sexual harassment education and training to each supervisory employee once every two years. New supervisors hired after July 1, 2005 must receive such training within six months of taking over supervisory duties.

Since it would be literally impossible for employers to conduct classroom-style training for 1.7 million California supervisors and AB 1825 does not specifically define what constitutes "effective interactive training," the Department of Fair Housing and Employment (DFHE) has strongly suggested that web-based training will be acceptable as "interactive" training under AB 1825.

There is no requirement that the two hours of sexual harassment prevention training be taken in one continuous training session. An employer may break the education into segments, such as two one-hour long training sessions. Employers should also strongly consider maintaining some sort of record keeping system in order to provide and ensure proof of compliance.

AB 1825 establishes a minimum threshold for sexual harassment training and education. Employers may provide additional training and education beyond that required by the statute to prevent and correct sexual harassment and discrimination.

For more information about AB 1825, please visit http://www.legislature.ca.gov/.