

Employee Benefits Report



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Compliance

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Discrimination Law and Your Company's Benefits

Many federal laws prohibit discrimination in employment. All apply to "any term, condition or privilege of employment," including benefits, and most apply to job applicants as well as to active employees.



The Age Discrimination in Employment Act of 1967 (ADEA) makes it illegal to discriminate against a worker age 40 or older because of age. The Older Workers Benefit Protection Act of 1990 (OWBPA) amended the ADEA to specifically prohibit employers from denying benefits to older employees. In limited circumstances, however, an employer may reduce benefits based on age, as long as it

pays the same for providing the reduced benefits to older workers as it pays to provide benefits to younger workers.

The Americans with Disabilities Act of 1990 (ADA) prohibits employers from discriminating against otherwise qualified individuals who have a disability, have a record of a disability or are regarded as having a disability. The ADA applies to employers with 15 or more employees and requires employers to regard disabled employees or

applicants with disabilities as qualified if they can perform the "essential functions" of the job with or without "reasonable accommodation."

The ADA Amendments Act of 2008 (ADAAA), which went into effect on January 1, generally makes it easier for an individual to qualify for accommodations for a disability. The ADA did not define "major life activities," leaving that up to the courts and the U.S. Equal Employment Opportunity Commission (EEOC). The ADAAA includes an exhaustive list of "major life activities" as well as "major bodily functions" in its definition of disability. The lists include, but are not limited to:

- ★ **Major life activities:** caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating,

Deadlines to comply with the Mental Health Parity and Addiction Equity Act of 2008 begin on October 3. If your plan year begins after October 3, you must bring your plan into compliance by the start date; all plans must comply by October 1, 2010.

The Act applies to employers with more than 50 employees that offer group health plans that include mental health and/or substance abuse benefits along with medical/surgical benefits. If your plan does not provide benefits for mental health or substance abuse, the Act does not require you to provide them.

The Act generally prohibits group health plans from placing stricter coverage limits or lower financial limits on mental health or substance abuse benefits than on medical/surgical benefits. Specifically, plans cannot 1) impose higher financial requirements (such as deductibles and copayments), 2) put stricter treatment limitations (number of visits or days of coverage), or 3) impose separate cost-sharing requirements or treatment limitations to mental health/substance abuse benefits. It requires plans to provide for out-of-network mental health/substance abuse benefits if it provides out-of-network medical/surgical benefits, and to make standards for "medical necessity" determinations and reasons for any denial of mental health/substance abuse benefits available upon request to participants.

We can review your plan documents for compliance; please call us for more information.

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Why Your Employees Need Disability Income

Now more than ever, employers and employees alike recognize the importance of having disability income protection.

Research by the U.S. Census Bureau and Cornell University clearly illustrates how having a disability can negatively affect a person's employment status and income. In 2007, the percentage of working-age people with disabilities working full-time/full-year in the US was 21.2 percent, as compared to 56.7 percent among the non-disabled—a difference of 35.5 percentage points. As you'd expect, those unable to work or unable to work full-time/full-year earn less than those able to work. But disabled individuals who work full-time/full-year still earn less than other full-time workers — a median of \$34,200 versus \$40,700, for a difference of \$6,500 per year in 2007.

Disability income insurance can protect your employees from a catastrophic loss of income when a disability makes them unable to work, or unable to work full-time.

How it works

Short-term disability (STD) coverage is the most commonly found type of group disability insurance. STD plans typically have a waiting period of 0 to 14 days before a covered individual will receive benefits, and they provide benefits for a maximum of six months to one year.

Long-term disability (LTD) policies usually begin paying benefits 30 to 180 days after the disability occurs, once the covered individual has exhausted sick leave and short-term disability benefits. Better plans pay benefits until the disabled individual returns to gainful employment or reaches age 65, whichever comes first. Many LTD plans also offer partial or residual disability benefits to help offset earnings lost while the employee transitions back to full-time work.

The most effective plan designs coordinate STD and LTD benefits, so that once

the employee exhausts sick pay and STD benefits, LTD benefits begin immediately.

Usually, group plans have very streamlined or no underwriting requirements so employees do not have to answer a lot of health questions. Your less-than-healthy employees will find it easier to obtain coverage through the group market than through individual policies. In addition, group coverage usually costs less than an individual policy.

Limits on coverage

Both STD and LTD policies replace only a portion of an insured's salary, typically 60 percent, up to the monthly maximum benefit. Most group policies have a maximum monthly benefit \$5,000, which does not include bonuses or dividends. In addition, most insurers will coordinate benefits from a group policy with benefits from any individual disability policies the employee might

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What does group disability income coverage cost?

STD: existing policies averaged \$205 per insured ("life," in insurer jargon); new policies averaged \$202 per life.

LTD: existing policies averaged \$238 per life; new policies averaged \$225 per life.

Source: 2008 U.S. Group Disability Market Survey by JHA. ■





DISCRIMINATION—continued from Page 1
thinking, communicating, and working.

★ **Major bodily functions:** functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

The Equal Pay Act of 1963 (EPA) forbids payment of unequal wages to men and women who perform jobs that require substantially equal skill, effort and responsibility, under similar working conditions within the same establishment, regardless of the title of the job.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions prohibiting “covered entities,” including most group health plans, from discriminating against employees and their dependents based on health factors, including prior medical conditions, previous claims experience and genetic information.

In the past, some group health plans limited or denied coverage if a new employee had a preexisting condition before enrolling in the plan. Under HIPAA, a plan can impose a preexisting condition exclusion only

if the individual received (or was recommended to receive) medical advice, diagnosis, care or treatment for that condition during the six months prior to enrollment in the plan. HIPAA also limits the preexisting condition period for most people to 12 months (18 months for those who enroll late).

The Pregnancy Discrimination Act of 1978 made discrimination on the basis of pregnancy, childbirth or related medical conditions unlawful sex discrimination under Title VII. Women who are pregnant or affected by related conditions must be treated in the same manner as other applicants or employees with similar abilities or limitations.

The Act specifically addresses health insurance as follows: 1) Employer-provided health insurance must cover pregnancy-related costs on the same basis as costs for other medical conditions. 2) Pregnancy-related expenses should be reimbursed exactly the same as those incurred for other medical conditions, whether payments are fixed amounts or a percentage of reasonable-and-customary charges. 3) Insurers cannot impose additional, increased or larger deductibles on pregnancy or related conditions. 4) Employers must pro-

vide the same level of health benefits for spouses of male employees as for spouses of female employees. 5) Pregnancy-related benefits cannot be limited to married employees. 6) If an employer provides benefits to workers on leave, the employer must provide the same benefits for those on leave for pregnancy-related conditions.

Title VII of the Civil Rights Act of 1964 prohibits an employer from discriminating against any individual because of race, color, religion, sex or national origin. The Act applies to employers of 15 or more employees, including state and local governments; however, it does not “apply to an employer with respect to the employment of aliens outside any state” — in other words, it does not cover foreign citizens. It also does not apply to a religious organization that employs individuals of a particular religion to perform its work.

Many states have stricter versions of some of these laws, while others have laws that provide protections to additional classes of employees. To make sure your benefit plans comply with all applicable federal and state laws, we recommend having an experienced benefit consultant review your plans. ■

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own, so he or she will not collect more than 80 percent of pre-disability pay.

Many group LTD policies use two different definitions of disability, depending on how long a claim lasts. These policies use a “modified own occupation” definition of disability during the first two years. This definition considers an insured disabled when “... unable to perform the material and substantial duties of your occupation, and [you] are not engaged in any other occupation...”

After two years, the definition of disability becomes more restrictive. Exact definitions vary, but most require the insured to be unable to perform any of the material and substantial duties of any occupation for which he or she is “reasonably qualified” by education, training or experience. If a policy does not provide partial or residual disability benefits, an insured must navigate chang-

ing disability definitions, accepting no work other than their own occupation during the first two years, and then taking any job for which they are qualified after that.

Group disability benefits can also have tax consequences. Under employer-paid plans, benefits received will be taxable income to the employee. Benefits from employee-paid (or voluntary) plans will be tax-free.

In short, group disability income coverage provides good, basic coverage for rank-and-file employees at a reasonable cost. However, some employees, particularly those with higher incomes, might want to supplement group coverage with an individual policy. In most cases, an insured can obtain higher maximum benefits and more liberal definitions of disability with an individual policy. For more information on disability income coverage, including voluntary (employee-paid) plans, please contact us. ■

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make employees’ out-of-pocket costs so high that it discourages them from filling their prescriptions or taking them as directed. Determine a reasonable out-of-pocket limit — say \$1,000 or \$1,500 — so employees can afford the drugs they need, or consider using a per-prescription coinsurance limit.

Education: In order to use their benefits wisely, employees need to know how they work. Do your plan materials provide them the information they need in a clear and understandable manner? Does your plan provide a means for employees to comparison-shop for their drugs?

We can help you examine your prescription drug costs and plan design for possible cost savings. For more information, please contact us. ■





Putting the Brakes on Prescription Drug Costs

AARP's annual survey of prescription drug prices found the average price of the most widely prescribed brand-name drugs increased 8.7 percent in 2008, while the general inflation rate was 3.8 percent. But the news isn't all bad: the average price of generic drugs dropped 10.6 percent in 2008.

Prescription drugs represent only 10 percent of total healthcare expenditures. So why all the employer, government and media attention to prescription drug costs? Spending on prescription drugs is growing at a much faster rate than other medical expenses. In fact, a recent Kaiser Family Foundation report found prescription drug spending increased 89 percent between 2000 and 2007, and all signs indicate the upward trend will likely continue. In addition, unlike some medical costs, such as emergency

treatment, plan participants can often shop around for their drugs.

Employers can modify several aspects of their prescription drug benefits to help control costs:

- ✱ Products
- ✱ Delivery channel
- ✱ Plan design
- ✱ Education

Products: Over-the-counter drugs cost the least, then generic drugs, then brand name drugs available from multiple sources. The most expensive drugs are single-source brand-name drugs and specialty drugs, or biologics. Of course, whenever possible you want to steer employees toward the lowest-cost option effective for their condition.

Most plans have a formulary, or a list of drugs and the amount of money the plan

will reimburse for each. Reimbursements depend on costs negotiated with the manufacturer; more cost-effective formulary designs also consider a drug's efficacy and cost as compared to other drugs.

Delivery channel: Drug delivery channels include retail pharmacies, mail order pharmacies and specialty pharmacies, along with physicians' offices and hospitals. Mail order pharmacies often provide the lowest prices, although specialty pharmacies might provide good prices and additional services for specialty drugs. When patients obtain drugs directly through their physician or the hospital, there is often less price transparency (and higher markups).

Plan design: Things to look for in a plan include tiered co-payment and coinsurance systems that steer plan participants to less-costly generics or proven "preferred brands." However, you will want to avoid plans that

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Specialty Drugs and Biologics: Economic Bane or Boon?

Specialty drugs can cost \$1,000 per month, while biologics can cost \$300,000 or more a year. According to *Workforce Management* magazine, specialty drugs and biologics currently account for 24 percent of an employer's drug spending. However, by 2030, they could account for 44 percent, said Dr. Brian Solow, vice president and medical director of clinical programs at Prescription Solutions.

Specialty drugs treat serious or chronic medical conditions such as multiple sclerosis and rheumatoid arthritis and typically can be self-administered by injection.

Manufacturers isolate biologics from a variety of natural sources — human, animal, or microorganism — and may use biotechnology and other cutting-edge methods. These drugs are often more difficult to manufacture, store and transport, and because relatively few patients need them, manufacturers must recoup their costs from a small patient pool.

A RAND study found that charging higher copayments for specialty drugs could be counterproductive. Often, specialty drugs or biologics are the only treatment available for a specific condition, and patients will continue to take them, no matter the cost. Charging higher copayments for such expensive drugs can cause considerable financial hardship, while covering them can increase employee loyalty.

Still, specialty drugs and biologics are often the subject of off-label, experimental or questionable uses. Both employers and employees can benefit if a plan takes steps to reduce inappropriate use of these drugs. Some health plans are linking a plan's payments for a drug to its efficacy — in other words, a "pay for performance" system. Others are using evidence-based treatment guidelines and precertification requirements to reduce off-label prescribing of specialty drugs. ■