LINDSTROM INSURANCE
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New Overtime Laws Effective December 1, 2016

New overtime pay rules from the Department of Labor have been released. This is the rule about compensation and salaried employees.

The new Federal law raises the salary threshold for eligibility from $455/week to $913/week ($47,476 per year) in order to be "exempt". This threshold will be updated every three years. In order to comply with the law, employers may:

1. Pay time-and-a-half for overtime work.
2. Raise workers' salaries above the new threshold.
3. Limit workers' hours to 40 per week.

If you have questions and would like to review this in more depth, here's a link to the Department of Labor website: https://www.dol.gov/whd/overtime/final2016/faq.htm

El Camino Hospital and Anthem Blue Cross Agree on Network Contract

Blue Cross and El Camino Hospital reached a multi-year agreement effective June 1, 2016. The hospital is in the HMO, PPO and EPO networks again.

For those who received services between March 1, 2016 and May 31, 2016, the contract is not retro-active. Please contact Blue Cross to determine how charges were processed on your account.

Kaiser Plans to be Offered in Santa Cruz County

Kaiser will be offering group and individual health plans (for those not eligible for Medicare) in Santa Cruz County beginning January 1, 2017. We should be able to give you a quote to show their plans and rates as early as November of this year.

Watsonville Hospital will be sharing their facility with Kaiser Doctors and the Kaiser computer system. Primary Physicians will be practicing in a small clinic in downtown Santa Cruz, while mutli-specialty clinics (with both primary care physicians and some specialists) will be located in Watsonville and Scotts Valley.

Members living or working in Santa Cruz will also have access to Kaiser facilities in other counties, such as their Santa Theresa and Santa Clara hospitals.

Email Address for Enrollment and Change Forms

In order to provide better service to those groups who submit enrolment forms, change forms, etc. to our office for processing and tracking, please use the special email address: Enrollment@lindstrominsurance.com
Remember to password protect those files!

If you need help with how to password protect a document, give us a call. We still have a paper fax machine, too, and will be happy to receive your forms at 831-335-5883.

Beware of CMS Data Match Letters – Medicare Eligible Employees

The Centers for Medicare and Medicaid Services, the Social Security Administration, and the Internal Revenue Service are working together and it may cost you money. The project is about Medicare Secondary Payer rules. If you receive a letter, DO NOT IGNORE IT.

Letters are going out pursuant to the 2007 Medicare Modernization Act, including higher recovery through CMS's coordination of benefits program, targeting employers where group insurance is primary and Medicare is secondary. (These are generally groups with 20 or more employees (all employees, not just full time, and including groups counted together under common ownership).

While there are fines for encouraging or enticing an employee to take Medicare instead of remaining on the group insurance ($5,000 per situation), the bigger hit is the bill for claims that Medicare has paid as primary versus what they should have paid as secondary.

The three government bureaucracies are looking for instances where an employee (or the dependent of an employee) is enrolled in Medicare and is also the employee of a group. They're running reports to see where someone's social security number is showing up both on the income tax withholding list for an employer and also on the Medicare rolls, hence the term "data match".

If you receive one of these letters, you have a 30-day deadline to respond. There are three different stages to the process that we know about. First, you must set up an account with the data match program.

Once that's complete, there's a 1-2 day wait so the account can connect with the data match questionnaire. The second stage will involve requests for information about health plan information back to 2011, including carrier info, group ID, RxPCN numbers and such, as well as questions about particular employees.

The third stage will be additional information requests involving those Medicare eligible employees who waived the group coverage. This is where your paper trail will be important. You'll want to be able to document that the employee requested to leave the group plan on their own or was not eligible based on the hours worked, etc.

If you have questions about how to handle an employee's request to leave the group plan upon Medicare eligibility, please give us a call!

Birth, Adoption, and Marriage are Special Enrollment Opportunities

You already know that the birth of a baby will trigger a Special Enrollment Period, which allows your employee to change plans, add or delete dependents, etc. Until recently, the change would always be effective on the first of the next month (after the date of birth or adoption). This is helpful for those wanting to downgrade coverage after the birth (to save on their premium cost).

With all of the new rules and regulations as carriers learn to comply with the Affordable Care Act, we've recently learned that these plan changes may now be effective as of the date of birth or date of adoption with most carriers.

Addition of a new spouse or a plan change due to marriage might be effective the date of the wedding, the first of the following month, or the first of the month following receipt of the change form. It seems to be differently administered by each insurance company.

To avoid an unwanted surprise, please call us and we'll check with your carrier before submitting a change form. That way you'll know when an employee can expect the new dependent to be covered and you can handle the payroll deductions appropriately.

Covered California Notices to Employers

As part of the Affordable Care Act, Covered California and other State Exchanges are required to notify employers when they have an employee who has received a subsidy to enroll in a health plan. Notices to employers are sent by the exchange to advise when one of your employees applies and gives the employer's name to Covered California. These are called 1411 Certifications (the applicable section of the ACA).

This may or may not mean you have a problem.

If your group is too small to be subject to the employer mandate, or the employee simply doesn't work enough hours to be considered full-time and eligible for benefits, you have nothing to worry about.

If your group is subject to the mandate and the employee applies for and receives the APTC (Advance Premium Tax Credit, or subsidy), we should have a conversation.

If the individual truly was eligible for your benefit plan, but their share of the premium for single coverage was more than 9.5% of the family's adjusted gross income on their tax return, you may be assessed a penalty. But receiving the subsidy is only the first step….the individual's tax return for the year won't be filed until next Spring, and they may earn more than expected (so they would have to return the APTC).

Bottom line, save the notice and file an appeal if the information does not appear to be correct. If the employee is not eligible, no longer works for you, etc., then you may not be effected. Keep the notice and call us to discuss!

Transgender Health Benefits may be Required under new HHS Guidance

New ACA regulations issued by the Office of Civil Rights at the U.S. Department of Health and Human Services may require employer group plans to provide coverage for transgender surgery and other transgender health benefits. The requirement takes effect the first day of the first plan year beginning on or after January 1, 2017.

The new regulations prohibit discrimination on the basis of race, color, national origin, sex, age or disability under a health program or activity receiving federal funds. Blanket exclusions in group health plans for all care relating to gender dysphoria or gender transition will no longer be permitted. Rather, transgender surgery and other transgender health benefits must be provided on a non-discriminatory basis.

Not all employer group health plans are subject to the new regulations. Employer group plans which must comply include:

1. Plans sponsored by hospitals, home health agencies, nursing homes and other health care providers receiving funds under Medicare Part A or Medicaid
2. Fully insured group health plans (sponsored by any employer) where the insurer is offering coverage on an exchange
3. Self-funded group health plans (sponsored by any employer) administered by an insurer offering coverage on an exchange.

New Benefits Person? Not Sure About Procedures? We Want To Help!

We're noticing some of our groups have hired new benefits administrators. Please let us know when you have a new person in this position!

We've developed a short training program and Carol will be happy to meet with your new office manager or benefits administrator to review the "Care and Feeding" of your benefit plans and privacy rules to avoid future problems and make things go more smoothly.

We're also happy to review procedures with your current benefits person and make sure you have the correct, up to date forms for your current plan(s). We'll bring you an electronic copy of the forms, review eligibility waiting periods, benefits offered, the employer contribution, etc., and generally want you to be comfortable with this important aspect of your business.

Additions and Terminations

And while we're on that subject, please remember that "new hires" are considered eligible when they've worked the requisite number of hours (usually 30 hours/week) for the eligibility waiting period (typically 30 or 60 days, but this varies by plan). Coverage generally starts the first of the following month.

Carriers have absolutely no sense of humor or inclination to be merciful if a deadline is missed. Late enrollees may be required to wait until your next open enrollment period to be added to the plan.

It's actually easier to have new hires complete an enrollment form (or online enrollment, if you have that set up) for your plan as soon as they start working 30 hours per week (or 20 if that's the case in your firm). If someone doesn't "make the cut" and you let them go before they should be eligible, it's easy to contact the carrier and stop the coverage from taking effect. Let the new hire know that you'll be submitting their form early, but coverage will not start until they meet the eligibility waiting period.

Newly eligible dependents must be added to the plan(s) within 30 days of the wedding, within 30 days of the adoption or birth.

If an employee reduces their hours, quits, you need to fire them, etc., there is generally a form to submit to notify the insurance carrier that coverage should end. Health Net just asks for a letter confirming the date of the termination or reduction in hours. Again, if you have enrollment online, the termination may also be processed electronically. Please call us if you need clarification on any of this.