volume XXVI / issue 3 / Summer 2018

CPI LIGHTS

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According to a recent study by the National Center for Health Statistics about 60% of adults age 18-64 obtained their health insurance from their employers as of 2017. This tells me that the workplace is still a primary purchase point for medical coverage for many working adults.

Employee benefits in today's market can be expensive and sometimes overwhelming for business owners. Next to payroll it is one of their highest budget items. But when more than half of working adults obtain one of their most important needs this way we have to work together to find an amenable solution.

Insurance Carriers are continually working to bring new benefit options to the group market. Many employers like the premium savings of high deductible health plans but struggle on how to help their employees fund their own health savings accounts without breaking the company's budget.

This feels all too familiar. Insurance seems to have come full cycle since the 1980s. Insurance used to be something that helped cover the big unexpected medical bills. Over time premiums increased, deductibles increased, and people needed to pay more out of pocket. The carriers developed new products that cost the same, had better benefits, but had provider and other limitations. Then the process started over again. People got used to insurance covering many of the medical bills in the 1990's and early 2000's.

Insurance benefits have evolved, and we have come back to insurance covering the big unexpected bills. There is no doubt that our current system is flawed. The government keeps trying to legislate the fix. But are they looking to fix the right problems? The ACA addressed accessibility, not affordability, for most Americans. Many Americans saw a significant premium increase under ACA, but others did benefit.

Not everyone will be winners with any new solution. But the solution should be that which benefits the most people. And it may not be resolved as timely as we would all like. Until then we have to keep working together to find the best solutions available to us now.

Thanks for continuing to read CPILights!

As always, if you would like to submit an idea or comment in writing you can reach me at:

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Regards,

Jon A. Cyganiak

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MILLENIAL SPENDING

According to a recent study on LendEDU.com young Americans ages 22 to 37 like to spend their money on personal comforts but they also understand the need to save for their future.

Over 1,000 Millennials were surveyed on their day-to-day spending and saving habits for a one-month period. And despite the fact that they do like to spend their hard-earned cash on coffee, dining out, concerts/sports and the like they also manage to save on average $480 per month for retirement.

Here is a peek at a month in the life….

$281 on groceries; 65% were spending more on groceries than retirement.

$38 on coffee; 27% were spending more on coffee than retirement.

$163 on dining out; 49% were spending more on dining out than retirement.

$75 on alcohol; 27% were spending more on alcohol than retirement.

$82 on clothes; 32% were spending more on clothes than retirement.

$49 on concerts/sports; 15% were spending more on concerts/sports than retirement

Even though Millennial Americans enjoy the finer things in their lives most also are savvy enough to save for their golden years.

Source: https://lendedu.com/blog/millennial-retirement-spending-study/

INSIDE:

- managing editor: Laura Bagin

LEGISLATIVE UPDATES

PRESCRIPTION COVERAGE NOTIFICATIONS

All employers sponsoring group health plans that include prescription drug coverage are required to notify all Medicare-eligible individuals whether their drug coverage is "creditable", or if it covers prescriptions, on average, at the same level as Medicare does.

Written notice must be provided annually prior to October 15th to the following individuals:

- Medicare-eligible active working individuals and their dependents
- Medicare-eligible COBRA individuals and their dependents.
- Medicare-eligible disabled individuals covered under an employer's prescription drug plan; and
- Any retirees and their dependents.

Model notices are available from the Centers for Medicare & Medicaid Services (CMS).

Employers are also required to complete an online disclosure to CMS to report the creditable coverage status of their prescription drug plans. This disclosure is also required annually, no later than 60 days from the beginning of a plan year.

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FEDERAL

The Centers for Medicare and Medicaid Services (CMS) has issued a final rule extending the duration of short-term health insurance policies. Previously short-term, limited-duration insurance policies could have a benefit period of no more than 90 days and was a one-time only purchase.

The new rule allows for these plans to have a benefit period up to 12 months, and may be renewable for up to 36 months. The policies will also clearly state the type of coverage people are purchasing. These plans do NOT comply with the ACA individual health provisions and are not considered qualified coverage. Short-term coverage is intended to be an affordable stop-gap when someone is transitioning from one plan to another.

Source: https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-final-rule

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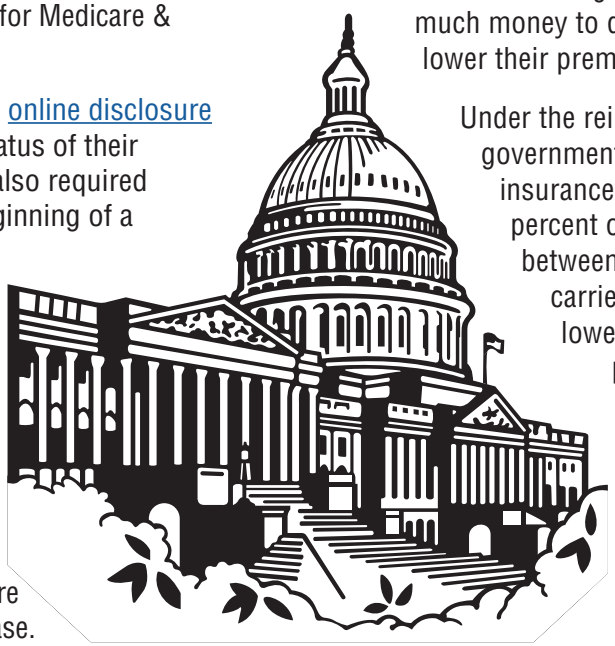
STATE

The federal government approved Wisconsin's request for its $200 million reinsurance program. The **Health Care Stability Plan** is aimed at people wanting to buy health insurance through the Marketplace but make too much money to qualify for federal subsidies to lower their premiums.



Under the reinsurance program the state government would provide funds to health insurance providers to pay about 50 percent of high-cost medical claims between $50,000 and $250,000. The carriers would in turn be able to offer lower premium plans to most of the program policy holders.

The administration expects that premiums will drop about 3.5 percent from the current level and will be about 11 percent lower than what they would have been in 2019 without the plan.

TERMINATING MARKETPLACE COVERAGE

CMS recently changed their stance on termination of coverage for Marketplace policyholders. In the past 14 days prior notice was required to cancel coverage. Now individuals may make same day termination requests or may schedule coverage to end on a specific future date.

Coverage should not be cancelled until you know when the new coverage will begin. Once coverage is terminated in the Marketplace you must wait until the next annual Open Enrollment period to re-enroll.

Termination of coverage for some or all family members can be done online through your Marketplace account. If only the household Marketplace contact needs to cancel coverage consumers must contact the Marketplace Call Center at 1-800-318-2596. Online cancelation of the household contact could result in coverage cancelation for the whole family.

THE Q & A CORNER

Aaron Bielawski
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The Cyganiak Planning Q & A Corner takes questions that our agents and sales/service associates were asked and provides detailed guidance from our HR advocacy firm to help you understand and resolve similar scenarios at your workplace, should they ever arise.

Question: Does our Section 125 document need to be handed to new employees?

Answer: The cafeteria plan document is not an ERISA plan (thought the underlying benefits likely are) so there is not a legal requirement to distribute it, but you are encouraged to do so and to also collect a signature page acknowledging the issuance. Many employers choose to do so, simply because it has information about important features such as mid-year event renewals, opt-out benefits or employer contributions.

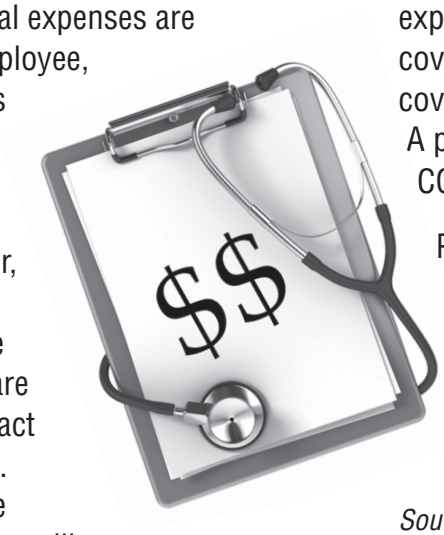
Oftentimes an employee may come to Human Resources mid-year and claim they were never told about many of the provisions that a POP or cafeteria plan document outlines (i.e. mid-year events) which can cause for some

tensions and frustrations with the plans and/or employer. Again, although not required, distributing the POP and obtaining signatures to the document could be seen as part of the ERISA fiduciary obligation to communicate important features about the plans, even if the POP distribution itself isn't technically required.

Disclaimer: Guidance provided above is opinion gathered from Cyganiak Planning Inc.'s Human Resources Advocacy Firm based on their research of specified topics and cannot be considered as legal opinion or legal fact. Please consult with your legal counsel for any specific and final guidance in any situation pertaining to your own company.

WHEN IS A HEALTHCARE FSA EXPENSE INCURRED?

For purposes of the Health Care Flexible Spending Account (FSA), medical expenses are incurred when the employee, their spouse or dependents, is provided with the medical care that gives rise to medical expenses, and not when the employee is billed, charged for, or pays for the medical care. The only exception to this rule is orthodontia expenses that are reimbursed based upon contract payments for ongoing service. For most online purchases the documentation of when an item will ship is used. This is similar to using a pharmacy "filled" date, because it is the date the service provider provides the product or service.



It is important to remember that an employees' medical expenses must be incurred during the period of coverage. This is when the applicable medical insurance coverage begins, not when the application is submitted. A participant's period of coverage may also include COBRA coverage.

Participants that have services performed close to the end of the plan year or coverage period if they are terminating mid-plan year, will need to be aware of when a medical expense is incurred to avoid any unnecessary forfeitures of remaining FSA balances.

Source: Employee Benefits Corporation, Compliance Buzz: "When is a Health Care FSA medical

WARNING…
ABOUT EMERGENCY ROOM AND URGENT CARE VISITS

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Recently doctors working in Emergency Rooms and Urgent Care centers have become more and more sparse. To combat this, provider systems have hired contract providers to staff their ER's and Urgent Care facilities. These contract providers do not work for the hospital as a regular employee, and often they are not contracted as in-network providers for your insurance.

This set up creates a problem when it comes time to pay your claim. Whenever you go to an in-network ER or Urgent Care you expect everything to apply as in-network benefits and be paid accordingly through your medical insurance. In the contract provider situation, when a non-network provider services you at an in-network facility you may run into a bill you were not expecting.

An insurance company pays claims based on codes they receive from the providers. You receive an Explanation of Benefits for your service that shows the in-network ER facility fee was discounted, some paid by insurance, and what you owe.

For the physician fee portion, the EOB shows discounts, insurance payments, and shows what you should owe, as though the doctor you saw was in network. It may also show that there is an extra non-covered charge for the physician, indicating an out-of-network provider. When the bills arrive, you may notice there is a separate higher charge for the ER physician and you have been balanced billed above what you thought you owed for using in-network providers and facilities.

This is legal, but not very transparent. The hospital can hire non-network providers and you can get caught up in this billing quagmire. The only thing you can do is fight it or pay it. The first step is recognizing it on your Explanation of Benefits and on the bills you receive. Call the billing department, call the provider group, explain the situation and ask them to write it off, discount it or make it right.

Be aware and try and save yourself money when you can. It may be better to use your own doctor's office rather than making an ER or Urgent Care visit depending on the timing and specific medical situation.

AFFORDABILITY PERCENTAGE FOR 2019

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With all the talk going on in Washington DC and lack of progress on 'fixing' healthcare, ALEs (Applicable Large Employers), any company or organization that has an average of at least 50 full-time employees or "full-time equivalents") still should review their contributions strategy in order to avoid the ACA employer penalty.

Employer sponsored coverage was originally defined as an employee contribution for self-only coverage of no more than 9.5% of the employee's household income. This safe harbor was established by the IRS due to employers not knowing an employee's exact household income.

The affordability percentage is indexed and has gradually increased reaching 9.69% in 2017 and 9.56% in 2018. Starting in 2019 the limit will increase to 9.86%. This requirement applies to the lowest cost single coverage option that the applicable large employer offers. Originally the requirement was to compare premium contribution for such coverage to the employee's household income. Below is an example for an employee with W-2 earnings of $45,000.

Year	Affordability %	Annual W-2	Affordability-Year	Monthly Max. Employee Contributions
2017	9.69%	$45,000	$4,360.50	$363.38
2018	9.56%	$45,000	$4,302.00	$358.50
2019	9.86%	$45,000	$4,437.00	$369.75

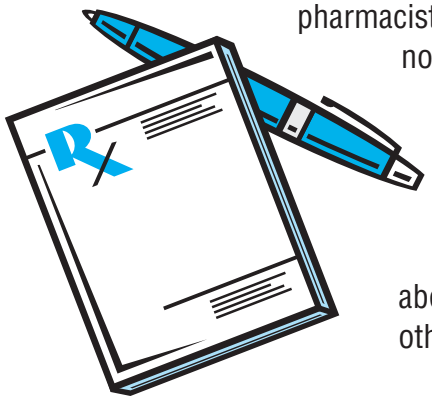
Large employers should take note that the affordability calculation will increase in 2019. This change will affect all offers of coverage that begin on or after January 1, 2019. To review the IRS revenue procedure announcing the 2019 affordability measure, https://www.irs.gov/pub/irs-drop/rp-18-34.pdf.

ASK YOUR PHARMACIST

The cost of prescription drugs has escalated significantly over the past several years and can be a large contributor to how insurance carriers calculate annual premium increases.

Doctors prescribe medication and the patient takes it. That is the way it has always been. If you need a medication it is important for you to have it; however, it is also prudent to make wise purchasing choices.

You can have a conversation with your doctor, but perhaps another person to speak with is your pharmacist. Often doctors may not know the expense of a drug. They know what to prescribe to help treat your conditions. The pharmacist knows about that and possible other alternatives.



The next time you get a prescription and your pharmacist says, “Do you have any questions?” think about asking the following:

- Is there a better value alternative for my prescription?
- Is there difference between the generic and its brand name counterpart?
- Is there a difference the side effects of the between the generic and brand name drug?
- Are there products over-the-counter that will treat my condition as effectively?
- Can I buy a higher dosage and split my tablet in half?
- What is the clinical GOAL of my medication?

The answers may surprise you and you may find that you are saving yourself money, both directly and indirectly.

BEHIND THE SCENES

We would like to bid a fond farewell to two people who have been part of the CPI family for a long time. Dale and Dianne Demski made the decision to retire the end of July. Dale has a long and distinguished 40-year career in the insurance industry, with the majority of them at Cyganiak Planning. His wife Dianne is leaving us after 20 years. We wish them all the best as they relocate to El Paso, TX to be closer to their grandchildren.

WEB SITES

Here are some sites you can surf on the net to find out more regarding your health insurance and health related matters.

https://www.irs.gov/pub/irs-drop/rp-18-34.pdf – IRS Premium Tax Credit table.

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html – CMS Model notice for Creditable Coverage notification

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html – Link for employer Creditable Coverage notification to CMS