



Golf Insurance Services

George Petersen Insurance Agency

News You Can Use

AFFORDABLE CARE ACT

All You Need to Know About Health Reform

FOLLOWING IS the most up-to-date information on many of the items in the Patient Protection and Affordable Care Act. We at George Petersen Insurance Agency hope that this document will help you understand your role as an employer, and those of your employees, in this new law.

New waiting period

Under the PPACA and with AB 1083 in California, waiting periods when offering coverage to new hires are limited to 60 days (that's less than the 90 days prescribed by federal law).

For plan years beginning on or after Jan. 1, 2014, the PPACA prohibits group health plans and group health insurance issuers from imposing a waiting period that exceeds 60 days.

A "waiting period" is any period of time that must pass before coverage becomes effective for an employee or dependent who otherwise meets plan eligibility requirements. The PPACA limits the lapse of time-based health care waiting periods to no more than 60 days.

Other eligibility conditions are generally valid, unless designed to avoid compliance with the 60-day waiting period limit.

A requirement based on cumulative hours of service (i.e. eligibility to enroll based on a certain number of hours of service) is permissible so long as it does not exceed 1,200 hours and is a one-time eligibility condition.

An employer must offer coverage to an eligible employee by the 61st calendar day, including weekends and holidays.

If an employee takes longer than 60 days to accept the offered coverage, the employer is not in violation of the 60-day limit, under current regulations.

Notice to all employees regarding the marketplace (exchange)

The PPACA requires that employers provide notices to all employees (whether covered by a health plan or not) regarding the existence of an electronic marketplace for the purchase of health care insurance coverage.

Employers must distribute the marketplace notice to all employees before October 1, 2013.

See 'This Year' on page 2



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Summary of Benefits and Coverage

GENERALLY EFFECTIVE with plan years that started on or after September 23, 2012, insurers and employer groups must provide a Summary of Benefits and Coverage (SBC) to potential applicants, new enrollees, and current policyholders for grandfathered and non-grandfathered medical plans (with some exceptions, such as retiree and dental-only plans).

The SBC summarizes a plan's benefits and cost sharing in a standardized, easy-to-read format. This allows people who are looking for coverage to compare plans easily.



(Continued from page 1)

Use This Year and Next to Prepare for Employer Mandate

Transitional reinsurance program tax

This program, designed to help stabilize premiums in the individual health insurance market for those with pre-existing conditions, will be effective from 2014 through 2016. Health insurance issuers and third-party administrators will pay the assessment to fund state nonprofit reinsurance entities, which will establish high-risk pools for the individual market. This tax amounts to about \$63 per enrolled member annually.

Health insurer tax

Health insurers will have to pay an annual tax, beginning 2014, to help fund premium subsidies and tax credits to be made available to qualifying individuals purchasing health insurance coverage on the exchanges – and has no end date. This tax will be passed on to employers through the premiums – increasing premiums from 2% to 3%.

Small group tax credit

Under the PPACA, certain small employers will be eligible for a tax credit, provided they contribute a uniform percentage of at least 50% toward their employees' health insurance.

For nonprofit (tax-exempt) organizations, the credit will be in the form of a reduction in income and Medicare tax that the employer withholds from employees' wages and the employer share of Medicare tax on employees' wages (with the credit thus limited by these amounts).

For all other qualifying employers, it will be in the form of a general business credit. This type of credit is not refundable, but is limited by the for-profit employer's actual tax liability. In other words, if a for-profit company had a year in which it ended up paying no taxes (i.e., it had no taxable income, after accounting for all its other deductions and credits), then the small business tax credit could not be used for that year; there would be no income tax for this credit to reduce.

However, as a general business credit, an unused credit amount can generally be carried forward up to 20 years.

For for-profit employers, the credit can be reflected in determining estimated tax payments for the year to which the credit applies in accordance with regular estimated tax rules.

Beginning in 2014, for for-profit employers, the maximum credit is 50% of the employer's contribution toward premiums, and 35% of employer contributions for nonprofit organizations.

The small business tax credit that is available beginning in 2014 is only available to an employer for two consecutive tax years.

Thus, the small business tax credit is potentially available for a total of six years—the initial credit availability from 2010 through 2013, plus the two-year credit period beginning in 2014.

Small employers will be able to claim the full tax credit amount if they meet the following two criteria:

- The employer has 10 or fewer full-time equivalent employees (FTEs). FTEs are calculated by dividing the total hours worked by all employees during the tax year by 2,080 (with a maximum of 2,080 hours for any one employee).
- The employer's average taxable wages are \$25,000 or less. This is calculated by dividing aggregate wages paid to the "employees" during the year by the number of FTEs (and rounding to the nearest \$1,000).

For calculating the number of FTEs and their wages, the term "employees" excludes seasonal workers (working no more than 120 days in a year). Also, the term "employee" excludes the following (as defined in the Internal Revenue Code): a self-employed individual, a 2% shareholder in an S-corporation, a 5% owner of an eligible small business, or someone who is a relation or dependent of these people. In other words, a business will not receive a credit for small business owners or their family members. ❖

Employer pay or play

THE TREASURY Department stated on July 2 that large employers (50+ full-time equivalent employees) and insurers will be exempt from the reporting disclosure requirements on group health insurance plans and eligibility rules until Jan. 1, 2015, effectively postponing the "pay or play" requirements under IRC Section 4980H.

These reporting requirements are the tool employers are to use to demonstrate compliance with the pay or play requirements.

The driving force behind the delay is feedback from employers on the issues they have in order to meet the original 2014 implementation deadlines.

Starting with renewal dates of Jan. 1, 2015 or later that year, the PPACA will require "applicable large employers" – companies that have employed an average of 50 or more full-time and/or full-time equivalent (FTE) employees during the preceding calendar year – to offer essential and affordable health plan coverage to full-time employees (and coverage to their dependents) or face a penalty if an employee receives federally subsidized coverage from the Covered California exchange.

Here is how each category of worker is used in the calculation of the total number of FTEs an employer has for each month of the year:

- Full-time (employees that work at least 30 hours per week in any month) - Counted as one full-time employee.
- Part-time – Calculated by taking the hours worked by all part-time employees in a month and dividing that amount by 120.
- Seasonal – Not counted in the calculation for those working up to 120 days in a year. ❖



WORKERS' COMP CLAIMS

Costs May Rise after Obesity Classified as Disease

THE AMERICAN Medical Association's recent decision to reclassify obesity as a treatable disease may have serious repercussions for workers' comp claims costs, according to a new report.

While obesity itself in most cases will not be compensable as a workplace illness, the condition will certainly play a role in the way obese claimants receive medical treatment.

And it could result in obesity being considered an outgrowth of the original workplace injury if an injured worker gains weight during rehabilitation.

According to the California Workers' Compensation Institute, obesity may be deemed "a compensable consequence of injury, just as sleep disorders, sexual dysfunction and psychological disorders became common workers' compensation 'add-ons' prior to passage of last year's workers' comp reforms."

"For example, this could be the case in claims where the employee remains off work and gains weight after being inactive for extended periods, or where they are treated with drugs that cause weight gain," the institute wrote.

Not only that, but workers who gain weight in sedentary jobs, such as long-haul trucking or desk jobs that require an individual to remain seated for extended periods of time, may also file workers' compensation illness claims, the Institute wrote in its report.

"In such scenarios the viability of the claim would likely hinge on proving that the work actually caused the obesity, which would be an issue ripe for dispute and which could lead to additional litigation," the institute wrote.

"In light of the increasing evidence of genetic pre-disposition for various medical conditions, defining causation and relative causation will be critical in claims involving obesity, and also may arise in other employment areas such as pre-employment screening."

The change may end up significantly increasing the costs of claims for workers' comp claimants who are already obese. And such claims are already expensive, according to the institute.

The definition of obese is someone who has a body-mass index of 30 or more, and 35.7% of U.S. adults fall into this category.

BMI is measured as a ratio of your weight to your height (weight divided by height).

It is an imperfect measurement, as muscular individuals and

athletes may tend to have higher BMIs and may not be considered overweight or obese.

To date, obesity in workers' compensation claims has been treated as a "co-morbidity" – a condition that occurs at the same time, but is typically independent of the work-related compensable injury or illness.

"For example, obesity as a co-morbidity within a workers' compensation claim can complicate the treatment of a compensable back or joint injury," wrote the institute.

An earlier study by the institute of claims filed between 2005 and 2010 found that claims with obesity as a co-morbidity have had significantly higher rates of lost time from work, permanent disability and attorney involvement, and have been much more likely to involve additional co-morbidities and prescriptions for opioid painkillers and psychotropic drugs.

The study found that of claims with obesity as co-morbidity:

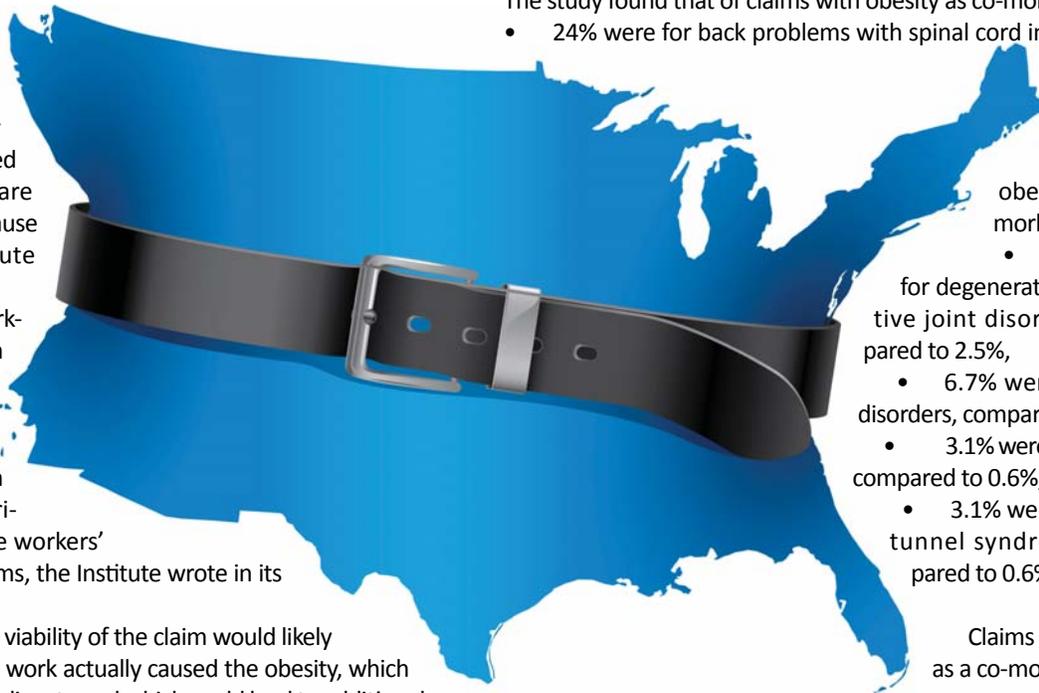
- 24% were for back problems with spinal cord involvement, compared to 14.1% for claims without obesity as a co-morbidity,
- 10.8% were for degenerative or infective joint disorders, compared to 2.5%,
- 6.7% were for spine disorders, compared to 1%,
- 3.1% were for hernias, compared to 0.6%,
- 3.1% were for carpal tunnel syndrome, compared to 0.6%.

Claims with obesity as a co-morbidity:

- Had average medical payments of \$68,468, compared to \$35,091 for those without;
- Had average indemnity (wage replacement) payments of \$47,970, compared to \$29,140 for those without; and
- Averaged 35 weeks of lost time, or 80% more than the average of 19 weeks for claims without the obesity co-morbidity.

Keep in mind that these costs were for workers' compensation claims filed when obesity was not classified as a disease by the American Medical Association.

"To the extent that such disparities continue in the future, these results suggest that any increase in the volume of claims involving obesity treatments could have a significant impact on workers' compensation payments," the institute wrote. ❖



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BRING YOUR OWN DEVICE

Is Your Data Secure Enough for Employee Phones?

WITH ABOUT 75% of employees using their own devices for their work communications and productivity, businesses must implement safeguards to avoid company data from being compromised should a device be stolen, hacked or contract a virus.

The BYOD (bring your own device) trend has grown as many employees have eschewed company-issued mobile devices, preferring to use their own.

But, while a company can install certain software and make security settings on its own phones, the task is harder when your workers want to use their own devices for their jobs, according to a new study by mobile solutions provider CDW.

Fortunately, the market has responded with systems and software to help businesses secure the personal smart phones and tablets that their employees use to conduct their jobs.

There are a number of benefits to allowing your staff to BYOD, according to the CDW report, including:

- **More employee satisfaction** – It allows them to choose the phone they prefer, and requires them to keep one device.
- **Increased productivity** – When your employees have access to your company's resources, they can do their work from anywhere that is convenient.
- **Cost savings** – You won't be shelling out for phones and cell phone plans, although you may need to pay for various security platforms.
- **Disaster recovery** – If disaster occurs, your staff can work remotely with their smart phone.

Also, because the employees are likely to have their phone plans through a variety of carriers, if one carrier goes down in a disaster others may still be operational.

But, increased mobility comes with more risk to your company's data or the information you store on your customers.

Some employees co-mingling personal and business uses on the phone poses dangers, particularly if the device is compromised and passwords discovered.

The biggest concern is hackers gaining access to an employee's personal files and using them as a gateway to your company's data.

This is made particularly easy if an employee uses the same password for both work and personal accounts.

Locked and loaded

The best weapon currently available for BYOD devices is what is known as Enterprise Mobile Device Management software.

Once installed on your employee's phone, it gives you the ability to set the security configurations for the device remotely.

There are a number of great features with this technology, according to the CDW report, including:

- The ability to prevent data from being saved to removable media that are outside the organization's control.
- The ability to restrict access to software, such as preventing use of the organization's information on a device with applications which the company has not approved for use.
- Encrypting the organization's data stored on a device, to stop unauthorized applications and users from accessing it.
- The ability to monitor each device's security settings in order to detect violations of the firm's security policies.
- The administrator can remotely lock a device if it has been stolen or lost. This will keep anybody without knowledge of the unlock password from using the device.
- The administrator can remotely issue a command and all of the organization's data and applications will be wiped from the phone.

Other security measures you can implement include:

- **Host-based firewalls** – These are on top of any firewalls you may have in your network, and are installed on the phone. However, these are new solutions and there are not many on the market currently.
- **Antivirus software** – This too is a relatively new development for mobile devices, but as needs grow the market will, as well. For now, research any software you are considering.
- **Mobile web security** – Many mobile phone browsers include security controls that can help thwart unwanted programs and viruses from getting a foothold as a result of an errant click on a bad link. ❖

