



In these ever-changing times, the McInnes group is here for you.

Assistance with regulatory changes is part of the service that we provide to our clients. We will keep you informed as the discussions of healthcare reform continue.

We appreciate your business and encourage you to call your Producer or Account Manager with questions.

## Upcoming and Prior Changes in the Healthcare Industry...

- **Missouri House Bill 231 changes the length of Missouri state continuation coverage now making it up to 18 months (was 9 months). This is for all continuations after June 26, 2009. In addition, carriers can no longer require employees to have been covered three months prior to termination to be eligible for continuation. As long as employee is on the health plan, they will be eligible.**
- **Mental Health Parity Equity Act was signed into law October 3, 2008. The requirements will apply to all fully insured and self insured plan years for effective dates on or after October 3, 2009.**
- **The Children's Health Insurance Plan (CHIP) Reauthorization Act became effective April 1, 2009. This law allows for premium assistance subsidy and special enrollment rights.**
- **The CMS Mandatory Reporting Law effective January 1, 2009 requires all plan administrators to provide social security numbers on all employees and dependents on new enrollments and for existing members.**
- **Michelle's Law requires up to one year extension of insurance coverage for students who take a medical leave of absence. This law applies to medical, dental and vision plans as groups renew beginning November, 2009 or for new groups effective October 9, 2009. The health carriers already allow to age 25 on health regardless of student status.**



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# INSIGHTS

## IRS issues 2010 contributions limits to HSA plans

The Internal Revenue Service recently released a notice outlining 2010 minimums and maximums for health savings accounts plans and high-deductible health plans.

For calendar year 2010, the annual HSA contribution limit for an individual with self-only HDHP coverage is \$3,050, up \$50 from 2009.

For an individual with family coverage under a HDHP, the new limit is \$6,150, up \$200 from 2009.

The 2010 minimum on HDHP deductibles, for self-only HDHP coverage, jumped to \$1,200 (up \$50 from 2009), and \$2,400 (up \$100 from 2009) for family coverage. The 2010 maximum on HDHP out-of-pocket expense increased to \$5,950 (up \$150 from 2009) for self-only HDHP coverage and \$11,900 (\$300 from 2009) for family HDHP coverage.



## Tax credits for wellness programs considered

Senate lawmakers are considering tax credits for sponsors offering employee wellness programs, in part to deter employers from curbing health benefits in a post-reform environment.

Currently House and Senate leaders are furiously working on a handful of bills in hopes of finding viable measures that can garner enough votes for approval. Key sticking points remain the cost of reform – in the area of \$1 trillion – and the possibility of a government-run public health plan option. Some key Democrats are pushing hard for a government plan to keep private insurers honest, but others favor a more moderate approach such as purchasing cooperatives operated by members.

Some analysts predict a government-run plan would prompt employers to cut health insurance programs, even if it meant they would have to pay a fee for not playing. That's why members of the Senate Finance Committee inserted a provision designed to hold the line on employer investments in wellness programs.

Under current tax code, costs for an employer-provided wellness program for employees are deductible by the sponsor as a business expense. Under the proposed option, a tax credit would be allowed for 50% of the costs paid by an employer for providing a "qualified wellness program" during a taxable year. The amount of the credit would be limited to an amount not exceeding \$200 for each employee not exceeding 200 employees, plus \$100 for each additional employee in excess of 200 employees.

Only employees generally working more than 25 hours per week are taken into account. For purposes of the credit, any amount paid for food or health insurance could not be included as a cost of the wellness program. The credit would not be refundable and would not be paid in advance and would be available for a maximum of five years.

Reports indicate that Senators would also like to give CDC money to serve as a resource for employers, to help them create and standardize wellness programs.

In order for a program to be a qualified wellness program under the proposal, all employees would be required to be eligible to participate in the program. Further, under the proposal, a qualified wellness program includes four components: health awareness (such as health education, preventive screenings and health risk assessment); employee engagement (such as mechanisms to encourage employee participation); behavioral change (elements proven to help alter unhealthy lifestyles such as counseling, seminars, on-line programs, self help materials); and a supportive environment (such as creating on-site polices that encourage healthy lifestyles, eating, physical activity and mental health).

For an employer with 500 or more employees, to be a qualified wellness program, a program would be required to include all four components. For an employer with less than 500 employees, to be a qualified wellness program, a program would only be required to include at least three of the four components. In addition, to be a qualified wellness program under the proposal, the program would be required to be consistent with evidence-based research and best practices, as determined by the Secretary, such as research and practices described in the Guide to Community Preventive Services and Guide to Clinical Preventive Services and the National Registry for Effective Programs. Options such as the wellness tax credits could emerge as important bargaining points as lawmakers continue to seek compromises and agreement on an omnibus package they might send to President Obama this fall.

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## This issue

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## Health care costs hit women harder

By Robert L. Whiddon  
May 19, 2009

Research from the Commonwealth Fund shows women are more likely to skip care and also spend a greater share of their income on medical services than their male counterparts.

"Although similar proportions of women and men were uninsured for at least part of the year or were underinsured, we found that women were more affected by exposure to health care costs," Michelle Doty, director of survey research for the group, says.

Fifty-two percent of women (compared to just 36% of men) had one of the following four problems getting care:

**Did not fill a prescription,**

**Did not see a specialist when needed,**

**Skipped a recommended medical test, treatment or follow-up,**

**Had a medical problem but did not visit a doctor or clinic.**

A similar division was found around cancer screenings and dental care. For example, 45% of women (compared to just 36% of men) delayed or did not receive the screening or care because of cost.

Also, the study — which is based on data from the group's 2007 biennial health insurance survey — shows that women are much more likely to spend a bigger chunk of their earnings on health care than men. The research looked at low, moderate and high-income women.

The percentage of women making \$40,000 to \$60,000 a year who spent more than 10% of their earnings on health care nearly doubled between 2001 and 2007 — jumping 20 points to 41%. What's more, while 60% of moderate income women (those earning \$20,000 to \$40,000) report having trouble paying medical bills, just 50% of men with moderate incomes said the same.

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## Economic crisis makes waves in drug, medical claims activity

Some cut back on medications; others hurry to get more care

By Leah Carlson Shepherd  
June 1, 2009

Amid this year's harsh economic climate, an alarming number of people are not taking the medications they need, while others are getting more medical treatments now because they're concerned about losing their health coverage.

At least 28% of Americans said they have taken potentially dangerous actions to save money, such as not filling prescriptions, skipping dosages and cutting pills in half without the approval of their doctor, according to a recent poll by the magazine Consumer Reports.

"We were surprised by the extent to which consumers are cutting corners and the risks they're taking as a result of belt-tightening. Patients need to talk to their doctors about the cost of drugs and let them know when they have difficulty paying for prescriptions," says Dr. John Santa, director of the Consumer Reports Health Ratings Center.

About 25% of the patients who are not adherent say the reason is cost, according to Jack Bruner, executive vice president of strategic development and marketing for CVS/Caremark.

"If you reduce the cost to the individual, you improve adherence by 8% to 30%," he adds.

Nonadherence is particularly a problem with so-called "silent" chronic diseases, like high blood pressure and diabetes, according to Dr. Brian Solow, a family practice doctor and medical director for clinical programs at Prescription Solutions, a Costa Mesa, Calif.-based pharmacy benefit manager.

In some cases, patients don't physically feel a difference when they skip the medication, so they wrongly assume it's fine to skip it.

Untreated chronic diseases can cause problems like increased risk of heart attacks, kidney disease or vision problems — which in turn causes pain for employers in the form of increased absenteeism and presenteeism.

Prescription nonadherence also can lead to very costly interventions, such as long hospital stays and surgeries, as the condition worsens.

To promote adherence, Solow recommends giving employees information about drug efficacy, safety and potential savings from the use of generics and mail-order programs.

He also suggests telling employees to contact the pharmacy benefit manager or the drug manufacturer to find out whether they qualify for a prescription assistance program.

Bruner recommends sending refill reminders, directing employees toward preferred pharmacies, lowering copays and coinsurance for certain medications, and encouraging the use of generic drugs.

Mike Thompson, a principal at the consulting firm PricewaterhouseCoopers, recommends taking a closer look at the incentives in your health programs and aligning those incentives with getting needed medical care.

For example, some employers have waived the copays for diabetes drugs and supplies to encourage diabetic employees to keep taking their medication exactly as the doctor ordered.

"A lot of [the nonadherence] has to do with the fact that employers have moved toward increased transparency and cost-sharing. [Employees] are much more cost-conscious," says Thompson. "They're being careful about how they spend their money in health care. That may mean thinking twice about going to the doctor."

They also might think twice about refilling their medication if the copay for the refill costs \$50 or \$100. "We've seen a very rapid movement toward three-tier formularies. The gaps between the copays have expanded," Thompson says.

"Because of that, people are more sensitive to the relative cost of the drugs. Like the rest of the economy, it's a shift toward value."

Overall, Bruner observes, "the use of prescription drugs has flattened somewhat. We see different patterns for different medications. There are people who stopped taking their medication because of the cost."



## SERVING COMPANIES, FAMILIES AND YOU

Specifically, he has noticed a decrease in the use of brand-name drugs to treat high cholesterol, diabetes and gastric reflux, and a corresponding increase in the use of generic drugs for those conditions).

He also has noticed an increase in diabetics taking statins (to treat high cholesterol) and ACE inhibitors (to treat high blood pressure).

### Uptick in claims

Employers should keep an eye on their medical and prescription claims to see whether employees are increasing their use of health care -finally getting around to doctor's visits or procedures that they had put off in the past. During economic slumps, there is a pattern of people trying to "make sure they get things covered while they have a job and are covered," Thompson confirms.

"People are very cognizant of the value that their benefits provide, especially when they feel they might lose those benefits in the event of a lay off."

The new federal subsidy for COBRA premiums can help to alleviate that situation by reassuring

employees that they will have the opportunity to continue coverage, even if they get laid off, Thompson states.

Employers should communicate with their employees about the COBRA subsidy, so they understand they don't need to "rush out and get everything done," he adds.

At times of high stress and financial crisis, employers might experience an increase in the number of employees taking medications to treat stress-related health problems.

Solow says he has seen more requests for sleep aids and antidepressants. He also has heard anecdotal evidence of an increase in abuse of painkillers and anti-anxiety drugs, like Xanax and Valium.

Some employees may be responding to layoffs, longer work hours, bigger workloads and financial losses by eating more junk food, smoking more cigarettes or drinking more beer.

Employers can counter that unhealthy trend by offering healthy food at the worksite, smoking-cessation programs and an employee assistance program.

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## New Additions to the McInnes Group

The McInnes Group is proud to welcome Tyler Brookfield, Bill Grosdidier, and Jarrod Cochran as Senior Benefit Consultants.



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