Employee Benefits & Workers' Comp News

MOC Insurance Services
Maroevich, O'Shea & Coghlan Insurance

Divisions of MOC Insurance Services
Farallon Associates Insurance Brokers
San Francisco Insurance Center

44 Montgomery Street, 17th Floor, San Francisco, CA 94104
Toll Free (800) 951-0600 | Main (415) 957-0600 | License # 0589960

Claims Administration February/March 2016 Volume 26 • Number 1

Physician Choice: Whose Right Is it?

When an employee suffers a work-related injury, workers' compensation law obligates the employer to pay for medical treatment. Who gets to choose the treating physician—and why does it matter?

In some states, the employer gets to choose the physician and all medical providers. This is called a full control program. In this type of system, covered employees can seek a second opinion if they are unsatisfied with their care and provide evidence that their care is inadequate, or if the employer fails to notify employees of their rights or neglects to enforce its rights to full control.

In a partial control program, the employer selects and posts a list of medical providers. It has the right to require employees to use one of

continued on next page

This Just In

A "host employer" is responsible for reporting injuries to temporary workers, says OSHA. In an October 2015 interpretation letter, OSHA clarified that the "host employer" must record injuries and illnesses of temporary workers if it supervises them on a day-to-day basis. The letter states: "OSHA's injury and illness recordkeeping regulation at 29 CFR 1904.31(a) requires employers to record the recordable injuries and illnesses of employees they supervise on a day-to-day basis, even if these workers are not carried on the employer's

continued on next page

these approved providers for a period of time specified by workers' compensation laws. Medical providers must have the skills and qualifications to treat workers' injuries or refer them to specialists with the employer's approval. After the initial period of employer control, the employee may continue using those employer-selected providers or choose their own. If the employee feels his/her care is inadequate, he or she will have to submit to an independent medical exam, and the employer may suspend workers' compensation payments until the employee complies.

Some states have **medical panels**. In this type of system, the workers' compensation jurisdiction (the state) maintains a list of approved medical providers. The employer and employee work together to select the providers that offer the best possibility of recovery. This model occurs most frequently in monopolistic states, in which the state's workers' compensation organization pays all claims.

Finally, some states allow **free choice**, where employees can use whatever licensed providers they choose. Some of these states require the employee to designate a "primary treating physician" before they are injured. For example, California requires employees to provide their employer with the name of a licensed medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. as the doctor with overall responsibility for treating their injuries. If employees do not predesignate a doctor, the employee must select a doctor from the employer's medical provider network. If the employer does not have a medical provider network, the employee must go to a doctor selected by the employer during the first 30 days after injury.

Why Does Physician Choice Matter?

While claimants perpetrate some types of workers' compensation fraud, such as passing off non-work injuries as work-related or malingering, physicians can also be guilty of fraud. Dishonest medical clinics, or claims mills, can scam insurers out of millions of dollars by inflating injuries or giving illegal kickbacks to workers. Others might have no licensed doctors and little useful medical equipment. The use of medical provider networks helps employers by ensuring that employees will be treated by prescreened providers. And it can help injured workers by ensuring that they will be treated by a practitioner qualified and experienced in treating workers' compensation injuries. For more information, please contact us. ■

continued from previous page

payroll. Section 1904.31(b)(2) further clarifies that the host employer must record the injuries and illnesses of temporary workers it supervises on a day-to-day basis."

In this instance, the temporary employment agency handled orientation, training and all personnel matters, including vacation/leave requests, reporting injury/illness, compensation and benefits, corrective action/discipline, and drug screening. It also provided onsite supervision for its employees 24 hours per day, five days per week.

Despite this, the fact that the host employer assigned daily tasks to the temporary workers made it responsible for recording injuries and illnesses. If you are unsure which recordkeeping and reporting responsibilities and other OSHA compliance rules apply to your business, please contact us for assistance.

How Medicare Works with Your Medical Benefits

Due to longer life spans, higher medical costs and recession-impacted savings, the percentage of Americans staying in the workforce past age 65 is increasing. How does this affect your medical benefit plans?

According to U.S. Census Bureau projections, the percentage of Americans age 65 and older will increase by more than 67 percent between 2015 and 2040. Seniors will represent 21.0 percent of the total population by 2040. If you don't have active employees who are eligible for Medicare yet, chances are good you will in the near future.

Traditional Medicare has two main parts: Part A provides hospital coverage, and Part B provides medical services. Part D pays the cost of prescription drugs.

For most beneficiaries, Medicare Part A (hospital insurance) is free. Beneficiaries who enroll in Part B and/or D pay premiums. To avoid late enrollment penalties, individuals must enroll during their initial enrollment period, which lasts for the three months before their 65th birthday, their birthday month, and the three months after it.

Employees can enroll in Medicare Parts B and D even if they have employer coverage. To avoid paying premiums for coverage they might not need, some people with employer coverage do not enroll when first eligible. They can avoid late enrollment penalties for Part D if their employer's plan qualifies as "creditable coverage." This means the plan has an actuarial value that's at least as good as Medicare Part D. In other words, the plan must provide benefits at least as good as Medicare's.

Employers that provide prescription drug coverage must give Medicare-eligible employees a notice each year that tells them whether their drug coverage is creditable. Employees should keep these notices, as they might need them if deciding to join a Medicare drug plan later.

continued on next page

Coordination of Benefits

Generally, employers with 20 or more employees must offer current employees age 65 and older the same health benefits, under the same conditions, that they offer younger employees. If the employer offers coverage to spouses, they must offer the same coverage to spouses 65 and older that they offer to spouses under 65. Failure to offer older employees the same benefits, or requiring them to enroll in Medicare, would violate ADEA, the Age Discrimination in Employment Act of 1967.

For employees who opt to have coverage under both the employer medical plan and Medicare, coordination of benefits rules would apply. These determine which plan will pay first if the employee or a covered member has a health expense covered by both plans. An employer's size determines which payer pays first.

If you need information or assistance regarding employee benefits for your older employees, please contact us. ■

Individuals covered	Employer size	Primary payer
Retirees also covered by employer plan	All	Medicare
Active employees over age 65	20 or more	Employer plan
Active employees over age 65	fewer than 20	Medicare
Active employee or family member under age 65 who qualifies for Medicare due to disability	100+	Employer plan
Active employee or family member under age 65 who qualifies for Medicare due to disability	fewer than 100	Medicare
Employee or family member with end-stage renal disease	Any	Group plan pays first for the initial 30 months after coverage eligibility; Medicare pays first after this period

What is a Flexible Spending Account?

As employers cut back on benefits or require employees to contribute more, establishing a flexible spending account (FSA) gives employees a valuable benefit at little cost to the employer.

A flexible spending account (FSA) is a tax-favored program offered by employers that allows their employees to pay for eligible out-of-pocket medical and dependent care expenses with pre-tax dollars. At the beginning of each plan year, employees decide how much they want to contribute. They contribute pre-tax dollars via payroll contribution to their accounts. Maximum contribution amounts adjust yearly with inflation. For 2016, employees can contribute up to $2,550 (unchanged from 2015).

Employers can offer two types of FSA:

1. **Medical FSAs** allow employees to spend their funds on eligible medical expenses that are not covered by their major medical plan. Eligible expenses can include dental work, vision care, chiropractic care, psychological care, and more.
2. **Dependent care FSAs** let employees pay

continued on next page

for eligible day care expenses they and their spouses need in order to work, look for work or attend school full-time. Eligible expenses include care for children under age 13 or anyone you can claim on your federal tax return who is physically incapable of self-care.

For employees, an FSA gives an immediate discount on these expenses that equals the taxes they would otherwise pay on those earnings. FSAs appeal to many younger employees, who like the cost savings they represent for day care expenses.

FSAs also help employers. Because they reduce employees' taxable income, they'll reduce your payroll and FICA tax liability. You can also deduct any administrative costs as a business expense.

Caveats: Employees

FSA elections are only effective for one benefit period. Employees who miss the annual open enrollment season must wait until the next one. Experiencing a "qualifying life event," such as marriage, divorce, birth or adoption of a child, will allow them to contribute outside of open season.

FSAs have always operated on a "use it or lose it" basis, with employees forfeiting any funds left at the end of the plan year. That changed a bit with the Affordable Care Act, which allows plans to permit employees to roll over up to $500 into the following year.

Plans also have the option of adding a 2½ month grace period. The grace period allows employees to apply FSA funds from the prior year's contributions to expenses incurred within the grace period.

Plans can offer either a rollover or a grace period, but not both.

Caveats: Employers

Although FSAs won't cost you anything in premiums, just a bit in administration, they do have a couple of pitfalls.

First, rules governing these plans give employees immediate access to their entire election amount, which could leave employers responsible for the shortfall. For example, an employee could elect to contribute $100 per month, or $1,200 per year. In January, with only one month's contribution made, he has $1,200 of dental treatments. If he submitted it to the plan for reimbursement, the plan would have to pay the entire amount. The employer would pay the shortfall.

Employers also run the risk that employees will leave the company before their salary deduction contributions match the funds they've already withdrawn from their FSA.

On the positive side, a FSA adds another layer to your benefits plan, allowing employees to select the type of FSA and contribution amount that best suits their situation. As employers trim their benefits due to increasing medical costs, funds from an FSA can help ease the sting. For more information on setting up and administering an FSA, please contact us.

more on next page

Study: Employers Do Not Understand OSHA's Recordkeeping Requirements

A study titled "Exploring the Relationship Between Employer Recordkeeping and Underreporting in the BLS Survey of Occupational Injuries and Illnesses" sought to gauge the accuracy of the Bureau of Labor Statistics' annual Survey of Occupational Injuries and Illnesses.

The study found that employers did indeed underreport injuries, largely because they either did not comply with or did not understand OSHA's recordkeeping requirements.

The study's authors estimated that the BLS survey underestimated injuries by 38 percent due largely to employer error. Specifically:

- 8.4 percent of employers kept no records at all. Of these, half were exempt, but the others should have kept records.
- Most of the employers that maintained OSHA records did not understand what to record. Half included all workers' compensation claims, all workplace injuries and illnesses that resulted in a medical visit, or all reported injuries regardless of severity.

To clarify what employers must report, OSHA states that, as of January 1, 2015, all employers must report:

- All work-related fatalities within 8 hours.
- All work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours.

You can report these to OSHA by:

- Calling OSHA's free and confidential number at 1-800-321-OSHA (6742).
- Calling or visiting the nearest OSHA area office during normal business hours.

For more information on your reporting requirements and other OSHA regulations that might apply to your organization, please contact us. ■

Employee Benefits & Workers' Comp News

THE INSURANCE 411 What you need to know about insurance
SmartsPro MARKETING
The information presented and conclusions within are based upon our best judgment and analysis. It is not guaranteed information and does not necessarily reflect all available data. Web addresses are current at time of publication but subject to change. This material may not be quoted or reproduced in any form without publisher's permission. All rights reserved. ©2015 The Insurance 411. Tel. 877-762-7877. http://theinsurance411.com. 30% total recycled fiber. Printed in the U.S. on U.S.-manufactured paper.