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FAQs RELEASED ON AFFORDABLE CARE ACT AND MENTAL HEALTH PARITY (PART XXIX)

The Department of Labor released on October 23, 2015 new Frequently Asked Questions (FAQs) on issues such as Coverage of Preventative Services, Wellness Programs, and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Contained below are some highlights from those FAQs.

Preventative Services

Lactation Counseling and Services

The FAQs discuss in detail issues concerning lactation and lactation counseling. Lactation services that are considered preventative services by the plan (and therefore no cost sharing by the insured can be required) are for services such as comprehensive prenatal and postnatal lactation support, counseling, lactation counseling, and lactation equipment rental. In addition, a health plan must disclose the names of all lactation counseling providers available under the plan.

The health plan must also treat out-of-network providers of lactation counseling services as in-network providers, without cost sharing, if no in-network providers provide lactation counseling, or if certain requirements cannot be met by in-network providers (e.g., no in-network lactation counselor can be licensed in the state, and health plan only covers the services of licensed providers). Coverage that only covers lactation counseling on an inpatient basis, rather than an outpatient basis, may also be problematic if it requires cost sharing for outpatient lactation counseling. Finally, health plans may not restrict the time period in which an individual may request breastfeeding equipment after the birth of a child.

Weight Management Services

Weight management services for adult obesity should also be included in health plan coverage of preventative services. This may include such things as obesity screening or intensive multi-component behavioral interventions for weight management. Multi-component behavioral interventions may include high intensity group/individual activities, improvement of diet and increase in physical exercise, addressing barriers to change, self-monitoring, and strategizing how to maintain lifestyle changes. The frequency of such interventions may be limited to what is reasonable.

Colonoscopy Coverage

Coverage of colonoscopy screening procedures are considered preventative services, and any specialist consultation services that are medically appropriate for the patient should be considered a preventative service (which takes effect after 60 days of the release of this FAQ guidance). In addition, pathology exams on polyp biopsies are also included as a preventative service. The effective date of the rule regarding pathology exams being included as a preventative service is 60 days after the release of these FAQs.

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FAQs Released on Affordable Care Act and Mental Health Parity (Part XXIX) (Continued)

Religious Accommodation for Contraceptive Services

There are two methods for requesting a religious accommodation for non-profit or closely held for-profit employers:

1) Complete the EBSA Form 700 at: http://www.dol.gov/ebsa/pdf/preventiveserviceseligibleorganizationcertificationform.pdf; or
2) Provide appropriate notice of the objection to the Department of Health and Human Services (HHS) at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Model-Notice-8-22-14.pdf

If a plan sponsor chooses to complete Form 700, the Form will act as a plan instrument, which relinquishes the plan sponsor's obligation to contract, arrange, or pay for objectionable contraceptive services, and legally designates a Third Party Administrator (TPA) as responsible for providing separate payment for those objectionable contraceptive services. If a written objection is provided to HHS (i.e., the second method) HHS will provide the written objection to the TPA, which designates it as the party responsible for separately providing objectionable contraceptive services.

Genetic Counseling and Testing for BRCA

Women found to be at increased risk, using a screening tool that analyzes a family history for certain conditions that may be associated with an increased risk of potentially harmful gene mutations, must receive coverage without cost sharing for genetic counseling, and if such tests indicate, testing for harmful BRCA mutations. This rule applies regardless of whether a woman has previously been diagnosed with cancer, so long as she is not currently symptomatic of or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.

Wellness Program Incentives

Wellness Programs

Wellness program incentives that are offered as non-financial (i.e., in-kind) rewards (e.g., gift cards, thermoses, sports gear, etc.), are subject to the same wellness program incentives as all other wellness reward based programs, meaning that they must meet all of the requirements issued by the DOL for wellness program incentives.

Mental Health Parity and Addiction Equity Act of 2008

Mental Health Parity and Addiction Equity Act of 2008 and Disclosure

A plan sponsor that denies a mental health disorder/substance use disorder claim cannot refuse to provide its medical necessity criteria for the denial based upon an assertion that the information is "proprietary" and/or has "commercial value." The criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying non-quantitative treatment limitation, must be disclosed with respect to mental health disorder/substance use disorder claims, regardless of any assertions as to the propriety nature or commercial value of such information.

Action Required

Plan sponsors of both fully-insured and self-funded plans should ensure that the above criteria are met in their health plans. Many of the above items should also be included as part of the Health Plan Document, as well as disclosed to employees through a Summary Plan Description or WRAP Document.

For the complete details, see FAQs: http://www.dol.gov/ebsa/faqs/faq-aca29.html

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EEOC RELEASES QUESTIONS AND ANSWERS ON NOTICE OF PROPOSED RULEMAKING FOR INCENTIVES RELATED TO SPOUSAL PARTICIPATION IN WELLNESS PROGRAMS

Background

Title II of the Genetic Information Nondiscrimination Act (GINA) prohibits employers from using genetic information when making decisions about employment. This law restricts employers from requesting, requiring, or purchasing genetic information, unless one or more of the six narrow exceptions apply. One of those exceptions allows an employer to request/require/purchase genetic information from an employee when the employee voluntarily accepts health or genetic services offered by the employer, including services that are offered through an employer wellness program.

While this rule seems to allow a narrow exception for employers to request the genetic information of employees, the rule appears to prohibit employers from requesting the genetic information of an employee's spouse.

Notice of Proposed Rulemaking

On October 30, 2015, the Equal Employment Opportunity Commission (EEOC) issued proposed regulations and Questions and Answers (Q&As) addressing how the above GINA nondiscrimination provisions would be modified to allow employers, as part of their health plan, to offer a limited incentive (in the form of a reward or penalty), to an employee whose spouse:

1) Is covered under the employee's health plan
2) Receives health or genetic services; and
3) Provides information about his or her current or past health status (e.g., Health Risk Assessment)

Any health services an employer offers to an employee's spouse must be reasonably calculated to promote health/prevent disease, and must not be overly burdensome to employees or their spouses. The total incentive for an employee and spouse to participate in a wellness program that is part of a group health plan cannot exceed 30 percent of the total cost of the plan in which the employee and dependents are enrolled. Additionally, no incentives would be permitted for a spouse to provide his/her own genetic information to the employer, or for employees to provide current or past health status information regarding the employee's children. Finally, employers may continue to ask questions about a child's health status, as part of providing genetic/health services to the child, on a **voluntary** basis.

No Action Required

These proposed rules should be welcome relief to employers who are offering incentives to employees for health status information in relation to an employee's spouse. Employers should be cautious when offering such incentives, and ensure that they are not asking for genetic information/tests of an employee's spouse. Employers should never ask for the health status of an employee's child.

For the complete details, see:

Q&As: http://www.eeoc.gov/laws/regulations/qanda-gina-wellness.cfm
Proposed Regulations: http://www.gpo.gov/fdsys/pkg/FR-2015-10-30/pdf/2015-27734.pdf

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AUTOMATIC ENROLLMENT PROVISION OF HEALTH CARE REFORM REPEALED

Previously, Health Care Reform amended the Fair Labor Standards Act (FLSA) to require employers with more than 200 full-time employees to automatically enroll employees into a health plan. No specific date of implementation was ever established, pending final regulations. However, on November 2, 2015, the President of the United States signed bipartisan budget legislation that included a provision to repeal Health Care Reform's automatic enrollment requirement. Therefore, employers with more than 200 full-time employees will no longer be required to automatically enroll employees into a health plan.

No Action Required

Employers that have more than 200 full-time employees are no longer responsible for the automatic enrollment of employees into their health plan.

For the complete details, see: https://www.congress.gov//114/bills/hr1314/BILLS-114hr1314enr.pdf

IRS RELEASES INDEX AND COST OF LIVING ADJUSTMENTS TO MANDATES AND FRINGE BENEFITS

The Internal Revenue Service (IRS) recently released Revenue Procedure 2014-62, in addition to Revenue Procedure 2015-53. The following are highlights from these updates.

Health Care Reform Related Indexing Adjustments (Revenue Procedure 2014-62)

For tax year 2016, the affordability threshold for the cost of coverage to an employee to receive subsidies within the public Marketplace (i.e., Exchange) is **9.66%** of an employee's household income. The threshold for an employee to receive an exemption from the Individual Mandate Penalty (i.e., Individual Shared Responsibility Payment), has increased to when applicable coverage costs more than **8.13%** of an employee's household income.

Qualified Transportation Fringe Benefit (Revenue Procedure 2015-53)

For tax year 2016, the monthly limitation for the qualified transportation fringe benefit will remain at **$130** per month. However, for qualified parking the monthly limitation has increased to **$255** per month, from $250 in 2015.

Some Action Required

Employers may want to be informed of an employee's eligibility threshold for subsidies in the Exchange, in addition to the potential for employee exemptions from the Individual Mandate. Employers should also consider adjusting their monthly limitation on qualified parking to the increased threshold.

For the complete details, see:

Revenue Procedure 2014-62: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf
Revenue Procedure 2015-53: https://www.irs.gov/pub/irs-drop/rp-15-53.pdf

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ELIZABETH, NEW JERSEY ADOPTS PAID SICK LEAVE AND JERSEY CITY EXPANDS SICK LEAVE ORDINANCE

Elizabeth, New Jersey Paid Sick Leave Ordinance

On November 3, 2015, the city of Elizabeth, New Jersey voted to implement a paid sick leave ordinance. The following are details of the Elizabeth, New Jersey ordinance.

Covered Employers

The ordinance applies to **all** employers who have employees in Elizabeth, New Jersey. However, the amount of required paid sick leave that accrues to employees is contingent upon the total number of employees of the employer.

Eligible Employees

Any employee who works 80 or more hours in a calendar year, in the city of Elizabeth, New Jersey, is eligible for paid sick leave. Any employees who are part of a collective bargaining agreement may waive their right to paid sick leave, as part of the collective bargaining agreement.

Accrual of Paid Sick Leave

Employees begin accruing sick leave effective March 2, 2016, or date of hire, if their hiring date occurs after March 2, 2016. Paid sick leave accrues at the rate of one hour of sick time for every 30 hours of work. Employers with 10 or more employees must allow employees to acquire up to 40 hours of paid sick leave per year. Employers with less than 10 employees must allow employees to accrue up to 24 hours of paid sick leave per year. Employers who employ child care workers, home health workers, and food service workers are required to allow employees to accrue up to 40 hours of paid sick leave a year, regardless of the employer's size.

Employees may rollover up to 40 hours of paid sick leave to the following year, but employees are still capped at using up to 40 hours of sick leave per year.

Use of Paid Sick Leave

Employees may begin using paid sick leave after 90 days of employment.

Employees may use paid sick leave for:

- The diagnosis, care, or treatment (mental and physical) of the employee or the employee's family members
- Time off necessitated by child care closures due to public health concerns; and
- Absences which are cause by the need for exclusion from the workplace for health reasons

Notice and Posting

Employers must provide individual written notice to each employee about his/her rights to paid sick leave under the ordinance, either at time of hire, or as soon as possible for current employees. Employers must also display a poster containing notice of the ordinance in a conspicuous place in each business establishment where employees work. The notice must be in English, in addition to any other language that is the primary language of more than 10% of the workforce.

Expansion of Jersey City Paid Sick Leave Ordinance

On October 29, 2015, the city of Jersey City, New Jersey broadened the scope of its paid sick leave ordinance. The following are details from the expansion of the ordinance.

Modifications to the Previous Ordinance

The following changes were made to the previous ordinance:

1) Employers with less than 10 employees are now required to provide 24 paid hours of sick time per year, in **addition** to 16 unpaid sick time hours per year **after** an employee has exhausted their 24 hours of accrued paid sick leave
2) Employers who employ child care workers, home health workers, and food service workers are required to allow employees to accrue up to 40 hours of paid sick leave a year, regardless of the employer's size
3) Collective bargaining employees are allowed to waive the paid sick leave benefit, so long as it is evidenced in that employee's collective bargaining agreement

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Elizabeth, New Jersey Adopts Paid Sick Leave and Jersey City Expands Sick Leave Ordinance (Continued)

Modifications to the Previous Ordinance (Continued)

4) Members of a construction union are excluded under this ordinance
5) The fines for violation of this statute have increased from $1,250 to $2,000

Action Required

Employers with employees in Elizabeth, New Jersey should begin modifying (if necessary) their paid sick leave policy to ensure compliance with the ordinance. Employers in Jersey City, New Jersey should begin considering how to offer paid sick leave under the expanded ordinance if they currently are not meeting those requirements.

For the complete details, see:

Elizabeth Paid Sick Leave Ordinance: unavailable at this time
Jersey City Paid Sick Leave Ordinance:
http://www.cityofjerseycity.com/UPLOADEDFILES/FOR_RESIDENTS/EARNED%20SICK%20LEAVE%20ORDINANCE.PDF

CALIFORNIA LIMITS OUT OF POCKET MAXIMUMS AND DEDUCTIBLES

On October 8, 2015, California adopted Assembly Bill (AB) 1305, which restricts the amount of out of pocket expenses an individual must incur on Essential Health Benefits (EHBs) before the health plan must pay for any excess amounts for health care during the year. This applies to policies issued, amended or renewed on or after January 1, 2015. This also applies to employers offering fully-insured family coverage plans (family coverage is defined as anything other than self-only coverage). In addition, for policies issued, amended or renewed on or after January 1, 2017, AB 1305 mandates that deductibles for fully-insured HSA-compatible High Deductible Health Plans (HDHPs) must include an embedded individual deductible limit for family coverage that is equal to the individual deductible set forth in the policy, or the family deductible minimum set forth by the United States code for HSA-compatible HDHPs, whichever is greater.

Out of Pocket Maximums

For non-grandfathered policies issued, amended or renewed on or after January 1, 2015, where an individual is covered under family coverage, any individual enrolled in family coverage shall not have a calendar year maximum out-of-pocket for covered, in-network and emergency out-of-network expenses that is greater than the calendar year maximum out-of-pocket for an individual covered with employee-only/individual coverage for that product. As a reminder, the federal rules, however, limit the total out-of-pocket maximum that an individual may incur on Essential Health Benefits (EHBs) to an adjusted dollar amount every year ($6,850 for individuals in 2016).

For example, assume an HSA-compatible HDHP plan offered by an employer has an in-network maximum out-of-pocket of $3,000 for employee-only coverage and $6,000 for employee-with-dependents coverage. If just one member of the family reaches $3,000 out-of-pocket due to covered, in-network and emergency out-of-network expenses, thereafter, any covered, in-network and emergency out-of-network expenses on EHBs for the individual should be paid at 100% by the policy/plan for the remainder of the calendar year. For any other family members, another $3,000 of out-of-pocket expenses on EHBs would need to be paid by the other family members (to get to the $6,000 family out-of-pocket maximum) before the plan/policy would pay 100% for any additional medical expenses of the other family members, in this example.

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California Limits Out of Pocket Maximums and Deductibles (Continued)

Embedded Deductibles

If an employee elects employee with dependent coverage in an HSA-compatible HDHP, the maximum deductible for any individual in the family is the greater of:

1) The minimum family deductible under federal law ($2,600 in 2016), or
2) The deductible in the employer-sponsored HDHP plan for an employee with employee-only coverage under the policy

For example, if an employer offered an HSA-compatible HDHP with a $1,500 employee-only in-network deductible and a $3,000 employee-with-dependents in-network deductible, the amount of the deductible for any individual in the family could not exceed $2,600. So, if only one person in the family incurred $2,600 of covered, in-network expenses applied to the individual's deductible, thereafter, the plan should begin providing benefits for that individual even though the family deductible has not been satisfied. Before benefits would be payable for other family members, a total of $3,000 of covered, in-network expenses would have to be applied to the family deductible (i.e., an additional $400 paid by other family members, in this example).

Action Required

Employers offering fully-insured policies issued, amended or renewed on or after January 1, 2015 should ensure that they are following the maximum out of pocket rules outlined above. In addition, employers should be aware of the changes that are to take effect in relation to deductibles for policies issued, amended or renewed on or after January 1, 2017.

For the complete details, see AB 1305:
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1305

QUESTION OF THE MONTH

Q: Our company offers coverage under a self-insured major medical plan to all full-time employees. Can we offer cash incentives to specified employees with a history of high claim costs to opt out of our plan and purchase individual policies instead?

A: No. According to guidance jointly issued by the DOL, IRS, and HHS, offering a choice between cash and enrollment in the employer's standard group health plan constitutes prohibited health status discrimination under health care reform and HIPAA if the offer is made only to employees with high claims risk. Although it may seem that you are treating the high-claims employees more favorably by giving them a choice between cash and coverage under your plan—especially now that health care reform guarantees availability of individual coverage without preexisting condition exclusions—the agencies do not view this choice as permitted discrimination in favor of individuals who have adverse health conditions. According to the agencies, these employees have a greater effective cost of coverage because their cost is deemed to include the cash they will forgo if they elect to enroll in your plan. In addition, the cash-or-coverage offer is considered to be an eligibility rule that discourages plan participation based on a health factor. Consequently, the agencies view these arrangements as discriminatory, regardless of whether (1) the cash payment is pre-tax or after-tax to the employee, (2) the employer is involved in the selection or purchase of individual insurance policies, or (3) the employee obtains any individual coverage.

In addition, because choosing between cash and tax-favored health coverage requires a cafeteria plan election, the agencies assert that imposing an additional cost to elect health coverage could result in prohibited discrimination under Code § 125. Note also that you could not condition availability of any financial incentive (whether or not based on health or claims history) on the employee's actual purchase of an individual insurance policy. Doing so creates an employer payment plan that violates health care reform's prohibition on annual dollar limits as well as the requirement to provide coverage of preventive services. Violating these provisions can result in substantial excise taxes.

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Question of the Month (Continued)

Moreover, the proposed incentive might raise concerns under HIPAA's privacy rule if you are considered to be using protected health information (PHI) (i.e., health or claims history) for a purpose unrelated to plan administration (i.e., to identify employees eligible for the cash incentive). Other federal laws, such as the Americans with Disabilities Act (ADA) or the Age Discrimination in Employment Act (ADEA), could also be implicated.

Source: Thomson Reuters/EBIA

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