Healthcare Alert

September 19, 2016

"If you have knowledge, let others light their candles in it." ~ Margaret Fuller

Understanding the Term "Full Time Employees" Under "Pay or Play"

Designation Determined by Hours Worked, Not Employer Classification

The employer shared responsibility provisions of the Affordable Care Act (also known as "pay or play") require applicable large employers ("ALEs")—generally those with at least 50 full-time employees, including full-time equivalent employees (FTEs)—to offer affordable health insurance that provides a minimum level of coverage to full-time employees (and their dependents) or pay a penalty tax if any full-time employee is certified to receive a premium tax credit for purchasing individual coverage on the Health Insurance Marketplace. The Internal Revenue Service recently addressed a question regarding how an employer's classification of employees as part-time or seasonal impacts full-time employee calculations under the pay or play provisions.

Determining "Full-Time Employees"

For purposes of pay or play, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week. In addition, 130 hours of service in a calendar month is treated as the monthly equivalent of **at least 30 hours of service per week**.

Generally, an hour of service means:

- Each hour for which an employee is **paid**, or **entitled to payment**, for the performance of duties for the employer; and
- Each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed **due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.**

Employer Classification of "Full-Time Employee" Not Determinative

The IRS recently addressed a question from an employee whose employer developed a policy restricting part-time or seasonal employees from working more than 29 hours of service in any week. Click the link to learn more.

IRS Offers Free Webinar on Determining "Full Time Employees" Under "Pay or Play" Provisions

The Internal Revenue Service is offering a free webinar for employers interested in learning more about how to determine 'full-time employees' for purposes of the employer shared responsibility ("pay or play") provisions of the Affordable Care Act (ACA). *Webinar Will Also Cover Look-Back and Monthly Measurement Methods.*

The webinar will take place on **Thursday, September 22 at 2 p.m. Eastern Time** (1 p.m. Central Time; 12 p.m. Mountain Time; 11 a.m. Pacific Time).

Webinar attendees will also learn about:

- How to determine full-time status for employees who are seasonal, part-time, or work non-traditional schedules;
- Using the look-back and monthly measurement methods; and
- Initial measurement, stability, standard measurement, and administrative periods.

Click here to register for the webinar.

Proposed 2018 Individual Mandate Required Contribution Percentage Released

Agencies Also Seek Codification of Certain Special Enrollment Periods

The U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) recently released the proposed Notice of Benefit and Payment Parameters for 2018. Among other things, the proposal seeks to establish the required contribution percentage under the individual mandate and codify certain special enrollment periods for plan years beginning in 2018.

Proposed 2018 Required Contribution Percentage

The Affordable Care Act's "individual mandate" provision requires every individual to have minimum essential health coverage for each month, qualify for an exemption, or make a penalty payment when filing his or her federal income tax return. Under the law, an individual qualifies for an exemption if the amount that he or she would be required to pay for minimum essential coverage (the required contribution) exceeds a particular percentage (the required contribution percentage) of his or her actual household income for a taxable year.

Under the proposed rule, the required contribution percentage for 2018 would be set at 8.05%, a decrease from the final required contribution percentage for 2017 (8.16%).

Special Enrollment Periods

In addition, the HHS is proposing to codify special enrollment periods for the following consumers who apply for coverage on the Exchange:

- Individuals and their dependents who apply for coverage and are later determined to be ineligible for Medicaid or CHIP;
- Individuals who resolve a data matching issue following the expiration of an inconsistency period; and

- Victims of domestic abuse or spousal abandonment and their dependents who seek to apply for coverage apart from the perpetrator of the abuse or abandonment.

Note: While these special enrollment periods are currently available to consumers, the agency is now seeking codification in order to ensure the rules are clear and to limit abuse.

Click here to read the proposed Notice of Benefit and Payment Parameters for 2018 in its entirety.

DOL Flags Potential Mental Health Parity Violations

In response to requests for examples of plan provisions that may violate the Mental Health Parity and Addiction Act of 2008, as amended by the ACA, ("MHPAEA"), the Department of Labor ("DOL") has provided guidance, and examples, on identifying provisions that require careful analysis to ensure compliance with mental health parity requirements.

The MHPAEA requires parity between ***medical or surgical*** benefits on one side and ***mental health or substance use disorder*** benefits on the other with respect to financial requirements (such as deductibles and copayments), quantitative treatment limitations (such as treatment or visit limits), and non-quantitative treatment limitations (such as preauthorization requirements and restrictions based on facility type). The guidance recently released by the DOL focuses on non-quantitative treatment limitations that require additional analysis to determine mental health parity compliance.

Under the MHPAEA, a plan may not impose a non-quantitative treatment limitation (such as pre-authorization) on mental health or substance use disorder benefits ***unless***, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical or surgical benefits of the same classification (e.g. in-network in-patient visits; out-of-network outpatient visits; or in-network prescription drugs or devices). Example provisions of non-quantitative treatment limitations that require careful review to determine parity compliance are listed below. While these plan terms do not automatically violate the law, the guidance notes that the plan should be able to provide evidence to substantiate compliance with the MHPAEA.

Preauthorization and Pre-Service Notification Requirements

- The plan requires preauthorization for all mental health and substance use disorder services.
- The plan states that precertification is required for inpatient stays for mental health.
- The plan delegates its medical management program review authority to attending physicians for medical or surgical services but conducts its own review for mental health or substance use disorder services.

- The plan requires preauthorization every three months for pain medications prescribed in connection with mental health or substance use disorder conditions.

Fail-First, Probability of Improvement, and Patient Noncompliance Provisions

- For any inpatient mental health or substance use disorder services, the plan requires that an individual first complete a partial hospitalization treatment program.
- The plan only covers services that result in measurable and substantial improvement in mental health status within 90 days.
- The plan excludes services for chemical dependency in the event that the covered person fails to comply with the plan of treatment, including the exclusion of benefits for mental health or substance use disorder services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.

Written Treatment Plan Requirements

- The plan requires a written treatment plan prescribed and supervised by a behavioral health provider for mental health or substance use disorder benefits.

Residential, Geographical, and Licensure Requirements

- The plan excludes residential level of treatment for chemical dependency.
- The plan imposes geographical limitations related to treatment for mental health or substance use disorder conditions but does not impose any geographical limits on medical or surgical benefits.
- The plan requires that mental health or substance use disorder facilities be licensed by a state but does not impose the same requirement on medical or surgical facilities.

To view the DOL's guidance in its entirety, please click here.

DOL Issues Compliance Guidance for Employee Benefit Plans in Wake of Louisiana Storms

FAQs Also Available

In light of recent storms and flooding in Louisiana, the U.S. Department of Labor (DOL) has issued guidance regarding **compliance with employee benefit plan rules** for those adversely impacted in the state since August 11, 2016. Highlights of the guidance are presented below.

Application of Guidance and Scope of Relief

The guidance generally applies to employee benefit plans, plan sponsors, employers and employees, and service providers to such employers who were located—as of August 11, 2016—in a parish identified as a covered disaster area due to storm devastation.

Note: The relief provided by the DOL is in addition to the filing relief (i.e., tax returns and Form 5500 series returns) already provided by the IRS, in accordance with LA-2016-20.

Verification Procedures for Plan Loans and Distributions

IRS Announcement 2016-30 provides relief from certain verification procedures that may be required under retirement plans with respect to plan loans to participants and beneficiaries, hardship distributions, and other pension benefit distributions. The DOL is **not expected to treat any person as having violated the provisions of Title I of the Employee Retirement Income Security Act** (ERISA) solely because he or she complied with the provisions of the IRS announcement.

ERISA Group Health Plan Compliance Guidance

Plan participants and beneficiaries may encounter an array of problems due to the storms and flooding, such as difficulties meeting certain deadlines for filing benefit claims and COBRA elections. According to the DOL, the guiding principle for plans must be to act **reasonably, prudently, and in the interest of the workers and their families** who rely on their health plans for their physical and economic well-being. Plan fiduciaries should make **reasonable accommodations to prevent the loss of benefits** in such cases and should take steps to **minimize the possibility of individuals losing benefits** because of a failure to comply with pre-established timeframes.

In addition, there may be instances when full and timely compliance by group health plans and issuers may not be possible. The DOL has stated that its approach to enforcement will be marked by **an emphasis on compliance assistance and include grace periods and other relief where appropriate**, including when physical disruption to a plan or service provider's principal place of business makes compliance with pre-established timeframes for certain claims' decisions or disclosures impossible.

Additional information, including details on participant contributions and loan repayments, is contained in the guidance. The DOL has also released a set of FAQs for participants and beneficiaries.