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ADP National Account Services
Outsourcing for HR, Benefits and Payroll

# Tech Flex

ESSENTIALS

**Topics Covered in this Issue:**

## Benefits:

- Final Essential Health Benefits Guidance Released
- Guidance Provided on ACA Preventive Care Provisions

## Payroll:

- USCIS Releases Revised Form I-9
- Wyoming Exempts Accrued Vacation from Termination Pay

## FINAL ESSENTIAL HEALTH BENEFITS GUIDANCE RELEASED

In the February 25, 2013 Federal Register, the Department of Health and Human Services (HHS) published the final regulation establishing standards for coverage of essential health benefits (EHB) that health insurers in the small group and individual markets must offer beginning January 1, 2014. In addition, on February 20, 2013, the HHS, Department of Labor (DOL) and the Treasury released frequently asked questions (FAQs) on the cost-sharing provisions of the Affordable Care Act (ACA).

It is important to note that self-insured employer plans, large group market insurers, and grandfathered plans are not subject to the EHB requirement. However, the final EHB regulations address an issue of direct concern to sponsors of self-insured and insured large group plans regarding the application of "out-of-pocket" (OOP) cost-sharing limits, as well as methods for determining "minimum value" of employer-sponsored coverage.

**Background**:

Effective for plan or policy years beginning on or after January 1, 2014, the ACA requires health insurance issuers offering non-grandfathered coverage in the individual or small group market to offer coverage that includes the "essential health benefits package."

In order to be considered providing an essential health benefits package, a plan must generally:

- provide essential health benefits;
- limit cost-sharing; and
- provide either bronze, silver, gold, or platinum level coverage (that is, the plan pays benefits that are actuarially equivalent to 60%, 70%, 80%, or 90% (respectively) of the total allowed cost of benefits provided under the plan), or catastrophic coverage (also known as "young invincibles" coverage).

In addition, an insurer that offers bronze, silver, gold, or platinum level coverage, as described is required to offer the same level of coverage in a "child-only plan" specifically designed for individuals under the age of 21.

Generally, essential health benefits include minimum benefits in the following ten categories and the items and services covered within those categories.

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Each state was required to select a benchmark plan for purposes of setting the EHB required in that state.

**Final Regulations:**

The final regulation implements a requirement in the ACA that non-grandfathered insured plans in the individual and small group markets cover essential health benefits (EHBs) for 10 categories of care as noted above, including basic services such as hospitalization and emergency care, as well as mental health and maternity care. In addition, plans must cover a minimum of 60% of the actuarial value of covered medical services. The rule applies to plans sold within the health insurance exchange markets that will be created under the ACA, as well as to plans sold outside of the exchanges. A few of the highlights of the final regulations are as follows:

**Cost-Sharing Limits:** The final regulation preamble clarifies issues regarding the applicability of the ACA's cost-sharing limits on deductibles and out-of-pocket maximums. With respect to deductibles, the preamble states that it is interpreted that limit applies only to non-grandfathered insured plans in the individual and small group market and not to self-insured employer plans, large group employer plans, or large group market insurers. With respect to out-of-pocket maximums (OOP), the preamble clarifies that all non-grandfathered group health plans must comply with the OOP limits.

**Mental Health Parity Requirement:** The final regulations confirmed that mental health and substance use disorder benefits will be required as an element of EHB and in order to satisfy the EHB package requirements, plans must provide mental health and substance use disorder benefits in a manner that complies with the federal Mental

Health Parity and Addiction Equity Act of 2008. In addition, the regulatory preamble clarifies that this requires plans in the small group and individual markets to comply with the mental health parity requirements in order to satisfy the requirement to offer EHB.

**Minimum Value Rules**: The final regulations generally adopt the proposed rules on minimum value (MV), which have great significance for employers that are subject to the shared responsibility rules in 2014. One of the necessary elements to avoid possible penalties is the requirement to offer full-time employees (generally those who work 30 hours a week or more) coverage that provides "minimum value." A plan is considered to provide MV if the plan covers at least 60% of the allowed costs of benefits under the plan. The preamble announces that the MV calculator, with accompanying continuance tables and the MV methodology are now available. Uses of this calculator or a safe harbor checklist are two options for determining a plan's minimum value retained from the proposed rules. (A plan can also be certified by an actuary as providing minimum value, subject to certain requirements.) The MV calculator may be accessed by clicking on the link provided below:

http://cciio.cms.gov/resources/regulations/index.html#pm

In addition, the final regulations add a provision to reflect that employer contributions to health savings accounts (HSAs) and amounts newly made available under integrated health reimbursements arrangements (HRAs) "that may be used only for cost sharing" may be taken into account in determining MV. In addition, it is noted in the preamble as to whether other types of integrated HRAs might count towards MV is being considered, and further guidance on the treatment of HRAs may be issued and the regulation amended as necessary.

For a copy of the FAQs on the limitations on cost-sharing under ACA, please click on the link provided below and see Questions 1 and 2.

http://www.dol.gov/ebsa/pdf/faq-aca12.pdf

For a copy of the final regulations, please click on the link provided below.

http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

## GUIDANCE PROVIDED ON ACA PREVENTIVE CARE PROVISIONS

On February 20, 2013, the United States Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) released a frequently asked questions (FAQ) document addressing the preventive care services required to be provided under the Affordable Care Act (ACA).

As a way of background, the ACA requires that group health plans and insurers provide certain preventive services, such as mammograms, colonoscopies and immunizations, without imposing any cost-sharing on plan participants receiving such services. Consequently, no deductibles, co-pays, co-insurance, or other cost-sharing may be imposed on these services. However, it is important to note that "grandfathered plans" (generally those plans in existence as of March 23, 2010 that meet certain requirements) are not required to comply with this ACA provision.

Group health plans and insurers that are subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements, when delivered by in-network providers:

- Evidence-based items or services recommended by the United States Preventive Services Task Force (USPSTF) with a rating of "A" or "B," such as genetic counseling and breast cancer susceptibility gene testing, if appropriate as determined by a health care provider.

- Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Care and screening for infants, children, adolescents and women provided for in guidelines supported by the Health Resources and Services Administration (HRSA).

- Plans or insurers must cover the full range of Food and Drug Administration (FDA) approved contraceptive methods and they may not limit coverage of contraceptives to one kind (for example, oral contraceptives as opposed to implanted devices). However, plan or insurers may use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, plans may cover a generic oral contraceptive or other drug without

cost-sharing and impose cost-sharing for equivalent branded drugs, but must accommodate any individual for whom either drug would be medically inappropriate, as determined by that individual's health care provider, by waiving any applicable cost-sharing for the branded drug.

The FAQ's, among a number of other matters, clarified the following:

- If a plan or insurer does not have an in-network provider that can provide the specified service, it must cover the service when performed by an out-of-network provider and may not impose cost-sharing for the service.

- Aspirin and other over the counter (OTC) items and services must be covered without cost-sharing but only when prescribed by a health care provider.

- Women's preventive services that will be covered without cost-sharing requirements include:

    - Well-woman visits: This includes an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their health care providers determine they are necessary.

    - Gestational diabetes screening: This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.

    - HPV DNA testing: Women who are 30 or older have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results.

    - Sexually Transmitted Infections (STI) counseling: Sexually-active women have access to annual counseling on STIs.

    - HIV screening and counseling: Sexually-active women have access to annual counseling on HIV.

    - Contraception and contraceptive counseling: Women with reproductive capacity have access to all Food and Drug Administration-approved

contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider.

- o Breastfeeding support, supplies, and counseling: Pregnant and postpartum women have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.

- o Interpersonal and domestic violence screening and counseling: Screening and counseling for interpersonal and domestic violence will be covered for all adolescent and adult women.

- Contraceptive methods such as sponges and spermicides that are generally available OTC are only included as preventive services if the method is both FDA-approved and prescribed for a woman by her health care provider. Contraception for men is not included.

- A plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening service. However, a plan or issuer may impose cost-sharing for a treatment that is not recommended preventive service, even if the treatment results from a recommended preventive service.

For a copy of the preventive care FAQs, please click on the link provided below and see Questions 3 through 20.

http://www.dol.gov/ebsa/pdf/faq-aca12.pdf

## USCIS RELEASES REVISED FORM I-9

On March 8, 2013, the United States Citizenship and Immigration Services (USCIS) announced in the Federal Register that a revised Employment Eligibility Verification Form (I-9) is now available.

By way of background, the Immigration Reform and Control Act of 1986 (IRCA) requires employers to verify that all newly-hired employees present documentation verifying their identity and legal authorization to accept employment in the United States. Form I-9 is provided by the federal government to verify identity and employment eligibility. Every newly hired employee must complete and sign Section 1 of Form I-9 no later than the first day of employment. As part of the process, employees must present a document or a combination of documents that establishes identity, and legal authorization to work in the United States.

Employers are required to maintain I–9s for as long as an individual works for the employer and for the required retention period after the employee terminates. The required retention period is either 3 years after the date of hire or 1 year after the date employment ended, whichever is later.

Note: Employers do not need to complete the new Form I-9 (Rev. 03/08/13 N) for current employees for whom there is already a properly completed I-9 on file, unless reverification applies.

When releasing the revised I-9, the USCIS stated that employers should begin using Form I–9 with a revision date of (Rev. 03/08/13)N to comply with their employment eligibility verification responsibilities right away. Past versions of the I-9 with the dates of February 2, 2009 or August 7, 2009 will be accepted only until May 7, 2013. After May 7, 2013, all prior versions of Form I–9 can no longer be used by the public. After May 7, 2013, employers who fail to use Form I–9 (Rev. 03/08/13)N may be subject to penalties.

The revised I-9 with a revision date of March 8, 2013 and an expiration date of March 31, 2016 is now two pages rather than one and its instructions have been expanded from four to seven pages. Highlights of the changes to the I-9 include the following.

**Instructions:**

- The instructions now clarify that border commuters from Canada and Mexico may use foreign addresses in Section 1 (but that all other employees must use United States addresses).

- The instructions now confirm that post office (P.O.) boxes are not acceptable.

- The instructions now clearly state that the social security number (for employees who do not use E-Verify), e-mail and telephone numbers are optional.

**Section 1:**

- The instructions (in the heading) have been clarified to read: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

- The form has updated terminology to make it more user-friendly, to reflect a better understanding of cultural norms, and to be more gender-neutral (”Family Name” in addition to “Last,” and “Other Names Used,” instead of “Maiden name”).

- Data fields have been added for E-mail Address and Telephone Number, although these fields are optional.

- Below the checkbox for "aliens authorized to work," data fields have been added for Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number.

- Data fields have been added for Foreign Passport Number and Country of Issuance (if applicable).

- Employee must provide all other legal names used, including maiden names. If the employee has used no other legal names, “N/A” should be inserted.

**Section 2:**

- The instructions (in the heading) have been clarified to read: “Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.”

- The revised instructions clarify that the person who examines the employee's documents must be the same person who signs Section 2 and that the examiner and the employee must both be physically present during the examination.

- The form now includes three dedicated fields for recording List A documents.

**Section 3:**

- The heading of Section 3 now reads “Reverification and Rehires” to clarify that there is no requirement that employers update the form for employee names changes.

- The signature line now includes a space to "Print Name of Employer or Authorized Representative."

**Lists of Acceptable Documents**

- The lists of acceptable documents remain unchanged; however, the following note has been added above the lists: “Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.”

- In List A, item 5 has been reformatted and punctuated for clarity: For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) the same name as the passport; and (2) An endorsement of the

alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.

- In List C, item 1 has been revised to include enumerated restrictions: A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION.

For a copy of the Federal Register announcing the revised I-9, please click on the link provided below.

http://www.gpo.gov/fdsys/pkg/FR-2013-03-08/pdf/2013-05327.pdf

For a copy of the revised I-9, please click on the link provided below.

http://www.uscis.gov/files/form/i-9.pdf

## WYOMING EXEMPTS ACCRUED VACATION FROM TERMINATION PAY

On February 18, 2013, Wyoming Governor Matt Mead signed into law House Bill 79 that excludes the value of vacation leave accrued at the date of termination from the definition of “wages” if the employer’s written policies provide that accrued vacation is forfeited upon termination of employment and if such policies are acknowledged in writing by the employee. This measure becomes effective on July 1, 2013.

As a result of the enactment of House Bill 79, as of July 1, 2013, Wyoming Section 27-4-501 will read as follows:

“27-4-501. Definitions.

(a) Whenever used in this act:

(iii) "Wages" means compensation, including fringe benefits, for labor or services rendered by an employee, whether the amount is determined on a time, task, piece, commission, or other basis, but does not include the value of vacation leave accrued at the date of termination if the written policies of the employer provide that accrued vacation is forfeited upon termination of employment and the written policies are acknowledged in writing by the employee;…”

For a copy of Wyoming House Bill 79, please click on the link provided below.

http://legisweb.state.wy.us/2013/Enroll/HB0079.pdf

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