

Tech Flex

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GUIDANCE ON REQUIRED WOMEN'S PREVENTIVE CARE RELEASED

Under the Patient Protection and Affordable Care Act (PPACA), effective for plan years beginning on or after September 23, 2010 group health plans (self and fully insured) must provide coverage without cost sharing such as co-payment or deductibles when services are delivered by an in-network provider for certain preventive services. Grandfathered plans (generally those in existence as of March 23, 2010 and who have not made prohibited plan modifications) are exempt from this requirement.

In accordance, the Departments of Health and Human Services (HHS), Department of Labor (DOL), and Treasury issued interim final regulations on July 14, 2010 requiring new plans and issuers to cover certain preventive services without any cost-sharing for the enrollee when services are delivered by in-network providers. This interim final guidance provided extensive "recommendations and guidelines" on what preventive services must be provided without cost-sharing when delivered by an in-network provider. Although the guidance refers to these services and items as "recommended preventive services", the interim final rule actually required that these services must be offered on a no cost sharing basis when provided by an in-network provider. For more information on the interim final guidance, please see the July 2010 Tech Flex. [\[LINK\]](#)

On August 1, 2011, the Health Resources and Services Administration (HRSA), an agency within the HHS, released supplemental guidance for group health plans and health insurance issuers relating to coverage of preventive services under PPACA specifically in relation to preventive care services for women. This guidance stipulated that effective for plan years commencing on or after August 1, 2012, non-grandfathered plans will be required to provide the following services, in addition to those preventive services included in the July 14, 2010 guidance on a first dollar basis to women participants:

- Annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.
- Screening for gestational diabetes.
- High-risk human papillomavirus DNA testing in women with normal cytology results.
- Counseling on sexually transmitted infections for all sexually active women.

- Counseling and screening for human immune-deficiency virus infection for all sexually active women.
- Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
- Screening and counseling for interpersonal and domestic violence.
- All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

It is important to note that in relation to contraceptive services, an exemption from the requirement has been provided to certain “religious employers” who meet the following requirements:

- Has the inculcation of religious values as its purpose.
- Primarily employs persons who share its religious tenets.
- Primarily serves persons who share its religious tenets.
- Is a non-profit organization as defined under the Internal Revenue Code.

For a copy of the HRSA guidance, please click on the link provided below.

<http://www.hrsa.gov/womensguidelines/>

UNIFORM NOTICE OF COVERAGE REQUIREMENTS GUIDANCE PROVIDED

The United States Treasury Department, Department of Labor (DOL) and Department of Health and Human Services (HHS) on August 17, 2011 released joint proposed regulations in relation to the Uniform Notice of Coverage Requirements enacted under the Patient Protection and Affordable Care Act (PPACA).

Under PPACA, not later than March 23, 2012, the plan administrator in the case of a self-insured plan, or the insurer in the case of a fully-insured plan, must prepare and distribute a paper or electronic summary of coverage describing the benefits and coverage under the plan to participants prior to enrollment. This document titled the

Summary of Benefits and Coverage (SBC) also must be provided at each open enrollment period. This notification requirement, which applies to both grandfathered and non-grandfathered plans, is in **addition** to the required Employee Retirement Income Security Act (ERISA) Summary Plan Description (SPD). Finally, the plan or issuer must notify plan participants of material changes to the coverage reflected in the most recent summary provided no less than 60 days in **advance** of the effective date of the coverage modification. Although church and governmental plans are exempt from providing the SPD under ERISA, such plans are NOT exempt from providing the SBC.

NOTE: Public Health Services Act (PHSA) mandates, such as the Uniform Notice of Coverage Requirements, do not apply to excepted benefits. Excepted benefits generally include dental-only and vision-only plans, most health flexible spending arrangements, Medigap policies, and accidental death and dismemberment coverage.

The proposed regulations generally adhere to the required elements as outlined in the PPACA legislation; thus requiring that the SBC contain the following regarding the group health plan:

- Description of coverage and cost-sharing (deductibles, co-pays) under the plan.
- Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand terms of (or exceptions to) their coverage.
- Premiums required (or in the case of a self-insured group health plan, cost of coverage).
- Information on exceptions, reductions and limitations on coverage.
- Renewability and continuation of coverage provisions.
- A coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing.
- With respect to coverage beginning on or after January 1, 2014, a statement as to:
 - Whether the group health plan provides minimum essential coverage.
 - Whether the group health plan pays less than 60 percent of the total cost of benefits under the plan.

- A statement that the SBC is only a summary and that the plan document, policy, or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage.
- Contact numbers and web addresses where the plan document, or the group certificate or policy may be obtained.

The SBC must be written in a “culturally and linguistically appropriate manner and utilize terminology understandable by the average plan enrollee” and be no more than four pages in length with print no smaller than 12 point font.

An SBC may be provided in paper form by a plan or issuer to a participant or beneficiary. However, the SBC may be delivered electronically IF the following conditions are met:

- Upon an individual’s request for information or request for an application for coverage, the individual makes a request electronically or when submitting an application, an individual completes an application for coverage electronically.
- If a plan and or issuer provides the SBC, it must:
 - Request that an individual acknowledge receipt of the SBC.
 - Make the SBC available in an electronic format that is readily usable by the public.
 - If the SBC is posted on the Internet, display the SBC in a location that is prominent and readily accessible to the individual, in electronic or non-electronic form, to each individual who requests information or applies for coverage that apprises that individual that SBC is available on the Internet and includes the applicable Internet address.
 - Promptly provide, without charge or penalty, a paper copy of the SBC upon the request of an individual. The individual must be provided the ability to request a paper copy of the SBC via the issuer / plan Web site or via a telephone number prominently displayed for such purpose on the issuer / plan web site.
 - Ensure that an SBC provided in electronic form is provided in accordance with the SBC appearance, content, and language requirements.

Alternatively, a plan may deliver the SBC electronically where such delivery meets the electronic delivery requirements under the ERISA provisions at 29 CFR 2520.104b-1.

Under the proposed regulations, if a group health plan or health insurance issuer offering group or individual health insurance coverage makes any material modification to the terms of the plan or coverage that effects the content of the most recent SBC provided and “occurs other than in connection with a renewal or reissuance of coverage”, the plan must provide notice of the modification to plan participants “not later than 60 days prior to the date on which such modification will become effective.” The modification notice must be provided in a form that is consistent with the SBC content and format requirements.

A health insurance issuer or non-federal governmental health plan that willfully fails to provide the SBC and modification information required is subject to a fine of not more than \$1,000 per failure.

Please find below links related to the SBC guidance released.

Proposed regulations:

http://www.ofr.gov/OFRUpload/OFRData/2011-21193_Pl.pdf

Proposed template and instructions:

http://www.ofr.gov/OFRUpload/OFRData/2011-21192_Pl.pdf

Healthcare.gov Fact Sheet:

<http://www.healthcare.gov/news/factsheets/labels08172011a.html>

LEGISLATION TO REPEAL OTC RESTRICTION INTRODUCED

On July 15, 2011, bipartisan legislation was introduced in both the United States House and Senate that would repeal Section 9003 of the Patient Protection and Affordable Care Act (PPACA). PPACA Section 9003 requires that medicine and drug expenses incurred on and after January 1, 2011 may be paid or reimbursed under a health FSA or health reimbursement arrangement (HRA) only if the medicine or drug:

1. requires a prescription;
2. is OTC and the individual obtains a prescription; or
3. is insulin.

In addition, distributions under a health savings account (HSA) or Archer MSA are restricted to the requirements stated above.

The bicameral legislation titled “Restoring Access to Medication Act” sponsored by Senators Pat Roberts (R-KS) , Ben Nelson (D-NE) and Congresswomen Shelley Berkley (D-NV) and Lynn Jenkins (R- KS) has been referred to the Senate Committee on Finance and the House Committee on Ways and Means.

For a copy of the “Restoring Access to Medication Act”, please click on the link provided below.

<http://www.gpo.gov/fdsys/pkg/BILLS-112s1368is/pdf/BILLS-112s1368is.pdf>

WISCONSIN MODIFIES DEPENDENT COVERAGE LAW

Governor Scott Walker of Wisconsin has signed into law legislation that modifies a current provision of Wisconsin law requiring employers with insured group health plans (and self-funded public sector health plans) that offer dependent health insurance coverage to their employees to include coverage for certain adult dependent children up to the day before the child’s 27th birthday.

The revised Wisconsin law now largely follows the requirements of the federal health care reform law (the Patient Protection and Affordable Care Act (“PPACA”)), which requires that employers provide coverage to adult children of employees up to age of 26.

The modification is generally effective on January 1, 2012. However, the change is effective at a later date when the terms of a collective bargaining agreement cover the subject employees/plan. In such case, the change is effective on the later of the day on which the collective bargaining agreement expires or the date on which the collective bargaining agreement is extended, modified, or renewed.

Consequently, Wisconsin employers sponsoring plans that were affected by the prior Wisconsin dependent coverage law must still provide coverage to dependents up to their 27th birthday through at least the end of 2011 (and possibly longer where a collective bargaining agreement defines the coverage).

It is important to note that the legislation modifying the age requirement did not rectify the disparity that is present in relation to the federal and state taxation of benefits provided to children of employees. The Internal Revenue Code (IRC) was amended to exempt the value of coverage provided to certain adult children regardless of whether the adult child qualifies as a tax dependent. However, Wisconsin did not conform to the amended IRC and consequently dependent coverage provided to an employee for a child who is not a tax dependent must be included in the employee’s state income.

OREGON CREDITOR GARNISHMENT INCOME EXEMPTION INCREASED

As a result of the enactment of Oregon H.B. 2682, the Oregon statute (ORS § 18.385) governing the amount of an employee's income that is exempt from creditor garnishment has been modified as follows:

75% of weekly disposable earnings or;

\$218 of disposable earnings per week (was \$196);

\$435 of disposable earnings for any two-week period (was \$392);

\$468 of disposable earnings for any half-month period (was \$420);

\$936 of disposable earnings for any one-month period (was \$840).

For a copy of the Oregon H.B. 2682, please click on the link provided below.

<http://www.leg.state.or.us/11reg/measures/hb2600.dir/hb2682.intro.html>

MINNESOTA CONFORMS TO AMENDED INTERNAL REVENUE CODE

On July 20, 2011, Minnesota Governor Mark Dayton signed an omnibus tax bill (H.F. 20) that updates the federal conformity date for purposes of computing corporation franchise tax and personal income tax liability.

Consequently Minnesota conforms to federal tax treatment of health care benefits for children of employees under the age of 27.

Minn. Stat. § 289A.02 has been amended to read as follows:

Section 1. Minnesota Statutes 2010, section 289A.02, subdivision 7, as amended by Laws 2011, chapter 8, section 1, is amended to read:

Subd. 7. Internal Revenue Code. Unless specifically defined otherwise, ~~for taxable years beginning before January 1, 2010, and after December 31, 2010,~~ "Internal Revenue Code" means the Internal Revenue Code of 1986, ~~as amended through March 18, 2010;~~ and ~~for taxable years beginning after December 31, 2009, and~~

~~before January 1, 2011, "Internal Revenue Code" means the Internal Revenue Code of 1986, as amended through December 31, 2010~~ April 14, 2011.

EFFECTIVE DATE. This section is effective the day following final enactment for taxable years beginning after December 31, 2009.

For a copy of H.F. 20, please click on the link provided below:

[https://www.revisor.mn.gov/laws/?year=2011&type=1&keyword_type=all&keyword=Chapter+8&doctype=Chapter&id=7.](https://www.revisor.mn.gov/laws/?year=2011&type=1&keyword_type=all&keyword=Chapter+8&doctype=Chapter&id=7)

AMENDMENT TO FMLA PROPOSED

Senator Jon Tester (D-Montana) has introduced a bill titled the "Parental Bereavement Act of 2011" that would allow parents grieving the death of a child to receive up to 12 weeks of job-protected time-off under the Family Medical Leave Act.

The proposed legislation would provide that the death of a child is treated like other life-altering events, allowing parents time to grieve. Parents are currently eligible for extended, unpaid time-off to care for newborn babies, adopted children and family members with serious health conditions.

A copy of the proposed legislation may be located on the link below:

http://tester.senate.gov/Legislation/upload/2011_07_13_Testler_Parental_Bereavement_Act.pdf

CALIFORNIA AMENDS ORGAN AND BONE MARROW DONATION LEAVE PROVISIONS

On August 1, 2011, Governor Jerry Brown signed into law a bill (SB 272) that clarifies the employment leave rights of employees who donate bone marrow or are organ donors. Existing law requires an employer to grant a leave of absence to an employee who is an organ donor or a bone marrow donor. The leave of absence to an organ donor is up to 30 days in a one-year period. The leave of absence for a bone marrow donor is up to 5 days in a one-year period.

The leave of absence for either donor is not a break in his or her continuous service for the purpose of his or her right to salary adjustments, sick leave, vacation, annual leave, or seniority. As a condition of an employee's initial receipt of the leave of absence, an employer may require the employee to take a specified number of days of earned but

unused sick or vacation leave, unless that would violate provisions of an applicable collective bargaining agreement.

This enactment of SB 272 serves to clarify that California Labor Code Section 1510 provides that the days of leave are business days rather than calendar days, and that the one-year period is measured from the date the employee's leave begins and consists of 12 consecutive months. In addition, the leave of absence is not a break in the employee's continuous service for the purpose of his or her right to paid time off. Further, the employer may condition the initial receipt of leave upon the employee's use of a specified number of earned but unused days for paid time off.

It is important to note that SB 272 stated the following:

“SEC. 2. The amendment of Section 1510 of the Labor Code made by this act does not constitute a change in, but is declaratory of, existing law.”

Consequently, the clarification to the leave law is effective immediately.

For a copy of SB 272, please click on the link provided below.

http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0251-0300/sb_272_bill_20110801_chaptered.pdf

CONNECTICUT ENACTS PAID SICK LEAVE LAW

On July 1, 2011, Governor Dan Malloy signed into law Senate Bill 913 requiring an “employer” to provide paid sick leave annually to “covered employees” classified as a “service worker.” The paid sick leave will accrue beginning January 1, 2012, or on the first date of employment for those employees hired after January 1, 2012. The paid sick time will accrue at a rate of one hour of paid sick leave for each forty hours worked in one-hour increments up to a maximum of forty hours per calendar year. Each employee will be entitled to carry over up to forty unused accrued hours of paid sick leave from the current calendar year to the following calendar year, but no employee will be entitled to use more than the maximum number of accrued hours in any year. The law becomes effective January 1, 2012.

Under the legislation, an employer subject to the requirement is one that employs 50 or more people in Connecticut in any one quarter of the prior year, determined as of January 1 each year. In order to be eligible for the leave, an eligible employee must be: (1) classified as nonexempt under the federal Fair Labor Standards Act and be paid hourly and (2) a “service worker” who has worked 520 hours in past 12 months.

A service worker is an employee primarily engaged in an occupation in certain occupation code numbers (e.g. (A) 11-9050) and titles (Food Service Managers) defined by the federal Bureau of Labor Statistics Occupational Classification system. A few examples include:

Librarians, Proof Readers, Registered Nurses, Retail Salespersons, Waiters and Waitresses, Nurse Midwives, Desktop Publishers, Taxi Drivers, Tellers and Therapists.

Employee Required Notices

Under S. 913, an employer can require a service worker to provide advance notice of up to seven days where the leave is foreseeable. If it is not foreseeable, the employer can require the service worker to give notice as soon as “practicable.” The term “practicable” was not defined.

If paid sick leave is for three or more consecutive days, the employer can require reasonable documentation that such leave is being taken for one of the purposes permitted under the act. For leave related to a health condition of the service worker or his/her spouse or child, documentation signed by the treating health care provider indicating the need for the leave and the number of days of such leave must be considered reasonable documentation. If the leave is due to family violence or sexual assault, a court record or documentation signed by the service worker or by a volunteer working for a victim services organization, an attorney, a police officer, or other counselor involved with the service worker must be considered reasonable documentation.

Employer Required Notices

At the time of hire, the employer must notify each service worker of the following:

- that he or she has a right to sick leave under the act;
- the amount of sick leave provided;
- the terms under which sick leave may be used;
- that retaliation against an employee for requesting or using sick leave is prohibited; and
- that the service worker may file a complaint with the Department of Labor for any violation.

The employer may comply with this notice requirement by displaying a poster that contains the required information in a conspicuous place accessible to service workers at the employer's place of business. **The information must be provided in both English *and* in Spanish.**

For a copy of S. 913, which includes a complete listing of occupation code numbers and titles of eligible employees, please click on the link provided below.

<http://www.cga.ct.gov/2011/act/pa/2011PA-00052-R00SB-00913-PA.htm>

OREGON AMENDS CRIME VICTIM LEAVE LAW TO INCLUDE HARASSMENT

As a result of the enactment of Oregon House Bill 3482, Oregon employers with six or more employees are now required to provide leave to employees who are victims of harassment to seek legal assistance, medical treatment, or relocate as a matter of safety.

Under Ch. 687 the term "victims of harassment" refers to an individual against whom harassment has been committed under the public offenses statutes. Employers may require employees to provide certification such as a police report or a copy of a protective order or other evidence from a court, administrative agency or attorney that the employee appeared in or was preparing for a civil, criminal or administrative proceeding related to harassment prior to taking leave, if feasible.

The law was effective upon the date of enactment; specifically August 2, 2011.

For a copy of OR HB 3482, please click on the link provided below.

<http://www.leg.state.or.us/11reg/measpdf/hb3400.dir/hb3482.en.pdf>

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****Please note that the information provided in this document is current as of the date it is originally published.****