Employee Benefits Report

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The ACA Expands Mental Health Benefits

The Affordable Care Act will create one of the largest expansions of mental health and substance use disorder coverage in a generation. Here's what you need to know about mental health benefits.

Mental health parity became a benefits compliance issue in 1996, with the passage of the Mental Health Parity Act of 1996 (MHPA). This federal law prohibited health plans that covered mental health services from placing lower aggregate lifetime and annual dollar limits on these benefits than on medical/surgical services. Plans could still restrict coverage of mental health services in other ways—for example, placing a limit on the number of covered visits.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded on the MHPA. It prohibits group health plans and self-insured entities from limiting mental health ser-

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This Just In…

Every year, influenza, or "flu," costs businesses approximately $10.4 billion in direct costs for hospitalizations and adult outpatient visits, says the U.S. Centers for Disease Control. Employers frequently offer employees seasonal flu vaccinations on site at no or low cost to minimize absenteeism. This option works well for employers with an on-site occupational health clinic. If you don't have a clinic, pharmacies and community vaccinators can provide on-site vaccination services.

If an on-site clinic is impractical for your organization, encourage employees to get vaccinated. Find out what health providers, pharmacies and clinics in your area provide seasonal flu vaccines. And check your group health plan. The Affordable Care Act requires new health plans to cover preventive services, such as vaccinations, without copayments

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vice coverage with more restrictive features such as co-pays, deductibles or visit limits, and it also extends protections to treatments for substance use disorders. As with the MHPA, it does NOT require any plan to provide mental health/substance use disorder benefits; it simply requires plans that provide them to cover them at the same level as medical/surgical benefits.

The MHPAEA applies to large group health plans; it does not apply to small group health plans. (The Employee Retirement and Income Security Act [ERISA] and the Internal Revenue Code define a small group health plan as one that has 50 or fewer workers. Until 2016, states may have different definitions of small groups for purposes of state insurance laws.)

In November 2013, the Departments of Health and Human Services, Labor and the Treasury jointly issued a final rule implementing the MPHAEA. It creates specific consumer protections, including:

- Applying parity to intermediate levels of care received in residential treatment or intensive outpatient settings;
- Clarifying the scope of transparency required by health plans, including plan participants' disclosure rights;
- Clarifying that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and
- Eliminating the "clinically appropriate standards of care" exception to parity requirements, which clinical experts advised was not necessary and is confusing and open to abuse.

The ACA Expands the MHPAEA

The Affordable Care Act (ACA) builds upon the requirements of the MHPAEA. The ACA requires health plans to cover mental health and substance use disorder services as one of ten "essential health benefits" (EHB) categories. Under the EHB rule, non-grandfathered individual and small group health plans must comply with these parity regulations as of January 1, 2014. "Grandfathered" plans are plans that were in place when the Affordable Care Act was enacted that have not been changed in certain specified ways. Health plans that must comply with the EHB requirements cannot put lifetime limits on these benefits.

Mental Illness, Substance Abuse and Your Bottom Line

The World Health Organization says that mental illness results in more disability in developed countries than any other group of illnesses, including cancer and heart disease. About 25 percent of all U.S. adults have a mental illness, and nearly 50 percent will develop at least one mental illness during their lifetime, reports the U.S. Centers for Disease Control. This creates a substantial economic burden, estimated at about $300 billion in 2002. Mental illness is also associated with chronic medical diseases such as cardiovascular disease, diabetes, and obesity.

Mental health professionals now recognize the psychological and physiological links between substance abuse and mental illness, classifying "substance use disorder" as a mental illness. Estimates of the total costs of substance abuse in the U.S., including productivity and health- and crime-related costs, exceed $600 billion annually. This includes approximately $193 billion for illicit drugs, $193 billion for tobacco, and $235 billion for alcohol.

Covering mental health services can help employers promote employee well-being and protect their bottom line. In addition to insurance coverage, employers can offer an employee assistance program (EAP). EAPs provide voluntary, free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems. They can address a variety of mental and emotional problems, such as alcohol and other substance abuse, stress, grief, family problems and psychological disorders. EAP counselors can also consult with managers and supervisors to address employee and organizational challenges. Many EAPs help organizations prevent and cope with workplace violence, trauma and other emergency response situations.

For more information on mental health/substance use disorder benefits and EAPs, please contact us.

and deductibles. However, this requirement does not apply to grandfathered health plans and self-insured plans.

The "seasonal flu season" in the United States can begin as early as October and last as late as May.

The CDC recommends vaccinations for everyone over the age of six months, particularly people with high risk of developing serious complications (like pneumonia) and those who live with or care for them.

Whatever Happened to Managed Care?

Think health cost inflation is something new? Back in 1973, encouraged by the Nixon administration, Congress passed the Health Maintenance Organization Act to bring cost-control measures to health plans. Today, managed care plans comprise the bulk of group and individual plans on the market. But healthcare costs more than ever. What happened?

Until the mid-1970s, if you had comprehensive health insurance, you had an indemnity plan. An indemnity plan reimburses the patient and/or provider as expenses are incurred. Most plans allow the insured to choose any provider without effect on reimbursement. They typically reimbursed the insured for a specified portion (often 80 percent) of the "usual, reasonable and customary" cost of services, or according to a fee schedule. The insured would pay the rest (the coinsurance).

The Health Maintenance Organization Act spurred the development of managed care by: 1) defining the term "health maintenance organization" as a legal entity that provides basic and supplemental health services to members, 2) authorizing the Secretary of Health, Education, and Welfare to make grants and guarantee loans to encourage the development of health maintenance organizations (HMOs), and 3) requiring all employers with an average of 25 or more employees that offered any health plan to their employees to also offer the option of membership in a qualified HMO.

HMOs assume the financial risks and responsibility for delivering all covered health services to members in a particular geographic area, usually in return for a fixed, prepaid fee. Some HMOs employ all providers and provide the facility or facilities. Others contract with medical groups, paying them a negotiated, per capita rate.

Problems with the HMO model soon appeared, however. Employees enrolled in HMOs began to push back against plan restrictions. In a true HMO, members must use a network provider or pay out of pocket, except when an emergency requires them to use an out-of-network provider. Second, as geography-based plans, HMOs offer a limited selection of providers. And third, because HMOs receive payment on a per-patient rather than per-service basis, they have incentives to promote wellness (at best) and to provide services only when needed (at worst). That perception led to consumer outcry that managed care plans' cost control efforts came at the cost of providing needed health services.

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In response to employee demand, many employers switched to POS or PPO plans. PPO (preferred provider organization) plans use a network of selected providers, but allow members to go outside the network. Members who opt to use non-network providers incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers. A POS (point-of-service) plan, a HMO/PPO hybrid, resembles HMOs for in-network services but usually reimburse services received outside the network in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

Today, the majority of people with group medical insurance have PPO or POS plans. Although less restrictive than HMOs, these plans include managed care provisions that allow insurers to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

Preadmission certification – A provision requiring group members to receive authorization from the insurer or a healthcare provider specified in the plan before non-emergency hospital admissions. Failure to obtain preadmission certification in non-emergency situations reduces or eliminates the insurer's obligation to pay for services rendered.

Utilization review – The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during or after the services are rendered.

Preadmission testing – A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.

Non-emergency weekend admission restriction – A limit on reimbursement to patients for non-emergency weekend hospital admissions, to encourage the use of primary care providers rather than emergency rooms for non-urgent care.

Second surgical opinion – A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended non-emergency or elective surgery. Some plans are voluntary; others reduce or deny reimbursement if the participant does not obtain the second opinion. Plans usually require that second opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

Although managed care plans do help control costs and ensure better-quality care by providing review and oversight of those who deliver healthcare services, the U.S. still spends more per capita on healthcare and lags behind other developed nations in several quality measures. In addition to having a relatively high rate of infant mortality, the U.S. loses 2,500 people to death and spends an additional $19.5 billion per year due to "preventable adverse events" (medical errors) in hospitalized patients. The Agency for Healthcare Research and Quality, a federal agency, says, "…the true number and impact of errors may be higher…" The Institute of Medicine noted that "…many of the errors in health care result from a culture and system that is fragmented, and improving health care needs to be a team sport."

Giving employees more control over their health spending decisions is only one step in controlling healthcare costs. The healthcare financial system still rewards hospitals and physicians for the number of services they provide, regardless of quality or need, often leading to unnecessary and sometimes detrimental treatments. Health plans must find alternative ways to incentivize hospitals and physicians to keep patients well and provide only the care needed.

Greater transparency among healthcare providers will also help—until consumers have transparent, unbiased information on the quality and effectiveness of specific providers and treatments, they cannot make truly informed decisions about their health. Insurers can play a role in enhancing healthcare quality and patient outcomes. Many are developing strategies that emphasize healthcare quality and patient safety by encouraging preventive and wellness treatments, promoting evidence-based care, requiring enhanced reporting and monitoring, and promoting a collaborative approach to care. For more information on managed care and suggestions on controlling your group medical costs, please contact us.

Transit Benefits: Get More Mileage Out of Your Benefit Budget

A properly structured transit benefit program can encourage ride-sharing, help eliminate employee stress due to commuting, and may even encourage better health through walking or biking. Best of all, qualified transit benefits can reduce your payroll tax obligations and give employees another tax-free benefit.

What Are Qualified Transportation Benefits?

Certain transportation benefits qualify for tax-preferred treatment. They include:

- A ride in a commuter highway vehicle between the employee's home and workplace.
- A transit pass.
- Qualified parking.
- Qualified bicycle commuting reimbursement.

Employees can exclude the value of these benefits from their gross income for income tax purposes; the employer can exclude them from employees' wages for payroll tax purposes. For 2014, employees can exclude a maximum of:

- $130 per month for public transit benefits, which includes mass transit and vehicles seating 14 or more passengers operated by a person in the business of transporting persons for pay or hire. (Note: this is a $115 decrease from the 2013 limit due to the sunsetting of a law requiring parity between tax-advantaged benefits for transit and benefits for parking.)
- $250 per month in qualified parking benefits. This includes parking on or near your premises or parking at the location where your employees commute to work using mass transit, commuter highway vehicles, or carpools.
- $20 per month in qualified expenses for bicycle commuting. This can include the purchase, repair, improvements and storage of a bicycle incurred during any month in which the employee regularly uses the bicycle for a substantial portion of travel between his/her residence and place of employment. He/she cannot receive employer-provided transportation in a commuter highway vehicle (such as a vanpool), transit pass or qualified parking benefits during that month.

Administering Commuter Benefits

Employers can structure a commuter benefit program in many ways.

1. Direct benefits - An employer can provide qualified transportation benefits directly to employees, by providing free parking, rides in company-provided van pools or vouchers or passes given directly to employees.
2. Reimbursement plan – Employees can set aside pre-tax dollars to use toward commuting expenses. To receive reimbursement, employees must present documentation of qualified work-related

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commuting expenses. Administering a reimbursement plan might cost an employer $4 to $5 per employee per month; however, the employer pays no FICA on money employees put into the plan.

Employers can usually exclude qualified transportation fringe benefits from an employee's wages even if you provide them in place of pay. However, qualified bicycle commuting reimbursements cannot be excluded if the reimbursements are provided in place of pay. If the value of a benefit for any month is more than its limit, you must include the amount over the limit in the employee's wages, minus any amount the employee paid for the benefit.

Self-employed individuals and 2 percent shareholders of S corporations do not qualify as employees for tax-favored treatment of transportation benefits. Treat these individuals as you would a partner in a partnership for fringe benefit purposes, but do not treat the benefit as a reduction in distributions.

For more information on setting up or administering a commuter benefits program, please contact us.

Affordable Care Act Update

These changes created by the Affordable Care Act become effective January 1.

- **Opening of the Health Insurance Marketplace.** Individuals and small businesses can buy qualified health plans and see what subsidies, if any, they qualify for.
- **Requiring Individual Financial Responsibility.** Most individuals must obtain basic health insurance coverage or pay a fee to offset the costs of caring for uninsured Americans.
- **Expanding Medicaid. In many states,** Americans who earn less than 133 percent of the poverty level (approximately $15,282 for an individual and $31,322 for a family of four in 2013) can enroll in Medicaid. Several states have elected to not expand Medicaid beyond the 100 percent of poverty level.
- **Eliminating Pre-Existing Condition Limitations and Gender-Rating.** Insurance companies cannot refuse to sell coverage or renew policies because of an individual's pre-existing conditions. In the individual and small group markets insurers cannot charge higher rates due to gender or health status.
- **Eliminating Annual Limits.** New plans and existing group plans cannot impose annual dollar limits on coverage of essential health benefits.
- **Protecting Individuals Participating in Clinical Trials.** Insurers cannot drop or limit coverage on an individual who participates in a clinical trial that treats cancer or other life-threatening diseases. Doesn't apply to grandfathered plans.
- **Offering Tax Credits to Lower- and Middle-Class Consumers.** People with income between 100 and 400 percent of the poverty line who are not eligible for other affordable coverage may obtain advanced premium tax credits to offset monthly premium payments.
- **Increasing the Small Business Tax Credit.** For-profit small employers (fewer than 25 full-time equivalent employees with wages averaging less than $50,000 per year) can receive a credit of up to 50 percent of their contribution toward employee health insurance; small non-profits can receive up to a 35 percent credit. In general, employers must pay at least half the cost of single coverage for employees, and they must buy coverage through the Small Business Health Options Program (SHOP) Marketplace to qualify. Required benefits make SHOP plans relatively expensive; your existing plan might cost less. We can help you compare your options.

If you have questions on how the Affordable Care Act affects your organization's benefits, please contact us.