Employee Benefits Report

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Your EEOC Responsibilities as an Employer

Employers have a responsibility to protect the rights of employees suffering from a mental health condition.

Depression, PTSD & Other Mental Health Conditions in the Workplace: Your Legal Rights" is a summary of an individual's rights under the Americans with Disabilities Act of 1990. The document is published by the U.S. Equal Employment Opportunity Commission (EEOC). A copy of the summary can be found at www.eeoc.gov/eeoc/publications/mental_health.cfm.

According to the document's summary, employers are obligated to guarantee an employee's rights to:

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Is Your Company HIPAA Compliant and Non-Discriminatory?

Health Insurance Portability and Accountability Act (HIPAA) regulations became effective in 2003. The law provides guidelines to ensure that group health plans, health providers and insurers protect the privacy of patient's medical records and other health related information. You might think, as an employer, that you're not subject to HIPAA regulations, but you can be in certain situations.

An employer must protect an employee's personal health information if they operate an employee health clinic; provide a self-insured health plan for employees; or act as the intermediary between employees and health care providers.

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Not be Discriminated Against or Harassed

Employers cannot discriminate against employees based on their mental health conditions. An example of discrimination would be to deny an employee a promotion because of a mental health issue. Employers also are required to address an individual's complaints about harassment and to keep it from occurring again.

Request Reasonable Accommodations

An employee may request a reasonable accommodation to do their job any time after they are employed. These accommodations could include requests, such as a different work or break schedule, a quiet space or permission to use electronic devices.

As the employer, you can ask the employee to put the request in writing, including an explanation as to how their condition will affect their work. You also can request a letter from their health care provider.

You're not required to provide burdensome accommodations that are expensive or difficult to arrange. However, you're also not allowed to ask the employee to repay any of the costs of accommodation.

If an accommodation isn't enough for the employee to do their job, they may be entitled to unpaid leave if that will help them to eventually resume their duties. An employee who is unable to perform their duties also can be assigned to a different position.

The EEOC summary also added the word "uncomfortable" when explaining that employers must provide reasonable accommodations if the employee's condition makes certain activities "more difficult, uncomfortable, or time consuming to perform." Many human resource experts are uncertain how to define "uncomfortable," which could be subject to various interpretations.

Privacy

Employees do not have to divulge that they have a mental health condition. At the same time, you are allowed to ask questions about employees' mental health under the following conditions:

- When the employee asks for an accommodation
- After an employee is hired, if all employees are asked the same question
- When you are engaging in affirmative action practices for people with disabilities
- When you have evidence an employee is unable to do their job adequately or is a safety risk to themselves or others

Dismissals

You cannot fire an employee for having a mental health condition. However, you don't have to keep an employee who is unable to do their job because of a medical condition or the side effects of the medicine they're taking. And, you don't have to hire a candidate who can't do the job or who may be a threat.

The important thing is not to rely on stereotypes when making a hiring or firing decision. You must have objective evidence that an employee can't perform the job or could be a threat. Objective evidence is information based on facts that can be proved by analysis, measurement and observation.

If you have questions or concerns about your EEOC responsibilities as an employer, please contact us.

Unfortunately, compliance is not easy to accomplish for some companies. The U.S. Department of Health and Human Resources reported this year that they have received 160,927 complaints about HIPAA violations since 2003.

In addition, in 2014 the Affordable Care Act added nondiscrimination provisions to HIPAA. Although there have been no new nondiscrimination regulations recently, compliance experts recommend employers regularly review their policies for compliance.

To be in compliance, employers who offer health plans must treat individuals within a group similarly. However, they can provide different health benefits for employees in different groups. A checklist for compliance can be found at https://tinyurl.com/y7ghxo3c.

What to Look for Before Signing a Group Health Plan Contract

To get the best benefit plan it's important to know your options

Most contracts for group health plans are standard and non-negotiable. However, a small portion of every contract is open for negotiation. It's important that you understand your options so you and your employees aren't surprised by the kind of benefits they will or won't receive.

In addition, keep in mind that health plans may change from year to year as the federal government implements new rules and regulations.

Medical Benefits

Determine what you and your employees will be required to pay in monthly premiums. If you decide that the premiums are too high, you may be able to make some adjustments to the contract to bring costs down, such as including a clause requiring employees to purchase generic medications.

The deductible is what a plan member will pay before the insurance begins covering costs. According to the Kaiser Family Foundation's annual employer health plan survey this year, deductibles have increased a whopping 255% just in the last decade. While it can be tempting to choose a high deductible plan to keep monthly premiums down, you should make sure the deductible is not so high that employees are discouraged from obtaining the insurance benefits.

The Affordable Care Act does not let you put a monetary limit on qualified benefits, but it does allow you to limit the frequency of benefits. For example, you might limit the number of chiropractor visits an employee can make. These kinds of limitations can help keep your plan's costs down.

Most contracts allow you to choose to be in or out of a network — with the understanding that in-network charges are usually lower, because the carrier has negotiated discounts with the various service providers. If you choose in-network coverage and there is a preferred hospital in your area, make sure it's covered in the plan.

Also, be aware of a new trend regarding networks. Some insurers now offer multiple tiers of preferred providers within a network. A member might pay $20 copay for a provider in Tier 1, but $35 for a provider in Tier 2. Although it's a way to offer more choices, it can be confusing for you and your employees.

Wellness programs are becoming more popular because in many instances they've been effective at lowering or controlling

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health care costs. If you don't offer a wellness program, check to see if your insurance carrier provides one.

Pharmacy Visits

Many contracts bundle in pharmacy contracts, so you don't always have choices here. You will have more leeway if you have a self-funded plan. Here are some options to consider if you can design your own pharmacy contract:

- Require step therapy where less expensive drugs must be tried first
- Remove or re-tier certain drugs that have recently spiked in price
- Re-tier expensive drugs to the higher co-pay or add coinsurance tiers
- Require mandatory generic drug usage when available and consistent with doctor's recommendation
- Provide access to designated pharmacies for certain drugs where deeper discounts are applied
- Require the purchase of maintenance medications through mail order instead of a retail pharmacy.

Administration

Does your plan year start in January or at another time of the year? Remind your employees if their deductibles are tracked against the plan year and reset at the beginning of the plan year — which isn't necessarily the start of the calendar year.

Confused? Don't Panic

It can be difficult guessing what type of coverage your employees want and need and how much these choices will cost you. Fortunately, we can guide you through the process and help you to make the best decisions for you and your employees. We look forward to hearing from you. ■

What Type of Group Health Plan is Right for Your Company?

These days there are a lot of group health plans to choose from. To pick the right one for your employees it's important to know the advantages and disadvantages of each.

Before your annual enrollment period, you must choose a group health plan that will fit your employees' needs and budgets, as well as your own. But what's best? HMO, PPO, POS, HDHP? Wading through this alphabet soup of acronyms can be daunting.

So, let's simplify. There are four basic types of health insurance — Health Maintenance Organizations (HMOs); Preferred Provider Organizations (PPOs); Exclusive Provider Organizations (EPOs); Point-of-Service (POS) plans; and High-Deductible Health Plans (HDHPs).

Think about which one will work best for your situation. Consider the main advantages and disadvantages.

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) is a managed care plan that provides cost savings and structure. Members only choose hospitals and providers in the network and must have a primary care provider who will manage all of their care and provide referrals.

ADVANTAGES: Members build long-term relationships with their physicians. Co-pays and prescription costs are low and there usually is no deductible.

DISADVANTAGES: Members can only see providers in the network and cannot see a specialist without a referral. Also, physicians have quotas, which could shorten the time spent with a patient. This is because they have to see a certain number of patients in a certain period. If the member finds a physician they like, they might have to leave that caregiver if they have a different insurance plan next year.

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) also is a managed care plan. Members choose a doctor, hospital or other health care provider from the PPO network to get a discount, but the network is usually large so members have a lot of choices. Members also

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can see providers who are out of network, but they will pay a higher cost. Some PPOs also have a deductible.

ADVANTAGES: Employees usually get faster treatment than employees with HMOs. PPO members say they like the option to go out of network if necessary, even though they must pay the provider and submit reimbursement paperwork. A plus is that they can see a specialist without having a referral.

DISADVANTAGES: Co-payments are more expensive for a PPO than other types of managed care, and the PPO may require the patient to pay 20 percent or more of all medical fees.

Exclusive Provider Organization (EPO)

An Exclusive Provider Organization (EPO) plan gives members the flexibility of a PPO with the cost-savings of an HMO.

ADVANTAGES: Members don't have to choose a primary care physician, and they don't need a referral to see a specialist.

DISADVANTAGES: Their choices of doctors and hospitals are limited and the plan won't cover care that is provided outside the network — except for emergencies. You must check if physicians and hospitals in the plan are nearby and are the ones your employees use.

Point-of-Service (POS)

A Point of Service plan is an HMO/PPO hybrid. Members have more in-network choices similar to a PPO, and they can see physicians and hospitals out of network if they're willing to pay more. However, they must designate a primary care physician, as with an HMO. That physician will make referrals to network specialists if necessary.

ADVANTAGES: Members have more freedom to choose their health care providers than with an HMO. Also, depending on the type of POS plan, employees might not be subject to a deductible. Like a PPO, members can use providers who are out of network if they're willing to pay some out-of-pocket costs.

DISADVANTAGES: What employees may not like is that they will be responsible for co-payments, coinsurance and an annual deductible. Plus, if they use an out-of-network physician or hospital, they will pay the bill and then submit paperwork to be reimbursed for some of the cost.

High-Deductible Health Plan (HDHP)

A High-Deductible Health Plan (HDHP) is similar to catastrophic coverage. Members pay a low premium. An HDHP is combined with one of the health plans — HMO, PPO, EPO or POS — and the choice of providers is dependent on the plan. Because HDHP members have higher out-of-pocket costs, employees are encouraged to have Health Savings Accounts (HSA) to help pay for care. The maximum contribution to an HSA in 2017 is $3,400 for individuals and $6,750 for families, and for 2018 rises to $3,450 for individuals and $6,900 for families, but the money is not taxed

ADVANTAGES: Monthly premiums are low and this is a good choice for employees who are rarely ill. Preventive care is free even if the member hasn't met the deductible.

DISADVANTAGE: Insurance claims will only be covered after an accumulation of claims have satisfied the high deductibles. ■

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Why You Should Consider Re-Enrolling Your Employees in Their 401(k)

It's important to make sure employees are on the right retirement path for their age.

Once you establish a 401(k) retirement plan for your employees, you might think your work is done. However, despite your retirement plan carrier's best efforts to educate employees on how to make good investment decisions, many employees do not have appropriately diversified portfolios.

One way to improve their retirement plan returns is to move all assets into a Qualified Default Investment Alternative (QDIA) managed by investment professionals. These plans are reviewed annually and rebalanced.

QDIA plans that also feature a Target Date Fund (TDF), which is based on each employee's birth date, have the advantage of ensuring that every employee is on the right investment path for their age. This eliminates the problem of older employees having contribution allocations that are too risky, and younger employees having investments that are too cautious.

To conduct a plan re-enrollment with a default fund, work with your agent and notify plan participants that their existing assets and future contributions will be invested in the plan's QDIA. Employees who are more sophisticated investors and don't wish to participate can choose to make their own investment elections. Once you have conducted a re-enrollment into a QDIA, you will need to distribute annual notices confirming that participants have the right to make their own investment decisions.

Setting up a QDIA also provides benefits to you, as the employer:

- This plan may relieve you from certain fiduciary responsibilities
- QDIAs help reduce the anxiety of employees who are not comfortable making investment decisions
- Your employees will have a more secure retirement future and may be more willing to retire early or on time

There are four types of QDIA you can choose:

- A lifecycle or target date fund
- A professionally managed account
- A balanced fund based on the characteristics of the group instead of each member's profile
- A stable value fund, which is a portfolio of highly rated corporate or government, short-term and intermediate-term bonds which come with principal protection.

To learn more about setting up a QDIA, please contact us. ■

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