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Healthcare Reform

Exchanges: New Grants Are in But Verdict is Out on Establishing State Systems

September, 2012
Life Health Pro

U.S. Health and Human Services (HHS) Secretary Kathleen Sebelius today awarded a new round of Affordable Insurance Exchange Establishment Grants to Arkansas, Colorado, Kentucky, Massachusetts, Minnesota and the District of Columbia amid turbulent times in many states as they set up exchanges.

All but one of these states received Level One Exchange Establishment Grants—one-year grants awarded to states to build exchanges. The District of Columbia received a Level Two Exchange Establishment Grant—a multi-year grant awarded to states further along in building their exchanges.

Under the PPACA, health care exchanges are supposed to begin operating in 2014, with open enrollment beginning a year from Oct. 1, 2012.

However, many states that passed legislation early and are constantly working on the build out, like California—the first to pass legislation and has an exchange board established—still acknowledge exchange-building is a formidable task.

Meanwhile, feuds and confusion in other states, coupled with Republican skepticism over the Obama health act and state insurance regulatory energy to all, collide as governors figure out whether they should wait until after the general elections to roll up their sleeves on the exchange build outs.

For example, in today’s grant-recipient Kentucky, Democratic legislators walked out of a debate last week when fellow committee Republicans tried to declare the governor’s executive order establishing the health care exchange illegal, Kentucky Public Radio (KPR) reported.

The Kentucky GOP legislators said that the state legislature should be the one to have given approval to create the exchange, based on state law.

And in Minnesota, the Democratic insurance regulator there, Commerce Commissioner Mike Rothman, and Gov. Mark Dayton have been setting up an exchange without the legislature passing any exchange statute, ultimately resulting in an agent-commissioner feud that led to an about-switch in authority when Dayton removed the exchange’s work product from Rothman and gave it to another state agency.

Late starts in decisions to go it alone or partner with the federal government in a federally facilitated exchange also mean that much work has yet to be done, with deadlines looming for all.

Agent and industry groups, like the National Association of Health Underwriters (NAHU), join some states in protesting that their work is further hampered by a lack of finalized rules from HHS on so many elements. They say it is unclear how to proceed in the design of products, in organizing workforces and the like.

Earlier this month Wyoming Republican Gov. Matt Mead announced in a press conference that his state would not be notifying HHS by the Nov. 16 exchange blueprint deadline of its plans for establishing an
exchange because it could not decide on its exchange plan—the state lacked crucial information needed make a decision, according to a write-up by McKenna Long & Aldridge LLP and news outlets. Mead spoke about unanswered questions and said that he won’t make any decisions on even how to proceed until after the state legislature adjourns in March, past critical deadlines, a Huffington Post piece reports.

Pennsylvania’s Insurance Commissioner Michael Consedine struck much the same note in his criticism of HHS and its lack of clarity and its unanswered responses to questions during his Congressional testimony Sept. 12.

Pennsylvania still lacks “clear direction and the flexibility promised us has not materialized, something that at this point poses a significant barrier to our ability to make informed decision on issues that could impact the lives of millions of Pennsylvanians,” Consedine testified.

Idaho’s insurance director Bill Deal expressed concern for a federally facilitated exchange barring the department’s future authority to regulate the health care industry in his state but also acknowledged a private-public hybrid version wouldn’t meet muster, either, according to the McKenna summary.

In Nebraska, confusion reigns, as well.

Nebraska Republican Gov. Dave Heineman has expressed doubt that the state would really retain that much control over its own exchange, even if it were state run, reportedly stated at a hearing. “We can’t make one single decision without getting approval from the federal government,” according to McKenna Long’s write-up. However, as it points out, exchange planning continues under the director of insurance with a draft RFP written for the all-important—and expensive—exchange IT system.

The exchanges are to be one-stop marketplaces that will provide access to quality, affordable private health insurance choices similar to those offered to members of Congress.

Consumers in every state will be able to buy insurance from qualified health plans directly through these marketplaces and may be eligible for tax credits to help pay for their health insurance.

“States continue to make progress toward building exchanges that work best for their residents,” Secretary Sebelius said. “The resources announced today will ensure states have the assistance they need to continue moving forward.” These competitive marketplaces promote competition in the insurance marketplace and provide consumers with more insurance choices.

HHS reports that a total of 49 states, the District of Columbia, plus four territories have received grants to begin planning their Exchanges, and 34 states and the District of Columbia have received grants to begin building their exchanges. The latest reports say 13 governors have signaled they would be setting up their own exchanges.

HHS hasn’t delayed any of the implementation deadlines but it has extended the grant timing and given notice that states that begin as a federal exchange or partnership can move to a state-run platform over time.

For a detailed breakdown of exchange grant awards made to states, including summaries of how states plan on using the awards announced today, see HHS’s exchange factsheet.

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Studies predict varying levels of decline in employer-sponsored coverage due to ACA, GAO finds

CCH, Incorporated

Researchers believe that certain provisions of the Patient Protection and Affordable Care Act (ACA) could affect employers’ future willingness to offer coverage, according to a new report from the Government Accountability Office (GAO). The report, Patient Protection and Affordable Care Act: Estimates of the Effect on the Prevalence of Employer-Sponsored Health Coverage (GAO-12-768), noted that some of the ACA provisions that could affect employer-sponsored coverage are: the individual mandate, the establishment of health insurance exchanges, group market reforms, and the “Cadillac” tax, among others.

The GAO was asked to review the research on this topic, and examined five microsimulation model studies (those which estimate the combined effects of multiple ACA provisions, based on multiple data sets and assumptions) and 19 employer surveys, that were published between Jan. 1, 2009, and March 30, 2012. GAO examined (1) estimates of the effect of the ACA on the extent of employer-sponsored coverage; (2) factors that may contribute to the variation in estimates; and (3) how estimates of coverage vary by the types of employers and employees that may be affected, as well as other changes employers may be considering to the health benefits they offer.

Microsimulation models. The GAO found that the microsimulation model studies generally predicted little change in prevalence of employer-sponsored coverage in the near term. The five microsimulation study estimates ranged from a net decrease of 2.5 percent to a net increase of 2.7 percent in the total number of individuals with employer-sponsored coverage within the first two years of implementation of key ACA provisions, affecting up to about 4 million individuals. Two of these studies also indicated that the majority of individuals losing employer-sponsored coverage would transition to other sources of coverage, the GAO noted.

Employer surveys. Among the 19 employer surveys examined, 16 reported estimates of employers dropping coverage for all employee types. Among these 16, 11 indicated that 10 percent or fewer employers were likely to drop coverage in the near term, but estimates ranged from 2 to 20 percent. Most surveys were of employers currently offering coverage and therefore did not also address whether other employers may begin to offer coverage in response to the ACA; however, the three that did found that between 1 percent and 28 percent would begin offering coverage as a result of the ACA.

Some of the 19 employer surveys indicated that the ACA may have a larger effect on small employers and certain populations and may prompt some employers to change benefit designs, according to the GAO. For example, four surveys found that smaller employers were more likely than other employers to stop offering health coverage in response to the ACA, and five found that employers in general were more likely to drop coverage for retirees than for all employees. Nine surveys also indicated that employers are considering key changes to benefit design, some of which may result in greater employee cost for health coverage.

SOURCE: http://www.gao.gov/products/GAO-12-768

HealthcareReformNews HealthInsuranceNews SurveyNews
Outcome-Based Incentives

September, 2012
The Rough Notes Company, Inc.

Wellness programs, in one form or another, have been used by employers for more than a dozen years. These programs promote activities and organizational policies that are designed to support healthful behavior inside and outside the workplace, and to ultimately improve health outcomes. Overall, they have gained significant traction over the last three or four years as employers struggle to find ways to reduce the cost of medical care for their employees. When properly structured, wellness programs, in theory, align economic incentives of both the employer and the employee. Obviously both have a financial stake in encouraging and engaging in more healthful behaviors that should help drive the cost of health care down.

A number of recent studies have demonstrated employers' increasing interest in using wellness programs as an important component to a comprehensive cost containment strategy. This has become even more pronounced over the last year or two. For example, Towers Watson's annual employer survey finds increased usage in workplace wellness programs this year over prior years. Plus, it also notes that even more implementation of these programs is in the works for 2013. A similar study was completed by the Society for Human Resource Management (SHRM), and the results were presented at their 2012 Annual Conference in Atlanta earlier this year. The SHRM study concluded that more employers are offering benefits that encourage employees to improve their health. Over the last five years, SHRM notes, benefits that reward employees for improving their health have jumped significantly.

The SHRM study goes on to point out that employers have quickly recognized that providing employees with the opportunity to improve their health can actually increase morale, confidence and productivity.

SHRM also notes a trend whereby employers have been consciously shifting more of the primary responsibility and control for these types of benefits to employees. For example, the study says that more employers are now offering defined contribution retirement savings plans than defined-benefit pension plans in 2012. Obviously this puts the impetus on employees to better manage their own retirement savings instead of relying on employer-provided pensions. The same kind of shifting of the primary responsibility is occurring in health care as well.

Carrot or stick?

One of the newer approaches to wellness programs has come by way of using outcome-based results. The crux of these workplace wellness programs is either incentives that reward employees who engage in healthful behaviors or alternatively penalize those who don't. While there are many approaches to the "carrot/stick" issue, most of the "carrots" revolve around decreasing some aspects of the employee's health insurance costs. On the other side of the coin, some of the "stick" approaches include setting higher deductibles or premiums for those who don't meet certain body mass indices or do not quit smoking. It would seem that both types of approaches to wellness are gaining traction as they are increasingly being utilized by programs throughout the country.

On the surface, either approach would appear to be appealing to both employer and employee; however, a number of consumer advocates state that some of the "stick" approaches could become a way of
discriminating against a sector of employees who don’t meet a given matrix. In an attempt to head this off, a recent guidance has been published in the *Journal of Occupational and Environmental Medicine*. It is intended to ensure that workplace wellness programs that utilize "stick" incentives are effective and fair to all employees and ultimately improve health results. What's unique about the guidance is that it represents the collaborative thinking of several well-respected organizations with diverse stakeholders. Among the participating organizations are: the Health Enhancement Research Organization, the American College of Occupational and Environmental Medicine, the American Cancer Society, the American Diabetes Association, and the American Heart Association, to name just a few.

It's clear at this point that employers play a significant role in influencing the health behavior of their workforce. What is also clear, is that a healthy workforce can reduce health care cost disability and absenteeism, all while increasing productivity. Obviously this should be a goal that is subscribed to by all employers. But the concern arises as employers seek new ways to engage employees in programs that change health behaviors, thus creating an increased interest in outcome-based results and a concomitant concern by the advocacy group.

It should be noted that the collaborative group is not recommending outcome-based programs but rather stating that, if they are adopted, these guidelines should be used. What they have tried to do is provide the tools and opportunities to improve health and wellness, but they are extremely apprehensive that they could be used in ways that undermine an employee’s ability to obtain adequate and affordable insurance coverage. They are concerned that these unintended consequences be avoided at all costs.

At the end of the day, outcome-based incentives represent a relatively new incentive design where employees receive either direct financial reward for meeting specific outcomes or a reduction in premium, deductibles, or co-pays. Obviously, there is also a penalty that may be imposed for failure to meet these standards. The collaborative notes that, if not implemented carefully, incentives such as these can also operate as penalties imposing financial or other burdens on employees. In the long run, this could be counterproductive. The goal of providing the guidance was to offer employers a framework for helping employees make healthful lifestyle changes, while providing proper protection and accommodation for those with disabilities or other barriers. The organizations also note that to be effective, incentive strategies such as these must be part of a comprehensive workplace health improvement plan.

**Successes**

Many of the wellness programs that are being marketed today are recent entries into this arena. One of the more experienced companies that has been offering wellness training since 2002 is Wellness Coaches USA. Recently, Wellness Coaches provided information on results in its 2011 *Employer Outcome* study. The study details how their employers promote engagement and health risk factor improvement over a three-year period 2009 to 2011. The company indicated in a press release that the results were achieved through implementation of their proprietary process, which incorporates a powerful engagement focus that includes an on-site wellness coaching methodology. This methodology can provide a large-scale improvement in many employee health risk factors. They point out that consistent results can be achieved and outstanding improvements flow from the integration of two critical elements. The first element is that exceptionally high employee engagement levels must be established. The second element is a state-of-the-art, on-site, face-to-face wellness coaching process that has been developed to accommodate logical requirements of on-site delivery.
The study summarizes data that cover approximately 50,000 eligible lives at more than 300 client locations in 30 states. The comparative group of 50,000 are longer-term clients and thus available for comparison over the past three years. Some of the results provided by Wellness Coaches are quite impressive.

One of the most impressive aspects of the program is that they have coached 90-plus% of all eligible employees or in excess of 45,000 employees per year during each of the past three years. In addition they also had 500,000 one-on-one coaching interactions per year during that same three-year period.

The improvements in comparable employee population health risk factors were favorable and are as follows:

- 56,000 health risk factors were improved—this compares to 41,000 in 2009
- 1.2 health risk factors improved for every eligible employee compared to 0.9 in 2009
- 24,000 employees improved their blood pressure compared to 19,000 in 2009
- 16,000 employees lost a combined 173,000 pounds compared to 12,000 employees losing 119,000 pounds in 2009
- 9,200 employees increased their weekly exercise compared to 6,500 in 2009

One can quickly see the dramatic results that Wellness Coaches was able to generate in the three-year period from 2009 to 2011. The company utilizes highly trained, on-site instructors that are focused on engaging their client's employees.

Conclusion

There is little doubt that wellness programs offer employers a significant opportunity for savings when employees are fully engaged in the process. A search of the literature on the subject indicates that wellness programs reduce health care costs, with reductions for larger firms averaging $3.27 for every dollar spent on wellness. In addition, studies have shown that health promotion programs at organizations of all sizes result in overall reductions of about 25%, not only in health care costs but in reducing sick leave and improving workers compensation and disability outcomes as well.

The newer approach to wellness programs, which tie incentives to actual outcomes, still lacks meaningful statistics. However, it does appear that if these programs can be implemented on an equitable basis, providing incentives to those employees who work to improve their health and, thus, reduce the overall cost of health care for the company, they offer new hope for employers.

One would expect to see significant involvement with wellness programs over the next several years. Not only are outcome-based incentives making a big splash in this area, a number of features incorporated within the Patient Protection and Affordable Care Act also deal with wellness. While these do not become mandatory for another year or two, employers will still need to consider them going forward.

While the primary objective of wellness programs obviously is to reduce the overall cost of health coverage, there are significant byproducts from these types of programs. In addition to reducing cost, these programs do improve morale and ultimately increase productivity—all of which are noble goals for any corporate program.

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COBRA Check Up
Gallagher Benefit Services, Inc.

Earlier this year, the IRS released its updated audit guidelines, signaling the potential for an increase in COBRA audits. How would your organization do? See below for a checklist of core compliance areas.

✓ COBRA Manual. Does your organization have a COBRA “manual” or at least written procedures on how to handle COBRA? If not, your organization should take time to establish written procedures. Or, if you’re outsourcing COBRA administration, ask for a copy of your third-party administrator’s current manual.

✓ Form Letters. Does your organization have form letters for COBRA elections, notices of unavailability of coverage, and notices of early termination of COBRA? If not, now is the time to develop form letters. The DOL has model forms available for some requirements such as the COBRA election notice.

✓ Internal Audit Procedures. Does your organization conduct COBRA audits to determine whether all COBRA notices, elections, and administration are being properly handled? If not, it is recommended that your organization develop audit procedures.

✓ Health Plan Documents. Does your Summary Plan Description (“SPD”) properly address COBRA? Do the provisions in your SPD match your COBRA notices, particularly your COBRA General (or Initial) Notice? Take time to ensure that your notices and your SPD (and plan document) language do not conflict. For example, make sure that the contact information for employee required notices is the same in your form notices and your plan documents.

✓ Correct Plans Identified. Is your organization offering COBRA for all the appropriate plans? Employers routinely offer COBRA continuation for medical, dental, and vision plans, but often overlook healthcare flexible spending accounts, health reimbursement arrangements, EAPs, wellness programs, and other programs that qualify as “health plans” under COBRA. Make certain that your organization has identified the correct plans.

✓ Litigation Records. Has your organization retained records from past or pending litigation based upon an alleged failure to properly provide COBRA continuation? Employers should retain such records in case of an audit.

✓ Records Retention. Has your organization properly documented COBRA continuation? IRS auditors will seek the following records: (1) name and address of each beneficiary; (2) dates of qualifying events; (3) copies of the notification letters sent to qualified beneficiaries; (4) proof that notices were sent to qualified beneficiaries informing them that they were eligible to elect coverage, were offered coverage, and that they received their notice of rights under COBRA; (5) type of coverage received under COBRA for each qualified beneficiary; (6) premium payments; (7) copies of letters to the insurance company/plan administrator providing notices of qualifying events; (8) reasons for termination of COBRA coverage properly elected by the qualified beneficiary; and (9) reasons for employment termination. If your organization is not properly documenting the items above, now is the time to revise your processes.
These are just a few key areas. For more information, employers should review the IRS manual, “Audit Techniques and Tax Law to Examine COBRA Cases (Continuation of Employee Health Care Coverage).”

The new audit manual is available at:


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**The Impact and Influence of Tax Incentives on Health and Retirement Benefits**

*September, 2012*

*Employee Benefit Research Institute*

Workers routinely rank their employment-based health coverage as the most important benefit they receive, followed by a retirement plan—but the tax preferences that support them are drawing increased scrutiny.

To examine the implications for private-sector health and retirement benefits, as well the costs and consequences and what the numbers are, the nonprofit, nonpartisan Employee Benefit Research Institute (EBRI) recently held a day-long policy forum in Washington, DC. Titled “‘After’ Math: The Impact and Influence of Incentives on Benefit Policy,” this was EBRI’s 70th biannual forum on benefits issues. It drew about 100 experts, benefits professionals, and policy makers to provide their perspectives and predictions.

As a new EBRI report about the forum notes, the reach and impact of these benefits is immense. Employment-based health benefits are the most common form of health insurance in the United States, covering almost 59 percent of all nonelderly Americans in 2010 and about 69 percent of working adults. Assets in employment-based defined benefit (pension) and defined contribution (401(k)-type) plans account for more than a third of all retirement assets held in the United States, and a significant percentage of assets held today in individual retirement accounts (IRAs) originated as a rollover account from an employer-sponsored program. Workers routinely rank their employment-based health coverage as the most important benefit they receive, followed by a retirement plan.

Since private-sector health benefits alone rank as the largest single “tax expenditure” in the federal budget, various proposals have been made to either reduce or even phase out the cost of that program to the government. Both for employers that sponsor these benefits—and the workers who receive them—the implications are enormous, the EBRI report points out.

“When you look at some of the recent proposals for reform, benefit plan tax incentives are an area of total and complete volatility, and neither employers nor workers can have any certainty of what lies ahead,” said Dallas Salisbury, president and CEO of EBRI.

Among the points made by industry experts and researchers on those topics, and other ways to impact and influence benefit plan outcomes at the policy forum:

Retirement benefits are a tax deferral rather than an exclusion from income—meaning the federal government will eventually recoup the forgone revenue. This distinguishes retirement plan deferrals from other tax exclusions.
A big difference between tax-expenditure estimates and revenue estimates for scoring tax reform is that the latter incorporates taxpayer behavior; whereas tax expenditure estimates do not.

Ten percent or fewer of those ages 55–60 are making withdrawals from their IRA, compared with 80 percent of those 71 and older.

On a historical basis, depending on the period measured, pre-retiree balances in defined contribution retirement plans double about every eight to nine years.

Employer match levels seemed to have a bigger impact on older workers, but automatic enrollment seems much more significant in terms of getting younger employees to participate in retirement plans.

Common challenges for underfunded retirement systems worldwide include the need to increase the state pension age and/or “normal” retirement age for full benefits; to promote higher labor-force participation at older ages; to encourage or require higher levels of private saving; to increase retirement coverage of employees and/or the self-employed; and to reduce savings “leakage” prior to retirement.


The Employee Benefit Research Institute is a private, nonpartisan, nonprofit research institute based in Washington, DC, that focuses on health, savings, retirement, and economic security issues. EBRI does not lobby and does not take policy positions. The work of EBRI is made possible by funding from its members and sponsors, which includes a broad range of public, private, for-profit and nonprofit organizations. For more information go to www.ebri.org or www.asec.org

**Benefit Trends & Surveys**

**Health care costs rose 4 percent for families in 2012: Kaiser/HRET – Survey Results**

*CCH, Incorporated*

In 2012, the average premium for family coverage was $15,745, a 4-percent increase from $15,073 in 2011, according to research from the Kaiser Family Foundation and the Health Research & Educational Trust (HRET). The 2012 Annual Employer Health Benefits Survey found that the average annual premium for single coverage in 2012 was $5,615, up 3 percent from $5,429 in 2011. Kaiser/HRET noted that since 2002, premiums have increased 97 percent, three times as fast as wages (33 percent) and inflation (28 percent).

“In terms of employee insurance costs, this year’s 4-percent increase qualifies as a good year, but it still takes a growing bite out of middle-class workers’ wages, which have been flat or falling in real terms,” said Drew Altman, president and chief executive officer of Kaiser.

Of the average premium, covered workers contributed an average of 18 percent of the premium for single coverage and 28 percent for family coverage. This is the same percentage as Kaiser/HRET found in 2011, and is relatively unchanged over the past decade, the survey noted. Workers in small firms (those with three to 199 workers) contributed a lower average percentage for single coverage compared to workers in
larger firms (16 percent versus 18 percent), but a higher average percentage for family coverage (35 percent versus 25 percent).

In addition to premium costs, most covered workers face additional plan costs when they use health care services. A large share of workers in preferred provider organizations (PPOs; 77 percent) and point-of-service (POS) plans (60 percent) have a general annual deductible for single coverage that must be met before all or most services are reimbursed by the plan. However, only 30 percent of workers in health maintenance organizations (HMOs) have a general annual deductible. The survey found that the average deductible amount for single coverage is $733 for workers in PPOs, $691 for workers in HMOs, $1,014 for workers in POS plans, and $2,086 for workers in high-deductible health plans with a savings account option (CDHPs).

Health reform. According to Kaiser/HRET, 2.9 million young adults were covered by employer plans in 2012 as a result of a provision in the Patient Protection and Affordable Care Act (ACA) that allows young adults up to age 26 without employer coverage of their own to be covered as dependents on their parents’ plan. Of the 2.9 million, 1.1 million have coverage through small firms and 1.8 million have coverage through larger firms. The survey also noted that young adult coverage has increased from 2.3 million in the 2011 survey.

Forty-eight percent of covered workers have coverage through a grandfathered plan, as defined under the ACA, down from 56 percent in 2011, Kaiser/HRET found. Grandfathered plans are exempt from some health reform requirements, including covering preventive benefits with no cost sharing and having an external appeals process. To retain this status, employers must not make significant changes to their plans to reduce benefits or increase employee costs. Of the workers that do not have coverage through a grandfathered plan (thus, those plans are required to comply with all the ACA provisions), 27 percent are in plans that were not in effect when the ACA was enacted. Roughly similar percentages of workers are in plans where the deductibles or copayments (36 percent) or employee premium contributions (34 percent) changed more than was permitted for plans to maintain grandfathered status, the survey noted.

Kaiser/HRET also found the following:

- **Offer rate.** Sixty-one percent of firms offered health benefits to their workers in 2012, similar to the percentage (60 percent) that offered coverage in 2011. Among firms that offer coverage, an average of 77 percent of workers are eligible for the health benefits offered by their employer. Of those eligible, 81 percent take up their employer’s coverage, resulting in 62 percent of workers in offering firms having coverage through their employer, noted Kaiser/HRET. PPOs are the most common plan type, enrolling 56 percent of covered workers. According to the survey, 19 percent of covered workers are enrolled in a CDHP, 16 percent in an HMO, and 9 percent in a POS plan.

- **Prescription drug coverage.** Almost all covered workers (99 percent) have prescription drug coverage, and nearly all face cost-sharing for their prescriptions, the survey found. In 2012, 78 percent of covered workers were in plans with three or more tiers of cost-sharing.

- **Wellness.** Employers continue to offer wellness and other programs as a benefit to their employees, according to Kaiser/HRET. Eighteen percent of employers offering health benefits ask employees to complete a health risk assessment. In addition, the majority of employers offering health benefits offered at least one of the following wellness programs in 2012 (63 percent):
weight loss programs, gym membership discounts or on-site exercise facilities, biometric screening, smoking cessation programs, personal health coaching, classes in nutrition or healthy living, web based resources for healthy living, or a wellness newsletter.

- **Retiree health care.** Twenty-five percent of large firms (those with 200 or more workers) that offered health benefits offer retiree health benefits in 2012, similar to the percentage that did so in 2011.

- **Domestic partner benefits.** In 2012, 31 percent of employers offered health benefits to same-sex domestic partners, up from 21 percent three years earlier. The survey also found that 37 percent of firms offered such benefits to unmarried opposite-sex partners, up from 31 percent in 2009.

The survey contains responses from 2,121 employers with three or more workers.

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**Health Plan Open Season Brings Rising Premiums And More Expensive Dependent Coverage**

*Kaiser Health News*
*By Michelle Andrews*

The fall health insurance open enrollment season is when many people consider changes to their health coverage. This year, premiums will rise, although perhaps not as much as last year, and dependent coverage may be noticeably more expensive than in the past. Comparing plans may be easier, though, thanks to new coverage summaries that group health plans and insurers must provide.

As employees review their plan options and benefit changes for next year, here are a few changes they can expect:

**--Moderate Premium Increases**

Health-care premiums are expected to rise 5.3 percent in 2013, to an average of $11,507 per employee, a slightly smaller increase than this year, according to a survey of mid-size to large companies by benefits consultant Towers Watson. Employees will pay an estimated $2,596 of that total.

Forty-two percent of employers said they planned to increase employees' share of premiums by 1 to 5 percentage points; another 13 percent said they would bump up their employees' share by 5 percentage points or more.

**--Higher Charges To Cover Dependents**

Thanks in part to the 2010 health law's provisions that allow adult children to stay on their parents' plans until they reach age 26, employers are scrutinizing their dependent coverage policies more closely, experts say.

"Companies are not really wanting to be a dependent magnet," says Tracy Watts, a partner at human resources consultant Mercer. "They want to be competitive, but not so generous that everybody comes onto their plan."
Expect to see more dependent-coverage options -- employee plus one child, employee plus two children, and so on -- say experts, priced accordingly.

Over the next three to five years, companies expect to subsidize employee-only coverage at 75 percent and dependent coverage at 69 percent, according to Aon Hewitt’s 2012 employer health care survey.

In 2013, 38 percent of employers said they plan to significantly reduce their subsidization of coverage for dependents and spouses, and 29 percent planned to discourage spouses with coverage available elsewhere from signing on with the employee’s plan through surcharges and other means, Towers Watson found.

--More Consumer-Driven Health Plans

Nearly 60 percent of employers who responded to the Aon Hewitt survey said they offered their employees a consumer-driven health plan last year, referring to health plans that are linked to an account used to pay medical expenses, either a health savings account (HSA) or a health reimbursement arrangement (HRA). These plans often, but not always, have deductibles exceeding $1,000. Consumer-driven health plans are now the second most common type of plan offered by employers, after preferred provider organizations, according to the survey.

--Wellness Programs Get More Muscle

To date, many employers have focused on simply encouraging employees to participate in wellness activities, such as filling out a health risk questionnaire or getting their cholesterol checked. Now, more employers are asking to see results.

"Employers are saying, 'OK, you took the questionnaire and checked your blood pressure; now what do you do about that?' " says Craig Rosenberg, national health care and welfare practice leader at Aon Hewitt.

Employees who keep their weight, blood pressure, blood sugar or cholesterol within recommended ranges or who participate in efforts aimed at meeting those targets may see a payoff in lower premiums, benefits experts say.

"People should look to see what their employers might be offering," says Julie Stone, a senior consultant at Towers Watson. Financial incentives may include employer contributions to a health savings account, for example, or to help cover the cost of a deductible.

--Easy-To-Understand Health Plan Overviews

Under the health care overhaul, employers and insurers now must provide consumers with a document that summarizes in easy-to-understand language a health plan's benefits and coverage details, cost-sharing requirements, and limitations and exceptions to coverage. Health plans must also provide examples of cost and coverage specifics for two real-world scenarios: having a baby and managing Type 2 diabetes.

Finally, the law requires that consumers be given a glossary of health insurance terms such as "deductible" and "coinsurance."
The concept has been popular with consumers. More than 80 percent of respondents on a Kaiser Family Foundation poll last year said they liked the idea. (KHN is an editorially independent program of the foundation.) But insurers and businesses had asked the government to delay the implementation of the forms, saying they were complicated, costly and an administrative burden.

The summaries will not, however, include the policy price, even though consumer advocates had pressed the Obama administration to require that.

Your employer or insurer may provide additional printed information about plan options as well as access to online comparison tools to help you decide which plan best meets your needs, say experts.

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Keep in mind that a few changes required under the Affordable Care Act will take effect next year:

--Flexible Spending Account Limits

Starting Jan. 1, the maximum amount an employee can deposit in 2013 into an FSA to cover medical expenses on a pretax basis will be $2,500. Currently there are no dollar limits, though many employers cap contributions at $5,000.

--Medical Expense Tax Deductions

Also as of January, you no longer will be able to itemize on your federal tax return deductions for unreimbursed medical expenses that exceed 7.5 percent of your adjusted gross income. The new threshold will be 10 percent.

--Coverage Costs To Appear On W-2 Forms

When you get your W-2 form in January, look for a box reporting the total cost of your health insurance coverage, including amounts both you and your employer contribute. The figure is for your information only; you won’t be taxed on it.

Please send comments or ideas for future topics for the Insuring Your Health column to questions@kaiserhealthnews.org.

What's in Store for Consumer-Driven Health Care?
September, 2012
Benefits Pro

As we enter the fourth quarter, it might be helpful to take a look at some of the consumer-driven strategies we’ve considered in the past—as well as some we’ve avoided—and see if they might be a good option for our clients both this coming year and when all hell breaks loose in 2014.
Past

We first dipped our toes into the consumer-driven pool back in the 1970s with flexible spending accounts. While some would argue FSAs aren’t really a consumer-driven approach at all (after all, they do encourage us to go on a spending spree at the end of the year if we over-estimate how much we’re going to spend on medical services), FSAs do make us think about our expected expenses ahead of time, and that’s more than most people normally do.

We kicked it up a notch with health reimbursement arrangements when the government ruled in 2002 that unused funds could roll over to the next year. With this ruling, HRAs accomplished something that FSAs by design could not—they encouraged people to shop around, to be wise consumers, and to save some of their money: “the less someone spends this year, the more they’ll have next year” was the idea. Of course, for the consumer, there’s no real planning with an HRA since the employer—not the employee—funds the account, so we sort of took one step forward and two steps back. Not only was the up-front planning eliminated, the employee wasn’t even contributing her own funds to the account.

With the advent of health savings accounts in 2004, we got the best of both worlds—people could plan ahead and set aside their own money on a tax-free basis to use for qualified medical expenses, but because unused funds roll over from year to year, they weren’t encouraged to act like animals and spend every penny in the account before the end of the year.

This third approach has worked pretty well. HSAs have grown at a steady rate for the past several years, and people are saving more than they’re spending. That’s in a down economy when the United States has a negative savings rate. There are now more than 6.8 million health savings accounts nationwide covering 13.5 million Americans, and HSA assets now total more than $12.4 billion.

Present

Consumer-driven plans took a punch to the gut in 2011 when one of the most popular features—the ability to use tax-free dollars to pay for over-the-counter drugs—died at the hands of the Patient Protection and Affordable Care Act.

While people with all three types of accounts were annoyed by this provision, the rule hurts FSAs the most. That’s because this was sort of the safety net for people with a flexible spending account—if they put too much money into their account, at least they could stock up on Tylenol at the end of the year rather than losing their money. So this rule actually could discourage FSA contributions.

HRAs continue to be a popular plan design for employers, but not so much because of the consumer-driven aspect. Instead, employers are increasing their deductibles and using a Section 105 HRA to “self-insure” the additional risk. These back-end HRAs are more of a funding strategy for the employer than a consumer-driven approach—most employees don’t even reach their deductible, and with this type of plan design the employer usually doesn’t include the rollover feature.

To help clients keep the two strategies separate in their minds, I prefer to use the term medical expense reimbursement plan for back-end HRAs and reserve the term health reimbursement Account for plans that provide employees with some up-front funds to use on qualified expenses and roll over unused amounts to the next year.
For a true consumer-directed approach, HSAs seem to be the way to go—and, continuing with the recent trend, they have grown exponentially in 2012. This is just the opposite of what some people expected. Because President Obama said publicly he thought HSAs only benefited the wealthy, a number of people concluded they’d be eliminated by the health reform legislation, and we did see a temporary leveling in HSA enrollment in 2010. But once brokers and employers realized HSAs are here to stay, adoption of account-based plans actually accelerated.

There are a ton of reasons for an employer to offer a consumer-driven plan as one of their plan options, and the only reason not to do so this year—that they might be eliminated by health reform—isn’t actually true.

Future

In football, a good quarterback throws not where the receiver is when he lets go of the ball but where the receiver is headed, and that’s the same strategy we should take when designing our benefits packages.

So what will the future look like? Looking at some of the decisions the Department of Health and Human Services has made in implementing the legislation we now have a pretty good idea.

Plan design

First, let’s look at plan design. There are four key provisions in the legislation that impact the way plans will look in 2014:

1) **Essential benefits**: The law calls for 10 categories of “essential benefits” that must be covered in all non-grandfathered plans, both inside and outside the exchange, but the government isn’t completely re-designing the plans. Instead, HHS has given states the option of choosing a “benchmark plan” for the next two years.

   The benefits covered by that plan would become the “essential benefits” that all small group and individual plans must cover, but the benchmark plan would have to be beefed up in any area where it’s deficient to include all 10 categories. The easiest way to think of essential benefits is that some new mandates that are being added to our already-existing plans. The essential benefits provision doesn’t address cost sharing on the plans and doesn’t impact consumer-driven plans one way or another.

2) **Deductible limits**: The law states that the maximum deductible in the small group market will be $2,000 for single coverage and $4,000 for family coverage unless there are contributions to an HSA, HRA, or FSA above this amount. I actually think we’ll see this provision delayed or even eliminated, but if I’m wrong it will actually help account-based plans because that’s the only way a group with 2-100 employees could have a higher deductible.

3) **Out-of-pocket limits**: Beginning in 2014, the out of pocket limit on all plans will be tied to the HSA-qualified plan out of pocket limit, which will be about $6,350 for single coverage in 2014. Because HSAs already meet this requirement but some current PPO copay plans have a higher member exposure than that, this provision will create a bigger price separation between HSA plans and traditional PPO plans.
4) **Actuarial value**: Within the exchange, plans will be rated based on the percentage of the cost of the essential benefits the plans pay. For a bronze level plan, for instance, the carrier would pay 60 percent of the cost of covered services for a large population and the members would pay 40 percent. At the silver level, the plan pays 70 percent, at the gold level it pays 80 percent, and platinum plans pay 90 percent. Under the individual mandate, most people will be required to have coverage that at least meets the bronze level requirement in 2014, and employers with more than 50 full-time equivalents will have to offer a plan that meets this standard or face a penalty if their employees purchase a subsidized plan through the exchange.

5) Nothing about the plan design rules indicate that HSAs would go away, and, in fact, there’s reason to believe that the difference in premium between HSA plans and traditional plans will increase, making HSAs even more attractive.

6) **Employer decision**: Of course, employers will need to figure out which plan or plans to offer to their employees, and when making that decision they will need to look at both the penalties in the large group market and the subsidies available through the individual exchange.

In order to avoid a penalty, large employers will want to offer a plan that meets the minimum essential coverage requirements while paying as much of the cost as they can so that employees will not spend more than 9.5 percent of their W-2 income on their portion of the premiums. The way to do this is by offering a bronze level plan as your base plan and then allowing employees to buy up if they would like. Since the bronze level plan is likely to be HSA compatible, this favors HSA growth.

For small employers, there’s no penalty, but they too will want to pay as much of the premium as possible for a qualified plan so that it’s actually a benefit for their employees. Since most employees with group coverage will be ineligible for a subsidized plan, the employer wants to make sure that their employees do better on the group plan than they would if the group plan didn’t exist and they instead qualified for a subsidy.

**Technology**

One final thing to consider when looking ahead to 2014 is how groups and individuals will purchase insurance. While most people without group coverage will likely buy coverage through the Exchange since that’s the only way they can get a premium tax credit, it’s just the opposite on the group side. While it’s true that small employers that qualify for a tax credit are likely to purchase coverage through the SHOP exchange, there will be very little incentive for other employers to participate in a state-based or federally-facilitated exchange."

Instead, there will be a strong outside market, but it will look much different than it does today. That’s because, with the new modified community rating rules and no medical underwriting, it will be much easier for groups of all sizes to purchase coverage online. Web-based offerings, which will be called private exchanges, will continue to evolve and will become the new standard.

Workers will have more choice than ever, which is great from a consumerism standpoint, and online decision-making tools will grow in popularity. Employees will be able to log-in, use interactive technology to select the best medical plan for themselves and their families, and sign up for all of their ancillary benefits at the same time.
Account-based plans will certainly be among the offerings, and because they will cost less than some of the other options and people will be able to learn how they work using the interactive technology, a lot of people will sign up.

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Electronic delivery of employee health plan communications continues to grow, survey finds

CCH, Incorporated

Employers are increasingly using electronic distribution and relying on outside assistance as existing and new federal regulations are requiring stepped up health plan communications, according to the findings of the fourth annual Compliance Communications Survey from HighRoads.

In key findings, interest in—and demand for—electronic distribution is continuing to grow. Currently, 80% of employers report using some form of electronic distribution, with online portals the most popular method. Specifically, with Summary Plan Descriptions (SPDs), 37% plan to shift to predominantly electronic distribution.

A new development this year is the advent of SBCs (Summaries of Benefits and Coverage) under the Affordable Care Act (ACA), which took effect September 23rd. To meet the aggressive timeframe, many employers will use a combined approach of online and hardcopy distribution. 20% will distribute SBCs exclusively online, while 16% will distribute only hardcopy SBCs.

Another critical finding is the increased use of electronic distribution and employees’ growing demand for mobile – and social media – access to their health plan information. More than half of the employers in the HighRoads survey said employees have asked them about receiving benefit information on their mobile devices. About a third of the employers are investigating the possibility of distribution by smartphone.

“Clearly, this is a time when employers are looking at compliance as a critical communications issue and making aggressive moves to embrace online delivery in order to respond to both regulatory requirements and employee needs,” said Kim Buckey, Principal, Communication Compliance Practice, HighRoads. “We are encouraged that the use of portals and mobile applications is increasing as a compliance solution, enabling employers to provide their plan participants with the most accurate and up-to-date plan information, in their preferred device. We expect to see employers explore additional forms of technology to meet changing workforce demands.”

Other key findings include:

- The biggest challenges facing employers in producing SPDs are having sufficient resources — time, staff and budget — and managing the review process.
- Some 87% of employers plan on updating SPDs within the next year, with some 73% now seeing SPDs as both a compliance and communication vehicle. This reflects a 10% increase in those who view SPDs as primarily a compliance vehicle.
• Few employers—only 16%—rely solely on internal resources to update and maintain SPDs. Three out of four employers work jointly with outside resources in the SPD process, while 9% rely completely on their vendors.

“Resource constraints continue to be a major challenge for employers, and 87% plan to update their SPDs over the coming year,” said Buckey. “It’s interesting that even with these challenges, most employers continue to view SPDs as valuable means to enhance employees’ understanding and appreciation of their benefit plans, she noted, observing that “33% of respondents plan to rewrite their SPDs to make them more user-friendly in the coming year.”

Mid- to large-sized employers throughout the United States, representing five million total plan participants, responded to the HighRoads survey. The employers were asked to share how they produce, update and distribute SPDs; their plans for increased use of technology to communicate benefit plan information, and the steps they are taking to meet the new SBC requirement.

SOURCE: www.highroads.com

CommunicationNews HealthInsuranceNews SurveyNews

Human Resources View

Employee Review Near FMLA Leave Time: A Slippery Slope

September, 2012
Thompson Publishing Group

When you must defend your decision to fire an individual based solely on his poor performance, no one likes the idea of having to scale a circumstantial Mount Everest in a court of law. But a cohesive paper trail of evidence is critical when you are asked to establish legal footing and justify your adverse employment action, particularly when the job termination occurs shortly after the employee’s return from federally protected medical leave.

To be clear, the Family and Medical Leave Act does not require an employer to adjust its performance standards for the time an employee is actually on the job. Employers, however, would be wise to adjust their performance standards to avoid penalizing an employee for being absent during FMLA-protected leave.

For example, if you terminate a salesperson for not meeting his sales quota and count the days that he missed for FMLA leave-related treatment in your performance assessment, then your measuring stick — inevitably examined as a genuine issue of material fact in a courtroom — is likely to raise eyebrows about whether you had a legitimate, nondiscriminatory ground for termination.

This brings us to the circumstances behind the firing of a high-paid sales account manager with a company car and a track record of large sales commissions. The timing of a supervisor’s abrupt evaluation and the account manager’s subsequent discharge proved suspicious and incongruous enough for an appellate court to reverse an Illinois district court’s summary judgment in the employer’s favor. The case is Pagel v. TIN Inc., No. 11-2318, 7th Cir. (Aug. 9, 2012).
Jeff Pagel, an account manager whose heart ailment qualified as a serious health condition under FMLA, succeeded in advancing his interference and retaliation claim against TIN Inc., a custom display manufacturer and supplier.

The 7th U.S. Circuit Court of Appeals agreed with Pagel’s primary argument that TIN’s claim of poor performance appeared to serve as “mere pretext” to his termination.

TIN seemed to hurt its defense by basing too much of Pagel’s poor performance on a one-day “sales ride-along,” a standard company practice in which the regional sales manager observes and evaluates the account manager’s performance on scheduled, in-person calls.

The timing of the hastily planned evaluation by the regional sales manager — just one day after Pagel had returned from testing for an irregular lung mass — worked against TIN.

Because the regional manager only provided Pagel one day of notice to set up and prepare the sales calls, the “request for a ride-along, at least at summary judgment, looks suspicious,” the appeals court found. “The record suggests that account managers need time to set up a sales call — perhaps as much as one week ... A reasonable jury could interpret this evidence as [the regional manager] setting up Pagel for failure.”

TIN also claimed that other pertinent grounds existed to find that Pagel’s performance had become unacceptable. For example, TIN contended that Pagel’s sales revenue and volume had declined and he had identified no new target customers, nor had he contacted two prospective customers in his territory.

This independent data alone, TIN argued, should permit Pagel’s firing. However, the accuracy of much of the documented evidence that TIN supplied to the courts remains in dispute. For example, the appeals court opined, if TIN’s claims about the drop-off in sales revenue and volume were true, then Pagel’s annual salary of $180,000 (base pay plus commission) should have declined instead of remaining stable.

**Takeaway Nugget**

Measuring the productivity of employees who take any form of leave in the same manner as those who don’t take leave is a hard practice to defend to a jury. Employers should avoid this problem by enacting a written policy that exempts employees who are on FMLA leave from performance or productivity-based evaluation during the entire period of the leave. This avoids having periods of protected leave play any role in the process.

For additional information about the FMLA and termination, see Thompson’s employment law library, including the *Family and Medical Leave Handbook*. 
Commission busy filing lawsuits against employers as fiscal year nears end; disability bias tops the list

CCH, Incorporated

As it approaches the end of its fiscal year on September 30, the U.S. Equal Employment Opportunity Commission (EEOC) has been busy filing new lawsuits. Among the most recent flurry of suits were the following dozen, more than half of which allege disability discrimination:

Disability bias. On September 26, the EEOC filed seven lawsuits in federal courts in Illinois, Minnesota, New York, Texas, and Wisconsin alleging that employers violated the Americans with Disabilities Act (ADA):

Aurora Health Care. According to the EEOC, Aurora Health Care, a health system operating in eastern Wisconsin and northern Illinois, violated the ADA by rescinding employment offers to two job applicants after it learned they had disabilities (EEOC v Aurora Health Care, Inc, EDWis, No 2:12-cv-00984).

The commission’s lawsuit alleges that Aurora extended job offers to Kelly Beckwith and Charlene Helms, conditioned on completion of a medical examination. Although both Beckwith and Helms were able to perform the essential functions of the jobs they had been offered, both disclosed disabling health conditions during their medical examinations: Beckwith suffers from multiple sclerosis and Helms from carpal tunnel disorder. After the medical examinations, Aurora rescinded its offers to the two, claiming they had failed to disclose their health conditions, the EEOC says.

Aurora contended that Beckwith failed to disclose a medication she was prescribed for MS treatment, but Beckwith had not been having MS symptoms and had not been taking the medication, according to the EEOC’s pre-suit investigation. Aurora purportedly learned about the prescription by accessing Beckwith’s private, patient records. According to the EEOC, Aurora said it had a policy of accessing patient records for job applicants undergoing medical examinations, even though the applicants were not being seen for treatment.

As to Helms, although Aurora contended that she did not disclose that she had surgery for carpal tunnel disorder, the EEOC said documents received during its investigation show disclosure of the condition and clearly reference the surgery.

The commission is seeking injunctive relief barring discrimination and prohibiting Aurora’s practice of reviewing job applicant’s patient medical records. The EEOC is also seeking back pay and compensatory and punitive damages on behalf of Beckwith and Helms.

Luminant Mining. The EEOC filed to two unrelated disability discrimination lawsuits in federal court in Texas on September 26. The first asserted that Luminant Mining violated the ADA by refusing to provide a reasonable accommodation to an employee with a club foot (WDTex, No 1:12-cv-895-LY).

The company required employee James Tarver to work on his feet for hours on hard concrete even though he has a club foot, according to the lawsuit. Tarver and his physician had informed Luminant that standing on hard surfaces for more than an hour at a time caused him severe pain and weakness, the EEOC said. Even though Tarver provided Luminant with medical documentation to support his request for a reasonable accommodation, the company fired him, the EEOC contends.
The EEOC is seeking back and front pay, compensatory and punitive damages, and injunctive relief to ensure no future discrimination.

**REDC Default Solutions, LLC.** According to the EEOC’s suit against REDC Default Solutions, LLC, the company, which provides services for auctions and alternatives to home foreclosures, denied an employee the reasonable accommodation of additional leave time that was required by her disability (NDTex, No 3:12-3885). Terria Wiley went out on medical leave in March 2011 after suffering a stroke. In response to a letter from the company’s HR director, Wiley promptly submitted a note from her treating physician indicating a specific date when she would be able to return to work without restrictions, the EEOC contends. But instead of granting a modest extension of leave as a reasonable accommodation, REDC fired Wiley, the commission asserts.

The commission seeks back pay and front pay, compensatory and punitive damages and injunctive relief to prevent future discrimination.

**Comprehensive Behavioral Health Center.** An East St. Louis, Illinois, nonprofit social service agency violated the ADA by subjecting an employee to disability discrimination and retaliation, according to a lawsuit filed by the EEOC in federal court in Illinois (EEOC v Comprehensive Behavioral Health Ctr of St. Clair County, Inc, SDII, No3:12-cv-01031WDS-CSW). The commission asserts that Comprehensive Behavioral Health Center (CBHC) refused to provide a reasonable accommodation to a disabled employee and then failed to rehire her after she was laid off because of her disability and in retaliation for complaining about the lack of accommodation.

Pamela Perry, a 23-year employee with CBHC, requested permission to wear athletic shoes to work in June 2002 because her disability, multiple sclerosis, caused numbness, pain and tingling in her feet, according to the lawsuit. The employer allowed her to wear athletic shoes until March 2010 when it disciplined her for wearing the shoes in violation of the dress code. Perry then made a written request for reasonable accommodation to help her complete paperwork required by her job; the MS made her hands and arms cramp and it had become increasingly difficult for her to complete paperwork in a timely fashion, the EEOC said. Perry also again requested permission to wear athletic shoes. According to the EEOC, CBHC refused to meet with Perry to discuss possible accommodations and denied her requests.

On August 29, 2010, Perry wrote a letter to CBHC complaining about its refusal to accommodate her. When she was laid off on August 31, 2010, she applied for a vacant position she had previously held for 11 years, the commission alleges. However, the employer instead hired a less qualified applicant, the EEOC contends.

**Silvercrest Center for Nursing and Rehabilitation.** Also facing an EEOC disability discrimination suit is Silvercrest Center for Nursing and Rehabilitation, located in Queens, New York. The commission asserts that the nursing home violated the ADA by firing a nurse’s assistant because she failed to submit a request for medical leave on Silvercrest’s preferred form (EDNY, No DN CV-12-4808).

The EEOC’s lawsuit alleges that in January 2011, Carolyn Belcon wrote a letter requesting leave after reinjuring her back, which she had previously hurt in a car accident. However, Silvercrest did not acknowledge her request, and instead insisted that she fill out the form, the EEOC said. The nursing home then ignored a subsequent request by Belcon to have SEIU-1199, her union, assist when filling out the form. According to the commission, Silvercrest fired Belcon later the same month, at no time acknowledging her requests.
The EEOC seeks a ruling that Silvercrest violated the ADA, plus lost back pay and compensatory and punitive damages.

*Applied Vacuum Technology.* Waconia, Minnesota manufacturer Applied Vacuum Technology violated the ADA when it fired an employee because it regarded him as having a disability, according to a lawsuit filed by the EEOC in federal court in Minnesota (*EEOC v. Applied Vacuum Tech, Inc*, DMinn, No 0:12-cv-02473–SRN-FLN).

The lawsuit asserts that when supervisor Larry Kating returned to work after being hospitalized for a week, Applied Vacuum fired him, although Kating had no work restrictions. Kating had worked as a supervisor in the company’s shipping and receiving department. Applied Vacuum contends that it fired Kating for not calling in every day of his hospitalization, even though it knew that Kating was physically incapable of doing so, according to the EEOC.

The federal agency seeks lost wages, damages for emotional distress, and punitive damages on behalf of Kating, as well as injunctive relief such as training for company managers and employees, and compliance monitoring by the EEOC.

*Bobby E. Wright Comprehensive Behavioral Health Center, Inc.* In still another disability discrimination lawsuit filed in federal court in Illinois, the commission contends that Bobby E. Wright Comprehensive Behavioral Health Center, Inc (BEW Center) violated the ADA by failing to accommodate and then firing an employee with a mental health disability (*EEOC v. Bobby E. Wright Comprehensive Behavioral Health Ctr, Inc*, NDll, No 12-cv-07695). BEW Center, located in Chicago, provides services to persons with mental health, behavioral, emotional, and substance abuse problems.

The EEOC’s suit asserts that BEW Center refused to accommodate the employee, who requested time off to seek treatment from her doctor for her depression and panic attacks. Instead, BEW Center required the employee to be treated by its doctor and then discharged her because of her disability, according to the commission.

**Pregnancy bias.** The federal agency also filed two lawsuits on September 26 that accuse employers of pregnancy discrimination:

*JC Wings Enterprises, LLC.* In a lawsuit filed in federal court in Texas, the commission contents that JC Wings Enterprises, LLC, *dba* as Bayou City Wings, a Baytown-based restaurant chain, violated Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act, when its managers laid off pregnant employees under a discriminatory policy (SDTex, No 4:12-cv-02885).

Maryann Castillo and other female workers were laid off after the third month of their pregnancies under a written policy set out in the company’s employee handbook, according to the EEOC’s lawsuit. Bayou City Wings owns and operates restaurants in Baytown, Houston and surrounding areas. The company’s district manager laid off Castillo pursuant to the policy even though she had provided a doctor’s note indicating she could work up to the 36th week of her pregnancy and that her doctor had not placed any restrictions on her ability to work.

During the EEOC’s investigation of a discrimination charge brought by Castillo, Bayou City Wings named eight female employees who were laid off from work because of their pregnancies. The EEOC said that
according to a Bayou City Wings general store manager, for a manager to keep a pregnant employee at work any longer would “be irresponsible in respect to her child’s safety” and would jeopardize his position with the company “for not following procedures.”

The EEOC is seeking an injunction, back pay with pre-judgment interest, reinstatement or front pay, and compensatory and punitive damages.

Kevin & J Company, Inc and SB & Company TN, Inc. A separate lawsuit filed by the agency in federal court in Tennessee contends that Atlanta, Georgia-based Kevin & J Company, Inc and SB & Company TN, Inc (operating as an integrated enterprise) violated Title VII by discriminating against an employee due to her pregnancy (EDTenn, No 1:12-cv-00321). The company, which sells retail clothing and apparel, terminated Jenny Thosychangh, who worked at its Chattanooga store location, immediately after she advised her store manager that she was pregnant, according to the suit.

The EEOC seeks monetary relief in the form of back pay, compensatory and punitive damages, reinstatement and an injunction against future discrimination, among other items.

Race bias. The EEOC has filed two lawsuits alleging race discrimination against employers: ’

Schindler Elevator Corporation. In a lawsuit filed in federal court in North Carolina on September 27, the federal agency asserts that Schindler Elevator Corporation, one of the leading global manufacturers, installers, and servicers of elevators, escalators and moving walkways, violated Title VII when it fired a black elevator mechanic because of his race (WDNC, No 3:12 CV 00639).

The suit asserts that Schindler discriminated against Ronnie White, who is African-American, when it selected him for layoff from a larger group of employees working at a company facility located in Charlotte. The company selected White for termination for purportedly having weaker technical and customer service skills than his Caucasian coworkers. However, the EEOC contends that Schindler did not have a formal layoff procedure in place, and instead allowed the process to be determined solely by a field superintendent. The field superintendent selected White for termination from a group of three employees in spite of the fact that White had higher scores in all of the considered categories than one of the white employees who was retained, and higher scores in all categories except one than the other Caucasian who was retained, according to the EEOC.

The commission is seeking back pay for White as well as compensatory and punitive damages, and injunctive relief.

Sandia Drilling Company, Ltd, LLP and Sandia Drilling of Texas, LLC. Two oil drilling companies violated Title VII when their supervisors and other employees subjected two African-American and a Hispanic worker to a racially hostile work environment and then fired one of them in retaliation for complaining, according to a lawsuit filed by the EEOC in federal district court in Texas on September 26 (EDTex, No 2-12-cv-00615).

The EEOC contends that Joe Johnson and Leon Alburty, two white supervisors on an oil rig in northeast Texas where employees slept and worked, addressed two black workers as “n----rs,” “black asses,” and other racially offensive slurs. Moreover, the supervisors segregated the men’s sleeping quarters and one even tried to place a black worker’s hand on the supervisor’s private parts, saying “grab this, boy,” the
EEOC alleges. One day, the two black workers found hangmen’s nooses on their trucks, and despite reporting the incident to the supervisors, the company did nothing to investigate the matter, according to the EEOC. One of the men resigned after one of the supervisors told him to carry out an unreasonably dangerous assignment or go home, the commission said. The other worker felt compelled to quit after a supervisor allegedly stated during an employee meeting that “n----rs can pick more cotton than whites.”

The lawsuit also contends that on another oil rig in northeast Texas, a supervisor/driller, Justin Smith, offensively taunted a Hispanic subordinate on almost a daily basis for dating a black woman by calling him a “n-----r” and a “n-----r lover,” degraded him by yelling out that he worked “like a wetback,” and often threatened to “whip [his] ass with a 24 [-inch pipe wrench].” The subordinate was terminated soon after reporting the harassment to a company superintendent, the EEOC says.

The EEOC seeks back pay and compensatory and punitive damages for the victims as well as injunctive relief intended to prevent further discrimination at the companies.

**Sexual harassment.** In the last suit discussed here, the federal agency accuses Dollar General Store of Bull Shoals, Arkansas, of subjecting female employees to sexual harassment by a male manager. (WDArk, No 3:12-cv-03128-PKH).

The suit, which was filed on September 26, asserts that Dollar General failed to take action to stop the sexual harassment by a store manager against women after complaints were made about his behavior. Two female workers were being sexually harassed in the form of improper comments and requests for sexual favors, according to the EEOC’s investigation.

The suit seeks monetary relief in the form of compensatory and punitive damages and an injunction against future discrimination.

### State Law Review

**New York State’s New Wage Deduction Bill**

*Gallagher Benefit Services, Inc.*

On September 7, 2012, Governor Andrew Cuomo signed a bill into law that amended New York State Labor Law Section 193 to: (1) establish additional categories of permissible wage deductions that may be taken by employers with the consent of employees; (2) provide for use of wage deductions to recapture overpayments of wages due to clerical or mathematical errors; (3) provide for use of wage deductions for repayment of advances on wages paid to employees; and, (4) enact and clarify other provisions with regard to wage deductions.

Please note that the New York State Labor Law defines an "employer" as any person employing an employee “whether the owner, proprietor, agent, superintendent, foreman or other subordinate”, including "any person, corporation, limited liability company, or association employing any individual in any occupation, industry, trade, business or service."

The law as it was previously written limited allowable payroll deductions to pension or health and welfare benefits, contributions to charitable organizations, the purchase of U.S. Bonds, or union dues and similar
payments for the benefit of the employee. The amendments to the law expand the list of permissible wage deductions, with employee consent, to now include:

- Costs associated with discounted mass transit tickets, passes, or user cards;
- Fitness, health club, or gym membership dues;
- Cafeteria, vending machine, and pharmacy purchases made at the employer’s place of business, and gift shops run by employers where the employer is a hospital, college or university;
- Tuition, room, board and fees for nursery, primary, secondary and post-secondary education costs; and,
- Daycare, before-and after-school care expenses;
- Purchases made at charitable events;
- Prepaid legal plans;

Payments for housing provided at no more than market rates by non-profit hospitals or affiliates

Employers are required to give employees access to their detailed current account information at no charge and must keep each employee’s deduction authorization for six years after the date that the employment relationship is terminated. An employee’s consent can be revoked in writing at any time. Upon receipt of an employee’s revocation, the employer must cease the wage deduction as soon as practicable and, in no event, more than four pay periods or eight weeks after the consent has been withdrawn, whichever is sooner.

With regard to the use of wage deductions for the purpose of recovering overpayments or for repayment of advances of wages, the amendments require that employers comply with the regulations promulgated by the Commissioner of Labor for this purpose. Those regulations include provisions governing: the types of payments that will be covered; the timing, frequency, duration and method of recovery or repayment; limitations on the periodic amount of such recovery or repayment; and, notice to employees before commencing the recovery or repayment, including notice of procedures for disputing any overpayments or delaying the start of recovery or repayment.

The new law will take effect on November 6, 2012; however, at the present it has sunset provisions and will expire after three years unless extended by future legislation.

Vermont Prescription Drug Changes
Gallagher Benefit Services, Inc.

Effective for plans issued, offered or renewed after October 1, 2012, a health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall not include an annual dollar limit on prescription drug benefits. Moreover, plans provided by issuers or pharmacy benefits managers must limit a beneficiary’s out-of-pocket expenditures for prescription drugs, including specialty drugs, to dollar amounts that are indexed to the minimum annual deductibles for self-only and family coverage under high-deductible health plans (HDHP) set by the IRS. For prescription drug benefits offered in conjunction with a HDHP, the plan may not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles for self-only and family coverage set by the IRS. Once the minimum deductible has been met under the
HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be applied as specified above.

Plans that provide coverage for chemotherapy must also provide coverage for orally administered anticancer medications that are used to kill or slow the growth of cancerous cells. The coverage offered with respect to the orally administered anticancer medication must be offered at no less favorable basis than the chemotherapy treatment. Furthermore, plans that provide for coverage for prescription drugs must also provide coverage for off-label drugs used to treat cancer. Plans cannot exclude coverage for a drug merely because it is not approved by the Food and Drug Administration, as long as that drug is medically accepted for treating cancer.

Since this is an insurance law ERISA preemption should be available to self-funded group health plans. Fully insured plans and non-ERISA plans will need to make appropriate changes.

What’s New in State Law Summaries

_CCH, Incorporated_

For busy Human Resources professionals who want ready access to what is new and what has recently changed in State laws, here is a brief update.

**Arizona Employment Verification/Immigration** In a decision on September 5, 2012, U.S. District Court Judge Susan Bolton refused to halt Arizona’s “show me your papers” policy, which allows police to check the immigration status of anyone they suspect to be in the country illegally. In the split ruling, however, Bolton blocked the law’s provision that would criminalize knowingly transporting or harboring undocumented immigrants.

**Arkansas Unemployment Insurance** For 2013, contribution rates in Arkansas will continue to range from 1.2% to 7.1%. These rates include the 0.8% stabilization tax, the 0.1% extended benefits tax, and the 0.2% advance interest tax. New employers pay a total rate of 4.0%, including the extra taxes noted above. Employers assigned the highest rate (6.0% in the basic rate table) may be required to pay an additional 2.0% or 4.0%, depending on circumstances. The taxable wage base remains at $12,000 for 2013.

**California Background Checks** The state has amended its Penal Code to clarify that certain provisions refer to state summary criminal history information that is initially furnished to authorized agencies, organizations, or individuals, for certain purposes. Additionally, when state or federal summary criminal history information is furnished pursuant to those provisions, the authorized agency or individual shall expeditiously furnish a copy of the information to the person to whom the information relates if the information is a basis for an adverse employment decision (A. 2343, L. 2012).

**California Child Labor** California’s child labor law requires the written consent of the Labor Commissioner before a minor under the age of 16 can be employed in certain types of work in the entertainment industry. A program under the law enables a minor's parent or guardian, if certain conditions are met, to obtain a temporary work permit prior to the first employment of a minor performer. California’s child labor law also prohibits the employment of an infant under the age of one month on a motion picture set.
or location unless a prescribed certification is made by a physician and surgeon who is board certified in pediatrics. This law is amended to provide that medical certification of the infant must be met before a temporary permit for the employment of the infant may be issued (Ch. 260 (A. 2396), L. 2012, enacted September 7, 2012, and effective January 1, 2013).

**California Fair Employment Practices** The state has enacted a law clarifying that the practice of wearing religious clothing or a religious hairstyle as a belief or observance is covered by protections under the Fair Employment and Housing Act (Ch. 287 (A. 1964), L. 2012).

**California Health Insurance Benefit Coverage** On January 1, 2013, employers in San Francisco with 100 or more employees will be required to spend $2.33 per hour per covered employee on health care, up from $2.20 in 2012. In July 2006, San Francisco enacted a plan for universal health care coverage of city residents, known as both the Health Care Security Ordinance (HCSO) and Healthy San Francisco.

In 2013, employers with 20 to 99 employees will have to spend at least $1.55 per hour, up from $1.46. If employers already provide the mandated level of coverage or higher, they have no obligations under the HCSO. If employers provide a lower level of coverage than what is mandated, they can either: (a) increase the amount of coverage they provide; (b) allow the employee to be reimbursed, up to the difference, for out-of-pocket health care expenses; or (c) pay Healthy San Francisco the difference for a medical reimbursement account for the covered employee (http://sfgsa.org).

**California Minimum Wage** Living wage rates for the following local jurisdictions have been updated: Pasadena, Petaluma, Santa Barbara, Santa Monica, Sonoma, and West Hollywood.

**California Posters** The Spanish version of the Santa Barbara living wage poster has been added, and the Ventura County living wage poster has been updated.

**California Prevailing Wages** California law requires that workers employed on public works projects be paid not less than the prevailing wage rate. A new provision is added to require the Director of Industrial Relations to post a list of every California code section and the language of those sections that relate to the prevailing wage rate requirements for workers employed on a public work project on the Internet website of the Department of Industrial Relations (DIR) on or before June 1, 2013, and update that list each February 1 thereafter (S. 1370, L. 2012, enacted September 7, 2012, and effective January 1, 2013).

**Colorado Employee Misclassification** Misclassification of employees as independent contractors is prohibited in Colorado and in violation of the “Colorado Employment Security Act.” This law is amended to revise definitions to clarify “Director” is the director of the division of employment and training in the department of labor and employment. House Bill 1120 revises the state unemployment insurance law generally to create the division of unemployment insurance in the department of labor and employment to administer the unemployment insurance program (Ch. 27 (H. 1120), L. 2012, effective June 1, 2012 (Effective date changed from August 8, 2012, to June 1, 2012, by H. 1002, Special Session)).

**Connecticut Minimum Wage** The current living wage rate for the City of Hartford is $13.30 per hour with comprehensive family health insurance and $20.69 per hour without such insurance.

**Delaware Health Insurance Benefit Coverage** Group insurers will be required to provide coverage for the diagnosis and treatment of autism spectrum disorders (S. 22, L. 2012, enacted August 13, 2012, effective 120 days after enactment).
**Illinois AIDS Testing** The AIDS Confidentiality Act has been amended with respect to disclosure of the identity of persons tested and test results (S. 3673, L. 2012).

**Illinois Background Checks** The Health Care Worker Background Check Act and the Secure Residential Youth Care Facility Licensing Act have been amended (P.A. 1109 (H. 3366), L. 2012).

**Illinois Child Support** The Income Withholding for Support Act is amended to provide that an income withholding notice must state a payor’s duties and possible penalties in bold face type. Employers who knowingly fail to withhold the amount designated in the income withholding notice or to pay an amount withheld to the State Disbursement Unit within seven business days after the date the amount would have been paid or credited to the obligor are subject to a penalty of $100 per day. The total penalty for failure, on one occasion, to withhold or pay to the State Disbursement Unit an amount designated in the income withholding notice may not exceed $10,000. A civil action to collect the penalty may not be brought more than one year after the date of the alleged failure to withhold or pay income.

Also, if an obligee who is receiving income withholding payments does not receive a payment required under the income withholding notice, the obligee must give written notice of the non-receipt to the payor. After receiving a written notice of non-receipt of payment, a payor must, within 14 days, either (i) notify the obligee of the reason for the non-receipt of payment or (ii) make the required payment, together with interest at the rate of 9% calculated from the date on which the payment of income should have been made. A payor who fails to comply with this provision is subject to the $100 per day (Public Act 97-994 (H. 5221, L. 2012).

**Illinois Disability Law** The Guide Dog Access Act has been retitled “The Service Animal Access Act.” “Service animal” is now defined as a dog or a miniature horse trained or being trained as a hearing animal, a guide animal, an assistance animal, a seizure alert animal, a mobility animal, a psychiatric service animal, an autism service animal, are specific provisions relating to the accommodation of miniature horse service animals in public places (P.A. 97-956 (H. 3826), L. 2012, effective August 14, 2012).

**Illinois Equal Pay** The Equal Pay Act of 2003 has been amended to clarify the circumstances under which corporate officers and agents will be deemed to be employers (P.A. 903 (S. 2847), L. 2012).


**Illinois Prevailing Wages** The Department of Labor revises the prevailing rate of hourly wages to be paid by the public body or entity, applicable to public works contracts, and the public body is responsible for notifying contractors and subcontractors of the revised rate. Effective January 1, 2013, a public body or other entity on a public works project will be considered to have met this duty to give notice if a written stipulation is inserted in all contracts or other written instruments that states the wage rates are revised by the Department of Labor and are available on the Department’s official website (Public Act 97-964 (H. 5212), L. 2012, enacted August 15, 2012).

**Illinois Whistleblower Protection** The Illinois False Claims Act relates to liability for false claims against the state for money or property and also protects employees from discharge, discipline or discrimination in employment when filing a proceeding or with regards to testimony involving this Act.
This Act is amended to provide that certain false claim actions must, unless opposed by the state, be dismissed by the court if substantially the same allegations or transactions as alleged in the action were publicly disclosed. The Act is also amended to provide that a civil action for relief from retaliatory actions may not be brought more than three years after the date when the retaliation occurred (Public Act 97-978 (H. 4190), L. 2012, amended effective August 17, 2012).

**Indiana Background Checks** The state has enacted a law restricting the criminal history information that is reported in background checks. If a job applicant’s records are restricted or sealed by court order, the person may legally state that on an application for employment or any other document that the person has not been arrested for or convicted of the felony or misdemeanor recorded in the restricted records. Employers are prohibited from asking an employee, contract employee, or applicant whether the person’s criminal records have been sealed or restricted. An employer who violates this subsection commits a Class B infraction (Public Law 69 (H. 1033), L. 2012).

**Kansas Background Checks** The state has enacted a law changing language in its statutes as follows: references to “mentally retarded” have been changed to “people with intellectual disability” (S. 397, L. 2012).

**Maine Employee Misclassification** Effective December 31, 2012, employee misclassification is prohibited as an unlawful employment practice under Title 26, Labor and Industry, of the Maine Revised Statutes. An employer that intentionally or knowingly misclassifies an employee as an independent contractor commits a civil violation for which a fine of not less than $2,000 and not more than $10,000 per violation may be adjudged. A determination of misclassification of a worker as an independent contractor may also result in the assessment of penalties under the state’s unemployment compensation or workers compensation laws (Ch. 643 (H. 960; L.D. 1314), L. 2012, effective December 31, 2012).

**Maine Minimum Wage** A resort did not violate minimum wage requirements when it paid its wait staff a portion of the “service charge” it added to the bills of banquet customers and treated that portion as a “tip” that satisfied the state minimum wage law, ruled the Maine Supreme Court (Hayden-Tidd v The Cliff House & Motels, Inc, September 11, 2012, Saufley, L). The employee asserted that the wage laws required the employer to treat its entire banquet service charge as a “tip” to be paid to the banquet servers for purposes of the tip credit statute. Here, the Maine high court agreed with the lower court that the employer’s compensation arrangement with its servers did not violate the tip credit statute.

**Massachusetts Health Insurance Benefit Coverage** Effective January 1, 2013, group insurers will be required to cover the treatment of cleft palate and cleft lip in children under the age of 18 (Ch. 234 (H. 3928), L. 2012).

**Massachusetts Wage Payment Correction:** H. 4304, “An Act Establishing a Temporary Workers Right to Know,” enacted August 6, takes effect January 31, 2013, not November 5, 2012, as previously reported. The legislation requires that staffing agencies provide employees with notice and basic information about a new job before being sent out by the agency (Ch. 225 (H. 4304), L. 2012).

**Massachusetts Labor Relations** The Massachusetts public employee labor relations law is amended to provide that if the Commonwealth has agreed to exercise statutory rights regarding the removal of employees in a certain manner with respect to the members of the employee organization, then the Commonwealth is to exercise such rights of removal in accordance with the terms of the collective bargaining agreement (Ch. 236 (H. 1402), L. 2012, enacted August 6, 2012).
**Michigan Posters** Living wage posters for the following local jurisdictions have been updated: Ann Arbor, Eastpointe, and Washtenaw County.

**Nevada Unemployment Insurance** For 2013, the taxable wage base in Nevada will be $26,900, an increase of $500 from the 2012 taxable wage base amount of $26,400.

**New Hampshire Employee Misclassification** The New Hampshire Workers’ Compensation Law clarifies the definition of “employee” for coverage purposes and provides exceptions, including criteria that must be met for determination of a worker as an “independent contractor”. This provision is amended to revise such criteria as follows: (a) the person possesses or has applied for a federal employer identification number or social security number, or in the alternative, has agreed in writing to carry out the responsibilities imposed on employers under this chapter; (b) the person has control and discretion over the means and manner of performance of the work, in that the result of the work, rather than the means or manner by which the work is performed, is the primary element bargained for by the employer; (c) the person has control over the time when the work is performed, and the time of performance is not dictated by the employer. However, this shall not prohibit the employer from reaching an agreement with the person as to completion schedule, range of work hours, and maximum number of work hours to be provided by the person, and in the case of entertainment, the time such entertainment is to be presented; (d) the person hires and pays the person’s assistants, if any, and to the extent such assistants are employees, supervises the details of the assistants’ work; (e) the person holds himself or herself out to be in business for himself or herself or is registered with the state as a business and the person has continuing or recurring business liabilities or obligations; (f) the person is responsible for satisfactory completion of work and may be held contractually responsible for failure to complete the work; (g) the person is not required to work exclusively for the employer. Under the law, if the labor commissioner finds that an employer has misrepresented the relationship between the employer and the person providing services, the commissioner may assess a civil penalty of up to $2,500; in addition, such employer may be assessed a civil penalty of $100 per employee for each day of noncompliance (Ch. 139 (H. 420), L. 2012).

**New Hampshire Posters** Revisions to the mandatory “New Hampshire Criteria to Establish an Employee or Independent Contractor Poster” were made effective August 6, 2012, to update criteria for determination of a person as an independent contractor under the state's workers compensation law, which prohibits misclassification of employees.

**New Mexico Unemployment Insurance** The maximum weekly benefit amount in New Mexico is $397 and the minimum weekly benefit amount is $74, both effective July 1, 2012. Also, for 2013, the taxable wage base in New Mexico will be $22,900, an increase of $500 from the 2012 taxable wage base amount of $22,400.

**New York Minimum Wage** As of August 1, 2012, the Nassau County living wage is $14.91 an hour, or $13.11 an hour with health benefits. This rate will stay in effect until August 1, 2013.

**New York Posters** The English and Spanish versions of the Nassau County living wage posters have been updated.

**New York Prevailing Wages** Provisions of the New York Labor Law relating to payment of prevailing wages on public work and building service work, previously amended by Ch. 678, L. 2007, and scheduled
to expire in 2012, are amended to make such changes permanent and to remove the expiration date (Ch. 389 (A. 9832), L. 2012).

**New York Recordkeeping Requirements** Effective November 6, 2012, employee authorizations for voluntary payroll deductions must be kept on file on the employer’s premises for the period during which the employee is employed by the employer and for six years after such employment ends (Ch. 451 (A. 10785), L. 2012).

**New York Smoking in the Workplace** New York’s public health law prohibits smoking in certain public and indoor areas, including places of employment. This law is amended to also prohibit smoking within 100 feet of the entrances, exits and outdoor areas of public and private elementary and secondary schools. This restriction does not apply to smoking in a residence or to the real property boundary lines of such residential property (A. 10141, L. 2012, effective September 5, 2012).

**North Carolina Employee Misclassification** North Carolina Governor Beverly Perdue issued Executive Order No. 125 on August 22, 2012, to establish the governor’s task force on employee misclassification. The task force is intended to protect workers, eliminate competitive advantages by those who violate the law, and to educate employers and employees regarding applicable legal requirements relating to the practice of employee misclassification. The task force will be charged with identifying business sectors where employee misclassification occurs most frequently and focusing on efforts to eradicate such unlawful conduct within those industries.

The task force will also be responsible for working with employers and community groups to reduce the prevalence of employee misclassification by providing educational materials explaining the distinction between employees and independent contractors and raising public awareness of the problems of employee misclassification. In addition to these and other duties, the task force will also determine regulatory and other state law changes likely to enhance efforts to enforce laws prohibiting employee misclassification.

**Ohio Minimum Wage** The current living wage rates for Lakewood are $13.27 per hour with health benefits, or $14.70 per hour without health benefits.

**Oklahoma Employee Misclassification** Effective November 1, 2012, the misclassification of employees as independent contractors is prohibited in Oklahoma. This law requires that contractors bidding on public construction projects provide proof of documentation required to be in their possession upon request. Contractors that intentionally misclassify individuals as independent contractors instead of employees will be fined by the Oklahoma Tax Commission an amount up to ten percent of the contractor’s total bid, in addition to any other penalties allowed by law. If such misclassification is made to affect procedures and payments relating to withholding and social security, unemployment tax or workers’ compensation premiums, the Tax Commission will fine the contractor an amount of up to ten percent of the contractor’s total bid, in addition to any other penalties allowed by law.

The Oklahoma Tax Commission, Oklahoma Workers' Compensation Court, Department of Labor, CompSource Oklahoma and Oklahoma Employment Security Commission are to share information and coordinate investigative and enforcement efforts for the purpose of detecting those contractors who intentionally misclassify individuals as independent contractors rather than employees for the purpose of affecting procedures and payments relating to withholding and social security, unemployment tax or workers’ compensation premiums (Ch. 351 (H. 2258), L. 2012).
South Carolina Garnishment The interest of an individual under a retirement plan is exempt from attachment, levy and sale to the same extent permitted under federal bankruptcy law Section 522(d) (11 U.S.C. 522(d)). This exemption is available whether the individual has an interest in the retirement plan as a participant, beneficiary, contingent annuitant, alternate payee or otherwise (Act 153 (S. 271), L. 2012).

Tennessee Unemployment Insurance Effective July 1, 2012, through December 31, 2012, Premium Rate Table 3 is in effect. Employer rates range from 0.40% to 3.3% for positive-balance employers and from 5.0% to 10.0% for negative-balance employers. An additional 0.6% premium applies to all experienced-based employers and new employers whose rates are based on industry-wide reserve ratios.

Texas Fair Employment Practices In a question of first impression, the Texas Supreme Court, in a 7-2 decision, ruled that the federal Lilly Ledbetter Fair Pay Act (Ledbetter Act) did not apply to a claim brought under the Texas Commission on Human Rights Act (TCHRA), so that the 180-day limitations period did not begin anew each time an employee received a paycheck containing a discriminatory amount (Prairie View A&M University v Chatha, August 31, 2012, Guzman, E). Title VII and the TCHRA are no longer analogous where discriminatory pay claims are concerned, and the legislature, not the court, is the proper governmental branch to amend the TCHRA. Thus, the court concluded that a pay discrimination claim must generally be brought within 180 days of the date the claimant is informed of the compensation decision.

Washington Garnishment A writ for continuing lien on employee earnings may be issued to require the employee’s employer to pay the creditor directly out of an employee debtor’s paycheck. This law relating to garnishment proceedings is amended to increase the wage exemption for writs for continuing liens on earnings to 35 times the federal minimum hourly wage (previously 25 percent) or 75 percent of the employee’s disposable earnings, whichever is greater. In addition, where a default judgment is entered against the employer and the employer makes a motion to have this default judgment reduced, the employer must pay the accruing interest, costs, and attorneys’ fees for any garnishment on the judgment against the employer. Further, a continuing lien on earnings has priority over any prior wage assignment, except an assignment for child support (Ch. 159 (H. 1552), L. 2012).

Wisconsin Minimum Wage For 2013, the living wage rate for Dane County will be $11.09 per hour. Effective January 2013, the living wage rate for Madison will be $12.19 per hour.

Wisconsin Posters The 2013 Dane County Living Wage Poster and the Madison Living Wage Poster have been added.

The intent of this Newsletter is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plan sponsors should seek proper legal advice for application of these rules to their plans. © 2012 Gallagher Benefit Services