Government Affairs Update – February 2013

SHRM Conference call:

Discussion topics:

1. Election results
2. Fiscal Cliff
3. Immigration reform
4. Regulatory/Legal Update
5. Workplace flexibility
6. SHRM's goal

Election results – historic election from the view point of diversity – more woman in the House and Senate.

Fiscal Cliff – attachment – What has transpired and what is about to

- Permanently extends employer-provided education assistance (Section 127 of the Internal Revenue Code), which allows an employee to exclude from income up to $5,250 per year in education assistance at the undergraduate and graduate level regardless of whether the education is job related.
- Permanently extends the increase in the monthly exclusion for employer-provided transit and vanpool benefits.
- Extends federal emergency unemployment benefits for one year.
- Reinstates and extends the Work Opportunity Tax Credit through 2013
- DID NOT include an extension of the 2 percent payroll tax cut of FICA

Immigration reform –

- Gang of 8's Principles for reform
    - Create a tough but fair path to citizenship for unauthorized immigrants currently living in the US – that is contingent upon securing our borders and tracking whether legal immigrants have left the country when required
    - Reform our legal immigration system to better recognize the importance of characteristics that will help build the American economy and strengthen American families
    - Create an effective employment verification system that will prevent identity theft and end the hiring of future unauthorized workers.
    - Establish an improved process for admitting future workers to serve our nation's workforce needs, while simultaneously protecting all workers

Regulatory/Legal Update

- Supreme Court upheld the constitutionality of the PPACA
- Next step for employers
    - Employer reporting on Tax year 2012 w-2 forms

- Health FSA changes - $2500 cap
- Employer notifications
- Shared Responsibility – Employer Mandate
- Shared Responsibility – Individual Mandate
- State health insurance exchanges must be operational
- Implementation issues

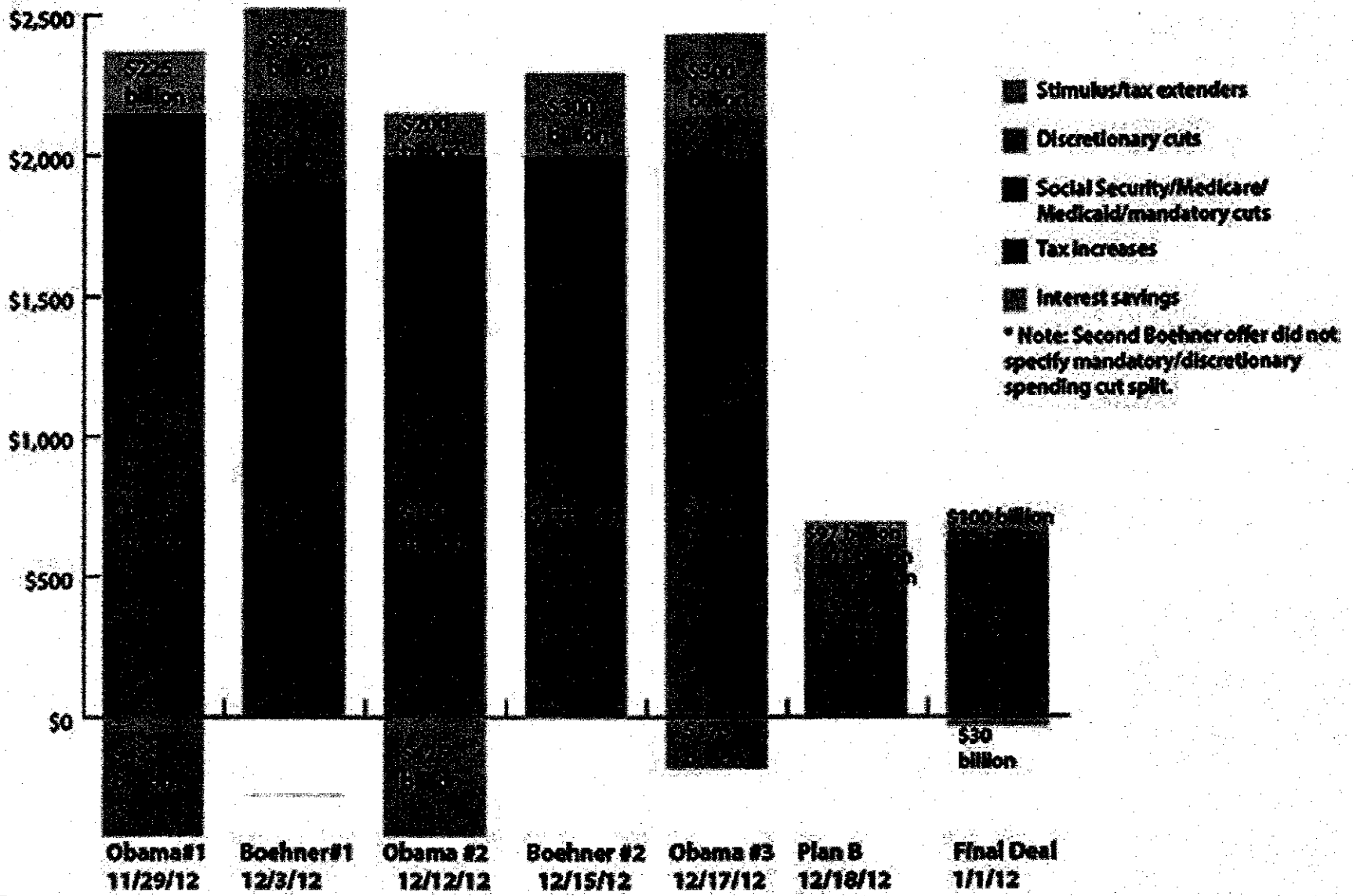
- U.S. Department of Labor
  - DOL proposed rule to expand military family leave under FMLA – final rule was released 2/5/2013
  - DOL "persuader" proposed rule – final rule may be promulgated in 2013
  - Right to Know – survey
- OFCCP
  - Affirmative Action program requirements for covered veterans
  - Compensation data collection tool.
  - Affirmative Action program for individuals with disabilities under Section 503 of the Rehabilitation Act of 1973
- NLRB
  - NLRB rule requiring employers to post 11x17 notices in the workplace
  - NLRB rule altering Representation Elections Procedures (Quick election rule" or "Ambush election rule")
  - NLRB Specialty Healthcare decision
  - NLRB Banner Health Decision

- EEOC
  - EEOC approved enforcement guidance related to consideration of arrest and conviction records in employment decisions
  - Potential 2013 guidance
    - Employer use of consumer reports and credit information
    - Leave as a reasonable accommodation under the ADA

SHRM Initiative

1. Workplace flexibility
   a. Expanded FMLA coverage
   b. Mandatory paid sick leave (S. 984, Healthy Families Act)
   c. Mandatory "right to request" workplace flexibility (S. 2142, Working Families Flexibility Act)

# Fiscal cliff offers

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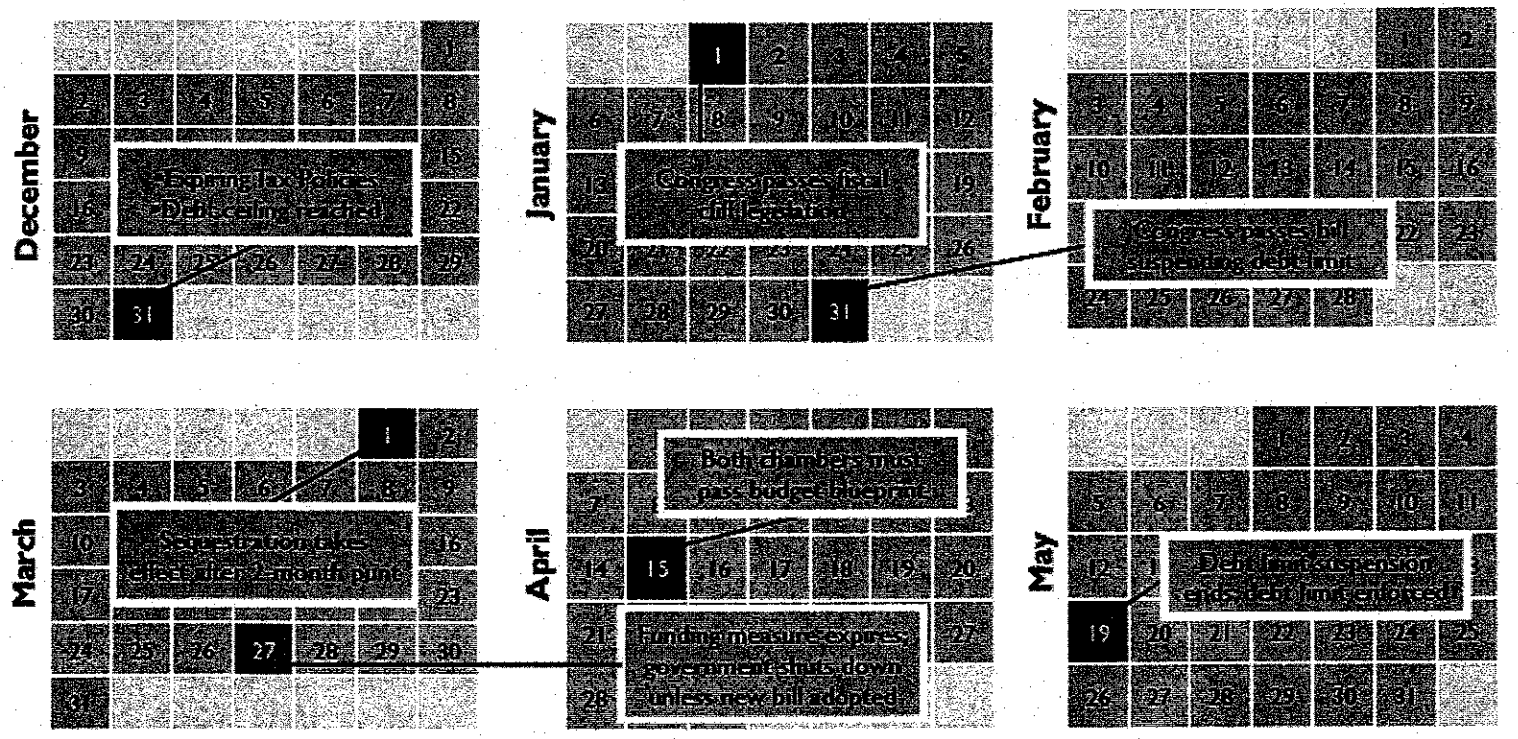
# *Here's a Snapshot of What's Transpired and is About To*

**NationalJournalMembership**

## Debt and Spending: Key Dates

Updated Feb. 1, 2013

■ Key date in the past ■ Key date in the future




*Source: "After the 'Fiscal Cliff': When Are the Next Battles in Congress?" Rosalind S. Helderman, The Washington Post, Jan. 2, 2013; "Here's What's in the Fiscal Cliff Deal," Catherine Hollander, National Journal, Jan. 2, 2013; Senate Dems Pass Bill to Suspend Debt Limit While House Republicans Push for Budget Plan," Billy House, National Journal, Jan. 31, 2013.*

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# ACA mental-health plan's growing pains

By: Kathryn Smith
February 20, 2013 04:42 AM EST

The Newtown, Conn., killings brought plenty of calls from policymakers to beef up public mental health programs. The Affordable Care Act is trying to do just that — so far, with modest success.

Aided by the health care law, some states have already put in place a model that creates a dramatically different way of caring for Medicaid mental health patients. But if the slow state uptake of the program is any indication, the patterns of spotty care for most low-income people with big mental health problems won't change quickly.

The idea is a "health home" for the mentally ill, a way of integrating behavioral health and primary care. Health homes aren't actual physical places. They're care systems that provide an individual with a chronic condition — such as a mental illness — with a team of caregivers who can coordinate and communicate. Funded by the health law, the goal is to provide comprehensive treatment, known as "whole person" care.

These patients need this kind of integrated care because people with behavioral health conditions frequently have other chronic, costly, but preventable — or at least manageable — health problems. A 2006 **study** from the National Association of State Mental Health Program Directors finds that individuals with severe mental illness die an average of 25 years earlier than those in the general population. Those with mental illnesses were much more likely to die from conditions like heart disease, diabetes or respiratory ailments.

Plenty of states have shown interest in adapting the medical home for mental illness. But while funding through the health law has been available for about two years, just **10 states** have health home initiatives approved by the Centers for Medicare & Medicaid Services, according to CMS spokesman Alper Ozinal.

And just six — Missouri, Rhode Island, New York, Oregon, Ohio and Idaho — target those with serious and persistent mental illnesses or substance abuse disorders, Ozinal said.

Getting the health homes up and running is a complicated, labor-intensive process, mental health advocates say. It requires knitting together a fabric of local health care stakeholders, gaining their trust and pushing them to communicate and share health data.

Chuck Ingoglia, vice president of public policy for the National Council for Community Behavioral Healthcare, said few states have enrolled so far because they're struggling with smaller budgets and inundated with other big Affordable Care Act tasks, like Medicaid expansion and streamlined enrollment.

"To be honest, I think part of it is just state bandwidth," Ingoglia said. "And part of it is, how many changes can we undertake simultaneously?"

In Missouri, Joe Parks, director of the Missouri Institute of Mental Health, said his state's

mental health homes — which treat 18,000 Medicaid patients with mental health needs — are led by nurse care managers who try to identify gaps in care and get them filled.

They also have a data-sharing system so that the care team members in the health home all know about a patient's health needs and provide "lifestyle coaching" to promote healthy behaviors.

The biggest challenge for Missouri, he said, is encouraging different parts of the health home to get used to actually using the new channels of communication, especially when it comes to sharing data.

"The IT is a challenge because of trust issues between the people involved," Parks said. "Technical stuff is easy if the human beings involved can get their relationships straight."

Parks said Missouri was able to put the health home program in action relatively quickly because it had already embarked on initiatives to improve the health of individuals with serious mental illness. That meant it had more of an infrastructure in place than other states.

In Ohio, chief of the Office of Health Integration Angie Bergefurd said it took a year and a half of intense preparation to launch the mental health home program in five counties last October. It currently serves 14,000 people.

"We spent at least a good 18 months being able to work through program design, logistical types of issues, state plan development, as well as administrative Ohio code rules. It was a significant amount of time — and we did it very quickly," Bergefurd said.

She agreed with Parks that data sharing poses a big challenge — as well as educating other hospital systems and primary care providers and specialists in Ohio communities about the purpose and role of the health homes.

Even though it's not easy, mental health advocates say health homes represent a decisive shift in thinking about mental health care. And that means they've come a long way already.

"This really is quite a dramatic change from, say, even three years ago. Certainly 10 years ago, when patients with severe mental illness got spotty care," Benjamin Druss of the Rollins School of Public Health at Emory University said. "There's a real frame shift and a lot of interest at the state level."

**Warn Act Developments**

On Thursday, Feb. 14, the U.S. house Subcommittee on Workforce Protections held a hearing to discuss employers' WARN Act responsibilities if sequestration occurs on March 1, 2013.

Sequestration refers to the automatic spending cuts for federal program slated to occur March 1 as a mandated by the January. 2 congressional budget deal to avert the fiscal cliff. Unless Congress agrees to sufficient federal spending reductions, funding totaling approximately $85 billion annually for selected federal programs (equally divided between defense and nondefense programs) will be reduced from the budget beginning March 1.

As a result, thousands of federal contract employees may be laid off in the event sequestration occurs. For months, there have been questions whether employers must issue Worker Adjustment and Retraining Notification (WARN) Act notices to employees for sequestration-related layoffs. Then confusion was perpetuated by a July 30, 2102, Department of labor guidance memo that argued federal contractors are not required to provide WARN Act notices to individual employed under government contracts funded from accounts that may be sequestered. Thursday's hearing only raided more questions.

At the hearing, Employment and Training Administration Assistant Secretary Jane Oates explained the DOL Guidance memo by saying, "Any potential plant closing or layoffs that might come about through sequestration-related contract terminations or cutbacks were speculative and unforeseeable, WARN Act notices…. were not required 60 days in advance of January 2, 2013 (the original effective date for sequestration)."

But Subcommittee Chairman Tim Walberg (R-M) questioned the department's guidance memo, noting that DOL has no enforcement authority for WARN.

"The guidance creates the impression that employers who follow the administration's opinion will be immune from future litigation," Walberg said. "Nothing could be further from the truth. If a worker fees they've been denied proper notice, they have every right to take their employer to court."

HR professional know that the WARN Act requires private employers with 100 or more employees to provide notice 60 days in advance of plant closings and mass layoffs.

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On Jan. 31, 2013, the Obama administration unveiled a **proposed rule** spelling out how birth control expenses will be covered for employees of religious-affiliated groups opposed to providing contraception to employees.

Officials announced in 2012 that under the preventive care provisions of the federal Patient Protection and Affordable Care Act, contraception should be provided without charge to women, although it exempted houses of worship, like churches. But the guarantee of coverage applied to such religious-affiliated organizations as hospitals and colleges. The policy sparked fierce opposition from leaders of Catholic and other religious groups, and it has led to more than 40 court challenges by other religious-affiliated groups and private employers opposed to providing contraception.

**Contraception Coverage**

The new regulations call for insurers who sell the coverage to pick up the cost of the contraceptives. For the first time, it also lays out a plan for religious institutions that self-insure. In those organizations, the administrator of the plan would need to find an insurer to provide a separate policy for women in that workplace and the insurer would be compensated with a reduction in the fees it pays to the state-based exchanges being established to provide coverage to individuals and small businesses.

The new rule also guarantees that religious employers are not disqualified from the exemptions even if their work extends "beyond the inculcation of religious values" or if they hire workers of different faiths.

Here are some common questions and answers from Kaiser Health News that help explain the administration's contraceptive policy and the opposition.

**Q. What does the new regulation require?**

A. Under the rule, women employed by nonprofit religious organizations opposed to contraceptives, such as Catholic hospitals or colleges and student health plans, are entitled to get contraceptive services and products without a co-payment. But the organization is not required to bear the cost of the service.

In those workplaces, the employer must tell its insurer that it will not cover the costs, and the insurer automatically would notify workers that it will provide the coverage without cost sharing or other charges through separate individual health insurance policies, according to a **fact sheet** released by the U.S. Department of Health and Human Services (HHS).

In the rule, the administration said this procedure "would alleviate the need for the eligible organization to contract, arrange, pay, or refer for contraceptive coverage while providing contraceptive coverage to plan participants and beneficiaries at no additional cost." It also said this should not increase costs for the insurer and may save money by eliminating some pregnancies.

The procedures will be a bit different for religious-affiliated workplaces that self-insure, which means the employer assumes the risk of the insurance but generally hires a private firm—often an insurer—to handle the administration of the coverage. In these plans, the administrator would "work with an insurer to arrange no-cost contraceptive coverage through separate individual health insurance policies," the fact sheet says. The insurer could offset the costs of those policies through an "adjustment" in the fees that will be charged to insurers participating in the health exchanges.

**Q: What led to this proposal?**

A: In 2012, the administration announced that all insurance plans would be required to cover contraception as part of the list of free preventive services mandated by the 2010 federal health law. That regulation exempted houses of worship, like churches, from the requirement to provide contraceptive services at no cost to employees, but religious-affiliated institutions, such as universities and hospitals, would have to provide coverage for contraception.

Some religious groups, including the United States Conference of Catholic Bishops, objected on the basis that it violated their religious freedom. The resulting furor quickly engulfed the White House and even some Democrats and Catholic groups that had supported the health law, such as the Catholic Health Association, turned against the policy.

In February 2012, President Barack Obama said the administration would revise the policy to make sure that the religious-affiliated groups did not have to pay for the coverage. But while announcing a compromise, he also insisted that women working at those groups should have access to contraceptives without charge.

**Q. How does the new federal rule and religious exemption compare with contraceptive coverage laws currently on the books in states?**

"substantial burden" on a person's "exercise of religion" unless it can prove that doing so is "the least restrictive means of furthering [a] compelling governmental interest."

The administration contends that the mandate is only an indirect burden on religious employers. Courts around the country are taking up the cases and results have been mixed. Some scholars believe the issue could land eventually at the U.S. Supreme Court.

The proposed rule does not provide the nonreligious businesses who are suing the same ability to avoid providing contraceptive coverage that is afforded religious-affiliated groups.

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