Employee Benefits & Workers' Comp News

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Marijuana and Workers' Compensation

Many states have loosened their laws on marijuana use. What does this mean for your workers' compensation safety program?

Twenty-three states and the District of Columbia now allow the medical use of marijuana. Colorado and Washington have also legalized its recreational use and possession; Oregon and Alaska will do so in 2015. Will this send employers' zero-tolerance policies up in smoke? Jeff Burgess, Program Coordinator, Technical Assistance for Employers in Oregon's Bureau of Labor and Industries, says in a recent report, "The answer is no." State laws "generally provide immunity from state and local criminal prosecution under certain circumstances. They do not provide employment protection, however."

Generally, employers can prohibit on-duty employees from using marijuana medicinally. Refusing to hire or otherwise discriminating against those who use medical marijuana on their own time remains a gray area in most states. However, Connecticut and Arizona have passed laws specifically protecting medical marijuana users from employment discrimination.

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This Just In

Stricter rules for reporting serious workplace injuries go into effect on January 1, 2015. OSHA final rules require all employers under its jurisdiction to report serious workplace incidents. The new rule applies even to employers who are exempt from routinely keeping OSHA records due to company size or industry.

Employers have eight hours after finding out about it to report any fatality that occurs within 30 days of a work-related incident. They have 24 hours after learning of it to report any in-patient hospitalization, amputation or eye loss that occurs within 24 hours of a work-related incident.

Employers reporting a fatality, in-patient hospitalization, amputation or loss of an eye to OSHA: must include the following information:

- **Establishment name**
- **Location of the work-related incident**

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Should Your Safety Program Include Drug Testing?

In some states, workers' compensation insurers will discount an employer's premiums if it institutes a drug-free workplace policy and program. There's good reason for that. Studies show that when compared with non-abusers, substance-abusing employees are more likely to:

- change jobs frequently
- be late to or absent from work
- be less productive than other employees
- be involved in a workplace accident
- file a workers' compensation claim.

Research also indicates that between 10 and 20 percent of the nation's workers who die on the job test positive for alcohol or other drugs.

Employers can test for drugs at different points in the employment process — during the application process, during employment at random or regular intervals, or after an accident. It can be done for some or all workers — for example, for safety-sensitive positions only, or for all workers. Because drug testing costs money, you may choose not to use this method for assessment. However, many workers' compensation experts recommend testing all employees after an accident or near-miss to rule out the use of drugs.

If you decide to implement a drug-testing program, remember that laws designed to protect workers' civil rights could affect your workplace drug policies. These laws include the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990. These statutes limit how far an employer can go in investigating and disciplining employee drug use.

Federal law still classifies marijuana as a Schedule I illegal drug. In an informal opinion, the Equal Employment Opportunity Commission said "…the ADA does not protect individuals who are currently engaging in the illegal use of drugs…" However, the EEOC considers past drug addiction a protected disability, so employers should avoid questions about past addiction to illegal drugs or participation in a rehabilitation program.

Many states and U.S. territories have their own laws and regulations dictating when and how workplace drug testing should be carried out. Some also require state and local contractors to develop drug-free workplace policies similar to those under the federal Drug-Free Workplace Act. No one set of rules and regulations applies throughout the country. Some states, such as Louisiana, allow drug testing in virtually every type of business and in both the public and private sectors. Others, such as Maine, restrict who can be tested, how they can be tested, and what kinds of rehabilitation and disciplinary options can result from a positive test.

Employers can take several simple steps to avoid legal problems with their drug testing policy:

- Consult an employment lawyer whenever you introduce a new drug-free workplace policy or change an existing policy.
- Make sure your drug-free workplace policy clearly stipulates penalties for violations. If your policy includes drug testing, spell out exactly who will be tested, when they will be tested, and what will happen to employees who test positive.
- Make sure every employee receives and signs a written copy of your drug-free workplace policy. Verbal agreements and unsigned agreements have little legal standing.
- Make sure that you, and all your supervisors, receive proper training in how to detect and respond to workplace drug and alcohol abuse.
- Maintain detailed and objective records documenting the performance problems of all your employees. Such records often provide a basis for referring workers to employee assistance programs.

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- **Time of the work-related incident**
- **Type of reportable event (i.e., fatality, inpatient hospitalization, amputation or loss of an eye)**
- **Number of employees who suffered the event**
- **Names of the employees who suffered the event**
- **Contact person and his or her phone number**
- **Brief description of the work-related incident**

For more information on complying with your OSHA reporting requirements, please contact us.

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- Never take disciplinary action against a worker or accuse a worker of a policy violation simply because that employee is acting impaired. Instead, try to clarify the reasons for the employee's impairment. If drug testing is a part of your workplace policy, obtain a positive test result before taking any action.
- Never accuse or confront an employee in front of coworkers. Instead, try to stage all discussions someplace private, with another manager present to serve as a witness.
- Never single out an individual employee or particular group of employees for special treatment — whether it is rehabilitation or punishment. Inconsistencies in policy enforcement may lead to discrimination charges.
- Try to get to know your employees as much as possible. This may help you more quickly identify workers who are in trouble or developing substance abuse problems.
- Most important, try to involve workers at all levels of your organization in developing and implementing your drug-free workplace policy. This will reduce misunderstandings about the reasons for a drug-free workplace program and help ensure that policies and procedures are fair to everyone.

The U.S. Department of Labor's (DOL) Working Partners for an Alcohol and Drug-Free Workplace Web site provides employers with free resources and tools to help establish and maintain drug-free workplace policies. And we recommend having a local employment attorney review your policy before implementation. For more suggestions on improving workplace safety, please contact us. ■

Return of the Association Health Plan?

The Affordable Care Act did away with association health plans. Or did it?

Some small employers have relied on association health plans (AHPs) to buy employee health insurance, rather than buying a small group plan. That's because it usually costs less for large organizations to provide health insurance than for small ones. This happens for several reasons:

- Workers in small firms, on average, have lower wages than workers in large firms. As a result, small-firm employees are less able to afford comprehensive health insurance, and less of a tax incentive exists for providing health insurance through their employer.
- Small firms pay more for a given benefit package than do larger firms because of higher administrative expenses per enrollee and less purchasing power.
- Small firms generally purchase insurance that is subject to state benefit mandates and other regulations, which tend to increase average premiums. Firms that self-insure—mostly large firms—are exempted from those state insurance rules by the Employee Retirement Income Security Act (ERISA). This means they do not have to provide certain benefits that states require plans sold within their borders to provide.

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The Affordable Care Act and AHPs

The Patient Protection and Affordable Care Act (ACA) requires plans sold through an association to individuals and small employers to meet the same rating and benefit requirements that other individual and small group plans must meet. This includes the requirement that health plans cover certain "essential health benefits." This makes AHPs less competitive than some had been in the past. However, the ACA created a loophole for an "ERISA bona fide group or association of employers," which allows these groups to be treated as a single large-group health plan. This exempts a "bona fide group"" from meeting the ACA's small-group health plan requirements.

Business Insurance recently reported on a study of association health plans by the Robert Wood Johnson Foundation. Researchers found that some states (particularly Oregon), are turning a blind eye on the requirement that AHPs be bona fide associations. "State regulators [in Oregon] indicated that the authority to determine whether or not health coverage through an association qualified for ERISA large-group coverage rests with the U.S. Department of Labor [instead of with the state regulators]." To meet the requirement, "Most insurers have simply asked the association to produce a legal opinion that it meets the criteria for 'ERISA bona fide' status, allowing the insurer to provide a single large-group health plan."

Legitimate association plans can help smaller businesses get quality coverage. If you are approached by someone offering an association plan for small businesses, you will want to ensure it is a bona fide association. Otherwise, you might not be complying with the requirements of the ACA. In addition, your plan will have appropriate state oversight. Past abuses by so-called ERISA plans have left some businesses without the coverage they paid for. State regulation of insurance helps consumers, by licensing and overseeing insurers and agents and by giving consumers somewhere to turn in cases of disputes with their insurer.

We provide small businesses with health plans and other benefits through quality insurers. For more information on your health plan options, please contact us.

How the Affordable Care Act Affects Dental Plans

Although dental plans are "excepted health plans" exempt from Affordable Care Act (ACA) reforms, two provisions in the ACA could affect dental plans.

Coordinating dental coverage with the Affordable Care Act's requirements poses some challenges for plan designers and sponsors.

Essential Health Benefits: The ACA requires all health plans sold on the individual and small group markets, both inside and outside of the Health Insurance Marketplace, to cover "essential health benefits." This package of ten items and services must include pediatric oral care, or dental care for children. This means medical plans for small groups and individuals must include benefits for oral health risk assessments and screen-

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ings and treatment for dental cavities (caries) with no cost-sharing.

But wait…although the exchanges must offer pediatric dental coverage, not all medical plans sold on the exchanges offer this coverage. The exchanges must offer standalone dental plans. It's up to the individual consumers to buy this coverage if they need it.

The situation differs for small group plans sold off the exchanges. They must offer pediatric dental benefits, unless the insurer is "reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan…"

Annual Dollar Limits: A typical standalone group dental plan might limit a plan member's annual benefits to somewhere between $1,500 and $2,000 per year. The ACA changes that for individual and small group plans. Because pediatric dental benefits are considered one of the essential minimum benefits, a plan must cover them with no annual limits. This could increase the cost of covering children significantly.

Deductibles: If a medical plan includes dental benefits, how will the deductible apply? If your employees have coverage through a high-deductible health plan and the same deductible applies to dental benefits, high out-of-pocket costs could prevent many employees from using their dental benefits.

Medical Loss Ratios: The ACA's medical loss ratio provision, or MLR, generally requires insurance companies to spend at least 80 percent of the money they take in on premiums on healthcare and quality improvement activities instead of administrative, overhead and marketing costs. If an insurer's spending doesn't meet this ratio, it must make premium rebates to policyholders. Also known as the 80/20 rule, the MLR provision ensures consumers get good value for their premiums.

The medical loss ratio requirement does not apply to standalone dental plans. However, some states (including California) have considered legislation that would require MLR standards to apply to dental plans offered on their health insurance exchanges. This could pose problems because dental plans often have lower loss ratios than medical plans. This happens because dental plans have the same sorts of administrative expenses (enrollment costs, marketing costs and claims-handling costs) as medical plans, but dental services typically cost less than medical services.

Considerations for Employers

Because the ACA spells out what type of preventive benefits a plan must cover, pediatric dental benefits under an exchange or small group plan might be more expensive than coverage under a standalone plan. Although it's too early to tell exactly what effect the ACA will have on dental benefits, many fewer people have enrolled in dental coverage through the exchanges than expected.

The National Association of Dental Plans (NADP) estimates the cost of covering a child under a small group dental plan at about $21 per child per month without orthodontia benefits. Adding orthodontia benefits at 50 percent coinsurance (the insured pays half and the insurer pays half of covered charges) would increase plan costs by about $2.80 per month per child.

While the Affordable Care Act still has bugs to be worked out, it has made some difference in the availability of dental coverage. Many studies have shown the link between having dental insurance and obtaining regular dental care. To ensure your employees' health and well-being, we offer a variety of dental plan designs to meet your needs and budget. Please contact us to learn more.

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The Importance of Dental Insurance

More than one-third of adults surveyed for the Surgeon General's study on oral health (2000) had not visited a dentist in the past 12 months. Laurence R. Weissbrot, FSA, MAAA, director of actuarial and underwriting at Northeast Delta Dental in Concord, N.H., says that "75 percent or more of the people who have dental coverage see their dentists on a regular basis. Fewer than 50 percent of people without dental coverage do so."

Unfortunately, oral health conditions can progress rapidly without treatment. Most adults show signs of periodontal or gingival (gum) diseases, with about 14 percent of those aged 45 to 54 having "severe" periodontal disease.

The Surgeon General's report points out that oral health is integral to general health. "You cannot be healthy without oral health…. Oral diseases are progressive and cumulative and become more complex over time. They can affect our ability to eat, the foods we choose, how we look, and the way we communicate. These diseases can affect economic productivity and compromise our ability to work at home, at school, or on the job."

Employees who drop their employer-based coverage will be able to buy standalone dental insurance on an individual basis on the Health Insurance Exchanges. However, Weissbrot points out that individuals buying coverage on the insurance exchanges will lack the double tax advantages employer-provided benefits enjoy: employers can deduct premiums as a business expense, and employees do not have to report their value as income.

Many employers, even some smaller employers, self-insure dental benefits. Even when they add the cost of using a third-party administrator to manage their plans, some employers may save money on dental benefits this way. Although standalone health reimbursement arrangements (HRAs) will not meet the ACA's "no annual limit" requirement, a dental HRA might fall under the "excepted health plan" exemption from ACA requirements.

Please contact us to discuss ways your organization can provide valuable dental benefits to your employees at reasonable cost. ■

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