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CALIFORNIA ENACTS PAID SICK LEAVE LAW

On September 10, 2014, California Governor Edmund G. Brown, Jr. signed into law the Healthy Families Act of 2014 ("California paid sick leave act"). The law is effective January 1, 2015 and applies to any employer with at least one employee who works more than 30 days in a year in the State of California.

Covered Employees

This legislation applies to all employees who work more than 30 days in a year in California and includes part-time and temporary employees. Employees who are not entitled to the mandatory paid sick leave include:

- Employees covered under a valid Collective Bargaining Agreement (CBA) that already provides for paid sick days or leave (including other required provisions)
- Employees in the construction industry covered under a valid CBA, so long as the CBA was entered into before January 1, 2015 or the CBA waives the sick leave requirement
- Providers of in-home care services; and
- Individuals employed by air carriers as either flight deck or cabin crew members (provided that they receive compensated time off)

Accrual and Maximum Amount of Sick Leave

- Beginning July 1, 2015, employees may accrue one hour of sick time for every 30 hours worked (including overtime hours). Exempt employees accrue sick time based on their normal work week or a 40-hour work week, whichever is less. However, employees will not begin to accrue paid sick time until they have worked in California for 30 days from July 1, 2015 or from the commencement of hire, whichever is later
- An employer may loan sick time to an employee in advance of accrual
- Employees may carry over all accrued paid sick days to the following year of employment. However, an employer may limit or cap accrual to a maximum of 48 hours of paid sick time, and they are permitted to cap use of paid sick time at 24 hours (or three days) in each year of employment

  Note: Paid sick leave need not be paid upon an employee's termination of employment

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California Enacts Paid Sick Leave Law (Continued)

Employee Utilization of Sick Leave

An employee may begin using accrued sick time after being employed by the employer for 90 days.
Sick leave may be used by an employee for either their own needs or their family member's needs in the following instances:

- The diagnosis, care, or treatment of an existing health condition
- The preventative care of an employee or family member; or
- If the employee is a victim of domestic violence, sexual assault, or stalking

Employee Notification to Employer Requirements

Employers must allow employees to request sick leave orally, as there is no requirement that the leave be requested in writing. If the leave is foreseeable by the employee, the employee must give "reasonable advance notification;" whereas, if the leave is not foreseeable, then the employee merely needs to notify the employer as soon as practicable.

There is currently no requirement for employees to provide documentation to an employer as evidence of the need for sick time. Documentation, however, may still be requested for other purposes, such as leave under the Family Medical Leave Act (FMLA).

Posting of Sick Leave and Notice Requirements

Posting

Employers must display a poster at each of their business locations. This poster will be created by the Labor Commissioner at a future date.

Individual Notice

A notice must also be provided to the employee regarding the sick leave at the time an employee is hired. Current employees must also be notified of the Act.

In addition, employees should be notified with a written notice each time wages are paid, which can be reflected in their wage statements.

AMENDMENTS TO D.C. SICK AND SAFE LEAVE ACT

On February 22, 2014, the District of Columbia passed the District of Columbia Sick and Safe Leave Act Amendments Act of 2013 (hereinafter "the Act"), amending the previous D.C. Accrued Sick and Safe Leave Act of 2008. The effective date of the Act was contingent upon the approval of the 2015 budget of the District, which occurred in September. Many of the previous provisions of the 2008 legislation continue to be in effect, but certain other amendments to the law were made by the Act, including the following:

- A revised poster (i.e., revised Official Notice), which includes these amendments and clarifications of the law
- Employees previously had to work 1,000 hours in the previous 12 months before they could take Sick and Safe Leave (SSL); now, employees may use SSL after 90 days of employment
- The revised Official Notice includes a provision notifying employees that their unused paid sick leave must carry over, year to year, with potential limits on the maximum amount of time taken each year (Note: Sick leave need not be paid out as wages)
- The group of covered workers has been expanded to include tipped restaurant employees, **regardless** of an employer's size
- Restaurant workers shall accumulate not less than one hour of paid leave for every 43 hours worked, not to exceed 5 days per calendar year
- The accumulation of sick leave is retroactive to February 22, 2014

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Amendments to D.C. Sick and Safe Leave Act (Continued)

Action Required

Employers in the District of Columbia area should be aware of these new requirements and amendments which affect the previous 2008 Act. Policies and procedures for paid sick time should be reviewed by employers to ensure compliance with this new amendment.

For the complete details, see:
http://does.dc.gov/sites/default/files/dc/sites/does/page_content/attachments/Earned%20Sick%20and%20Safe%20Leave%20Amendment%20Act%20of%202013.pdf

SUPREME COURT OF THE UNITED STATES DENIES REVIEW OF SAME-SEX MARRIAGE CASES

On October 6, 2014, the Supreme Court of the United States (SCOTUS) declined to review all seven of the petitions arising from state bans on same-sex marriage. Because the Court declined to intervene on these lower court decisions, the lower court decisions will continue to stand as the law in those specific jurisdictions. Highlights below.

As a direct result of SCOTUS' decision to deny review of these cases, the following State bans on same-sex marriage will be lifted, and same-sex marriage will be made legal in:

- Virginia (Fourth Circuit, Federal Court of Appeals)
- Indiana (Seventh Circuit, Federal Court of Appeals)
- Wisconsin (Seventh Circuit, Federal Court of Appeals)
- Oklahoma (Tenth Circuit, Federal Court of Appeals)
- Utah (Tenth Circuit, Federal Court of Appeals)

Also, at some point, because the Federal Appellate Circuit Courts oversee multiple states within its Circuit, many other states in these Circuits may be required to provide same-sex couples the ability to marry. These States include:

- North Carolina (Fourth Circuit, Federal Court of Appeals)
- South Carolina (Fourth Circuit, Federal Court of Appeals)
- West Virginia (Fourth Circuit, Federal Court of Appeals)
- Colorado (Tenth Circuit, Federal Court of Appeals)
- Kansas (Tenth Circuit, Federal Court of Appeals)
- Wyoming (Tenth Circuit, Federal Court of Appeals)

SCOTUS may one day make a final decision on the issue of same-sex marriage, but at this time, same-sex marriage is left to each of the Circuit Courts, leading to a patchwork of decisions.

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Supreme Court of the United States Denies Review of Same-Sex Marriage Cases (Continued)

Action Required

Employers who previously were not providing coverage to same-sex spouses in the above mentioned States should do so at this time.

FINAL REGULATIONS ISSUED ON EXCEPTED BENEFITS

On October 1, 2014, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury released the final regulations that address the issues of dental and vision benefits and Employee Assistance Programs (EAPs) as excepted benefits. Excepted benefits are generally exempt from many of health care reform's market reform requirements. These rules are effective beginning January 1, 2015. The final rules include some changes to the proposed regulations. The final regulations did not address the new category of "limited wraparound coverage." This limited coverage will be addressed in future rulemaking. The final regulations address the following topics.

Dental and Vision Benefits

The requirements to be considered excepted benefits for dental and vision benefits have evolved. The proposed regulations state that dental and vision plans will only be considered an excepted benefit if participants are required to pay an additional premium or contribution for the limited-scope benefit. The final regulations remove the requirement that a dental or vision plan must have an additional premium or contribution to be considered an excepted benefit (and therefore not subject to the market reform requirements). This should be welcome relief for employers with self-funded plans who do not charge a separate contribution for limited-scope dental or vision benefits in addition to medical coverage.

The final regulations do not require limited-scope vision or dental plans to have a separate contract or independent election to be considered an excepted benefit. However, the limited-scope dental and vision plan cannot be considered an "integral" part of the major medical plan to be considered an excepted benefit. The limited-scope dental or vision coverage will not be considered integral if **either** requirement is met:

- A participant may decline coverage in the limited-scope dental or vision plan; **or**
- Claims for the limited-scope dental or vision benefit are administered under a separate contract under the plan

Employee Assistance Programs (EAPs)

For an EAP to be considered an excepted benefit (not subject to the market reform requirements), it must meet all of the following requirements:

- The EAP does not provide significant medical benefits
- The EAP is not coordinated with the benefits under another group health plan:
    1) The EAP benefits do not need to be exhausted before the group health benefits are triggered; and
    2) The EAP eligibility is not contingent upon participation in the major medical plan
- The EAP may not require a premium or contribution
- The EAP does not contain any cost-sharing requirements

The previous requirement that an EAP could not be funded by another group health plan has been removed in the final regulations.

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Final Regulations Issued on Excepted Benefits (Continued)

Action Required

Employers should compare the above requirements to their current limited-scope dental plan, limited-scope vision plan, or EAP to ensure that their plans will not be subject to the market reform rules.

For the final regulations on excepted benefits, go to: http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23323.pdf

FREQUENTLY ASKED QUESTIONS ISSUED ON HEALTH PLAN IDENTIFIER

Recently, the Department of Health and Human Services (HHS) released a set of Frequently Asked Questions (FAQs) in relation to the Health Plan Identifier (HPID) that health plans are required to file to report Controlling Health Plan (CHP) information. Below are highlights of the FAQs.

Q1: Are Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), Health Savings Accounts (HSAs), wrap-plans, or cafeteria plans required to get HPIDs?

A1: FSAs and HSAs are individual accounts directed by the consumer to pay health care costs. As such, they do not require an HPID.

HRAs may require an HPID if they meet the definition of health plan. HRAs that cover deductibles only or out-of-pocket costs do not require HPIDs as these are more like additional plan benefits than stand-alone plans.

Wrap-plans and cafeteria plans can be composed of combinations of health plan arrangements (i.e., self-insured, fully-insured, FSA, HSA, HRA). The rules governing these types of plans are the same as for the individual plan types.

For example, a wrap-plan that includes a fully-insured medical plan, self-insured dental plan, and HRA that covers deductibles would require the employer to obtain an HPID only for the self-insured dental plan. The carrier would be responsible for obtaining the HPID for the fully-insured medical plan. The HRA only covers deductibles; therefore, an HPID is not required.

Q2: Are self-insured health plans required to get a Health Plan Identifier (HPID)?

A2: A self-insured health plan must answer two questions to determine whether it must obtain an HPID:

- Does it meet the definition of health plan? A health plan (defined under 45 CFR 160.103) is an individual or group plan that provides or pays the cost of medical care
- If it does meet the definition of a health plan, is it a controlling health plan (CHP)? A CHP is a health plan that controls its own business activities, actions, or policies or is controlled by an entity that is not a health plan. A health plan is also a CHP if it has one or more sub health plans (SHP) that it controls by directing the SHP's business activities, actions, or policies

Q3: Are third-party administrators (TPA) representing self-insured plans required to obtain Health Plan Identifiers (HPIDs)?

A3: No. All controlling health plans (CHPs) must acquire an HPID. Many self-insured plans are controlling health plans and are required to get an HPID whether they conduct standard transactions or not. Since many of them contract with third-party administrators (TPAs) or other vendors administer their health plan operations, they may not be aware of this requirement or understand it. A TPA, acting on behalf of a health plan, is not a health plan and is not required to enumerate or identify itself as a health plan in standard

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Frequently Asked Questions Issued on Health Plan Identifier (Continued)

transactions. However, a health plan may authorize an entity like a TPA to obtain an HPID on its behalf, but the HPID still belongs to the health plan, not the TPA.

Action Required

Employers with self-funded plans should obtain an HPID by November 5, 2014.

For a list of all recently released HPID Frequently Asked Questions by CMS, go to:
https://questions.cms.gov/faq.php?id=5005&rtopic=1851&rsubtopic=8230

CLARIFICATION RELEASED ON REFERENCE-BASED PRICING AND MAXIMUM OUT-OF-POCKET COSTS

On October 10, 2014, the Departments of Labor, Health and Human Services (HHS) and the Treasury released a Frequently Asked Question to address the issue of reference-based pricing as it relates to the requirement for plans to limit maximum out-of-pocket costs under the Affordable Care Act (ACA). The FAQ and background information can be found below.

Background

The Public Health Service section 2707(b) outlines the maximum out-of-pocket limits an individual or family may pay in relation to a non-grandfathered group health plan. Previous guidance attempted to address the concerns stakeholders had with reference-based pricing and its impact on maximum out-of-pocket limits imposed on health plans. Under reference-based pricing, the plan pays a fixed amount for a particular procedure which certain medical providers would consider as payment in full. Concerns arose for plan sponsors and insurance providers because without reference-based pricing, there would be no assurance that more expensive medical providers would not be used by policyholders, exposing plans to more expensive fees after the maximum out-of-pocket limit by a policyholder was reached. Policyholders were concerned, however, that if reference-based pricing were allowed, policyholders would face a choice between: 1) lower quality of care; or 2) exposure to greater out-of-pocket expenses.

The FAQ attempts to address both concerns.

Frequently Asked Question (FAQ)

Q1: Under PHS Act section 2707(b), what specific factors will the Departments consider when evaluating whether a non-grandfathered plan that utilizes reference-based pricing (or similar network design) is using a reasonable method to ensure that it provides adequate access to quality providers at the reference-based price?

A1: Pending issuance of future guidance for purposes of enforcing the requirements in PHS Act section 2707(b), the Departments will consider all the facts and circumstances when evaluating whether a plan's reference-based pricing design (or similar network design) that treats providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers is using a reasonable method to ensure adequate access to quality providers at the reference price, including:

1. *Type of service*. Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs and does not function as a subterfuge for otherwise prohibited limitations on coverage. For this purpose:

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Clarification Released on Reference-Based Pricing and Maximum Out-Of-Pocket Costs (Continued)

Frequently Asked Question (FAQ) (Continued)

a. In general, reference-based pricing that treats providers that accept the reference amount as the only in-network providers should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider

b. Limiting or excluding cost-sharing from counting toward the MOOP with respect to providers who do not accept the reference-based price would not be considered reasonable with respect to emergency services. Furthermore, any provision in a non-grandfathered plan that involves a more restrictive network cannot be applied to emergency services pursuant to PHS Act section 2719A and its implementing regulations

2. *Reasonable access*. Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries. For this purpose, plans are encouraged to consider network adequacy approaches developed by States as well as reasonable geographic distance measures, and whether patient wait times are reasonable (Insured coverage is also subject to any applicable requirements under State law)

3. *Quality standards*. Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards

4. *Exceptions process*. Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:

a. Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance)

b. The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues)

5. *Disclosure*. Plans should provide the following disclosures regarding reference-based pricing (or similar network design) to plan participants free of charge

a. *Automatically*. Plans should provide information regarding the pricing structure, including a list of services to which the pricing structure applies and the exceptions process. (This should be provided automatically, without the need for the participant to request such information, i.e., through the plan's Summary Plan Description or similar document)

b. *Upon Request*. Plans should provide:

i. A list of providers that will accept the reference price for each service

ii. A list of providers that will accept a negotiated price above the reference price for each service; and

iii. Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards

The Departments will continue to monitor the use of reference-based pricing and may provide additional guidance in the future, including guidance relating to requirements other than those under section 2707(b) that is applicable to non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act.

No Action Required

For the Frequently Asked Question issued by the Departments, go to:
http://www.dol.gov/ebsa/faqs/faq-aca21.html

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PATIENT CENTERED OUTCOMES RESEARCH FEE INCREASES

Recently, the Internal Revenue Service (IRS) released Notice 2014-56 to address the adjusted applicable dollar amount for the Patient Centered Outcomes Research Institute Fee (PCORI Fee) to be multiplied by the average number of covered lives for plan years ending on or after October 1, 2014 and before October 1, 2015. This fee has increased from $2.00 (for plan years ending on or after October 1, 2013 and before October 1, 2014) to $2.08 (for plan years ending on or after October 1, 2014 and before October 1, 2015).

Action Required

Employers with self-funded plans (including HRAs) should be aware of the increase to the applicable dollar amount for the PCORI fee ($2.08) and ensure that this amount is paid to the IRS by July 31st of the year following the end of the applicable plan year. **For IRS Notice 2014-56, go to:** http://www.irs.gov/pub/irs-drop/n-14-56.pdf

QUESTION OF THE MONTH

Q: Can We Use Our Medical Loss Ratio Rebate to Pay for Plan Administrative Expenses?

A: How the MLR rebate can be used depends in part on whether the rebate belongs to the employer or the plan. (As background, health care reform requires insurers to pay rebates to policyholders if the insurer's medical loss ratio—cost of claims plus amounts expended on health care quality improvement as a percentage of total premiums—is less than a specified percentage.) In general, the portion of the rebate that belongs to the employer can essentially be used for any purpose. But the portion that is a plan asset must be handled in accordance with ERISA's fiduciary responsibility rules and DOL guidance regarding permissible uses for MLR rebates.

Whether the rebate is a plan asset depends on several factors, such as who the insurance policy is issued to, the terms of the policy and other plan documents, and the manner in which the plan sponsor and participants share the cost of the policy. Since you indicate that the employer and participants each pay a fixed percentage of the premiums, a percentage of the rebate equal to the premium percentage paid by participants (i.e., 50% in this case) would be considered plan assets (assuming no contrary indication in the policy and other documents). Under ERISA's plan asset rules, plan assets must be held in trust unless the plan meets the requirements of the DOL's trust nonenforcement policy. For insured plans, the nonenforcement policy provides that plan assets derived from participant contributions can only be used to pay premiums and must be forwarded to the insurer within certain timeframes. A related rule specifies that insurance refunds, to the extent they constitute plan assets, must be returned to participants within three months of receipt. As a result, an insured plan relying on the nonenforcement policy cannot pay administrative expenses from refunds that are plan assets. This conclusion appears to be supported by Technical Release No. 2011-04 (issued by the DOL to help ERISA group health plans in handling MLR rebates), which does not include payment of plan administrative expenses among the approved uses for a plan's MLR rebate.

So, what can your plan do with its MLR rebate? Rebates can be used to reduce future premiums or enhance benefits. Alternatively, they can be returned to participants, but doing so raises tax and administrative issues. Finally, keep in mind that the MLR rebate should only be used for the plan to which the rebate relates—that is, the rebate cannot be used for another of the employer's plans.

Source: EBIA Thomson Reuters

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