BARNEY&BARNEY™
Legislative Compliance

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA Western Edition
November 2014 | Issue 11

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MASSACHUSETTS ENACTS PAID SICK LEAVE LAW

On November 4, 2014, voters in Massachusetts approved a ballot measure requiring employers to provide sick leave to employees. The law becomes effective on July 1, 2015.

Covered Employers

The legislation is divided into two kinds of employers:

- Employers with **more than 10** employees will be required to provide up to 40 hours of **paid** sick leave time to employees per calendar year
- Employers with **10 or less** employees will be required to provide up to 40 hours of **unpaid** sick leave time to employees per calendar year

Covered Employees

All employees, including those employees who work on a temporary or part-time basis

Accrual and Maximum Amount of Sick Leave

- Beginning July 1, 2015, (or from date of hire, whichever is later) employees may accrue one hour of sick time for every 30 hours worked, up to a maximum of 40 hours per calendar year
- Employees may carry-over up to 40 hours of earned and unused sick time to the following year, and employers are permitted to cap use of paid sick time to a maximum of 40 hours in each calendar year of employment. **Note: Paid sick leave need not be paid upon an employee's termination of employment.**

Massachusetts 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:

- Care for the mental or physical illness or injury of the employee or the employee's child, spouse, parent, or parent of a spouse
- To attend routine medical appointments of the employee or the employee's child, spouse, parent, or parent of a spouse; or
- To address the effects of domestic violence on the employee or the employee's dependent child.

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 make a "good faith effort" in notifying an employer of the use of earned sick time.

An employer may require certification of the sick leave time by an employee when the sick leave time is more than 24 consecutively scheduled work hours.

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 Attorney General 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.

Action Required

Employers in Massachusetts should be aware of this new sick leave law. Policies and procedures for paid sick time should be reviewed by employers to ensure compliance with this new law.

For the complete details, see: http://www.sec.state.ma.us/ele/ele14/pip144.htm

PREMIUM REIMBURSEMENT ARRANGEMENTS NOT ALLOWED UNDER THE AFFORDABLE CARE ACT

On November 6, 2014, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) prepared FAQs addressing Premium Reimbursement Arrangements. Although previously issued guidance on September 13, 2013 addressed Health Reimbursement Arrangements (HRAs), certain Health Flexible Spending Accounts (FSAs), and other employer health care arrangements, it did not specifically address reimbursements of individual policy premiums by employers on a post-tax basis.

However, this new guidance affirmatively states that premium reimbursement arrangements, whereby an employer reimburses employees the cost of an individual policy on a pre-tax or post-tax basis, are considered employer sponsored coverage and are therefore subject to the market reform rules under the Affordable Care Act. Because these types of plans violate the market reform rules, employers offering them will be subject to significant penalties for offering coverage under a premium reimbursement arrangement. Therefore, these FAQs prohibit employers from providing reimbursements for the policies of executives and individuals.

In addition, employers may not offer the opportunity for high claims risk employees to either participate in the employer sponsored plan or pay the employee a cash distribution for opting out of coverage.

The following FAQs address the different scenarios in relation to employer premium reimbursement arrangements:

Q1: My employer offers employees cash to reimburse the purchase of an individual market policy. Does this arrangement comply with the market reforms?

A1: No. If the employer uses an arrangement that provides cash reimbursement for the purchase of an individual market policy, the employer's payment arrangement is part of a plan, fund, or other arrangement established or maintained for the purpose of providing medical care to employees without regard to whether the employer treats the money as pre-tax or post-tax to the employee. Therefore, the arrangement is group health plan coverage and is subject to the market reform provisions of the Affordable Care Act applicable to group health plans.

Such employer health care arrangements cannot be integrated with individual market policies and, therefore, will violate many provisions within the Affordable Care Act, such as the prohibition on lifetime and annual dollar maximums as well as the requirement that employer plans provide preventative services at no cost to the employee.

Q2: My employer offers employees with high claims risk a choice between enrollment in its standard group health plan or cash. Does this comply with the market reforms?

A2: No. The PHS Act and HIPAA prohibit discrimination based on one or more health factors. Offering only those employees with a high claims risk a choice between enrollment in the standard group health plan or cash constitutes such discrimination. While the Departments' regulations implementing this provision permit more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination), in the Departments' view, cash-or-coverage arrangements offered only to employees with a high claims risk are not permissible benign discrimination. Accordingly, such arrangements will violate the nondiscrimination provisions, regardless of whether (1) the cash payment is treated by the employer as pre-tax or post-tax to the employee, (2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance.

Such offers fail to qualify as benign discrimination for two reasons.

First, if an employer offers a choice of additional cash or enrollment in the employer's plan to a high-claims-risk employee, the opt-out offer does not reduce the amount charged to the employee with the adverse health factor. Rather, the employer's offer of cash to a high-claims-risk employee who opts out of the employer's plan effectively increases the premium or contribution the employer's plan requires the employee to pay for coverage under the plan because, unlike other similarly situated individuals, the high-claims-risk employee must accept the cost of forgoing the cash in order to elect plan coverage. For example, if the employer's group health plan requires all employees to pay $2,500 toward the cost of employee-only coverage under the plan, but the employer offers a high-claims-risk employee $10,000 in additional compensation if the employee declines the coverage, for purposes of discrimination analysis, the effective required contribution by that high-claims-risk employee for plan coverage is $12,500 – that is, the $2,500 required employee contribution for employee-only coverage under the employer's plan plus the $10,000 of additional compensation that the employee would forgo by enrolling in the plan. Because a high-claims-risk employee must effectively contribute more to participate in the group health plan, the arrangement violates the rule that a group health plan may not on the basis of a health factor

Premium Reimbursement Arrangements Not Allowed Under the Affordable Care Act (Continued)

require any individual (as a condition of enrollment) to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan.

Second, the Departments' regulations generally permit providing (based on an adverse health factor) enhancements to eligibility for coverage under the plan itself but not cash as an alternative to the plan. In particular, the regulations permit providing plan eligibility criteria that offer extended coverage within the plan and subsidization of the cost of coverage within the plan based on an adverse health factor. An example in the Departments' regulations illustrates that a plan may have an eligibility provision that provides coverage to disabled dependent children beyond the age at which non-disabled dependent children become ineligible for coverage. Another example in the regulations illustrates that a plan may provide coverage free of charge to disabled employees while other employees pay a participant contribution towards coverage. However, in the Departments' view, providing cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the group health plan. This type of arrangement differentiates based on a health factor and is outside the scope of the Departments' regulations on benign discrimination, which permit only discrimination that helps individuals with adverse health factors to participate in the health coverage being offered to other plan participants. The Departments intend to initiate rulemaking in the near future to clarify the scope of the benign discrimination provisions.

Finally, because the choice between taxable cash and a tax-favored qualified benefit (the election of coverage under the group health plan) is required to be a Code section 125 cafeteria plan, imposing an effective additional cost to elect coverage under the group health plan could, depending on the facts and circumstances, also result in discrimination in favor of highly compensated individuals in violation of the Code section 125 cafeteria plan nondiscrimination rules.

Q3: A vendor markets a product to employers claiming that employers can cancel their group policies, set up a Code section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies, and allow eligible employees to access the premium tax credits for Marketplace coverage. Is this permissible?

A3: No. The Departments have been informed that some vendors are marketing such products. However, these arrangements are problematic for several reasons. First, the arrangements described are themselves group health plans and, therefore, employees participating in such arrangements are ineligible for premium tax credits (or cost-sharing reductions) for Marketplace coverage. The mere fact that the employer does not get involved with an employee's individual selection or purchase of an individual health insurance policy does not prevent the arrangement from being a group health plan. DOL guidance indicates that the existence of a group health plan is based on many facts and circumstances including the employer's involvement in the overall scheme and the absence of an unfettered right by the employee to receive the employer contributions in cash.

Second, such arrangements are subject to the market reform provisions of the Affordable Care Act, including the prohibition on annual limits and the requirement to provide certain preventive services without cost sharing. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate the PHS Act (among other provisions) which can trigger penalties such as excise taxes under section 4980D of the Code.

Action Required

Employers who are offering a premium reimbursement plan that reimburses employees for payments made to individual policies should stop doing so immediately. Employers should also avoid offering high claims risk employees a cash out option as an alternative to employer sponsored coverage.

These FAQs can be found here: http://www.dol.gov/ebsa/faqs/faq-aca22.html

Non-Enforcement of HIPAA Health Plan Identifier

On October 31, 2014, the Department of Health and Human Services (HHS) announced that the enforcement of the HIPAA Health Plan Identifier (HPID) would be delayed indefinitely. Previously, controlling health plans were required to register for a unique plan identifier by November 5, 2014. Because of the delay, plans are no longer required to register for an HPID.

The delay was caused by comments from the National Committee on Vital and Health Statistics (hereinafter NCVHS) regarding the lack of benefit and value in using HPIDs.

No Action Required

Employers with self-funded plans who previously registered for an HPID need do nothing further. Those employers with self-funded plans need not register for an HPID at this time, if they previously had not done so.

The guidance on the delay of the HPID is contained here: http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html

NEW YORK CITY EMPLOYERS REQUIRED TO OFFER COMMUTER BENEFITS IN 2016

Recently, New York City Mayor Bill de Blasio signed into law the Affordable Transit Act, which will require employers in New York City to offer commuter benefits to employees. The ordinance requires employers with 20 or more full-time employees in New York City to offer commuter benefits to employees on a pre-tax basis. Full-time employee is defined as any employee who averages 30 or more hours of work a week. Public employers are exempt from the Act.

The Act will be effective January 1, 2016, but no penalties will be assessed for violations of the Act until July 1, 2016, providing a six month grace period for compliance with the law. Penalties for violations against the law include up to a $250 penalty for the first 90 days of violation of the Act, and up to an additional $250 fine for every 30 day period that follows.

Action Required

New York City employers with 20 or more full-time employees should begin thinking about the planning and implementation of commuter benefits to employees in 2016.

For the Affordable Transit Act, go to:
http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=1739313&GUID=5CAAD882-03E1-4420-9F73-3E2C8F878BBD&Options=ID|Text|&Search=295

FLEXIBLE SAVINGS ACCOUNT LIMITS FOR 2015 RELEASED

The Internal Revenue Service (IRS) released the 2015 Cost-of-Living-Adjustments (COLA) for Flexible Savings Accounts (FSAs). Highlights are as follows:

Contribution Limits for Flexible Savings Accounts (FSA'S)

	2014	2015	Change
FSA contribution limit (employee)	$2500	$2550	+$50
Dependent Care FSA limit (filing individual or joint return)	$5,000	$5,000	No change
Dependent Care FSA limit (married and filing separately)	$2,500	$2,500	No change

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SUPREME COURT TO HEAR KING V. BURWELL

The Supreme Court of the United States has agreed to hear the case of *King v. Burwell*. *King v. Burwell* is a case that will test whether the Federal government has the authority to distribute premium tax credits to individuals who purchase coverage in the Federal Marketplaces (i.e. Federal Exchanges). Because the law states that premium tax credits will be made available to individuals in Exchanges "established by a state," a very large question revolves around whether the language should be interpreted to allow premium tax credits for Exchange coverage to be provided in State Exchanges **only**, or whether those premium tax credits may also be utilized for coverage provided for in the Federal Exchange.

Whether premium tax credits can be utilized by individuals in the Federal Exchange is an important question. In order for penalties to be assessed against an employer, a full-time employee must purchase coverage in an Exchange and receive a subsidy. Therefore, if a full-time employee is unable to obtain a premium tax credit, a penalty could not be assessed against an employer in a state with a Federal Exchange.

This matter will be heard by the Supreme Court of the United States most likely in the spring or summer of 2015.

No Action Required

Employers in Federal Exchange states should pay close attention to the holding in the case of *King v. Burwell* and should anticipate a decision to be made in spring or summer of 2015.

QUESTION OF THE MONTH

Q: Now that individual health insurance is available with no preexisting condition exclusions through Exchanges, must we continue to offer COBRA to terminating employees and other qualified beneficiaries?

A: Yes. The availability of coverage through Exchanges (also known as the Health Insurance Marketplace) does not affect the COBRA rights of terminating employees or other qualified beneficiaries. Assuming your group health plan is otherwise subject to COBRA, you must continue to offer COBRA to all qualified beneficiaries losing coverage under the plan due to a COBRA qualifying event. This means (among other things) that you must continue to provide an initial notice of COBRA rights when an employee enrolls in coverage and an election notice when coverage is lost due to a qualifying event. COBRA notices should be updated to include information about the alternative coverage that is available through an Exchange—the DOL's model COBRA notices include suggested language.

As Exchange coverage becomes more widely utilized and understood, qualified beneficiaries losing coverage under employer-sponsored group health plans face the decision of whether to remain on their employers' plans by electing COBRA or to seek individual coverage through an Exchange. For some individuals and their families, Exchange coverage may be much less expensive than COBRA coverage and therefore the clear choice. For other individuals, however, COBRA is a viable or even preferred option. For instance—

- Some qualified beneficiaries may face higher premiums on an Exchange than they would on COBRA;
- Employers may subsidize all or a portion of COBRA coverage, making it less expensive;
- Certain qualified beneficiaries (e.g., active employees losing coverage due to a reduction of hours) may have the option to pay COBRA premiums pre-tax; and
- Qualified beneficiaries may prefer COBRA coverage to Exchange coverage because of physician networks, level of coverage, or familiarity.

Employers must continue to be diligent in their COBRA compliance efforts, even as the availability of Exchange coverage expands the options for qualified beneficiaries.

Source: EBIA Thomson Reuters