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Legislative Compliance

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA Western Edition
December 2014 | Issue 12

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HHS RELEASES PROPOSED RULE FOR 2016 PAYMENT PARAMETERS

On November 21, 2014, The Department of Health and Human Services (HHS) released a Notice of Benefit and Payment Parameters for a proposed rule on various topics, including the transitional reinsurance program, cost sharing under the Affordable Care Act (ACA), and regulations addressing self-insured expatriate plans. Some highlights are included below.

Transitional Reinsurance Contributions for 2016

The transitional reinsurance program was created to help stabilize medical insurance premiums for individuals to reduce the cost increases that insurers would be responsible for in order to become ACA compliant. The per member reinsurance fee in 2014 was $63.00, and the 2015 reinsurance fee will decrease to $44.00. The newly proposed 2016 fee is $27.00 per member.

In addition, the proposed regulations also state that fully-insured carriers who submit reinsurance fees on behalf of employers should use the same counting methods for members in a state for the 2015 and 2016 years. This requirement would not apply to self-funded plans.

Finally, if a self-funded employer does **not** use an outside Third Party Administrator to administer its self-funded plan and instead opts to self-administer the plan, the plan will not be subject to paying a reinsurance fee. For purposes of whether the TPA is considered as an "outside" TPA is defined pursuant to common ownership rules under IRC § 414.

Self-insured Expatriate Plans

Previous guidance on expatriate plans only excluded **insured** group health plans from making reinsurance contributions. Under the proposed regulations, **self-funded** expatriate plans will also be excluded from having to make reinsurance contributions (at least for 2015 and 2016). As a reminder, expatriate health coverage is defined as a plan that limits enrollment to primary insureds (and dependents) who reside outside of their home country for at least six months of the plan year.

Out-of-Pocket Maximums

Non-grandfathered health plans are prohibited from having a maximum out-of-pocket (MOOP) limit that is greater than the yearly threshold. In 2015, that maximum out-of-pocket threshold is $6,600 for self-only coverage and $13,200 for other than self-only (family) coverage.

The proposed regulations state that for 2016, the MOOP limit for self-only coverage is $6,850 and the MOOP limit is $13,700 for other than self-only (family) coverage.

The regulations also clarify that even in other than self-only (family) coverage, the self-only coverage MOOP limit applies to each individual member of the non-self only coverage. For example, if a non-self only plan has a $12,000 MOOP limit and an individual incurs $15,000 in medical expenses in 2016, the individual would only pay the MOOP limit for self-only coverage in 2016 in the amount of $6,850.

The MOOP limit applies for the entire **plan** year and is not interrupted or reset by a new calendar year for a non-calendar year plan.

SHOP and Individual Marketplace (i.e. Exchange) Coverage

The proposed rules clarify that employers participating in the Small Business Health Options Program (SHOP) through the Marketplace may offer former employees (e.g. retirees and COBRA qualified beneficiaries) and dependents coverage, so long as the plan does not **only** offer coverage to former employees. In addition, business owners may also enroll in SHOP coverage, so long as there is at least one active employee enrolled in the plan. The SHOP may receive premiums on behalf of COBRA beneficiaries, but may not perform the regular functions of a COBRA administrator (e.g. distribution of required notices).

Individual coverage offered through the Exchange has also added a special enrollment period for employees who are discontinuing coverage in a non-calendar year plan.

Action Required

Employers with self-funded plans should plan on reviewing their reinsurance contributions in 2016 and account for the decrease in reinsurance fee contributions. In addition, if employers have a self-funded expatriate plan, the news of not paying a reinsurance fee for the next two years on such plan should be a welcome relief. Finally, employers should begin planning for the increase in MOOP limits for 2016 in addition to ensuring that their plans currently attribute the self-only MOOP limit for individuals in non-self only (family) coverage.

For the complete details, see:

http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf

FINAL RULE ON INDIVIDUAL MANDATE IMPACTS AFFORDABILITY OF EMPLOYER SPONSORED COVERAGE

On November 26, 2014, the Internal Revenue Service (IRS) issued final regulations on the Affordable Care Act's (ACA) Individual Mandate. The Individual Mandate requires that individuals be enrolled in Minimum Essential Coverage or pay a penalty. The penalty will be waived if an individual is able to qualify for an exemption. One exemption to the Individual Mandate is if coverage offered to an employee through an employer sponsored plan is greater than 8% of that employee's household income, the individual will not be subject to the Individual Mandate penalty. The final regulations address situations that may impact the affordability of employer sponsored plans.

These clarifications also impact the affordability of employer sponsored plans. As a reminder, employers may be subject to penalties for failing to offer affordable coverage (9.5% of household income for self-only coverage) to employees. Therefore, these affordability provisions, although related to the Individual Mandate, also apply to the Employer Mandate. It is essential that employers calculate the affordability of their employer sponsored plans based upon the following information.

Cafeteria Plan Contributions

An employee's contributions to a medical coverage premium made to a cafeteria plan will only be reduced by employer contributions made to the medical coverage premium if the contribution is made available in the plan year, and only if the employer contribution:

- Is not taken as a taxable benefit by the employee
- May be used to pay for Minimum Essential Coverage (MEC); and
- Is only used for IRC § 213 qualified medical care.

Therefore, employers providing payments to employees such as cash-in-lieu, opt-out credits, waiver credits, or credits to be used for anything other than IRC § 213 medical care should be advised that such payments will not be counted as employer contributions, but as employee contributions, which may significantly impact the affordability of the plan to employees.

Health Reimbursement Arrangements Providing Premium Reimbursement

Contributions made to an employee's Health Reimbursement Account (HRA) by an employer will reduce the employee's contribution towards medical premiums only if:

- The HRA is "integrated" with a primary major medical plan
- The reimbursements from the HRA are only used for premiums for the primary major medical plan; and
- The amounts that may be reimbursed under the HRA under the plan's terms are available or otherwise determinable within a reasonable time prior to the enrollment of the employee

HRAs that reimburse employees on the cost of medical care (and are not used towards premium reimbursement) will not be calculated towards the affordability of the plan to the employee, but will go into calculation of the Minimum Value of the primary major medical plan.

Wellness Incentives

Non-discriminatory wellness program incentives that provide premium discounts/surcharges/rebates will only be considered earned if the discount to the premium to the employee for the cost of coverage is related **exclusively** to a tobacco cessation program. Thus, whether the premium is affordable will be based upon the discounted premium versus the higher premium charged to tobacco users (or non-tobacco cessation program participants).

If the wellness program offers a discount that is unrelated to tobacco cessation, or if the employee, in order to receive a discount, must complete a wellness program related to tobacco use **along** with a program that is not related to tobacco use, the discount/incentive is treated as **not** earned. Therefore, when calculating affordability, employers should differentiate the incentives related to tobacco cessation programs from that of other wellness programs and **only** base the affordability of a plan upon successful involvement with the exclusive tobacco cessation program.

Action Required

Employers should compare and closely follow the above final regulations. Employers need to ensure that premiums are considered affordable given the rules provided. Any employer that provides a cash-in-lieu/waiver credit in their benefits plan provides an HRA that only reimburses medical expenses and not premiums, or only provides a discount for participation in a tobacco cessation program that is not exclusive of other wellness programs should calculate employee contributions accordingly.

For the complete details, see:

http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27998.pdf

CITY OF OAKLAND MANDATES SICK LEAVE

On November 24, 2014, voters in the City of Oakland passed a measure providing mandatory sick leave for eligible employees. The law is effective March 2, 2015, and although it applies to all employers, it applies differently to small employers versus larger employers.

Covered Employers

All employers in Oakland are subject to the sick leave ordinance. However, small employers (defined as having less than 10 employees in any given week, including employees outside of the City, and any part-time, full-time, and temporary workers), may cap the accumulation of paid sick leave at 40 hours per year, per employee, versus large employers (defined as having 10 or more employees in any given week, including employees outside of the City, and any part-time, full-time, and temporary workers) who may cap the accumulation of paid sick leave at 72 hours per year, per employee.

Accrual and Maximum Amount of Sick Leave

Employees shall accumulate one hour of sick time for every 30 hours worked. Such leave shall only accrue in hour-unit increments. However, employees need not be entitled to **use** sick time until after 90 calendar days of employment.

Sick leave must be carried over to the following year, but accumulation of such time is limited to the aforementioned caps under the "Covered Employers" section above.

Covered Employees

This legislation applies to all employees who work at least 2 hours per week for an employer within the City and who are entitled to receive minimum wage from an employer under the California minimum wage law.

Employee Utilization of Sick Leave

Sick leave may be used by an employee for either their own medical needs or the medical needs of blood related and non-blood related persons, which include:

- Child, parent, legal guardian/ward, sibling, grandparent, grandchild, and spouse or domestic partner
- Adoption relationships, step-relationships, foster care relationships, and children of domestic partners; and
- For a person with no spouse or domestic partner, an individual who the employee designates prior to the accumulation of sick leave time (and every year thereafter, a ten day window must be provided to allow an employee to change that previously elected individual).

Considerations in Relation to California Paid Sick Leave

- California Paid Sick Leave Act only requires employers to pay for 24 hours of paid sick leave in one year, whereas the Oakland ordinance requires that an employee be provided up to 72 hours of paid sick leave a year
- The Oakland ordinance only requires Small Businesses to provide a maximum of 40 hours of accumulated paid sick leave hours to be provided to an employee, whereas California's Paid Sick Leave Act requires at least 48 hours of paid sick time for **all** sizes of employers

Paid Sick Leave Comparison Chart

Because of the confusing nature of all of the paid sick leave laws in California, a chart of the outstanding paid sick leave laws is contained on the following page.

	California	San Francisco	San Diego	Oakland
Effective Date	7/1/15	2/5/07	N/A	3/2/15
Eligibility	Any employee who works at least 30 days in California in their first year of employment.	Employees who work at least 56 hours in one calendar year within the geographical boundaries of the City of San Francisco.	Employees who work at least two hours within the geographical boundaries of the City of San Diego in one or more calendar weeks of the year.	Employees who work at least two hours within the geographical boundaries of the City of Oakland and are covered by California's minimum wage law.
Allows Waiver and/or Modification through Collective Bargaining	Yes, upon meeting certain conditions.	Yes.	No.	Yes.
Accrual Method	One hour of paid sick leave for every 30 hours worked	One hour of paid sick leave for every 30 hours worked.	One hour of paid sick leave for every 30 hours worked.	One hour of paid sick leave for every 30 hours worked.
Accrual Caps	48 hours.	40 hours for small employers (Caution: California law requires 48 hours); 72 hours for large employers.	No.	40 hours for small employers (Caution: California law requires 48 hours); 72 hours for large employers.
Usage Caps	24 hours/year	No.	40 hours/year.	No.
Medical Certification	No provisions.	Employer cannot require, unless leave is in excess of three consecutive work days or in instances involving a pattern or clear instance of abuse.	Cannot require unless leave is in excess of three consecutive work days.	Employers can request; however, an employee cannot be required to incur certain expenses associated with it.
Allows Employee to Designate Member for Care	No.	Yes, so long as employee has no spouse or registered domestic partner.	No.	Yes, so long as employee has no spouse or registered domestic partner.

Action Required

Employers in Oakland should begin reviewing their paid sick leave policies to ensure compliance with the new paid sick leave law.

For the complete details, see:

http://www.acgov.org/rov/elections/20141104/documents/MeasureFF-V3.pdf

GUIDANCE ON TRANSIT BENEFITS RELEASED IN IRS NOTICE 2014-32

On November 21, 2014, the Internal Revenue Service (IRS) provided guidance on different payment arrangements involving transportation related fringe benefit plans. The Notice covered a wide variety of topics including smart cards and debit cards. Below are some highlights of the Notice.

Smartcards and Terminal Restricted Debit Cards

The Notice begins by addressing whether smartcards are a fringe benefit that is excludable from an employee's gross income. A smartcard is defined by the IRS as a card that:

- Includes a memory chip that stores information that uniquely identifies the card and value stored on the card; and
- Can only be used as fare media or to purchase fare media.

The Notice also defines a terminal restricted debit card as a card that is:

- Restricted for use only at merchant terminals at points of sale; and
- Can only purchase fare media where local transit system fare media is sold.

An employer would make monthly payments to the transit system on behalf of its employees, which is then allocated to each employee's smartcard/debit card. Substantiation of the use of the smartcards/debit cards is not necessary by the employee.

The IRS Notice states that because the credits stored on the smartcard/debit card may only be used for fare media on a transit system, the definition of transit pass under IRC § 132(f)(5)(A) is met, and, therefore, a smartcard/debit card would qualify as a non-taxable fringe benefit and would be excluded from the gross income and wages of the employee.

MCC restricted Debit Cards

The ruling also addresses the use of debit cards that are restricted for use at merchants that have been assigned a merchant category code, designating that it is a merchant who sells fare media (who may also sell other merchandise). The example provided by the IRS indicates that an employer who provides employees with an MCC restricted debit card on the date of hire, who does not require employees to substantiate transit expenses, and who has employees certify that the card will only be used to purchase fare media would still not be considered a qualified transit benefit.

The IRS does **not** consider this arrangement to be a bona fide reimbursement arrangement, and therefore any monies put on the MCC restricted debit card would be gross income to the employee. The reason the MCC restricted debit card would be taxed as income to the employee is because it provides for an advance payment to the employee (rather than a reimbursement), the program relies solely on employee certifications to justify the expense, and the MCC debit card could allow an employee to purchase merchandise with the MCC restricted debit card.

Vanpool Delivery Charges

The Notice describes another scenario whereby an employer provides employees with a debit card which must be used to buy vanpool vouchers. The voucher provider does not sell any other merchandise, and employees may purchase the vouchers online or in person. For online purchases of vouchers, the vendor charges a reasonable and customary delivery charge for the vouchers. The employee's debit card is used to pay for the voucher as well as the delivery charge. The combined cost of the voucher and delivery charge does **not** exceed the monthly transit benefit limit.

Pursuant to the Notice, so long as they do not exceed the cost of the monthly transit benefit limit, the vanpool vouchers and the delivery charge may be excluded from an employee's gross income.

Use of Cash Reimbursements Restricted

Previously, the IRS allowed for (in Revenue Ruing 2006-57) an employer to provide cash reimbursements to employees when they purchased qualified transit passes when the only available voucher was a terminal-restricted debit card. Because terminal-restricted debit cards are more widely used now, however, the IRS has not reversed its position since the Ruling.

Cash reimbursements are no longer acceptable by the IRS even if the only reasonable voucher is a terminal-restricted debit card. Effective January 1, 2016, employers may no longer provide qualified transportation fringe benefits in the form of cash where terminal-restricted debit cards are readily available within the geographic area. If cash reimbursements are provided in this circumstance, they will be treated as wages and income to the employee.

Action Required

Employers providing transit benefits to employees should be aware of the allowed methods for employees to receive those benefits. Employers should be particularly careful now in providing cash reimbursements to employees for transit benefits.

For further review of Revenue Ruling 2014-32, see:

http://www.irs.gov/pub/irs-drop/rr-14-32.pdf

UPDATED SELF-COMPLIANCE TOOL INCLUDES MENTAL HEALTH PARITY ASSISTANCE

In November, the Department of Labor (DOL) updated its self-compliance tool. This self-compliance tool helps plan sponsors verify whether its group health plan complies with part 7 of ERISA, which includes the topic of mental health parity. The tool is a form checklist in the DOL Compliance Assistance Guide, which also includes various FAQs on mental health parity.

The updated tool also includes an Affordable Care Act section as well as information on wellness program compliance.

The largest change is the inclusion of the application of enhanced claims and appeals to judgments about mental health and substance use disorder benefits. In addition to requesting plan documents, participants and beneficiaries are now allowed to ask for additional information on whether the plan provides benefits in accordance with the mental health parity requirements, as well as the health plan's determination regarding the financial treatment limitations and whether those treatment limitations comply with the Mental Health Parity Act.

Action Required

Employers should familiarize themselves with the self-compliance tool. Specifically, the guide helps employers that are offering mental health benefits ensure that they are compliant with the Mental Health Parity Act.

For the updated self-compliance tool, go to:

http://www.dol.gov/ebsa/pdf/cagappa.pdf

DOL RELEASES ADVANCED COPIES OF 2014 FORM 5500s AND FINAL M-1

On December 15, 2014, the U.S. Department of Labor's Employee Benefits Security Administration, the Internal Revenue Service, and the Pension Benefit Guarantee Corporation released advanced informational copies of the 2014 Form 5500 and Form 5500-SF annual return/report and related instructions. Although these Forms are being released for informational purposes only (these Forms cannot be filed), they provide insight into the actual Forms.

Examples of these changes include:

- **DOL Form M-1 Compliance Information** – Form M-1 for MEWAs that was previously filed as an attachment now appears as three new questions on Form 5500
- **Active Participant Information** – Filers are now required to provide the total number of active participants at the beginning of the plan year, as well as at the end of the plan year
- **Multiple-Employer Plan Information** – The Form 5500 now requires multiple-employer welfare plans to include an attachment that generally identifies each participating employer, and include a good faith estimate of each employer's percentage of the total contributions during the year

In addition, the final M-1 annual report (for MEWAs) for 2014 was released by the Departments, with minor clarifications on the previous year's Forms.

No Action Required

Employers should become familiar with the changes made to Form 5500 and Form 5500-SF. In addition, MEWAs should be aware of the new final Form M-1 for the 2014 year.

For more information regarding these Forms, go to:

http://www.dol.gov/ebsa/newsroom/2014/EBSA121514.html

QUESTION OF THE MONTH

Q: We are a large employer with thousands of employees. As a way of reducing overall benefit costs, only employees and their dependent children are offered coverage under our company's group health plan. We do not extend coverage to an employee's spouse. Would spousal exclusion subject us to penalties under health care reform's employer shared responsibility requirements? What if an employee's spouse received subsidized coverage on the Exchange?

A: The failure to offer health coverage to an employee's spouse would not subject your company to penalties under the employer shared responsibility rules (sometimes referred to as "play or pay"). As background, an "applicable large employer" (generally employing an average of at least 50 full-time employees, including full-time equivalent employees) may be subject to penalties for failing to offer coverage to full-time employees and their dependents. For this purpose, "dependents" means an employee's children, as defined in Code § 152(f)(1), who are under 26 years of age (but does not include stepchildren or foster children).For purposes of employer penalties, the term "dependents" does not include any individuals other than an employee's children, as defined above. Thus, an applicable large employer is not required to offer coverage to an employee's spouse to avoid employer shared responsibility penalties. Even if an employee's spouse purchased subsidized coverage on the Exchange (i.e., received a premium tax credit), your company would not be subject to penalties. This is because a penalty generally applies only if a full-time employee is certified to the employer as having received a premium tax credit for coverage purchased through an Exchange.

Source: EBIA Thomson Reuters