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FINAL FORMS 1094-C AND 1095-C RELEASED (EMPLOYER REPORTING REQUIREMENTS)

On February 8, 2015, the Internal Revenue Service released the final forms for the Employer Mandate reporting requirements (Forms 1094-C and 1095-C), in addition to the final forms for insurance provider reporting (Forms 1094-B and 1095-B).

The Forms have not changed significantly from the previously released Draft Forms.

The deadline for reporting on the Forms has not changed, which is 2016, for the 2015 calendar year.

Some changes in the Final Instructions for the Final Forms include:

- Self-funded employers are required to report any individual who participates in the self-funded plan. Previously, employers were required to report certain non-employees only on Form 1094-B. The Final Instructions allow a new option that allows self-insured plan sponsors/employers to report non-employees (i.e., non-employee directors, retired employees from previous years, terminated employees from previous years, and non-employee COBRA beneficiaries) on *either* Part III of Form 1095-C, or in Forms 1094-B and 1095-B. Reporting non-employees on Part III of Form 1095-C helps reduce the number of Forms required for employees who transition to non-employees during the calendar year.
- The Final Instructions clarify that an employer must offer coverage to dependent children to be considered as having made a Qualifying Offer to 98 percent (Form 1094-C, Line 22) of full-time employees.
- The Employer Identification Number (EIN) may be truncated on the employee reporting forms, but NOT on the government transmittal forms
- For determination of the total employee count for an Applicable Large Employer (ALE), an employer may use the first or last day of the **first payroll period** that starts in each month, or the first or last day of the month.
- ALEs must include a country code with the employee's address in Part I of Form 1095-C, even if the employee resides in the US.
- An offer of coverage to an employee's dependent children is only considered a qualifying offer of coverage if it was offered to all of the employee's dependent children, as defined under the Affordable Care Act.
- If spouses (or employee and dependent child) are employed with the ALE member who is self-insured, and one employee covers the family member under his/her family coverage, the family member should only be reported on Part III of the employee who enrolled in the coverage.
- An ALE member need not file a Form 1095-C for an individual who, for ALL months of the calendar year, is either not an employee of the ALE member, or is in a limited non-assessment period. However, for those months the individual was an employee of the employer in a limited non-assessment period, they would be included in the total count of employees for that month on Form 1094-C.
- For reporting purposes, an offer to a spouse is still considered an offer to a spouse, even if the spouse is allowed an offer of coverage subject to a reasonable condition (e.g., spouse may only participate in the plan if they have no offer of coverage from another employer).

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FINAL FORMS 1094-C AND 1095-C RELEASED (EMPLOYER REPORTING REQUIREMENTS) (CONTINUED)

Action Required

Employers should be familiar with the reporting Forms and Form Instructions, and should begin collecting the appropriate information as to whom employer sponsored coverage was offered, whether it provided Minimum Value, and whether such coverage was Affordable. This information should be collected on a month-by-month basis in 2015, to be reported in 2016.

For the complete details, see:

Form 1095-C - http://www.irs.gov/pub/irs-pdf/f1095c.pdf

Form 1094-C - http://www.irs.gov/pub/irs-pdf/f1094c.pdf

Instructions for Forms 1094-C and 1095-C - http://www.irs.gov/pub/irs-pdf/i109495c.pdf

MASSACHUSETTS EXTENDS PATERNITY RIGHTS

Background

Massachusetts, under the existing Massachusetts Maternity Leave Act (MMLA), requires employers with six or more employees to provide eligible female employees eight weeks of protected leave for the birth or adoption of a child. The federal Family Medical Leave Act (FMLA), however, applies to employers with 50 or more employees, and provides up to 12 weeks of protected leave, in a 12 month period, for female and male employees who have been with the employer for 12 months and worked 1250 hours in the previous 12 months prior to taking leave.

A female employee, under MMLA, would be entitled to protected leave if she:

- Completed an employer's initial probation period (not to exceed six months). If an employer has no probationary period, then the probationary period shall be three months; and,
- Gives at least two weeks' notice for her leave and return date.

MMLA also requires that an employer restore the employee to the same or similar position without any loss of employee benefits during the eight weeks of leave (MMLA does not require employer contributions during the leave, but FMLA may).

An Act Relative to Parental Leave

On January 7, 2015, Massachusetts Governor Deval Patrick signed into law An Act Relative to Parental Leave Law, which expanded the class of eligible employees under the MMLA to include male employees, in addition to female employees. The legislation becomes effective April 7, 2015.

Covered Employers

Employers with at least six employees must provide at least eight weeks of protected parental leave to all employees (regardless of gender), to biological and adoptive parents.

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MASSACHUSETTS EXTENDS PATERNITY RIGHTS (CONTINUED)

Eligible Employees

Employees become eligible for leave after the employer's initial probationary period (i.e., the time prior to an employee becoming a permanent employee), which is not to exceed three (3) months. If no probationary period exists, then eligibility for the leave shall begin after three months of full-time employment, by default.

Qualified Purposes for Leave

Protected leave may be used for caring for children under 18 years of age, or under age 23 if the child is physically or mentally disabled.

Two Parents of Same Child Works for One Employer

When two parents work for the same employer, and are caring for the same child, the two parents are limited to a combined total of eight weeks of leave.

MMLA Leave and Other Leave

Protected leave may be used for caring for children under 18 years of age, or under 23 years of age, if the child is physically or mentally disabled.

Protections and Effects of Leave on Other Employee Rights

Leave should not affect the employee's right to vacation time, bonuses, sick leave, benefits, or other programs for which the employee was eligible for at the time of leave. The employer, however, is not required to pay for any benefits or programs during the leave, unless the employer does so for all employees on a leave of absence (However, caution should be used, as FMLA may require an employer to maintain the same contribution towards benefits).

Notice Requirement

Employees generally must provide at least two weeks' notice in advance of their leave date, but may provide notice later (as soon as practicably possible) if the reason for the delayed request was beyond the individuals control.

Protections for Leave Longer than Eight Weeks Under the Act

If an employer is more generous and offers more than eight weeks of leave, an employee may be protected for a longer period than eight weeks, unless the employer notifies the employee, in writing, of his/her termination if he/she is gone longer than the protected eight weeks.

Action Required

Employers in Massachusetts should update their Parental Leave policies to include male employees if they currently do not offer them parental leave. In addition, employers should ensure that employees have the ability to begin using parental leave after three months of full-time work. Employers should ensure that employee handbooks and leave policies reflect these above changes to the law.

For the complete details, see:

https://malegislature.gov/Bills/188/Senate/S865

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CALIFORNIA ISSUES EMERGENCY REGULATIONS ON NARROW PROVIDER NETWORKS

On February 2, 2015, the Department of Insurance in California issued emergency regulations to address a concern regarding carriers offering very narrow networks, which have delayed access to services, longer wait times, and the increased use of non-network providers.

Some believe that these regulations only affect policies/plans that are governed by the California Department of Insurance.

Some highlights are included below.

Provider Service Access and Adequacy

- There must be an adequate number of primary care physicians in a network that accepts new patients.
- The network must provide adequate mental health and substance use disorder treatment, which includes having a substance use disorder professional within 30 minutes or 15 miles of a member's residence or workplace.
- An adequate number of primary care providers and specialists with admitting and practice privileges must be made available in the network.
- An adequate number of network outpatient retail pharmacies and prescribed laboratory facilities that are in sufficient proximity to plan members.
- If medically appropriate care cannot be secured within the network, the carrier is required to arrange for required care with providers outside of the network. All of these services must be charged at in-network cost-sharing (e.g. co-pays, coinsurance, deductible, out-of-pocket maximums).
- The network must have some capacity for medically necessary organ, tissue, and stem cell transplant surgery.

Standards for Appointment Wait Times

- If a participant requests an appointment with an urgent care provider, an appointment must be made available within 48 hours (no prior authorization required) or 96 hours (prior authorization required).
- Non-urgent appointments for medical care must be provided within 10 days of the request for primary care or mental health care, or 15 days for specialists.
- Telephone support for plan participants must be made available 24 hours a day, 7 days a week. During normal business hours, wait times for participants to speak to a customer services agent cannot be greater than 10 minutes, or 30 minutes for the carrier to call back a participant.

In-Network Provider List Must be Accurate

- Carriers must update online network provider directors on a weekly basis, and must distribute paper copies of directories annually, and update them quarterly.
- The network provider directory must include the following pieces of information:
    - The name, location, and gender of the provider and specialty area(s)
    - Whether the provider is currently accepting new patients and whether a referral is necessary to see the provider
    - Languages spoken at the provider's office
    - List of network facilities where the provider has admitting privileges
    - Whether the provider is a primary care physician
    - Whether the office is ADA accessible

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CALIFORNIA ISSUES EMERGENCY REGULATIONS ON NARROW PROVIDER NETWORKS (CONTINUED)

Standards for Access to Pediatric Vision and Oral Care (Essential Health Benefits)

- For plans that include pediatric vision and oral care benefits as Essential Health Benefits, the provider network must have an adequate number of care providers that accept new enrollees.
- For urgent appointments with a pediatric vision or oral care provider, appointments must be made available within 72 hours of a request for the appointment. For non-urgent appointments, within 36 business days of the request.
- Preventative pediatric vision or oral care appointments must be made available within 40 business days of the request.

Reporting Requirement to the California Department of Insurance

- Beginning June 1, 2015, and annually thereafter, carriers will be required to report to the California Department of Insurance on the adequacy of their networks for all current and new health insurance plans issued by them.

No Action Required

Employers should be familiar with the above basic requirements for narrow network plans when choosing health plans to be offered to employees, to ensure that plans meet the above network standards/qualifications.

For the complete details, see:

http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/upload/nr012-NetworkAdequacyApproval.pdf

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Eugene, Oregon Releases Proposed Paid Sick Leave Rules

The city of Eugene, Oregon published its proposed rules that provide important details of its sick leave ordinance. The following are the details of the ordinance.

Covered Employers

The ordinance applies to **all** employers who have employees in Eugene, Oregon. Under the ordinance, if an employee does work in the city of Eugene, Oregon, the employee must accrue sick leave.

Eligible Employees

Any employee who does work in Eugene, Oregon.

Accrual of Paid Sick Leave

Employees would begin accruing sick leave beginning July 1, 2015, or date of hire, if their hire date occurs after July 1, 2015. Paid sick leave accrues at the rate of one hour of sick time for every 30 hours of work. An employee may acquire up to 40 hours per year (the definition of year to be determined by the employer), and employers are allowed to provide all 40 hours of paid sick leave at the beginning of the accrual year.

Use of Paid Sick Leave

Employees may begin using paid sick leave after 90 days of employment. Employees who are based **outside** of Eugene may not use accrued paid sick leave until they have worked at least 240 hours in Eugene, Oregon.

Employees may use paid sick leave for:

- The diagnosis, care, or treatment of the employee or the employee's family members,
- Time off related to domestic violence, harassment, sexual assault, or stalking,
- Time off necessitated by child care provider closures; and,
- Absences which are caused by the need for displacement from the workplace for health reasons.

Carryovers of Unused Paid Sick Leave Time

Employers must allow employees to carryover up to 40 hours of unused paid sick leave time to the following year. Although it is possible that an employee could accumulate more than 40 hours of paid sick leave time in a year, an employer need not let an employee use more than 40 hours of paid sick leave time in any given year.

An employer who offers employees all 40 hours of paid sick leave at the beginning of each year (rather than accumulation of sick time over the year), need not allow any carryover of paid sick leave time.

Paid sick leave time need **not** be paid out to an employee upon termination.

Current Leave Policies

Employers need not modify current PTO policies that meet or exceed the ordinance's prescribed sick leave time.

Action Required

Although this ordinance only contains proposed rules, most likely these rules will be adopted in their entirety, so employers should begin considering how to offer paid sick leave under the ordinance if they currently are not meeting those requirements.

For the complete details, see:

http://www.eugene-or.gov/sickleave

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QUESTION OF THE MONTH

Q: Can health insurance coverage that supplements group health coverage by providing additional categories of benefits, be characterized as supplemental excepted benefits?

A: It depends. The Departments' prior guidance provided an enforcement safe harbor for supplemental insurance products that are specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. In determining whether insurance coverage sold as a supplement to group health coverage can be considered "similar supplemental coverage" and an excepted benefit, the Departments will continue to apply the applicable regulations and the four criteria indicated in the guidance referenced above. In addition, the Departments intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing under the primary plan are considered to be specifically designed to fill gaps in primary coverage. Specifically, the Departments intend to propose that coverage of additional categories of coverage would be considered to be designed to "fill in the gaps" of the primary coverage only if the benefits covered by the supplemental insurance product are not an essential health benefit (EHB) in the State where it is being marketed. If any benefit in the coverage is an EHB in the State where it is marketed, the insurance coverage would not be an excepted benefit under our intended proposed regulations.

We note that this standard applies to coverage that purports to qualify as an excepted benefit as "similar supplemental coverage provided to coverage under a group health plan" under the PHS Act. This standard does not apply to other circumstances where the coverage may qualify as another category of excepted benefits, such as limited excepted benefits.

Pending publication and finalization of the above proposed regulations, the Departments will not initiate an enforcement action if an issuer of group or individual health insurance coverage fails to comply with the provisions of the PHS Act, ERISA, and the Code, as amended by the Affordable Care Act, with respect to health insurance coverage that (1) provides coverage of additional categories of benefits that are not EHB in the applicable State (as opposed to filling in cost-sharing gaps under the primary plan); (2) complies with the applicable regulatory requirements and meets all of the criteria in the existing guidance on "similar supplemental coverage"; and (3) has been filed and approved with the State (as may be required under State law). As noted above, for purpose of the second criterion of the existing guidance, coverage would be considered designed to "fill gaps in primary coverage" even if it does not include coverage of cost-sharing under the group health plan, only if the benefits are not covered by the group health plan and are not EHBs in the State. The Departments encourage States that have primary enforcement authority over the provisions of the PHS Act, as amended by the Affordable Care Act, to utilize the same enforcement discretion under such circumstances.

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