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IRS REITERATES SOME PREMIUM REIMBURSEMENTS PROHIBITED BUT OFFERS RELIEF FOR SMALL GROUPS

On February 18, 2015, the Internal Revenue Service (IRS) released Notice 2015-17, reiterating the prohibition of employer premium reimbursement used to assist employees purchasing individual health insurance coverage. While the prohibition applies to all employers, of any size, this latest guidance provides temporary transitional relief from penalty for small employers (defined as employers with fewer than 50 Full-Time or Full-Time Equivalent "FT/FTE" employees, using the preceding year or any consecutive six-month period in the preceding year to determine the number of employees).

The Notice specifically addressed whether employers can use Health Reimbursement Arrangements (HRA) or some other form of employer premium payment plans to pay for or reimburse employees for individual market coverage (including Medicare and TRICARE). The IRS finds that these "employer payment plans" are group health plans that must comply with the Affordable Care Act's (ACA) market reforms (meaning, importantly, that they must cover at least preventive care and may not have annual dollar limits). Employers could be subjected to a fine of $100 per employee per day if offering such arrangements. Other highlights from the Notice can be found below.

Transition Relief for Small Employers

- Small employers are those that had 50 or fewer employees or full-time employees in 2014
- No penalty for premium payment arrangements provided in the 2014 calendar year
- Small employers have until June 30, 2015 to cease offering such arrangements, or be subject to the penalty

Internal Revenue Code Subchapter S Corporations ("S-corp")

- Employers reimbursing S-corp employees who are also 2-percent shareholders are provided transition relief from penalty, until further guidance is issued on this subject
- Employers may pay for directly, or reimburse, individual market premiums for employees who are also 2-percent shareholders (i.e., owns at least 2-percent of the corporation)
- Payment for premiums is imputed and taxed as income
- The 2-percent shareholder may deduct the premiums on their individual taxes
- The 2-percent shareholder may still be eligible for premium tax credits through the Exchange marketplace (if meeting all requirements). Therefore, employers should be aware of whether this arrangement could subject them to ACA employer mandate penalties

IRS Reiterates Some Premium Reimbursements Prohibited but Offers Relief for Small Groups (continued)

- An S-corp cannot use a premium payment arrangement for employees who are not also 2-percent shareholders

Medicare Part B or D & TRICARE Premiums

- Employers may reimburse Medicare Part B or D premiums for active employees (barring other prohibitions) if:
  - The employer offers a group health plan not consisting solely of HIPAA-excepted benefits and provides ACA minimum value
  - The employee is actually enrolled in Medicare Parts A and B
  - The reimbursement plan is available only to employees enrolled in Medicare Part A, B or D
  - The reimbursement plan is limited to reimbursement of Medicare Part B or D premiums and HIPAA-excepted benefits, including Medigap premiums
  - To the extent such an arrangement is available to active employees, not just retirees, these arrangements are still potentially subject to other legal requirements, such as the Medicare Secondary Payment Statute, which prohibits incentivizing employees to take Medicare over an employer plan
- Employers may directly pay Medicare Part B or D premiums for retired employees in retiree-only plans (retiree-only plans are not subject to the ACA market reforms)
- Employers may reimburse the medical expenses of TRICARE enrollees through an HRA or other premium payment arrangement
- Employers may offer more than one type of reimbursement or payment plan arrangement for its employees provided each meet applicable integration requirements or other rules

Action Required for Some Employers

Small employers offering employees reimbursements for their individual health insurance premiums should be working towards a June 30, 2015 deadline to cease doing so. An HRA integrated with an ACA-compliant group health plan that is still permitted so long as not reimbursing individual market premiums.

The Notice specifically states that employers may increase an employee's taxable wages in lieu of offering health insurance as long as the money is not specifically designated for premiums. If the pays or reimburses premiums specified in any way, even if using after-tax monies, this would be considered a prohibited premium payment plan subject to penalty. Therefore, employers should be clear to not directly offer to or in fact blatantly reimburse employees for individual market premiums, except for those permitted exceptions list above.

For IRS Notice 2015-17, see: http://www.irs.gov/pub/irs-drop/n-15-17.pdf

PHILADELPHIA ENACTS PAID SICK LEAVE LAW

On February 12, 2015, the Philadelphia City Council passed and the Mayor signed, the "Promoting Healthy Families and Workplaces Ordinance", making Philadelphia the latest region mandating sick leave (following California, Connecticut, Massachusetts, Seattle, Portland, Eugene, San Francisco, Oakland, Jersey City, Newark, the District of Columbia and New York City). Highlights are as follows.

- Covered employers are those with 10 or more employees, counting all employees, including part-time, and temporary employees
  - Regardless of the number of employees, "chain establishments" are required to provide paid sick leave
    - Includes those with at least 15 establishments doing business under the same trade name, regardless of location and ownership type
- Employers with fewer than 10 employees are required to provide unpaid sick leave
- Covered employees are those that work within the City at least 40 hours each year
  - Excludes independent contractors, seasonal workers, temporary workers working for less than six months, adjunct professors, interns in educational institutions, certain healthcare professionals working based on availability, state and federal employees and employees covered under a bona fide collective bargaining agreement
  - Full-time and part-time employees who work within the City limits for at least 40 hours a year are eligible to receive sick leave
- Employees are eligible to accrue sick time beginning May 13, 2015
- Sick time accrues at a rate of one hour for every 40 hours worked within the City, capped at 40 hours per calendar year
- Employees working for employers with fewer than 10 employees are eligible for the same accrual rate, but the sick time need not be paid
- Employees are eligible to use sick leave 90 days after the accrual begins
- Unused time must be carried over unless the employer provides 40 hours of sick leave at the start of every calendar year
- Employers are not required to pay unused sick time upon termination
- Employees may use sick leave for self or family member[1] diagnosis, care or treatment of health condition, preventative care, issues related to being a victim of domestic violence, sexual assault or stalking
- Employers may require that paid sick leave be used in "reasonable minimum" increments of an hour or any smaller increment used by the employer to account for absences
- Sick leave must be provided upon an employee's oral or written request
- Employees must provide "reasonable advance notification" if the need to use sick leave is foreseeable
- Employers may only request that employees provide reasonable documentation that the paid sick time has been used for a purpose covered by the Ordinance after the employee has used sick leave for more than two consecutive days
- Employers must provide written notice of an employee's entitlement to sick leave or post a sign (to be prepared by the City) visible to all employees as well as maintain records documenting hours worked and sick time taken

[1] "Family member" is defined under the ordinance to include a: biological, adopted or foster child, stepchild or legal ward or a child to whom the employee stands in loco parentis; biological, foster, stepparent or adoptive parent or legal guardian of an employee or an employee's spouse or a person who stood in loco parentis when the employee was a minor child; person to whom the employee is legally married under state law; grandparent or spouse of a grandparent; grandchild; biological, foster, or adopted sibling or spouse of a biological, foster or adopted sibling; and Life Partner (as defined in another section of the Philadelphia Code). This definition is much broader than the definition of "family member" under the federal Family and Medical Leave Act.

Philadelphia Enacts Paid Sick Leave Law (continued)

Action Required

Employers with employees in Philadelphia should ensure compliance with this new law. Employers that already provide up to 40 hours of paid leave per year, including vacation, floating holidays, personal days, parental leave or Paid Time Off (PTO), are not required to provide additional leave in order to comply with this new law.

For the complete details, see: https://phila.legistar.com/LegislationDetail.aspx?ID=2101250&GUID=5D12D54D-B1A7-4446-B646-95BE528F771C

DOL FINALIZES RULE ON DEFINITION OF SPOUSE FOR FMLA PURPOSES

The Department of Labor (DOL) has issued final rules defining "spouse" for purposes of the Family Medical Leave Act (FMLA). Effective March 27, 2015, the determination of spouse under FMLA will be based on the marriage's "place of celebration", rather than the employee's "state of residence." The place of celebration rule will provide all legally married couples (based on the laws of the state in which the marriage was performed) the same FMLA rights, regardless of where they reside. The final rule, which is unchanged from the previously reported proposed rule, specifically includes individuals in lawfully recognized same-sex and common-law marriages, including those validly entered into outside of the United States so long as they could have been entered into in at least one state.

No Action Required

Employers should have already been complying with this rule following the release of the proposed rule last year.

For the complete details, see:

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2015-02-25/pdf/2015-03569.pdf
FAQs: http://www.dol.gov/whd/fmla/spouse/faq.htm
Fact Sheet: http://www.dol.gov/whd/fmla/spouse/factsheet.htm
Press Release: http://www.dol.gov/whd/media/press/whdpressVB3.asp?pressdoc=national/20150223.xml

In related news, the Office of Management and Budget (OMB) extended the expiration date for the FMLA forms by 30 days to March 31, 2015. If new forms are not released by this date, employers may continue to use the old forms even after the expiration date and until further notice. The DOL's forms–with the March 31, 2015 expiration date–can be accessed here: http://www.dol.gov/whd/forms/wh385V.pdf

HHS RELEASES REINSURANCE PARAMETERS FOR 2016

The Department of Health and Human Services (HHS) recently released the Notice of Benefit and Payment Parameters for 2016, finalizing proposed regulations released this past November (for details, see the *Barney & Barney December 2014 Legislative Compliance Newsletter*). The final regulations clarified that the self-only annual limitation on cost-sharing applies to each individual, regardless of whether the individual is enrolled in a self-only or other-than-self-only plan. No other major clarifications or changes were contained in the final regulations from the proposed regulations. Highlights of the parameters for 2016 are as follows.

Reinsurance Contributions

- Annual contribution amount per enrollee in 2016: $27 per enrollee for 2016 (compared to $44 per enrollee for 2015)
- Applies to all health insurers and self-insured group health plans (regardless of size) providing major medical coverage

Cost-sharing Parameters

- Maximum annual limits on cost-sharing for 2016 will be $6,850 for self-only coverage and $13,700 for other-than-self-only coverage (compared to $6,600 and $13,200, respectively, for 2015)

Minimum Value

- Applicable large group employers subject to ACA must not only meet the quantitative minimum value threshold of 60%, but must also provide a benefits plan that includes inpatient and hospitalization services, as well as physician services

Action Required

Employers offering self-funded plans, excluding HIPAA-excepted benefits, indemnity plans, Flexible Spending Accounts (FSA), Health Reimbursement Arrangements (HRA) integrated with ACA-compliant major medical plans, Health Savings Accounts (HSA), and Employee Assistance Programs (EAP) not offering major medical coverage, should ensure they are prepared for the changes in contributions required in 2016. Important deadlines include: November 15 – plan enrollee counts due to HHS; December 15 – HHS will invoice plans; and, January 15 –payment is due to HHS (if using installments, the second payment is due November 15).

Employers should also ensure their plans meet all minimum value qualitative and quantitative requirements, as well as maximum cost-sharing limitations for 2016.

For the complete details, see:

Notice of Benefits and Parameters for 2016, go to: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

Fact Sheet: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf

Cost-sharing FAQs: https://www.regtap.info/uploads/library/FamilyofoneMOOPPolicyFAQ_5CR_031015.pdf

IRS ISSUES NOTICE INTENDED TO "INITIATE AND INFORM" THE PROCESS FOR DEVELOPMENT OF REGULATIONS FOR THE ACA CADILLAC TAX

The Internal Revenue Service (IRS) recently released Notice 2015-16 "intended to initiate and inform the process of developing regulatory guidance regarding the excise tax on high-cost employer-sponsored health coverage" (a.k.a., the Cadillac Tax). Beginning in 2018, plans may be subject to a 40% excise tax for amounts above the threshold limit (for 2018 the limits are $10,200 for self-only coverage and $27,500 for other-than-self-only coverage. After 2018, limits will be adjusted subject to Cost of Living Adjustments (COLA)) for the aggregated cost of applicable employer-sponsored plan. The Notice is not binding or law, but rather solicits comment on possible implementation approaches to various issues, such as: defining applicable coverage, determining the cost of applicable coverage, and applying the annual dollar limit to the cost. Additional IRS Notices will be issued addressing other relevant matters related to the Cadillac Tax provisions, including procedural issues for calculation and assessment of the tax. Highlights of the Notice are as follows.

Applicable Coverage

- Types of plans specified under Internal Revenue Code § 4980I (the Code) as applicable coverage:
  - Health Flexible Spending Accounts (FSA)
    - The Notice confirms that the cost of applicable coverage for health FSAs equals the sum of salary reduction contributions and any reimbursements under the arrangement in excess of the salary reduction contributions, such as employer flex credits
  - Health Savings Accounts (HSA)
  - Governmental plans
  - Retiree coverage
  - On-site medical clinics
- Types of plans, under the Code, specifically excluded from applicable coverage:
  - Long-term care plans
  - Stand-alone dental or vision plans
  - Fixed indemnity plans
- Implementation rules being considered:
  - Employer HSA and Archer Medical Savings Account (MSA) contributions (including salary reduction HSA contributions) may be considered applicable coverage
    - Employee after-tax contributions would be excluded
  - On-site clinics providing only de minimis medical care may be excluded
  - Employee Assistance Programs (EAP) may be excluded
  - Limited-scope dental or vision benefits (whether insured or self-insured) that are HIPAA-excepted benefits may be excluded

Cost of Applicable Coverage

- Excise tax is determined based on the cost of applicable coverage in which the employee is actually enrolled
- Determined under rules similar to those for determining the COBRA applicable premium
- Costs are calculated separately for "self-only" coverage and "other-than-self-only" coverage
- Special rules apply for retiree coverage, health FSAs, HSAs, and Archer MSAs
- Health Reimbursement Arrangements (HRA) used in determining the cost of applicable coverage based on amounts made newly available each year, without regard to carryover amounts may:
  - Permit employers to determine the cost of coverage by adding all HRA claims and administrative expenses for a particular period (separately for each coverage level, such as self-only or family) and dividing that sum by the number of covered employees (for the period and coverage level); or,
  - Permit or require employers to use the actuarial basis method to determine an HRA's cost of coverage

IRS Issues Notice Intended to "Initiate and Inform" the Process for Development of Regulations for the ACA Cadillac Tax (continued)

No Action Required

Employers offering plans that may potentially be subject to a Cadillac Tax in 2018, should prepare by anticipating the increase in costs due to the penalty, or consider revising their plan offerings. This guidance, although not binding or law, is helpful in anticipating how the IRS will apply this rule through forthcoming regulations.

Barney & Barney will issue more in-depth guidance in the future on this recent information, as well as any new legislation or regulatory guidance issued in the future.

For the complete details, see: http://www.irs.gov/pub/irs-drop/n-15-16.pdf

QUESTION OF THE MONTH

Q: One of our DCAP participants has asked to be reimbursed for an application fee paid to a day-care center. Can our DCAP reimburse application fees, deposits, and similar expenses?

A: Under IRS regulations, expenses such as application fees and deposits that are not directly for care may qualify for reimbursement from a DCAP if the employee is required to pay the expenses in order to obtain related care. To be reimbursable, these "indirect" expenses must otherwise meet the requirements for reimbursement under the DCAP rules and the plan document, and the care to which they relate must be provided. Consequently, these expenses will not be reimbursable if the care they relate to is not ultimately received. For example, assume that a DCAP participant is planning to switch day-care providers for her infant child in three months and must pay a $100 application fee in order for the child to obtain care from the new provider. The application fee is considered to be for care and can be reimbursed by your company's DCAP, but not before the related care is provided to the participant's child. Now assume that a DCAP participant pays a $100 deposit to a preschool in May to reserve a place for the participant's child in the fall. However, the participant later decides not to enroll the child in the preschool, makes other day-care arrangements, and forfeits the $100 deposit. Because the preschool did not provide care to the participant's child, the deposit is not an employment-related expense and will not qualify for reimbursement from your company's DCAP.

The regulations do not indicate whether indirect expenses can be reimbursed in full as soon as the care commences or must be reimbursed proportionately over the duration of the agreement with the provider. Absent IRS guidance, the more cautious approach is to provide reimbursement over the agreement's duration. For example, if a participant has a month-to-month agreement with a provider, it might be acceptable to reimburse the entire fee after the first month of related care has been provided. But if the agreement has a longer duration, then the fee would be prorated. Although not official guidance, the federal government's flexible spending plan takes this approach with certain fees (e.g., up-front au pair fees are reimbursed proportionately over the duration of the agreement with the au pair).

Source: Thomson/Reuters