BARNEY&BARNEY™
Legislative Compliance

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA Western Edition
June 2015 | Issue 6

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FAQs RELEASED ON 1094/95-C REPORTING

The Internal Revenue Service (IRS) recently released Frequently Asked Questions (FAQ) about the employer information reporting on Forms 1094-C and 1095-C. Highlights of the IRS FAQs are below.

Background

Employers subject to section 4980H of the Internal Revenue Code (Code), generally meaning employers with 50 or more full-time employees (including full-time equivalent employees) in the preceding calendar year, are required to use Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, and Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, to report the information required under Code sections 6055 and 6056 about offers of health coverage and enrollment in health coverage for their employees. Form 1094-C must be used to report to the IRS summary information for each employer and to transmit Forms 1095-C to the IRS. Form 1095-C is used to report information about each employee. The information reported on Form 1094-C and Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee for the premium tax credit.

Employers that offer employer-sponsored self-insured coverage also use Form 1095-C to report information to the IRS and to employees about individuals who have minimum essential coverage under the employer plan and therefore have met the individual shared responsibility requirement for the months that they are covered under the plan.

Highlights of the FAQs

What forms must an Applicable Large Employer (ALE) member file with the IRS to report the required information under sections 6055 and 6056?

The section 6056 regulations provide, under the general method of reporting, that an ALE member must file a separate Form 1095-C (or a substitute form) for each of its full-time employees, and a transmittal on Form 1094-C (or a substitute form) for all of the returns filed for a given calendar year. These forms must be filed regardless of whether the ALE member offers coverage, or the employee enrolls in any coverage offered. A more complete discussion of the information that must be reported to the IRS (including simplified methods of reporting) can be found in the final section 6056 regulations, in the final section 6055 regulations, and in the instructions to Form 1094-C and Form 1095-C.

FAQs Released on 1094/95-C Reporting (continued)

The section 6056 return (and, if the employer maintains a self-insured plan, the section 6055 return) also may be made by filing a substitute form, but the substitute form must include all of the information required on Form 1094-C and Form 1095-C and satisfy all form and content requirements as specified by the IRS.

For which employees must an ALE member file Form 1095-C?

Generally, an ALE member must file Form 1095-C (or a substitute form) for each employee who was a full-time employee of the ALE member for any month of the calendar year. (See below for exceptions.) For guidance on how to determine who is a full-time employee, see section 4980H Questions and Answers.

In addition, an ALE member that sponsors a self-insured plan must file Form 1095-C for each employee who enrolls in the self-insured health coverage or enrolls a family member in the coverage, regardless of whether the employee is a full-time employee for any month of the calendar year.

What information must an ALE member furnish to its full-time employees?

An ALE member must furnish to each full-time employee a completed Form 1095-C (or a substitute form). This form must be furnished regardless of whether the ALE member offers coverage, or the employee enrolls in any coverage offered. An ALE member is not required to furnish to its full-time employees a copy of Form 1094-C as filed with the IRS.

A substitute form must include the information on Form 1095-C and must comply with generally applicable requirements for substitute forms. See FAQ on page three of this newsletter and original FAQs for further information about simplified employee statements that may be used under the Qualifying Offer reporting method.

For which employees is an ALE member not required to file a Form 1095-C?

Form 1095-C is not required for the following employees (unless the employee or the employee's family member was enrolled in a self-insured plan sponsored by an ALE member):

- An employee who was not a full-time employee in any month of the year
- An employee who was in a limited non-assessment period for all 12 months of the year (for example, a new variable hour employee still in an initial measurement period). See the definition of Limited Non-Assessment Period in the instructions to Form 1095-C for more details

Which ALE members should complete Part III of Form 1095-C?

An ALE member that sponsors a self-insured health plan should complete Part III of Form 1095-C for employees and family members who enroll in the self-insured coverage.

If an ALE member sponsors a health plan that includes self-insured options and insured options, the ALE member should complete Part III of Form 1095-C only for employees and family members who enroll in a self-insured option.

An ALE member that offers coverage through an employer-sponsored insured health plan (and does not sponsor a self-insured health plan) should **NOT** complete Part III. Instead, information about coverage will be furnished to employees on Form 1095-B, which is filed by the insurance provider.

FAQs Released on 1094/95-C Reporting (continued)

How does an ALE member complete its authoritative transmittal Form 1094-C and Form 1095-C if the ALE member is eligible to use the Qualifying Offer method?

If an ALE member has made a Qualifying Offer for all 12 months of the year to one or more full-time employees (and the employee did not enroll in self-insured coverage), the ALE member may use an alternate reporting method for those employees who received a Qualifying Offer for all 12 months of the year. A Qualifying Offer is an offer that satisfies all of the following criteria:

- An offer of minimum essential coverage that provides minimum value
- The employee cost for employee-only coverage for each month does not exceed 9.5 percent of the mainland single federal poverty line divided by 12
- An offer of minimum essential coverage is also made to the employee's spouse and dependents (if any)

On Form 1094-C, Line 22 Certifications of Eligibility, the ALE member should check box A, Qualifying Offer Method. On Form 1095-C, line 14, the ALE member should enter code 1A, Qualifying Offer, for each employee receiving a Qualifying Offer for all 12 months of the year. When an employee receives a Qualifying Offer, no entry is required in line 15, Employee share of Lowest Cost Monthly Premium for Self-Only Minimum Value Coverage.

The Form 1095-C must be filed with the IRS; however, as an alternative to furnishing the employee with a copy of Form 1095-C filed with the IRS, the employer may furnish a statement containing certain information and stating that because the employee received a Qualifying Offer for all 12 months of the year, the employee is not eligible for the premium tax credit. This alternative may not be used by an employer that sponsors a self-insured plan with respect to any employee who has enrolled in the coverage under the plan because the employer is required to report that coverage on Form 1095-C. In that case the employer must furnish a copy of the Form 1095-C as filed with the IRS which will include enrollment in coverage information (Part III) as well as offer of coverage information (Part II).

For additional details on the reporting rules for a Qualifying Offer, including the contents of the alternative statement, see section 6056 regulations and the instructions for Forms 1094-C and 1095-C.

Action Required

Applicable large employers and small, self-funded employer/plan sponsors should familiarize themselves with the reporting requirements that will apply to them for their 2015 plan year. These FAQs provide additional information that may be helpful when completing Form 1094-C and Form 1095-C. For general details about the reporting requirements under section 6056, including guidance on who is an ALE member, see section 4980H Questions and Answers and section 6056 Questions and Answers. For additional details about reporting requirements applicable to sponsors of self-insured health plans under section 6055, see Questions and Answers on Information Reporting by Health Coverage Providers.

For complete details on these recent FAQs, see: http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Employer-Information-Reporting-on-Form-1094-C-and-Form-1095-C

For more information on resources for electronic filing of the Form 1094/95 returns, see:
http://www.irs.gov/PUP/for_taxpros/software_developers/information_returns/Draft_%20Publication_%205164.pdf ; and,
http://www.irs.gov/PUP/for_taxpros/software_developers/information_returns/Draft_Pub_5165_04_2015.pdf

CITY OF EMERYVILLE ENACTS PAID SICK LEAVE LAW

On June 2, 2015, the Emeryville City Council approved not only a minimum wage increase, but a paid sick leave law similar to the San Francisco and Oakland paid sick leave laws. Effective July 1, 2015, employees who work at least two hours (in a calendar week) within the city will be eligible to accrue paid sick leave. Highlights are below.

Accrual of Paid Sick Leave

- For employees of small businesses, there shall be a cap of 48 hours of accrued paid sick leave
- For employees of all other employers, there shall be a cap of 72 hours of accrued paid sick leave
- Accrued paid sick leave for employees carries over from year to year (whether calendar year or fiscal year), but is limited to the aforementioned caps. Nothing herein precludes an employer from establishing a higher cap or no cap on the number of accrued hours

Use of Paid Sick Leave

- For an employee's own illness or injury or for the purpose of receiving medical care, treatment, or diagnosis
- To aid or care for a family member of employee when the family member or members is or are ill or injured or receiving medical care, treatment, or diagnosis
    - If the employee has no spouse or registered domestic partner, the employee may designate one person as to whom the employee may use paid sick leave to aid or care for that person in lieu of a spouse or registered domestic partner
        - The employee may use all or any percentage of his or her paid sick leave to aid or care for the aforementioned persons
        - The opportunity to make such a designation shall be extended by the employer to the employee no later than 30 calendar days after the date on which the employee begins to accrue paid sick leave
        - There shall be a window of 14 calendar days for the employee to make this designation after notice from the employer has been provided
        - Thereafter, the opportunity to make such a designation, including the opportunity to change such a designation previously made, shall be extended by the employer to the employee on an annual basis by January 31st of each year, with a window of 14 calendar days for the employee to make the designation after notice from the employer has been provided
- An employee may use paid sick leave to aid or care for a guide dog, signal dog, or service dog

Notice and Posting

- Each employer shall give written notification to each current employee and to each new employee at time of hire, of his or her rights
- The notification shall be in English and other languages as provided in any implementing regulations, and shall also be posted prominently in areas at the work site where it will be seen by all employees
- Every employer shall also provide each employee at the time of hire with the employer's name, address, and telephone number in writing

City of Emeryville Enacts Paid Sick Leave Law (continued)

Action Required for Some Employers

Employers with employees in Emeryville, CA should familiarize themselves with this new mandate. Additional regulations are expected to clarify how to determine if your company is subject to the new law.

For complete details, see http://www.ci.emeryville.ca.us/DocumentCenter/Home/View/7971

UPDATED FMLA FORMS RELEASED

The Department of Labor (DOL) recently released updated forms for employers subject to the Family Medical Leave Act (FMLA). The new forms replace the forms that expired this past February and include reference to the Genetic Information Nondiscrimination Act (GINA). GINA was enacted in 2008 and prohibits employers from requesting or requiring disclosure of genetic information of an employee or family member. Included in GINA is a safe harbor rule that releases employers from liability if they include the following language in any request for medical information about the employee:

> *The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

The new DOL forms do not include the full safe harbor language. Employers should consider modifying these forms before using them in order to ensure complete protection from liability.

Action Required

Employers subject to FMLA should ensure they are using the latest forms.

For complete details, see: http://www.dol.gov/whd/fmla/2013rule/militaryForms.htm

HHS RELEASES FURTHER CLARIFICATION ON MAXIMUM OUT-OF-POCKET LIMITS

Background

In February of 2015, the Department of Health and Human Services (HHS) released its 2016 Notice of Benefit and Payment Parameters. The majority of this Notice focused on the Marketplaces (i.e., Exchanges), but some guidance within the Notice also related to issues that affect employer-sponsored plans, such as Out-of-Pocket Maximum Limits (OOP Maximums). Specifically, HHS mentioned in the preamble that OOP Maximums would increase in 2016 to $6,850 for self-only coverage, and $13,700 for other than self-only coverage. In addition, HHS stated that the individual OOP Maximum would apply to all individuals, regardless of whether that individual was participating in self-only coverage or other than self-only coverage (e.g., family coverage).

Highlights of the FAQs

On May 26, 2015, the Department of Treasury, along with HHS (the Departments), issued Frequently Asked Questions (FAQ), clarifying the 2016 Notice of Benefit and Payment Parameters, in addition to previously released FAQs. The following clarifications were made to the OOP Maximums rules.

- The self-only OOP Maximum will apply to all tiers of coverage (self-only and other than self-only coverage)
- The self-only OOP Maximum rule will apply to all non-grandfathered group health plans, including self-funded plans as well as large group health plans
- In 2016, this will mean that an individual will have a $6,850 OOP Maximum, even if that individual participated in family coverage that included a total OOP Maximum of $13,700

An example was also included in the FAQs. It explains how the OOP Maximum will apply to an individual participating in family coverage. The example included is the following:

- Mother participating in family coverage incurs claims associated with $10,000 in cost sharing
- Father, son, and daughter **each** incur claims associated with $3,000 in cost sharing (totaling $9,000)
- The new OOP Maximum rule will require that the Mother's cost sharing limit be capped at $6,850, meaning the plan would pay the Mother's remaining $3,150 of cost sharing ($10,000 - $6,850 = $3,150)
- In addition, the plan will pay another $2,850. This is calculated by the total amount of claims incurred by the family of $15,850 (Mother's claim of $6,850 + Father, son, and daughter incurring claims of $9,000 = $15,850), minus the OOP Maximum for family coverage of $13,000, which equals $2,850 ($15,850 - $13,000 = $2,850)

High Deductible Health Plans and OOP Maximums

Employers and employees should be cautious if employees are participating in a High Deductible Health Plan (HDHP), as there is a minimum deductible required for family HDHP coverage, if contributions are to be made to an HSA. In addition, now the individual embedded deductible should not exceed the OOP Maximum limit for self-only coverage of $6,850 for 2016.

HHS Releases Further Clarification on Maximum Out-of-Pocket Limits (continued)

Action Required

Employers should ensure that their health plans are compliant with the new legislation beginning with their 2016 plan year. The new FAQs affirm that the self-only annual limit will apply to each covered individual, regardless of whether the coverage is self-only coverage, under all non-grandfathered group health plans, including self-insured plans, large group health plans, and plans that are HDHP. In addition, employers with HDHPs should be cautious about the potential impact this may have on deductible limits. If you have any questions regarding whether your insurance provider is in compliance with this new regulation regarding Out-of-Pocket Maximums, please feel free to reach out to your Barney & Barney team member.

For the complete details, see: http://www.dol.gov/ebsa/pdf/faq-aca27.pdf

FAQs RELEASED ON ACA PREVENTIVE CARE MANDATE

On May 11, 2015, the Departments of Labor, Health and Human Services and Treasury (the Departments) released additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act (ACA). The FAQs highlighted below answer questions that relate to the ACA's preventive services requirement (i.e., cost sharing requirements for recommended genetic counseling and BRCA genetic testing, and coverage of certain forms of contraception and contraceptive methods).

Highlights of the FAQs

Must a plan or issuer cover without cost sharing recommended genetic counseling and BRCA genetic testing for a woman who has not been diagnosed with BRCA-related cancer but who previously had breast cancer, ovarian cancer, or other cancer?

Yes. The USPSTF recommends that "primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing." The USPSTF's Final Recommendation Statement related to BRCA testing indicates that the recommendation "applies to asymptomatic women who have not been diagnosed with BRCA-related cancer." Therefore, as set out in the recommendations described above, as long as the woman has not been diagnosed with BRCA-related cancer, a plan or issuer must cover preventive screening, genetic counseling, and genetic testing without cost sharing, if appropriate, for a woman as determined by her attending provider, consistent with PHS Act section 2713 and its implementing regulations.

FAQs Released on ACA Preventive Care Mandate (continued)

Highlights of the FAQs (continued)

If a plan or issuer covers some forms of oral contraceptives, some types of IUDs, and some types of diaphragms without cost sharing, but excludes completely other forms of contraception, will the plan or issuer comply with PHS Act section 2713 and its implementing regulations?

No. Plans and issuers must cover without cost sharing the full range of Food and Drug Administration-identified methods. Thus, plans and issuers must cover without cost sharing at least one form of contraception in each method that is identified by the FDA. The FDA currently has identified 18 distinct methods of contraception for women. A plan or issuer generally may use reasonable medical management techniques and impose cost sharing (including full cost sharing) to encourage an individual patient to use specific services or FDA-approved items within the chosen contraceptive method. If utilizing reasonable medical management techniques, plans and issuers must have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the individual (or a provider or other individual acting as a patient's authorized representative) to ensure coverage without cost sharing of any service or FDA-approved item within the specified method of contraception as described in the FAQ below. In this example, even though the plan provides coverage in multiple methods, the plan's exclusion of some of the methods for women currently identified by the FDA means the plan fails to comply with PHS Act section 2713 and its implementing regulations

If multiple services and FDA-approved items within a contraceptive method are medically appropriate for an individual patient, what is a plan or issuer required to cover without cost sharing?

If multiple services and FDA-approved items within a contraceptive method are medically appropriate for an individual, the plan or issuer may use reasonable medical management techniques to determine which specific products to cover without cost sharing with respect to that individual. However, if the individual's attending provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the plan or issuer must cover that service or item without cost sharing. The plan or issuer must defer to the determination of the attending provider with respect to the individual involved. As previously stated, the plan or issuer must cover at least one service or item within each of the methods (currently 18) identified by the FDA for women.

Action Required

Employers should ensure that their health plans are compliant with the new FAQs.

For the complete details, see: http://www.dol.gov/ebsa/faqs/faq-aca26.html

Compliance Reminder: PCORI Fee due July 31st

The Patient-Centered Outcomes Research Institute (PCORI) fee is a temporary fee established under the Affordable Care Act (ACA) and levied on issuers of health insurance policies and plan sponsors of applicable self-insured group health plans. Insurers calculate and pay the fee for insured plans, and plan sponsors calculate and pay the fee for self-insured plans. The PCORI fee is a variable fee that is based on the average number of covered individuals under an applicable health plan during the plan year. Covered lives include employees, spouses, dependents and COBRA participants.

Calculating the Fee. Plan sponsors of self-funded plans may choose one of three counting methods when determining the number of covered lives under their plan: the Actual Count Method, the Snapshot Method and the 5500 Method.

Note: When calculating the fee, plan sponsors should keep in mind the following:

- PCORI fees will not apply to plans that provide only excepted benefits
- Contributory health FSAs may be considered "Excepted Benefits"
- Special counting allowance when plan sponsor offers two self-funded plans with the same plan year
- Organizations that maintain a multiple or multi-employer plan will be responsible for payment and reporting

More details regarding the above can be found on the IRS website by viewing the Application of the PCORI Fee to Common Types of Health Coverage or Arrangements Table and FAQs

	Plan Year	Applicable Rate
File Return No Later Than July 31, 2015	February/2013 – January/2014 March/2013 – February/2014 April/2013 – March/2014 May/2013 – April/2014 June/2013 – May/2014 July/2013 – June/2014 August/2013 – July/2014 September/2013 – August/2014 October/2013 – September/2014	$2.00
	November/2013 – October/2014 December/2013 – November/2014	$2.08
	January/2014 – December/2014	$2.08

Payment of the Fee. Plan sponsors must report the PCORI fee on Form 720. Plan sponsors who are required to pay the PCORI fee but are not required to report any other liabilities on the Form 720 will be required to file only once a year. Plan sponsors who are required to pay the PCORI fee as well as other liabilities on a Form 720 will use their second quarter Form 720 to report and pay the PCORI fee that is due July 31. A failure to designate properly "2nd Quarter" on the Form 720 Payment Voucher will result in the IRS's software generating a "tardy filing notice".

Since the PCORI fee is a tax assessed against the plan sponsor, the fee may not be paid out of plan assets (i.e., employee benefit trust). The IRS issued an internal memorandum in 2013 indicating that health insurance issuers and plan sponsors may generally deduct the required PCORI fee as an ordinary and necessary business expense paid or incurred in carrying on a trade or business.

The Form 720 may be filed by mail, electronically or by private delivery services as described in the instructions to the Form.

Compliance Reminder: PCORI Fee due July 31st (continued)

Action Required. Self-funded plan sponsors should ensure reporting and fee remittance of Form 720 for PCOR fees by July 31, 2015 for their applicable plan year.

QUESTION OF THE MONTH

Q: Our organization paid reinsurance contributions for our self-insured health plan for 2014. We understand there is an exemption for certain self-insured health plans for 2015 and 2016; how do we know if our plan is eligible for this exemption?

A: There is a very narrow exemption from making reinsurance contributions that is available only to plans that are both self-insured and self-administered. As explained below, if your organization uses an unrelated third-party administrator (TPA) to perform any plan administration functions, the exemption from paying reinsurance contributions for 2015 and 2016 is likely not available.

The exemption is available only to self-insured health plans that do not use a TPA for any claims processing, claims adjudication, or plan enrollment functions, other than with respect to pharmacy or excepted benefits. For this purpose, a self-insured health plan that uses a TPA only to obtain provider network and related claim repricing services, or uses a TPA for up to 5% of its claims processing, claims adjudication, or plan enrollment functions, will not be deemed to use a TPA. (The 5% threshold may be determined by the number of transactions processed by the third party, or the value of the claims processing and adjudication and plan enrollment services provided by the third party.) Most self-insured health plans rely extensively on TPAs and thus will not be eligible for this exemption.

In analyzing your plan's potential reinsurance contribution obligations, you should consider the extent to which your organization relies on one or more TPAs to perform the "core administrative functions" of claims processing, claims adjudication, and plan enrollment. For example, if your organization currently handles some or all of these functions internally (or has the capability to do so without jeopardizing compliance or incurring expenses greater than your reinsurance contributions), then you might consider "in-sourcing" all of the core administrative functions so that the plan will be both self-insured and self-administered, and thus eligible for the exemption. If this approach seems feasible, you may want to discuss it with your TPA and find out whether you will continue to have access to provider network and claim repricing services through the TPA if you handle claim administration and enrollment internally. On the other hand, you might conclude that your organization does not have the internal resources to dedicate to claims processing/adjudication and enrollment, and thus it is better to continue making reinsurance contribution payments than to attempt forgoing a TPA. And as you evaluate what changes to make to your plan's administration, keep in mind that the reinsurance contribution program is scheduled to end after 2016.

Source: Thomson/Reuters