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Marsh & McLennan Insurance Agency LLC

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA West Edition

January 2017 | Issue 1

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FAQS ON THE AFFORDABLE CARE ACT: SPECIAL ENROLLMENT, PREVENTATIVE SERVICES, AND SMALL EMPLOYER HRAS

On December 20, 2016, the Department of Labor, Health and Human Services, and the Treasury (collectively, the Departments) issued Part 35 of the Implementation of the Affordable Care Act, through a series of Frequently Asked Questions (FAQs). The topics addressed in these FAQs include:

- Special enrollment into a group health plan due to loss of individual coverage
- Coverage of preventative services specifically related to women's preventative services; and
- Clarifications in relation to Qualified Small Employer Health Reimbursement Arrangements and the Cures Act

These topics are further elaborated upon below.

Special Enrollment for Group Health Plans

Under the Health Insurance Portability and Accountability Act (HIPAA), group health plans are required to provide special enrollment periods to current employees (or his/her dependents) who previously declined an employer's health coverage. A special enrollment period must be offered to an employee (or his/her dependents) when an employee (or his/her dependents) loses group health coverage in which they were previously enrolled, and/or under certain life events, such as birth, marriage, or adoption.

The new FAQ on special enrollments explains that an individual who loses eligibility for coverage (other than from failure to pay premiums, or termination of coverage for cause) in the individual market (including Marketplace/Exchange coverage), is entitled to special enrollment in a group health plan, regardless of whether they may enroll in other individual market coverage (including Marketplace/Exchange coverage). What this seems to indicate is that if a health plan is no longer offered in the individual market, an individual would be eligible for a special enrollment in a group health plan. However, if an individual simply did not want to enroll in that individual coverage, this may not create a special enrollment right (because that individual did not "lose" eligibility for the individual plan). Further guidance on the term "loses eligibility" for such coverage would be helpful from the government.

Coverage of Preventative Services

Under current ACA regulations under PHS Act 2713, non-grandfathered group health plans offered in the group/individual market must offer preventative services without imposing cost-sharing on an individual/patient.

The new FAQ on women's preventative services states that new updated guidelines for women's preventative services (at no cost-share to the patient) which were released on December 20, 2016, will become effective for plan/policy years beginning on or after December 20, 2017. Until that time, health plans should provide coverage with no cost-sharing for women's preventative services from previous Health Resources and Services Administration (HRSA) guidelines.

FAQs on Affordable Care Act: Special Enrollment, Preventative Services, and Small Employer HRAs (Continued)

Qualified Small Employer Health Reimbursement Arrangements

On December 13, 2016, The Cures Act was adopted as law for plan years beginning **on or after December 31, 2016**, allowing certain **small** employers (defined as employers with less than 50 full-time and/or full-time equivalent employees in the previous year) to offer stand-alone HRAs, also called "Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)." Small employers, therefore, may offer stand-alone HRAs, so long as they meet **all** of the following requirements:

- The employer does **not** offer a group health plan
- The employer employed less than 50 full-time and/or full-time equivalent employees
- The HRA is only funded by an employer, and never by the employee through salary reductions
- The HRA only reimburses an employee for health expenses (qualified medical, dental, or vision expenses…etc., under IRS Section 213) or health insurance premiums, after the employee provides proof of such expenses to the plan sponsor
- The amount of payments and reimbursements do not exceed $4,950 for individuals, and $10,000 for family members of the employee; and
- The HRA is provided to all "eligible" employees of the eligible employer, under the same terms to each employee.

If an employer/plan sponsor meets all of these requirements, the stand-alone HRA will not be considered an employer sponsored plan, therefore avoiding the prohibition on lifetime or annual dollar maximums (and the prohibition against cost-sharing by individuals for preventative services) for employer sponsored plans.

The new FAQ clarifies that under previous guidance, the rule against stand-alone HRAs and Employment Payment Plans to reimburse individual premiums is still prohibited, with the exception of QSEHRAs. The guidance further seeks to clarify that The Cures Act also provided transition relief for small employer plans that reimbursed employees' individual premiums **prior** to **December 31, 2016**. The FAQ goes on to state that if a small employer previously provided a stand-alone HRA that reimbursed individual health insurance (medical, dental, vision, etc.) premiums prior to December 31, 2016, that the employer need not pay penalties or file a Form 8928 in the past for offering that stand-alone HRA that reimbursed health insurance (medical, dental, vision) premiums. However, the FAQ further clarifies that if the employer offered an HRA that reimbursed health expenses (medical, dental, vision expenses, etc.), that this transition relief would **not** apply to those employers, meaning that those employers who continued to offer HRAs that reimbursed health expenses (medical, dental, vision, etc.) may still be subject to excise tax penalties and are required to file Form 8928.

No Action Required

Employers should be aware of these new clarifications on employer sponsored plans, and should make any applicable changes to any outdated policies and procedures.

For the complete details, see:

FAQs about Affordable Care Act Implementation Part 35:

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf

Women's Preventative Service Guidelines, updated December 20, 2016:

https://www.hrsa.gov/womensguidelines2016

FAQS ON THE AFFORDABLE CARE ACT: INTEGRATING FAMILY HEALTH REIMBURSEMENT ARRANGEMENTS

On January 12, 2017, the U. S. Department of Labor, Health and Human Services, and Treasury (collectively "Departments") issued Part 37 of the Implementation of the Affordable Care Act, through a series of Frequently Asked Questions (FAQs). Specifically, the Departments released two new FAQs addressing employee Health Reimbursement Arrangements (HRAs) which reimburse family health expenses that are integrated with group health plans offered by an employee's spouse's employer.

As a reminder, generally, HRAs must be integrated with a group health plan (i.e., stand-alone HRAs are no longer compliant under the ACA) in order to comply with the ACA's prohibition on annual/lifetime dollar limits and the prohibition on employee cost sharing for any preventative services. The IRS subsequently released guidance that HRAs which reimburse qualified health expenses of an employee's spouse/dependents (i.e., family HRA) must be integrated with **family coverage** under a group health plan, and cannot be integrated with self-only coverage.

However, what the previous guidance did not address was whether a family HRA could reimburse family health expenses when it is integrated with an employee's **spouse's** health coverage that covers the spouse and dependents, if the employee was enrolled in self-only coverage under their own employer. The FAQs released on January 12, 2017, address these questions as detailed below.

FAQ#1 discusses whether a family HRA can be integrated with family group coverage under the spouse's employer plan. The DOL states that an employer may rely on an employee's "reasonable representation" that the employee's spouse/dependents are covered under other qualifying non-HRA family group health plan coverage (e.g., under the spouse's group health plan).

FAQ #2 discusses whether a family HRA can reimburse the health expenses of family members of an employee, when that employee is enrolled in self-only coverage, but the employee and/or family members of the employee are enrolled in other qualifying non-HRA family coverage through a spouse's employer sponsored group health plan. The DOL takes the position that because there is no requirement that the HRA and the non-HRA group health plan coverage share the same plan sponsor, and no requirement that all those covered under the HRA must covered by the **same** group health plan to which the HRA is integrated, a family HRA **may** be integrated with a combination of the employee's self-only coverage, and the spouse and dependent's coverage through the spouse's employer-sponsored group health plan. Essentially, as long as all individuals covered by the family HRA have other qualifying non-HRA coverage, that coverage can be from any separately offered qualifying group health plan.

The DOL also provided the following example to illustrate FAQ#2: A family HRA that reimburses the expenses of an employee, spouse, and one dependent child may be integrated with the combination of (1) the employee's self-only coverage under the non-HRA group health plan of the employee's employer, and (2) the spouse and dependent child's coverage under the non-HRA group health plan of the spouse's employer, provided that both non-HRA group health plans are qualifying non-HRA group health plans.

No Action Required

Employers who offer HRAs that reimburse family expenses should be aware that these family HRAs can be integrated with qualifying non-HRA health coverage under the employee's spouse's group health plan, even if the employee only has self-only coverage. Employers should revise their policies on what will qualify as "reasonable representation" from employees in order to confirm the family under the HRA has qualifying coverage.

For complete details, see the FAQs about ACA Implementation (Part 37):

https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-37.pdf

FINAL NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2018: MAXIMUM OUT-OF-POCKET LIMITS

On December 16, 2016, Health and Human Services (HHS) released the Final Notice of Benefit and Payment Parameters for 2018. The Notice discusses many topics, including the Marketplace/Exchange, the risk adjustment program, and the Maximum Out-of-Pocket limits of health plans, which become effective on January 17, 2017. The focus of this short article is the Maximum Out-of-Pocket limits for 2018.

The Maximum Out-of-Pocket limits for plans for 2018 are as follows:

- $7,350 for self-only coverage (up from $7,150 in 2017); and
- $14,700 for other than self-only coverage (up from $14,300 in 2017)

Health plans should be aware of these changes in preparation for 2018.

No Action Required

Employers/Insurers should be aware of the increase in Maximum Out-of-Pocket limits for 2018.

For the Final Rule on HHS Notice of Benefit and Payment Parameters for 2018, see:

https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-30433.pdf

WASHINGTON, D.C. COUNCIL PASSES PAID PARENTAL, FAMILY, AND MEDICAL LEAVE BILL

Background and Effective Date

On December 20, 2016, the Council of the District of Columbia (the District) passed the Universal Paid Leave Amendment of 2016, Bill 21-415, (Act). This Act has been sent to Mayor Muriel Bowser for signature, though the D.C. Mayor has yet to sign or veto the Act. Should the Mayor veto the Act, the Council will reconsider the bill with the option of overriding the mayoral veto with a two-thirds vote, which would require the bill to be sent to Congress for approval.

Although the Act has not officially passed, the below article discusses the details of the Act, so that employers in the District are aware of the potential changes they may need to make to their paid leave policies, should the Act be approved.

Covered Employers

All private employers will be subject to the Act should it become law. Covered employers do not include the United States, District of Columbia, or any other employer who the District of Columbia is not authorized to tax under federal law or treaty. All covered employers must comply with the requirements of this Act, regardless of whether they currently offer paid family leave.

Covered Employees

All private-sector and nonprofit employees, both full-time and part-time, are eligible for paid leave under the Act. Eligible workers must spend more than 50 percent of his/her work time working for a covered employer in the District of Columbia, regardless of their state of residence. District of Columbia and federal employees are excluded under the Act.

Washington, D.C. Council Passes Paid Parental, Family, and Medical Leave Bill (Continued)

Types of Leave and Permitted Uses

The Act provides for three types of paid leave: (1) qualifying parental leave; (2) qualifying family leave; and (3) qualifying medical leave. Each type of qualifying leave provides employees with varying lengths of paid leave, as follows:

- **Qualifying Parental Leave:** Eight (8) weeks of paid leave to care for a new child (birth, adoption, or placement of a foster child)
- **Qualifying Family Leave:** Six (6) weeks of paid leave to care for a "family member" who has been diagnosed with a serious "health condition"; and
- **Qualifying Medical Leave**: Two (2) weeks of paid leave following the occurrence or diagnosis of a serious health condition of the employee.

A "family member" is defined as an employee's:

- Child (biological, adopted, foster child, stepchild, a legal ward, child of a domestic partner, or a person to whom an individual stands in loco parentis)
- Parent (biological, foster, or adoptive, parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee)
- Domestic Partner or Spouse (to whom the employee is related to by a domestic partnership or marriage); and
- Grandparent

A "serious health condition" for which paid leave may be taken, includes: a physical or mental illness, injury, or impairment that requires inpatient care in a hospital, hospice, or, residential health care facility, or continuing treatment or supervision at home by a health care provider or other competent individual.

Employees may only use each type of leave **once** in a 52 workweek period.

Program Funding

All covered employers must contribute 0.62% of each employee's annual wages (i.e., a payroll tax) to the "Universal Paid Leave Fund." This Universal Paid Leave Fund will then be used to fund wages to employees for leave taken under the Act. Currently, the Act states that the first payment made by employers to the Universal Paid Leave Fund is to occur on March 1, 2019.

Self-employed Individuals

Self-employed individuals may elect to opt-in to the paid leave program by contributing 0.62 percent of his or her annual self-employment income to the Universal Paid Leave Implementation Fund. A self-employed individual will remain continuously enrolled in the program until he/she elects to opt-out. Self-employed individuals may only enroll in the program or opt-out of the program during an open enrollment period. Individuals who choose to enroll or re-enroll must contribute to the paid leave fund for no less than three consecutive years.

Payment of Benefits

An employee who qualifies for any of the three types of leave is subject to a one (1)-week waiting period before benefits are paid.

The rate of pay while an employee is on qualified leave varies depending on the employee's average wage, as follows:

- Employees earning 1.5 times the District's minimum wage or less are eligible to receive benefits totaling 90% of their weekly wage.
- Employees earning more than 1.5 times the District's minimum wage will receive 90% of their earnings, up to 150% of the District's minimum wage, and then 50% of their earnings after the threshold payment is reached.

Benefits are capped at $1,000 per week, and will be paid biweekly.

Anti-retaliation

The Act also includes an anti-retaliation provision, which allows an employee to take legal action if they claim to have been retaliated against by an employer for exercising their rights under the law.

Washington, D.C. Council Passes Paid Parental, Family, and Medical Leave Bill (Continued)

Notice

The Mayor will provide a notice to covered employers explaining the employee's rights to paid benefits under this Act, that retaliation is prohibited, that a covered employee has a right to file a complaint, and that an employee who works for a covered employer with under 20 employees is not entitled to job protection if he or she takes paid leave pursuant to this Act.

Each employer must provide this notice to each covered employee at the time of hiring and annually thereafter. Covered employers must also post and maintain the notice in a conspicuous place in English and all languages the notice has been published in.

Moving Forward

If the Mayor or Council approves the Act, the Mayor will be required to notify covered employers within 180 days of the effective date of the law about how the District will collect funds from employers for the Universal Paid Leave Fund. If approved, the District must begin paying benefits to eligible employees by March 15, 2020.

Action Required

The Universal Paid Leave Amendment Act has not yet become law in Washington, D.C., however Washington, D.C. employers should review their sick leave policies and compare their existing PTO benefits to what the Act will require.

For complete details, see the Act:

https://trackbill.com/s3/bills/DC/21/B/415/texts/votingnotes.pdf

QUESTION OF THE MONTH

What is the Form 1094/1095 Filing Obligation of Affiliated Employers in an Aggregated ALE Group?

QUESTION: We are a wholly owned subsidiary of a corporation with several hundred full-time employees, but we employ only 10 full-time employees. Since we have fewer than 50 full-time employees, are we obligated to file Forms 1094 and 1095? If we have to file, can our parent company file on our behalf?

ANSWER: Since you are part of a group of employers with more than 50 full-time employees, you are obligated to file Forms 1095-C for your full-time employees even though you employ fewer than 50 full-time employees. You will use Form 1094-C to transmit those forms to the IRS. As explained below, there is no such concept as consolidated reporting by the parent company for purposes of this filing.

The reporting obligation is tied to the definition of "applicable large employer" (ALE) for purposes of employer shared responsibility under Code § 4980H. Code § 4980H applies the Code's controlled group rules when determining whether an employer is an ALE. If the employers in the controlled group employed at least 50 full-time (and full-time equivalent) employees on a combined basis during the preceding calendar year, then each employer is treated as an ALE member within an aggregated ALE group for the current calendar year.

Although the number of employees is combined to determine whether there is an aggregated ALE group, once that determination is made, each separate legal entity (i.e., each ALE member) has an independent reporting obligation. This obligation extends to each employer within the aggregated ALE group, including those with fewer than 50 full-time (and full-time equivalent) employees. Thus, each ALE member within the aggregated ALE group (including both the parent corporation and the subsidiary corporation in your case) is generally required to file Form 1095-C for each of its employees who was a full-time employee for at least one month during the calendar year. Each ALE member also is generally required to transmit Forms 1095-C for its full-time employees by filing an authoritative transmittal with the IRS on Form 1094-C, using its own employer identification number (EIN). (Part II, line 21 on the authoritative transmittal is used to indicate that the ALE member is part of an aggregated ALE group.) Note that the 2016 instructions for Forms 1094-C and 1095-C (see our article) contain an expanded discussion (including more examples) for filings made by ALE members that are part of an aggregated ALE group.

There is no provision under health care reform for aggregated or consolidated reporting on Forms 1094 and 1095 for employers within an aggregated ALE group. Your parent corporation may agree to prepare the necessary forms for you to file, but the forms must reflect your company's information, and your company will not be relieved of liability for any errors in the forms prepared by your parent corporation. For more information, see EBIA's Form 1094/1095 Workbook at Sections VII.C ("Completing Form 1094-C") and VIII ("Form 1095-C Report/Employee Statement: Employer-Provided Health Insurance Offer and Coverage"). See also EBIA's Health Care Reform manual at Sections XXVIII.B ("Large Employers Are Potentially Subject to an Assessable Payment (Penalty Tax)") and XXXVI.D ("Information Reporting of Employer-Sponsored Coverage (Applicable Large Employers)").

Contributing Editors: EBIA Staff

CONTACTS

Christopher K. Bao, Esq.
Manager, Employee Benefits Compliance & Regulatory Affairs, MMA West
chris.bao@barneyandbarney.com
415.230.7224

Iris F. Chou, Esq.
Manager, Employee Benefits Compliance & Regulatory Affairs, MMA West
iris.chou@barneyandbarney.com
949.540.6924

Brittany D. Botterill, Esq.
Manager, Employee Benefits Compliance & Regulatory Affairs, MMA West
brittany.botterill@barneyandbarney.com
858.587.7511