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PITTSBURGH CITY COUNCIL APPROVES PAID SICK LEAVE LAW

On August 3, 2015 the Pittsburgh City Council passed the Pittsburgh Paid Sick Leave Act which will require all employers within the city to provide paid sick leave. Pittsburgh is the 20th major city to mandate that employers provide paid sick leave to employees (joining California, Connecticut, Massachusetts and Oregon, and a number of major cities in Washington, New Jersey and Maryland, to name a few). Highlights of this new law can be found below.

Covered Employers

- Any employer in or doing business in Pittsburgh that employs one or more persons

Covered Employees

- All full-time and part-time employees working in the City

- Excludes:
  - Independent contractors
  - State and federal employees
  - Members of a construction union covered by a collective bargaining agreement, and
  - Seasonal employees provided that they will work no more than 16 weeks during the calendar year

Accrual of Sick Time

- Employees may accrue one hour of paid sick time for every 35 hours worked (including overtime hours) in the City
  - Employers with 15 or more employees must provide a cap of no less than 40 hours of paid sick leave per year
  - Employers with fewer than 15 employees must provide a cap of no less than 24 hours of unpaid sick time per year

- A "calendar year" is any regular, 12-month period defined by the employer and communicated to employees

- Exempt employees under the federal Fair Labor Standards Act (i.e., administrative, executive, or professional employees) will accrue paid sick time based on either the employee's normal workweek or a 40-hour workweek, whichever is less

Pittsburgh City Council Approves Amended Paid Sick Leave Bill (continued)

- Employees must be permitted to carry over accrued sick leave from year to year, but are not entitled to use more than 40 hours (or 24 hours for employees of small employers) per year
  - Carry-overs are not required if the employer provides a full year's accrual at the beginning of the calendar year

Reasons for Leave

- An employee's own mental or physical illness, injury, or health condition, including diagnostic, treatment, and preventative medical care
- Care of a family member with a mental or physical illness, injury, or health condition, including diagnostic, treatment, and preventative medical care
- Closure of the employee's place of business by order of a public official due to a public health emergency
- An employee's need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency
- An employee's need to care for a family member when it has been determined by health care authorities or providers that the family member's presence in the community would jeopardize the health of others because of the family member's exposure to a communicable disease

Notice

- Employers must provide written notice to employees of their entitlement to paid sick time, the amount to which they are entitled, the terms under which leave can be used, the guarantee against retaliation, and the right to file a complaint regarding violations of the ordinance
- Model notices will be drafted by the City

Additional Provisions

- Records on hours worked and sick time taken must be kept for two years
- Sick time is to be based on the employee's base rate of pay; no pay is required for lost tips and commissions
- Employers are not required to cash out unused paid sick time at the time of termination from employment

Action Required for Some Employers

Applicable Pittsburgh private-sector employers should familiarize themselves with this ordinance. In most cases, if the employer is in compliance with the California Paid Sick leave law, they may already be prepared for compliance with this new city ordinance. Employers may continue to maintain other paid leave policies, such as vacation, sick, floating holidays, personal days or other Paid Time Off (PTO), and satisfy the requirements of the Ordinance if those policies meet or exceed the accrual requirements of the Ordinance and allow employees to use the leave for the same purposes and under the same conditions as paid sick leave under the Ordinance. The City Controller will publish regulations and model notices, 90 days after which this new law will become effective.

For complete details, see: http://s3.documentcloud.org/documents/2190958/sick_leave_pittsburgh.pdf

THE ACA SUMMARY OF BENEFITS AND COVERAGE REQUIREMENT SOON SUBJECT TO NEW FINAL RULES

The Departments of Labor, Health and Human Services and Treasury (the Departments) recently issued final regulations on the Affordable Care Act's (ACA) Summary of Benefits and Coverage (SBC) and Uniform Glossary (UG) requirements. The December 2014 regulations, finalized this summer, generally apply to group health plans for plan years beginning on or after September 1, 2015. Additionally, final regulations explain that the Departments anticipate finalizing revisions to the SBC template, instructions, and uniform glossary by January 2016; the revised materials will apply to plan or policy years beginning on or after January 1, 2017. Highlights of the final regulations can be found below.

Applicability

- For group health plan enrollments and re-enrollments, the final regulations apply to open enrollment periods that begin on or after September 1, 2015, and to enrollments other than via open enrollment (e.g., newly eligible enrollees and special enrollees) on the first day of the first plan year that begins on or after September 1, 2015. For disclosures to plans, the final regulations apply to health insurers beginning on September 1, 2015
- New template (and any coinciding documents), expected out January 2016, would need to be delivered by the first plan year that begins on or after January 1, 2017

Exemption

- Group health plan benefit packages that provide Medicare Advantage benefits are now exempt from the SBC requirements

Other Provisions

- If an insurer has provided an SBC before the application for coverage and the information required to be in the SBC is unchanged then:
  - The requirement to provide an SBC upon application is deemed satisfied
  - The insurer need not automatically provide another SBC upon application
  - If there has been a change in the information required to be included in the SBC, a new SBC reflecting the change must be provided upon application as soon as practicable following receipt of the application but no later than seven business days following receipt of the application
- Where a plan sponsor enters into a binding contract with a third-party vendor for SBC distribution, the plan is deemed to have provided the SBC if it monitors the service provider's performance under the contract. Appropriate corrective action is necessary for noncompliance and must be completed as soon as practicable
- Plan administrator is responsible for providing complete SBCs for the plan
  - An enforcement safe harbor allows a plan administrator to either:
    - Synthesize information into a single SBC, or
    - Provide multiple partial SBCs that, together, provide all of the relevant information needed to satisfy the SBC content requirements
- Insurers must include an internet address where copies of a group certificate of coverage or individual coverage policy can be reviewed and obtained. Sample group certificates of coverage for each applicable insurance product may be provided where the group market certificate of coverage is not available until after the plan sponsor has negotiated the terms of coverage with the insurer

The ACA Summary of Benefits and Coverage Requirement Soon Subject to New Final Rules (continued)

- SBCs may be provided electronically either as part of an individual's online enrollment or online renewal of coverage provided there is the option to receive a paper copy upon request

Action Required

Employers should familiarize themselves with current and upcoming requirements for SBCs to ensure they are compliant with the SBC guidelines for content and distribution.

For the Summary of Benefits and Coverage and Uniform Glossary Final Rule Fact Sheet, go to:
https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Fact-Sheet_SBCFinalRule-6-11-15-MM-508.pdf

ACA PREVENTIVE SERVICES FINAL REGULATIONS RELEASED

Recently, the Department of Health and Human Services (HHS) released final regulations on the Affordable Care Act's (ACA) preventive services mandate. This latest round of regulations confirm previously proposed regulations on billing practices, as well as provide guidance for employers claiming a religious objection exemption to the mandate to cover FDA-approved contraceptive services. Highlights of the final regulations can be found below.

Background

Under the preventive services mandate, non-grandfathered group health plans must cover certain preventive care services without cost-sharing. These include services in the following categories:

- Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF)
- Immunizations for routine use in children, adolescents and adults that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention
- Evidence-informed preventive care and screenings for infants, children and adolescents provided in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)
- Evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of the USPSTF for women

ACA Preventive Services Final Regulations Released (continued)

Preventive Services Final Regulations Requirements

- When a preventive service is billed together with an office visit, a plan must look to the primary purpose of the visit when determining whether it may impose cost-sharing with respect to the office visit

- For plans that maintain a network of providers, a plan that does not have an in-network provider who can offer a particular recommended preventive service must nevertheless cover that service without cost-sharing when performed by an out-of-network provider

- Plans should document the evidence base underlying a reasonable medical management technique should a participant file an ERISA claim or appeal

- Plans may impose cost-sharing at their discretion, consistent with applicable law, for preventive services not on the list of recommended preventive services

- If a recommendation or guideline for a preventive service does not specify the frequency, method, treatment or setting for that service, the plan may use reasonable medical management techniques to determine any coverage limitations

- Plans required to provide coverage for a preventive service on the first day of a plan year must provide coverage for that service for the entire plan year even if the recommendation or guideline for that service changes or is eliminated during the plan year

- Plans must cover a new recommendation or guideline beginning the first plan year following one year from the date that the new recommendation or guideline goes into effect

Employers with Religious Objections to Providing Contraceptive Coverage

- Eligible non-profit organizations may continue to choose between using EBSA Form 700 or the alternative process of notifying HHS in writing of a religious objection to covering all or a subset of contraceptive services
  - A model notice is available for this purpose: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Model-Notice-8-20-14.pdf

- Exemption from this mandate is also available to closely-held, for-profit entities that are not publicly traded, are majority-owned by a relatively small number of individuals, and object to providing contraceptive coverage based on its owners' religious beliefs
  - Such an entity must be more than 50 percent owned directly or indirectly by five or fewer individuals, or have an ownership structure that is substantially similar
  - If an entity is unsure if its structure meets the requirements for the accommodation, it may send a description of its ownership structure to HHS at accommodation@cms.hhs.gov (if a response is not provided within 60 calendar days, the entity will be considered to have met the requirement as long as it maintains that structure)
  - The highest governing body (e.g., Board of Directors) must adopt a resolution (or take other similar action) establishing that the organization objects to covering some or all of the contraceptive services due to its owners' sincerely held religious beliefs
    - The organization need not provide HHS with this resolution but must furnish notice of this exemption decision under the same process that must be followed by non-profits (as stated above)

ACA Preventive Services Final Regulations Released (continued)

Action Required for Some Employers

Employers seeking a religious exemption should be aware of the final regulations and comply accordingly. Additionally, employers must ensure their preventive services coverage comply with any new recommendations or guidelines beginning on the first day of the first plan year that begins on or after September 14, 2015.

For complete details, see https://www.federalregister.gov/articles/2015/07/14/2015-17076/coverage-of-certain-preventive-services-under-the-affordable-care-act

IRS ISSUES ADDITIONAL GUIDANCE ON ACA APPLICATION TO EX PAT PLANS

Recently, the Internal Revenue Service (IRS) released IRS Notice 2015-43, which provides interim guidance on the application of certain provisions of the Affordable Care Act (ACA) to expatriate (ex pat) health insurance issuers, plans, and plan sponsors (as defined in the Expatriate Health Coverage Clarification Act of 2014 (EHCCA)). The Departments of the Treasury, Labor, and Health and Human Services (collectively, the Departments) intend to publish proposed regulations implementing and providing guidance on the ACA requirements for ex pat plans, but in the meantime, this guidance may be followed. Highlights of the notice can be found below.

Expatriate Health Coverage Clarification Act of 2014 Key Points

- Generally applies to ex pat health plans issued or renewed on or after July 1, 2015
- Generally provides that the ACA does not apply
- Generally provides that health coverage provided by an expatriate health plan to qualified expatriates is minimum essential coverage for purposes of the individual mandate
- Exemption from §§ 6055, 6056,and 4980H
- Excludes an ex pat health plan from the health insurer fee and is effective for calendar years after 2015 (special rule for the fee for the 2014 and 2015 calendar years)
- Provides definitions and special rules for ex pat plans
- Defines three types of expatriates

Interim Guidance

It has been determined by the Departments that more time and guidance is needed for issuers, employers, and plan sponsors to modify current arrangements to comply with the EHCCA's requirements. Until the issuance of further guidance and except as otherwise provided in this notice, taxpayers are generally permitted to apply the requirements of the EHCCA using a reasonable good faith interpretation of the EHCCA.

IRS Issues Additional Guidance on ACA Application to Ex Pat Plans (continued)

Interim Guidance (continued)

Provisions not exempt under the EHCCA:

- PCORI Fees: for plan years beginning prior to July 1, 2015.
  - For plan years thereafter, issuers and plan sponsors may exclude the lives covered under a specified health insurance policy that is issued or renewed on or after July 1, 2015, or under an applicable self-insured health plan for plan years starting on or after July 1, 2015 if the policy or plan:
    - Was designed and issued specifically to cover primarily employees who are working and residing outside the United States, or who are not citizens or residents of the United States but who are assigned to work in the United States for a specific and temporary purpose or who work in the United States for no more than six months of the policy year or plan year; or
    - Was designed to cover individuals who are members of a group of similarly situated individuals for purposes of § 3(d)(3)(C) of the EHCCA. For purposes of determining whether an insured is residing outside the United States, issuers and plan sponsors may rely on the most recent address on file for the primary insured

- Health insurer fees for the 2014 and 2015 fee years

- Employer reporting requirements: providers of minimum essential coverage must comply with the requirements of § 6055 and applicable large employers must comply with the requirements of § 6056, regardless of whether the coverage is offered and/or provided through an ex pat health plan
  - However, for ex pat health plans, statements to individuals reporting minimum essential coverage under § 6055 or offers of employer coverage under § 6056 may be furnished in electronic format unless the recipient refuses consent

Action Required

Employers with ex pat plans should familiarize themselves with this recent guidance. Though the Departments will recognize good faith efforts to comply with the requirements surrounding ex pat plans, and more guidance is needed to clarify statutory definitions of the terms ex pat health plan and qualified expatriates, as well as the interaction of the EHCCA with existing relief for expatriate health plans, certain employers must be aware of and implement procedures for compliance with employer reporting, PCOR and health insurer fee requirements.

For the complete details, see IRS Notice 2015-43 at: http://www.irs.gov/pub/irs-drop/n-15-43.pdf

IRS REQUESTS MORE COMMENTS ON THE CADILLAC TAX

On July 30, 2015, the Internal Revenue Service (IRS) released Notice 2015-52, seeking additional comments on the framework for their regulation creation for the Affordable Care Act's (ACA) provision on the Excise Tax on High Cost Employer-Sponsored Health Coverage (Cadillac Tax). Notice 2015-52 acts as a supplement to the previously released IRS Notice 2015-16. Both Notices provide some insight into the future applicability of the Cadillac Tax. Ultimately these notices are only a request for comments from stakeholders and not binding. Rather, these notices and their associated comments will be used by the IRS to draft future proposed and final regulations on the Cadillac Tax. Highlights on this latest request for comments can be found below.

IRS Requests More Comments On The Cadillac Tax (continued)

Background

IRC § Section 4980I(a) imposes a non-excludable, 40 percent excise tax on the aggregate cost of coverage per month above the applicable threshold dollar limit. Currently, the annual thresholds for 2018 will be $10,200 for individual coverage, and $27,500 for other than self-only coverage. The aggregate cost of coverage will include all medical coverage under any group health plan which is excludable from the employee's gross income (IRC § 106), including Health Savings Account (HSA), Flexible Spending Account (FSA), and Health Reimbursement Arrangement (HRA) contributions. The Cadillac Tax will be paid by the coverage provider. Coverage providers are defined as the following:

- The insurance issuer/provider that provides health insurance coverage
- The employer, if such employer makes contributions to an employee's HSA
- The administrator of the plan (which may include the plan sponsor)
- For all "other" applicable coverage, the coverage provider would be the person that administers the plan benefits

Employers are generally responsible for the calculation and determination of the excise tax. Employers in the same aggregated controlled group are treated as one single employer. Employers will also be responsible for allocating any applicable tax among insurance coverage providers and the providers will remit payment to the IRS.

Notice 2015-52 Request for Comments

- Clarification on the Person that Administers the Plan Benefits
  - Where the coverage provider was not clearly defined in the Cadillac Tax legislation, but only defined as the "person that administers the plan benefits," the IRS sought comments on two potential approaches to defining that term:
    - The Administrator approach
      - The entity that completes the day-to-day functions of administering the plan should be considered the "person that administers the plan benefits"
      - These duties include receiving and processing the claims, responding to inquiries, or providing a technology platform for the plan benefits information
      - In the case of a self-funded plan, the administrator would typically be the Third Party Administrator (TPA)
    - The Sponsor approach
      - The entity who has ultimate authority or responsibility under the plan or arrangement over the administration of the plan benefits should be considered the "person that administers the plan benefits," even if they are not routinely involved with the plan
      - In the case of a self-funded plan, this is typically the employer

- Employer Aggregation Rules
  - Comments were sought on whether the application of the employer aggregation rules under IRC § 414 (i.e., aggregated controlled group rules) would create practical challenges in the administration of the Cadillac Tax rules

- Determination Period
  - Comments were requested about the IRS calculating the cost of applicable coverage for Cadillac Tax in a similar manner as calculating the COBRA applicable premium
  - Comments were also requested as to whether such calculation was possible if the calculation of the applicable cost of coverage occurred after the taxable period

IRS Requests More Comments on the Cadillac Tax (continued)

Notice 2015-52 Request for Comments

- The IRS requested comments on whether two different approaches could be potential solutions for a situation where a coverage provider did incur a tax burden for transferring the Cadillac Tax to an employer
  - Have the coverage provider be attributed income at their specific marginal tax rate, or
  - Create a standard marginal tax rate for all coverage providers for the attributed income

- The IRS requests comments on its proposed rule that if an employer contributes non-elective flex credits to an FSA, the cost of coverage that would be attributable to the FSA would be limited to those amounts that were actually reimbursed to the employee from the employer contributions made in excess of the employee's contributions to the FSA (based upon a valuation of the cost of coverage at the end of the taxable year)
  - If any employer contribution amount was rolled over into future years, those reimbursed amounts would be accounted for in future years

- The IRS requests comments on its proposed rule on age and gender adjustment to the threshold dollar limit
  - The IRS proposes two possible options that would allow for some adjustments to the threshold amount, based upon the demographics of specific employers (i.e., employers that typically have more expensive plans, due to gender and age disparities, compared to other parts of the nation)

Action Required

Employers should begin preparing, as best as they can, for the Cadillac Tax. These provisions are set to be implemented beginning January 1, 2018. Employers need to monitor the cost of the coverage that is being offered, as well as employer and employee contributions made to account-based programs. Employers may want to start considering plan or account changes now to mitigate potential exposure in 2018 to the Cadillac Tax.

For the complete details, see IRS Notice 2015-52 at: http://www.irs.gov/pub/irs-drop/n-15-52.pdf

For details on the preceding Notice 2015-16, see the Barney & Barney March edition of the Legislative Compliance Monthly newsletter at: http://www.barneyandbarney.com/assets/files/2015-3-March-Legislative-Compliance-Monthly-Newsletter(1).pdf

VETERANS' HEALTH COVERAGE EXEMPTED FROM ACA EMPLOYER MANDATE AND HSA ELIGIBILITY RULES

On July 31, 2015, President Obama signed highway funding legislation (titled the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41, § 4007), which includes provisions that eliminate application of the employer mandate and HSA eligibility rules where there is veterans' health coverage. The law also changed the due dates for filing a number of federal tax forms for years beginning after 2015, including Form 5500s (which will be allowed a maximum extension of 3-1/2 months, rather than the current 2-1/2 months). Below are highlights of the veterans' health coverage provisions.

Employer Mandate

- Certain individuals (primarily veterans) may be disregarded solely for the purpose of determining whether an employer is an Applicable Large Employer (ALE) subject to the employer mandate
- Such employees are not taken into account for the ALE determination for any month that he or she has medical coverage provided by any of the uniformed services (including TRICARE) or under certain Veterans Affairs (VA) health care programs
- Exemption applies for months beginning after December 31, 2013

Health Savings Accounts (HSAs)

- A veteran's receipt of VA hospital care or medical services for a service-connected disability will not affect his or her ability to make HSA contributions effective January 1, 2016

Action Required for Some Employers

Employers with HSAs or employees with VA or TRICARE coverage should familiarize themselves with these new exemptions. For example, employers whose ALE status could change will need to identify the employees that can be disregarded because they have TRICARE or VA coverage. Additionally, employers that make or facilitate pre-tax HSA contributions will need to update their plan documents to reflect VA hospital care or medical services for a service-connected disability.

For the complete details, see Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41, § 4007 (July 31, 2015) at: https://www.congress.gov/114/bills/hr3236/BILLS-114hr3236enr.pdf

QUESTION OF THE MONTH

Q: Our Company sponsors an insured group health plan. Are we, or our insurer, responsible for providing an SBC?

A: If your plan is fully insured, the obligation to timely provide a summary of benefits and coverage (SBC) lies both with the insurer and the plan administrator (usually the plan sponsor, unless another entity is named as such in the plan documents). Note that a different rule applies in the case of SPDs and SMMs, for which ERISA plan insurers are never directly liable.

A special rule prevents unnecessary duplicates of SBCs by treating the plan's SBC obligation as satisfied so long as any entity has provided the SBC in a timely manner and in accordance with applicable rules. Thus, if the insurer provides a timely and compliant SBC, the plan administrator's obligation is satisfied. An enforcement safe harbor first set forth in FAQ guidance and later finalized in regulations provides that a plan administrator (or other entity) that enters into a binding contract with another party (e.g., an insurer) to provide the SBC will be treated as satisfying the SBC requirement if the following obligations are met:

- The plan administrator monitors performance under the contract;
- If the plan administrator has knowledge of a violation of the SBC rules and has the information to correct it, the plan administrator must correct it as soon as practicable; and
- If the plan administrator has knowledge of a violation of the SBC rules and does not have the information to correct it, the plan administrator must communicate with participants and beneficiaries regarding the lapse and begin taking significant steps as soon as practicable to avoid future violations.

You should discuss with your insurer whether it will provide the SBC, and if so, document the agreement and monitor the insurer's performance to ensure that SBCs are being provided in a timely and compliant manner.

Source: Thomson/Reuters