UP AND COMING HR – BENEFITS RELATED ISSUES
2016 EMPLOYEE BENEFITS UPDATE

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AGENDA

- Affordable Care Act ("ACA") Update for 2016 - 2017
- Transgender Benefits
- Wellness Program Compliance
- Mental Health Parity
- Fiduciary Rules

ACA Updates
Compliance for 2016 - 2017

ACA EMPLOYER SHARED RESPONSIBILITY

- Employers with 50 or more full-time and/or full-time equivalent employees must offer “affordable” and “minimum value” health care coverage to full-time employees and their dependent children or face penalties.
- Remember that full-time employee = 30 hours per week / 130 hours per month!
- Two methods to determine full-time status
  - Look back
  - Monthly
- Make sure plan documentation updated to reflect eligibility.

AFFORDABILITY

- ACA requires that employer sponsored health coverage be "affordable"
- Coverage is affordable if employee's "required contribution" for self-only coverage under lowest cost option does not exceed 9.5% (indexed) of employee's household income (9.66% in 2016)
- 3 safe harbors
- IRS Notice 2015-87 and proposed regulations address how to treat HRA contributions, flex credits and opt-out payments for purposes of determining employee's required contribution

AFFORDABILITY

- HRA contributions.
- Amounts made available for the current plan year under an HRA reduces employee's required contribution if:
  - Employee may use to pay premiums for an eligible employer-sponsored plan (even if they can also be used for cost-sharing or other health benefits not covered by the plan).

AFFORDABILITY

- Flex credits.
- Employer flex credits reduce employee's required contribution if:
  - Employee may not opt to receive the amount as a taxable benefit.
  - Employee may use the amount exclusively to pay for medical care.

AFFORDABILITY

- Flex credits.
- Example. Employer offers employees coverage under a group health plan through a cafeteria plan. An employee elects coverage and is required to contribute $200 per month towards the cost of coverage. Employer offers flex credit of $600 that may be applied towards the employee's share of the contribution for the group health plan or a contribution to a health flexible spending account.
- Conclusion. The $600 flex credit reduces the employee's required contribution, even if the employee doesn't elect to apply the amount towards the health contribution.

AFFORDABILITY

- Opt-out payments.
- Proposed regulations issued this year.
- The availability of an unconditional opt-out payment (i.e., no requirement to show proof of other health coverage) increases the employee's required contribution.
- The value of a conditional opt-out payment is not included in the required contribution if opt-out is available only to those who attest that the employee and all tax dependents have minimum essential coverage (other than individual coverage).
- Example. Employer requires employees to contribute $200 per month towards the cost of medical coverage and offers an additional $100 per month in taxable wages to each employee who declines the coverage.
- Conclusion. The offer of $100 in additional compensation has the economic effect of increasing the employee's contribution to $300 because the employee electing coverage must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.
- Note: Opt-out may be included in regular rate of pay under FLSA.

HOURS OF SERVICE CALCULATION

- Full-time employee status depends on hours of service worked.
- Regulations define an "hour of service", in part, as each hour for which an employee is paid, "or entitled to payment by the employer, for a period of time during which no duties are performed **due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence**.
- Incorporates DOL regulations.
- Notice clarifies:
    - 501 hour limitation does not apply.
    - Credit service for no performance of services when receiving payment due to short-term and long-term disability.
        - BUT, if coverage is paid with after-tax wages, then resulting payments do not result in "hour of service".

LEAVES OF ABSENCE

- ACA requires large employer to offer coverage to full-time employees or pay a penalty
- Many employers determine full-time status using a look back measurement method
  - If employee works an average of 30 or more hours per week during the look back measurement period, is considered full-time for a subsequent stability period regardless of hours worked during the stability period.
- What happens if employee is on an extended leave of absence working no hours during stability period?
    - Follow terms of plan/insurance contract
    - Potential for ACA penalty

PENALTIES

- The $2,000 and $3,000 penalty amounts set forth in § 4980H(b)(1) and (c)(1) are adjusted annually:
    - For 2016, the amounts are $2,160 for failure to offer coverage and $3,240 for failure to offer affordable, minimum value coverage.

OVERVIEW OF ACA REPORTING REQUIREMENTS

	Fully Insured <50 FTEs	Self Insured <50 FTEs	Fully Insured 50 + FTEs (ALE)	Self Insured 50 + FTEs (ALE)
Forms to Employees:	1095-B Return Form	1095-B Return Form	1095-B Return Form, plus 1095-C Offer and Coverage Form sections 1 & 2	All sections on 1095-C Offer and Coverage Form
Completed by:	Health Insurance Issuers	Plan sponsors (employers)	1095-B: by health insurance issuers 1095-C: by plan sponsors (employers)	Plan sponsors (employers)
Used to:	Reports on tax return that MEC existed to avoid the individual shared responsibility payment	Report on tax return that MEC existed to avoid the individual shared responsibility payment	1095-B: Report on tax return that MEC existed to avoid the individual shared responsibility payment 1095-C: contains info on insurance offer, premium share and info on employer shared responsibility	1095-C: Contains info on insurance offer, premium share and info on employer shared responsibility
Forms to IRS:	1094-B Transmittal Form	1094-B Transmittal Form (with copies of all 1095-Bs)	1094-B Transmittal Form plus copies of all 1095-Bs, plus 1094-C with copies of all 1095-Cs	1094-C Transmittal Form plus copies of all 1095-Cs
Completed by:	Health Insurance Issuers	Plan sponsors (employers)	1094-B and 1095-Bs; Health Insurance issuers 1094-C and 1095-Cs Plan sponsors (employers)	Plan sponsors (employers)
Used to:	Verify that MEC existed and employers that are not subject to the employer shared responsibility provisions still need to file report about covered individuals	Verify that MEC existed and employers that are not subject to the employer shared responsibility provisions still need to file report about covered individuals	Report about individuals who are covered by MEC and not liable for the individual shared responsibility payment and to report information required about offers of health coverage and enrollment in health coverage for employees	Report about individuals who are covered by MEC and not liable for the individual shared responsibility payment and to report information required about offers of health coverages and enrollment in health coverage to employees

Source: Employee Benefits Advisors, LLC

ACA REPORTING – WHAT'S NEW?

- Updated Forms and instructions issued for 2016.
    - Review instructions/new codes.

- Reporting to IRS due by February 28th of the following year, or March 31st if return is filed electronically.
    - Automatic 30-day extension available by filing Form 8809.

- Statements to employees due by January 31st of following year.

- New codes for conditional offers of coverage to spouse.

- COBRA reporting.

ACA REPORTING – WHAT'S NEW?

- Supplemental minimum essential coverage.
  - If an employee is covered by more than one plan providing minimum essential coverage (MEC) provided by the same reporting entity, reporting is required for only one of the plans (medical plus HRA).
  - Reporting is not required for MEC that is conditional upon being covered by other reportable MEC.

HEALTH REIMBURSEMENT ARRANGEMENTS

- Stand-alone HRAs for active employees violate ACA provisions regarding dollar limits and preventive service requirements.
- Going forward HRAs must be "integrated" with a group health plan – two permissible methods.
    - IRS Notice 2015-87 clarifies that HRA coverage cannot extend to spouse or dependent unless spouse/dependent are also enrolled in qualifying employer sponsored coverage.
- Cannot be used to purchase individual coverage.
- Effective for plan years on and after January 1, 2014.
- Does not impact retiree only HRAs.
    - IRS Notice 2015-87 confirms that HRA is minimum essential coverage and therefore retiree is not eligible for premium tax credit.

INDIVIDUAL PREMIUM REIMBURSEMENTS

- Arrangements that provide cash reimbursement for purchase of individual policies are prohibited because they fail to comply with the ACA market reform provisions which cannot be integrated with individual policies.

- Prohibited regardless of pre-tax or post-tax basis.

    - IRS Notice 2015-87 clarifies that salary reductions through cafeteria plan may not be used to purchase coverage on individual market.

- Can trigger penalties such as excise taxes under Code section 4980D ($100 per violation, per day).

- Solution….offer taxable compensation with “no strings attached”!

STUDENT PREMIUM REDUCTION ARRANGEMENTS

- Premium reduction arrangements are arrangements designed to reduce the cost of student health insurance to students through a credit, offset, reimbursement, stipend, or similar arrangement.
- Colleges and universities use these types of arrangements to pay for some or all of the cost of student health coverage for their graduate students.
- Transition period to comply – no enforcement for plan years or policy years that begin before January 1, 2017.

TRANSGENDER BENEFITS

ACA NONDISCRIMINATION

- ACA prohibits individuals from being excluded from participation in, denied the benefits of, or subjected to discrimination under health programs and activities on the basis of sex
    - Applies to employers that receive federal financial assistance from HHS (e.g., grants, loans, credits, Medicaid, self-funded health plan that applies to Retiree Drug Subsidy under Medicare Part D payments)
    - Extends to entity's employee health benefit programs
    - Effective for plan years beginning on or after January 1, 2017
- Employee health benefit plan may not
    - Deny or limit coverage or impose additional cost-sharing or other limitations or restrictions on coverage for sex-specific health services provided to transgender individuals just because the individual seeking such services identifies as belonging to another gender
    - Categorically exclude coverage for all health services related to gender transition

WELLNESS PROGRAM COMPLIANCE

WELLNESS PROGRAMS

Current Legal Landscape:

- Final HIPAA wellness program rules took effect 1/1/14 to incorporate changes mandated by the ACA subjecting programs to more rules and regulations.

- Americans with Disabilities Act ("ADA") issues in the spotlight.
    - EEOC continues to scrutinize and has filed several lawsuits against employers claiming violations of the ADA.

    - EEOC issued final rule providing guidance on how wellness programs can comply with both HIPAA and ADA requirements.

- GINA updated regulations

HIPAA WELLNESS PLAN RULES

Five Requirements:

1. Annual Qualification: Must give individuals the opportunity to qualify for the reward at least once per year (same for activity and outcome based programs)
2. Limit on Amount of Reward: Reward for all health-contingent programs with respect to an individual may not exceed 30% of the cost for employee-only coverage under the plan (same for activity and outcome based programs)
   - Based on total costs (including employer and employee premium share)
   - If spouses and/or dependents may participate in wellness program, then based on total cost of coverage in which spouse and/or dependents are enrolled
   - Reward can be up to 50% for smoking cessation programs
   - "Reward" is defined to include both obtaining a reward (e.g. premium discount) or avoiding a penalty (e.g. absence of a premium surcharge)
   - Examples: 30% for BMI + 20% for tobacco use = permissible; 30% for BMI + 50% for tobacco use = not permissible

HIPAA WELLNESS PLAN RULES

3. Reasonable Design: Wellness program must be reasonably designed to promote health or prevent disease
   - —Must have a "reasonable chance" of improving health or preventing disease
   - —Must not be overly burdensome
   - —Must not be subterfuge for discriminating based on a health factor
   - —Must not be highly suspect in the method chosen to promote health or prevent disease
   - —Determination based on all relevant facts and circumstances – using evidence-based clinical guidelines are encouraged as "best practices"

HIPAA WELLNESS PLAN RULES

4. Uniform Availability and Reasonable Alternative Standard: Wellness programs must provide reasonable alternatives to obtaining rewards

   - Reward must be available to all similarly situated employees – accomplished by providing a "reasonable alternative standard"

   - Different requirements for activity-based and outcome-based programs

5. Notice of Availability of Reasonable Alternative Standard: Must disclose availability of reasonable alternative standard in all plan materials describing the wellness program

AMERICANS WITH DISABILITIES ACT (ADA)

- Employers cannot deny, on the basis of a disability, qualified individuals an equal opportunity to participate in, or receive benefits under, employer programs
- Generally prohibits employers from making medical inquiries or requiring medical examinations unless
  - Job-related and consistent with business necessity
  - Voluntary and part of an employee health program
- ADA applies to all wellness programs that include disability related questions or require participants to undergo medical examinations

AMERICANS WITH DISABILITIES ACT (ADA)

- Final regulations published May 16, 2016, effective for plan years beginning on or after January 1, 2017
  - Seeks to harmonize HIPAA and ACA rules with ADA requirements that medical inquiries or medical examinations must be voluntary
    - Explain what an employee health program is
    - Define what it means for an employee health program to be voluntary
    - Clarify that employer may offer limited incentives as part of a wellness program

AMERICANS WITH DISABILITIES ACT (ADA)

- Employee health program - programs must be reasonably designed to promote health or prevent disease
  - Reasonable chance of improving health or preventing disease
  - Programs can't be overly burdensome or highly suspect in its method

AMERICANS WITH DISABILITIES ACT (ADA)

- Voluntariness:
  - May not require employees to participate
  - May not deny health coverage for non-participation
  - May not limit health coverage or benefits for non-participation except as specifically allowed
  - May not take any other adverse action or retaliate against, interfere with, coerce, intimidate or threaten employees

AMERICANS WITH DISABILITIES ACT (ADA)

- Other requirements:
  - —Employers must provide notice explaining what medical information will be obtained, how it will be used, who will receive it and how it will be kept confidential
  - —Programs may offer incentives of up to 30 percent of cost of employee-only coverage
  - —Programs must include reasonable accommodations
  - —Employers may only receive information in aggregate format

GINA

- No incentive for providing genetic information.
- May offer reward for spouse providing
- Can offer a 30% incentive for a spouse to provide information related to spouse's manifestation of a disease or disorder.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

MENTAL HEALTH PARITY AND ADDICTION EQUITY

- If plan provides medical/surgical benefits and mental health or substance abuse benefits, the plan must provide parity with respect to
    - Financial requirements (deductibles, copayments, coinsurance and out-of-pocket maximums
    - Quantitative treatment limitations (number of visits or treatments or days of coverage)
    - Non-quantitative treatment limitations (medical management standards)
- Big focus on compliance at individual plan level

FIDUCIARY INVESTMENT ADVICE RULES

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- Final regulations recently issued.
- Plans subject to new fiduciary investment advice rules include:
    - ERISA retirement and certain welfare plans (Note: Only applies to welfare plans if they contain an investment component)
    - ERISA covered 403(b) plans
    - IRAs

FIDUCIARY INVESTMENT ADVICE RULES

- Defines an "investment advice" fiduciary as a person who provides, to a plan, fiduciary, participant, beneficiary, IRA or IRA owner, for a fee or other compensation (direct or indirect):
  - Investment recommendation(s); or
  - Investment management recommendation(s)
- "Recommendation" means a communication that, based on its content, context, and presentation, would reasonably be viewed as a suggestion that the advice recipient engage in or refrain from taking a particular course of action.
  - Facts and circumstances.
  - The more individually tailored the recommendation is to a specific recipient, the more likely the DOL is to view it as a recommendation.

FIDUCIARY INVESTMENT ADVICE RULES

- Certain communications that are not considered fiduciary investment advice:
  - Investment Education
  - Platform Providers
  - General Communications
- Best Interest Contracts ("BICs") Exemption - Allows investment firms and advisors to continue using compensation arrangements if take specific steps to acknowledge fiduciary status, adopt policies and procedures to mitigate conflicts of interest, and disclose information about conflicts and cost of advice.

THANK YOU!

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