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SML
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Employee Benefits | Life Insurance | Risk Management

INSURANCE BRIEF

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ACA Reporting—What's Next

Now that the initial employer reporting deadlines have passed, what can you expect in the coming weeks?

Correcting Reporting Errors. A corrected return should be filed as soon as possible after an error is discovered. Corrected Forms 1094-C should be submitted to the IRS only. Corrected Forms 1095-C must be sent to both the IRS and affected employees/enrollees.

- If correcting information on the Authoritative Transmittal, file a standalone fully completed Form 1094-C including the correct information and enter an "X" in the CORRECTED checkbox. Do not file a return correcting information on a Form 1094-C that is not the Authoritative Transmittal. Do not file any other documents (e.g. Form 1095-C) with the corrected Authoritative Transmittal.
- If correcting information on a Form 1095-C that was previously filed with the IRS, file a fully completed Form 1095-C including the correct information and enter an "X" in the CORRECTED checkbox. File a Form 1094-C Transmittal (DO NOT mark the CORRECTED checkbox on the Form 1094-C) with corrected Form(s) 1095-C. Furnish the employee a copy of the corrected Form 1095-C.
- Correcting both a Form 1094-C and Form 1095-C requires two separate submissions, which can be included with the same transmittal to the IRS.

Question: What should we do if we receive a Social Security number mismatch/no match notification after we submit our 1095-Cs to the IRS?

Answer: The ACA Information Returns (AIR) system, the system designed by the Internal Revenue Service (IRS) to accept Forms 1095 and 1094 electronically, includes a verification feature. The system will return an error message if the employee name and Social Security number (SSN) on Form 1095-C do not match the name and SSN in the records of the Social Security Administration (SSA). The most common example is a female employee who changed her name due to marriage or divorce but did not update her name with the SSA. The error also may be as simple as a typo or misspelling of the name in either your records or the SSA's records.

You will need to verify the correct name and SSN with the employee. For instance, request a copy of the employee's Social Security card and check the employee's W-4. Either your records or the SSA's records may need updating. Typically, you should use the employee's name exactly as shown in the SSA's records for all governmental reporting and payroll matters.

2016 Reporting: If you would like to change vendors or begin using a vendor to complete the reporting, please contact your SML Account Team as soon as possible. Employers will need to move quickly to provide all the necessary information for timely reporting.

Sick Leave Laws Increasing

California saw a state sick leave law go into effect last July 1st and since then many cities across the country have added their own laws. California in particular has seen new laws in San Francisco, Los Angeles and now San Diego. Following are highlights from some of these laws.

San Diego Minimum Wage and Paid Sick Leave Ordinance. On June 7, 2016, San Diego voters approved a local minimum wage and paid sick leave ordinance (Ordinance O-20390).

Under the sick leave provisions, employees who perform at least two hours of work in San Diego in a year will be entitled to one hour of paid sick leave for every 30 hours worked. There is no cap on accrual of paid sick leave; however, employees are limited to using only 40 hours of paid sick leave per year. Employees may carry over accrued, unused sick leave from year to year. Employers may set a reasonable minimum increment for the use of earned sick leave not to exceed two hours. Unused sick leave does not have to be paid out upon termination of employment. Effective date: The ordinance will go into effect upon certification of the election results.

Amendments to San Francisco's Paid Sick Leave Ordinance (Eff. January 1, 2017). On June 7, 2016, San Francisco voters approved Proposition E amending the city's paid sick leave ordinance (PSLO) to be more compatible with California's Healthy Workplaces, Healthy Families Act. Proposition E amends the PSLO to parallel broader state law provisions so that, with some exceptions, an employer who complies with the PLSO would also comply with state law.

Proposition E adds provisions to the PSLO consistent with broader state law so that:

- Employees begin to accrue paid sick leave under the PSLO on the first day of employment.
- Employees who leave a job and are rehired by the same employer within a year will have their unused PSLO sick leave reinstated.

Additionally, an employee may use paid sick leave for the broader purposes authorized by state law. Specifically, in addition to current uses:

- An employee may use PSLO leave for legal or other purposes when the employee is a victim of domestic violence, stalking, or sexual assault.

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2017 HSA Limits

The IRS has released the 2017 cost-of-living adjustments affecting HSAs and HDHPs. Here are the details:

- *HSA Contribution Limits.* The 2017 annual HSA contribution limit for individuals with self-only HDHP coverage is $3,400 ($50 increase from 2016), and the limit for individuals with family HDHP coverage is $6,750 (unchanged from 2016).

- *HDHP Minimum Required Deductibles.* The 2017 minimum annual deductible for self-only HDHP coverage is $1,300 (unchanged from 2016) and the minimum annual deductible for family HDHP coverage is $2,600 (unchanged from 2016).

- *HDHP Out-of-Pocket Maximums.* The 2017 maximum limit on out-of-pocket expenses (including items such as deductibles, co-payments, and co-insurance, but not premiums) for self-only HDHP coverage is $6,550 (unchanged from 2016), and the limit for family HDHP coverage is $13,100 (unchanged from 2016).

- Post-55 "Catch-Up" Limit remains $1000

Rev. Proc. 2016-28 Available at https://www.irs.gov/pub/irs-drop/rp-16-28.pdf

2016 PCORI Fees

The Patient Centered Outcomes and Research Institute (PCORI) fee, also known as the Comparative Effectiveness Research (CER) fee, is due annually using IRS form 720 by July 31st.

Background: This fee applies to both insured and self-insured medical plans. It is based on the number of covered lives—employees and dependents. For insured plans, the fee is paid by the carrier and included in premiums. For self-insured plans, the employer plan sponsor must calculate and pay the fee. The fee is based on the average number of covered lives for the 12-month policy period that ended in the preceding year.

Rates: For policies ending between January 1, 2015 through September 30, 2015, the cost is $2.08 per person. For policies ending between October 1, 2015 through December 31, 2015 the fee is $2.17.

Counting Methods: There are three allowable counting methods for self-insured policies. Once chosen, the plan sponsor must use only the one method for that reporting year. Here are the options:

Actual Count Method. Plan sponsors calculate the sum of lives covered for each day of the plan year and then divide that sum by the number of days in the year. This count includes employees plus dependents.

Snapshot Method. Plan sponsors calculate the sum of the lives covered on one or more dates in each quarter of the plan year and then divide that number by the number of dates used. Each date must be within three days of the date used for the first quarter. E.g. If using February 15th (1st quarter), then must use a day between May 12 – 18th (2nd quarter). Under this method, the plan sponsor can count the number of covered employees and multiply that number by 2.35 to obtain the spouse and dependents count.

The 5500 Method. By adding the total number of employee lives on the first day of the plan year to the total number of lives on the last day of the plan year as reported on the Form 5500 (without dividing by 2). Can only use this method if the 5500 for that plan year is filed no later than the due date for the fee imposed for that plan year. E.g. Calendar plan year 2015, the 5500 is due by 7/31/16, and the employer obtains an automatic 2 ½ month extension. The employer is not eligible to use the Form 5500 method because they did not file by the 7/31 fee due date.

Health Reimbursement Account (HRA). In the event the employer has a self-funded medical plan and a HRA covering the same group, the fee will be payable on the self-funded medical plan. If the employer offers a self-funded medical plan to one class (e.g. management employees) and a self-funded HRA to non-management employees, then the fee would be based on the aggregate number of covered lives. If the employer has a fully-insured medical plan and a HRA covering the same group, the fee is payable on the HRA. Most HRA third-party administrators are able to provide the covered lives count required to make payment.

Retiree Coverage: The fee applies to health insurance policies and self-insured health plans that provide accident and health coverage to retirees, including retiree-only policies and plans.

COBRA continuation coverage: COBRA and similar continuation coverage (Cal-COBRA, for example) must be taken into account when determining the PCORI fee.

Please contact your SML Account Team if you have any questions.

Sick Leave Laws *cont'd*

- Employees may use PSLO leave to care for a biological, adoptive, or foster parent, step-parent, or guardian of their spouse or registered partner, or the employee's guardian when the employee was a minor.

Under Proposition E, if an employer provides an employee with three days of paid sick leave at the beginning of the year under state law, those three days would be treated as an "advance" on paid sick leave not yet accrued under the PSLO.

Proposition E also authorizes the Board of Supervisors to amend the PSLO to adopt provisions parallel to state or federal law in order to provide broader protections or coverage to employees.

Los Angeles Passes Paid Sick Leave Ordinance. As we discussed in Memorandum 2016-4 dated May 18, 2016, the Los Angeles City Council voted to approve a proposal requiring employers to offer at least six days of paid sick leave per year. On June 2, 2016, Los Angeles Mayor Eric Garcetti approved a paid sick leave ordinance (Ordinance 184320) that requires employers to provide 48 hours of paid sick leave annually to employees that work two or more hours per week within the city.

Effective date: The ordinance goes into effect in two phases. Effective July 1, 2016, the ordinance applies to employers with more than 25 employees. Effective July 1, 2017, the law applies to employers with 25 or fewer employees. Paid sick leave begins to accrue on an employee's first day of employment or July 1, 2016, whichever is later. Employees may begin using paid sick leave on July 1, 2016 or on their 90th day of employment, whichever is later. Employers may choose to provide the entire 48 hours to an employee at the beginning of each year of employment, calendar year, or 12-month period; or allow an employee to accrue one hour of paid sick leave per every 30 hours worked.

Employees are entitled to take up to 48 hours of paid sick leave in each year of employment, calendar year, or 12-month period. Any unused accrued paid sick leave carries over to the following year, but employers may limit carryover to 72 hours. Upon termination, employers are not required to pay the employee for unused accrued paid sick leave hours. However, if a terminated employee is re-hired within one year, that employee is entitled to receive the accrued but unused paid sick leave time.

Employers should note that the definition of family member is broader under the ordinance than under state law and includes "any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship."

Minneapolis, MN Passes Paid Sick Leave Law (Eff. July 1, 2017). On May 27, 2016 The Minneapolis City Council passed Ordinance 2016-040, which requires employers doing business in Minneapolis to provide employees with one hour of paid sick/safe time leave for every 30 hours worked. Employees can accrue up to 48 hours of paid sick leave per year rolled over from one year to the next until they accrue a maximum of 80 hours. Covered employees include any individual who performs work within the geographic boundaries of the City for at least 80 hours in a year for the employer.

Chicago City Council Passes Sick Leave Ordinance (Eff. July 1, 2017). On June 22, 2016, the Chicago City Council passed Ordinance 02016-2678 that will require most Chicago employers to provide their employees with at least five paid sick days per year. Under the ordinance, employees will accrue one paid sick leave hour for every 40 hours worked, with a cap of five sick days per year. Employees may rollover one-half of their annual unused paid sick leave to the following year to a maximum of 20 hours, except that employees covered under the Family and Medical Leave Act (FMLA) can rollover up to 40 hours to use exclusively for FMLA purposes. Covered employees include those that work at least 80 hours within a four-month period

Medical Loss Ratio Rebates

It's nearly time for carriers to send out notices on medical loss ratio (MLR) rebates.

Background: Under the Affordable Care Act the MLR requirements set minimum percentages of premium dollars that health plans must spend on health care (medical costs and activities that improve health care quality). For large groups the minimum is 85% and for small groups and individual it is 80%. The large or small group status varies by state, and in California is currently defined as 100+ full-time and full-time equivalents for large group and 1-99 for small group. If an insurer spends less than the minimum percentage required they have to pay a rebate to policyholders.

All policyholders (employers sponsoring group policies) will receive a notice of rebate on or before September 30 if the policyholder is due a rebate. These notices have details about the rebate and a check will be enclosed. The final regulations and the Department of Labor's Technical Release 2011-04 address how an employer can use this money.

Key Provisions: Under ERISA any monies attributable to employee payments are considered plan assets and must be used for the exclusive benefit of plan participants. If the employer pays 100% of employee and dependent premiums then there are no plan assets and the full rebate remains with the employer. The rebate must be used within 90 days of receipt or the employer will need to hold the money in a trust.

If payments to MLR year participants are not cost-effective (e.g., are "de minimis" or create tax consequences) the rebates may be used for other permissible purposes including premium reductions, cash payments or benefit enhancements. Under general principles, cash payments are W-2 wages for FICA and federal income tax withholding purposes. Different rules apply to public agency and church plans. For these plans, only a reduction in premiums or refunds to employees is permissible. Benefit enhancement is not an option. In addition, church plans must enter into an agreement with the issuer to make a distribution.

What Portion of Rebate Goes to the Participant? The employer must calculate both the amount of premiums paid by the employer and the amount paid by employees, as a percent of total premiums for the MLR year, calendar 2015. If the rebate is not for all policy designs with the carrier the calculation should only include those premiums paid for the rebated policy(ies). The employer should document their allocation method. This will be yet another area that will fall under DOL audits.

If the plan has multiple policies, the rebate from one policy (PPO 20, PPO 30, HMO 25, etc.) should generally benefit only those covered by that policy. For example, if Anthem is only rebating their HMO 25 product then the employee share should be distributed to the HMO 25 participants only.

If a policy has been terminated and there is no successor policy, the regulations allow the employer to keep the rebate. They are under no obligation to distribute the rebate to former plan participants. If there is a replacement or successor policy, the employer may elect to use it to reduce future employee contributions to the replacement/successor policy or to enhance benefits.

Deadline: Rebates should be used within three months of receipt to pay premiums or refunds. If an employer fails to distribute the rebate within this time they will trigger a requirement to set up a trust account to hold the rebate monies and complete a 5500 filing for that trust. If you cannot spend all of the rebate through premium reductions within the three month period paying a cash refund is recommended. Under this option all current participants receive a taxable payment which would be included on their W-2.

As always, contact your SML Account team if you have any questions.

EEOC Final Wellness Rules

On May 16, 2016, the Equal Employment Opportunity Commission (EEOC) released final rules and related Interpretive Guidance on employer wellness programs under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). The proposed rules held discrepancies between EEOC and ADA approaches to wellness programs. Despite various entities urging the EEOC to align its regulations with ACA, the final rules largely retained the structure and content of the proposed rules.

In the preamble to the final rule the EEOC states their belief that recent litigation losses involving wellness programs were "wrongly decided." Federal courts have ruled against the EEOC relying upon an application of the ADA's "bona fide benefit plan" safe harbor to employers' decisions to offer rewards or impose penalties in connection with wellness programs that included disability-related inquiries or medical examinations. This will likely result in further legal challenges.

Key Provisions:

- The rule applies to *all* wellness programs (e.g., participatory and health-contingent) that include disability-related inquiries and/or medical examinations, regardless of whether the program is offered as part of or separate from a group health plan;
- A 30% wellness incentive cap (reward or penalty, financial or in-kind), which applies to all workplace wellness programs, including participatory programs and smoking cessation programs (except smoking cessation programs that merely ask employees whether they smoke), along with four different methods for calculating the cap in the following scenarios:
    - when participation in the wellness program depends on enrollment in a particular group health plan = 30% of the cost of self-only coverage (including employee and employer contributions);
    - when an employer offers a single group health plan, but participation in the wellness program does not depend on the employee's enrollment in the plan = 30% of the cost of self-only coverage under that plan;
    - when an employer has multiple group health plans, but participation in the wellness program does not depend on enrollment in any of the plans = 30% of the cost of the lowest-cost self-only coverage under a major medical plan offered by the employer; and
    - when an employer does not offer any group health plan/coverage = 30% of the cost of the second lowest-cost Silver Plan available on the exchange in the state of the employer's principal place of business if such a plan is purchased by a 40-year-old non-smoker;
- All wellness programs (e.g., participatory and health-contingent) must satisfy the EEOC's "reasonably designed to promote health or prevent disease" standard (a standard applied in the ACA context only to health-contingent wellness programs);
- A prohibition on so-called "tiered health plans" that condition eligibility for a particular health plan/plan design on participation in a wellness program (e.g., certain comprehensive plans made available only to wellness program participants);
- A special notice requirement explaining to participating employees what medical information will be obtained, how the information will be used, who will receive the information, the restrictions on disclosures of such information, and the methods the employer uses to prevent improper disclosure (the EEOC plans to release a model notice within 30 days); and

The final rule does clarify that because the ADA's prohibitions on discrimination apply only to applicants and employees, these regulations do not address incentives wellness programs may offer in connection with dependent or spousal participation. Further, the EEOC declined to incorporate an affordability standard into the final rule.

Effective Date: The 30% cap on rewards and penalties under both the ADA and GINA and the new ADA notice apply in the first wellness program year starting on or after January 1, 2017. The EEOC considers other aspects of the rules to be clarifications of current law.