Employee Benefits Report

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Affordable Care Act Update

As this issue went to press, the Supreme Court was hearing arguments in *King v. Burwell*, which could decide the fate of the Affordable Care Act (ACA). Meanwhile, other changes have affected administration of the ACA.

No More Skinny Plans: In past issues, we've discussed so-called skinny plans, or medical plans that large employers have argued would fulfill their requirement to provide affordable medical coverage to employees. The ACA requires individual and small group health plans to cover certain preventive services and to cover a list of "essential health benefits." Large employer plans don't have this requirement. Instead, they

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This Just In

The ruling in the case *Tibble v. Edison International* could bring greater scrutiny to 401(k) plan fees and fiduciary duties toward participants. The Supreme Court recently heard arguments in the case. Plaintiffs claim that administrators of Edison's retirement plan breached their fiduciary duties by offering plan participants retail-class mutual funds, when identical institution-class mutual funds were available at lower cost.

The district court where the case originated granted summary judgment for Edison. It reasoned that the plaintiffs' claim was time-barred under ERISA, the Employee Retirement Income Security Act. ERISA requires plan participants to file lawsuits for breach of fiduciary duties within six years of when the breach occurred. At question is whether fiduciaries

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must provide coverage that is affordable and meets minimum value standards, which means covering at least 60 percent of the total cost of medical services for a standard population.

Skinny plans cover the required preventive services, but do not provide hospitalization benefits, which is one of the most costly “essential benefits.” These plans save money…and some meet the minimum value standard.

In late February, the Department of Health and Human Services (HHS) finalized a proposed rule that requires employer-sponsored health plans to cover hospitalization benefits. It said a plan that does not offer hospital benefits “is not a health plan in any meaningful sense.” This means large employers offering only a skinny plan would be subject to the ACA’s penalties of up to $3,000 per employee.

Employees covered by these plans now officially lack qualifying coverage, which would make them subject to penalties. Many of these workers are in low-wage industries, such as restaurants and retail. HHS is granting them relief, allowing them to receive subsidies to buy comprehensive individual coverage.

HHS is allowing employers that signed contracts before November 4, 2014 to retain these plans for this year.

Health Reimbursement Arrangements Okay…for a Few More Months: Small employers with health reimbursement arrangements (HRAs) have gotten a temporary reprieve from the Obama administration. In late February, the Internal Revenue Service and Treasury Department announced that they will not levy penalties against small businesses that use standalone HRAs until July. This will give small employers more time to change their plans.

HRAs allow employers to reimburse employees for qualified healthcare costs with before-tax dollars, benefitting both employer and employee. Since the implementation of the Affordable Care Act (ACA), though, employers using standalone HRAs are subject to fines. HRAs have annual limits, which violates the ACA’s prohibition on health plans with annual limits.

The federal agencies overseeing the ACA—the Departments of Health and Human Services, Treasury and the IRS—determined that employers can offer an HRA to active employees if they are also covered by a group health plan that complies with ACA rules. Under the new rules, an HRA can reimburse non-essential health benefits, such as premium expenses for Medicare and/or deductibles. Employers can offer standalone HRAs to retirees.

IRS Begins Working on Details of “Cadillac Plan” Tax: To fund coverage subsidies, the ACA includes a tax on so-called “Cadillac” health plans. These high-cost health plans insulate individuals from the cost of their health care.

The ACA specifies the 40 percent excise tax will apply to plans that cost more than $10,200 for self-only coverage and $27,500 for family coverage. In insured plans, the health insurer will pay the tax; in self-insured plans, the plan sponsor, usually the employer, will pay. The IRS must create rules implementing the tax, which goes into effect in 2018, so many details remain unknown at this point.

In a notice issued on February 23, the IRS defined “applicable coverage” for purposes of the tax. The notice clarified that it does not matter whether the employer pays all, or any premiums, for the plan. Even if the employee pays for coverage with after-tax dollars, if the employer sponsors the plan, the tax will apply. Types of plans the Cadillac tax will apply to include:

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have a duty to monitor investments on an ongoing basis, if the initial investment was made more than six years earlier. If the Supreme Court agrees that plan fiduciaries have an ongoing monitoring responsibility, it could open the door to more fiduciary breach lawsuits.

Lockheed Martin recently settled a case involving fees in retirement accounts for $62 million. Plaintiffs’ attorneys said it was the largest settlement ever in a lawsuit over fees in retirement plans.

- Health FSAs (flexible spending arrangements)
- Archer Medical Savings Accounts
- Health Savings Accounts (not including certain contributions by individuals)
- Government group health plans covering civilian employees. (This excludes military coverage.)
- Coverage for on-site medical clinics, except for clinics that provide only de minimis medical care
- Retiree coverage
- Multiemployer plans
- Indemnity plans, when payment for coverage is excluded from gross income or a deduction is allowed. This would include most critical illness coverage, dread disease insurance (such as cancer insurance), and hospital indemnity plans or other health plans that pay a specified amount per occurrence or claim.

The IRS also states that it expects that executive physical programs and health reimbursement arrangements (HRAs) will likely be included in the definition of applicable coverage.

The Department of the Treasury and IRS are inviting comments on this initial notice and will issue further notice on the calculation and assessment of the tax.

For more information on the Affordable Care Act and how it affects your organization's benefits programs, please contact us.

FLMA Leave Benefits Now Apply to Employees in Same-Sex Marriages

In February, the U.S. Labor Department updated the Family and Medical Leave Act's (FMLA) definition of spouse. This extends the benefits under the FMLA to workers in legal same-sex marriages, regardless of where they live.

The Department of Labor's rule change updates the FMLA so the law complies with the U.S. Supreme Court ruling in *United States v. Windsor.* That ruling struck down the federal Defense of Marriage Act provision that defined "marriage" and "spouse" as limited to opposite-sex marriage for purposes of federal law.

Before this rule change, the regulatory definition of "spouse" did not include same-sex spouses if an employee resided in a state that did not recognize the employee's same-sex marriage. Under the new rule, eligibility for FMLA leave depends on the law of the place where the marriage was entered into. This "place of celebration" provision allows all legally married couples, whether opposite-sex or same-sex, to have consistent federal family leave rights regardless of whether the state in which they currently reside recognizes such marriages.

Enacted in 1993, the FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. Employees can take leave for their own medical needs or to take care of a family member who has a serious health condition.

What are "covered employers"? The FMLA applies to any employer that employs 50 or more workers in a 75-mile radius each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Which employees are eligible? Employees can take FMLA leave if they have worked for an FMLA-qualified employer for at least 12 months and have worked for at least 1,250 hours over the previous 12 months.

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How much leave can workers take? Eligible workers can take up to 12 weeks of leave per year.

What can employees take leave for? Eligible employees can take leave for their own serious health conditions, to care for a family member (spouse, child or parent) with a serious health condition, or for childbirth, adoption or foster care. Workers can take leave consecutively or intermittently. Leave may run concurrently with workers' compensation, short-term disability and salary continuation.

What is "a serious health condition"? The FMLA defines this as incapacity or treatment that involves inpatient care (an overnight stay) in a medical care facility, as well as subsequent treatment related to inpatient care. It also includes any period of incapacity due to pregnancy, a chronic serious health condition or a health condition lasting more than three days that requires treatment by a health care provider. The FMLA also applies to absences to receive multiple treatments to address serious conditions.

What other responsibilities do employers have? Employers that provide health benefits must continue them during an employee's leave. Following the 12 weeks of unpaid leave, employers must reinstate the employee in the same job or an equivalent one. Employers that deny or restrict an employee's rights under FMLA may be liable for lost wages and benefits, as well as damages and legal fees. Keep in mind that medical privacy rules apply to FMLA, and safeguard any medical information.

The employer has the ultimate responsibility of designating FMLA-eligible leave as FMLA leave based upon information furnished by the employee. You may not wait to designate FMLA leave after the leave has been completed and the employee has returned to work, unless you are: (1) awaiting medical certification to confirm a serious health condition, (2) unaware that leave was for an FMLA reason, and later receive employee requests for additional leave or (3) unaware of the situation and the employee notifies the company of the FMLA leave within two days after returning to work.

What are employees' obligations? To qualify for FMLA leave, an employee must provide sufficient information to substantiate the need for leave. For medical leave, they do not have to have their medical provider supply a specific diagnosis, but merely certify the need for medical leave. Once an employee qualifies for FMLA leave, he or she does not have to provide advance notice if the leave is not foreseeable — for example, a migraine sufferer could leave work every time he gets a headache.

To complicate things, many states have their own family or medical leave laws. State leave laws may be more generous in certain areas, including: (1) employee hours requirement (1,000 vs. 1,250 hours), (2) the minimum number of employees required for the law to apply (15 vs. 50 workers) and (3) the definition of family member (to include in-laws). You'll want to check to make sure that your leave policies comply with state laws.

For more information on the FMLA and other compliance matters, please contact us.

FLMA Leave Benefits Now Apply to Employees in Same-Sex Marriages

In his State of the Union address, President Barack Obama promised to "streamline child care tax incentives" to help 5.1 million families. But his proposal could jeopardize dependent care savings accounts, a benefit valued by millions.

Around the same time as the State of the Union address, the U.S. Bureau of Labor Statistics released a report on employer-provided dependent care benefits. It looked at dependent care reimbursement accounts and workplace-funded childcare. According to the BLS, about 13 million American families with one or both parents working had children under 6 years old.

No law requires employers to provide dependent care benefits (which includes benefits for elder care). Yet many employers opt to provide these benefits, knowing they help their recruitment and retention efforts, ease work-family conflicts, reduce tardiness and absenteeism in the workplace, and increase employee morale and productivity. In 2014,

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36 percent of private industry workers had access to dependent care reimbursement accounts, while 10 percent had access to workplace-funded childcare.

Dependent care reimbursement accounts also have tax benefits. They allow employees to deposit some of their pretax salary to a flexible spending account (FSA), which they can use to pay for dependent care while they work or look for work. The IRS considers expenses to care for children up to age 13 eligible dependent care expenses, along with care for adults and elders who cannot care for themselves. Eligible expenses include daycare, babysitters, before- and after-school programs and summer camps (not overnight). Employees must use the funds for expenses they incur within that calendar year. Employees can contribute up to $5,000 per year. High-wage workers are more likely to have these benefits. The BLS found that 58 percent of management, professional and related workers in private industry had access to dependent care reimbursement accounts. Only 18 percent of service and part-time workers had access.

Employees may be able to exclude workplace-funded childcare benefits from their taxable income. Employees who receive dependent care benefits from their employer might have a lower dollar limit on the amount of tax credit they can take.

The Obama administration wants to eliminate dependent care spending accounts. Instead, it would increase the dependent care tax credit. The credit currently allows taxpayers to use up to $3,000 in expenses for one child and $6,000 for more than one to figure the credit. The percentage of these expenses you can claim as a tax credit varies with your adjusted gross income, but you can get a credit of up to $1,000 per qualifying child.

Dependent care reimbursement accounts offer some advantages to employers that increasing the tax credit doesn't. Offering these benefits can help employers recruit and retain younger employees with families, or those with eldercare responsibilities. Employers also reduce their payroll tax burdens, since employees contribute pre-tax dollars.

For more information on dependent care reimbursement accounts and other benefits you can use to attract younger workers, please contact us.

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King v. Burwell Will Determine Affordable Care Act's Fate

As this newsletter went to press, the U.S. Supreme Court was hearing arguments in the case *King v. Burwell.* Their ruling could determine the fate of the Affordable Care Act.

The case revolves around five words in the 1,000+ page Act. The Act makes subsidies to buy health insurance available to people who buy plans on an "Exchange established by the State." The petitioners are challenging the legality of subsidies in states that lack a state-based insurance Marketplace. Only 13 states and the District of Columbia have state-established insurance exchanges. The others have either a federally supported state-based program, a transitional partnership program or a federally facilitated Marketplace.

Congress could solve the problem by amending the Affordable Care Act, but that's unlikely to happen in the current Congress. If the petitioners are successful, they will likely achieve their goal of dismantling the ACA. The success of any health insurance program requires achieving high participation levels. If younger and healthier people don't buy coverage, only the sick and elderly will buy coverage. These people cost more to insure, which will drive costs up further, ending in a so-called "insurance death spiral." Without subsidies, Marketplace health plans would become unaffordable for many younger people.

Health insurance blogger Frederick Pilot noted the timing of the case presents problems, and hopes for a ruling to come soon rather than just before the court's current session ends in June. If the court rules that subsidies in the federally facilitated exchanges are illegal, "states will need sufficient time to authorize and set up their own exchanges and select exchange qualified health plans prior to the start of plan year 2015 open enrollment on November 1." He also notes that the decision will affect health insurers, which need to know if subsidies will be available to determine what plans they will offer in affected states. ▪

Employee Benefits Report

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