Employee Benefits Report

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Could Paid Family Medical Leave Be in Your Company's Future?

Although the federal Family and Medical Leave Act (FMLA) requires some employers to provide *unpaid* leave to workers for family or medical reasons, several states now mandate employers to provide *paid* leave.

California was the first state in the country to pass a paid family leave law. New Jersey has had partial paid leave since 2009 and Rhode Island since 2014. New York's paid leave laws went into effect this year and the District of Columbia and Washington state's programs are scheduled to start in 2020. Twenty-one other states have proposed similar legislation.

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Grandmothered Health Insurance Plans Given a Reprieve

The deadline to end grandmothered health insurance plans has been extended — again.

Officials with the Centers for Medicare & Medicaid Services announced in April 2018 that they will extend the deadline to Dec. 31, 2019 — provided that the plans were purchased on or before Oct. 1, 2019. The plans originally were scheduled to end Oct. 1, 2014, but were extended several times, with plans to end the program in 2018. Thirty-five states currently allow grandmothered plans.

A grandmothered plan is health coverage that was pur-

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Even without state mandates, some employers provide paid time off for parenting and care giving, but most do not.

Generally, employees receive partial pay from an insurance policy they pay into. Sometimes, the employer pays, too.

Why Interest is Growing

Paid leave is becoming a popular benefit as employers look for ways to retain and attract talented employees and build a supportive company culture. And with more families needing two incomes and single-parent families on the rise, many families can't afford to make do for very long without a paycheck.

What FMLA Provides

FMLA is a federal law that applies to employers with 50 or more employees. FMLA provides eligible employees up to 12 work weeks of unpaid leave in a 12-month period. However, the job-protected leave can only be taken for specified family and medical reasons:

- Birth and care of a newborn child
- Time to bond with an adopted or foster child
- To care for an immediate family member who has a serious health condition
- To recover from a serious health condition
- Assist a family member who has been called to active duty

Up to 26 weeks leave is available in a single 12-month period for employees who need to care for a service member who has a qualifying serious injury or illness.

FMLA also requires employers to restore the employee to the same or equivalent job and to maintain the employees' health benefits.

Some states offer more generous FMLA coverage — such as requiring smaller employers to offer coverage — so it pays to check your state's laws.

How Paid Leave is Handled on the State Level

For an example of what regulations might look like if similar paid leave programs are implemented in your state, take a look at what New York did at the beginning of this year.

The New York Paid Family Leave (PFL) is one of the most comprehensive family leave programs in the nation. The program requires employers to provide their employees with job-protected time off to bond or care for a new child (birth, adoption, foster), to care for a family member with a serious health condition, or to handle qualifying military exigencies for a family member.

PFL benefits provide insurance coverage and are funded through employee payroll deductions. All PFML laws have caps based on income, and some laws cap the weekly benefits at $1,000 per week.

The rules are different for employers who self-insure.

The maximum weekly employee contribution for coverage is 0.126% of an employee's weekly wage. Based on an average wage, the employee would pay $1.65 per week.

The number of weeks of paid leave varies according to the state and situation. For example, Washington, D.C., awards paid time off based on the situation, while Rhode Island provides for 4 weeks leave and California and New Jersey provide for 6 weeks. New York plans to increase its paid time off to a maximum of 12 weeks by 2021.

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

chased by a small group or individual between March 23, 2010 and Dec. 31, 2013, and is not in full compliance with Affordable Care Act (ACA) regulations. It is similar to a "grandfathered" plan, but grandfathered plans were purchased prior to March 23, 2010 — before the ACA was enacted. Grandfathered plans do not expire.

Small groups and individuals were allowed to keep these transition relief plans because, in most cases, the ACA-compliant plans are more expensive.

If you have a grandmothered plan, you should have received a notice from the federal government about the extension, along with information about steps you can take to purchase an ACA-compliant policy.

ACA Compliance Issues for 2018

Even though the Affordable Care Act (ACA) is in its eighth year, many employers are not especially confident they know how to stay in compliance with the controversial health care reform law.

Some of the confusion stems from President Donald Trump and Congress. Trump dismantled parts of the law after the House and Senate failed to pass a promised repeal. Republicans long have campaigned against the ACA reasoning that government should not intrude in private industry, while Democrats have rallied to keep the plan wholly intact as the way to provide all Americans with access to health care.

Another way Trump has modified the ACA is with an executive order to allow health insurers to sell health plans to small employers who have banded together to form an association. These association plans are less expensive, but have fewer benefits than ACA-compliant plans. Last October, the Trump administration also stopped paying cost-sharing subsidies to insurance companies. Insurance companies used these funds to cover expenses from lower deductibles and out-of-pocket costs mandated under the law for individuals with low incomes.

Another significant change was Congress eliminating the individual mandate which required most Americans to have health insurance or pay a penalty. That change will be effective in 2019.

Despite the changes, many ACA rules and regulations are still in effect. Here is a list of some of the important actions employers must do to manage their 2018 benefits compliance efforts.

Pay or Play Regulations (for Large Employers)

Employers who have 50 or more full-time or full-time equivalent employees must provide a "minimum essential coverage" health care plan that is affordable and meets minimum value requirements. These requirements are known as the "employer shared responsibility" or "play or pay" provisions. If an applicable large employer (ALE) does not offer this type of coverage, they may be subject to penalties. Even if you have fewer than 50 full-time employees, it will be worth your time to double check your ALE status at www.irs.gov and search "ALE information."

- **Minimum Value:** An employer-sponsored plan is one that provides "minimum value" when it covers certain types of medical expenses and pays at least 60 percent of employees' health care costs.
- **Affordability:** The health coverage you provide is considered affordable if an employee's required contribution to the plan doesn't exceed 9.5 percent of the employee's household income for the taxable year. The 2018 adjusted percentage is 9.56 percent. This can be difficult to determine since you're unlikely to know your employees' household incomes. Therefore, to make the affordability determination, you can use Form W-2 wages; an employee's rate of pay; or the federal poverty line instead of household income.

Health Plan Reporting (for Large Employers)

If you are an ALE you must complete and submit Form 1094-C to the Internal Revenue Service (IRS) and Form 1095-C to the IRS and your employees. These forms will not be due until the beginning of 2019. The federal government uses the forms to determine wheth-

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er employers are providing the minimum essential coverage to employees.

Notifications (Small and Large Employers)

- **Summary of Benefits and Coverage (SBC):** The SBC is a document you give to employees when they enroll in your group health benefit plan. The SBC explains the employee's benefits and coverage in plain language. You also must provide it on request. For health plans with open enrollment periods or plan years beginning on or after April 1, 2017, make sure you use the template that was issued on April 16, 2016.
- **Marketplace (Exchange) Notice:** You must notify new employees within 14 days that they can purchase coverage on the Marketplace.
- **Patient Protection Notice:** Provide this notice at enrollment and include it in the SBC if you have a non-grandfathered plan.
- **W-2 Reporting of Health Coverage:** You must report the aggregate cost of health coverage on Forms W-2 — unless you filed fewer than 250 W-2s the prior year.
- **Medical Loss Ratio Rebates:** You must notify plan participants if you received rebates from insurers because they collected too much in premiums. You may be responsible for sharing a portion with your employees if the refund is considered a plan asset.

Fees (Employers Who Self-Fund Their Health Benefit Plans & Health Insurance Providers)

- **Patient Centered Research Institute Fee:** This fee must be paid to the IRS through 2019. For policy and plan years ending after Sept. 30, 2016, and before Oct. 1, 2017, the applicable dollar amount is $2.26. For policy and plan years ending after Sept. 30, 2017, and before Oct. 1, 2018, the applicable dollar amount is $2.39.

This is not a complete list and it does not include each state's specific insurance regulations. For more information about compliance and other issues related to ACA, please contact us. ■

What's The Best Health Care Account for Your Employees?

Help your employees achieve more control over their health care decisions and expenses by providing them with a savings account for medical expenses.

One of the most popular ways to save for health expenses is with a Health Savings Account (HSA). The Medicare Prescription Drug, Improvement and Modernization Act created HSAs in 2003 as a way for employees in qualified High Deductible Health Plans (HDHP) to save money on a tax-free basis to pay for qualified health care expenses. With money set aside for illnesses or injuries, employees have the freedom to shop for the best option for them and their families.

Other popular types of savings plans include the Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA). These accounts are similar, but differ according to how much can be saved annually, who can contribute to the plan and how the funds can be used.

Health Savings Account (HSA)

An HSA must be paired with a qualified HDHP, which covers serious illnesses or injuries and some preventive care. Since the deductible must be met before any plan benefits are paid, employees can use the money in their HSA to pay for qualified expenses, including medical and dental care, vision, prescription and some over-the-counter expenses; COBRA; retirement medical insurance premiums; LTC premiums or expenses.

Annual contribution limits for 2018 are $3,450 for individuals and $6,850 for families.

Advantages

- An employer — not just the employee — can contribute to the employee's account.
- Employees can take the account with them to their next job if they leave your company.
- If there is money left in the HSA at the end of the year, 100 percent rolls over to the next year.

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- Employees get triple tax savings.
- Funds from the account can be used to pay Medicare premiums and qualified long-term care premiums.
- Employer contributions are not taxable.

Disadvantages

- It can be difficult for employees to raise enough money to meet a deductible, in addition to saving enough money to pay for health related expenses.
- Employees pay a penalty if they withdraw funds for anything other than health care expenses.
- An HDHP/HSA is not always a good choice for those who have significant health expenses.
- Some HSAs charge a monthly maintenance fee or a per transaction fee.

Flexible Spending Account (FSA)

The Revenue Act of 1978 created the FSA program. An FSA is similar to an HSA because it allows employees to save money tax free for qualified medical expenses, including medical, dental, vision, prescription and some over-the-counter costs. Employees also can use FSA funds to pay deductibles, and copayments, but not insurance premiums.

FSAs don't have to be tied to a health plan, but account funds must be used during the plan year. You can offer a grace period of up to two and a half months; or you can let employees carry over as much as $500 each year — but not both. Any money not used by the end of the stated period is lost.

2018 contribution limits are $2,650 for healthcare expenses.

Advantages

- An employer, in addition to the employee, can add money to the account.
- Allows employees to set aside pre-tax money annually.
- Employer contributions are not taxable.
- 100-percent of the employee's annual election is available to them on the first day of the FSA plan year.

Disadvantages

- Employees cannot take the account when they move to another company.
- Only $500 can be rolled over to the next year (at the employer's discretion).

Health Reimbursement Arrangement (HRA)

A Treasury Department Revenue Ruling in 2002 created the Health Reimbursement Account. HRAs are self-funded, tax-favored programs that do not have to be, but usually are paired with a health plan or HDHP.

HRAs must be funded solely by the employer. The employee cannot fund the plan through a salary deduction. Employers can contribute any amount in a lump sum or per pay period. Employers can deduct the cost of both insurance plans and HRAs as a business expense.

Employees can use HRA funds to pay for medical, dental and vision care; prescriptions; and some over-the-counter expenses, as defined by their plan.

Advantages

- An HRA is funded by the employer and therefore is not portable, although it is allowed to cover former employees. When an individual's job status changes, the HRA funds stay with the employer. Employers may set up and fund a retirement HRA, and the HRA is subject to COBRA regulations.
- One hundred percent of any money left in the HRA at the end of the year rolls over to the next year if you allow it.
- Employer contributions are not taxable.
- There are no contribution limits.
- Small employers, under 50 full-time employees, can take advantage of a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) to allow contributions to reimburse individual health insurance premiums or healthcare expenses but have annual contribution limits.

Disadvantages

- Employees cannot contribute money to the account and must rely on the employer contribution.

Please contact us to discuss implementing any of these arrangements for your plan.

New Disability Insurance Regulations Designed to Provide Safeguards for Policy Holders

New regulations will affect employers and plan administrators who offer short-term and long-term disability plans.

New Employee Retirement Income Security Act (ERISA) regulations will change how employers handle disability claims and appeals. The U.S. Department of Labor's revised regulations became effective April 1, 2018.

If you offer your employees group disability plans, be sure to check if you and your vendors comply with the new regulations.

New Regulations

- Insurers cannot give bonuses to claims examiners or medical experts for denying claims. The purpose of the new regulation is to make sure claims and appeals are decided impartially.
- Insurers must send a detailed letter explaining the reason a claim is denied, the explanation must include why the insurer did or didn't agree with the disability determinations; an outline of company rules or guidelines the insurer used to determine the claim; and information about the claimant's right to access their claim file and relevant documents.
- Claimants have the right to appeal the decision within 45 days. Check your plan to ensure an appeal process is included.
- Plan administrators must follow procedures when retroactively rescinding a disability plan. Claimants don't have to go through a plan's claims procedures (including the appeal process) if the plan administrator does not follow the procedures. Plan administrators must respond within 10 days in writing when the claimant requests an explanation.
- Communications must be understood by all policyholders. Translation services — written and oral — should be available to claimants who speak languages other than English. In counties where at least 10 percent of the population doesn't speak English, denial letters must include a statement in that language about the availability of translation services.
- When claimants are denied benefits, they must receive an exact deadline for bringing a suit. The notification must include a description of the contractual limitations period and the actual calendar expiration date. ■

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