EMPLOYEE BENEFITS: 2016 BENEFITS UPDATE & WHAT EMPLOYERS NEED TO KNOW TO STAY COMPLIANT

2016 Labor & Employment Law Conference

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AGENDA

- Affordable Care Act ("ACA") Update
- Wellness Programs
- Fiduciary Responsibility
- Retirement & Deferred Compensation Plans

ACA UPDATE

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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
- Don't forget… employer size is based on controlled groups!
- Remember that full-time employee = 30 hours per week / 130 hours per month!
- Make sure plan documentation updated to reflect eligibility

ACA REPORTING REQUIREMENTS

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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

DEADLINES

- Reporting required for calendar years starting with 2015
- IRS extended reporting deadlines for 2015, but currently for 2016 filing and beyond, reports are due by February 28th of the following year, or March 31st if return is filed electronically
- For 2016 and beyond, statements to employees will be due by January 31st of following year (similar to W-2 deadline)
- Reporting is on a calendar year basis regardless of actual plan year

PENALTIES

- The penalty for failure to file generally is $100 for each return not to exceed $1,500,000 per calendar year
- The penalty for failure to provide a correct payee statement is $100 for each statement, not to exceed $1,500,000
- Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to furnish a payee statement
- Good faith compliance applied for last year's reports, unclear if strict compliance will be required going forward

IRS NOTICE 2015-87

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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 9.66% of employee's household income (indexed to 9.69% in 2016)
- Three safe harbors
- IRS Notice 2015-87 addresses 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

- HRA contributions
- Example
  - The employee contribution for medical coverage is $200 per month. For the current plan year, the employer makes available $1,200 under an HRA that the employee may use to pay the employee share of contributions for the medical coverage, pay cost-sharing, or pay towards the cost of vision or dental coverage.
- Conclusion
  - The $1,200 employer contribution to the HRA reduces the employee's required contribution for the medical coverage. The employee's required contribution for the medical plan is $100 ($200 - $100) per month because 1/12 of the $1,200 HRA amount per month is taken into account as an employer contribution.

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
- The availability of an opt-out payment may have the effect of increasing the employee's required contribution
- Anticipates that regulations will be issued with a prospective effective date
- 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

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
  - The amounts of these penalties have not been determined for 2017, but it is expected that they will increase slightly

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"

NON-DISCRIMINATION

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CODE SECTION 105(H)

- Internal Revenue Code Section 105 – general rule is that self-funded plans cannot discriminate in favor of highly compensated individuals (five highest paid officers, shareholders owning more than 10% of the employer's stock, or the highest paid 25% of all employees) in terms of benefits offered, waiting period, eligibility, etc.
- Complex rules and tests, historically not highly enforced by IRS
- ACA extends nondiscrimination rules to insured health plans… exact requirements and effective date unknown at this time
- Steep penalties for non compliance
- Employers should examine current arrangements with executives and former executives to prepare once these new rules take effect

CADILLAC TAX

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CADILLAC TAX

- ACA imposes a 40% excise tax on the cost of certain employer-provided health care plans that exceed a standard cap of $10,200 for annual individual coverage and $27,500 for all other categories of coverage
- Implementation date has been extended until 2020 (originally 2018)
- Recent legislation also provides that any payments of the tax will be tax-deductible
- Significant opposition to this provision of the ACA, but political turmoil makes repeal uncertain
- Employers negotiating union collective bargaining agreements that may be in effect leading up to or through 2020 should consider addressing potential Cadillac tax issues now rather than deferring them

WELLNESS PROGRAM COMPLIANCE

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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"): EEOC is concerned with whether these programs are voluntary under the ADA where they involve an "incentive/penalty" based on the level of participation, and the EEOC has filed several lawsuits against employers claiming violations of the ADA
- EEOC is also concerned that wellness programs that seek health-related information about an employee's spouse may run afoul of the Genetic Information Nondiscrimination Act ("GINA")

EEOC'S ADA/GINA REGULATIONS

- In May 2016, the EEOC finalized new regulations addressing how wellness programs must be structured to comply with the ADA and GINA
- Generally, the EEOC's rules have a broader scope and tighter limits than the ACA/HIPAA rules

	ACA/HIPAA STANDARD	ADA/GINA STANDARD
Type of Programs	Only health-contingent	Both health-contingent & participatory if health factors are assessed (e.g. biometric screenings)
Incentives Limit	30% of cost of coverage applicable to employee (single vs. family); 50% for tobacco cessation programs	30% of cost of single coverage, regardless of what coverage employee actually has
Reasonable Accommodations	Must provide reasonable alternative standard	Must provide reasonable alternative standard for all types of programs

EEOC'S ADA/GINA REGULATIONS

- The EEOC's new rules take effect beginning January 1, 2017 (or the first day of the next plan year beginning after that date)
- Several court cases have challenged the EEOC's position and authority to issue these regulations
- By contrast, AARP filed suit in October arguing that the EEOC's 30% threshold for incentives was too high and would allow employers to pressure employees into divulging health-related information
- Prior to the issuance of the rules, one federal court had ruled that an employer could use an incentive of up to 100% of the coverage premium for its participation-only wellness program

STATUS OF WELLNESS PROGRAMS

- It's unlikely that any of the current cases will be resolved before the effective date of the new EEOC rules, so employers with wellness programs should evaluate whether their program complies with the rules
- In addition, the EEOC's new rules require that employers sponsoring wellness programs that collect employee health information must give a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential

MISCELLANEOUS

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MISCELLANEOUS

- 2017 out-of-pocket maximums increased
  - $7,150 for self-only ($6,850 for 2016)
  - $14,300 for other than self-only ($13,700 for 2016)
- Summary of Benefits & Coverage (SBC): a new version of the SBC form (used to provide employees with information about what the plan covers and its cost-sharing provisions) has been issued and will be effective after April 1, 2017
- *Marin v. Dave & Busters* - class action, survived motion to dismiss
  - Involves employees who were working full-time hours and had been eligible for medical plan coverage before hours were reduced below 30; allegedly, the employer reduced hours due to the cost of complying with the ACA
  - Whether an employer, by reducing its employee's full-time hours to avoid providing health insurance or paying a penalty under ACA, is discriminating in violation of ERISA Section 510

FIDUCIARY RESPONSIBILITY

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WHO IS A FIDUCIARY?

- Based on functions, not title
- There must be at least one named fiduciary in the plan (can be the president, board of directors, administrative committee, etc.)

ERISA SECTION 3(21)

- A person is a plan fiduciary to the extent
  - He exercises any discretionary authority or discretionary control respecting management of the plan or exercises authority or control of management or disposition of plan assets
  - Renders investment advise for a fee or other direct or indirect compensation with respect to plan assets, or has authority or responsibility to do so
  - Has any discretionary authority or discretionary responsibility for plan administration

ERISA SECTION 3(38)

- "Investment manager" means any fiduciary
  - Who has the power to manage, acquire, or dispose of any asset of a plan
  - Is requested as an investment adviser, is a bank, or is a qualified insurance company
  - Has acknowledged in writing it is a fiduciary

FIDUCIARY

- Will ordinarily include the trustee, investment advisers, individuals exercising discretion in administration, plan administrator (but see DOL regulations explaining non-fiduciary "ministerial acts")
- Key: Are they exercising discretion or control over the plan?
- Some decisions are business decisions, not fiduciary decisions
  - Decision to establish plan
  - Decision to amend a plan
  - Decision to terminate a plan
- However, taking steps to implement a business decision and carry out actions likely involves fiduciary action

FOCUS ON FIDUCIARY RESPONSIBILITY

- DOL has increased its focus on fiduciary matters in recent years
- Fiduciary rules apply to any retirement or health/welfare plan subject to ERISA and the Code
- Plaintiff's lawyers are increasingly bringing ERISA fiduciary claims and class actions
- Important to ensure plan fiduciaries are well educated about their responsibilities
  - Identify fiduciaries
  - Conduct fiduciary training
- Violating ERISA's fiduciary rules can result in personal liability for fiduciaries, as well as significant civil penalties and excise taxes

RETIREMENT & DEFERRED COMPENSATION PLANS

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NEW PROPOSED REGULATIONS - SECTION 457 PLANS

- The IRS issued long-awaited proposed regulations on certain deferred compensation plans sponsored by tax-exempt and governmental employers under Section 457 of the Internal Revenue Code
- The proposed regulations provide needed guidance on many issues such as imposing a substantial risk of forfeiture on compensation, bona fide sick and vacation leave plans and how a participant treats a loss in value
- The proposed regulations define "substantial risk of forfeiture" generally in line with the definition under Section 409A of the Code (which applies generally to nonqualified deferred compensation plans), but includes different rules on noncompetition covenants and "rolling" risks of forfeiture
- These new rules may provide flexibility and important planning opportunities, so eligible employers who sponsor 457 plans should review those plans and their administrative procedures in light of the proposed regulations

IRS DETERMINATION LETTER PROGRAM

- Big changes have been made to the IRS determination letter program due to lack of funding
- Beginning January 1, 2017, the staggered five-year remedial cycles for individually designed plans will end
- Individually designed plans will still be able to obtain a determination letter upon **initial plan qualification** and **upon plan termination**
- Transition rule: Sponsors of Cycle A plans will continue to be permitted to submit determination letter applications from February 1, 2016 through January 31, 2017 (sponsors with EINs ending in 1 or 6)
- The remedial amendment period for individually designed letters will no longer last until end of plan's five-year remedial amendment cycle after December 31, 2016; instead look to Regulation 1.401(b)-1
- Extended relief available for those transitioning to a pre-approved prototype or volume submitter plan by January 31, 2017

QUESTIONS?

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THANK YOU

Legal Disclaimer: This document is not intended to give legal advice. It is comprised of general information. Employers facing specific issues should seek the assistance of an attorney.

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