WELLS FARGO INSURANCE

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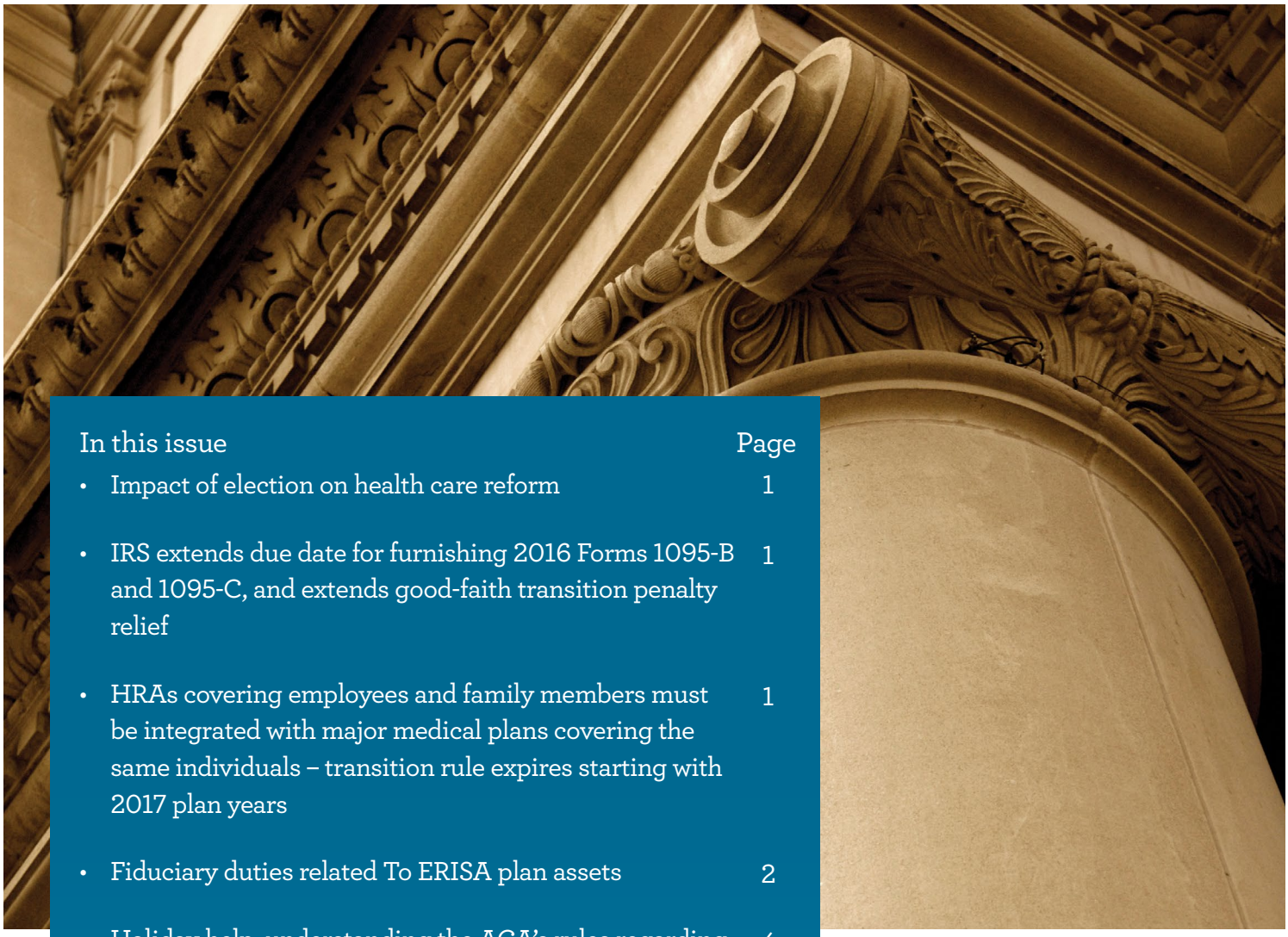
Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice



In this issue

Together we'll go far

Impact of election on health care reform

With the historic election behind us, one of many questions is: What impact will the results have on health care reform? We know employers and employees are anxiously waiting for clarity on this matter. Although there will be a lot of predictions and speculation in the news, it will take time for anyone to answer this question with accurate facts.

Even after the new President and Congress start work in January, it will take some time for any specific legislative, regulatory, and executive actions to take shape and become effective. For the time being, the Affordable Care Act (ACA) is still the law. Until it is changed, prudent employers are advised to continue to comply with its statutory and regulatory requirements. Among other things, this means complying with the ACA reporting requirements for the 2016 calendar year, which have deadlines in early 2017.

For more information, please see our recently released Employee Benefits Compliance Alert on this issue.

IRS extends due date for furnishing 2016 Forms 1095-B and 1095-C, and extends good-faith transition penalty relief

On November 18, 2016, the Internal Revenue Service ("IRS") issued Notice 2016-70 announcing an automatic extension of the due date for furnishing the 2016 Forms 1095-B and 1095-C to intended recipients, as well as extending "good-faith" transition penalty relief for 2016. The extensions apply to the reporting requirements, and related penalties, under sections 6055 (Issuer of Minimum Essential Coverage) and 6056 (Applicable Large Employer or "ALE") of the Internal Revenue Code, which are parts of the Affordable Care Act ("ACA").

These extensions are similar, but not identical, to those provided for furnishing and filing the 2015 forms under IRS Notice 2016-4. Under Notice 2016-70, however, the IRS only expressly grants a 30-day extension, to March 2, 2017, for furnishing of the 2016 Forms 1095-B and 1095-C, while providing no automatic extension for filing the forms with the IRS.

For more information, please see our recently released Employee Benefits Compliance Alert on this issue.

HRAs covering employees and family members must be integrated with major medical plans covering the same individuals – transition rule expires starting with 2017 plan years

In brief:

- Prior ACA guidance generally prohibits stand-alone general HRAs for active employees.
- HRAs for active employees must be integrated with other non-HRA group major medical coverage.
- IRS Notice 2015-87 provides that HRAs that reimburse expenses for employees' family members must be integrated with other group coverage covering the same family members.
- Transition rule generally allows family members to continue HRA coverage without being covered by other group coverage; however, the transition rule expires for plan years beginning on or after January 1, 2017.
- For 2016 reporting on Forms 1095-C or 1095-B, rules require an HRA plan sponsor to report actual coverage for family members covered under the HRA but who are not otherwise enrolled in the sponsor's non-HRA group health plan.

Generally, health reimbursement arrangements (HRAs) are any type of self-funded employer arrangement where an employer reimburses employees for certain medical expenses (including health insurance premiums) up to specified dollar amounts. These plans are generally "group health plans," and because dollar amounts are limited, most "stand-alone" HRAs run afoul of the prohibition on annual dollar limits on essential health benefits under the Affordable Care Act (ACA). Federal regulators provided specific guidance on this issue in September 2013 (See our October 16, 2013 Legislative Alert). The guidance also provided for permissible HRAs when they meet certain conditions, including being integrated with another non-HRA group health plan that does meet the annual dollar limit rule (but not with individual market insurance products).

The Internal Revenue Service (IRS) issued comprehensive ACA guidance in Notice 2015-87. Included in the Notice was clarification that proper integration of an HRA to another non-HRA group health plan requires that individuals whose eligible medical expenses can be reimbursed under an employer's HRA (mainly, those of an employee's spouse and dependents) must also be enrolled in the employer's other non-HRA group health plan. The guidance does not make clear whether it is sufficient for the HRA sponsor to verify that family members also be enrolled in a non-HRA group health plan of another employer (see our January 2016 Employee Benefits Compliance Update).

The Notice also provided a transition rule where an HRA can be treated as integrated even though the HRA reimburses expenses of family members not enrolled in the same employer's other non-HRA group health plan. However, that transition rule will cease to apply for plan years beginning on or after January 1, 2017. Because an HRA is self-funded, any HRA plan sponsor who took advantage of the transition rule for 2016 must report the family members covered under the HRA and not enrolled in the sponsor's non-HRA group health plan on either Form 1095-B, or under Part III of Form 1095-C.

Action steps for HRA plan sponsors:

- Confirm that the terms of the HRA document limit coverage under the HRA only to the employee and family members who are also enrolled in the same sponsor's non-HRA group health plan.
- Include in open enrollment materials for the 2017 plan year that each employee enrolling in the HRA will only be allowed to obtain reimbursement for expenses incurred by the employee and family members covered under the non-HRA group health plan.
- If not required already, require employees enrolling in the HRA to list family members for whom they might seek reimbursement of medical expenses, and verify that such family members are also listed as covered under the non-HRA group health plan.
- Confirm proper reporting on 2016 Forms 1095-C (or perhaps 1095-B) with respect to family members for whom medical expenses were reimbursed in 2016, but who were not enrolled in the non-HRA group health plan.

Fiduciary duties related To ERISA plan assets

In brief:

- If a group health and welfare benefit plan is subject to federal ERISA law, then money, credits, refunds, dividends, demutualization payments, excess surplus distributions and rebates from a vendor, insurance carrier or service provider related to the plan must be handled in accordance with ERISA standards, if the funds are considered plan assets.
- Funds that are considered plan assets under ERISA are subject to ERISA's exclusive benefit rule, which means that the funds must be used for the exclusive benefit of participants and beneficiaries in the plan.

An employer that maintains a group health and welfare benefit plan for employees will often receive money or other funds while operating the plan. For example, participants generally make contributions towards the cost of their plan coverage. A vendor, insurance carrier, or service provider may provide a refund, rebate, dividends, credits, demutualization payments, or excess surplus distribution, as required by contract or perhaps as a result of Federal

or state law. While it may be tempting for the employer to incorporate these funds automatically into its general assets, it first needs to consider whether these funds are "plan assets" under the Employee Retirement Income Security Act of 1974 (ERISA). If all or a portion of the funds are plan assets, then ERISA fiduciary requirements will apply.

Not all group health and welfare benefit plans are subject to ERISA. Under federal law, governmental plans and church plans are exempt from ERISA. Also exempt are plans maintained outside of the U.S. primarily for the benefit of persons substantially all of whom are nonresident aliens, plans maintained solely for the purpose of complying with workers' compensation laws or unemployment compensation or disability insurance laws, and unfunded, excess benefit plans. All other group health and welfare benefit plans (both insured *and* self-insured plans) are subject to ERISA.

Plan assets

ERISA does not define whether or when property is considered a plan asset. However, the U.S. Department of Labor has issued regulations that address specific situations, such as when participant contributions are considered plan assets. Otherwise, plan assets generally are identified on the basis of ordinary notions of property rights.

The identification of whether or not funds or other proceeds are plan assets requires consideration of plan documents, contracts and other legal instruments involving the plan, as well as the actions and representations of the parties involved. Participant contributions (whether paid by the employee from personal assets, or withheld from their salary by the employer) are considered plan assets from the moment they can be reasonably segregated from the employer's general assets.

In recent years, plan assets have arisen in a variety of scenarios, as described below.

- *Medical loss ratio rebates.* The Affordable Care Act requires health insurance carriers to report and calculate the medical loss ratio (MLR) for various market segments of insured health insurance products that they sell for each calendar year. MLR rebates may constitute plan assets under ERISA.
- *Demutualization proceeds.* When a mutual life insurance company changes its structure to a stock life insurance company owned by shareholders, a demutualization occurs. Demutualization proceeds may constitute plan assets under ERISA.
- *Self-funded plan refunds.* Plan designs sometimes require the third-party administrator or other service provider to return funds to the plan if the experience for a year is favorable. These returned funds may constitute plan assets under ERISA.
- *Pharmacy benefit manager rebates.* The pharmacy benefit manager or third party agent that administers pharmacy benefits may negotiate rebates with drug manufacturers or distributers. These rebates may constitute plan assets.

ERISA fiduciary requirements

Funds that are considered plan assets under ERISA are subject to ERISA's exclusive benefit rule, which means that the funds must be used for the exclusive benefit of participants and beneficiaries in the plan (including to defray reasonable administrative expenses attributable to the plan).

Plan assets must be held in trust for the benefit of participants and beneficiaries. For example, funds in a 401(k) plan are maintained in a trust, and are not part of the employer's general assets. Note, however, that DOL Technical Release 92-01 provides a non-enforcement policy that allows group health and welfare benefit plans to waive the ERISA trust obligation if the plan accepts pre-tax participant contributions under a section 125 cafeteria plan. This non-enforcement policy extends even if the plan receive COBRA premium payments, which are rarely made through a Section 125 cafeteria plan.

ERISA does not require that plan assets be used in a particular manner. Plan documentation and policy language may describe how the plan assets should be handled. If they do not, the plan assets must be used in a manner consistent with ERISA's fiduciary standards. For example, they could reduce future premiums (e.g., a premium holiday), provide enhanced benefits, or fund a cash payment.

Steps to Follow

As a best practice, when any money, credits, refunds, dividends, demutualization payments, excess surplus distributions or rebates are received from a vendor, insurance carrier or service provider, then the following steps should be taken.

1. Review plan documentation (including the insurance policy) for language addressing ownership or division of rebates or refunds. Consider making clarifying plan amendments (if necessary).
2. Determine what portion of the proceeds constitutes an ERISA "plan asset" that must be used for the exclusive benefit of participants.
3. Decide exactly how to pass on the participant's portion to participants (for example, by reducing future employee contributions in the form of a premium holiday, lump-sum direct refund payment to participants, or benefit enhancement).
4. Decide whether the proceeds should be paid to (a) participants in the plan for the year in which the funds were received, or (b) participants who were covered under the plan during the year to which the rebate relates. Consideration should also be given to allocating different amounts to participants who paid different contribution amounts for different tiers of coverage, and to different classes of participants, such as COBRA qualified beneficiaries and retirees.
5. Understand the income tax implications. Generally, the funds will be taxable to the recipient (i.e., employer or employee) if their original contributions were deducted for tax purposes or paid on a pre-tax basis.
6. If the funds constitute plan assets, and the employer decides to distribute them among participants, then the proceeds should be sent to participants in a timely manner.
7. Maintain records showing all of the facts relating to the funds and how they were handled. For example, the records should contain the date of receipt, the date of disbursement, the names and addresses for the recipients, dollar amounts, and other pertinent information.

Holiday help: understanding the ACA's rules regarding seasonal workers for ALE determination

In brief:

- Employers that hire seasonal or holiday workers, should know how these employees are counted under the ACA.
- If an organization's workforce exceeds 50 full-time employees for 120 days or fewer during a calendar year, and the employees in excess of 50 during that period were seasonal workers, that organization is not considered an ALE.

The employer shared responsibility (or "play or pay") penalty tax and reporting requirements of the Affordable Care Act (ACA) apply to applicable large employers (ALEs). An applicable large employer for a calendar year is an employer who employed (along with members of its controlled group) an average of at least 50 "full-time employees" (including full-time equivalent employees) on business days during the preceding calendar year. However, there is an exception for seasonal workers.

Employers that hire seasonal or holiday workers, should know how these employees are counted under the ACA. If an organization's workforce exceeds 50 full-time employees for 120 days or fewer during a calendar year, and the employees in excess of 50 during that period were seasonal workers, that organization is not considered an ALE. For this purpose, a seasonal worker is an employee who performs labor or services on a seasonal basis.

The regulations define a "seasonal worker" as a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term "seasonal worker" and a reasonable good faith interpretation of the DOL regulation (including as applied by analogy to workers and employment positions not otherwise covered under the regulation).

Example 1: During 2016, Holiday Store has 40 full-time employees for the entire calendar year, none of whom are seasonal workers. In addition, Holiday Store also has 80 full-time workers who work from September through December 2016. Holiday Store has no part-time employees who would be counted as full-time equivalent employees during 2016.

Before applying the worker exception, Holiday Store has 40 full-time employees during each of eight calendar months of 2016 and 120 full-time employees during each of four calendar months of 2016, resulting in an average of 66.67 employees [(40 × 8) plus (120 × 4) divided by 12 equals 66.67].

However, Holiday Store can apply the seasonal worker exception because its workforce exceeded 50 full-time employees for only four calendar months (treated as the equivalent of 120 days) during 2016, and the number of full-time employees would be less than 50 during those months if seasonal workers were disregarded. Thus, Holiday Store is not an ALE for 2017.

Example 2: Same facts as above example, except that Holiday Store has 20 full-time equivalent employees in August, some of whom are seasonal workers.

The seasonal worker exception described above does not apply if the number of an employer's full-time employees (including seasonal workers) and full-time equivalent employees exceeds 50 for more than 120 days during the calendar year. Because Holiday Store has at least 50 full-time employees for a period greater than four calendar months (treated as the equivalent of 120 days) during 2016, the exception does not apply. Holiday Store averaged 68 full-time employees in 2016: [((40 × 7) + (60 × 1) + (120 × 4)) ÷ 12 = 68.33]. Accordingly, Holiday Store is an ALE for calendar year 2017.

Arizona and Washington adopt paid sick leave mandates

In brief:

- Effective July 1, 2017, Arizona employers must begin providing paid sick leave benefits to employees.
- Effective January 1, 2018, Washington State employers must begin providing paid sick leave benefits to employees .

Last month we provided a link to our chart summarizing the paid sick leave requirements of various states and cities. The most recent states to adopt paid sick leave mandates are Arizona and Washington State. The highlights of those states' rules are outlined below, and will be incorporated into the chart shortly.

Arizona

Covered employers:

- Effective July 1, 2017, most private and municipal employers in Arizona.
- Narrow exemption for small businesses that have annual gross revenues of less than $500,000 and are not engaged in interstate commerce or in the production of goods for interstate commerce.
- Excluded employers are the U.S. government and the state of Arizona.

Covered employees:

- Most employees, including part-time and temporary.
- Excluded are those employed by a parent or sibling, and casual babysitters.
- Exempt are employees covered by a collective bargaining agreement to the extent that it waives the paid sick leave law requirements in clear and unambiguous terms.

Approved reasons for paid sick leave:

- Leave can be taken:
  - For the mental or physical illness, injury, or health condition; or need for medical diagnosis, treatment, or preventive care; of an employee or the employee's family member.
  - For the closure of the employee's place of business, or the closure of the school or place of care of a family member, by order of a public official due to a public health emergency.
  - For absence related to obtaining support or services for an employee or a family member who is a victim of domestic violence, sexual violence, abuse or stalking.
- Family member includes the employee's spouse or registered domestic partner; biological, adopted or foster child, stepchild, legal ward, individual to whom the employee stands or stood in loco parentis, or child of a domestic partner; parent, stepparent, legal guardian or one who stood in loco parentis to the employee/spouse/domestic partner; sibling, grandparent, or grandchild of an employee/spouse/domestic partner; or any other individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Sick leave accrual:

- Employees begin accruing paid sick leave on July 1, 2017, or the commencement of employment, whichever is later.
- Employees accrue at least one (1) hour of paid sick leave for every 30 hours worked.
- Employees can begin using paid sick leave 90 days after employment begins.
- Employees in businesses with at least 15 employees are entitled to accrue and use up to 40 hours of paid sick time in a year.
- Employees in businesses with 14 or fewer employees are entitled to accrue and use up to 24 hours of paid sick time in a year.
- Employees may carry over accrued unused paid sick leave into the next year, unless their employer pays them for those hours at the end of the year and front-loads the full minimum amount of required paid sick leave at the beginning of the next year.
- Employees who are rehired within nine (9) months of separation must have their unused sick leave reinstated and available for use, and begin accruing additional paid sick leave upon re-employment.

Notice requirement:

- Employers must give employees notice of their paid sick leave rights by July 1, 2017, or the commencement of employment, whichever is later.
- Employers must give employees individualized paid sick leave information on or with their regular paychecks.
- Where the need for leave is foreseeable, an employee must make a good faith effort to provide advance notice and schedule the leave.
- An employer must provide written procedures if it requires notice of the need to use paid sick leave where the need is not foreseeable.
- For absences of three (3) or more consecutive work days, an employer may require reasonable documentation that an employee's use of paid sick leave is for an authorized purpose.

Enforcement:

- An employer who fails to pay earned paid sick time shall be required to pay the employee three times the unpaid earned sick time.
- An employer who retaliates against an employee for exercising paid sick leave rights shall be fined a minimum of $150 per day.
- Private right to sue in court.
- Enforced by the Industrial Commission of Arizona.

Washington State

Covered employers:

- Beginning January 1, 2018, every employer (both public and private) in Washington State.

Covered employees:

- Workers employed by an employer in Washington State (except for workers exempt from the state's Minimum Wage Act).

Approved reasons for paid sick leave:

- Leave can be taken:
  - For the mental or physical illness, injury, or health condition; or need for medical diagnosis, treatment, or preventive care; of an employee or the employee's family member.
  - For the closure of the employee's place of business, or the closure of the school or place of care of the employee's child, by order of a public official for any health-related reason.
  - For an absence that qualifies for leave under the domestic violence leave act, chapter 49.76 RCW.
- Family member includes the employee's spouse, registered domestic partner, grandparent, grandchild, sibling; biological, adopted or foster child, stepchild, or a child to whom the employee stands in loco parentis, is a legal guardian, or is a de facto parent; or the parent, stepparent or legal guardian of the employee/spouse/domestic partner; or a person who stood in loco parentis when the employee was a minor child.

Sick leave accrual:

- Employees accrue at least one (1) hour of paid sick leave for every 40 hours worked.
- Employees can begin using accrued paid sick leave 90 days after employment begins.
- Workers are entitled to carry over up to 40 hours of unused accrued paid sick time into the next year.
- Employers can front-load leave in advance of accrual provided that carryover, use and accrual requirements are met.
- Employees who are rehired within 12 months of separation must have their unused sick leave reinstated, and the period of prior employment must be counted toward the (up to) 90-day waiting period to use paid sick leave.

Notice requirement:

- An employer may require that employees give reasonable notice of an absence, provided this does not interfere with lawful use of paid sick leave.
- For absences exceeding three days, an employer may require verification that an employee's use of paid sick leave is for an authorized purpose.

Enforcement:

- Private right to sue in court.
- Enforced by the Washington Department of Labor and Industries.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.

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