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ERIC Critiques EEOC’s Proposed GINA Regulations

Spencer’s Benefits

The ERISA Industry Committee (ERIC) has submitted comments to the Equal Employment Opportunity Commission (EEOC) expressing concerns about discrepancies in wellness reward limits as set forth in both the Genetic Information Nondiscrimination Act (GINA), and the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). The comments reference a recently-issued EEOC proposed rule that clarifies how the EEOC’s rules will affect employer-sponsored wellness programs. ERIC advocates for employee benefit and compensation interest for some of the country’s largest employers.

ERIC says that the promotion of wellness for workers and their families is of extreme importance for ERIC’s members, who are apparently seriously concerned about where wellness provisions found in GINA diverge with those of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148), in section 1201. For example, ERIC says that the EEOC would set limits on rewards paid in conjunction with health risk assessments, but the ACA does not limit incentives paid for these assessments or other “participatory” wellness programs.

Consistency concerns. According to ERIC’s Senior Vice President of Health Policy Gretchen Young, “It cannot be emphasized enough how important it is that the rules from the different parts of the government concerning wellness programs be in alignment with each other.” ERIC states that a principal concern is the existence of inconsistent inducement limits, since the EEOC’s inducement limits for health risk assessments are inconsistent with ACA rules, which do not impose incentive limits for participatory wellness programs, including health risk assessments.

The EEOC proposed regulations clarified that an employer-sponsored wellness program may offer limited wellness program inducements to employees and their spouses who complete a health risk assessment. The inducements may be positive or negative, and may be financial or in-kind. An inducement may not exceed 30 percent of the total annual cost of plan coverage in which an employee and any dependents are enrolled. The inducement limit was apparently an attempt by the EEOC to parallel ACA limits on health-contingent wellness programs, but ERIC points out that, under the ACA, health risk assessments are not health-contingent wellness programs subject to incentive limits. ERIC warns that the decision to limit inducements for health risk assessments greatly complicates the administration of ACA-compliant wellness programs, and it is urging the EEOC to eliminate those requirements.

In ERIC’s opinion, inducement limits for health risk assessments are not necessary to protect the voluntary nature of wellness programs because the EEOC’s rules require inducements to be paid whether or not an employee or the employee’s spouse answers questions on genetic information.

ERIC adds that, even if an inducement limit for health risk assessments were necessary, it is also concerned about the so-called “apportionment” rule, which ERIC says its members believe is inconsistent with ACA rules, adding that it may have the perverse effect of permitting greater inducements for spouses and lesser inducements for employees. Under the apportionment rule, the overall inducement limit must be apportioned between an employee and the employee’s spouse, and the employee’s share of the overall limit cannot exceed 30 percent of the cost of employee-only coverage.

ERIC says the apportionment rule is unnecessary, and is inconsistent with ACA rules which recognize that
different limitations are appropriate, without apportionment, depending on whether the employee is enrolled in an employee-only coverage tier or whether the employee and his or her spouse are enrolled in a higher tier of coverage. ERIC also says that the apportionment rule is inconsistent with common plan designs that provide uniform health risk assessment inducements for both an employee and the employee’s spouse. ERIC also complains that there is a lack of clarity regarding the impact of GINA on incentives related to tobacco usage.

**Requirement of health risk assessments.** The EEOC proposed regulations requested comments on a variety of questions, including whether employers that offer inducements to encourage the spouses of employees to disclose information about current or past health must also offer similar inducements to persons who choose not to disclose such information, but who instead provide certification from a medical professional stating that the spouse is under the care of a physician and that any medical risks identified by that physician are under active treatment. ERIC reports that its members strongly oppose the notion that GINA requires inducements to be offered merely because an employee or the employee’s spouse provide certification from a medical professional, and it reasons that such certification is not comparable to the identification of someone’s risk factors and encouragement to participate in wellness programs designed to mitigate those risk factors.

ERIC adds that employers seek health information from employees in order to identify broad demographic risks, which would enable them to tailor wellness activities for the population as a whole. A doctor’s certification would not provide information on population risks, ERIC points out. ERIC stresses that a health risk assessment process will only be successful at identifying health risks and encouraging their reduction if employers can condition inducements on the completion of health risk assessments. ERIC also asserts that the health risk assessment process has been diminished by existing regulations that already permit someone to obtain a health risk assessment inducement without answering questions on genetic information.

On a positive note, ERIC praised recent attempts to align GINA’s permissible inducement limits with the ACA’s incentive limits, and said its members are encouraged by clarifications confirming that GINA does not preclude inducements for the completion of a health risk assessment by an employee’s spouse.

**SOURCE:** ERIC’s letter to the EEOC and ERIC press release, January 26, 2016.

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**U.S. Supreme Court Rules that ERISA Preempts Vermont Health Reporting Law**

*Arthur J. Gallagher & Co.*

On March 1, 2016, the U.S. Supreme Court ruled 6-2 that the Vermont law which created the Vermont Healthcare Claims Uniform Reporting and Evaluation System is preempted to the extent that it applies to self-insured health plans subject to ERISA. The Vermont regulation requires health insurers and health plans, including self-insured plans and third party administrators, to submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information. Insurers and health plans are required to report specific data about health care services provided to Vermonters (regardless of whether they are treated in Vermont or out-of-state) and about non-Vermonters who are treated in Vermont. Failure to comply with the reporting requirement could result in penalties as high as $2,000 per day plus administrators could be disqualified from performing services in the state.

One large employer with 80,000 employees in 50 states that self-insures its medical plan sued to prevent the State of Vermont from requiring the employer’s third party administrator to provide information to the State on it self-insured plan. The U.S. District Court ruled in favor of the State of Vermont. Subsequently the U.S. Court
of Appeals for the Second Circuit ruled in favor of the employer leading to an appeal by the State of Vermont and the Supreme Court’s review and decision.

The Supreme Court’s Ruling

The employer argued that the Vermont regulation was preempted by ERISA based on the language of ERISA which states that ERISA pre-empts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” The Supreme Court’s case law to date has described two categories of state laws that ERISA pre-empts. The second category, which is at issue in this case, is that ERISA pre-empts a state law that has an impermissible “connection with” ERISA plans. An impermissible “connection with” generally means that the state law governs a central matter of plan administration or interferes with nationally uniform plan administration.

In the decision the majority noted that requiring ERISA plans to master the relevant laws of 50 States would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrations – burdens that are ultimately borne by the beneficiaries. The Court noted that ERISA already contains comprehensive regulatory requirements which include reporting and disclosure and that the functions of reporting, disclosure and recordkeeping are central to ERISA and an essential part of the uniform system of plan administration contemplated by ERISA. It also notes that Vermont’s requirement for plans to report detailed information about the administration of benefits in a systematic manner is a direction regulation of a fundamental ERISA function. The Vermont reporting regime which compels plans to report detailed information about claims and plan members thus “intrudes” on a central matter of plan administration and “interferes” with nationally uniform plan administration.

The majority also commented that any difference between the ERISA and Vermont reporting purposes does not save Vermont’s law. The Court went on to say that “[t]he fact that reporting is a principal and essential feature of ERISA demonstrates that Congress intended to pre-empt state reporting laws like Vermont’s, including those that operate with the purpose of furthering public health.” The majority concluded that ERISA pre-emption is necessary to prevent States from imposing novel, inconsistent, and burdensome reporting requirements on plans.

However, two dissenting Justices agreed with the State of Vermont. They do not believe that the Vermont law imposes a significant administrative or cost burden on plans and that the Vermont law should not be pre-empted because Vermont’s data collection is for a purpose that is different from ERISA’s.

Impact on Employers

This ruling is important to employers with self-insured health plans, particularly employers with multi-state operations. Had the Supreme Court ruled that ERISA did not pre-empt the Vermont law, employers with self-insured ERISA health plans could be faced with additional plan reporting that would undoubtedly complicate administration and increase plan costs. As a practical matter the impact of the Court’s decision is limited to employers that sponsor self-insured ERISA plans. Not affected are plans that are fully insured since ERISA does not pre-empt state laws regulating insurance and plans that are not subject to ERISA – generally plans sponsored by employers that are governments or churches – that are typically bound by state laws such as this Vermont law.

Additionally, it is important to note that numerous other states have similar reporting laws as Vermont.1 While the Supreme Court’s decision does not directly invalidate other States’ reporting regulations, it may cause self-insured ERISA plans to examine those reporting requirements more closely in light of this ruling. Employers

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1 In a footnote in the decision, the Court notes that states (in addition to Vermont) that so far maintain all-payer claims databases are: Arkansas, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Tennessee, Utah, Virginia, Washington, and West Virginia.
with self-insured ERISA plans may want to wait for developments to see what, if anything, happens in other states that have a law similar to Vermont’s. Employers with self-insured plans subject to ERISA that are considering challenging a similar law in another state should consult with their legal counsel before proceeding. At least one Justice commented that the Department of Labor (“DOL”) has the authority to require this type of reporting under ERISA and could choose to do so either for its own purpose or on behalf of a State or States. Should the DOL decide, either now or in the future, to adopt additional reporting requirement(s) under ERISA, there is a greater likelihood that it would be on a national basis rather than State-by-State basis.

Wellness Programs Appear to Improve Medication Adherence for Some Diseases but Not Others
Employee Benefit Research Institute

Workplace wellness programs appear to have a bigger impact on medication adherence for some diseases than others, according to new research from the nonpartisan Employee Benefit Research Institute (EBRI).

Using actual health claims data from a large Midwest manufacturer that increased financial incentives to workers participating in its workplace wellness programs, EBRI found improved medication adherence among workers with two of six chronic diseases.

Specifically, EBRI found that biometric screenings (a key part of the wellness program) led to improved medication adherence for those with high blood pressure and depression. However, the screenings had no impact on medication adherence for those with four other chronic conditions, including cholesterol problems (dyslipidemia), diabetes, congestive heart failure, and asthma/chronic obstructive pulmonary diseases.

Health risk assessments and biometric screenings are increasingly used by employers that offer health insurance to identify existing or potential health issues among their plan members. The hope is that information derived from these wellness programs will prompt patients to make meaningful lifestyle changes, use preventive care, and commence and comply with recommended treatment.

Paul Fronstin, director of EBRI’s Health Research and Education Program and co-author of the report, said the findings support earlier EBRI research that biometric screenings led to increased prescription drug use for high blood pressure and depression. However, he added, more research is needed to quantify the economic costs and consequences of wellness programs, since they may generate longer-term cost offsets and productivity enhancements for some chronic diseases.

“Whether these future benefits outweigh the costs is an empirical question that needs a longer-term study and a greater number of wellness programs,” Fronstin said.

The full report, “Impact of Workplace Wellness-Program Participation on Medication Adherence,” is published in the January 2016 EBRI Notes and online at http://www.ebri.org

EBRI’s publications can also be accessed through mobile device apps, available in the Apple store for Apple devices and Google Play for Android devices.

The Employee Benefit Research Institute is a private, nonpartisan, nonprofit research institute based in Washington, DC, that focuses on health, savings, retirement, and economic security issues. EBRI conducts objective research and education to inform plan design and public policy, does not lobby and does not take policy positions. The work of EBRI is made possible by funding from its members and sponsors, which include
What do Employers Want From Telehealth?

Benefits Pro

Industry experts estimate that by 2018, 80 percent of employers will be offering a telehealth benefit to their employees.

To uncover what’s behind this growth, and to gain an understanding of employer involvement with and perceptions of telehealth, American Well, creator of the Amwell telehealth app, conducted a broad survey of this sector in Q4 2015.

We invited companies of all sizes, from small organizations with fewer than 1,000 employees to large companies with over 20,000 employees. We heard from companies across a variety of industries, from banking to biotech to health care to manufacturing to retail and more.

Our benchmark survey gathered 241 responses from Human Resources benefits managers, brokers, and other individuals responsible for purchasing employer benefits. Here we share key insights.

Employer telehealth is on the rise

Our findings confirm that telehealth is on the rise in the employer market.

One-third of employers already offer telehealth. In fact, for the largest organizations surveyed (organizations with more than 5,000 employees), that number is even higher—39 percent.

These numbers represent a significant increase from 2014, when only 22 percent of employers offered telehealth.

We anticipate this momentum will continue, as 49 percent of employers who had not yet deployed telehealth reported plans to add this benefit in 2016.

We identified five key reasons employers are increasingly embracing telehealth. They see telehealth as a tool to help with the following:

1. Reduce medical costs
2. Improve access to care
3. Make employees happy
4. Improve employee productivity
5. Attract new talent

Among employers that were unsure when they would add telehealth, the overall theme was a need for education regarding the benefits of telehealth and potential ROI.

We anticipate that our survey will help fill in these knowledge gaps and provide employers in the awareness and consideration phases with the information they need to make an adoption decision.
Employers have a broad vision for telehealth use cases

We surveyed employers both about the services they currently offer through telehealth and about the services they want to offer in the future—and the responses in both cases went far beyond urgent care.

Employers have expansive vision when it comes to telehealth.

After urgent care, the top five use cases for both current and future services are general health assessments, behavioral health, diet and nutrition services, diabetes counseling, and smoking cessation.

Many employers also expressed interest in more specialized services, some of which are occupational health, asthma counseling, and lactation support.

Employers seek support in utilization and reporting

Employers who operate telehealth programs today come up against two main challenges: maximizing utilization and getting adequate reporting.

Half of employers surveyed reported utilization of 10 percent or less. An experienced telehealth service can help employers improve utilization through proven practices such as timely, themed email campaigns, enrollment incentives, coupons to try the service for free, and quarterly communications across a variety of channels.

Employers who follow these best practices can expect engagement above and beyond 10 percent.

On a related note, our survey also showed that there is a reporting gap—over a third of employers didn’t even have utilization data for their telehealth service.

A telehealth service vendor or health plan can assist here, providing at least monthly reports detailing not only utilization but other key metrics such as diagnoses, visit times of day, and more.

Market impact

Although there is still much to learn about the impact of a telehealth benefit for both employers and employees, our survey uncovered information that is not only valuable to employers, but that also impacts health plans, private exchanges, and health systems.

The message across all markets is that there is a demand for this service, and organizations that do not yet offer the benefit or have plans to do so risk becoming laggards.

Urgent care will not be enough to satisfy employers—they are looking for a robust telehealth offering that supports their wellness programs and specialized use cases.

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QMCSOs and NMSNs after PPACA

Arthur J. Gallagher & Co.

Employers sponsoring group health plans have been receiving Qualified Medical Child Support Orders (“QMCSOs”) and/or National Medical Support Notices (“NMSNs”) for many years. Employers receiving a qualified QMCSO or properly completed NMSN are required to enroll the named child (called an alternate
recipient) under their group health plans. And while the passage of the Patient Protection and Affordable Care Act (“PPACA”) may have reduced the number of QMCSOs/NMSNs (collectively referred to as “Orders”) that employers receive, it hasn’t eliminated them. Employers may still receive these Orders and need to have procedures in place to respond as required.

**Background**

QMCSOs are generally court orders, such as a domestic relations order, issued in connection with a divorce. There is no specific form for a QMCSO. A NMSN is a standardized medical child support order used by state child support enforcement agencies. ERISA requires plans to respond to qualified QMCSOs and properly completed NMSNs. In addition, nonfederal governmental plans and church plans are required to comply with NMSNs. The Employee Benefit Security Administration (“EBSA”), which is part of the Department of Labor, provides guidance and enforces the requirements for plans subject to ERISA; while, the Office of Child Support Enforcement (“OCSE”), which is part of Health and Human Services, and the EBSA jointly provide guidance and enforcement for NMSNs.

In general, when an employer receives a QMCSO or NMSN, the employer is required to review the Order to determine if it is qualified (QMCSO) or properly completed (NMSN). While the guidance for QMCSOs and NMSSNs is similar, it is not identical. The EBSA regulations do not provide a specified number of days for responding to a QMCSO; rather, employers are only required to respond within a reasonable period of time. Guidance issued on NMSNs however, includes specified action steps and specific time frames.

If the Order is qualified (QMCSO) or properly completed (NMSN), the employee is eligible for coverage and dependents are also eligible under the group health plan, then the employer or plan administrator must take steps to enroll the child as specified in the Order. The actual process is detailed and a number of issues may arise. For example, what does the employer do if the employer’s health plan has multiple coverage options and the Order does not include enough information for the employer to determine in which option the child should be enrolled? To assist employers, both the EBSA and OCSE have useful information available on their websites:

**EBSA Website**


The site has a summary of QMCSO requirements, 31 QMCSO FAQs, nine NMSN FAQs and links to other resources.

**OCSE Website**


**How Did PPACA Affect QMCSOs and NMSNs?**

Prior to PPACA, many group health plan eligibility provisions included residency and/or dependency requirements for children such as: the child must reside with the employee, the child must be a full-time student if over a specified age – often 19, the child must be financially dependent on the employee, or the child must be the employee’s tax dependent. As a result, under many plans, if an employee was a noncustodial parent, then the

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2 Some of the FAQs have not been updated for PPACA changes. For example, FAQ #31 covers pre-existing condition limitations which are prohibited by PPACA and the 63-day break in coverage rule which is no longer applicable.
child might not have been eligible to enroll under the employer’s plan without an Order. However, PPACA specifically prohibits these types of requirements before the child reaches age 26. As a result, PPACA has likely reduced the number of Orders that employers receive.

Another reason that some employers may be receiving fewer Orders is because the coverage that is now available in the Marketplace may be less costly than group health plan coverage – even if the group health coverage can be purchased on a pre-tax basis. This outcome is more likely in situations where the group health plan requires substantial contributions for dependent coverage. Prior to PPACA, individual health insurance might not have been available either because child only policies were not available or because those policies were subject to medical underwriting. In addition pre-PPACA restrictions applicable to individual medical insurance such as pre-existing condition exclusions might have substantially reduced the value of those policies that were available. As a result, before the passage of PPACA a parent might not have been able to satisfy an Order to provide coverage by purchasing an individual policy. For many individuals the only available source of coverage for the child might have been the employer’s group health plan. However, since PPACA eliminated certain restrictions, such as medical underwriting and pre-existing conditions, and made child only individual health insurance policies available, it now may be less costly for an employee to purchase an individual health insurance policy to cover his/her child.

However, there may still be situations when an Order is needed to enroll a child in a group health plan, or at least, to enroll a child on a pre-tax basis. For example, a mid-year divorce may result in the need for an Order to enable an employee to enroll a child (or children) mid-year on a pre-tax basis. Although divorce is a change in status under current IRS cafeteria plan regulations, the regulations include a consistency rule that requires a change in eligibility in order for an individual to enroll for coverage mid-year. Before PPACA a change that would permit a new election could have been a loss of eligibility under one parent’s plan and/or the gain of eligibility under the other parent’s if the child no longer satisfied the plan’s residency or support requirement. But since PPACA no longer permits these type of restrictions, the child may not lose (or gain) eligibility under either parent’s plan as a result of a divorce. However, an Order constitutes a “change in status” under IRS rules and employees are permitted to make an election change when complying with the Order. Therefore, the issuance of an Order, following a divorce, may allow the employee to add the child mid-year on a pre-tax basis. Without an Order, the employee could still add the child, but would need to make post-tax contributions. Likewise, in a situation in which an employee does not want to pay for the child’s health coverage; then, under those circumstances the Order would be needed to enroll the child.

Note: The PPACA requirement to extend eligibility for children to age 26 does not apply to excepted benefits such as stand-alone dental or vision. QMCSOs/NMSNs may require dental and/or vision coverage so an employer may need to provide coverage for those benefits. However, PPACA’s age 26 requirement would not apply to excepted benefits. In addition the Order may require only coverage to a younger age such as 18.

How Should Employers Respond to a QMCSO or NMSN?

Although employers may see fewer Orders than in the past, they still need appropriate procedures in place to make certain that they respond appropriately. Here are some steps an employer should take:

- Review the DOL and HHS guidance to determine what processes must be included in the written procedures for responding to Orders.
- Review your current procedures to determine if your plan is already in compliance with the requirements, or if your procedures need to be modified.
• Make sure that your procedures include a specific process and assign responsibility for responding if/when a QMCSO is received. For example, it should indicate who will review the order to determine if it is qualified or properly completed and the time frame that the response must be provided by.

• Make sure that plan materials, such as the plan document and SPD, have the necessary language.

• Confirm that COBRA coverage is offered to alternate recipients following a qualifying event.

• Update plan communications, such as annual enrollment materials including SBCs, that are sent to alternate recipient; and, ensure that procedures are in place to send enrollment materials to alternate recipient.

• For excepted benefits, determine if the plan uses an age other than age 26 for loss of eligibility.

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**Feds Hint at Coming Mental Parity Suits**

*Life Health Pro*

The U.S. Department of Labor has a hard time enforcing some Mental Health Parity and Addiction Equity Act (MHPAEA) requirements, and it may hire experts to help it sue plans that violate the rules, officials say in a new report to Congress.

Drafters of the 2008 law wanted to improve an older law, the Mental Health Parity Act of 1996 (MHPA), by adding strict, detailed, easy-to-enforce quantitative parity requirements.

But, in the real world, some of the MHPAEA parity requirements are difficult to apply, and statutory curbs on the authority of the U.S. Department of Labor limit the kinds of enforcement actions the department can execute, according to officials at the Employee Benefits Security Administration (EBSA), the Labor Department arm that oversees benefit plans.

MHPAEA now prohibits large group health plans that cover behavioral health care from setting different nonquantitative treatment limits for behavioral care and other types of health care.

Deciding whether a plan violates the MHPAEA parity requirements for nonquantitative treatment limits is complicated, and it takes input from experts, EBSA officials say.

EBSA "has been coordinating with experts related to open health plan investigations and will continue to evaluate the staffing and expertise needed to identify and establish violations, and, if necessary, litigate instances of noncompliance," officials say.

EBSA conducted a total of 3,118 health plan civil investigations from 2010 through 2015 and considered MHPAEA issues when conducting 1,515 of those investigations, officials say.

About 171, or 11 percent, of the MHPAEA investigations led to citations for MHPAEA violations, according to officials.

About 58 percent involved violations of the nonquantitative treatment limit requirements, and 14 percent involved violations of provisions requiring parity for deductibles, out-of-pocket spending maximums, and other cumulative benefits limits.
When reviewing plans, "EBSA focuses on plans' and claims administrators' actual conduct, not just the words on the formal plan instruments," officials say.

EBSA officials noted that a provision in the Employee Retirement Income Security Act of 1974 (ERISA) prohibits the Labor secretary from bringing enforcement actions against state-licensed health insurance issuers.

In spite of that limitation, EBSA has succeeded at working with several large insurers to remove plan provisions that violate MHPAEA requirements, officials say.

DOL Issues Fact Sheet on Joint Employment

Arthur J. Gallagher & Co.

The Department of Labor ("DOL") recently released Administrator’s Interpretation 2016-1 (the “AI”) and a Fact Sheet #28N (the “Fact Sheet”) that discusses joint employers’ responsibilities under the Family and Medical Leave Act (“FMLA”). The analysis for determining joint employment status under the Family and Medical Leave Act (“FMLA”) is the same as under the FLSA, and that determination is important because it may affect employers’ obligations under the FMLA. For example, where joint employment exists, hours worked for both employers must be counted when determining if the employee may be eligible for FMLA leave.

Who is a Joint Employer?

The definitions of “employer” and “joint employment” under the FLSA and thus the FMLA are broader than the common law concepts of employment and joint employment which look to the amount of control that an employer exercises over an employee. As stated in the DOL’s AI: “In sum, the expansive definition of ‘employ’ as including ‘to suffer or permit to work’ rejected the common law control standard and ensures that the scope of employment relationships and joint employment under the [FLSA] is as broad as possible.” Following the FLSA rules, the DOL recognizes two types of joint employment for the purposes of the FMLA – horizontal and vertical joint employment.

Horizontal joint employment may occur when two or more employers employ the same employee and are sufficiently associated with or related to each other with respect to the employee. The AI lists seven factors that may be relevant when analyzing the degree or association between, and sharing of control by, potential joint employers. The AI includes two example of a potential horizontal joint employment situation where an employee is employed at two locations of the same restaurant brand. In the first example, the specific circumstances indicate joint employment; in the second example, a different set of circumstances indicate that there is no joint employment.

Vertical joint employment may occur when an employee of an intermediary employer is also employed by another employer – the potential joint employer. In vertical joint employment, the other employer has generally arranged with the intermediary employer to provide it with labor and/or perform some employer functions such as hiring and payroll. There is usually an established relationship between the employer and intermediary employer, and the work is typically for the benefit of the other employer. The AI describes seven factors to consider when determining if a vertical joint employment situation exists:

1. Directing, controlling, or supervising the work performed
2. Controlling employment conditions
3. Permanency and duration of relationship
4. Repetitive and rote nature of work
5. Integral to business
6. Work performed on premises
7. Performing administrative functions commonly performed by employers

The AI also includes two examples – one where the specific facts indicate that there is a joint employment relationship and a second set of facts which indicate that there is not a joint employment relationship.

The DOL has a web page with more detailed information on joint employment on their website at:

http://www.dol.gov/whd/flsa/jointemployment.htm

**FMLA Requirements for Joint Employers**

When an individual is employed by two employers in a joint employment situation, in most cases one employer will be the primary employer and the other employer the secondary employer. Joint employment is important in determining employer coverage and employee eligibility under the FMLA. In addition, the joint employers’ responsibilities vary depending on whether the employer is the primary employer or the secondary employer. As a result, employers in joint employment relationships will need to determine which one is the primary employer and which one is the secondary employer. When a joint employment situation exists, determining which employer is primary and which is secondary will depend on the specific facts and circumstances. The Fact Sheet lists three factors to consider when making the determination of which is primary and which is secondary:

- who has the authority to hire and fire, and to place or assign work to the employee;
- who decides how, when, and the amount that the employees paid; and
- who provides the employee’s leave or other employment benefits.

The Fact Sheet also notes that in the case of a temporary placement or staffing agency, the agency is usually the primary employer.

Employees who are jointly employed by two employers must be counted by both employers when determining employer coverage and employee eligibility under the FMLA. When determining whether an employee who is jointly employed works at a worksite where the employer employs at least 50 employees within 75 miles, the employee’s worksite is the primary employer’s office from which the employee is assigned (or to which the employee reports). There is, however, an exception. If the employee has physically worked at a facility of the secondary employer for one year or longer, that worksite is the employee’s location.

The primary employer has more duties than the secondary employer. The primary employer must: (1) give required FLMA notices to employees, (2) provide FMLA leave, maintain group health insurance benefits during the leave, and (3) restore the employee to the same job (or equivalent job) upon return from FMLA leave. In addition, the primary employer may not interfere with an employee’s exercise of his or her FMLA rights and may not fire or discriminate against an employee for opposing a practice that is not lawful under the FMLA. Finally, the primary employer must keep all of the records required by the FLMA.

The secondary employer’s responsibilities are more limited. First, the secondary employer may not interfere with the employee’s exercise of his or her FMLA rights and may not fire or discriminate against an employee for opposing a practice that is not lawful under the FMLA. Under certain circumstances, the secondary employer may be responsible for restoring the employee to the same job (or equivalent job) on return from FMLA leave. For example, if the secondary employer is a client of a placement agency and continues to use the services of the agency and the agency places the employee with that client employer. A secondary employer is also responsible
for keeping basic payroll records and identifying employee data with respect to any jointly-employed employees.

The Fact Sheet includes the following helpful chart showing the responsibilities of the primary and secondary employers under the FMLA. [Click here](#) for a copy of the Fact Sheet.

<table>
<thead>
<tr>
<th>FMLA Responsibilities of Joint Employers</th>
<th>Primary Employer</th>
<th>Secondary Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Count jointly-employed employees for coverage and eligibility determinations (Fact Sheet #28)</strong></td>
<td>Yes.</td>
<td>Yes.</td>
</tr>
<tr>
<td><strong>For employee-eligibility determination, use its worksite for the eligibility test (50 employees within 75-miles of the worksite) (Fact Sheet #28)</strong></td>
<td>Yes, unless the employee has physically worked at the secondary employer’s facility for at least one year.</td>
<td>No, unless the employee has physically worked at the secondary employer’s facility for at least one year.</td>
</tr>
<tr>
<td><strong>Provide FMLA notices to the jointly-employed employee (Fact Sheet #28D)</strong></td>
<td>Yes.</td>
<td>No; however the secondary employer must provide FMLA notices to its own employees.</td>
</tr>
<tr>
<td><strong>Provide FMLA leave to the jointly-employed employee (Fact Sheet #28F)</strong></td>
<td>Yes.</td>
<td>No; however the secondary employer must provide FMLA leave to its own eligible employees.</td>
</tr>
<tr>
<td><strong>Maintain benefits for the jointly-employed employee (Fact Sheet #28A)</strong></td>
<td>Yes.</td>
<td>No; however the secondary employer must maintain benefits for its own employees who take FMLA leave.</td>
</tr>
<tr>
<td><strong>Restore the jointly-employed employee to work (Fact Sheet #28A)</strong></td>
<td>Yes.</td>
<td>No, unless the secondary employer is continuing to use the placement agency and the agency places the employee with that secondary employer.</td>
</tr>
<tr>
<td><strong>Not retaliate, discriminate or interfere (Fact Sheet #28A and Fact Sheet #77B)</strong></td>
<td>Yes.</td>
<td>Yes.</td>
</tr>
<tr>
<td><strong>Keep records</strong></td>
<td>Yes, the primary employer keeps all required records.</td>
<td>Yes, the secondary employer keeps payroll data and identifying employee information.</td>
</tr>
</tbody>
</table>

Employers that are joint employers should review their responsibilities under the FMLA and make changes, if any, needed to comply with their responsibilities as primary or secondary employer. Employers that are not sure if they are joint employers under the expansive definition used for the FLSA should discuss their specific situations with their legal counsel.
Use The "Rolling" Method to Calculate FMLA Leave! This Employer Learned the Hard Way
Jeff Nowak
FMLA Insights

Every once in awhile, I find myself counseling an employer with either no FMLA policy or one completely lacking any meaningful details. Often, these policies fail to include key provisions to protect against liability.

Take, for instance, the FMLA 12-month period.

As employers are aware, an otherwise eligible employee is entitled to 12 weeks of FMLA leave in a 12-month period. Notably, this “12-month period” is defined by the employer. What happens when an employer fails to disclose the 12-month period in its FMLA policy? They may end up like the Illinois Department of Corrections (IDOC).

IDOC apparently maintained an FMLA policy, but it failed to inform employees how the 12-month FMLA period was defined. When that happens, the 12-month option that provides the most beneficial outcome for the employee is used. IDOC learned this the hard way. One of its employees, Mike, took and seemingly exhausted FMLA leave. He later was terminated for three unexcused absences.

Finding that IDOC did not inform employees of what it was using as the 12-month FMLA period, the court determined that the “most beneficial” outcome should be used for Mike, effectively earning him back two weeks of FMLA leave that he could have used in this instance. Caggiano v. Illinois Dept. of Corrections (pdf)

Ouch. That stings.

How Many Ways are There to Count to 12?

Let’s use IDOC’s loss as an opportunity to discuss what 12-month FMLA period you should use for your workforce. The FMLA regulations allow employers to utilize any one of four different methods to calculate the amount of FMLA leave an employee uses within a 12-month period. Per the regulations, an employer may choose any one of the following 12-month periods:

1. The calendar year
2. Any fixed 12-month “leave year,” such as a fiscal year, a year required by state law or a year starting on an employee’s “anniversary” date
3. The 12-month period measured forward from the date any employee’s first FMLA leave begins
4. A “rolling” 12-month period measured backward from the date an employee uses any FMLA leave

Pros and Cons in Choosing a Particular 12-Month Period

Employers may select any one of these four counting methods, so long as the method is applied consistently and uniformly for all employees. Once the employer chooses a particular 12-month period, however, it cannot change to another 12-month period without first giving all employees at least 60-days’ notice of the change. 29 CFR 825.200(d)(1) As I referenced above, if the employer fails to select one of the above 12-month periods, or if the employer has changed the method but it is within the 60-day window, the employer must use the 12-month period that provides the most beneficial outcome to that employee.

Clearly, there are pros and cons with each of these four methods. But one method stands out above the rest: the “rolling” 12-month period measured backward from the date an employee uses any FMLA leave.
Let me explain.

**Methods One and Two**

The first two methods are materially the same in that they set a fixed point in time by which to start calculating FMLA leave. Although these two options are by far the easiest to administer, they allow for employees to “stack” 12-week FMLA periods back to back, thereby potentially providing more leave than necessary. “Stacking” means taking FMLA leave for a subsequent FMLA leave year right after leave taken during the previous year.

Take Jane, for example. Under her employer’s “calendar year” method, Jane takes four weeks of FMLA leave the first time on February 1. Later in November, she takes another eight weeks of leave, which takes her through the end of the calendar year. In theory, beginning on January 1, Jane could utilize another 12 weeks of FMLA leave. In this example, this method of calculation allows Jane a total of 20 consecutive weeks of FMLA leave. (It could have been worse — Jane could have taken 12 weeks at the end of the year and another 12 at the beginning of the following calendar year, for a total of 24 consecutive workweeks of FMLA leave.) For employers seeking a continuity of business operations, this unintended result might be a difficult pill to swallow.

**Method Three**

The third method is not entirely different from the two above, but it offers a marginally better balance between protecting the continuity of businesses operations and ease of administration. Under this method, an employee would be entitled to 12 weeks of leave during the year beginning on the first date FMLA leave is taken. From an administrative perspective, this is easier to understand: the employee begins leave on February 1, so the employee’s leave year begins on February 1. However, this method does not avoid the “stacking” conundrum identified above. Here, employers cannot avoid a situation where an employee takes FMLA leave later in the FMLA leave year, which is followed consecutively by as many as 12 weeks taken at the beginning of the following FMLA year (on February 1).

Notably, under the FMLA regulations, employers must use this method when calculating leave for an employee who is caring for a covered servicemember with a serious injury or illness. 29 C.F.R. § 825.200(f)

**Method Four**

The most common method (but clearly the most confusing) that employers use is referred to as the “rolling” method. Under the “rolling” method, known also in HR circles as the “look-back” method, the employer “looks back” over the last 12 months, adds up all the FMLA time the employee has used during the previous 12 months and subtracts that total from the employee’s 12-week leave allotment. Therefore, when calculating an employee’s available FMLA leave, the employee’s remaining available balance is 12 weeks minus whatever portion of FMLA leave the employee used during the 12 months preceding that day.

The regulations provide a fairly straightforward example of how the employer would calculate leave using this method:

If an employee used four weeks beginning February 1, 2008, four weeks beginning June 1, 2008, and four weeks beginning December 1, 2008, the employee would not be entitled to any additional leave until February 1, 2009. However, beginning on February 1, 2009, the employee would again be eligible to take FMLA leave, recouping the right to take the leave in the same manner and amounts in which it was used in the previous year. Thus, the employee would recoup (and be entitled to use) one additional day of FMLA leave each day for four weeks, commencing February 1, 2009. The employee would also begin to recoup additional days beginning on June 1, 2009, and additional days beginning on December 1, 2009. Accordingly, employers using the rolling 12-month period may need to calculate whether the
employee is entitled to take FMLA leave each time that leave is requested, and employees taking FMLA leave on such a basis may fall in and out of FMLA protection based on their FMLA usage in the prior 12 months. For example, in the example above, if the employee needs six weeks of leave for a serious health condition commencing February 1, 2009, only the first four weeks of the leave would be FMLA-protected.

29 C.F.R. 825.200(c)

The Winner

When using the rolling calendar or look-back period, an employee’s FMLA leave remaining in his or her 12-week FMLA leave entitlement literally can change daily, since the employer must add days (or hours) used upon the 12-month anniversary of an FMLA absence. Although this method can be confusing to administer (such as calculating the leave available from different FMLA dates for each employee, and to do so each time FMLA leave is requested), it is the only method available under the regulations to ensure that an employee will not take a block of FMLA leave for more than 12 consecutive weeks. Implementing this method is an employer’s best defense against FMLA abuse, and it tends to save costs in the long run. Moreover, it discourages employees’ use of extended periods of leave across consecutive 12-month periods. When balanced against the others, this method often is the best choice for employers.

Work with your employment counsel to ensure you’re using an FMLA year that meets your operational and business needs.

But REMEMBER!

Don’t make the same mistake IDOC did above. Regardless of what 12-month FMLA period you choose, make sure it is clearly defined in your FMLA policy.

10 Reasons for Helping Employees Be More Resilient

Benefits Pro

“Resilience” could be the trending workplace buzzword, as employers search for better ways to get the work done without burning out those who are doing the work.

Betting on this trend is meQuilibrium, a company that specializes in resilience research and training. The company offers a plethora of tools for enhancing the quality of resilience in employees.

It defines resilience as “an individual’s ability to properly respond to stress and adversity.” The company says an investment in resilience leads to “measurable, positive effects on worker health and performance.”

As part of its mission to build resilient workers, it has released a list of 10 reasons why a company’s 2016 benefits package should address the matter of employee resilience. The information is drawn from various research studies and can be found on the company website. Among them are these 10:

1. Stress is as bad a secondhand smoke.

This follows from the results of a Harvard Business School study cited by meQuilibrium that equates the unhealthy side effects of stress to those of secondhand smoke.
2. **Stress costs companies.**

U.S. companies shell out $300 billion annually to pay the price of workplace stress, through their health insurance, absenteeism, and poor performance.

3. **Stress exacerbates costly health conditions.**

Stress makes such disorders as heart disease, obesity, and insomnia worse, all of which are major contributors to health plan costs.

4. **Resilience measurably reduces stress.**

Resilient workers report having 46 percent less stress in their lives than non-resilient workers.

5. **Resilience=job satisfaction.**

Resilient workers are four times more likely to be satisfied with their jobs than non-resilient employees.

6. **Resilient workers show up.**

Resilience pays off in days worked; resilient workers show up an average of three more days a month than those who lack resilience.

7. **Resilience=better health.**

Resilient workers are five times more likely than their non-resilient co-workers to report being in very good or excellent health.

8. **Resilient workers stick around longer.**

Those judged to be resilient are 50 percent less likely to quit their jobs.

9. **Burn-out avoidance.**

Resilient workers are 57 percent less likely to say they’re burned out than their less resilient cohorts.

10. **And the big payoff: ROI.**

A business can realize an estimated return of $600,000 per 1,000 employees if the resilience rate among the workforce moves up 3 percent.

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**IRS Clarifies Midyear Changes to ‘Safe Harbor’ 401(k) Plans**

*Thompson Publishing Group*

The IRS on Jan. 29 provided some long-awaited guidance on which midyear amendments to “safe harbor” 401(k) retirement plans it will allow — and which remain prohibited. The guidance, effective immediately,
should put to rest years of confusion among practitioners over when they can adjust plans to reflect short-term changes without putting their plan’s qualification at risk.

The federal tax Code normally allows plan changes only at 12-month intervals. IRS Notice 2016-16, however, outlines several routine changes to plans that may be made midyear without violating the Code, if appropriate participant election and notice periods are given. The new notice revokes IRS Announcement 2007-59 on the same topic.

Safe harbor 401(k) plan designs started with the 1999 plan year to help avoid costly and time-consuming nondiscrimination testing of all plan participants. Among other features, safe harbor plans are based on specified matching or employer contributions. By using these safe harbors, the plan sponsor can eliminate the need to test every single employee under the actual deferral percentage test applicable to employee deferrals and the actual contribution test applicable to employer matching contributions.

In return for avoiding the tests — and the potential limits or reductions on highly compensated employees’ 401(k) benefits — the plan must offer either matching contributions of up to 4 percent of compensation, or nonelective employer contributions of 3 percent of compensation, for all nonhighly compensated employees.

**Changes Now Allowable at Midyear**

Typical routine changes now allowable during the year, for which plan sponsors long have been seeking IRS clearance, include a minor adjustment to an employer matching amount or a switch in the default investment fund in the plan. Up to now, plan sponsors had to wait a full 12 months to effect such changes.

At the same time, the notice outlines the following changes that remain prohibited at midyear:

- an increase in the number of completed years of service required for an employee to have a nonforfeitable right to his account balance under qualified automatic contribution arrangements;
- a reduction or narrowing of the group of employees eligible to receive safe harbor contributions;
- a switch in the type of safe harbor plan, such as moving from a traditional 401(k) safe harbor plan to a QACA safe harbor plan; and
- a modification in, or addition of, a formula used to determine matching contributions, if the change increases the amount of the matching contributions.

The notice includes several examples that plan sponsors and their service providers may review to put the new guidance into practice.

**10 Ways Retirement is Changing in the U.S.**

*Benefits Pro*

Retirement just isn’t what it used to be.

With changes afoot in the demographics of retirees, as well as in the numbers and social changes behind retirement, the Urban Institute took a scalpel to the statistics to try to explain America’s aging phenomenon and the very process of retirement.
Using data from its own Dynamic Simulation of Income Model (DYNASIM), household surveys, the Social Security Administration and other government sources, the Urban Institute compiled a picture of how retirement in the U.S. is changing.

Here are the top 10 factors that are determining the current, and future, picture of an aging America.

1. **An exploding older population.**

In 2015, 48 million Americans were 65 or older—that’s 18 percent more than only five years earlier.

But by 2030, that number will skyrocket to 74 million—and to 98 million by 2060.

Increased longevity is one factor affecting the shape of retirement—money will have to last retirees longer.

As a result many older workers are remaining in the workforce past the time when they might otherwise have taken their (figurative) gold watch and headed out the door.

2. **A shrinking birth rate.**

Not only are people living longer, they’re having fewer children.

That means a smaller workforce to contribute to Social Security, pensions, and other retirement plans.

According to National Vital Statistics reports, fertility rates are decreasing across all segments of the female population.

At the peak of post-World War II fertility, in 1957, women in the U.S. averaged 3.8 children over their lifetimes. In 2014, that had fallen to 1.9.

And since many elders rely on adult children to provide care as they age or become ill, the growing number of childless seniors—particularly single women—will become increasingly reliant on more distant relatives, friends, or paid helpers.

3. **A more racially and ethnically diverse older population.**

Non-Hispanic whites make up a lower share of the older population than they used to.

In 2000, they accounted for 81 percent of adults 65 and older, but by 2015 that had fallen to 76 percent. By 2060, they will only make up 57 percent.

But in the 60 years between 2000 and 2060, the share of Hispanics in the older population will have nearly tripled, increasing from 7 to 20 percent.

This ethnic shift, according to the report, will have far-reaching consequences, because race and ethnicity influence lifetime earnings, wealth accumulation, health status, caregiving networks, and service needs.

4. **More older married women, fewer older married men.**

As the life expectancy gap shrinks between men and women, there will be fewer widows, with fewer women outliving their husbands.

In spite of increasing divorce and never-married rates, older women will be more likely to live with a spouse in 2060 than they were in 2000.

However, older men will become less likely to live with a spouse over time.
That change in marital status will have a major effect on seniors, since married couples can be better off financially thanks to shared living expenses and to the likelihood of both partners receiving income—whether Social Security or a pension of some kind.

In addition, spouses provide both emotional and actual support for a partner in need of care—something those living alone can’t count on.


People born in the 1980s, the study found, are only half as likely to lack a high school diploma as those born 50 years earlier.

They’re also nearly twice as likely to have completed four years of college.

Even though they won’t hit their 70s till 2050, they’ll change the face of retirement too, because of that education.

People with better education tend to earn more, accumulate more wealth and even have fewer health problems than people who didn’t get as far in school.


In the 14 years between 1998 and 2012, the percentage of adults age 80 and older in fair or poor health decreased from 43 to 34 percent.

Healthier people can work longer, as well as save money on Medicare and out-of-pocket medical costs.

The study pointed out, however, that recent health declines among middle-aged adults could stop, or even reverse, the trend.

It cited an increase from 17 to 22 percent of adults reporting fair or poor health between 1992 and 2010, with an increase among the population of diabetes.

7. Disappearing pensions, more 401(k)s.

Pension plans, as everyone knows, are disappearing. While they covered 30 percent of adults born in the 1940s and 1950s with a lifetime benefit, only 11 percent of adults born in the 1980s will have one.

Instead most will have 401(k)s, most of which have no lifetime income option.

In addition, participants must spend a lot more time focusing on a 401(k) than their elders did on pensions.

They must contribute enough money to see them through their retirement years, invest that money prudently, not take money out before retirement and keep on managing the money wisely once they do retire.

8. Women are earning more and saving more for retirement.

In the 1930s, women who worked earned only about a quarter the amount that men did.

That’s improved, although pay parity remains a distant goal—women born in the 1970s will earn just 70 percent of what their male counterparts do over their lifetimes.

While there’s still a gender pay gap, women are making more money than they used to.

That will bring them higher Social Security benefits, as well as more money in IRAs and 401(k)s.
9. Older adults are working longer.

Better health, better education and less strenuous jobs in some fields—as well as the need or desire to keep working—are all keeping people in the workplace longer.

Between 1994–2014, men working, or looking for work, aged 62–64 increased from 45 percent to 56 percent, while men aged 65–69 who were working or looking for work rose from 27 to 36 percent.

Over the same period, women working or looking for work who were aged 62–64 rose from 33 to 45 percent, while those aged 65–69 working or looking for work rose from 18 to 28 percent.

Those who work longer not only stand to increase retirement savings and accumulate additional Social Security benefits but also shorten the amount of time they’ll have to depend solely on retirement income.

10. More older adults are retiring with outstanding debt.

Older people are carrying a heavier load of debt into retirement than they used to.

That’s going to cut into what they have available to pay retirement expenses.

Between 1998–2012, the share of adults age 65 and older with household debt rose from 30 to 44 percent.

And in 2012, 24 percent of older households had an outstanding mortgage; that’s also an increase, from 16 percent in 1998. Other types of debt have also been on the increase, including credit card debt.

Not only are more people in debt in retirement, they owe more money.

The median debt level among older adults with outstanding debt increased 74 percent in inflation-adjusted dollars over the period, to $24,500

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State Law Review

What’s New in State Laws

CCH, Incorporated

For busy Human Resources professionals who want ready access to what is new and what has recently changed in State laws, here is a brief update.

Arizona Minimum Wage

The current living wage rate in Pima County for the 2016 calendar year is $11.85 per hour for employees who do not receive benefits and $10.55 per hour with $1.30 in benefits for those employees who do receive benefits.

Arizona Unemployment Insurance

For 2016, all employers with positive reserve ratios, except new employers and those with a rate of 0.03%, will receive increases in the basic rates, which will range from 0.03% to 4.29%. The rates of employers with
negative reserve ratios also will increase in 2016, and will range from 4.70% to 8.91%. An employer whose reserve ratio is zero will pay 4.46%. New employers will pay 2.0%.

California Minimum Wage

On January 12, 2016, the City Council of Santa Monica voted to adopt a minimum wage ordinance that includes a phased-in increase to reach $15 in 2020 for most businesses; with a one-year delay ($15 by 2021) for businesses with 25 or fewer employees as well as for qualifying nonprofit organizations. Major provisions of the law are to match the City and County of Los Angeles for regional coordination. The ordinance also includes a higher wage for hotel workers, matching the City of Los Angeles in 2017, and going beyond Los Angeles in applying to hotels of all sizes; the minimum wage for hotel workers is scheduled to increase to $13.25 on July 1, 2016, and to $15.37 on July 1, 2017.

The ordinance also provides for sick leave (nine days large businesses; five days smaller businesses); a service charge regulation to protect worker income and ensure consumer transparency; first time worker/seasonal exemption; best practice enforcement provisions including protection from retaliation and a private right of action; focus on education and outreach through community based organization partnerships; and an exception for collective bargaining.


Also, the Long Beach City Council passed a proposal on January 20, 2016, to raise the minimum wage, also phased-in, to reach $13 an hour by 2019. The proposal calls for increases in the minimum wage as follows: $10.50 on January 1, 2017; $12.00 per hour on January 1, 2018; and $13.00 an hour on January 1, 2019. Small businesses with 25 or fewer employees and nonprofit corporations would receive a one-year delay in implementing each of the elements of the minimum wage policy (City of Long Beach, Minimum Wage Proposal, File 16-0043, http://longbeach.legistar.com/LegislationDetail.aspx?ID=2547614&GUID=24B165E9-1691-4BC3-B866-28744CCB8A03&Options=ID%7CText%7C&Search=&FullText=1).

California Unemployment Insurance

The TDI maximum and minimum weekly benefit amounts in California for 2016 are $1,129 and $51, respectively. Also, the disability elective coverage rate is 4.67% for 2016.

Connecticut Minimum Wage

The living wage for Manchester is currently calculated to be $13.41/hour for employees that are provided comprehensive health care benefits, or $17.13/hour for employees that are not provided comprehensive health care benefits.

Additionally, the living wage for New Haven will increase from $16.13 per hour to $16.16 per hour effective July 1, 2016.
Connecticut Unemployment Insurance

For 2016, the fund tax rate is 1.4%. Accordingly, the minimum contribution rate is 1.9%, and the maximum contribution rate is 6.8%. The new employer’s rate for 2016 is 4.3%.

Delaware Unemployment Insurance

For 2016, the State Experience Factor is 40, the supplemental assessment rate is 0.2%, and the training tax assessment is 0.085%. Rates range from 0.1% to 8.0%. Rates for construction employers are 2.4% (NAICS 236), 6.0% (NAICS 237), and 3.7% (NAICS 238). New nonconstruction employers pay 1.9% in 2016.

The maximum weekly benefit amount in Delaware for 2016 is $330, and the minimum weekly benefit amount is $20.

District of Columbia Child Support Enforcement


District of Columbia Pregnancy Discrimination

The district has declared the existence of an emergency with respect to the need to amend the Protecting Pregnant Workers Fairness Act of 2014 to require an employer to make a reasonable accommodation for an employee whose ability to perform the functions of the employee’s job are affected by a pre-birth complication.

The Protecting Pregnant Workers Fairness Amendment Act of 2016, introduced on January 5, 2016 (Bill 21-563), is under review by the Council of the District of Columbia (DC R 554, effective February 2, 2016).

District of Columbia Sick/Safe Leave

The Accrued Sick and Safe Leave Act of 2008 has been amended on an emergency basis to clarify that employees in the building and construction industry covered by a bona fide collective bargaining agreement shall be exempted from the paid leave requirements of the act only if the agreement expressly waives those requirements (Act 291 (B. 561), L. 2015, enacted January 27, 2016).

District of Columbia Unemployment Insurance

Rate Table V remains in effect for 2016 in the District of Columbia. The 0.2% Administrative Assessment is also in effect this year.

Florida Affirmative Action

The state has enacted a law revising its equal employment opportunity policy to include individuals who have a disability (Ch. 2016-3 (H. 7003), L. 2016, effective July 1, 2016).

Florida Minimum Wage

All service contractors entering into, renewing or extending a contract to provide covered services to Broward
County must pay their employees providing covered services a living wage of no less than $11.84 per hour with qualifying health benefits of at least $1.54 per hour, or otherwise $13.38 per hour, effective January 1, 2016.

**Florida Unemployment Insurance**

For 2016, the minimum rate is 0.1%, and the maximum rate is 5.4%, except that employers participating in the short-time compensation program will be subject to a maximum rate of 6.4%. New employers pay 2.7% in 2016. The noncharge ratio is .0024, the excess payment ratio is .001, the gross benefit ratio is .011, the fund size ratio is 0.0, the multiplier is .3091, and the final adjustment ratio is .0010.

**Hawaii Unemployment Insurance**

For 2016, Rate Schedule C applies. New employers pay 2.4% under Schedule C. Rates range from 0.0% to 2.4% for positive-balance employers, and from 2.8% to 5.6% for negative-balance employers. The Employment and Training Assessment rate remains 0.01%.

**Idaho Unemployment Insurance**

Contribution rates in Idaho for 2016 range from 0.425% to 1.417% for positive-balance employers, and from 2.551% to 5.4% for deficit-balance employers. The standard rate for 2016 is 1.488%. Also, the maximum weekly benefit amount in Idaho for 2016 is $410.

**Illinois Unemployment Insurance**

Effective for 2016, the maximum weekly benefit amount for an individual is $437, the maximum weekly benefit amount for an individual with a spouse is $521, and the maximum weekly benefit amount for an individual with a child is $595.

**Indiana Unemployment Insurance**

For 2016, the solvency surcharge rate is 1.0%. Applied rates for employers with an account credit reserve balance range from 0.505% to 3.838%, and penalty rates for employers with an account credit reserve balance range from 2.515% to 5.848%. Applied rates for employers with an account debit reserve balance range from 4.949% to 7.474%, and penalty rates for employers with an account debit reserve balance range from 6.959% to 9.484%. New employers pay a rate of 2.50%, and new governmental employers pay a rate of 1.60% in 2016. In 2016, the new construction employer rate of 3.51% applies unless certain conditions are met. New employers are exempt from the solvency surcharge.

**Kansas Unemployment Insurance**

For 2016, the ratio of the fund balance to total payrolls is 0.958%. Eligible positive-balance employers pay rates ranging from 0.20% to 5.40%. New employers pay 2.70%, except new construction employers pay 6.0%. Negative-balance employers pay rates ranging from 5.60% to 7.60%. New rated government employers pay 0.12% for 2016.

**Kentucky Unemployment Insurance**

The taxable wage base for Kentucky in 2016 is $10,200, up $300 from the 2015 taxable wage base amount of $9,900.

Also, for 2016, the rates listed in Schedule E are in effect. Those rates range from 1.00% to 3.50% for positive-balance employers, and from 7.50% to 10.00% for negative-balance employers. The new employer rate for 2016
is 2.7%, except new construction employers will pay 10.00%.

**Louisiana Unemployment Insurance**

For 2016, contribution rates for eligible positive reserve ratio employers range from 0.10% to 2.05%. Rates for eligible negative reserve ratio employers range from 2.10% to 6.20%. The maximum and minimum weekly benefit amounts in Louisiana for 2016 are $247 and $10, respectively.

**Maine Unemployment Insurance**

Contribution rates in Maine for 2016 are adjusted by 0.06% for the Competitive Skills Scholarship Fund (CSSF) rate that is now in effect. As adjusted, rates for 2016 range from 0.57% to 5.40%. New employers pay an adjusted rate of 2.10% for 2016.

**Maryland Unemployment Insurance**

For calendar year 2016, rates are determined under Table A, and range from 0.3% to 7.5%. New employers pay 2.6% for 2016, except that new construction employers headquartered in another state pay 7.5%.

**Massachusetts Minimum Wage**

Employers with at least 25 full-time equivalent employees and who have been awarded a service contract of $25,000 or more from the City of Boston must pay employees a living wage of 14.11 per hour (effective until June 30, 2016).

The Town of Brookline must pay its employees a living wage. In addition, service contractors (and subcontractors) must pay a living wage to workers who provide direct services under contracts of $5000 or more awarded by the town. The current living wage rate is $13.45 per hour.

The town exempts certain employees from the living wage. Exempt positions are to be paid no less than $1 more than the state minimum wage; employees exempt from the living wage must currently be paid no less than $11.00 per hour (effective January 1, 2016).

**Michigan Child Support Enforcement**

The Uniform Interstate Family Support Act has been revised to uniform laws relating to support enforcement. Under the Act, an income withholding order issued in another state may be sent by or on behalf of the obligee, or by the support enforcement agency, to the person defined as the obligor's employer, without first filing a petition or comparable pleading or registering the order with a tribunal of this state. Enforcement of out-of-state income withholding orders is now covered under Article 5 of Chapter 552, Sections 552.2501 through 552.2507 (P.A. 255 (H. 4742), L. 2015, effective January 1, 2016).

**Michigan Minimum Wage**

For 2016, the Ingham County living wage is $15.19 per hour.

**Michigan Wage Payment**

To the extent allocation of employer responsibilities between a franchisor and a franchisee is permitted by law, the franchisee is considered the “sole employer” of workers for whom it provides a benefit plan or pays wages, except as specifically provided in a franchise agreement (Act 266 (S. 492), L. 2015, effective March 22, 2016).
**Minnesota Unemployment Insurance**

For 2016, the base rate is 0.10%, and the Workforce Development Fee is also 0.10%. There is no additional assessment of 14.0% of the tax due in effect for 2016. High experience-rated industry new employers will be assigned a total rate of 8.54%. All other new employers will be assigned a total rate of 1.69% for 2016. There is also no federal loan interest assessment in effect for 2016.

**Missouri Unemployment Insurance**

For 2016, the contribution rate of an experience-rated employer may range from 0.0% to 9.750%. For experience-rated employers that are participating in the workshare program, contribution rates may range from 0.0% to 13.650%. These rates reflect all surcharges imposed for 2016. The rate payable by new employers in 2016 is 3.51%, except for those employers in special industries. New construction employers will pay 4.362% in 2016. Note, however, the nonprofit contribution rate remains at 1.30%.

**Montana Fair Employment Practices**

On January 18, 2016, Montana Governor Steve Bullock issued an executive order prohibiting discrimination in state employment and contracts (E.O. 04-2016).

Specifically, E.O. 04-2016 prohibits discrimination based on race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status, or marital status.

Executive Order 04-2016 supersedes and rescinds Executive Order 41-2008, issued by Governor Brian Schweitzer on November 14, 2008.

**Montana Unemployment Insurance**

For 2016, Schedule I is in effect, and there is also a 0.13% Administrative Fund Tax (AFT) in effect for employers in Rate Class 1 and 2, and a 0.18% AFT for all other experience-rated employers. Total rates for positive-balance employers range from 0.13% to 1.60%. Total rates for negative-balance employers range from 3.10% to 6.30%. New employers that are rated by industry classification pay the following rates, which include the 0.18% AFT, for 2016: agriculture, forestry, hunting, and fishing employers, 1.68%; construction employers, 2.78%; mining employers, 1.38%; finance, insurance, and real estate employers, 1.18%; manufacturing employers, 1.48%; retail trade employers, 1.18%; services employers, 1.18%; utilities, transportation, and warehousing employers, 1.18%; wholesale trade employers, 1.18%; and unclassified employers, 2.78%.

**Nebraska Minimum Wage**

Effective until June 30, 2016, the living wage for Lincoln is $11.65 per hour with health benefits, and $12.82 per hour without health benefits.

**Nebraska Unemployment Insurance**

For 2016, the maximum weekly benefit amount in Nebraska is $392.

**New Hampshire Child Support Enforcement**

The Uniform Interstate Family Support Act has been repealed and reenacted by Ch. 75 (S. 11), L. 2015, effective January 1, 2016. Provisions of the Act covering enforcement of income withholding orders issued in another state, without registration, are now covered under Article 5 of Chapter 546-B of the New Hampshire
Revised Statutes, Section 546-B:32 through 546-B:38.

New Jersey Prevailing Wages

The New Jersey Prevailing Wage Act has been amended to provide the Commissioner of Labor and Workforce Development with the authority to obtain proof, and question, a worker’s identity in order to determine if the worker is accurately included or reported in the employer’s wage records for enforcement purposes (Ch. 281 (A. 3043), L. 2015, enacted effective January 19, 2016). Also, the Act has been amended concerning dissemination of information to contractors who bid on or perform prevailing wage public work.

The Commissioner is to create, maintain and distribute an informational list to contractors and subcontractors who bid on and perform a public work that includes wage payment, recordkeeping and registration requirements, and applicable penalties for violations, pursuant to the New Jersey Prevailing Wage Act or the Public Works Contractor Registration Act. The informational list is to be displayed on the Department of Labor and Workforce Development Internet website, and is to be distributed to any contractor, subcontractor, or public body, upon request, as well as the list of names of those contractors and subcontractors who have failed to pay prevailing wages or who have failed to pay state employer payroll tax (Ch. 282 (A. 3044), L. 2015, enacted effective January 19, 2016).

New York Fair Employment Practices

Gender identity regs. In October 2015, Governor Cuomo became the first executive in the nation to issue state-wide regulations prohibiting harassment and discrimination on the basis of gender identity, transgender status or gender dysphoria.

On January 20, 2016, the governor announced that the New York State Division of Human Rights has adopted new regulations that ban discrimination and harassment against transgender people in both public and private employment. The regs, effective January 20, 2016, affirm that transgender individuals are protected under the state’s Human Rights Law.

The regs confirm that the Division of Human Rights will accept and process Human Rights Law complaints alleging discrimination because of gender identity, on the basis of the protected categories of both sex and disability, and provide important information to all New Yorkers regarding unlawful discrimination against transgender individuals (Office of the Governor Press Release, January 20, 2016).

New York City Human Rights Law – caregiver status. New York City Mayor Bill de Blasio has signed legislation expanding the New York City Human Rights Law to include “caregiver status” as an additional protected category in employment. “Caregivers are our unsung heroes. They literally keep families together. It’s critical we give them the employment protection they need and deserve,” Mayor de Blasio said.

The City Human Rights Law protects several classes of persons from employment discrimination. Protected classes covered under the law include race, national origin, disability, sexual orientation, citizenship status, gender, age, and others.

The addition of caregiver status to these categories by Int. No. 108-A means that an employee who is caring for a minor child or an individual with a disability cannot be terminated, demoted or denied a promotion because of his or her status or perceived status as a caregiver.

New York Minimum Wage

Effective January 1, 2016, Suffolk County businesses and their subcontractors receiving compensation from the county and employing 10 or more people must pay their employees not less than $11.93 per hour with health
benefits, or $13.58 per hour if no health benefits are provided. There are different rates for child care providers.

**Ohio Unemployment Insurance**

For 2016, the maximum weekly benefit amount for an individual with no dependents is $435, the maximum weekly benefit amount for an individual with one or two dependents is $527, and the maximum weekly benefit amount for an individual with three or more dependents is $587.

**Oklahoma Unemployment Insurance**

The maximum weekly benefit amount in Oklahoma for 2016 is $505.

**Oregon Paid Sick Leave**

Rules have been adopted by the Bureau of Labor and Industries to implement the state’s Paid Sick Leave Law (Oregon Administrative Rules, Chapter 839, Division 7, Rules 839-007-0000 through 839-007-0120, effective January 1, 2016).

**Pennsylvania Child Support Enforcement**

The Uniform Interstate Family Support Act has been revised by Act 94 (H. 1603), L. 2015, effective December 28, 2015. Provisions of the Act relating to enforcement of income withholding orders for child support issued in another state without registration are covered in the Pennsylvania Consolidated Statutes under Title 23, Chapter 75.

**Pennsylvania Unemployment Insurance**

For calendar year 2016, the following unemployment compensation solvency measures are in effect: (1) the additional employer contribution is 0.65%; (2) the surcharge tax is 5.1%; (3) the interest factor tax is 1.1%; and (4) the employee tax is 0.07%. The maximum state adjustment factor for 2016 is 1.0%. Rates for experience-rated, nondelinquent employers will range from 2.8010% to 10.8937% for 2016, including the surcharge, additional employer contribution, and the interest factor tax. Rates for delinquent employers will range from 5.9540% to 14.0467% for 2016, also including the surcharge, additional employer contribution, and the interest factor tax.

New nonconstruction employers pay 3.6785%, and new construction employers pay 10.1947%. These rates include the surcharge only as the other two taxes do not apply to new employers.

**Puerto Rico Child Support Enforcement**

The Uniform Interstate Family Support Act (UIFSA) has been revised. Under UIFSA, an income withholding order issued in another state may be sent by or on behalf of the obligee, or by the support enforcement agency, to the employee obligor's employer under the income withholding law of Puerto Rico without first filing a petition or comparable pleading or registering the order with a tribunal of Puerto Rico (Act 103 of July 6, 2015).

**Texas Unemployment Insurance**

Contribution rates in Texas range from 0.45% to 7.47% for 2016. Also for 2016, the replenishment ratio is 1.27, the replenishment tax rate is 0.30%, and the obligation assessment ratio is 0.17. In addition, the interest tax rate is 0.0%, and the employment and training investment assessment rate is 0.10%.

**Utah Unemployment Insurance**

The maximum weekly benefit amount in Utah for 2016 is $509.
**Washington Minimum Wage**

After a public process that included four meetings to solicit community feedback, Tacoma’s minimum wage rules are now final and available at http://cms.cityoftacoma.org/finance/minimum-wage/minimum-wage-rules.pdf. These rules will guide the implementation of Initiative Measure No. 1B, which was approved by Tacoma voters in November 2015.

Initiative Measure No. 1B called for the Tacoma minimum wage to increase to $10.35 per hour on February 1, 2016 (the same effective date as the Paid Leave Ordinance passed in January 2015). The Tacoma minimum wage would increase to $11.15 per hour on January 1, 2017, and to $12 per hour on January 1, 2018. Starting in 2019, the minimum wage is to be adjusted annually based on the rate of inflation (City of Tacoma, News Release, January 7, 2016, http://www.cityoftacoma.org/cms/One.aspx?portalId=169&pageId=95978).

For the City of SeaTac, the minimum wage is currently $15.24. The minimum wage did not increase for 2016, but instead remains at the 2015 wage rate. The rate applies to certain hospitality and transportation workers in the City of SeaTac. In addition, per an August 20, 2015, Washington Supreme Court ruling, the minimum wage and other employment standards are enforceable at the Seattle-Tacoma International Airport (Filo Foods, LLC, et al. v. The City of SeaTac, et al.) (SeaTac City Manager Minimum Wage Bulletin for 2016, http://www.ci.seatac.wa.us/Modules/ShowDocument.aspx?documentid=11646).

**Washington Unemployment Insurance**

For 2016, contribution rates (including the graduated social cost rate) range from 0.10% to 5.70%. There is also an Employment Administration Fund tax in effect for 2016, which brings the total rate range to 0.13% to 5.72%. Note, delinquent employer rates range from 0.83% to 7.73%.

**Wisconsin Child Support Enforcement**

Provisions of the Uniform Interstate Family Support Act relating to enforcement of child support orders issued out of state are amended. These provisions allow for an income withholding order issued in another state to be sent by or on behalf of the obligee, or by the support enforcement agency, to the obligor’s employer, or other debtor, without first filing a petition or comparable pleading or registering the order with a tribunal of Wisconsin (Act 82 (S. 173), L. 2015).

**Wyoming Unemployment Insurance**

For 2016, experience-rated employers pay rates ranging from 0.27% to 8.77%. Note that any delinquent employer is assessed 2.0% plus the assignable basic rate, the total of which may not exceed 8.77%. For 2016, new employers pay the following rates by industry classification: raw materials and energy production, 1.18%; distribution and transportation of goods, 1.00%; information, 1.00%; finance, insurance, real estate, and rental and leasing, 1.00%; professional and business services, 1.03%; education, health, and social assistance, 1.00%; leisure, accommodation, and food services, 1.19%; other services (except public administration), 1.00%; public administration, 1.00%; unclassified employers, 3.58%; construction, 2.63%; and manufacturing, 1.29%. These figures do not include the adjustment factor of 0.016% for inefficiently and noncharged benefits or the employment support fund tax of 0.011%. For 2016, the fund balance adjustment factor is 0.00%.
Important Reminder!

Upcoming Deadlines

Keeping track of all of the compliance requirements that face employers sponsoring health and welfare plans has always been a challenge. The additional requirements imposed on employers by the Patient Protection and Affordable Care Act (“PPACA”) has added significantly to the burden. Each month this article will provide information on deadlines that are coming up in the next three months for a calendar year plan. Key requirements for April, May, and June are listed below.

Dates are based on the timing for a calendar year plan (except as noted); employers with non-calendar year plans will need to modify dates as appropriate.

Note: The IRS issued Notice 2016-4 on December 28, 2015 delaying the due dates for filing Forms 1094-B, 1095-B, 1094-C and 1095-C for the 2015 calendar year. The chart below reflects the new deadlines.

Deadlines for April, May, and June

- **April 30, 2016** – last day to file the San Francisco Healthcare Security Ordinance Annual Reporting Form. This requirement applies to employers with respect to employees that work in San Francisco regardless of the employer’s primary location. Click here for more detailed information.

- **May 2, 2016** – due date for quarterly payment of the Michigan Health Insurance Claims Assessment (an assessment based on health claims paid in Michigan with a limit of $10,000 per individual).

- **May 31, 2016** - (due to extension in Notice 2016-4) – due date for filing paper copies of Forms 1095-B or 1095-C for 2015 with the IRS.

- **June 30, 2016** - (due to extension in Notice 2016-4) due date for electronic filing Forms 1095-B or 1095-C for 2015 with the IRS.

2017 Medicare and HSA Values

Updated values for Medicare Parts A and B were released in November. Updated values for Medicare Part D (drug coverage) were released in May. Updated values for Medicare Part D for 2017 are expected to be released in April or May 2016; updated 2017 values for HSAs in May 2016.

Ongoing Activities (Selected)

Many compliance requirements apply every month. Some of the key ongoing requirements are:

- Marketplace notices - to all newly hired employees within 14 days of hire

- Provide the following materials when an employee becomes eligible for/enrolled in the health plan:
  - Summary of Benefits and Coverage (“SBC”) – upon eligibility
  - HIPAA Privacy Notice – upon enrollment
  - COBRA General (Initial) Notice – to employee (& spouse if married) – upon enrollment
HIPAA Special Enrollment Rights Notice – upon eligibility

Medicare Part D certificate of creditable/noncreditable drug coverage – upon enrollment

In addition to federal requirements, some states have additional requirements such as reporting on the availability of dependent health coverage. Employers should check with their state(s) to determine what requirements and deadlines will apply.

Note: We include information about the above required communications indicating whether the requirement is triggered by the employee’s eligibility or enrollment in the plan. Exact timing varies by requirement.

Our list focuses on major federal and, in some cases state, requirements that will impact a significant number of employers. It is not intended to be a comprehensive list.

The intent of this Newsletter is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plan sponsors should seek proper legal advice for application of these rules to their plans. © 2016 Arthur J. Gallagher & Co.