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Payroll and Business Services

PrimeFlex—(877) 769-3539

JJH Employer Services
Insurance & HR Administrative Solutions

Solutions@JJHemployerservices.com
www.JJHemployerservices.com
Ph. 516-506-1875

PrimeFlex Administrative Services Compliance Guide

How to use this guide

As part of PrimeFlex's commitment to service, compliance, and education, we provide you with this Compliance Guide, which addresses a number of common yet important issues in our industry, as well as running a business as a whole. We believe that it will be an important tool and instrumental in performing your due diligence with both new clients and renewing clients. The corresponding checklist will assist you in making the process as effortless as possible as well as making sure you address with your clients the important issues they may know about or maybe could use some more guidance.

The information provided will serve as a reference and can be distributed freely one topic at a time, or several, as long as PrimePay, PrimeFlex, or any phone number is not removed and the "General Disclaimer" on pg. 3 is also distributed.

Topics, Group Size and State Resources

By clicking on a topic below, it will bring you to the appropriate page. If you would like to view Federal Laws according to Employer Size, you may click here. You can view information specific to your state by clicking here.

All links to external sites are green, and all links to places in this guide are underlined red.

Federal Regulations Pgs. 6-10	**Employee Retirement Income Security Act (ERISA)**
	Important Documents Under ERISA
	HIPAA Portability Rules
	HIPAA Privacy Rules
	HIPAA Business Associates
Benefits Pgs. 11-17	**COBRA**
	Government Mandated Benefits
	Family Medical Leave Act (FMLA)
	MSP Reporting
	Non-discrimination Rules Under 105(h)
	HEART Act
	Tax Treatment of Fringe Benefits
CDHP Pgs. 18-24	**Cafeteria Plan (Section 125)**
	Cafeteria Plan Rules
	Simple Cafeteria Plans
	FAQs Regarding FSAs
	Health Reimbursement Arrangement
	Cafeteria Plan and HRA Eligibility
	Funding Techniques for FSAs, HRAs, & MSAs
CDHP cont. Pgs. 25-28	**Health Savings Account**
	Funding Techniques for HSAs
	Stacking Rules for CDHP
	Domestic Partners
PPACA Pgs. 29-38	**Healthcare Reform Timeline 2011-2012**
	Healthcare Reform Timeline 2013-2015
	Grandfathered Plans
	Dependent to Age 26
	Small Business Tax Credit
	Summary of Benefits and Coverage
	W-2 Reporting
	Wellness Programs & Class Act
	Annual Limit Prohibition
	PPACA Misc.
Human Resources Pgs. 39-43	**Classifying Employees: W-2 vs. 1099**
	Employee Handbook
	Labor Law Posters
	Social Media at Work
	Red Flags Rule

Have a topic you would like addressed in a future update? Contact your PrimeFlex Representative for more details.

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Compliance Checklist

Company: **Date:**

# of Employees:

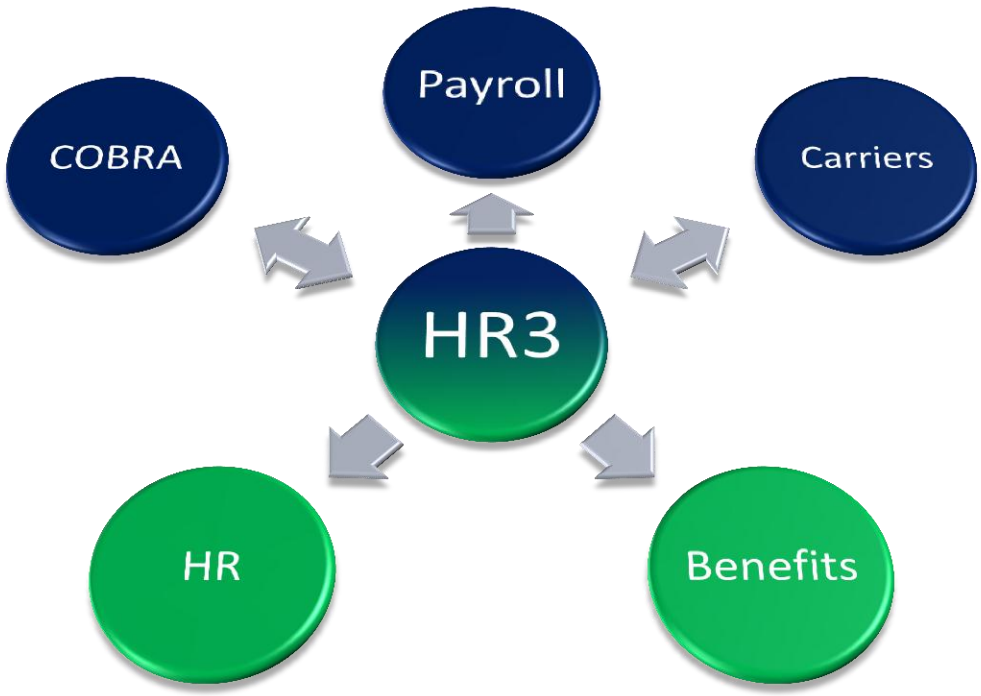
- ☐ Compliance by employer size
- ☐ State resources
- ☐ Employee Retirement Income Security Act (ERISA)
  - ☐ Covered plans
  - ☐ Requirements
  - ☐ Fiduciaries and responsibilities
  - ☐ Documents
- ☐ HIPAA
  - ☐ Portability Rules
  - ☐ Privacy Rules
  - ☐ Business Associates
- ☐ COBRA
  - ☐ Covered plans
  - ☐ Qualifying events
  - ☐ Qualified beneficiaries
  - ☐ COBRA timeline
- ☐ Government Mandated Benefits
  - ☐ Social Security and Medicare
  - ☐ Workers' Compensation
  - ☐ Unemployment Compensation
- ☐ Family Medical Leave Act (FMLA)
  - ☐ Covered employers
  - ☐ Eligible employers
  - ☐ Reasons for leave
- ☐ MSP Reporting
  - ☐ Who/what must be reported?
  - ☐ Reporting for HRAs
  - ☐ Exceptions
- ☐ Non-discrimination Rules Under 105(h)
  - ☐ What/how is it determined?
  - ☐ HCI and key employees
- ☐ HEART Act
  - ☐ Qualified Reservist Distribution
  - ☐ Plan Amendments
- ☐ Tax Treatment of Fringe Benefits
- ☐ Cafeteria Plan (Section 125)
  - ☐ Qualified benefits
  - ☐ Rules
  - ☐ Simple Cafeteria Plans
  - ☐ FAQs Regarding FSAs
- ☐ Health Reimbursement Arrangement
  - ☐ 213(d)
  - ☐ Non-discrimination
  - ☐ Continuing coverage
- ☐ Cafeteria Plan and HRA Eligibility
  - ☐ Owners
- ☐ Funding Techniques
  - ☐ FSAs
  - ☐ HRAs
  - ☐ MSAs
- ☐ Health Savings Account
  - ☐ Who can participate?
  - ☐ QHDHP
  - ☐ Distributions
  - ☐ Funding Techniques
- ☐ Stacking Rules for CDHP
  - ☐ FSA/HRA/HSA Combinations
  - ☐ Mid-year renewals
- ☐ Domestic Partners
  - ☐ Taxation of benefits
- ☐ PPACA
  - ☐ Healthcare Reform Timeline 2011-2015
  - ☐ Grandfathered Plans
  - ☐ Dependent to Age 26
  - ☐ Small Business Tax Credit
  - ☐ Summary of Benefits and Coverage
  - ☐ W-2 Reporting
  - ☐ Wellness Programs & Class Act
  - ☐ Annual Limit Prohibition
  - ☐ PPACA Misc.
- ☐ Human Resources
  - ☐ Classifying Employees: W-2 vs. 1099
  - ☐ Employee handbook
  - ☐ Labor Law Posters
  - ☐ Social Media at Work
- ☐ Red Flags Rule
  - ☐ Participating employers
  - ☐ Identity Theft Prevention Program

General Disclaimer

To be distributed to all clients, Employers, Brokers, or anyone else who will use this guide.

The information provided in this guide is only intended as a general summary of publically available information. It is not intended to take the place of either the written law or regulations and is not to be used or relied upon for legal, accounting tax or other professional advice. This guide is not sponsored or endorsed by any government agency and is strictly for the promotional and marketing purposes for PrimeFlex Administrative Services and its affiliates (hereinafter "PrimeFlex"). Copyright is not claimed for materials originating from US government sources. For more information please consult the U.S. Department of Labor, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Trade Commission, Internal Revenue Service or other corresponding government agency. Readers are cautioned that laws are subject to change and new rules, orders or cases may change the interpretation of laws at any time. While every effort has been taken in compiling this information to ensure that its contents are totally accurate and up-to-date, PrimeFlex cannot guarantee such accuracy and is not responsible for penalties or damages of any kind as a result of using this guide. As always, readers are encouraged to seek the assistance of competent professional advisors for specific advice with respect to their particular question or situation.

For more information visit us on the web at www.primepay.com or call us today at 877.7.MY.FLEX.



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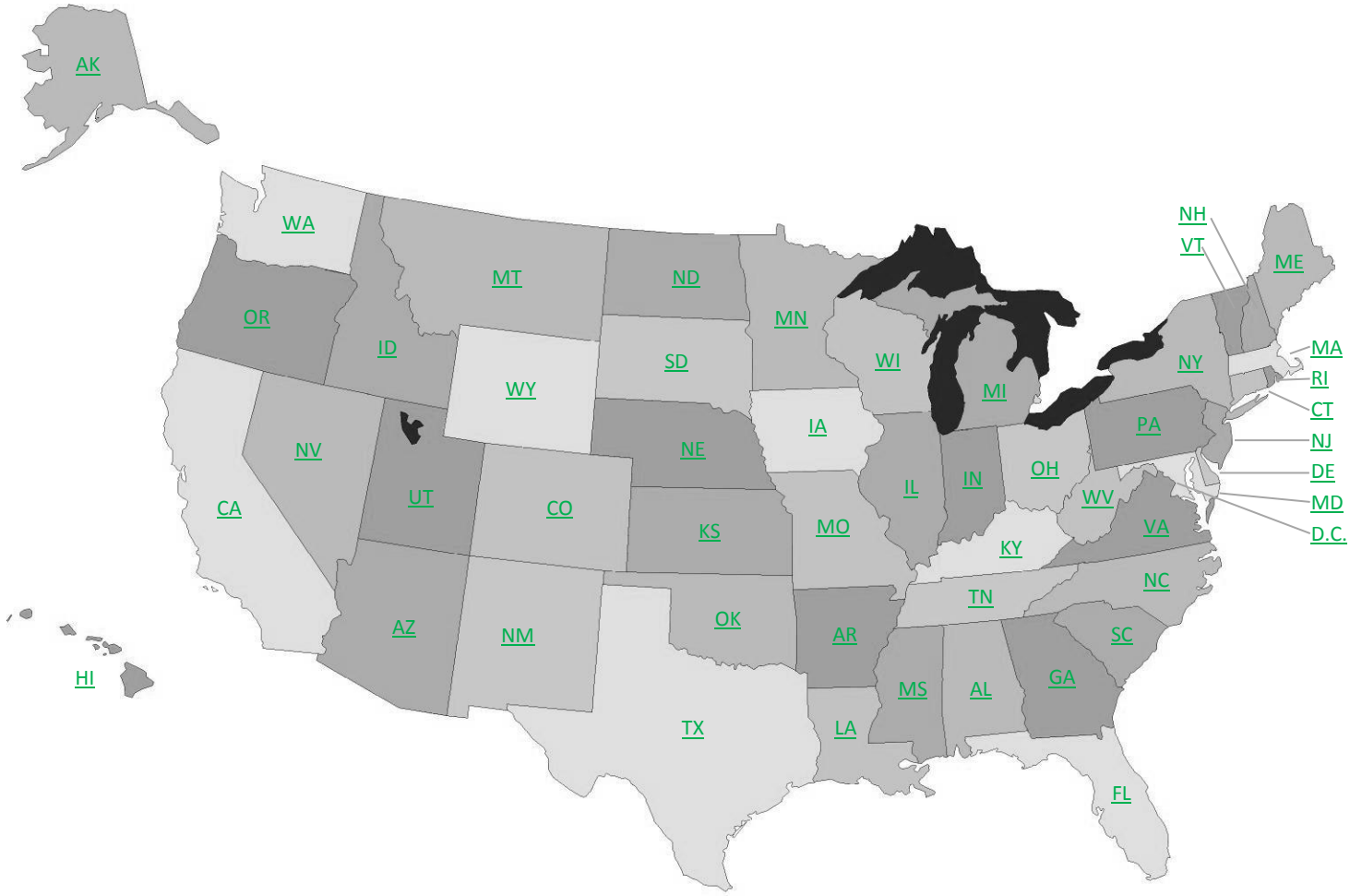
State Resources



Alabama	Alaska	Arizona	Arkansas	California
Colorado	Connecticut	D.C.	Delaware	Florida
Georgia	Hawaii	Idaho	Illinois	Indiana
Iowa	Kansas	Kentucky	Louisiana	Maine
Maryland	Massachusetts	Michigan	Minnesota	Mississippi
Missouri	Montana	Nebraska	Nevada	New Hampshire
New Jersey	New Mexico	New York	North Carolina	North Dakota
Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island
South Carolina	South Dakota	Tennessee	Texas	Utah
Vermont	Virginia	Washington	West Virginia	Wisconsin
Wyoming				

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Compliance by Employer Size

Clicking on a link will bring you to information about the corresponding law.

1-14	National Labor Relations Act	1935	Wagner Act or NLRA
	Federal Insurance Contributions Act	1935	FICA
	Fair Labor Standards Act	1938	FLSA
	Labor-Management Relations Act	1947	Taft-Harley Act
	Equal Pay Act	1963	EPA
	Consumer Credit Protection Act	1968	CCPA
	Occupational Safety & Health Act	1970	OSHA
	Fair Credit Reporting Act	1970	FCRA
	Employee Retirement Income Security Act	1974	ERISA
	Jury System Improvements Act	1978	—
	Immigration Reform & Control Act	1986	IRCA
	Employee Polygraph Protection Act	1988	EPPA
	Uniformed Services Employment & Reemployment Rights Act	1994	USERRA
	Health Information Portability and Accountability Act	1996	HIPAA
	Personal Responsibility and Work Opportunity Reconciliation Act	1996	PRWORA
	Fair and Accurate Credit Transactions Act	2003	FACTA
15-19	**ALL LAWS AS REQUIRED IN THE 1-14 GROUP AND:**		
	Title VII of the Civil Rights Act	1964	Title VII
	Pregnancy Discrimination Act	1978	—
	Title I of the American with Disabilities Act	1990	ADA
	Genetic Information Non-discrimination Act	2008	GINA
20-49	**ALL LAWS AS REQUIRED IN THE 1-19 GROUP AND:**		
	Age Discrimination in Employment Act	1967	ADEA
	Consolidated Omnibus Budget Reconciliation Act	1985	COBRA
50-99	**ALL LAWS AS REQUIRED IN THE 1-49 GROUP AND:**		
	Family Medical Leave Act	1993	FMLA
	EEO-1 Report	—	Federal Contractors, Filed Annually
100+	**ALL LAWS AS REQUIRED IN THE 1-99 GROUP AND:**		
	Worker Adjustment & Retraining Notification Act	1989	WARN
	EEO-1 Report	—	Filed Annually

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ERISA

Overview

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for retirement and health benefit plans in private industry. ERISA does not require any Employer to establish a plan, but requires that those who establish plans, meet certain minimum standards.

Covered plans

ERISA covers retirement, health, and other welfare benefit plans (e.g., life, disability, and apprenticeship plans). Among other things, ERISA provides that those individuals who manage plans (and other fiduciaries) must meet certain standards of conduct. The law contains detailed provisions for reporting to the government and disclosure to participants. There also are provisions aimed at assuring that plan funds are protected and that participants who qualify receive their benefits.

Requirements

ERISA requires plan administrators to give plan participants the most important facts they need to know about their retirement and health benefit plans including plan rules, financial information, and documents on the operation and management of the plan, in writing. Some of these facts must be provided to participants regularly and automatically by the plan administrator. Others are available upon request, free-of-charge or for copying fees.

One of the most important documents participants are entitled to receive automatically when becoming a participant of an ERISA-covered retirement or health benefit plan or a beneficiary receiving benefits under such a plan, is a summary of the plan, called the summary plan description or SPD. The plan administrator is legally obligated to provide to participants, free of charge, the SPD.

Plan Fiduciaries

Many of the actions involved in operating a plan make the person or entity performing them a fiduciary. Using discretion in administering and managing a plan or controlling the plan's assets makes that person a fiduciary to the extent of that discretion or control. Thus, fiduciary status is based on the functions performed for the plan, not just a person's title.

The structure of the plan will affect who has fiduciary responsibilities. Most Employers sponsoring fully or partially self-funded group health plans exercise some discretionary authority and therefore are fiduciaries. If the Employer sponsors a fully insured plan, fiduciary status depends on whether the Employer exercises discretion over the plan.

A plan must have at least one fiduciary (a person or entity) named in the written plan, or through a process described in the plan, as having control over the plan's operation. The named fiduciary can be identified by office or by name. For some plans, it may be an administrative committee or a company's board of directors. A plan's fiduciaries will ordinarily include plan administrators, trustees, investment managers, all individuals exercising discretion in the administration of the plan, all members of a plan's administrative committee (if it has such a committee), and those who select committee officials. Attorneys, accountants, and actuaries generally are not fiduciaries when acting solely in their professional capacities. Similarly, a third party administrator, record-keeper or utilization reviewer who performs solely ministerial tasks is not a fiduciary; however, that may change if he or she exercises discretion in making decisions regarding a participant's eligibility for benefits. The Key to determining whether individuals or entities are fiduciaries is whether they are exercising discretion or control over the plan.

Fiduciary Responsibilities

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a plan and their beneficiaries. These responsibilities include acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them, carrying out their duties prudently, following the plan documents (unless inconsistent with ERISA), holding plan assets (if the plan has any) in trust, and paying only reasonable plan expenses.

ERISA—Important Documents

Summary Plan Description

The SPD is a plain language explanation of the plan and must be comprehensive enough to apprise participants of their rights and responsibilities under the plan. It also informs participants about the plan features and what to expect of the plan. Among other things, the SPD must include basic information such as: plan name, address, and contact information, what the plan benefits are, how to get the benefits, and duties of the plan and/or Employee.

More specific information must also be provided, including: **(1)** the plan's claims procedure, **(2)** a participant's basic rights and responsibilities under ERISA, **(3)** information on any applicable premiums, cost-sharing, deductibles, copayments, etc., **(4)** any caps (annual or lifetime) on benefits, **(5)** procedures for using network providers (if PPO/HMO) and composition of network, **(6)** conditions regarding pre-certification, **(7)** a description of plan procedures governing Qualified Medical Child Support Orders (QMSCO), and **(8)** notices and descriptions of certain rights under HIPAA and other health coverage laws. This document is given to Employees within 90 days after they are covered by the plan. If there have been material changes to a plan, SPDs must be redistributed every 5th year and provided within 30 days of a request. If no material changes have been made, the SPD must be redistributed every 10 years. The SPD must be current within 120 days.

Summary of Material Modification

The SMM apprises participants and beneficiaries of material changes to the plan or to the information required to be in the SPD. The SMM or an updated SPD for a group health plan must be furnished automatically to participants within 210 days after the end of the plan year in which material change was adopted. However, if the changes to the plan or changes to the required information in the SPD result in a material reduction in covered services or benefits, then the SMM must be distributed no later than 60 days from the date the change was adopted. A material reduction is any plan change that eliminates benefits, reduces benefits payable, increases premiums, deductibles, coinsurance or copayments, reduces the service area covered by an HMO, or establishes new conditions or requirements (such as pre-authorization) for obtaining services or benefits.

Summary Annual Report and Form 5500

The SAR outlines in narrative form the financial information in the plan's Annual Report, the Form 5500, and is furnished annually to participants in plans that are required to file the Form 5500. The Form 5500 reports information about the plan, its finances, and its operation. This information is used by the U.S. Department of Labor, the IRS, other government agencies, organizations, and the public. Participants and beneficiaries can receive a copy of the Form 5500 upon request from the plan. Depending on the number of participants covered and plan design, there may be exemptions from the full filing requirements. A group health plan with fewer than 100 participants at the beginning of the plan year that is either fully insured or self-funded (or a combination of both) does not need to file an annual report. Plans with 100 or more participants that are fully insured or self-funded can file a limited report. You may access the DOL's "Reporting and Disclosure Guide for Employee Benefit Plans" for more information on this topic.

Tips for Employers with Group Health Plans

- ☐ If you are hiring third-party service providers, have you looked at a number of providers, given each potential provider the same information, and considered whether the fees are reasonable? Have you documented the hiring process?
- ☐ Are you aware of the schedule to deposit participant contributions and payments by participants to the plan and forwarding them to the insurance company, and have you made sure it complies with the law?
- ☐ Have you reviewed your plan document in light of current plan operations and made necessary updates? After amending the plan, have you provided participants with an updated SPD or SMM?
- ☐ Does your plan have a reasonable claims procedure that is being followed by plan fiduciaries?
- ☐ Does your plan have a procedure for handling Qualified Medical Child Support Orders (QMCSO)?
- ☐ Have you identified parties in interest to the plan and taken steps to monitor transactions with them?
- ☐ Are you aware of the major exemptions under ERISA that permit transactions with parties in interest, especially those Key for plan operations (such as hiring service providers)?
- ☐ Have required reports (i.e. Form 5500) been filed timely with the government?

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HIPAA—Portability Rules

Overview

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance.

HIPAA Portability Rules affects group health plan coverage with two or more participants who are current Employees in the following ways: **(1)** places strict limitations on a plan's ability to impose a pre-existing condition exclusion, **(2)** requires group health plans and health insurance issuers to provide certificates of prior health coverage, **(3)** provide certain individuals special enrollment rights in group health coverage when specific events occur, and **(4)** prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors, and guarantee that health coverage be available to, and can be renewed by, certain individuals. In addition, HIPAA does not apply to excepted benefits, such as some health FSAs and dental and vision coverage.

Pre-existing conditions

A pre-existing condition exclusion is any limitation or exclusion of benefits for a health condition because it was present before coverage began, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that day.

HIPAA says: **(1)** any exclusion for a pre-existing condition must relate to a condition during the 6-month period prior to an individual's enrollment in the plan, **(2)** the maximum period an exclusion can be applied to an individual is 12 months (or 18 months for late enrollees), **(3)** the 12- or 18-month maximum exclusion period is shortened by the number of days an individual had prior "creditable coverage", **(4)** certain people and conditions can never be subject to a pre-existing condition exclusion, i.e. newborns, and **(5)** health plans must give a general notice disclosing that the plan applies a pre-existing condition exclusion and a separate individual notice that informs an Employee or their dependent of the specific exclusion that applies to them.

Creditable coverage

Group health plans are required to furnish a certificate of creditable coverage to an individual in order to document the individual's prior creditable coverage under the plan. This certificate can be used as evidence of creditable coverage for the individual's new group health plan to reduce the length of a pre-existing condition exclusion period that might apply.

Special enrollment

Group health plans are required to provide special enrollment periods during which individuals that previously declined health coverage, may be allowed to enroll, regardless of any open enrollment period. Special enrollment can occur when: **(1)** an individual loses eligibility for coverage under a group health plan or other health insurance coverage, i.e. spouse's plan, **(2)** when an Employer terminates contributions toward the individual's health coverage, **(3)** the individual has a qualifying life event, i.e. marriage or birth, and **(4)** an individual loses coverage under a state sponsored plan or becomes eligible to receive premium assistance towards a group health plan.

Non-discrimination requirements

Under HIPAA, individuals may not be denied or continued eligibility for enrollment in a group health plan based on any health factors they may have. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factor, such as: health status, medical condition including physical and mental illnesses, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, or disability.

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HIPAA—Privacy Rules

Overview

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance.

HIPAA Privacy Rules provide provisions for protecting the privacy of Personal Health Information (PHI), including: **(1)** the information that doctors, nurses, and other health care providers put in a participant's medical records, **(2)** conversations a doctor has regarding a patients care with nurses or others, **(3)** the information contained on the computer systems of health insurers, **(4)** the billing information of individuals at medical care providers, and **(5)** most health information about participants held by those who follow these laws.

The HIPAA Privacy Rule's major purpose is to outline under what conditions an individual's PHI may be used or disclosed by covered entities.

Covered entities

Covered entities that must comply with HIPAA Privacy Rules include health plans, health care providers, and health care clearinghouses.

(1) Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations, Medicare, Medicaid, and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include Employer-sponsored group health plans, government and church-sponsored health plans, and multi-Employer health plans.
(2) Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity.
(3) Health care clearinghouses are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa.

Protected Health Information

The Privacy Rule protects all "individually identifiable health information," which is information, including demographic data (name, address, DOB, SSN, etc.) that relates to the individuals past, present, or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.

The Privacy Rule does not apply to information contained in employment records, including health-related information, as defined in the Family Educational Rights and Privacy Act.

Uses and disclosures

A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: **(1)** as the Privacy Rule permits or requires, or **(2)** as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

A covered entity must disclose protected health information in only two situations: **(1)** to individuals (or their personal representatives) when they specifically request access to or an accounting of disclosures of, their protected health information, and **(2)** to HHS when it is undertaking a compliance investigation or review or enforcement action.

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HIPAA—Business Associates

Overview

By law, the HIPAA Privacy Rule applies only to covered entities, i.e. health plans, health care clearinghouses, and certain health care providers. However, most health care providers and health plans do not carry out all of their health care activities and functions by themselves. Instead, they often use the services of a variety of other persons or businesses. The Privacy Rule allows covered providers and health plans to disclose protected health information to these "Business Associates" (BA) if: **(1)** the providers or plans obtain satisfactory assurances that the BA will use the information only for the purposes for which it was engaged by the covered entity, **(2)** will safeguard the information from misuse, and **(3)** will help the covered entity comply with some of the covered entity's duties under the Privacy Rule. Covered entities may disclose protected health information to a BA only to help the covered entity carry out its health care functions, not for the BAs independent use or purposes, except as needed for the proper management and administration of the BA.

General provision

The Privacy Rule requires that a covered entity obtain satisfactory assurances from its BA that the BA will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be in writing, whether in the form of a contract or other agreement between the covered entity and the BA.

"Business Associates"

A "Business Associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of a covered entity. A member of the covered entity's workforce is not a BA. A covered health care provider, health plan, or health care clearinghouse can be a BA of another covered entity. The Privacy Rule lists some of the functions or activities, as well as the particular services, which make a person or entity a BA, if the activity or service involves the use or disclosure of protected health information. The types of functions or activities that may make a person or entity a BA include payment or health care operations activities, as well as other functions or activities regulated by the Administrative Simplification Rules.

BA functions and activities include: claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing. BA services are: legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, and financial.

Examples of BAs

(1) A third party administrator that assists a health plan with claims processing, **(2)** a CPA firm whose accounting services to a health care provider involve access to protected health information, **(3)** an attorney whose legal services to a health plan involve access to protected health information, **(4)** a consultant that performs utilization reviews for a hospital, **(5)** a health care clearinghouse that translates a claim from a non-standard format into a standard transaction on behalf of a health care provider and forwards the processed transaction to a payer, **(6)** an independent medical transcriptionist that provides transcription services to a physician, and **(7)** a pharmacy benefits manager that manages a health plan's pharmacist network.

Business Associate contracts

A covered entity's contract or other written arrangement with its BA must: **(1)** describe the permitted and required uses of protected health information by the BA, **(2)** provide that the BA will not use or further disclose the protected health information other than as permitted or required by the contract or as required by law, and **(3)** require the BA to use appropriate safeguards to prevent a use or disclosure of the protected health information other than as provided for by the contract. Where a covered entity knows of a material breach or violation by the BA of the contract or agreement, the covered entity is required to take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful, to terminate the contract or arrangement. If termination of the contract or agreement is not feasible, a covered entity is required to report the problem to the Department of Health and Human Services (HHS) Office for Civil Rights (OCR). Sample Business Associate Contract

COBRA

Overview

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that amended the Employee Retirement Income Security Act (ERISA) to require most group health plans to provide temporary continuation of group health coverage that otherwise might be terminated.

Covered Employers

COBRA must generally be offered to all private-sector group health plans, maintained by Employers that have 20 or more Employees on 50% of its typical business days during the previous calendar year. Both full and part-time Employees are counted to determine whether a plan is subject to COBRA (part-time Employees count as a fraction of a full-time Employee). Mini-COBRA is state-level continuation coverage for Employers with 2-19 Employees. Please check your state laws to determine if mini-COBRA must be followed. Plans sponsored by the federal government, churches, and certain church related organizations are not subject to COBRA.

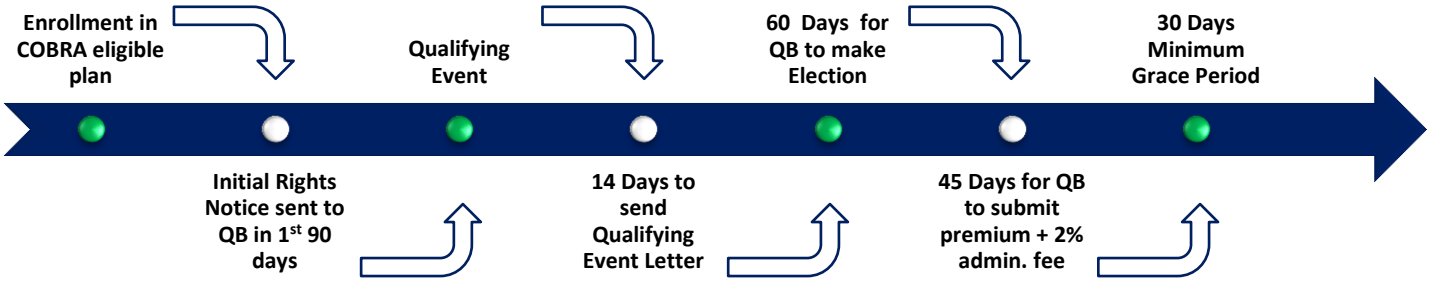
Covered plans

Plans that are eligible for COBRA are offered from an Employer to an Employee and include: **(1)** group health plans that provide for the medical care of Employees and their families ("medical care" includes: in and out-patient hospital care, physician care, surgery and other major medical benefits, prescription drugs, dental, and/or vision care), **(2)** Wellness programs, **(3)** discount programs, **(4)** health FSAs (if the health FSA qualifies for the Special Limited COBRA obligation, then COBRA need only be offered to an Employee if the amount they have contributed plan-to-date is greater than the amount they have been reimbursed. Health FSAs that do not meet the "Special Limited COBRA" requirements under HIPAA's Portability Rules must offer COBRA), **(5)** HRAs, and **(6)** employee assistance programs (EAP) that constitute a group health plan. Group life and disability plans are not considered "medical care" and are not subject to COBRA.

If a qualified beneficiary loses coverage under a plan because of a qualifying event, COBRA must generally be offered subject to the following conditions:

Qualifying Event	Qualified Beneficiaries	Maximum Period of Coverage
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	18 Months (29 months for disability extension and 36 months for a second qualifying event)
Employee enrollment in Medicare	Spouse Dependent Child	36 Months
Divorce or Legal Separation	Spouse Dependent Child	36 Months
Death of an Employee	Spouse Dependent Child	36 Months
Loss of "Dependent Child" status under the plan	Dependent Child	36 Months

Timeline



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Government Mandated Benefits

Overview

When most people hear the term Employee benefits, they think of things like health insurance, vacation time, and 401(k) plans. Employee benefits are much more than that though, "*a benefit is a service or right provided by an Employer in addition to wages or salary*."

Some of these services or rights are government mandated and companies are required by law to provide them to their Employees. So while you may choose to offer your Employees fringe benefits like a retirement plan or dental insurance, there are 3 mandated benefits that most small and mid-size business owners must provide their Employees.

Mandated benefits

In addition to paying your Employees a salary or hourly wage, the following are government mandated Employee benefits which most businesses are required by law to provide.

(1) Social Security & Medicare Contributions
(2) Workers' Compensation Insurance
(3) Unemployment Compensation Contributions

Depending on the size of your company and the benefits you offer your Employees, you may also be required to provide COBRA, CHIPRA (Children's Health Insurance Program Reauthorization Act) and Family and Medical Leave.

Social Security & Medicare

Social Security and Medicare are federally-funded and mandated benefits programs. These 2 government taxes are paid equally by both the Employee and their Employer as payroll deductions. Social security benefits provide income to Employees after they retire or in instances where they become permanently disabled. Medicare provides health insurance programs for people age 65 or older and in some cases, people that are younger than 65 due to certain disabilities or medical conditions.

Workers' Compensation

Workers' compensation insurance provides medical care and treatment, rehabilitation and replacement income for Employees due to job related injuries and illnesses. Workers' comp is provided by an Employer through either a state run insurance fund or through an insurance company.

Unemployment Compensation

The purpose of unemployment compensation is to provide temporary and partial income replacement to Employees that have involuntarily lost their jobs. Terminated Employees may not collect unemployment if they were let go due to certain circumstances, i.e. gross misconduct. Unemployment insurance is a combination of federal and state run programs that both Employees and Employers pay into.

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Family and Medical Leave Act

Covered Employers

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more Employees for each working day during each of 20 or more calendar workweeks in the current or past calendar year (state regulations may differ).

Basic Leave Entitlement and Eligibility

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons: **(1) f**or incapacity due to pregnancy, prenatal medical care or child birth, **(2)** to care for the employee's child after birth, or placement for adoption or foster care, **(3)** to care for the employee's spouse, son or daughter, or parent, who has a serious health condition, or **(4)** for a serious health condition that makes the employee unable to perform the employee's job.

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies, include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember, who has a serious injury or illness incurred in the line of duty, during a single 12-month period.

Use of Leave, Benefits, and Protections

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis. During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon returning from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with normal call-in procedures. Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities, otherwise, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-leave and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Enforcement

FMLA makes it unlawful for any employer to: **(1)** interfere with, restrain, or deny the exercise of any right provided under FMLA, and **(2)** discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA. FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights. An employee may file a complaint with the Dept. of Labor or may bring a private lawsuit against an employer.

MSP Reporting

Overview

Medicare Secondary Payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA Section 111) adds mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under group health plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers' compensation.

Purpose of MSP Reporting

Some people who have Medicare also have group health coverage. Often, Employer-provided group health coverage must pay before Medicare does. In that case, Medicare is the secondary payer. The purpose of the Section 111 GHP reporting process is to enable CMS to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility. Section 111 authorizes CMS and responsible reporting entities (RREs) to electronically exchange health insurance benefit entitlement information.

On a quarterly basis, an RRE must submit GHP entitlement information about Employees and dependents to the Coordination of Benefits Contractor (the COBC). In exchange, the COBC will provide the RRE with Medicare entitlement information for those individuals in a GHP that can be identified as Medicare beneficiaries. This mutual data exchange helps to assure that claims will be paid by the appropriate organization at first billing.

RREs and individuals

A GHP organization that must report under Section 111 is defined as an entity serving as an insurer or third party administrator for a group health plan and in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary.

Reportable individuals include: **(1)** all individuals covered in a GHP age 45 and older who have coverage based on their own or a family member's current employment status, **(2)** all individuals covered in a GHP who have ESRD, receiving kidney dialysis or who have received a kidney transplant, regardless of their own or a family member's current employment status and regardless of their age, and **(3)** all individuals covered in a GHP who are under age 45, entitled to Medicare, and have coverage in the plan based on their own or a family member's current employment status.

MSP reporting for HRAs

Starting October 1, 2010, participants (Employees, spouses, and dependents) in a Health Reimbursement Arrangement receiving $1000 or more worth of coverage, who are 45 years of age or older, have had a kidney transplant or on dialysis, or are enrolled in Medicare, must follow the same MSP reporting requirements as GHPs. Effective October 3, 2011, only HRA coverage that reflects an annual benefit level of $5000 or more is to be reported. Amounts rolled over from previous year's coverage must be included when calculating the current year's annual benefit amount. The new $5000 annual benefit threshold applies to new or renewing HRA coverage effective on or after October 3, 2011. HRA coverage in effect prior to this date must continue to report at the present threshold until the employer's HRA benefit period is renewed.

Notice of termination

Effective September 27, 2011, a notice of termination is to be submitted to the COBC (at the next regularly scheduled MSP Input file) when an HRA insured's HRA benefit coverage is exhausted and no additional funds will be added to HRA for the remainder of the HRA's current benefit coverage term.

Exception to MSP reporting requirements

If an Employer has fewer than 20 Employees, participants 45 years of age or older in either a GHP or HRA do not necessarily have to be reported to CMS.

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Non-discrimination Rules Under 105(h)

Overview

Section 105(h) of the Internal Revenue Code provides the non-discrimination rules that must be followed for several plans. PPACA has indicated that within the next few years, all group health plans may be subject to these non-discrimination rules. Plans that must follow 105(h) rules will cease to exist if they do not pass the non-discrimination tests. In short, a self-insured medical reimbursement plan does not meet the non-discrimination requirements unless all benefits provided to highly compensated participants are provided for all other participants.

"Non-discrimination"

A self-insured medical reimbursement plan satisfies the requirements of non-discrimination if:

(1) The plan does not discriminate in favor of highly compensated individuals as to eligibility to participate, and
(2) The benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals.

In short, plans that don't discriminate based on age, years of service, or compensation will generally comply with 105(h) rules.

Non-discrimination tests

A plan will be found to be non-discriminatory, if such plans benefit:

(1) 70% or more of all Employees, or
(2) 80% or more of the participants in the plan if 70% or more of all Employees are eligible to benefit under the plan, or
(3) A classification of Employees under the Employer, which is found to be non-discriminatory by the Secretary.

The following individuals may be excluded from non-discrimination testing: **(1)** Employees who have not completed 3 years of service, **(2)** Employees who have not attained age 25, **(3)** part-time or seasonal Employees, **(4)** Employees not included in the plan who are a part of a collective bargaining agreement, and **(5)** Employees who are nonresident aliens and who receive no earned income from the Employer which constitutes income from sources within the United States.

"Highly Compensated Individual"

For the purposes of 105(h), a highly compensated individual is: **(1)** one of the 5 highest paid officers, **(2)** a shareholder who owns more than 10% in value of the stock of the Employer and any family member who is an employee, or **(3)** among the highest paid 25% of all Employees.

Excess reimbursement of a highly compensated individual

The excess reimbursement of a highly compensated individual which is attributable to a self-insured medical reimbursement plan is:

(1) In the case of a benefit available to highly compensated individuals but not to all other participants, the amount reimbursed under the plan to the Employee with respect to such benefit.
(2) In the case of benefits paid to a highly compensated individual by a plan which fails to satisfy the requirements, the total amount reimbursed to the highly compensated individual for the plan year multiplied by a fraction:
   a. The numerator of which is the total amount reimbursed to all participants who are highly compensated individuals under the plan for the plan year, and
   b. The denominator of which is the total amount reimbursed to all Employees under the plan for such plan year.

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HEART Act

Overview

The Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), among other things, amended Section 125 of the Internal Revenue Code to provide a special rule allowing distributions of unused amounts in a health Flexible Spending Account (health FSA) to reservists ordered or called to active duty. The HEART Act applies to distributions made on or after June 18, 2008.

View a summary of the other provisions in the HEART Act.

Generally, new sub-section 125(h) provides that a plan or other arrangement does not fail to be a Cafeteria Plan or health FSA merely because the arrangement provides, in certain circumstances, for an Employee to receive all or a portion of the balance in their health FSA by way of "qualified reservist distributions" (QRDs).

Qualified Reservist Distribution

In general, a QRD is a distribution to an individual of all or a portion of the balance in the Employee's health FSA if:

(1) The individual is a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period,
(2) The request for distribution is made during the period beginning with the order or call to active duty and ending on the last day of the plan year (or grace period, if applicable) that includes the date of the order, or
(3) The individual is called to active duty.

QRDs are an exception to the rule that a health FSA may not make distributions other than reimbursements of substantiated medical expenses.

QRD optional with Employer

A Cafeteria Plan is not required to provide for a QRD. The decision of whether to allow a QRD from a health FSA is optional with the Employer.

Plan must be amended

A QRD may not be made before the Cafeteria Plan is amended to provide for a QRD from a health FSA. A plan may be amended at any time on a prospective basis. The QRD amendment must apply uniformly to all participants in the Cafeteria Plan.

Tax Treatment of Fringe Benefits

Type of Fringe Benefit	Income Tax Withholding	Social Security and Medicare	Federal Unemployment
Accident and health benefits	Exempt[1, 2], except for long-term care benefits provided through a flexible spending or similar arrangement	Exempt except for certain payments to S corporation Employees who are 2% shareholders	Exempt
Achievement awards	Exempt[1] up to $1,600 for qualified plan awards ($400 for nonqualified awards).		
Adoption assistance	Exempt[1,3]	Taxable	Taxable
Athletic Facilities	Exempt if substantially all use during the calendar year is by Employees, their spouses, and their dependent children and the facility is operated by the Employer on premises owned or leased by the Employer.		
Cell Phones (employer provided)	Exempt	Exempt	Exempt
***De minimis* (minimal) benefits**	Exempt	Exempt	Exempt
Dependent care assistance	Exempt[3] up to certain limits, $5,000 ($2,500 for married Employee filing separate return).		
Educational assistance	Exempt up to $5,250 of benefits each year.		
Employee discounts	Exempt[3] up to certain limits.		
Group-term life insurance coverage	Exempt	Exempt[1, 4], up to cost of $50,000 of coverage. (Special rules apply to former Employees	Exempt
Health Savings Accounts (HSAs)	Exempt for qualified individuals up to the HSA contribution limits.		
Lodging on your business premise	Exempt[1] if furnished for your convenience as a condition of employment.		
Meals	Exempt if furnished on your business premises for your convenience.		
	Exempt if *de minimis*.		
Moving expense reimbursements	Exempt[1] if expenses would be deductible if the Employee had paid them.		
No-additional-cost svcs.	Exempt[3]	Exempt[3]	Exempt[3]
Retirement planning services	Exempt[5]	Exempt[5]	Exempt[5]
Transportation benefits	Exempt[1] up to certain limits if for rides in a commuter highway vehicle and/or transit passes, qualified parking, or qualified bicycle commuting reimbursement[6]		
	Exempt if *de minimis*.		
Tuition reduction	Exempt[3] if for undergraduate education (or graduate education if the Employee performs teaching or research activities).		
Volunteer firefighter and emergency medical responder benefits	Exempt	Exempt	Exempt
Working condition benefits	Exempt	Exempt	Exempt

(1) Exemption does not apply to S corporation Employees who are 2% shareholders.
(2) Exemption does not apply to certain highly compensated Employees under a self-insured plan that favors those Employees.
(3) Exemption does not apply to certain highly compensated Employees under a program that favors those Employees.
(4) Exemption does not apply to certain Key Employees under a plan that favors those Employees.
(5) Exemption does not apply to services for tax preparation, accounting, legal, or Brokersage services.
(6) If the Employee receives a qualified bicycle commuting reimbursement in a qualified bicycle commuting month, the Employee cannot receive commuter highway vehicle, transit pass, or qualified parking benefits in that same month.

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Cafeteria Plans

Overview

A Cafeteria Plan (Section 125), including a Flexible Spending Account, is a written plan that allows Employees to choose between receiving cash or taxable benefits instead of certain qualified benefits for which the law provides an exclusion from wages. If an Employee chooses to receive a qualified benefit under the plan, the fact that the Employee could have received cash or a taxable benefit instead will not make the qualified benefit taxable.

Generally, a Cafeteria Plan does not include any plan that offers a benefit that defers pay. However, a Cafeteria Plan can include a qualified 401(k) plan as a benefit. Also, certain life insurance plans maintained by educational institutions can be offered as a benefit even though they defer pay.

Qualified benefits

A Cafeteria Plan can include the following benefits: **(1)** accident and health benefits (but not Archer MSAs or long-term care insurance), **(2)** adoption assistance, **(3)** dependent care assistance, **(4)** group-term life insurance coverage (including costs that cannot be excluded from wages), and **(5)** contributions to Health Savings Accounts (HSAs).

Employee

For these plans, treat the following individuals as Employees: **(1)** a current common-law Employee, **(2)** a full-time life insurance agent who is a current statutory Employee, and **(3)** a leased Employee who has provided services to you on a substantially full-time basis for at least a year if the services are performed under your primary direction or control.

Exception for S corporation shareholders

Do not treat a 2% or greater shareholder of an S corporation as an Employee of the corporation for this purpose. A 2% shareholder for this purpose is someone who directly or indirectly owns (at any time during the year) more than 2% of the corporation's stock or stock with more than 2% of the voting power. Treat a 2% shareholder as you would a partner in a partnership for fringe benefit purposes, but do not treat the benefit as a reduction in distributions to the 2% shareholder.

Plans that favor highly compensated Employees

If your plan favors highly compensated Employees as to eligibility to participate, contributions, or benefits, you must include in their wages the value of taxable benefits they could have selected. A plan you maintain under a collective bargaining agreement does not favor highly compensated Employees.

A highly compensated Employee for this purpose is any of the following Employees: **(1)** an officer, **(2)** a shareholder who owns more than 5% of the voting power or value of all classes of the Employer's stock, **(3)** an Employee who is highly compensated based on annual compensation, and **(4)** a spouse or dependent of a person described in (1), (2), or (3).

Plans that favor Key Employees

A Key Employee during 2011 is generally an Employee who is either of the following: **(1)** an officer having annual pay of more than $160,000 in the prior plan year, or **(2)** an Employee or family member who during the prior plan year was either of the following: a 5% owner of your business or a 1% owner of your business whose annual pay was more than $150,000.

If your plan favors Key Employees, you must include in their wages the value of taxable benefits they could have selected. A plan favors Key Employees if more than 25% of the total nontaxable benefits you provide for all Employees under the plan go to Key Employees. However, a plan you maintain under a collective bargaining agreement does not favor Key Employees.

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Cafeteria Plans—Rules

Overview

A Cafeteria Plan is the exclusive means by which an Employer can offer Employees a choice between taxable and nontaxable benefits without the choice itself resulting in inclusion in gross income by the Employees. Unless a plan satisfies the requirements of Section 125 and the regulations, the plan is not a Cafeteria Plan.

Reasons that a plan would fail to satisfy the Section 125 requirements include: **(1)** offering nonqualified benefits, **(2)** not offering an election between at least one permitted taxable benefit and at least one qualified benefit, **(3)** deferring compensation, **(4)** failing to comply with the uniform coverage rule or use-or-lose rule, **(5)** allowing Employees to revoke elections or make new elections during a plan year (unless subject to a qualifying event), **(6)** failing to comply with substantiation requirements, **(7)** paying or reimbursing expenses incurred for qualified benefits before the effective date of the Cafeteria Plan or before a period of coverage, **(8)** allocating experience gains (forfeitures) other than as expressly allowed in the new proposed regulations, and **(9)** failing to comply with grace period rules.

Written benefit plan

IRS guidelines state that a Cafeteria Plan will not be recognized or become effective until the provisions of the plan are included in a written document. The written plan must include the following provisions: **(1)** a specific description of each benefit available under the plan and the period of coverage, **(2)** the rules governing which Employees are eligible to participate in the plan, **(3)** the procedures for making elections under the plan, including when elections may be made, the rules governing irrevocability of elections and the periods for which elections are effective, **(4)** the manner in which Employer contributions may be made such as by salary reduction agreement between the Employer and Employee, by non-elective Employer contributions or by both, **(5)** the maximum amount of Employer contributions available to any participant (to meet this requirement, the plan must describe the maximum amount of elective contributions available to any Employee either by stating the maximum dollar amount or maximum percentage of compensation that may be contributed as elective contributions or by stating the method for determining the maximum amount or percentage of elective contributions that an Employee may make), and **(6)** the plan year.

Non-discrimination Rules

Cafeteria plans must follow the non-discrimination rules as described in Section 105(h).

(1) A Cafeteria Plan must not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions, and/or benefits for that plan year.

(2) If for any plan year, the statutory nontaxable benefits provided to Key Employees exceed 25% of the aggregate of statutory nontaxable benefits provided for all Employees through the Cafeteria Plan, each Key Employee includes in gross income an amount equaling the maximum taxable benefits that he or she could have elected for the plan year.

(3) A Cafeteria Plan that provides health benefits is not treated as discriminatory as to benefits and contributions if: **(1)** contributions under the plan on behalf of each participant include an amount which equals 100% of the cost of the health benefit coverage under the plan of the majority of the highly compensated participants similarly situated, or equals or exceeds 75% of the cost of the health benefit coverage of the participant (similarly situated) having the highest cost health benefit coverage under the plan, and **(2)** contributions or benefits under the plan in excess of those described in **(1)** of this section bear a uniform relationship to compensation.

Plans must be passing non-discrimination tests on the last day of the plan year, taking into account all non-excludable Employees (or former Employees) who were Employees on any day during the plan year.

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Simple Cafeteria Plans

Overview

After December 31, 2010, eligible Employers meeting contribution requirements and eligibility and participation requirements can establish a simple Cafeteria Plan. Simple Cafeteria Plans are treated as meeting the non-discrimination requirements of a Cafeteria Plan and certain benefits under a Cafeteria Plan.

Eligible Employer

You are an eligible Employer if you employ an average of 100 or fewer Employees during either of the 2 preceding years. If your business was not in existence throughout the preceding year, you are eligible if you reasonably expect to employ an average of 100 or fewer Employees in the current year. If you establish a simple Cafeteria Plan in a year that you employ an average of 100 or fewer Employees, you are considered an eligible Employer for any subsequent year as long as you do not employ an average of 200 or more Employees in a subsequent year.

Eligibility and participation requirements

These requirements are met if all Employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate and each Employee eligible to participate in the plan may elect any benefit available under the plan. You may elect to exclude from the plan Employees who fit the following description:

(1) Under age 21 before the close of the plan year,
(2) Less than 1 year of service with you as of any day during the plan year,
(3) Covered under a collective bargaining agreement, or
(4) Nonresident aliens working outside the United States whose income did not come from a U.S. source.

Contribution requirements

Employers must make a contribution to provide qualified benefits on behalf of each qualified Employee in an amount equal to:

(1) A uniform percentage (not less than 2%) of the Employee's compensation for the plan year, or
(2) An amount which is at least 6% of the Employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified Employee, whichever is less.

If the contribution requirements are met using option (2) above, the rate of contribution to any salary reduction contribution of a highly compensated or Key Employee cannot be greater than the rate of contribution to any other Employee.

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FAQs Regarding FSAs

Q: Can an Employer fund an employee's FSA account?
A: Yes, the funding can be made each payroll period, monthly, quarterly or annually. The contribution may be in the form of a match or fixed dollar amount. The Employer's contribution must be consistent to all eligible employees.

Q: If I have an HRA, can I still implement an FSA?
A: Yes, these benefits co-exist very well together. In no case may an employee be reimbursed for the same medical care expense by both an HRA and a Health FSA. If coverage is provided under an HRA and a Health FSA for the same medical care expenses, the Plan Document for the HRA may specify the ordering rules for these expenses.

Q: Do all claims need to be substantiated?
A: Yes, an FSA may only provide benefits that reimburse expenses for medical expenses as defined in § 213 (d). Each medical care expense submitted for reimbursement must be substantiated.

Q: Can you contribute to an FSA if you are contributing to a Health Savings Account (HSA)?
A: No, you are unable to contribute to an HSA if you are currently participating in a general-purpose FSA. You may participate in a limited-purpose FSA (for vision, dental and preventative services only) or post-deductible FSA and contribute to an HSA.

Q: Is an FSA subject to COBRA continuation requirements?
A: Yes, if the health FSA qualifies for the Special Limited COBRA obligation, then COBRA need only be offered to an employee if the amount they have contributed plan-to-date is greater than the amount they have been reimbursed. If the health FSA does not qualify for the Special Limited COBRA obligation, COBRA must be offered for all FSAs and again offered at open enrollment. FSA COBRA premiums are equal to the employee's monthly contributions plus an additional 2% administrative fee (optional). In the event an employee fails to make premium payments, the employer has the right to terminate COBRA coverage.

Q: Can all owners participate in the FSA Plan?
A: No, sole proprietors, 2% or greater S-Corp shareholders (includes family members) and partners in a partnership are not eligible to participate.

Q: Are all employees eligible to participate?
A: Yes, however, the employer has the ability to exclude employees based on the number of hours worked, a minimum age requirement, a waiting period for newly hired employees and being members of a bargaining unit (certain family members may also be excluded).

Q: Are there nondiscrimination testing requirements for an FSA? What about the IRS 5500 form?
A: Yes, there is an annual non-discrimination testing requirement that focuses on the Highly Compensated and Key Employees of the company. You only need to file a 5500 form if you have 100 or more employees participating in the Health FSA at the beginning of the plan year.

Q: If my spouse participates in an FSA through his/her Employer, can I also participate?
A: Yes, however claims may not be reimbursed under both accounts. In addition, if both you and your spouse have signed up for the Dependent Care Account, the maximum election between both accounts is still $5000.

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Health Reimbursement Arrangements

Overview

A Health Reimbursement Arrangement (HRA): **(1)** is paid for solely by the Employer and not provided pursuant to salary reduction election or otherwise under a Cafeteria Plan, **(2)** reimburses the Employee for eligible medical care expenses as defined by Section 213(d), incurred by the Employee and the Employee's spouse and dependents, and **(3)** provides reimbursements up to a maximum dollar amount for a coverage period, subject to new PPACA regulations. Distributions under an HRA are usually excluded from an Employee's gross income under Section 105.

An HRA may neither reimburse a medical care expense that is incurred before the date the HRA is in existence nor reimburse a medical care expense that is incurred before the date an Employee first becomes enrolled under the HRA. Reimbursements for insurance covering medical care expenses as defined in Section 213(d) are allowable reimbursements under an HRA, including amounts paid for premiums for accident or health coverage for current Employees, retirees, and COBRA qualified beneficiaries.

Section 213(d)

Section 213(d) of the Internal Revenue Code provides for a list of qualified medical care expenses reimbursable under an HRA. In general, "medical care" means amounts paid: **(1)** for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, **(2)** for transportation primarily for and essential to any medical care, **(3)** for qualified long-term care services, or **(4)** for insurance covering medical care or qualified long-term care. Click here for a complete list of eligible items.

All claims for reimbursement must be properly substantiated. Any reimbursement received for an ineligible expense will cause all distributions to be counted against an Employee's gross income. Furthermore, only expenses not eligible for reimbursement under any other accident or health plan can be reimbursed through an HRA.

Unlike a health FSA

The following restrictions on health FSAs under Section 125 are NOT applicable to HRAs: **(1)** the prohibition against Employees carrying over unused contributions or plan benefits from one plan year to another, **(2)** the requirement that the maximum amount of reimbursement must be available at all times during the coverage period, **(3)** the mandatory twelve-month period of coverage, and **(4)** except as otherwise provided in this notice, the limitation that medical expenses reimbursed must be incurred during the period of coverage.

Non-discrimination

Section 105(h) sets forth non-discrimination rules for self-insured medical expense reimbursement plans. To the extent an HRA is a self-insured medical expense reimbursement plan, the non-discrimination rules under Section 105(h) apply to the HRA.

Continuing coverage

An HRA is a group health plan generally subject to the COBRA continuation coverage requirements. HRAs fall under two categories in terms of COBRA eligibility: **(1)** if the HRA requires participation in the Employer's group health plan, than the Employee must elect COBRA coverage in the group health plan in order to elect coverage for the HRA. **(2)** Otherwise COBRA coverage must be offered for the HRA. HRA COBRA premiums are equal to last year's utilization rate multiplied by the current plan's maximum available benefit divided by twelve. If this is the first year the HRA is offered, use up to 75% for the utilization rate. A 2% administrative fee may be added and in the event an Employee fails to make premium payments, the Employer has the right to terminate COBRA coverage.

The plan may also provide that the maximum reimbursement amount available after retirement or other termination of employment is reduced for any administrative costs of continuing such coverage. Additionally, an HRA may or may not provide for an increase in the amount available for reimbursement of medical care expenses after the Employee retires or otherwise terminates employment (even if the Employee does not elect COBRA continuation coverage).

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Cafeteria Plan and HRA Eligibility

Sole Proprietor	No
Employee Spouse*	Yes
Employee Dependent	Yes
General Partners	No
Employee Spouse*	Yes
Employee Dependent	Yes
Limited Partner	Yes (if not receiving guaranteed payments) No (if receiving guaranteed payments)
Employee Spouse*	Yes
Employee Dependent	Yes
Greater than 2% owner S-Corp	No
Employee Spouse*	No
Employee Dependent	No (included child, parent, and grandparent)
C-Corp Shareholder	Yes
Employee Spouse*	Yes
Employee Dependent	Yes
LLC Member	Yes (if LLC is taxed as a subchapter Corp) No (if treated as Partner, Sole Proprietor, or S-Corp
Employee Spouse*	See appropriate category based on how member is treated
Employee Dependent	See appropriate category based on how member is treated

*Must be bona fide Employee and may not be deemed to be self-employed. Spouse must not have invested his or her own assets in the business and must not be an owner under state marital or community property laws.

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Funding Techniques—FSAs, HRAs & MSAs

Flexible Spending Account (FSA)

An Employee can contribute to an FSA by electing an amount to be voluntarily withheld from their pay by the Employer. This technique is sometimes called a salary reduction agreement. An Employer may also contribute to an FSA subject to defined limits.

FSA limits

For a health FSA, there is no limit on the amount an Employee can contribute, unless specified by the Employer in the plan documents (in 2013, the maximum employee contribution is $2,500). A dependent care account has a federal maximum contribution limit of $5,000, which cannot be increased by the Employer. For a premium reimbursement account, there is no limit on the amount an Employee can contribute, unless specified by the Employer in the plan documents.

Health Reimbursement Arrangement (HRA)

HRAs are funded solely through Employer contributions and may not be funded through Employee salary deferrals under a Cafeteria Plan.

HRA limits

There is no limit on the amount of money an Employer can contribute to the accounts. Additionally, the maximum reimbursement amount credited under the HRA in the future may be increased or decreased by amounts not previously used. See also annual limit prohibition under “PPACA Misc.”.

Taxation on FSA/ HRA contributions

In neither the FSA nor HRA, are contributions (Employee or Employer) included in the Employee’s income; the Employee will not have to pay federal income taxes or employment taxes on amounts contributed.

Medical Savings Account (MSA)

For an Employee, their Employer may make contributions to their Archer MSA (the Employee does not pay tax on these contributions). If the Employer does not make contributions to the Employee’s Archer MSA, or the Employee is self-employed, the Employee can make contributions to their Archer MSA. Both the Employee and the Employer cannot make contributions to an Archer MSA in the same year. The Employee does not have to make contributions to their Archer MSA every year.

If an Employee’s spouse is covered by the Employee’s HDHP and an excludable amount is contributed by the spouse's Employer to an Archer MSA belonging to the spouse, the Employee cannot make contributions to their own Archer MSA that year.

MSA limits

There are two limits on the amount you or your Employer can contribute to your Archer MSA:

(1) The annual deductible limit:
- **a.** An Employee or Employer can contribute up to 75% of the annual deductible of the HDHP (65% if self-only plan) to an Archer MSA. The Employee must have the HDHP all year to contribute the full amount.

(2) An income limit:
- **a.** The Employee cannot contribute more than they have earned for the year, from the Employer sponsoring the HDHP.

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Health Savings Account

Overview

A Health Savings Account (HSA) is an account that you can put money into to save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment. An HSA allows for contributions to be made on a pre-tax basis by an Employee or an Employer. Any unused balance will be rolled forward to the next year.

Participation

In order to be able to participate in contributing to an HSA, an individual must: **(1)** have coverage under an HSA-qualified high deductible health plan (QHDHP), **(2)** have no other first-dollar medical coverage, including FSAs and HRAs but not including dental care, vision care etc., **(3)** not be enrolled in Medicare, and **(4)** not be able to be claimed as a dependent on someone else's tax return. Children cannot establish their own HSAs, and spouses, if eligible, can establish their own HSAs. There are no income limits on who may contribute to an HSA, and no requirement to have earned income to contribute to an HSA.

QHDHP

A qualified high deductible health plan, in general, provides for medical care to an Employee and their spouse/dependents. A QHDHP has a deductible amount, which must apply to all medical expenses (including prescriptions) covered by the plan. Preventative services, such as annual physicals, mammograms, immunizations, etc., must be given first-dollar coverage (with or without a copay). To be able to contribute to an HSA, the QHDHP must have a minimum deductible of $1,200 Single and $2,400 family for plan years beginning in 2011 or 2012.

Distributions

Distributions from the HSA are tax-free if taken for qualified medical expenses incurred on or after the HSA was established (open and funded). The individual covered by the QHDHP, their spouse and dependents, can take distributions as long as no other reimbursement has been or will be sought. If a distribution is not for a qualified medical expense, the amount is included in gross income, and an additional 20% excise tax will be added (was 10% before PPACA) if under the age of 65. Employees cannot treat insurance premiums as qualified medical expenses unless the premiums are for: **(1)** long-term care insurance (subject to limits), **(2)** health care continuation coverage (such as coverage under COBRA or USERRA), **(3)** health care coverage while receiving unemployment compensation under federal or state law, or **(4)** Medicare and other health care coverage if you were 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).

All distributions from an HSA must be accounted for. This can be done with receipts, invoices, or EOB's. If the IRS conducts an audit, the individual who has the HSA, may need to prove that all distributions were for qualified medical expenses and not reimbursed elsewhere. Another reason is because the insurance company may require an individual to prove that their QHDHP deductible was met.

Expenses incurred in years past can also be reimbursed through the HSA as long as they were incurred after the HSA was established. If for some reason an HSA distribution is taken out by mistake, it can be returned as long as: **(1)** clear and convincing evidence must be shown that that distribution was a mistake, and **(2)** it must be repaid by April 15th of the year following the year in which the individual knew or should have known the distribution was a mistake.

In addition

Accounts grow through investment earnings, just like an IRA. The funds and investment options available depend on the bank with which the HSA is setup. IRAs, MSAs, and other HSAs can roll funds into an HSA.

An Employer cannot restrict rollovers or how the money in the HSA is distributed. However, the HSA custodian or trustee can put reasonable limits on accessing the money in the account including the frequency and size of distributions.

Account holders must file form 8889 as part of their annual tax return if they have contributed to their HSA.

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Funding Techniques—Health Savings Account

Overview

Any eligible individual can contribute to an HSA. For an Employee's HSA, the Employee, the Employee's Employer or both may contribute to the Employee's HSA in the same year. For an HSA established by a self-employed (or un-employed) individual, the individual can contribute. Family members or any other person may also make contributions on behalf of an eligible individual. Contributions to an HSA must be made in cash.

If an Employer is going to contribute to the HSAs of Employees, certain rules must be followed.

Comparable contributions

If an Employer decides to make contributions, they must make comparable contributions to all comparable participating Employees' HSAs. The Employer's contributions are comparable if they are either the same amount, or the same percentage of the annual deductible limit under the HDHP covering the Employees.

The comparability rules do not apply to contributions made through a Cafeteria Plan.

Comparable participating Employees

- **(1)** Are covered by the Employer's HDHP and are eligible to establish an HSA,
- **(2)** Have the same category of coverage (either self-only or family coverage), and
- **(3)** Have the same category of employment (less than 30 hours/week, 30 hours or more/week, or former Employees).

For purposes of making contributions to the HSAs of non-highly compensated Employees, highly compensated Employees shall not be treated as comparable participating Employees. To meet the comparability requirements for eligible Employees who have not established an HSA by December 31st or have not notified their Employer that they have an HSA, the Employer must meet a notice requirement and a contribution requirement. The Employer will meet the notice requirement if by January 15th of the following calendar year a written notice is provided to all such Employees. See A-14(c) for a sample of the notice. The Employer will meet the contribution requirement for these Employees if by April 15th, the Employer contributed comparable amounts plus reasonable interest to the Employee's HSA for the prior year.

Rollovers

Employees are allowed in certain circumstances to rollover funds from eligible FSAs, HRAs, and IRAs. See Publication 969.

Excise tax

If the Employer made contributions to their Employees' HSAs that were not comparable, the Employer must pay an excise tax of 35% of the amount contributed.

Limits

For any given year, the Employee must reduce the amount they, or any other person, can contribute to their HSA by the amount of any contributions made by the Employer that are excludable from the Employee's income. This includes amounts contributed to the HSA through a Cafeteria Plan. For each eligible individual age 55 or older, an additional $1,000 may be contributed. Beginning the first month you are enrolled in Medicare, your contribution limit is zero.

	2011	2012
Single/Family max. contribution	$3,050/$6,150	$3,100/$6,250
Single/Family min. Deductible for HDHP	$1,200/$2,400	$1,200/$2,400

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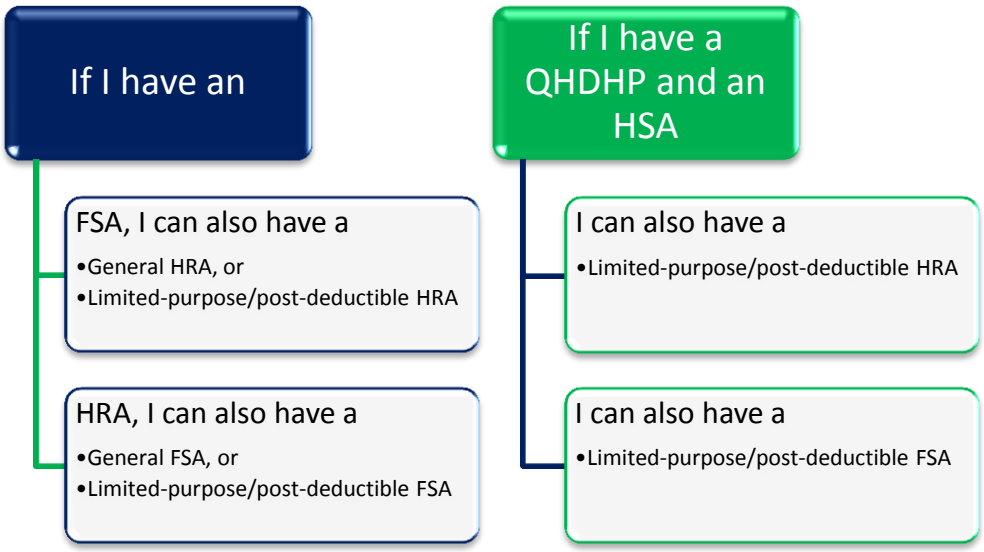
Stacking Rules for Consumer Driven Health Plans



A limited-purpose FSA or HRA can only be used to pay for dental or vision expenses. A post-deductible HRA is a general HRA that is turned on after the minimum QHDHP deductible has been satisfied.

When combining FSAs and HRAs, the plan documents must state the ordering rules; i.e. HRA pays first: Employer reimburses expenses as they are incurred or FSA pays first: FSA must be exhausted before the HRA may reimburse the expense.

Switching to a new QHDHP plan

Employer has a traditional health plan and a general FSA with 2½ month grace period renewing 1/1 and would like to switch to an HSA.

The first thing the Employer needs to do is find a qualified high deductible health plan (QHDHP). Any Employee that wishes to contribute to the HSA starting January 1st must have a zero balance in their FSA account by 12/31. HSA accounts must be open and funded by the 1st of the year so that individual's expenses become qualified as of the start of the year. If the Employer still wants to keep an FSA to pay for dental and vision expenses, they may do so by setting up a limited-purpose FSA. If the Employer wants to keep the general FSA they may do so in two ways: **(1)** offer two health plans for Employees to choose from, an HSA compatible plan and an FSA compatible plan, or **(2)** amend the current plan documents so that the FSA is turned on after the minimum QHDHP deductible has been met.

Employer has a traditional health plan renewing 1/1 and a general FSA with 2 ½ month grace period renewing 3/1 and would like to switch to an HSA.

The Employer has a few options: **(1)** the Employer could amend the FSA to make it a limited FSA. The Employee may not change their elections retroactively. With far less choices to spend FSA dollars, Employees may stand to forfeit a significant amount of money. **(2)** The Employer can terminate the FSA Plan before the health plan renews; however, Employees may stand to forfeit money in their FSAs, or **(3)** The Employer could renew their current health plan as of 1/1; and when the FSA renews, make it a short plan year to coincide with the health plan. This won't allow certain eligible individuals to setup HSAs immediately, but Employees will have the least chance of forfeiting money elected.

In any case, in order to setup the HSA: **(1)** the Employer must offer a QHDHP, **(2)** there must be a zero balance in the FSA or HRA before the renewal, and **(3)** the HSA must be opened and funded as soon as possible so that the expenses are deemed eligible for reimbursement.

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Taxation of Benefits for Domestic Partners

Definition of marriage

The Federal Government, considers the word "marriage" to mean only a legal union between one man and one woman as husband and wife, and the word "spouse" refers only to a person of the opposite sex who is a husband or a wife [I.R.C 1.1 §7].

Type of Benefit	I.R.C.	Married Couples	Federal Law for Domestic Partners
Employer contributions to an employee's accident or health plan.	§106(a)	The amount paid by the employer for the employee, spouse, and dependents is excluded from gross income.	If an employer sponsored plan allows for the coverage of domestic partners and the partners dependents, the estimated amount paid by the employer to cover the partner and the partner's dependents is included in the employee's gross income, for tax purposes. This is not true if the employee's partner and the partner's dependents are a qualified relative as defined in the Internal Revenue Code §152.
Reimbursements made by an employer for an employee's medical expenses.	§105(b)	The amount reimbursed by the employer for the employee, spouse, and dependents is excluded from gross income.	Federal law does not allow an exclusion for medical expense reimbursements paid by the employer for a registered domestic partner and the partner's dependents unless they are a qualifying relative under Internal Revenue Code §152.
For tax purposes, a deduction can be made for incurred medical expenses.	§213(a)	Medical expenses incurred by an individual, spouse, and dependents can be deducted.	Federal law does not allow a deduction for medical expenses incurred for a registered domestic partner and the partner's dependents unless they are a qualifying relative under Internal Revenue Code §152.
For tax purposes, a deduction can be made for qualified long-term health care insurance deductibles.	§213(a)	Long-term care expenses incurred by an individual, spouse, and dependents can be deducted.	Federal law does not allow a deduction for long-term health care insurance expenses paid for a registered domestic partner and the partner's dependents unless they are a qualifying relative under Internal Revenue Code §152.
For tax purposes, a self-employed individual can take a deduction for health insurance expenses.	§162(l)	For a self-employed individual, insurance expenses incurred by an individual, spouse, and dependents can be deducted.	Federal law does not allow a deduction for self-employed health insurance expenses incurred for a registered domestic partner and the partner's dependents unless they are a qualifying relative under Internal Revenue Code §152.

Healthcare Reform Timeline 2011-2012

Improving quality and lowering costs

(1) **Offering Prescription Drug Discounts**—seniors who reach the coverage gap will receive a 50% discount when buying Medicare Part D covered brand-name prescription drugs. Download the brochure… Closing the Prescription Drug Coverage Gap. *Effective January 1, 2011*.
(2) **Providing Free Preventive Care for Seniors**—the law provides certain free preventive services, such as annual Wellness visits and personalized prevention plans for seniors on Medicare. *Effective January 1, 2011*.
(3) **Improving Health Care Quality and Efficiency**—the law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. *Effective January 1, 2011*.
(4) **Improving Care for Seniors After They Leave the Hospital**—the Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities. *Effective January 1, 2011*.
(5) **Introducing New Innovations to Bring Down Costs**—the Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. *Administrative funding becomes available October 1, 2011*.

Increasing access to affordable care

(1) **Increasing Access to Services at Home and in the Community**—the new Community First Choice Option allows states to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes. Effective *beginning October 1, 2011*.
(2) **Providing New, Voluntary Options for Long-Term Care Insurance**—the law creates a voluntary long-term care insurance program – called CLASS (Community Living Assistance Services and Supports) – to provide cash benefits to adults who become disabled. The Secretary shall designate a benefit plan no later than *October 1, 2012*.

Holding insurance companies accountable

(1) **Bringing Down Health Care Premiums**—to ensure premium dollars are spent primarily on health care, the new law generally requires that at least 85% of all premium dollars collected by insurance companies for large Employer plans are spent on health care services and health care quality improvement. *Effective January 1, 2011*.
(2) **Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage**—the new law levels the playing field by gradually eliminating Medicare Advantage overpayments to insurance companies. *Effective January 1, 2011*. Download the brochure… Medicare and the New Health Care Law – What it Means for You.

Improving quality and lowering costs

(1) **Linking Payment to Quality Outcomes**—the law establishes a hospital Value-Based Purchasing program (VBP) in Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. *Effective for payments for discharges occurring on or after October 1, 2012*.
(2) **Encouraging Integrated Health Systems**—the new law provides incentives for physicians to join together to form "Accountable Care Organizations." These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. *Effective January 1, 2012*.
(3) **Reducing Paperwork and Administrative Costs**—health care remains one of the few industries that rely on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. *First regulation effective October 1, 2012*.
(4) **Understanding and Fighting Health Disparities**—to help understand and reduce persistent health disparities, the law requires any ongoing or new federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help identify and reduce health disparities. *Effective March 2012*.

Healthcare Reform Timeline 2013-2015

Improving quality and lowering costs

(1) **Improving Preventive Health Coverage**—the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. *Effective January 1, 2013.*
(2) **Expanding Authority to Bundle Payments**—the law establishes a national pilot program called "Payment Bundling" to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. *Effective no later than January 1, 2013.*

Increasing access to affordable care

(1) **Increasing Medicaid Payments for Primary Care Doctors**—as Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government. *Effective January 1, 2013.*
(2) **Providing Additional Funding for the Children's Health Insurance Program**—under the new law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid. Learn more about the Children's Health Insurance Program (CHIP). *Effective October 1, 2013.*
(3) **Increasing Access to Medicaid**—Americans who earn less than 133% of the poverty level (approximately $14,000 for an individual and $29,000 for a family of four) will be eligible to enroll in Medicaid. *Effective January 1, 2014.*
(4) **Promoting Individual Responsibility**—under the new law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. Learn more about Individual Responsibility. *Effective January 1, 2014.*
(5) **Ensuring Free Choice**—workers meeting certain requirements who cannot afford the coverage provided by their Employer may take whatever funds their Employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance Exchanges. *Effective January 1, 2014.*

New consumer protections and improving quality and lowering costs

(1) **Prohibiting Discrimination Due to Pre-Existing Conditions or Gender**—the law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual's pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status. *Effective January 1, 2014.*
(2) **Eliminating Annual Limits on Insurance Coverage**—the law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may receive. *Effective January 1, 2014.*
(3) **Ensuring Coverage for Individuals Participating in Clinical Trials**—insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. *Effective January 1, 2014.*
(4) **Making Care More Affordable**—tax credits to make it easier for the middle class to afford insurance will become available for people with income between 100% and 400% of the poverty line who are not eligible for other affordable coverage. *Effective January 1, 2014.*
(5) **Establishing Health Insurance Exchanges**—starting in 2014 if your Employer doesn't offer insurance, you will be able to buy insurance directly in an Exchange -- a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. *Effective January 1, 2014.*
(6) **Increasing the Small Business Tax Credit**—the law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50% of the Employer's contribution to provide health insurance for Employees. Download the brochure—The Affordable Care Act Increases Choice and Saving Money for Small Businesses. *Effective January 1, 2014.*
(7) **Paying Physicians Based on Value Not Volume**—a new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care. *Effective January 1, 2015.*

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PPACA—Grandfathered Plans

Overview

The Affordable Care Act gives American families and businesses more control over their health care by providing greater benefits and protections for family members and Employees. It also provides the stability, and also the flexibility, that families and businesses need to make the choices that work best for them. While it requires all health plans to provide important new benefits to consumers, it allows plans that existed on March 23, 2010 to innovate and contain costs by allowing insurers and Employers to make routine changes. These plans are termed "grandfathered plans".

New rights for all plans

All health plans, whether or not they are grandfathered plans, must provide certain benefits to their customers for plan years starting on or after September 23, 2010 including: **(1)** no lifetime limits on coverage for all plans, **(2)** no rescissions of coverage when people get sick and have previously made an unintentional mistake on their application, and **(3)** extension of parents' coverage to young adults under 26 years old.

For the vast majority of Americans who get their health insurance through Employers, additional benefits will be offered, irrespective of whether their plan is grandfathered, including: **(1)** no coverage exclusions for children with pre-existing conditions, and **(2)** no "restricted" annual limits.

New rules for Grandfathered Plans

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with State or other federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Compared to their policies in effect on March 23, 2010, grandfathered plans: **(1)** cannot significantly cut or reduce benefits, **(2)** cannot raise co-insurance charges, **(3)** cannot significantly raise copayment charges (compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those copays by no more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points), **(4)** cannot significantly raise deductibles (compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points), **(5)** cannot significantly lower Employer contributions (grandfathered plans cannot decrease the percent of premiums the Employer pays by more than 5 percentage points), **(6)** cannot add or tighten an annual limit on what the insurer pays, unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit, and **(7)** may change insurance companies. An Employer with a group health plan can switch plan administrators as well as buy insurance from a different insurance company without losing grandfathered status, provided the plan does not make any of the above six changes to its cost or benefits structure.

If a plan loses its grandfathered status, it cannot achieve grandfathered status again. In addition, the individuals in these plans will gain additional new benefits including: **(1)** coverage of recommended prevention services with no cost sharing and **(2)** patient protections such as guaranteed access to OB-GYNs and pediatricians.

Protection from abuse

To prevent health plans from using the grandfather rule to avoid providing important consumer protections, the regulation provides for: **(1)** promoting transparency by requiring a plan to disclose to consumers every time it distributes materials whether the plan believes it is a grandfathered plan or not (the plan must also provide contact information for enrollees to have their questions and complaints addressed), **(2)** revoking a plan's grandfathered status if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections, or **(3)** revoking a plan's grandfathered status if it is bought by or merges with another plan simply to avoid complying with the law.

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PPACA—Dependent Coverage to Age 26

Overview

The Affordable Care Act gives American families and businesses more control over their health care by providing greater benefits and protections for family members and Employees. It also provides the stability, and also the flexibility, that families and businesses need to make the choices that work best for them. Before the President signed the Affordable Care Act into law, many health plans and issuers could remove adult children from their parents' policies because of their age, whether or not they were a student or where they lived. The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until the adult child reaches the age of 26. Many parents and their children who worried about losing health insurance after they graduated from college no longer have to worry.

Eligibility and benefits

The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new Employer plans. It also applies to existing Employer plans unless the adult child has another offer of Employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's Employer plan even if they have another offer of coverage through an Employer.

Any qualified individual must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status. The qualified young adult cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status.

Tax treatment

Under a change in tax law included in the Affordable Care Act, the value of any Employer-provided health coverage for an Employee's child is excluded from the Employee's income through the end of the taxable year in which the child turns 26. This tax benefit applies regardless of whether the plan or the insurer is required by law to extend health care coverage to the adult child or the plan or insurer voluntarily extends the coverage.

A child is defined as an individual who is the son, daughter, stepson, or stepdaughter of the Employee, and a child includes both a legally adopted individual of the Employee and an individual who is lawfully placed with the Employee for legal adoption by the Employee. A child also includes an "eligible foster child," defined as an individual who is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Exceptions

Group plans in existence on March 23, 2010 may exclude adult children who are eligible to enroll in an Employer-sponsored health plan (unless it is the group health plan of their parent). This exception is no longer applicable for plan years beginning on or after January 1, 2014. In addition, this provision does not apply to Medicare.

For HSAs, the QHDHP will need to comply with the Age 26 Rule; however, the distributions may still only be taken tax-free by the owner, covered spouse, or other dependent as defined by IRC Section 152.

Additional rules apply to Flexible Spending Accounts and Health Reimbursement Arrangements.

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PPACA—Small Business Health Care Tax Credit

Overview

Under Section 45R of the Internal Revenue Code, certain small businesses and tax-exempt organizations (qualifying Employers) may qualify to receive a tax credit if they offer health insurance for the first time, or maintain coverage they already have. It is effective for taxable years beginning in 2010 and will be enhanced beginning in 2014.

Qualifying Employers

In general, small Employers that provide health care coverage to their Employees and meet the requirements below will be eligible:

(1) The Employer must have fewer than 25 full-time equivalent Employees (FTE's) for the tax year.
(2) The average annual wages of its Employees for the year must be less than $50,000 per FTE.
(3) The Employer must pay at least 50% of the cost of health insurance for its workers based on the single rate.

Amount of credit

For tax years before 2014, qualifying Employers (other than tax-exempt Employers) may receive a maximum credit of 35% of the Employer's premium expenses that count towards the credit. Tax-exempt Employers may receive a maximum credit of 25% of the Employer's premium expenses that count towards the credit. In either case, to receive the maximum credit you must have no more than 10 FTEs with average wages no more than $25,000. Employers between 10 and 25 FTEs and/or $25,000 and $50,000 average wages will receive a reduced credit.

Claiming the credit

Qualifying Employers (other than tax-exempt Employers) must fill out Form 8941 along with their annual income tax return showing the calculation of the credit. Tax-exempt Employers must file Form 990-T with an attached Form 8941 showing the calculation of the claimed credit.

Examples

(1) For the 2010 tax year, a qualified taxable Employer has 9 FTEs with average annual wages of $23,000 per FTE. The Employer pays $72,000 in health care premiums for those Employees, which does not exceed the average premium for the small group market in the Employer's state, and otherwise meets the requirements for the credit. The credit for 2010 equals $25,200 (35% x $72,000).

(2) For the 2010 tax year, a qualified Employer has 12 FTEs and average annual wages of $30,000. The Employer pays $96,000 in health care premiums for those Employees, which does not exceed the average premium for the small group market in the Employer's state, and otherwise meets the requirements for the credit.

The credit is calculated as follows:

a. Initial amount of credit determined before any reduction: (35% x $96,000) = $33,600
b. Credit reduction for FTEs in excess of 10: ($33,600 x 2/15) = $4,480
c. Credit reduction for average annual wages in excess of $25,000: ($33,600 x $5,000/$25,000) = $6,720
d. Total credit reduction: ($4,480 + $6,720) = $11,200
e. Total 2010 tax credit: ($33,600 – $11,200) = $22,400.

Solutions@JJHemployerservices.com
www.JJHemployerservices.com
Ph. 516-506-1875

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PPACA—Summary of Benefits and Coverage

Overview

Recently proposed regulations would require health insurers and group health plans to provide the 180 million Americans with private insurance clear, consistent and comparable information about their health plan benefits and coverage. Specifically, the proposed regulations provide rules implementing Affordable Care Act provisions that would ensure consumers have access to two forms that will help them understand and evaluate their health insurance choices. These forms include: **(1)** an easy to understand Summary of Benefits and Coverage, and **(2)** a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-pay".

Summary of Benefits and Coverage

Under the proposed rules, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The proposed regulations contain standards that are intended to ensure that this summary document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven days of requesting a copy from their health insurance issuer or group health plan. The DOL has created a template for employers to work off of.

The SBC must be presented in a uniform format, may not be longer than 4 double-sided pages, and may not have print smaller than 12-point font.

Uniform Glossary of Terms

Under the proposed regulations, consumers will have a new tool to help them understand some of the jargon that makes it impossible to figure out what is covered and how one insurance plan stacks up compared to another. To allow apples-to-apples comparison, terms would be the same across all plans. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-pay". To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website.

Implementation and other information

Under the rules in the proposed regulations, beginning on March 23, 2012, all health insurance issuers and group health plans will provide the Summary of Benefits and Coverage and the uniform glossary to consumers.

Often, health plans only provide marketing material on the plan or policy before its purchased, giving consumers a selective understanding of what they are buying. Now, consumers will have the critical information on their choices upfront, before they buy coverage, allowing them to make a more informed decision.

An issuer or health plan will automatically provide a Summary of Benefits and Coverage to a consumer prior to enrolling in coverage and 30 days prior to reissuance or renewal of their health coverage so they are informed about the coverage they have.

When coverage changes, people enrolled in a health plan must be notified of any significant changes to the terms of coverage reflected in the Summary of Benefits and Coverage at least 60 days prior to the effective date of the change.

A shopper or person enrolled in coverage can request a copy of the Summary of Benefits and Coverage and must receive it within seven days. The uniform glossary will also be made available upon request, as well as in a link provided in the coverage label by the plan or insurance company.

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PPACA—W-2 Reporting

Overview

The Affordable Care Act (ACA) requires Employers to report the cost of Employer-provided health care coverage on their Employees' Form W-2. The purpose of the reporting is to inform Employees of the cost of their health coverage. Employer-provided health coverage continues to be excludable from an Employee's income and the amount reported is not taxable for federal income tax purposes. Notice 2010-69, issued last fall, made this requirement optional for all Employers for the 2011 Forms W-2, which would generally be provided to Employees in January 2012.

Employers subject to reporting

(1) Smaller Employers filing fewer than 250 W-2s for 2011 are not required to report the cost of health care coverage on the 2012 W-2s, giving them transition relief for 1 year.
(2) Employers filing more than 250 W-2s for 2011 will not be required to report the cost of health coverage on any 2012 W-2s furnished to Employees prior to January 2013.
(3) The total cost of coverage is not required to be reported on Form W-3, Transmittal of Wage and Tax Statements.

Using a question-and-answer format, Notice 2011-28 provides guidance for Employers that are subject to this requirement for the 2012 W-2s and those that choose to voluntarily comply with it for either 2011 or 2012. The notice includes information on how to report, what coverage to include and how to determine the cost of the coverage.

Reportable benefits

(1) Employer and Employee paid health insurance premiums
(2) Employer contributions to a health flexible spending account (FSA)
(3) Qualified on-site medical clinics

Excluded from reporting

(1) Archer MSA (Medical Savings Account) contributions
(2) Health Savings Account (HSA) contributions
(3) Employee contributions to a Flexible Spending Account (FSA)
(4) Health Reimbursement Arrangement (HRA)
(5) Stand-alone dental and vision plans
(6) Coverage for members of the military
(7) Self-insured plans not subject to COBRA

PPACA—Wellness Programs and CLASS Act

Wellness Programs

The Affordable Care Act issued new regulations regarding the use of Wellness Programs in the workplace. In 2011, small Employers will be provided grants for up to five years when they establish Wellness programs. As of this publication, it has not been implemented, and is awaiting final regulations.

In addition, starting in 2014, the maximum reward that can be provided under a health-contingent Wellness program will move from 20% to 30% in an effort to make Wellness programs more attractive to Employees. It will also start a 10-state pilot program to apply similar rewards to the individual market.

CLASS Act (DELAYED AS OF OCTOBER 2011 AND IN THE PROCESS OF BEING REPEALED)

The Community Living Assistance Services and Supports (CLASS) Act, created under PPACA, establishes a national voluntary insurance program for purchasing community living assistance services and supports in order to: **(1)** provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports, **(2)** establish an infrastructure that will help address the Nation's community living assistance services and supports needs, **(3)** alleviate burdens on family caregivers, and **(4)** address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

Eligibility

An individual will be eligible to receive benefits under CLASS if that individual: **(1)** has paid premiums for enrollment in such program for at least 60 months, **(2)** has earned, with respect to at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under Section 213(d) of the Social Security Act for the year, and **(3)** has paid premiums for enrollment in such program for at least 24 consecutive months (if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual's enrollment and ends on the date of such determination).

Benefits and triggers

The benefit amount provides an eligible beneficiary with not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

(1) The individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual.
(2) The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment.
(3) The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level of functional limitation described in clause (1) or (2).

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Ph. 516-506-1875

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PPACA—Annual Limit Prohibition

Affected plans: GHPs and some HRAs

For plan years starting between September 23, 2010 and September 22, 2011, plans may not limit annual coverage of essential benefits such as hospital, physician and pharmacy benefits to less than $750,000. The restricted annual limit will be $1.25 million for plan years starting on or after September 23, 2011, and $2 million for plan years starting between September 23, 2012 and January 1, 2014. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

Group health plan (GHP) means any arrangement made by one or more Employers or Employee organizations to provide health care directly or through other methods such as insurance or reimbursement, to current or former Employees, the Employer, others associated or formerly associated with the Employer in a business relationship, or their families, that:

(1) Is of, or contributed to by, one or more Employers or Employee organizations.
(2) If it involves more than one Employer or Employee organization, provides for common administration.
(3) Provides substantially the same benefits or the same benefit options to all those enrolled under the arrangement.

The term includes self-insured plans, plans of governmental entities (federal, State and local), and Employee organization plans; that is, union plans, Employee health and welfare funds or other Employee organization plans. The term also includes Employee-pay-all plans, which are plans under the support of one or more Employers or Employee organizations but which receive no financial contributions from them. The term does not include a plan that is unavailable to Employees, for example, a plan only for self-employed persons. All HRAs that are subject to the requirements of section 2711 and that were in effect prior to September 23, 2010 are exempt from having to apply individually for an annual limit waiver for plan years beginning on or after September 23, 2010 but before January 1, 2014.

Supplemental HRA guidance from CMS

CMS has issued revised guidance as to how HRAs are defined and applicable to the annual limit prohibitions under PPACA.

All HRAs that are subject to the requirements of Section 2711 and that were in effect prior to September 23, 2010 are exempt. All new HRA plans, "as long as the HRA is integrated with the major medical plan, which must also meet the compliance requirement; then even if they are under separate ERISA plans, the HRA is still considered integrated" are also exempt.

Excepted benefits that are also made exempt from the original guidance include HRAs limited to dental and vision only plans as well as HRAs offered to retirees.

Effective on or after September 23, 2010, any new HRA not integrated with the employer-sponsored major medical plan that is reimbursing any unreimbursed 213(d) medical expense must comply with the Annual Limit Prohibition. Meeting the following conditions would qualify the HRA as an excepted benefit and it would be exempt from the rule:

(1) 1st year plans—projected COBRA rate is 75%; plan would qualify as a "flexible spending arrangement" under IRS Section 106
(2) Subsequent years—actual COBRA rate is ≥ 20%; plan would qualify as a "flexible spending arrangement" under IRS Section 106
(3) Can the plan itself be designed to reflect no annual limit?

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PPACA Misc.

OTC drug changes

Effective Jan. 1, 2011, distributions from health FSAs, HRAs, HSAs, and Archer MSAs will be allowed to reimburse the cost of over-the-counter medicines or drugs ONLY if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

The new rule does not apply to items for medical care that are not medicines or drugs. Thus, equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits will still qualify for reimbursement by a health FSA or HRA if purchased after Dec. 31, 2010, and a distribution from an HSA or Archer MSA for the cost of such items will still be tax-free, regardless of whether the items are purchased using a prescription.

Preventative care

The Affordable Care Act requires that new plans—beginning on or after September 23, 2010—and issuers must cover the recommended list of preventative services according to the United States Preventative Services Task Force without any cost-sharing for the enrollee when delivered by in-network providers. New and renewing plans beginning August 1, 2012, must cover an additional list of preventative services, specific to the changing needs of a woman, must be covered without any cost sharing for the enrollee when delivered by in-network providers, including:

(1) well-woman visits
(2) screening for gestational diabetes
(3) human papillomavirus (HPV) DNA testing for women 30 years and older
(4) sexually-transmitted infection counseling
(5) human immunodeficiency virus (HIV) screening and counseling
(6) FDA-approved contraception methods and contraceptive counseling
(7) breastfeeding support, supplies, and counseling
(8) domestic violence screening and counseling

The Preventative Care provision does not apply to grandfathered plans and issuers.

HSA tax % Increase

In 2011, the excise tax for distributions from Health Savings Accounts for non-qualified medical expenses for individuals under age 65 increases from 10% to 20% and from 15% to 20% for Archer Medical Savings Accounts.

Health FSA limit

Starting in 2013, the maximum amount an employee in a health FSA can elect is $2,500. This limit does not apply to employer health FSA contributions or dependent care and premium reimbursement FSAs.

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Ph. 516-506-1875

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Classifying Employees: W-2 vs. 1099 Employees

Overview

It is critical that business owners correctly determine whether the individuals providing services are employees or independent contractors. Generally, you must withhold income taxes, withhold and pay Social Security and Medicare taxes, and pay unemployment tax on wages paid to an employee. You do not generally have to withhold or pay any taxes on payments to independent contractors.

Independent contractor

People such as doctors, dentists, veterinarians, lawyers, accountants, contractors, subcontractors, public stenographers, or auctioneers who are in an independent trade, business, or profession in which they offer their services to the general public are generally independent contractors. However, whether these people are independent contractors or employees depends on the facts in each case. The general rule is that an individual is an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done.

Employee

Under common-law rules, anyone who performs services for you is your employee *if you can control what will be done and how it will be done.* This is so even when you give the employee freedom of action. What matters is that you have the right to control the details of how the services are performed.

A quick test

The IRS has created a 20-point list for helping to determine whether an individual is an employee or independent contractor. In general, "no" answers to questions 1-16 and "yes" answers to questions 17-20 indicate an independent contractor. For more information, please consult a qualified professional or view the IRS' website.

(1) Must the individual take instructions from your management staff regarding when, where, and how work is to be done?
(2) Does the individual receive training from your company?
(3) Is the success or continuation of your business somewhat dependent on the type of service provided by the individual?
(4) Must the individual personally perform the contracted services?
(5) Have you hired, supervised, or paid individuals to assist the worker in completing the project stated in the contract?
(6) Is there a continuing relationship between your company and the individual?
(7) Must the individual work set hours?
(8) Is the individual required to work full time at your company?
(9) Is the work performed on company premises?
(10) Is the individual required to follow a set sequence or routine in the performance of his work?
(11) Must the individual give you reports regarding work?
(12) Is the individual paid by the hour, week, or month?
(13) Do you reimburse the individual for business/travel expenses?
(14) Do you supply the individual with needed tools or materials?
(15) Have you made a significant investment in facilities used by the individual to perform services?
(16) Is the individual free from suffering a loss or realizing a profit based on his work?
(17) Does the individual only perform services for your company?
(18) Does the individual limit the availability of his services to the general public?
(19) Do you have the right to discharge the individual?
(20) May the individual terminate his services at any time?

Settlement program

The IRS announced at the end of September 2011 announced a program that will enable employers to resolve past worker misclassification issues by voluntarily reclassifying their workers. For more information regarding the program, please see the full IR-2011-95 notice.

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Employee Handbook

Overview

A number of court cases have confirmed that business owners can help protect themselves against legal disputes by creating a published Employee handbook. An Employee handbook or policy manual is one of the most essential communication tools between your company and your Employees. By creating an Employee handbook and related HR personnel policies, every Employee receives the same information on the rules of the workplace. Your Employees know what is expected of them and they know what they can expect from the company. A well written, up-to-date HR handbook is a must for all small and mid-size businesses.

Workplace policies

Regardless of how many Employees you have working at your company, creating an Employee handbook or personnel manual that clearly explains your workplace policies is critical for your business. When company policies are not provided in a consistent manner or when benefit plans are not explained properly, misunderstandings occur. Those misunderstandings can become legal disputes when the issues involve things like discrimination, workplace harassment, overtime and attendance policies.

Essential components

An HR personnel manual or Employee handbook includes information on general work policies, Employee classification, orientation & training, workplace harassment, compensation & benefits, attendance, personal conduct, termination of employment, internet/email policies, etc. When distributing the company's policy manual to your Employees, it is recommended that you have them sign an acknowledgement form showing that they have received a copy of the Employee handbook.

Several policies, topics and sections you may want to include in your Employee handbook are: **(1)** at-will disclaimer, **(2)** general policies & procedures, **(3)** federal employment laws & standard employment practices, **(4)** compensation and performance, **(5)** employment benefit programs and leave policies, **(6)** standards of conduct policies, and **(7)** internet and email policies.

The actual policies, guidelines and topics you decide to include in your Employee handbook may vary from company to company depending on how many Employees you have and the benefits you offer. Once you hire your first Employee, your company personnel manual should be one of the first formal communications you give to them.

Download a sample Employee Handbook here.

The materials in this 37-page sample handbook are intended to provide a general reference or resource, giving you a good foundation to start with. Every company is unique. Each organization has its own culture, Employee requirements and expectations. Some companies may have casual Fridays, where others may allow their Employees to be casual all the time. Education assistance and tuition reimbursement may be part of an Employee's benefits package in some companies and not in others. It's important to carefully review the sample Employee handbook and enhance it so it outlines the policies, guidelines, responsibilities, practices and procedures of your organization.

Federal and state laws are always changing. Depending on where your business is located, your state may have additional or different laws and regulations not considered by a specific policy in this sample Employee handbook. Your state may also provide broader protections to certain classes of Employees than federal law does. Access the US Department of Labor's website for state specific labor laws.

The federal, state and local laws governing employment are too complex to create a "one size fits all" Employee handbook. The materials in our handbook are not intended to provide advice on HR, legal, accounting or any other professional service. We recommend that you work with experienced legal counsel to develop and implement an Employee handbook that fits the needs of your company.

Labor Law Posters

Overview

If your business has at least one Employee, you are required by law to post federal, State and OSHA mandatory labor law posters in your workplace. As an Employer, posting these labor law posters in the workplace will inform your Employees of their labor and employment rights and give them a better understanding of what is required of them. Employment law posters should be displayed in prominent areas that can easily be seen by every Employee. These include areas such as break rooms, lunch areas, reception areas or where your Employees clock in and out.

Failure to display these required government labor law postings can result in steep fines and citations during an inspection. Fines vary by poster and by the enforcing agency, ranging from as low as $110 up to a potential maximum of $10,000.

Mandatory posters

State and federal labor law posting requirements may vary by industry, number of Employees, and type of business. Each state has their own mandatory posting requirements and specific employment regulations. The U.S. Department of Labor provides more guidance on the requirements for small businesses and other Employers when it comes to workplace posters. Most businesses must display the following six postings in each workplace location:

(1) Minimum Wage compliance poster
(2) Occupational Safety and Health Act (OSHA) poster
(3) Equal Employment Opportunity (EEO) poster
(4) Family Medical Leave Act (FMLA) poster (depending on the number of Employees at the company)
(5) Employee Polygraph Protection Act (EPPA) notice
(6) Uniformed Services Employment and Reemployment Rights Act (USERRA) notice/poster

Staying compliant

As federal, state, and OSHA agencies make labor law changes, you will need to update your posters to stay in compliance with employment regulations. On average, hundreds of labor law changes occur every year. A large percentage of those changes will require Employers to display new posters. The easiest way to stay in compliance is to subscribe to a labor law poster service that automatically sends you updated posters as regulations change that require new posters to be displayed.

Bilingual posters

Some states require that Employers display bilingual labor law posters. If your business is located in AZ, CA, FL, GA, NM, NY or TX and 5% of your Spanish-speaking Employees use English as a second language, it is mandatory that you post-employment law posters in both English and Spanish. If your business is not located in one of these states, but you do have Spanish speaking Employees that do not read English, it is highly recommended that you display bilingual posters even though you are not required to do so by law.

Need New or Updated Labor Law Posters for Your Business?

NLRA Rights

The National Labor Relations Board has issued a Final Rule that will require employers to notify employees of their rights under the National Labor Relations Act as of November 14, 2011. Private-sector employers (including labor organizations) whose workplaces fall under the National Labor Relations Act will be required to post the employee rights notice where other workplace notices are typically posted. Also, employers who customarily post notices to employees regarding personnel rules or policies on an internet or intranet site will be required to post the Board's notice on those sites. A fact sheet with more information is available here, or you may download a free 11 x 17 version.

JJH Employer Services
Insurance & HR Administrative Solutions

Solutions@JJHemployerservices.com
www.JJHemployerservices.com
Ph. 516-506-1875

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Social Media at Work

Overview

The boundaries between personal and professional have become increasingly blurred because of the growing popularity of social media sites such as Facebook, Google+, LinkedIn and Twitter. While social media outlets may be excellent platforms for employees to network and promote your business, a number of problems may result from an employee's improper or unlawful use of your company's name, reputation or confidential information while using social media.

Employee Use of Firm Identity

If an employee uses your company name or a company email address to communicate with or otherwise use social media, a third-party may be led to believe that the employee is speaking or writing on behalf of your company. For this reason and others, the FTC implemented rules that went into effect on December 1, 2009, regulating the use of testimonials in advertising. Under these rules an employer may be held responsible for employee maintained blogs or other employee postings about the company's products and services. In an effort to avoid these problems, a social media policy may: **(1)** direct employees in such situations to use a disclaimer explicitly stating that his or her views are not those of their employer, or **(2)** provide that employees are not permitted to act or speak as a representative of the company while using social media, unless given prior permission.

Confidentiality & Intellectual Property Protections

A social media policy should address employees' online use and dissemination of an employer's confidential and proprietary information. The policy should clearly define what information is confidential to your business and state how employees may or may not use such information. Employers may risk any right they have to protect client contact information by encouraging employees to connect with, link to or friend the employer's clients through the employee's personal social media accounts. These risks need to be balanced with the potential benefits to your business. The policy should also provide that the employer's intellectual property, including trademarks, logos and copyrighted material, may not be used by the employee while using social media without the company's prior consent.

Workplace & Co-Worker Privacy

Employees who use social media should be reminded of the need to honor the privacy rights of their co-workers. A policy may state that employees should seek permission from co-workers before writing or displaying information that might be considered a breach of privacy or confidentiality. A company's social media policy should prohibit employees (including supervisors) from gaining or attempting to gain unauthorized or unlawful access to another employee's private and secure social media platform, which may, for instance, be a violation of the Federal Stored Communications Act and various state privacy laws.

The Employer's Right to Monitor

Companies should be open with their employees and inform them of the company's right to lawfully monitor their use of social media to protect legitimate business interests. The social media policy should also prohibit employees from using any information derived from an applicant's or employee's use of social media to unlawfully discriminate against that individual.

Create a Social Media Policy for Your Business

Need help creating a social media policy that fits the needs of your company? Social Media Governance has over 170 sample social media policies in its database… which can be accessed by industry type. View and download social media guidelines, blogging & Twitter policies and best practices for online communications from organizations like Wal-Mart, Yahoo!, IBM, SAP, Nordstrom, Microsoft, Coca-Cola, Reuters and the U.S. Navy.

JJH Employer Services
Insurance & HR Administrative Solutions
Solutions@JJHemployerservices.com
www.JJHemployerservices.com
Ph. 516-506-1875

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Red Flags Rule

Overview

The Red Flags Rule requires many businesses and organizations to implement a written Identity Theft Prevention Program to detect the warning signs, or "red flags", of identity theft in their day-to-day operations. By focusing on red flags now, you'll be better able to spot suspicious patterns that may arise, and take steps to prevent a red flag from escalating into a costly episode of identity theft. As a practical matter, the Rule applies to you if you provide products or services and bill customers later.

Entities that must comply

The Rule requires "financial institutions" and "creditors" that hold consumer accounts designed to permit multiple payments or transactions, or any other account for which there is a reasonably foreseeable risk of identity theft, to develop and implement an Identity Theft Prevention Program for new and existing accounts. The definition of "financial institution" includes:

(1) All banks, savings associations, and credit unions, regardless of whether they hold a transaction account belonging to a consumer, and
(2) Anyone else who directly or indirectly holds a transaction account belonging to a consumer.

A change in the law on December 18, 2010 amended the definition of "creditor," and limits the circumstances under which creditors are covered. The new law covers creditors who regularly, and in the ordinary course of business, meet one of three general criteria:

(1) Obtain or use consumer reports in connection with a credit transaction,
(2) Furnish information to consumer reporting agencies in connection with a credit transaction, or
(3) Advance funds to, or on behalf of someone, except for funds for expenses incidental to a service provided by the creditor to that person.

Creating an Identity Theft Prevention Program

Your Identity Theft Prevention Program is a "playbook" that must include reasonable policies and procedures for detecting, preventing, and mitigating identity theft.

(1) Your Program must include reasonable policies and procedures to identify the "red flags" of identity theft you may run across in the day-to-day operation of your business. Red flags are suspicious patterns or practices, or specific activities that indicate the possibility of identity theft. For example, if a customer has to provide some form of identification to open an account with your company, an ID that looks fake would be a "red flag" for your business.
(2) Your Program must be designed to detect the red flags you've identified. For example, if you've identified fake IDs as a red flag, you must have procedures in place to detect possible fake, forged, or altered identification.
(3) Detail your appropriate response to any red flags you detect to prevent and mitigate identity theft.
(4) Detail how you will administer your program, including how the program will be updated periodically to reflect changes in risks from identity theft.

Putting it into action

Just getting something down on paper won't reduce the risk of identity theft. That's why the Red Flags Rule sets out requirements on how to incorporate your Program into the daily operations of your business. Your board of directors (or a committee of the board) has to approve your first written Program. If you don't have a board, approval is up to an appropriate senior-level Employee. Your Program must state who's responsible for implementing and administering it effectively. Because your Employees have a role to play in preventing and detecting identity theft, your Program also must include appropriate staff training. If you outsource or subcontract parts of your operations that would be covered by the Rule, your Program also must address how you'll monitor your contractors' compliance.

