Employee Benefits Report

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Happy Birthday, FMLA?

2013 marks the 20th anniversary of the Family and Medical Leave Act, or FMLA.

Congress passed the Family and Medical Leave Act (FMLA) in 1993 to help employees retain job rights while coping with the serious illness of themselves or a family member.

When signed into law by President Bill Clinton, the law allowed workers to take up to 12 weeks of unpaid leave to bond with a newborn, newly adopted or newly placed child; care for a seriously ill child, spouse or parent; or care for their own serious health condition without fear of losing their jobs. Subsequent amendments also allow workers to take time away from work to attend to situations arising from a parent, spouse, or child's foreign military deployment, and up to 26 weeks of leave to care for a family member in the armed services with a serious injury or illness.

Earlier this year, the U.S. Department of Labor released a nationwide survey of employers and employees on leave taking under the FMLA. The survey found that:

- Nearly 60% of employees meet all criteria for coverage and eligibility under FMLA.
- 13% of all employees re-

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This Just In…

In March, the U.S. Department of Health and Human Services (HHS) proposed delaying employee choice in the Small Business Health Options Program (SHOP). Affordable Care Act implementing regulations originally called for the SHOP to begin allowing employees of small employers to select their own coverage on an insurance exchange in 2014. The HHS's proposed rule would delay the opening of employee choice in SHOPS until 2015. Health insurers will still offer plans to small businesses through exchanges, although employers, rather than employees, will select plans.

ACA establishment rules required the SHOP to give employers the option of offering employees all qualified health plans (QHPs) at a level of coverage chosen by the employer. HHS now proposes that for

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ported taking leave for a FMLA reason in the past 12 months.

- 91% of employers report that complying with the FMLA has had either a positive effect or no noticeable effect on employee absenteeism, turnover and morale.
- Fewer than 2% of covered worksites reported confirmed misuse of FMLA.
- Fewer than 3% of covered worksites reported suspicion of FMLA misuse.
- Less than one-quarter (24%) of FMLA leave is intermittent leave.
- Fewer than 2% of employees who take intermittent leave are off for a day or less.

Compliance

Although 85 percent of employers reported that complying with the FMLA is very easy, somewhat easy, or has no noticeable effect, noncompliance can result in penalties. Employers subject to FMLA should understand the rules and ensure their leave procedures comply. The following brief refreshermight help:

Employers subject to the FMLA: Employers that employ at least 50 employees within a 75-mile radius.

Required postings: Covered employers must display a poster summarizing the major provisions of the FMLA, available at www.dol.gov/whd/regs/compliance/posters/fmlaen.pdf.

Eligible employees: Employees who have been employed by the employer for at least one year and worked at least 1,250 hours in the current or previous calendar year.

Allowable reasons for leave: The employee's own serious health condition, a serious health condition of an immediate family member, or the birth or adoption of a child.

Maximum leave allowed: 12 workweeks during the year. Employees do not have to take leave all at once—they can take time in increments as small as the lowest increment used by the employer's payroll system.

Advance notice required: Employees must provide 30 days' advance notice of the need to take FMLA leave when foreseeable. Employees who qualify for FMLA leave do not have to provide advance notice in unforeseeable circumstances, such as an accident or sudden illness. In that case, they should provide notice as soon as possible, and comply with the employer's normal call-in procedures. When employees need to take intermittent leave for an ongoing or chronic condition, they don't have to provide advance notice, either. For example, a migraine sufferer could leave work whenever he gets a headache.

Notice after leave required: Eligible employees must notify the employer within two days after taking time off if they want leave to qualify for FMLA leave. The employer must track time taken. The U.S. Department of Labor provides optional forms you can use for this and other FMLA administrative tasks at its website, www.dol.gov/compliance/laws/comp-fmla.htm#etools.

Health benefits: An employer that provides group health coverage must continue coverage for an employee on FMLA leave on the same terms as for active employees, including providing family coverage if it does so. The employee will continue to make any normal contributions toward health insurance. If the leave is unpaid, the employee must pay his/her share of premium, unless the employer opts (at its discretion) to pay premiums for all employees on FMLA leave. If an employee decides not to continue health insurance coverage during leave, the employer must reinstate coverage on the same terms as before the leave without any qualifying period, physical examination, exclusion of pre-existing conditions, etc.

Other benefits: An employee's rights to benefits other than group health insurance (including any employer contributions to retirement plans) while on FMLA leave depend upon the employer's established policies. Any benefits that would be maintained while the employee takes other forms of leave, including paid leave if the employee substitutes accrued paid leave during FMLA leave, must be maintained while the employee is on FMLA leave.

Job continuation benefits: The FMLA requires the employer to return an employee coming back from FMLA leave to the same or an equivalent position. ■

plan years beginning before January 1, 2015, a SHOP would not be required to offer employees of qualified employers a choice of QHPs but would have this option. For plan years beginning before January 1, 2015, federally facilitated SHOPs (FF–SHOPs) would instead assist employers in choosing a single QHP to offer their qualified employees.

The U.S. Small Business Administration also recently reminded employers that they can use their existing broker to access health plans on an exchange.

GAO Report Highlights Problems with 401(k) Rollovers

When employees leave your organization before retirement age, they must either roll funds from your 401(k) into another retirement plan or IRA or pay taxes and a hefty penalty. The rollover option they select can greatly affect their retirement savings over the long term.

A 401(k) participant leaving his/her employer can roll funds into another employer's 401(k) or defined benefit plan, a 457(b) government or 403(b) nonprofit retirement plan, a Roth individual retirement account (IRA), traditional IRA, or designated Roth plan. But plan participants who want to do a rollover encounter obstacles, such as waiting periods under the new employer plan, complex verification procedures to ensure savings are tax-qualified, wide divergences in plans' paperwork, and inefficient practices for processing rollovers. These make IRA rollovers an easier and faster choice, especially given that IRA providers often offer assistance to plan participants when they roll their savings into an IRA.

Although IRAs are the easiest choice, they might not be the best. When employees roll their funds into an IRA, they miss out on the employer match and other advantages of an employer-sponsored plan, such as economies of scale, the plan sponsor's easier access to expertise in fund management and retirement education options available under an employer-sponsored plan.

In March, the U.S. Government Accountability Office released a report suggesting improvements to the rollover process for 401(k) participants. The GAO conducted the study in response to a request by several congressional representatives who were concerned about the number of participants who opted to roll their funds into IRAs instead of options that could be more in their interest.

GAO was asked to identify challenges plan participants who leave their jobs may face in (1) implementing rollovers; (2) obtaining clear information about which option to choose; and (3) understanding distribution options.

To help plan participants make better choices, the GAO recommended the following actions:

1. Have the Secretary of Labor clarify the Employee Benefits Security Administration (ERISA) definition of fiduciary. This would require plan service providers, when assisting participants with distribution options, to disclose any financial interests they may have in the outcome of those decisions.
2. Have the Secretary of Labor develop a concise written summary explaining a participant's four distribution options and listing key factors a participant should consider when comparing possible investments. Require sponsors to provide that summary to a participant upon separation from an employer. Should Labor conclude that additional statutory authority is needed to take this action, it should seek that authority from the Congress.
3. Have the Commissioner of Internal Revenue and Secretary of Labor identify obstacles and disincentives to leaving funds in a 401(k) by reviewing policies that affect separating employees who leave retirement savings in an employer's plan and the process of plan-to-plan rollovers. As part of such a review, the Commissioner of Internal Revenue should revise rules

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that allow plans and providers to send direct-rollover distribution checks to individuals rather than to the receiving entities to which the checks are written.

4 The Commissioner of Internal Revenue and the Secretary of Labor should work together to communicate to plan sponsors IRS's guidance on the relief from tax disqualification provided for plans that accept rollovers later determined to have come from a plan that was not tax qualified.

5 The Commissioner of Internal Revenue and the Secretary of Labor should review the lack of standardization of sponsor practices related to plan-to-plan rollovers and of policies affecting participants who leave plan savings in a former employer's plan, with the aim of taking any regulatory action they deem appropriate. Such action could address obstacles like sponsors refusing to accept rollovers from other plans, and disincentives like plans restricting participants' control over savings once they separate from the employer, and charging different fees for inactive participants.

Some benefit experts have cautioned that increasing a plan administrator or sponsor's fiduciary responsibilities could have a chilling effect on their willingness to provide any type of education that might be construed as advice. For more information on educating your employees about their 401(k) benefits or administering your 401(k) plan, please contact us. ■

The DOMA Case and Your Benefits

As this issue went to press, the U.S. Supreme Court was considering two cases involving same-sex marriage. The court's decision could have implications for employers' payroll and benefits administration.

Background

Enacted in 1996, the federal Defense of Marriage Act (DOMA) defines "marriage" under any federal law, rule or regulation exclusively as "a legal union between one man and one woman as husband and wife" and "spouse" exclusively as "a person of the opposite sex who is a husband [or] wife."

Currently, nine states (Connecticut, Iowa, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont, and Washington) and the District of Columbia allow same-sex marriage. Delaware, Hawaii, Illinois and Rhode Island have civil union laws, and a civil union law is due to go in effect in Colorado on May 1. In these states, same-sex partners who undergo a civil union have essentially the same rights and privileges as married partners.

Other states, including California, Oregon and Nevada allow domestic partnerships, which gives registered domestic partners (whether between people of the same sex or opposite sexes) most of the rights and privileges of married partners.

In these states, conflicting definitions of spouse or partner can create confusion for employers in administering their payroll, benefit and leave programs.

Programs Affected

In general, state laws govern insured benefits, including health insurance, disability and life benefits, and workers' compensation. Although ERISA, the federal law governing employee benefits, pre-empts state law, it only requires employer-sponsored plans to meet certain minimum standards. States are free to enact laws requiring employers to provide benefits that exceed ERISA stan-

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dards. (Witness the many "state-mandated" benefits included in health insurance policies.) Self-insured plans, however, are usually exempt from these requirements.)

However, certain benefits, such as family leave under the Family and Medical Leave Act (FMLA), health insurance continuation rights under COBRA, and health plan enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) were created by federal law. Thus, the federal definition of "spouses" as a man and woman only would apply.

IRS Code governs taxation of benefit plans. This includes employer-provided medical plans, health reimbursement arrangements (HRAs), flexible spending accounts (FSAs) and health savings accounts (HSAs). Since federal law does not recognize same-sex spouses, any benefits received by a same-sex spouse under these plans would not qualify for preferential tax treatment and would be included in taxable income.

In addition, same-sex spouses cannot receive benefits, or a portion thereof, from an employee's retirement plan under a qualified domestic relations order (QDRO). And unlike opposite-sex spouses, they cannot delay minimum distributions from a deceased spouse's employer retirement plan until age 70½. They must begin taking minimum distributions within a year of the employee's death or take full payment within five years.

The Cases

Hollingsworth v. Perry: This case arrived at the Supreme Court on appeal from the Ninth Circuit Court of Appeals, which found California's Proposition 8 discriminatory. Prop. 8 amended the state's constitution to define "only marriage between a man and a woman [as] valid or recognized in California." The Supreme Court's decision in Hollingsworth will likely directly affect employers in California only.

Windsor v. United States: Also known as the "DOMA case," this case involves involves Section 3 of DOMA, or the definition of marriage for federal purposes. Even if the Supreme Court rules Section 3 unconstitutional, DOMA's Section 2 would remain intact. This section preserves the states' rights to govern marriage by stating, "No State, territory, or possession of the United States, or Indian tribe, shall be required to give effect to any public act, record, or judicial proceeding of any other State, territory, possession, or tribe respecting a relationship between persons of the same sex that is treated as a marriage under the laws of such other State, territory, possession, or tribe, or a right or claim arising from such relationship."

Facts

- If the Supreme Court strikes down DOMA, it will affect insured employer-sponsored benefits only in states where same-sex marriage is legal. ERISA, a federal law, regulates self-insured plans, so the federal definition of marriage would apply to these plans.
- If the Supreme Court strikes down DOMA, employers with insured plans will not have to provide benefits to same-sex partners in states that do not allow same-sex marriage or recognize same-sex marriages performed in other states. Employers do not have to provide spousal benefits in any state; employers that prefer not to provide benefits to same-sex partners can opt not to provide benefits to any spouses.
- If the Supreme Court upholds DOMA, that will not prevent employers from voluntarily providing benefits to same-sex spouses (or domestic partners, if they so choose). Benefit recipients might have tax liability for the value of these benefits, however.

Bottom line: in states where same-sex marriage is legal, employers might have to change their spousal benefit offerings if the Supreme Court overturns DOMA's definition of spouse. For more information on the various laws and regulations affecting administration of your benefit plans, please contact us. ■

Critical Illness Coverage Growing in Popularity

The number of critical illness policies in force nearly doubled between 2008 and 2011, found the annual Gen Re/National Association for Critical Illness Insurance Market Survey. During that time, total benefits insured by those policies grew from $4.96 billion to $8.7 billion.

The surveys only account for sales among companies responding to the survey—total U.S. critical illness policy numbers are likely much higher. Why is critical illness coverage growing so rapidly?

Some of the trends that have made critical illness benefits more attractive include employer health policies that provide more limited benefits and higher employee contributions. These trends are likely to continue for the foreseeable future. Particularly as more employers shift toward consumer-driven health plans (CDHPs), critical illness policies provide flexible benefits that help employees better manage their health and financial needs.

What exactly is critical illness insurance? A type of health insurance, a critical illness policy provides benefits when an insured develops a serious health condition, such as cancer, heart attack or stroke. Illnesses covered under the policies vary, but can include Alzheimer's, paralysis, coma, multiple sclerosis and loss of hearing. Unlike your group medical plan, which reimburses healthcare providers for services they provide on behalf of insured individuals, the critical illness policy pays a lump sum directly to the insured upon diagnosis. The insured can use policy proceeds for anything he or she chooses—co-payments, travel costs, experimental treatments or even to replace wages of a family member leaving work to provide support.

Critical illness costs much less than major medical coverage. Maximum benefits under critical illness policies typically average around $25,000, with premiums costing about $300 to $500 annually, depending on the health, gender, age and location of the insured. Higher-end policies covering a dozen or more conditions generally pay benefits of more than $100,000 and cost about $1,500 to $2,000 a year.

Critical illness policies cannot replace a major medical plan; they simply supplement coverage available under your medical and disability plans. We can write policies on an employer-paid or entirely employee-paid (voluntary) basis. For more information, please contact us. ■

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