Employee Benefits Report

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Human Resources/Compliance October 2014 Volume 12 • Number 10

Avoiding Pregnancy Discrimination Claims

The EEOC has had pregnancy discrimination on its radar screen for a while. A Supreme Court case, *Young v. UPS*, will likely bring more attention to the issue.

Many laws and regulations affect pregnancy and discrimination, disability, leave and accommodations. With women now comprising 47 percent of the U.S. labor force, at some point your HR department will likely have to determine how they apply to one of your employees.

The Pregnancy Discrimination Act (PDA) of 1978 extended protections under Title VII of the Civil Rights Act of 1964 to women who are pregnant or have related medical conditions. This makes employment discrimination based on pregnancy, childbirth or related medical conditions a prohibited form of sex discrimination. The PDA applies to all areas of employment: hiring, determining promotions, qualifying for benefits and allowing accommodations for pregnancy-related disability.

What Employers Need to Know

You probably already know that you cannot take "adverse employment actions" against an employee due to her pregnancy or possibility of becoming pregnant. That includes firing or failing to promote, and failure to hire someone on the basis of pregnancy (or the possibility of becoming pregnant). But you might not know some of the other actions that the EEOC considers discrimi-

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This Just In…

Will the Affordable Care Act (ACA) end "job lock"? Job lock occurs when people stay in jobs they don't want because they need health insurance and can't find affordable coverage on their own. If the ACA makes the cost of individual coverage comparable to coverage under employer plans, how will that affect your labor force?

In 2013, the National Bureau of Economic Research estimated that between 500,000 and 900,000 people might exit the labor market due to the Affordable Care Act. Forty percent of employed workers said they would quit their jobs if they could buy health insurance on their own that compared to their employer's plan in cost and coverage.

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natory. Here's a partial list from a recently issued EEOC guidance:

Light-Duty Work:

- An employer has to provide light duty, alternative assignments, disability leave or unpaid leave to pregnant workers if it does so for other employees who are similar in their ability or inability to work.
- An employer may not limit a pregnant worker's access to light duty based on the source of her impairment (e.g., it may not deny light duty to a pregnant worker based on a policy that limits light duty to employees with on-the-job injuries).
- However, if an employer's light duty policy restricts the number or duration of light duty assignments, the employer may lawfully apply those restrictions to pregnant workers, if it applies the same restrictions to other workers.

Job Restrictions: An employer cannot restrict a pregnant woman from certain job duties, such as working with hazardous chemicals, unless it also restricts non-pregnant employees. This applies even if the employer is trying to avoid fetal injury and has the employee's best interests at heart.

Leave:

- Employers cannot compel an employee to take leave because she is pregnant, as long as she is able to perform her job. However, they must allow women with physical limitations resulting from pregnancy to take leave on the same terms and conditions as other similarly situated individuals.
- Employers cannot require employees disabled by pregnancy or related medical conditions to exhaust their sick leave before using other types of accrued leave, unless they impose the same requirements on employees seeking leave for other medical conditions.
- Employers cannot impose shorter maximum leave periods for pregnancy-related leave than for other types of medical or short-term disability leave.
- Title VII does not require or allow an employer to provide more favorable leave terms to pregnant employees than it does to other employees. For example, an employer cannot provide six months' paid parental time for mothers to bond with their new babies if it does not also provide similar benefits for fathers.

Disability/ADA Accommodations: Pregnancy on its own never creates a disability that triggers an employer's responsibilities under the Americans with Disabilities Act (ADA). If an employee develops a pregnancy-related disability, you must treat her the same as you would any other disabled worker. That means providing "reasonable accommodations" that allow her to continue to work. It also means allowing—but not requiring—pregnant employees to use leave available under the Family and Medical Leave Act (FMLA) and other leave laws.

Do You Have the Right Kind of Insurance?

In 2011, the U.S. Equal Employment Opportunity Commission (EEOC) received 5,797 complaints of pregnancy discrimination. Claimants received $17.2 million in benefits that year. This does NOT include money they received from litigation, which could total many millions more.

More than half (56 percent) of respondents said they had considered leaving their jobs but didn't want to give up their health insurance.

The survey sponsor, Securian Financial Group, also found that an overwhelming majority of employees (83 percent) were very or somewhat satisfied with their employer's health plan.

The moral for employers? Employees value their health benefits, and they play an important role in employee retention. For more information on benefit design, please contact us.

It therefore pays to know the employment laws that apply to any given situation. If you don't, please consult an employment practices attorney.

Because employment law is always changing, it also pays to protect your organization with employment practices liability insurance, or EPLI. Your commercial general liability or business owner's policy excludes coverage for employment-related actions. EPLI coverage fills this important gap. It covers your legal defense costs if an individual brings a discrimination or other employment practices claim against the firm, plus any resulting legal settlements.

Buying EPLI coverage also gives you access to expertise that smaller firms usually lack. When you file a claim, your insurer will assign an attorney who has expertise in that type of claim to your case. This will help bring your case to resolution sooner, so you can get back to business. For more information on EPLI or avoiding other compliance problems, please contact us. ■

Critical Illness Fills a Benefits Gap

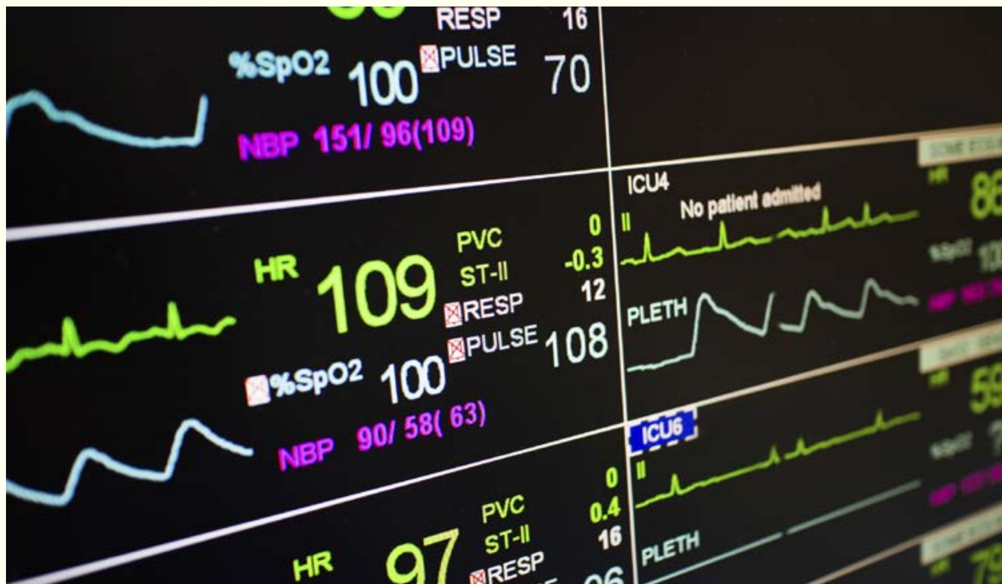
Sales of critical illness insurance grew 90 percent (in premiums) between 2011 and 2012. Yes, 90 percent. Perhaps it's time to consider adding critical illness insurance to your benefits portfolio.

Critical illness plans have only been available in the U.S. since the mid-1990s. They were rather slow to take off at first, but the growth of high-deductible health plans (HDHPs) and increasing medical costs have changed that.

Why Your Employees Need Critical Illness Insurance

People of working age experience critical illnesses. In fact, people age 55 and under filed nearly half (47 percent) of critical illness claims in 2011. The study, by the American Association for Critical Illness Insurance (AACII) and General Re Life Corporation, also found that roughly 13 percent of policyholders who received critical illness benefits were younger than 45.

Having medical insurance can protect your employees from some of the costs of a major medical problem or serious accident. However, it doesn't eliminate the problem. Deductibles and copayments may apply when an insured becomes ill. After a critical illness, many individuals face huge out-of-pocket health costs.



More employees today are living paycheck to paycheck. This makes any emergency a potential financial disaster. While most major medical plans limit what a member must pay for out-of-pocket medical expenses every year, HDHPs place these limits relatively high. In 2014, a family in an HDHP can pay as much as $12,700 for covered medical expenses before their health plan will pay 100 percent.

What does this mean, in real terms, for a family with health coverage through an HDHP? In a bad year, health expenses could look something like this:

Annual deductible: $2,500*
+ Balance of coinsurance paid at 50-90%,
+ copays, up to $10,200
= Annual out-of-pocket expenses: $12,700 (family plan)**

Of course, this doesn't include other costs related to illness, such as payments for uncovered medical and alternative medicine treatments, transportation to and from medical appointments and income lost due to lost work time. It also doesn't cover any employee contribution to premiums, which would have to continue while the employee recuperates.

High Deductibles + Copayments + Lack of Emergency Funds = Financial Stress.

In a recent survey, 86 percent of employers

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said that financial stress among employees led to absenteeism, decreased productivity and increased distraction in the past year.

Critical illness policies can help employees bridge the gap between their healthcare bills and what their health plan pays. These policies typically pay benefits in a lump sum, per diagnosis. When an employee receives a diagnosis of a covered illness, he or she can use policy benefits to:

- Cover deductibles.
- Cover copayments before the health plan's out-of-pocket maximum kicks in.
- Cover out-of-pocket expenses.
- Pay for uncovered medical expenses, including experimental and alternative treatments.
- Cover medical transportation costs.
- Replace income lost due to illness.
- Pay for home healthcare, or replace the income a family member loses to provide care.
- Pay for modifications to living space, such as widening doors to accommodate a wheelchair, etc.

Critical Illness Insurance vs. Health Insurance

Critical illness policies differ from health insurance in several important ways.

- First, they pay benefits only when the insured is diagnosed with a critical illness specifically listed in the policy. Health plans, on the other hand, cover all illnesses and injuries unless the policy explicitly excludes them.
- Most policies will pay a lump sum benefit. When insured employees receive a diagnosis or treatment for one of the covered diseases or "benefit triggers" specified in the policy, they can file a claim. Depending on the particular benefit trigger, the payment could range from 50 to 100 percent of the policy's face value.
- Critical illness insurance pays benefits directly to the insured. This differs from a health or major medical policy, which will reimburse healthcare providers when an insured obtains covered services. Policyholders can decide how they use their critical illness benefits themselves.
- Critical illness insurance cannot substitute for a major medical plan. It does not provide comprehensive medical coverage. Rather, it gives insureds the extra financial assistance they need when they suffer a serious illness.

The conditions covered by critical illness insurance vary by policy. The vast majority of policies cover heart attack, stroke and cancer. Some also cover coronary artery (bypass) surgery, kidney failure, major organ transplant, paralysis, blindness, multiple sclerosis, heart valve replacement and surgery of the aorta, according to the American Association of Critical Illness Insurance (AACII).

Like major medical policies, critical illness policies usually have exclusions or waiting periods on pre-existing conditions. Employers can offer coverage on an employer-paid basis to cover gaps in their group health plan. However, many employers offer critical illness insurance on a voluntary (employee-paid) basis. For more information, please contact us.

Your Reporting Responsibilities

The Affordable Care Act (ACA) requires certain employers to provide "minimum essential" health coverage to their full-time employees. It also requires them to make certain reports.

W-2 Reporting

The ACA requires employers that provide health coverage to calculate and report the cost of that coverage on employees' W-2 forms. The IRS will use this information to track "Cadillac" health plans, which will be subject to a 40 percent excise tax beginning in 2018.

Which employers need to make W-2 reports? Employers that file 250 or more Forms-W2 must report the cost of health coverage they offer to full-time equivalent employees. The requirement was supposed to apply to all employers with 50 or more full-time equivalent employees. However, the IRS delayed this requirement for smaller employers due to employer outcry. The requirement will go into effect for employers with 50-250 employees when the IRS issues final regulations. Until then, reporting for these employers remains optional.

Employers must report the value of the following employer-sponsored benefits, whether provided through a fully insured or self-insured plan:

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- Major medical coverage
- Amounts received under health reimbursement arrangements (HRAs)
- Employer contributions to a health savings account (HSA) or Archer medical savings account (MSA)
- Employer-provided Medicare Advantage plans
- The value of treatment from on-site medical clinics, except for "de minimis" care
- Limited benefit plans

Employees' salary reduction contributions to health flexible spending arrangements (FSAs) are exempt, as are stand-alone vision or dental insurance, long-term care insurance, hospital indemnity and cancer or "dread disease" coverage (if the employee pays with after-tax dollars), and accidental death and disability insurance.

Self-insured employers calculate the value of coverage using rules similar to those that apply to calculating COBRA continuation coverage premiums. Employers with insured plans simply report the premium the insurer charges to cover that employee during the reporting period.

Although this information appears on employees' Forms W-2, these amounts are not taxable income. Employers can use the updated W-2s to reinforce to your employees the value of their health benefits.

Minimum Essential Coverage Reporting

The ACA also requires individuals to prove they have qualifying "minimum essential coverage" beginning in 2014. Individuals who do not have qualifying coverage must pay an "individual shared responsibility payment," or penalty, with their taxes. To help individuals prove their compliance, health plans and self-insured employers that provide minimum essential coverage must file reports.

The Affordable Care Act's "employer mandate" requires "large employers" (those with 50 or more full-time equivalent (FTE) employees) to provide minimum essential coverage to all full-time employees or pay a penalty. Coverage must also meet certain affordability standards.

The forms: In August 2014, the IRS re-released the forms health plans and employers must use to report the minimum essential coverage they offer (or don't). Form I094-C is a transmittal form. Employers will submit this form to the IRS with information about the employer itself, the coverage it provided and when it provided it. Employers will also list full-time employees and the months during which, if any, they had coverage under an employer-sponsored plan.

Large employers will also have to complete a Form 1095-C for each full-time equivalent employee. Self-insured employers must complete this form for any individual, including part-time employees and employee family members, who enrolled in the self-insured plan. Employers will provide a copy to the IRS and to each applicable employee.

Employees will use Form 1095-C to prove they had qualifying minimum essential coverage and to file an accurate tax return. They can also use it to claim a tax credit for insurance coverage, if eligible.

The deadlines: Employers with 100+ employees will file Forms 1094-C and 1095-C with their 2015 tax return, in early 2016. To be ready, these employers should begin developing systems for tracking and reporting now.

The IRS has recently released draft forms and instructions. You can find copies at the IRS website. However, the IRS cautioned that filers should not use or rely on the draft forms or instructions.

For more information on your responsibilities under the ACA, please contact us.

Retirement Plan Basics

Virtually all retirement plans fall into one of two categories: defined contribution plans or defined benefit plans. Here's a review of these two types of plans.

Defined contribution plan: A defined contribution plan provides each participant with an individual account. Retirement benefits depend on the amount contributed to that account, and how the contributions are invested. If investments perform well, benefits will be higher. A defined contribution plan can be a profit-sharing plan or a money purchase plan invested in stock or mutual funds. 401(k)s are a very popular example of a defined contribution plan.

Defined benefit plan: These so-called "traditional" plans promise participants a specific benefit at retirement. Plans express this as an exact dollar amount or a formula. A plan might provide a flat dollar amount per month, or a monthly amount for every year of service with the company, or a percent of a worker's salary times years of service. Generally, a company funds the pension plan and plan assets are invested, usually by a professional money manager.

Cash balance plans, often called hybrid plans, are defined benefit plans. These plans express retirement benefits as a balance in a hypothetical account. A worker accumulates pay credits (usually a percentage of pay) and interest credits (usually a percentage of the total account balance). The interest credit is frequently based on the interest rate on a U. S. Treasury security. The pay and interest credits, specified in the plan, resemble the actual contributions and earnings a worker accumulates under a 401(k) plan.

Cash balance plans contain many of the important advantages of traditional defined benefit plans:

- Benefits do not depend on how much a worker is willing or able to contribute.
- The employer bears the investment risk.
- Plans must offer an annuity with a survivor benefit.
- Benefits are insured by the PBGC.
- They offer a predictable benefit at retirement.

Cash balance plans also have advantages of defined contribution plans:

- They are easier to understand.
- They often provide higher benefits for younger workers and shorter-service workers, who are often women.
- They offer benefits that are more portable than a defined benefit plan.

For more information on selecting and administering a retirement plan, please contact us.

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