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Employee Benefit Compliance Developments 2018

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IRS Employer Shared Responsibility Payment (ESRP) Letters

2018 IRS ESRP Letters

Issue: In 2018 the IRS started penalizing large employers for not providing ACA affordable, minimum value coverage to full time employees in 2015.

Range from $134,000 to $1.7 million

List of employees who triggered the penalty by their receipt of a premium subsidy or tax credit.

30 days to respond from the date of the letter

IRS has been good about granting 30 day extensions.

Positive impact of President Trump's **January 20, 2017 Executive Order** directing federal agencies (i.e. IRS) to exercise authority and discretion available to them to reduce potential burden on individuals and employers subject to the ACA.

2018 IRS ESRP Letters

- Generic Response. Be organized. Be concise.
- Contact your broker/payroll provider
- Collect 2015 Open Enrollment kit, W-2s for referenced employees, 1094-C for 2015, 1095-C forms for referenced employees, DOL Form 5500. Use them as exhibits in your appeal.
- What was the employment history for the referenced employees during 2015? Start date? Termination date? Eligibility? Waiting period?
- Investigate possible coding errors on Forms 1094-C and 1095-C
- Most common errors: Wrongly stating on 1094-C that coverage was not offered in 2015…incomplete coding of forms 1095-C for referenced employees.
- Do the math! Assess whether coverage was affordable (9.5%) for the referenced employee. Did you have 2015 transitional relief?

Massachusetts: Beware of Emergency Medical Assistance Contribution (EMAC) Penalties.

What is an EMAC Penalty and Why Is An Employer Subject To it?

The Massachusetts legislature started the EMAC fee in 2014 after it repealed the employer mandate under Massachusetts Health Care Reform.

In late 2018, because of a significant budget shortage for the state's support of its MassHealth Medicaid program, the annual EMAC fee was increased last fall from .34% on the first $15,000 of an employee's wages which caps out at $51 per employee per year to .51%, or $77 per employee per year starting on January 1, 2018.

The Massachusets' legislature also created a new $750 annual "supplement" for employers to pay for every employee who enrolled in MassHealth. The supplement is scheduled to expire at the end of 2019.

Important: The EMAC legislation and subsequent regulations define the word "employee" very broadly to include any employee for whom the employer pays any unemployment assistance coverage. Employers would have learned about any "supplemental" EMAC assessments when they received their first 2018 quarterly bill from the DUA.

Change in Employee Affordability Index from 9.69%(2017) to 9.56%(2018) to 9.86 (2019)

Change in Affordability Index from 9.69% to 9.56% for 2018 and to 9.86% for 2019 Plan Year

Coverage offered by a large employer is “affordable” if the employee cost for self-only coverage is not more than 9.5% of household income or of one of the three affordability safe-harbors **(W-2, Rate of Pay, FPL**).

Affordability is inflation adjusted each year. Currently 9.69% for 2017.

IRS Rev. Proc. 2017-36 (May 4, 2017) confirms that the 2018 inflation adjustment will be reduced to **9.56%.**

This will put additional pressure on employers in the face of rising healthcare costs. Employees will pay less premium %, employers will pay more % of rising healthcare premium.

NOTE: IRS recently announced in IRS Rev. Proc. 2018-34 that affordability metric will be 9.86%

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IRS Releases New Forms 1094-C and 1095-C

2018 1094-c and 1095-C Forms

- Guidance released in September
- January 31, 2019: Form 1095s need to be provided to individuals
- February 28, 2019: Paper filings with the IRS are due. This is an option for employers with less than 250 Form 1095Cs.
- April 1, 2019: Electronic filings with the IRS are due. While all employers can file electronically, it is required by employers with 250+ Form 1095Cs.
- **Extensions**
- You can get an automatic 30-day extension of time to file by completing Form 8809, Application for Extension of Time To File Information Returns. The form may be submitted on paper, or through the FIRE System either as a fill-in form or an electronic file. No signature or explanation is required for the extension. However, you must file Form 8809 on or before the due date of the returns in order to get the 30-day extension. Under certain hardship conditions you may apply for an additional 30-day extension.

FMLA Paid Leave Tax Credit…More Sizzle than Steak for most Employers

FMLA Paid Leave Employer Tax Credit

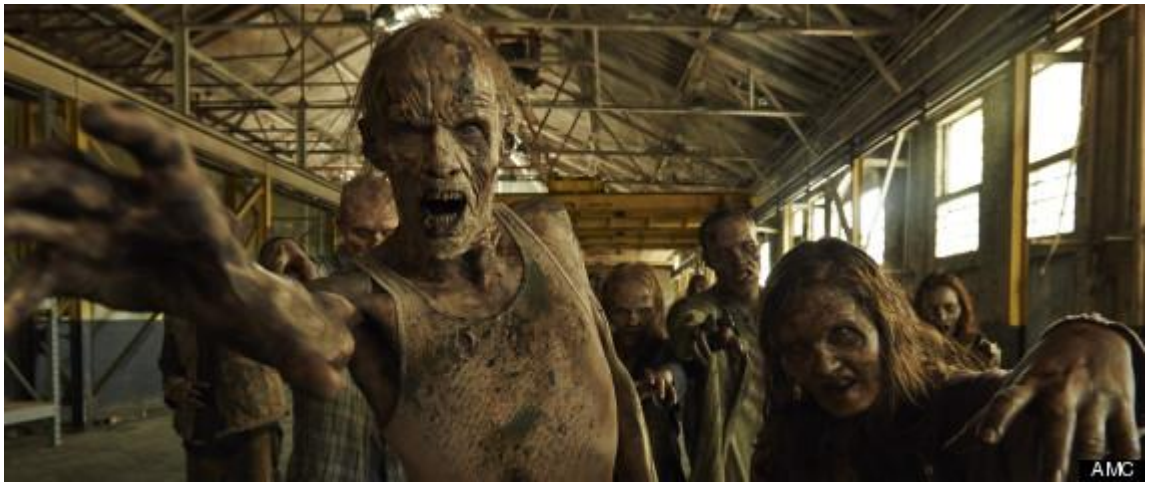
- An employer must allow all “qualifying” full-time employees not less than two weeks of annual paid family and medical leave (and a commensurate amount of leave on a pro rata basis for less-than-full-time employees.
- The leave program must provide for at least 50% of the wages normally paid to an employee.
- Deal killer for most employers? Vacation leave, personal leave, or other medical or sick leave would not be considered family and medical leave. Leave paid for or mandated by a state or local government is not taken into account.

FMLA Paid Family Leave Employer Tax Credit

- **Which Employees are Eligible**?
- A “qualifying” employee is an employee who has been employed by the employer for one year or more, and who for the preceding year, had compensation not in excess of 60% of the compensation threshold for highly-compensated employees ($120,000 for 2018).
- **How Big is the Employer Tax Credit?**
- A general business tax credit equal to 12.5% of the wages the employer pays to qualifying employees when the employee takes “family and medical leave.” The credit will increase by a quarter percentage point for every percent above the 50% rate the employer pays the employee on leave, up to a maximum tax credit of 25% if the employer pays the employees 100% of their regular wages. This credit is available for up to 12 weeks of paid leave per employee per year

Wellness Plans: Update

Wellness Plans: The Invasion of the EEOC Regulators and Courts



A. Regarding Wellness: What the ACA Clearly Provides.

A plan sponsor can use up to a 30% reward/discount or penalty/surcharge associated with a health standard based wellness program.

A plan sponsor can use up to a 50% reward/discount or penalty/surcharge

associated with a health standard program.

Wellness Plans: The Invasion of the EEOC Regulators

B. The 2015 EEOC Wellness Litigation Onslaught

EEOC v. Honeywell (Minn. 2014)

If an employee did not complete biometric testing, the employee would be required to pay a $1,500 premium surcharge for health coverage and would not be eligible for contributions (up to $1,500) that the employer would otherwise make to the employee's health savings account.

If an employee's spouse also did not complete the biometric testing, the employee would be required to pay another $1,000 surcharge for health coverage.

Court denies EEOC's request for TRO and injunctive relief.

Wellness Plans: The Invasion of the EEOC Regulators

EEOC v. Flambeau (ED Wisc. 2015) (EEOC appealed to the 7th Circuit)

Court holds that that an employer did not violate the ADA by requiring its employees to participate in a wellness program, including by undergoing health risk assessments and biometric screenings, as a precondition of participating in the employer's health insurance plan.

ADA "safe harbor" for benefit plans applies.

EEOC v. Orion (ED Wisc. 2015)

The employer paid 100 percent of the cost of the health plan for employees who completed an HRA and a fitness test.

If an employee did not complete an HRA, the employee was required to pay the full cost of the health plan premium.

If an employee did not complete the fitness test, the employee was penalized $50.

Summary judgment briefs filed. No decision yet.

Wellness Plans: The Invasion of the EEOC Regulators

Seff v.Broward County (11th Circuit, 2012)

An employee complained about a program in which the employer deducted $20 per biweekly paycheck from any employee who did not complete an HRA and biometric screening.

Seff court sided with Broward County, relying on an exception under the ADA that provides that the rules on medical examinations do not prohibit employers from "establishing, sponsoring, observing or administering the terms *of a bona fide benefit plan that are based on underwriting risks, classifying risks or administering such risks that are based on or are not inconsistent with state law*."

The court reasoned that the wellness program fit within this exception because, among other reasons, the employer used aggregate data from the HRAs to classify various employee health risks and decide on the types of benefits that should be offered in the future to reduce plan costs.

Court recognizes that the ADA has a "safe harbor" /carve out for medical plans. Court concludes that a bona fide wellness program is a critical part of a medical plan and is exempt form EEOC oversight.

Wellness Plans: The Invasion of the EEOC Regulators

C. May 2016 Wellness Regulations: Effective Day 1 of the 2017 Plan Year

What Did the EEOC say about Flambeau, Orion and Broward County?

The safe harbor applies to actuarial based risk classification.

“The Commission believes that the cases were wrongly decided…the agency has the authority and responsibility to provide its own considered analysis of the statutory provision…”

Wellness Plans: The Invasion of the EEOC Regulators

EEOC Issues ADA/Wellness Regulations

Directed at wellness programs that require employees to ask disability related questions or undergo a medical examination to avoid a penalty/surcharge.

Wellness programs need to be “voluntary.”

New Notice and confidentiality requirements.

A program is not voluntary if it is coercive. A plan sponsor looks to the size of the incentive to determine if the plan is coercive.

Maximum incentive is 30% of the total cost of the lowest cost self only coverage if the wellness program is open only to the employee.

Example: Total cost of self only coverage is $6,000. Maximum incentive is $1800.

Wellness Plans: The Invasion of the EEOC Regulators

EEOC ADA/Wellness Regulations and smoking cessation programs

30% cap on incentives apply if there are disability related questions or a medical examination is required.

Can go up to 50% if simply asking the employee whether they are a smoker**.**

EEOC Issues Genetic Information Nondiscrimination Act (GINA) Regulations

Section 1635.8

Can offer an inducement to an employee whose spouse provides information about the spouses' health as part of a health risk assessment.

Cannot offer an inducement to an employee's spouse to provide information about his/her health as part of a health risk assessment.

Cannot offer an inducement to an employee to provide health information about their children.

Cannot condition access to coverage to employee or spouse on making them provide health related information. (No gatekeeper plans).

Wellness Plans: The Invasion of the EEOC Regulators

GINA and Inducements…

30% limit of the total cost of the lowest cost self only coverage on inducements for participation in Wellness program.

Example: Total cost of family coverage is $14,000, self only is $6,000.

If employee and spouse participate in wellness program, the max inducement for the employee is $1,800 and $1,800 for the spouse. (30% of $6,000).

If a health plan offers several self only coverage options, the 30% is based on the lowest cost option.

Wellness Plans

- Never mind….or….**TIME OUT EVERYBODY**!
- **AARP v. EEOC**. (2017-2018…DC Fed Crt)
- AARP challenges 30% cap under the EEOC regulations as not necessary in order for participation in the biometric testing or health risk assessment (HRA). Allegation that the 30% cap was not "voluntary" and was coercive, which violates ADA requirements.
- A federal court agreed with the AARP, and vacated the 30% incentive cap effective January 1, 2019. (Other provisions of the ADA regulations, including notification and confidentiality rules, remain in effect.) The court allowed the EEOC to publish new proposed regulations on the voluntary standard by August 31, 2018. **The EEOC advised the court that it will not publish new regulations!**

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Association Health Plans

Association Health Plans…Background

- October 12, 2017, President Trump issued Executive Order 13813, "Promoting Healthcare Choice and Competition Across the United States," stating that "[i]t shall be the policy of the executive branch, to the extent consistent with law, to facilitate the purchase of insurance across State lines and the development and operation of a healthcare system that provides high-quality care at affordable prices for the American people."
- To advance this policy, the Executive Order directed DOL to consider issuing regulations or revising guidance, consistent with law, that would expand access to more affordable health coverage by permitting more employers to form AHPs.
- The Executive Order specifically directed DOL to consider expanding the conditions that satisfy the commonality of interest requirements under existing DOL advisory opinions interpreting the definition of an "employer" under ERISA section 3(5) and also to consider ways to promote AHP formation on the basis of common geography or industry

Association Health Plans Regulations (June 2018)

- **DOL Purpose**: To allows small employers – many of whom are facing much higher premiums and fewer coverage options– ***a greater ability to join together*** and gain many of the regulatory advantages enjoyed by large employers.
- AHPs can *serve employers in a city, county, state, or a multi-state metropolitan area, or a particular industry nationwide*. Sole proprietors as well as their families will be permitted to join such plans. In addition to providing more choice, the new rule makes insurance more affordable for small businesses. Just like plans for large employers, these plans will be customizable to tailor benefit design to small businesses' needs. These plans will also be able to reduce administrative costs and strengthen negotiating power with providers from larger risk pools and greater economies of scale.
- Consumer protections and healthcare anti-discrimination protections that apply to large businesses will also apply to AHPs organized under this rule. As it has for large company plans since 1974, the Department's Employee Benefits Security Administration will monitor these new plans to ensure compliance with the law and protect consumers.

Association Health Plans Regulations…June 2018

- Expand the definition of “Employer: under ERISA.
- **PAST**: DOL historically has recognized that a group or association of employers may sponsor a single “multiple employer” plan, if certain factors are present.
- The key factors have been **commonality of interests** of employer members and control of the benefit arrangement by the employer members. These factors are present when an organized group or association of employers with common interests unrelated to the provision of benefits, acting in the interest of its employer members, establishes a benefit program for the employees of member employers.
- Past DOL guidance generally refers to these entities as “bona fide” employer groups or associations.

Association Health Plans

- What is “commonality of interests?”
- DOL Issue: Does the group or association has a sufficiently close ***economic or representational nexus*** to the employers and employees that participate in the plan? This “commonality of interest” standard is intended to distinguish bona fide groups or associations of employers that provide coverage to their employees and the families of their employees from arrangements that more closely resemble State-regulated private insurance offered to the market at large. *See, e.g.,* Advisory Opinion 94-07A; Advisory Opinion 2001-04A.
- Courts have held that there must be some cohesive relationship between the provider of benefits and the recipient of benefits under the plan so that the entity that maintains the plan and the individuals who benefit from the plan are tied by a ***common economic or representational interest.***

Association Health Plans

- Commonality of Interests Summary
- Three sets of issues: (1) Whether the group or association is a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits; (2) whether the employers share some commonality and genuine organizational relationship unrelated to the provision of benefits; and (3) whether the employers that participate in a benefit program, either directly or indirectly, exercise control over the program, both in form and substance.
- Past: DOL wanted to assure that employee benefit plans focused on *employment-based arrangements* rather than *merely commercial insurance-type arrangements* that lack the requisite connection to the employment relationship.

Association Health Plans

- **New** Commonality of Interests Consideration
- Employer groups or associations would meet the commonality of interest criteria if their members
- 1. were in the same trade, industry, line of business, or profession, or;
- 2. maintained their principal places of business in a region that does not exceed the boundaries of the same State, or in the same metropolitan area (even if the metropolitan area includes more than one State;
- 3. establish clear criteria under which working owners, such as sole proprietors and other self-employed individuals, could participate in AHPs.
- **LITIGATION CHALLENGE!**

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Expansion of Short Term Duration Individual Coverage

Short Term Limited Individual Coverage Expansion

- Background:
- Short-term coverage is designed to fill a temporary gap in coverage. A consumer might enroll in a short-term plan when they are, for instance, between jobs or otherwise need individual coverage outside of the open enrollment period (and do not qualify for a special enrollment period).
- Short-term individual plans do not have to comply with the ACA's market reforms. Short-term insurers can charge higher premiums based on health status, exclude coverage for preexisting conditions, impose annual or lifetime limits, opt not to cover entire categories of benefits (such as substance use disorder treatment or prescription drugs), rescind coverage, and require higher out-of-pocket cost-sharing than under the AC

Short Term Limited Individual Coverage Expansion

- Can be less than 12 months
- Can be extended and renewed up to 36 months.
- Must include prominent consumer warnings.

- **Somewhat related…**
- **ACA Marketplace Open Enrollment is Thursday November 1, 2018 to Saturday, December 15, 2018**.
- **Plans will start January 1, 2019**

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2019 Form 5500 Changes?

Proposed Revision To Form 5500 Regulations: Would Apply to 2019 Plan Year

General:

Form 5500 Annual Return/Report is the primary source of information about the operation, funding, assets, and investments of pension and employee benefit plans. In addition to disclosing important information to plan participants and beneficiaries, the Form 5500 Annual Return/Report is an essential compliance and research tool for the federal government.

Proposed Revision To Form 5500 Regulations: Would Apply to 2019 Plan Year

A. More information will be required concerning 401K and pension plans. The asset breakouts on the balance sheet component of Schedule H (Financial Information) would be modified to add more investment categories and subcategories.

I. Require plan administrators to disclose more detailed information about the nature of plans' administrative expenses.
II. New reporting subcategories on Schedule H would be designed to capture amounts paid for salaries, audit, legal, recordkeeping and actuarial fees, and other plan expenses.
III. Small plans eligible to file on Form 5500-SF (covers fewer than 100 participants) would be required to provide certain additional information about the plans' investments. Plans will be required to categorize the plans' investments into one of eight categories, which include cash/cash equivalents, money market funds and publicly traded stock. If a small plan is not invested in one of the eight listed categories, it would not be eligible to file on Form 5500

Proposed Revision To Form 5500 Regulations: Would Apply to 2019 Plan Year

B. **IMPORTANT !**: DOL will eliminate for group health plans the current exemption from Form 5500 reporting for small insured and self-insured welfare benefit plans (less than 100 plan participants).

UNCLEAR: Impact of President Trump's Executive Order Calling for a Freeze/Review of Federal Regulations.

Mental Health Parity and Addiction Equity Act (MHPAEA) Developments

Mental Health Parity and Equity Addiction Act Developments

MHPAEA requires all group health plans and health insurers who are providing both medical-surgical coverage and mental health/substance use coverage to guarantee compete parity fro limitations on treatment, day and visit numbers and for all financial requirements.

Mental health coverage cannot be more restrictive or more expensive than medical surgical coverage.

April 2018 HHS releases ***Mental Health and Substance Use Disorder Action Plan For Enhanced Enforcement***

1. ***Increased MHPAEA audit of health plans***
2. ***Self compliance checklist available on DOL website.***
3. ***Issuance of DOL FAQ guidance***
4. ***Issuance of Non Quantitative Treatment Limitations***

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2018 Case Law Development

2018 CASE LAW DEVELOPMENTS

- Why an anti assignment clause?
- ***Univ. Spine Ctr. v. Aetna*** and ***Univ. Spine Ctr v. United Healthcare***
- ***Suggest…particularly if you self fund!***
- ***1. Review your plan documents***
- ***2. Include anti assignment language in both the plan and document and the SPD***
- ***3. Explicitly indicate that the language applies to healthcare providers***
- ***Specify that any attempted assignment is void or invalid if performed without the plan's consent and that the plan will not recognize any such assignment.***

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ERISA Employee Benefit Self Audit

Recommended: Better late than never!

ERISA Self Audit

- Review plan documentation (including plan documents, summary plan descriptions…) to confirm compliance and that the plans provide the intended coverage to the intended employee groups. All ERISA-covered plans must, by law, be administered in accordance with a written plan document.
- Review third party agreements (FSA,HRA)and insurance contracts to determine eligibility, covered benefits and other matters relating to the benefit plans to make sure they coordinate with plan documents. Sometimes plan documentation and administrative procedures do not correspond with the third party agreements or insurance contracts.
- Do you need non discrimination testing? Examine you plans to determine compliance with federal non-discrimination laws.

ERISA Self Audit

- Review Form 5500 Annual Report filings and, if necessary, make required corrections. If an employer fails to file a Form 5500 in a timely manner, the employer may submit the late filings using the Department of Labor's ("DOL's") Delinquent Filer Voluntary Compliance (" DFVC") program.
- Review plan administrative procedures for all required notices and forms, including: the distribution of SPDs, SBCs and summaries of material modifications; open enrollment materials; and legally required employee notifications (*e.g.,* summary annual reports, the Women's Health and Cancer Rights Act notice, the Medicare Part D notice and the most recent notices required under the Affordable Care Act).
- Did you do your 1094-C/1095-C filing and Employee Distributions?

ERISA Self Audit

- Does your health plan have access to PHI? Review the group health plan's administrative procedures for compliance with the HIPAA Privacy, Security and Breach Notification Rules. HIPAA's Privacy and Security Rules require group health plans to protect the health information of covered individuals. These rules also apply to health flexible spending account plans.
- Examine COBRA notifications and administrative procedures to determine compliance. Compliance with COBRA is essential for all group health plans since employers can be subject to employee lawsuits and government sanctions for failure to do so.

ERISA Self Audit

- Review plan document procedures for Qualified Domestic Relations Orders and Qualified Medical Child Support Orders. ERISA requires a plan to have written procedures to determine an order's qualified status, to administer benefits under a qualified order, to provide prompt notification of the procedures to each person named in the order, and to name a representative to receive copies of any notices.

Questions?

Thank You!