CBP
Creative Benefit Plans
INSURANCE MADE EASY

2018: Year in Review

Compliance Digest

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Short-Term Spending Bill Delays Cadillac Plan Tax and Extends CHIP

Published: January 30, 2018

On January 22, 2018, Congress approved a short-term spending bill (the "Bill") that will fund the government until February 8, 2018. The Bill was signed into law the same day. During its annual appropriation exercise, Congress provides funding for the agencies and programs it has authorized. Because Congress failed to adopt a regular appropriation bill, a continuing resolution was adopted on December 22, 2017 to continue government funding until January 19, 2018. The current Bill secures temporary funding to allow agencies and programs to continue to function, but a regular appropriations bill is required to secure funding for the entire year
(until September 30, 2018).

Notable to employers sponsoring group health plan coverage, the Bill will further delay the effective date of the Cadillac Plan Tax until January 1, 2022. The Bill also suspends other health care related taxes and extends the Children's Health Insurance Program ("CHIP").

Suspension of Health-Related Taxes

Several taxes were included as part of the Affordable Care Act ("ACA") to increase health insurance coverage (e.g., individual and employer mandates), reduce health care costs (e.g., Cadillac Plan Tax) and finance health care reform (e.g., PCOR fee). While some taxes have been in effect for several years, others have been delayed or suspended by congressional action.

The Bill delays or suspends the following ACA taxes:

- **High Cost Employer-Sponsored Health Coverage** ("Cadillac Plan Tax;"). This is a 40% excise tax on the value of coverage above $10,200 for self-only coverage and $27,500 for coverage other than self-only. Originally scheduled to take effect January 1, 2018, subsequent legislation delayed the effective date until January 1, 2020. This Bill once again delays the effective date until January 1, 2022.

- **Medical Device Tax.** This is a tax equal to 2.3% of the price of the product, imposed on the sale of any taxable medical device by the manufacturer, producer, or importer. It was previously suspended and is further delayed until January 1, 2020.

- **Annual Fee on Health Insurance Providers.** This fee is assessed on health insurance carriers. Carriers generally build the cost into premiums (3% to 4%) of insured medical, dental, and vision plans. The tax took effect in 2014, was suspended for 2017 and will again be suspended for calendar year 2019. The tax will be collected for 2018.

The Healthy Kids Act

The Bill expands coverage for children under CHIP and the Public Health Funding Extension Act for a period of six years. CHIP provides health coverage to eligible children who are ineligible for Medicaid, but cannot afford health insurance. Under the program, the federal government matches state funds to expand health insurance coverage for children.

In addition, the Bill expands funding for the following programs:

- **Childhood Obesity Demonstration Project** a comprehensive model used to reduce childhood obesity by awarding grants to eligible entities.

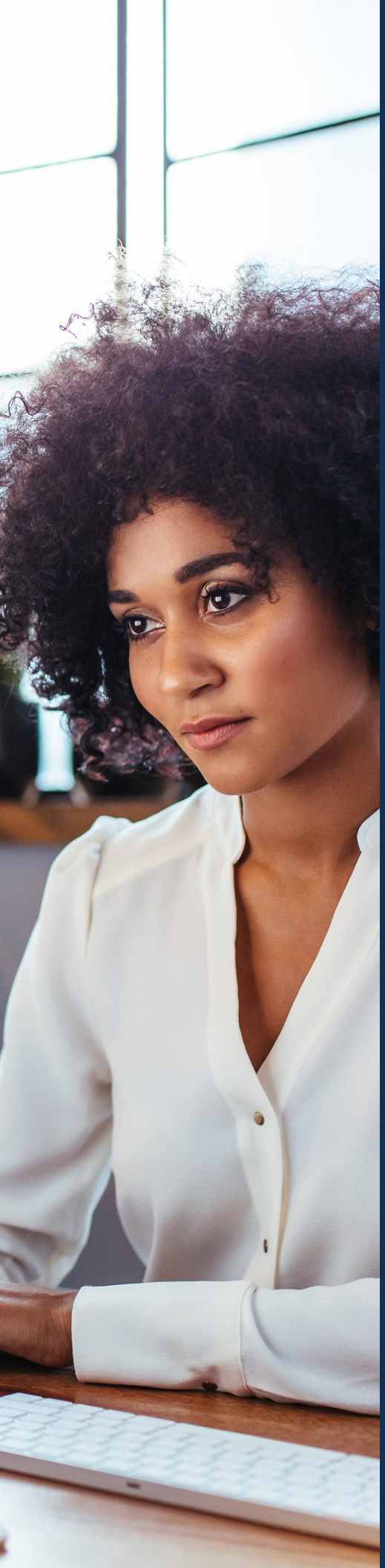
- **Pediatric Quality Measures Program** aims at improving and strengthening core child health.

- **Outreach and Enrollment Program** designed to increase the enrollment and participation of eligible children.

Finally, the Bill also provides that states may offer a plan that mirrors CHIP benefits for children under the age of 19 that do not qualify for CHIP or Medicaid, a "qualified CHIP look-alike program," that is funded from state funds or through premiums. Thus, the program would allow over-age children to continue to maintain health coverage at reduced costs.

Resources

For additional information, see:
https://www.congress.gov/115/bills/hr195/BILLS-115hr195enr.pdf



DOL Penalties Increase for 2018

Published: February 6, 2018

In 2015, Congress passed the Federal Civil Penalties Inflation Adjustment Act of 2015 (the "Inflation Adjustment Act") to direct federal agencies to adjust the civil monetary penalties for inflation every year. Civil penalties ensure compliance with federal regulation by incentivizing employers not to violate federal regulation and providing federal agencies the power to ensure compliance. However, when penalties are too low, or have failed to be increased for inflation, compliance with federal regulation remains stagnant.

The Department of Labor (DOL) recently published the annual adjustments for 2018 that increase certain penalties applicable to employee benefit plans.

The updated penalties went into effect on January 2, 2018 and apply to penalties assessed after the effective date.

Annual Penalty Adjustments for 2018

The following updated penalties are applicable to health and welfare plans subject to ERISA.

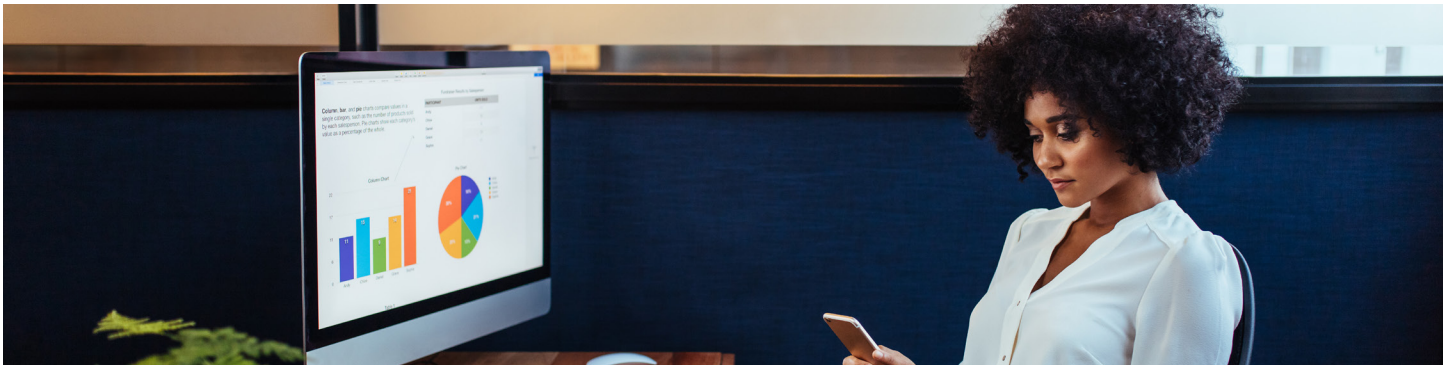
Annual Penalty Adjustments for 2018

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	Current Penalty	Updated Penalty
Failure to file **Form 5500**	Up to $2,097 per day	Up to $2,140 per day
Failure of a **MEWA** to file reports	Up to $1,527 per day	Up to $1,558 per day
Failure to provide **CHIP Notice**	Up to $112 per day per employee	Up to $114 per day per employee
Failure to disclose CHIP/Medicare Coordination to the State	$112 per day per violation (per participant/beneficiary)	$114 per day per violation (per participant/beneficiary)
Failure to provide **SBCs**	Up to $1,105 per failure	Up to $1,128 per failure
Failure to furnish **plan documents** (including SPDs/SMMs)	$149 per day $1,496 cap per request	$152 per day $1,527 cap per request
Genetic information failures	$112 per day	$114 per day
De minimis failures to meet genetic information requirements	$2,790 minimum	$2,847minimum
Failure to meet genetic information requirements – not de minimis failures	$16,742 minimum	$17,084 minimum
Cap on unintentional failures to meet genetic information requirements	$558,078 maximum	$569,468 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.



Medicare Part D

CMS Notification Reminder

Published: February 12, 2018

Employers sponsoring a group health plan need to report information on the creditable status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at:

https://www.cms.gov/Medicare/Prescription-Drug-coverage/CreditableCoverage/CCDisclosureForm.html.

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the **beginning** date of the plan year;
- Within 30 days after the **termination** of the prescription drug plan; and
- Within 30 days after any **change** in the creditable coverage status.

An employer with a calendar year plan **(January 1 – December 31, 2018) must complete this reporting no later than March 1, 2018.**

Additional guidance on completing the form, including screen shots, is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html.

IRS Decreases Some 2018 Limits

Including Maximum Family HSA Contribution

Published: March 12, 2018

Due to the new tax reform law, on March 5, 2018, the IRS released Revenue Procedure 2018-18 announcing that it has recalculated some of its previously-released 2018 limits for health saving accounts ("HSAs"), Archer medical savings accounts ("MSAs"), adoption assistance programs, and the small employer health insurance credit.

HSAs

The 2018 HSA maximum contribution for the family tier is reduced from $6,900 to **$6,850.** The other HSA limits remain the same.

Note that:

1. Although the limit is announced on an annual basis, it is actually determined monthly so individuals who are not HSA-eligible for all of 2018 are generally limited to the number of months they are HSA-eligible and enrolled in family coverage multiplied by $570.83 per month (rather than $575 per month).

2. Individuals who already contributed the full 2018 limit (i.e., who front-loaded) or otherwise end up going over the limit need to contact the HSA trustee/custodian for a taxable distribution ($50 if HSA-eligible all year) by the due date of his or her 2018 tax return to avoid penalty. Additional information:

    - The trustee or custodian of an individual's HSA is not responsible for determining whether contributions to the HSA exceed the maximum annual contribution. This is the responsibility of the account beneficiary who is also responsible for informing the trustee or custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution. In this case, the trustee will make a distribution and report on Form 1099-SA.

- The excess contribution (from the employee or employer) and income are included in the participant's gross income.

- Excess contributions for a year and the income attributable to them should be returned by the due date of the participant's income tax return, including extensions, for that year.

- If not timely returned, the excess contributions will be subject to a 6% penalty.

3. HSA elections can be changed monthly. For HSAs to which employees are able to make pre-tax contributions, the Code Sec. 125 rules generally apply, but because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, an employee may increase or decrease the election at any time (and at least monthly) as long as the change is effective prospectively, without a status change.

   Employers can consider announcing to employees that there is a deemed automatic election to reduce the contribution unless the employee objects. This entails consulting the payroll department or vendor and adjusting the contributions accordingly. For an employer with 26 pay periods, the original maximum per pay HSA contribution for family coverage has been $265.38. However, with the announced reduction, the new amount is $263.46.

   For example, if the contribution for January – March 23 was $1,592.28 ($265.38 X 6 pay periods), the remaining contributions through December would be $262.88 per pay period ($5,257.72 / 20 pay periods), with a small rounding consideration.

4. An announcement should be made to employees about the new limit. There is no particular format required. Any materials printed already should be marked with the new limit, if feasible. Any materials not printed already should be amended, if feasible.

Archer MSAs

These arrangements are not common as they have generally been replaced by HDHP and HSA programs.

For MSA purposes, the coordinating plan must have:

- for self-only coverage, an annual out-of-pocket maximum (other than for premiums) for covered benefits of $4,550 (was $4,600); and

- for family coverage, an annual deductible of at least $4,550 (was $4,600).

The other limits remain the same.

Adoption Assistance Programs

For employer adoption assistance programs, the maximum amount that can be excluded from an employee's gross income for qualified adoption expenses is reduced from $13,840 to $13,810. Further, the adjusted gross income threshold after which the adoption exclusion begins to phase out is reduced from $207,580 to $207,140.

The other limits remain the same.

Small Employer Health Insurance Credit

An eligible small employer may claim, subject to a phaseout, a credit equal to 50% of nonelective contributions for health insurance for its employees. The credit is reduced under certain circumstances, including if the average annual full-time equivalent wages per employee are more than $26,600 (was $26,700).

Tax Credit Available for Employees on Paid Family or Medical Leave

Published: March 23, 2018

For 2018 and 2019 only, there is a tax credit available to certain employers as to FMLA-qualifying circumstances (whether under FMLA or not) for employees earning $72,000 or less for whom paid family and medical leave is provided. Nothing in the rules requires the employer to be subject to FMLA to receive the tax credit. Thus, it is available to employers with less than 50 employees. Notably, paid leave must be provided to both full-time and part-time employees in order to claim the credit; if part-time employees are excluded from a paid leave policy, this credit is not available.

Additional information follows.

Amount of Credit

The credit is generally 12.5% of the amount of wages paid to qualifying employees (although it increases by .25% for every percentage point an employee's FMLA wages exceed 50% of their normal wages, capped at 25%).

The credit is also capped with respect to each employee to the normal hourly wage rate of such employee for each hour (or fraction thereof) of actual services performed for the employer multiplied by the number of hours (or fraction thereof) for which family and medical leave is taken. In the case of any employee who is not paid on an hourly wage
rate, the wages of such employee are prorated to an hourly wage rate under regulations to be established by the Secretary of the Treasury.

Form of Credit

The credit is in the form of a general business credit.

Eligible Employer

To take the credit, an employer must have in place a written policy that provides not less than 50% of the wages normally paid to such employee and:

- in the case of a qualifying employee who is full-time (customarily employed for at least 30 hours per week), provides not less than 2 weeks of annual paid family and medical leave; and
- in the case of a qualifying employee who is a part-time employee (customarily employed less than 30 hours per week), provides an amount of annual paid family and medical leave that is not less than a prorated amount. Note that many existing programs do not offer paid leave to part-time employees and thus would not qualify for the credit (unless there is no part-time workforce).

If an otherwise eligible employer (whether or not subject to FMLA) provides paid family and medical leave outside of what is required under FMLA to an eligible employee, there are protections it must ensure in order to take advantage of the tax credit. In that case, the otherwise eligible employer must provide paid family and medical leave in compliance with a written policy which ensures that the employer:

- will not interfere with, restrain, or deny the exercise of or the attempt to exercise, any right provided under the policy; and
- will not discharge or in any other manner discriminate against any individual for opposing any practice prohibited by the policy.

All entities in the same controlled group under Code Sec. 52(a) and (b) (more than 50% common ownership) are treated as a single employer.

Qualifying Employees

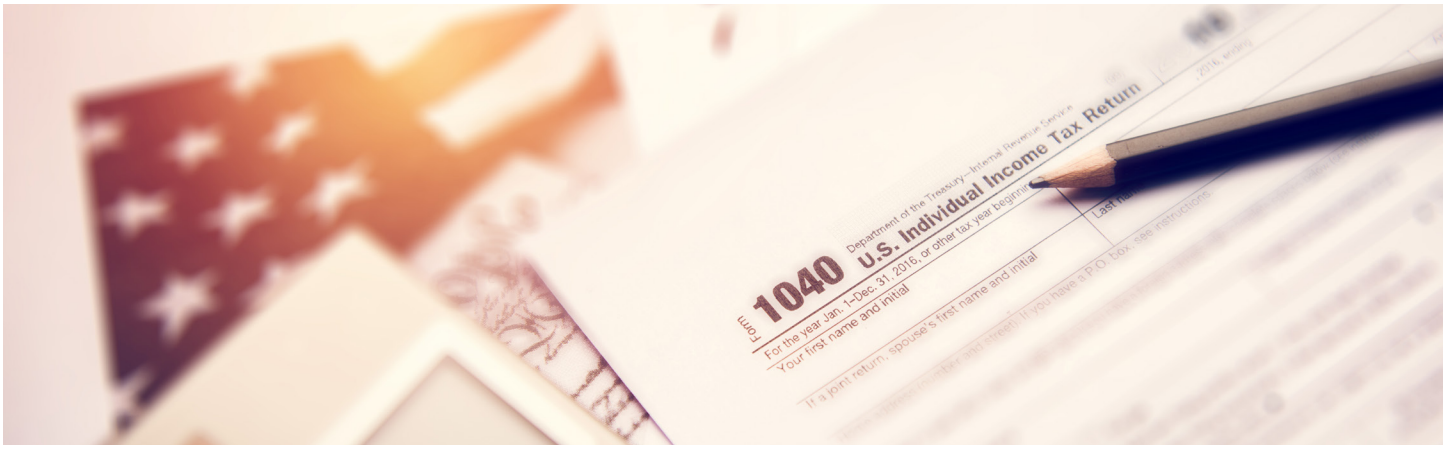
An employee for whom a credit is available is any employee who:

- has been employed for at least one year; and
- had compensation of no more than $72,000 for 2018 (to be indexed in 2019).

Qualifying Circumstances

"Family and medical leave" means leave for any one or more of the following purposes whether the leave is provided via FMLA or by a policy of the employer:

- Because of the birth of a son or daughter of the employee and in order to care for such son or daughter.
- Because of the placement of a son or daughter with the employee for adoption or foster care.



- In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition.
- Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee.
- Because of any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- To care for a servicemember as to an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember.

Vacation leave, personal leave, and medical or sick leave for any other purpose is not counted.

It is not clear whether short-term disability benefits count for this purpose.

Any leave which is paid by a state or local government or required by state or local law is not considered in determining the amount of paid family and medical leave provided by the employer.

Maximum Amount of Leave

The amount of family and medical leave that may be taken into account is up to 12 weeks.

Examples

Example 1: Employer pays $10,000 of wages to qualifying employees during a period in which those employees are on family and medical leave. This amount is 50% of the wages normally paid to the employees for services rendered to the employer. Employer can claim a paid family and medical leave credit of $1,250 (12.5% of $10,000).

Example 2: Employer pays $12,000 of wages to qualifying employees during a period in which those employees are on family and medical leave. This amount is 60% of the wages normally paid to the employees for services rendered to the employer. The 60% rate of payment exceeds 50% by 10%. As the applicable percentage of 12.5% used to determine the credit is increased (but not above 25%) by .25% for each percentage point by which the rate of payment exceeds 50%, Employer's credit is increased by 10 × 0.25%, or 2.5%. Employer can thus claim a paid family and medical leave credit of $1,800 (15% (12.5% plus 2.5%) of $12,000).

Effective Date

This credit is permitted from January 1, 2018 – December 31, 2019.

A taxpayer may elect to have this section not apply for any taxable year.

Employer Action

The Treasury Department is expected to issue guidance to better understand the various requirements of the tax credit. Employers should review existing policies to understand whether they are eligible to claim a credit for 2018 and await further guidance.

San Francisco HCSO
Calculating Self-Funded Expenditures in 2018

Published: March 26, 2018

Employers sponsoring self-funded health plans with Covered Employees in San Francisco will need to calculate health care expenditures differently beginning with calendar year 2018. Historically, self-funded employers used the COBRA equivalent rate to determine if the health care expenditure was sufficient.

Beginning in 2018, employers will need to adopt a new technique, either the "No Return of Premium" or "Pay-As-You-Go," to determine whether the employer's contributions meet the minimum San Francisco requirements.

For calendar year 2017, employers may still use the COBRA equivalent rate to determine health care expenditures (including on their Annual Reporting Form for 2017 due by April 30, 2018).

Background

In 2008, San Francisco implemented the Health Care Security Ordinance ("the Ordinance"), a "pay or play" law requiring employers to make health care expenditures on behalf of Covered Employees. Under the Ordinance, the annual expenditure by a covered employer for 2017 may total more than $5,000 per Covered Employee.

Briefly, a Covered Employee is an employee who (1) has been employed at least 90 days and (2) performs at least 8 hours of services a week in San Francisco.

To satisfy the spending requirement, a Covered Employer must make health care expenditures on behalf of covered employees at the following rates:

Employer Size	# of Employees*	2017 Expenditure Rate	2018 Expenditure Rate
Large	All employers w/ 100+ employees	$2.64 per hour payable	$2.83 per hour payable
Medium	Businesses w/ 20-99 employees Nonprofits w/ 50-99 employees	$1.76 per hour payable	$1.89 per hour payable
Small	Businesses w 0-19 employees Nonprofits w/ 0-49 employees	Exempt	Exempt

** all employees, not just those working in SF*

Generally, the Covered Employer must calculate the required expenditure for each covered employee. However, there are special rules that can be used to determine the expenditure requirement for plans that provide uniform health coverage (meaning coverage in the same health plan) or a self-funded arrangement.

What's New for a Self-Funded Plan?

Under a rule change effective in 2017, all health care expenditures must be made irrevocably. This change eliminates the possibility that a Covered Employer can recover unused funds allocated to Covered Employees, for example through reimbursement accounts.

Guidance issued October of 2017, describes how the irrevocability rule affects the calculation of health care expenditures made to self-funded health plans. Specifically, amounts that are not irrevocably spent cannot be considered in determining whether a self-funded plan complies with the spending requirement.

Beginning with calendar year 2018, an employer may comply with the spending requirement by providing a self-funded uniform health plan to some or all of its Covered Employees, so long as that plan satisfies one of the following conditions:

1. No return of premium. The employer pays premiums and/or fees to third-party administrator (TPA) to administer the self -funded health plan and:
    a. no portion of those premiums or fees are returned to the employer; and
    b. the premiums and fees paid for a calendar quarter meet or exceed the required expenditure for each Covered Employee for that quarter.
2. Pay as you go. The employer pays claims as they are incurred, and the average hourly expenditures meet or exceed that year's expenditure rate for the employer.
    a. This option is limited to uniform health plans, meaning the plan must have the same benefit design for all covered employees, including co-pay requirements, out-of-pocket maximums, deductibles, coverage tiers, and eligibility criteria.
    b. The average hourly Health Care Expenditure for employees in a uniform health plan is calculated by dividing the total amount of required Health Care Expenditures for employees in the plan by the total number of Hours Payable to each of the employees in the plan during that quarter.
    c. The employer shall receive credit toward the spending requirement in the amount of the average actual expenditures per Covered Employee.

Pay As You Go

To meet the minimum expenditure requirement under the pay-as-you-go method, the average hourly expenditure for a calendar year must meet or exceed that year's expenditure rate.

For 2018, you will use the actual claims data for the year in determining the average hourly expenditure.

To determine the total spent on the self-insured health plan, only irrevocable employer contributions are counted. Do not include before or after-tax employee contributions.

In the following two examples, assume the employer is considered a Large Employer under HCSO.

Example 1	
Covered Employees in 2018	100
Total spending on self-insured health plan for those employees in 2018	$600,000
Total hours payable to covered employees in 2018	206,400
Average hourly expenditure	$2.91 ($600,000/206,400)
Does the average hourly expenditure equal or exceed $2.83?	Yes

Example 2	
Covered Employees in 2018	75
Total spending on self-insured health plan for those employees in 2018	$350,000
Total hours payable to covered employees in 2018	154,800
Average hourly expenditure	$2.26 ($350,000/154,800
Does the average hourly expenditure equal or exceed $2.83?	No-additional employer expenditure needed to satisfy spending requirement

If the spending requirement is not satisfied (as reflected in Example 2), the employer may "top off" expenditures by February 2019. Options available to the employer to satisfy this requirement include:

- Employer contributions toward premiums for other medical benefits (e.g., dental or vision) or make additional contributions toward a spouse or dependent's coverage.
- Contribute to the City Option.

Employer Action

Employers sponsoring a self-funded group health plan and planning to use employer contributions to meet the requirements of the HCSO for 2018 will want to carefully review these new calculation options.

While the 2017 expenditures (which are due to be reported by April 30, 2018) may be determined with the COBRA equivalent method, effective 2018, a new method will be use to determine the expenditure amount.

Relief for HDHPs Required to Provide Male Contraceptives

Published: April 2, 2018

Certain state laws require insured medical plans to cover male sterilization or male contraceptives (jointly referred to here as "male contraceptives") before the minimum statutory high deductible health plan ("HDHP") deductible has been met. This would mean that the HDHP was not a qualifying HDHP (i.e., one necessary for health savings account ("HSA") eligibility). However, the IRS recently provided relief, preserving HSA eligibility before 2020.

Background

A qualifying HDHP is a health plan that has certain indexed amounts with respect to annual deductibles and out-of-pocket expenses. A qualifying HDHP provides "significant benefits" and does not reimburse medical expenses before a minimum deductible is met, subject to a few exceptions. One such exception is for preventive care. "Preventive care" is defined federally and does not include male contraceptives. This is an issue because at least four states have enacted laws requiring insurers to cover male contraceptives without cost-sharing:

- **Illinois** requires insured plans to cover voluntary sterilization procedures without cost-sharing.
- **Maryland** requires insurers to provide coverage for male sterilization without any copay, coinsurance, or deductible with respect to all non-grandfathered plans.
- **Oregon** requires coverage of sterilization without cost-sharing effective with the 2019 renewal date.
- **Vermont** has a rule like those above except to the extent it would disqualify an HDHP from being a qualifying HDHP.

Relief

On March 5, 2018, the IRS issued Notice 2018-12 which provides transition relief until 2020 for individuals who are covered under a health insurance policy that provides male contraceptives before the statutory deductible is met if the only reason for HSA-ineligibility is due to the required pre-deductible male contraceptive coverage. This transition relief is put in place to give states a chance to change their laws, perhaps by following Vermont's lead and carving out qualifying HDHPs from any male contraceptives mandate. This does not affect self-funded plans.

Final DOL Disability Benefits Claims Procedures Effective April 1, 2018

Published: April 4, 2018

The Department of Labor (the "Department") announced a final rule on December 16, 2016, revising the claims procedure regulations under ERISA for employee benefit plans providing disability benefits. The final rule revised and strengthened the prior rules by adopting certain procedural protections and safeguards for disability benefit claims that were currently applicable to claims for group health benefits pursuant to the Affordable Care Act ("ACA"). This rule affects plan administrators and participants and beneficiaries of plans providing disability benefits (insured and self-insured), and others who assist in the provision of these benefits, such as third-party benefits administrators and other service providers.

After much delay, this rule finally became effective as of April 1, 2018.

Background

ERISA requires every employee benefit plan to "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant" and "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."

On November 18, 2015, the Department published a proposed rule regarding the claims procedure for plans providing disability benefits under ERISA. The final rule largely adopts the proposed rule with some notable changes.

Changes

Notable changes include:

- Adding vocational experts to the list of persons involved in the decision-making process who must be insulated from the plan's conflicts of interest;

- Requiring adverse benefit determinations to contain a discussion of the basis for disagreeing with the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- Requiring notices of adverse benefit determinations on review to include a description of any applicable contractual limitations period and its expiration date.

Summary

The major provisions in the final rule amend the Department's current claims procedure regulation for disability plans by incorporating the following improvements to the processing of claims and appeals for disability benefits:

- **Improvement to Basic Disclosure Requirements.** Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards used in making the decision. For example, the notices must include a discussion of the basis for disagreeing with a disability determination made by the Social Security Administration if presented by the claimant in support of his or her claim.

- **Right to Claim File and Internal Protocols.** Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents. Currently this statement is required only in notices denying benefits on appeal. Benefit denial notices also have to include the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying a claim or a statement that none were used. Currently, instead of including these internal rules and protocols, benefit denial notices have the option of including a statement that such rules and protocols were used in denying the claim and that a copy will be provided to the claimant upon request.

- **Right to Review and Respond to New Information Before Final Decision.** The final rule prohibits plans from denying benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

- **Avoiding Conflicts of Interest.** Plans must ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated or compensated based on the likelihood of the person denying benefit claims.

- **Deemed Exhaustion of Claims and Appeal Processes.** If plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, unless the violation was the result of a minor error and other specified conditions are met. If the claimant is deemed to have exhausted the administrative remedies available under the plan, the claim or appeal is deemed denied on review without the exercise of discretion by a fiduciary and the claimant may immediately pursue his or her claim in court. The final rule also provides that the plan must treat a claim as re-filed on appeal upon the plan's receipt of a court's decision rejecting the claimant's request for review.

- **Certain Coverage Rescissions are Adverse Benefit Determinations Subject to the Claims Procedure Protections.** Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (e.g. errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals procedures. Rescissions for non-payment of premiums are not covered by this provision.

- **Notices Written in a Culturally and Linguistically Appropriate Manner.** The final rule requires that benefit denial notices have to be provided in a culturally and linguistically appropriate manner in certain situations. The final rule essentially adopts the ACA standard for group health benefit notices. Specifically, if a disability claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language services. The plan would also be required to provide a verbal customer assistance process in the non-English language and provide written notices in the non-English language upon request.

Effective Date

The final rule is effective thirty (30) days after its publication in the Federal Register, and the improvements in the claims procedure process are generally applicable to disability benefit claims submitted on or after April 1, 2018.

Employer Action

Employers sponsoring disability programs will be subject to these rules with respect to disability claims submitted on or after April 1, 2018. Employers should review and timely update their disability plan documents, Summary Plan Descriptions, and other related materials to conform to the new regulation. They should also review the new regulations with their service providers to ensure carriers are prepared to implement the changes in the final regulation.

New FAQs Address Tax Credit for Paid Family and Medical Leave

Published: May 7, 2018

On April 9, 2018, the IRS released its first round of guidance in the form of FAQs concerning the new employer credit for paid family and medical leave (FML) under Code Section 45S.

Background

Added by the Tax Cuts and Jobs Act, Code Section 45S provides that for tax years 2018 and 2019, eligible employers can claim a general business tax credit for wages paid to qualifying employees who are on FML if certain requirements are satisfied. While the FAQs released by the IRS offer little in the way of new guidance, they do provide a helpful summary of the credit, particularly on the eligibility rules.

Overview of FAQs

To claim the credit, employers must have a written policy in place that provides at least two weeks of paid FML annually to all qualifying employees who work full time (prorated for employees that work part time) and the paid FML must provide at least 50 percent of the wages normally paid to the employee. For purposes of the credit, a qualifying employee is any employee under the Fair Labor Standards Act who has been employed for one year or more and who, for the preceding year, did not receive compensation beyond a certain threshold (to claim the 2018 credit, the employee's income may not exceed $72,000 in 2017).

As provided in the FAQs, FML is leave for one or more of the following reasons:

1. Birth of an employee's child and to care for the child.
2. Placement of a child with the employee for adoption or foster care.
3. To care for the employee's spouse, child, or parent who has a serious health condition.
4. A serious health condition that make the employee unable to perform the functions of his or her position.

5. Any qualifying exigency due to an employee's spouse, child, or parent being on covered active duty (or having been notified of an impending call or order to covered active duty) in the Armed Forces.

6. To care for a service member who is the employee's spouse, child, parent, or next of kin.

To the extent an employer complies with the requirements under Code Section 45S, a minimum credit of 12.5% will be applied to qualified wages paid to an employee while on FML. The amount of the credit will increase 0.25% for each percentage point paid to a qualifying employee that exceeds 50% of the employee's wages, to a maximum of 25%. However, as emphasized by the FAQs, any leave paid by a state or local government or required by state or local law will not be considered in determining the amount of employer-provided paid FML. Furthermore, any wages taken into account in determining any other general business credit may not be used in determining this Section 45S credit.

Conclusion

Although this IRS FAQ provided a helpful summary of the credit eligibility rules, many questions regarding the Section 45S employer credit for paid FML remain. Specifically, the IRS recognizes that these FAQs fail to address all questions related to the written policy requirements, the impact of state and local requirements, and how to treat wages paid by the employer's insurance provider in the event of employee disability, among others.

The IRS expects to issue additional guidance in the coming months. In the meantime, employers wishing to take advantage of this credit should review the conditions set forth in Code Section 45S and these FAQs to satisfy the requirements necessary to claim the credit.

For IRS FAQs, visit https://www.irs.gov/newsroom/section-45s-employer-credit-for-paid-family-and-medical-leave-faqs.

New Jersey Enacts Paid Sick Leave Law

Published: May 8, 2018

On May 2, Governor Murphy signed the New Jersey Paid Sick Leave Act into law, requiring New Jersey employers to provide up to forty (40) hours of paid sick leave per year to covered employees. The law applies to all employers in the State of New Jersey, including temporary help service firms, but excludes public employers required to provide their employees with sick leave. The new law will go into effect on October 29, 2018 and preempts all existing and future municipal ordinances in New Jersey regarding paid sick time.

Who is a Covered Employee?

The Act covers most employees working in the State of New Jersey. Employees in the construction industry, employed under a collective bargaining agreement, per diem health care employees, and public employees who already have sick leave benefits are specifically excluded from the Act.

Accrual of Leave

Employers must designate any period of 12 consecutive months as a benefit year, and cannot change the benefit year without first notifying the New Jersey Department of Labor and Workforce Development. In each benefit year, an employee may accrue up to 40 hours of paid sick leave benefits at a rate of one hour for every 30 hours worked. Employers are permitted to "frontload" the full 40 hours at the beginning of the benefit year. Employees may carry over accrued but unused benefits, but employers are not required to provide more than 40 hours of paid sick leave in a single benefit year. Employers may choose to offer employees the ability to payout unused but accrued sick leave in the final month of the employee's benefit year. If an employee chooses to receive such a payment, the employee can choose the full amount of unused sick time or 50% of such sick time and carry-over the rest, as long as it's not more than 40 hours.

Paid time off (PTO) policies may be used to satisfy the Act's requirements so long as the policy provides at least the same benefits as those provided under the Act.

Current employees will begin accruing sick time on October 29, 2018. Employees hired after October 29 will begin to accrue sick time on the first date of their employment. With respect to temporary help service firms, paid sick leave will accrue on the basis of the total time worked on assignment with the firm, not separately for each client firm where the employee is assigned.

How can Leave be Used?

A covered employee may use paid sick leave benefits for any one of the following:

- Diagnosis, care or treatment of, or recovery from, the employee's own mental or physical illness, including preventive medical care;
- Diagnosis, care or treatment of, or recovery for a family member's mental or physical illness, including preventive medical care;
- Time needed due to the employee or employee's family member being a victim of domestic or sexual violence, including counseling, legal services, or participation in any civil or criminal proceedings;
- Time needed when the employee's workplace or school/ childcare of the employee's child is closed by order of a public official or other public health emergency; and
- Time to attend a school-related conference or meeting to discuss a child's health condition or disability.

The term "family member" is broadly defined to include any individual related by blood or whose close association with the employee is the equivalent of a family relationship.

Employers are permitted to choose the increments employees may use accrued sick time; however, the largest increment chosen may not be larger than the number of hours an employee was scheduled to work in a given shift.

Notice and Recordkeeping

If an employee's absence is foreseeable, an employer may require notice, not to exceed seven (7) days, from an employee of the date leave is to begin and the expected duration of such leave prior to using sick leave. If unforeseeable, the employee must give notice as soon as practicable. If an employee is absent for at least three (3) consecutive days, an employer may require the employee to provide reasonable documentation confirming the leave is for a purpose permitted under the Act.

The Commissioner of the Department of Labor will be developing a model notice detailing employees' rights under the Act. Employers are required to post the notice and provide a copy to employees within 30 days after the notice has been issued. The notice must be given to new hires upon hire and to any employee upon request.

Employers must retain records documenting hours worked and earned sick leave used by employees for a period of five (5) years, and allow access to the Department of Labor.

Employer Action

Employers should review their current paid time off and sick leave policies to determine compliance with the Act and determine whether they will need to implement new policies or amend existing policies. Employers should also review their employee handbooks and make any necessary revisions. Finally, employers should keep their eyes open for the model notice from the Department.

2019 Inflation Adjusted Amounts for HSAs

Published: May 14, 2018

The IRS released the inflation adjustments for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2019. Most limits increased from 2018 amounts.

Annual Contribution Limitation

For calendar year 2019, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,500.** For calendar year 2019, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$7,000**.

High Deductible Health Plan

For calendar year 2019, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,350 for self-only coverage** or **$2,700 for family coverage,** and the **annual out-of-pocket expenses** (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,750 for self-only coverage or **$13,500 for family coverage**.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

PCOR Fee Filing Reminder for Self-Insured Plans

Published: May 14, 2018

The PCOR filing deadline is July 31, 2018 for all self-funded medical plans and HRAs for plan years ending in 2017.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2016 – January 31, 2017	$2.26/covered life/year	July 31, 2018
March 1, 2016 – February 29, 2017	$2.26/covered life/year	July 31, 2018
April 1, 2016 – March 31, 2017	$2.26/covered life/year	July 31, 2018
May 1, 2016 – April 30, 2017	$2.26/covered life/year	July 31, 2018
June 1, 2016 – May 31, 2017	$2.26/covered life/year	July 31, 2018
July 1, 2016 – June 30, 2017	$2.26/covered life/year	July 31, 2018
August 1, 2016 – July 31, 2017	$2.26/covered life/year	July 31, 2018
September 1, 2016 – August 31, 2017	$2.26/covered life/year	July 31, 2018
October 1, 2016 – September 30, 2017	$2.26/covered life/year	July 31, 2018
November 1, 2016 – October 31, 2017	$2.39/covered life/year	July 31, 2018
December 1, 2016 – November 30, 2017	$2.39/covered life/year	July 31, 2018
January 1, 2017 – December 31, 2017	$2.39/covered life/year	July 31, 2018

For the Form 720 and Instructions, visit:
https://www.irs.gov/uac/form-720-quarterly-federal-excise-tax-return.

The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators and USI, cannot report or pay the fee.

Short Plan Years

The IRS issued FAQs that address how the PCOR fee works with a self-insured health plan on a short plan year.

Does the PCOR fee apply to an applicable self-insured health plan that has a short plan year?

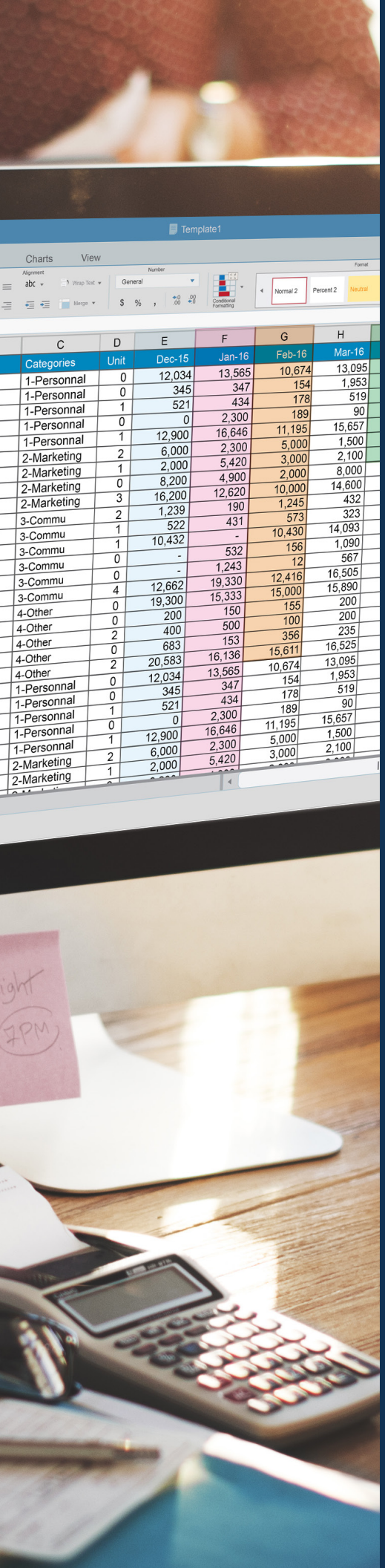
Yes, the PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

What is the PCOR fee for the short plan year?

The PCOR fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

Thus, for example, the PCOR fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2017, and ends on Dec. 31, 2017, is equal to the average number of lives covered for April through Dec. 31, 2017, multiplied by $2.39 (the applicable dollar amount for plan years ending on or after Oct. 1, 2017, but before Oct. 1, 2018).

See FAQ 12 & 13, https://www.irs.gov/affordable-care-act/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers.



IRS Restores Original 2018 Family HSA Contribution Limit

Published: May 15, 2018

On April 26, 2018, the IRS announced relief associated with the decrease from $6,900 to $6,850 for 2018 HSA contributions tied to family coverage that was previously announced in Revenue Procedure 2018-18.

New IRS guidance in Revenue Procedure 2018-27 allows taxpayers to once again treat the 2018 maximum HSA contribution for the family tier as $6,900 – not the reduced limit of $6,850 that was unexpectedly announced on March 2, 2018.

Why was the Limit Changed Back?

The IRS and Treasury Department determined that it was in the best interest of taxpayers to reinstate the originally published limit of $6,900. IRS and the Treasury noted that the $50 reduction to the family HSA contribution limitation imposed numerous unanticipated administrative and financial burdens. The agencies ultimately concluded that the burden to taxpayers and employers outweighed the benefit of the $50 reduction.

What if an Individual Already Adjusted His/Her HSA?

If an individual has already made changes to his or her HSA contributions based on the $6,850 deduction limitation, this guidance clarifies what taxpayers can do in light of this relief:

- Those that have already received an excess contribution distribution from an HSA based on the $6,850 deduction limit may treat the distribution as a mistake and repay the HSA up to $6,900 by April 15, 2019. The repaid contribution (including earnings on that contribution) **will not** be included in the taxpayer's gross income and **will not** be subject to excise taxes.

- Alternatively, an individual who received an excess contribution distribution (with earnings) from an HSA based on the $6,850 deduction limit may choose to not repay the $50 distribution into the HSA. This distribution **will not** be subject to the 20% tax for non-qualified medical expense distributions.

Employer Action

- An announcement should be made to employees informing them that the maximum HSA contribution for those with family coverage is $6,900 (not $6,850). There is no particular format required. Any materials printed already should be revised, if feasible. Any materials not printed already should be reviewed to ensure the limit is published as $6,900 and revised, if necessary.

- Allow impacted employees to increase their annual HSA election to $6,900, if applicable. HSA elections can be changed monthly. This includes pre-tax HSA contributions made through a Code Sec. 125 plan. These rules permit HSA contribution elections to increase or decrease at any time (and at least monthly), as long as the change is effective prospectively, without a corresponding status change.

- Work with payroll vendors and HSA trustees/ custodians to update systems with the new limit.

Review of the 2018 HSA/HDHP Limits

The 2018 HSA contribution limits and high-deductible health plan ("HDHP") requirements are as follows:

- Maximum HSA contributions of $3,450 for those with self-only coverage

- Maximum HSA contributions of $6,900 for those with family coverage

- Catch-up contribution (for those 55 or older) of $1,000

- Minimum deductibles of $1,350 self-only / $2,700 family

- Maximum out-of-pocket expenses of $6,650 self-only / $13,300 family

MHPAEA Enforcement Update, Compliance Tools Released & Proposed FAQs Issued

Published: May 22, 2018

DOL and HHS Enforcement Highlights

The Department of Labor's Employee Benefits Security Administration ("EBSA") recently released its Fiscal Year 2017 Mental Health Parity and Addition Equity Act ("MHPAEA") Enforcement Fact Sheet summarizing its enforcement activity. MHPAEA applies to most group health plans either directly or through the fact the plan offers Essential Health Benefits which include mental health and substance use disorder benefits. Simultaneously, EBSA along with the Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), released an Action Plan detailing past enforcement actions as well as planned enforcement and compliance assistance efforts.

- EBSA closed 347 health investigations (187 of which were plans subject to MHPAEA) in FY 2017.
- Of the 187 plans that were subject to MHPAEA, 92 were cited with violations.
- CMS has completed five (5) investigations of non-federal governmental plans to detect MHPAEA violations and conducted one (1) Market Conduct Examination related to MHPAEA since the beginning of 2016.
- EBSA announced there are now 400 EBSA investigators that review plans for compliance with ERISA; a 15% decrease in investigative staff compared to previous years. Although, it announced it is establishing dedicated MHPAEA enforcement teams to conduct investigations of behavioral health organizations and insurance companies. If the violation involves a service provider such as insurance carrier, it will seek global correction for all plans affected by requiring plans to remove offending plan provisions and pay any improperly denied benefits.

- In 2017, HHS and DOL brought together federal experts and state insurance department officials to share best practices and conduct technical assistance on MHPAEA implementation. These Parity Policy Academies focused on advancing parity compliance in the commercial market and Medicaid/CHIP market.

Compliance Assistance Tools and Other Resources

To assist plans and issuers with compliance going forward, EBSA issued a MHPAEA Self-Compliance Tool which plans may use to determine whether the coverage offered to participants complies with MHPAEA rules. This tool, with its eight complex questions and step-by-step analysis, aims to give the user a basic understanding of MHPAEA rules and evaluate compliance generally. EBSA plans to update this tool with more comprehensive guidance on a biennial basis.

HHS and DOL plan to publish reports from the Parity Policy Academies held in 2017. Also, the HHS-Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with EBSA, is developing a "clear language" tool to provide families and caregivers with important information and resources to actively support the individuals in their care. SAMHSA is also developing a tool kit to help state insurance regulators, behavioral health authority staff, insurance executives and human resource professionals develop a basis for understanding Federal parity law and regulations.

HHS plans to continue updating its Parity Portal (https://www.hhs.gov/programs/topic-sites/mental-health-parity/index.html) which is a resource to help consumers to determine if they have experience a MHPAEA violation, solve MHPHAEA coverage issues, file complaints, and submit an appeal.

EBSA and CMS plan to release information on enforcement efforts and action plans annually.

Proposed MHPAEA FAQs Issued

The Departments of Labor, Health and Human Services and Treasury issued proposed FAQs providing implementation guidance on the Mental Health Parity and Addiction Equity Act (MHPAEA). Specifically, the FAQs provide helpful clarification as to Non-Quantitative Treatment Limits (NQTL) that trigger MHPAEA violations and guidance on MHPAEA's disclosure obligations.

Background

MHPAEA applies to:

- Employers with more than 50 employees offering group health plan coverage, insured or self-funded, that includes any Mental Health or Substance Use Disorder (MH/SUD) benefits.

- Non-grandfathered insured plans, including coverage in the small group health plan market.

Briefly, MHPAEA:

- Requires that if a plan provides MH/SUD benefits in any classification, those benefits are provided in every classification in which medical/surgical benefits are provided.

- Prohibits a plan from imposing a financial requirement or Quantitative Treatment Limit (QTL) on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of the same type applied to substantially all medical/surgical benefits.

    - A financial requirement includes copays, deductibles, cost-sharing, coinsurance and out-of-pocket maximums.

    - A QTL means annual, episode and lifetime days and/or visit limits (e.g., number of treatments, visits or days of coverage).

    - Prohibits a plan from imposing a NQTL on MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.

Non-Quantitative Treatment Limits

The guidance provides detailed examples of various plan designs and operations that may violate MHPAEA.

Exclusion for Experimental Treatment, Autism, ABA Therapy

In Q/A-2, a plan identifies Autism as a MH condition. The plan denies ABA therapy (used to treat some children with autism) as experimental.

Pursuant to the plan's written terms, experimental and/or investigative treatment for both MH/SUD and medical/surgical benefits is not covered. The plan states that when no professionally recognized treatment guidelines define clinically appropriate standards of care for the condition, and fewer than two randomized controlled trials are available to support the treatment's use with respect to the condition the treatment for the condition is considered experimental (and therefore not covered by the plan).

The Departments conclude denying ABA treatment as experimental violates MHPAEA as the exclusion for treatment of ABA therapy is a NQTL that is imposed more stringently on MH/SUD because ABA therapy meets professionally recognized treatment guidelines and the requisite number of randomized controlled trials support the use of ABA therapy to treat children with Autism Spectrum Disorder.

Dosage Limitations

Plans may impose dosage limits as a medical management technique with respect to prescription drug coverages. Such limits are NQTLs.

The Departments' regulations require that the processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD prescription drug benefits (in this case, a dosage limit on buprenorphine to treat opioid use disorder) must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying dosage limits to prescription drugs to treat medical/surgical conditions.

If the plan follows the dosage recommendations in professionally-recognized treatment guidelines to set dosage limits for prescription drugs in its formulary to treat medical/surgical conditions, it must also follow comparable treatment guidelines, and apply them no more stringently, in setting dosage limits for prescription drugs, including buprenorphine, to treat MH/SUD conditions.

Provider Reimbursement Rates

While a plan is not required to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers, a plan's standards for admitting a provider to participate in a network (including the plan's reimbursement rates for providers) is an NQTL. In Q/A-7, where the plan reduces reimbursement rates for non-physician practitioners providing MH/SUD services but does not have a comparable process for non-physician medical/surgical practitioners, the plan violates MHPAEA.

Eating Disorders

A plan provides benefits for the treatment of eating disorders but excludes all inpatient, out-of-network treatment outside of a hospital setting for eating disorders, including residential treatment (which it regards as an inpatient benefit). FAQ-9 makes clear such an exclusion violates MHPAEA because such a restriction based on facility type is a NQTL and it is being more stringently applied to a MH/SUD condition (eating disorder) than other medical/surgical conditions by excluding residential treatment when no such exclusion applies to other medical/surgical benefits.

Other NQTL Examples

- Q/A-3 provides an example of an impermissible NQTL when the plan (in operation) reviews and covers certain treatments for medical/surgical conditions that have a "C" rating on a treatment-by-treatment basis but denies all benefits for MH/SUD treatments that have a rating of "C" or below. The fact the plan may deny some treatment for medical/surgical benefits with a "C" rating does not negate the fact a more stringent unconditional exclusion applies when a "C" treatment is requested for a MH/SUD condition.

- Q/A-5 provides an example of a plan with a blanket exclusion for all treatment (including prescription drugs) associated with bi-polar disorder. In this example, such an exclusion does not violate MHPAEA. However:
  - If coverage is insured, such an exclusion may violate state mental health parity rules that are more stringent than what federal law requires (including whether such benefits constitute an essential health benefit under the applicable state benchmark plan).
  - This guidance does not address whether such exclusion for treatment of bi-polar disorder raises other issues in Federal law, including possible claims under the ADA.

- Q/A-6 illustrates how a step-therapy plan design (commonly known as "step therapy protocols" or "fail-first policies") is an NQTL and a more stringent standard that required two attempts at out-patient treatment to be eligible for in-patient, in-network SUD benefits versus a one attempt requirement at outpatient treatment to be eligible for in-patient, in-network medical/surgical benefits is an impermissible NQTL

- Q/A-8 addresses network adequacy, generally applicable to insured plans and the carriers offering insured coverage.

- Q/A-10 provides an emergency room care scenario and whether the benefits being received are for medical/surgical or MH/SUD when there is a physical injury that may result from a MH/SUD condition.

Applicable MHPAEA Disclosures

- The criteria for medical necessity determinations with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request.

- The reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available to participants and beneficiaries.

- To comply with ERISA's document request and claims appeals rules, plans must include information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

FAQs 11-12 provide the following guidance:

- If an ERISA-covered plan utilizes a network, its SPD must provide a general description of the provider network. The list of providers in that SPD must be up-to-date, accurate, and complete (using reasonable efforts). The list may be provided as a separate document that accompanies the plan's SPD if it is furnished automatically and without charge and the SPD contains a statement to that effect. An out-of-date provider directory is not permissible.

- ERISA plans may provide a hyperlink or URL address in enrollment and plan materials for a provider directly where, among other things, MH/SUD providers can be found.

Employer Action

These FAQs, as well as other recent MHPAEA enforcement guidance, indicates MHPAEA remains a top enforcement priority for the Departments. Employers should review these proposed FAQs and may wish to evaluate their plan(s)'s MHPAEA compliance.

Resources

- Fiscal Year 2017 Mental Health Parity and Addition Equity Act ("MHPAEA") Enforcement Fact Sheet, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf

- Action Plan for Enhanced Enforcement of the Mental Health and Substance Abuse Disorder Coverage, https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/21st-century-cures-act-section-13002/index.html

- MHPAEA Self-Compliance Tool, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.docx

IRS Explains Letter 227

Published: May 31, 2018

The IRS recently published additional guidance explaining the Letter 227, which is an IRS acknowledgement letter regarding an Applicable Large Employer's (ALE) response to Letter 226-J (which notified the ALE of potential liability for an Employer Shared Responsibility Payment (ESRP)). The IRS used the information provided in response to the initial Letter 226-J to review the ESRP. The Letter 227 version explains the outcome of that review and the next steps to take to fully resolve the ESRP (if there are any).

Briefly, the guidance:

- Explains the 5 versions of Letters 227, one of which will be issued to the ALE in response to receipt of the employer's Letter 226-J submission (generally, Form 14764 and other materials as applicable).
- Describes next steps the ALE should take, as necessary.
- Provides answers to some commonly asked questions.

ALEs that responded to a Letter 226-J should anticipate receiving Letter 227 from the IRS. It is important to carefully review and address, as applicable, Letter 227 to preserve any available appeals rights.

Letter 227 **is not a bill**. A separate bill, CP220J, will be received after the ESRP has been assessed.

Letter 227 – Five Versions

- **Letter 227-J** acknowledges receipt of the signed agreement Form 14764, ESRP Response, and that the ESRP will be assessed. After issuance of this letter, the case will be closed. No response is required.
  - In this instance, the ALE may receive a separate CP220J – which is the bill to pay any owed ESRP that was not previously paid.

- **Letter 227-K** acknowledges receipt of the information provided and shows the ESRP has been reduced to zero. After issuance of this letter, the case will be closed. No response is required.

- **Letter 227-L** acknowledges receipt of the information provided and shows the ESRP has been revised. The letter includes an updated Form 14765 (Premium Tax Credit (PTC) Listing) and revised calculation table. The ALE can agree or request a meeting with the manager and/or appeals.

- **Letter 227-M** acknowledges receipt of information provided and shows that the ESRP did not change. The letter provides an updated Form 14765 (PTC Listing) and revised calculation table. The ALE can agree or request a meeting with the manager and/or appeals.

- **Letter 227-N** acknowledges the decision reached in Appeals and shows the ESRP based on the Appeals review. After issuance of this letter, the case will be closed. No response is required.
  - In this instance, the ALE may receive a separate CP220J – which is the bill to pay any owed ESRP that was not previously paid.

It's important to note that if an ALE receives a **227-L or 227-M, a response is required.**

Employer Action

- An ALE that receives a 227-L or 227-M will need to complete the response Form 14764 indicating agreement or disagreement with the proposed ESRP.

- If the ALE **disagrees** with the proposed assessment, the ALE must explain its reasoning and indicate any further changes on Form 14756. All documents **must be returned to the IRS by the If response date**.

- the ALE **agrees** with the ESRP, sign the response form and return it with payment.

Helpful Hints

- Review Forms 1094-C and 1095-C from the appropriate calendar year to determine whether the information the IRS shows is accurate with your records.

- Review your submission to the IRS in response to the Letter 226-J.

- Keep copies of any submission to the IRS for your records.

- Contact the IRS at the phone number provided in the letter if you have questions or feel that you need additional time to respond.

For More Information

- https://www.irs.gov/faqs/irs-procedures/notices-letters/understanding-your-letter-227

- https://www.irs.gov/affordable-care-act/individuals-and-families/are-you-an-applicable-large-employer-review-your-status-annually

NYC Paid Sick Leave Law Now Includes Safe Leave

Published: June 1, 2018

Due to an amendment made to the Earned Sick Time Act, covered employers must provide their employees working in New York City for more than 80 hours in a calendar year with notice of the new "safe time" leave available to them under the revised law. Employers are required to provide notice of this change to their employees by **Monday, June 4, 2018.**

Background

Mayor de Blasio signed an amendment to the Earned Sick Time Act on November 6, 2017, allowing employees to use paid sick leave under "safe time." Effective May 5, 2018, the revised law, the Earned Safe and Sick Time Act, requires employers to provide paid time off for hours taken in connection with family offense matters, such as sexual offenses, stalking, or human trafficking. The change does not require an employer to provide additional time off for safe leave, instead, the amendment requires employers to allow employees to use earned sick leave for safe leave purposes.

Use of Safe Leave

Under the revised law, new circumstances allow absences from work when the employee or the employee's family member has been the victim of a family offense matter, sexual offense, stalking or human trafficking. These new circumstances include:

a. to obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking, or human trafficking;

b. to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members from future family offense matters, sexual offenses, stalking, or human trafficking;

c. to meet with a civil attorney or other social service provider to obtain information and

d. advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;

e. to file a complaint or domestic incident report with law enforcement;

f. to meet with a district attorney's office;

g. to enroll children in a new school; or

h. to take other actions necessary to maintain, improve, or restore the physical, psychological, or economic health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.

Notice Requirement

- New York City employers are required to provide an updated Notice of Employee Rights to employees by June 4, 2018. To review the Notice of Employee Rights please visit: https://www1.nyc.gov/assets/dca/downloads/pdf/about/PaidSickLeave-MandatoryNotice-English.pdf
- Employers are required to provide this notice in the employee's primary language, if available on the Department of Consumer Affairs (DCA) website. To review the Notice of Employee Rights in 25 additional languages please visit: https://www1.nyc.gov/site/dca/about/paid-sick-leave-law.page

Employer Action

New York City employers should review current paid sick leave policies to ensure alignment with the revised Earned Safe and Sick Time Act to include safe leave. Further, employers should disseminate the newest Notice of Employee Rights to employees by June 4, 2018.

For more information and FAQs on the New York City Earned Safe and Sick Time Act please visit: https://www1.nyc.gov/site/dca/about/paid-sick-leave-law.page

IRS Announces 2019 ACA Affordability Indexed Amount

Published: June 5, 2018

The IRS recently announced in Revenue Procedure 2018-34 that the Affordable Care Act (ACA) affordability indexed amount under the Employer Shared Responsibility Payment (ESRP) requirements will be **9.86%** for the 2019 plan year. The increase from the 2018 amount (9.56%) is the largest percentage increase to date for affordability under the ESRP requirements.

Background

Revenue Procedure 2018-34 specifically addresses the increase as it pertains to obtaining a subsidy through the Exchange under Section 36B (premium tax credit). However, in IRS Notice 2015-87, the IRS explained that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2019

An employer will not be subject to a penalty with respect to an ACA FTE if that employee's required contribution for 2019 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

1. **The W-2 safe harbor.**
   The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.86% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. This amount does not take into account any elective deferrals to a 401(k), 403(b), or cafeteria plan.

2. **Rate of pay safe harbor.**
   The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.86% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

3. **Federal Poverty Level (FPL) safe harbor.**
   Coverage is affordable if it does not exceed 9.86% of the FPL. Under this safe harbor, for plan years that begin before July 1, 2019, the employee monthly cost for self-only coverage under the lowest cost plan that provides a minimum value must be no more than $99.75 (48 contiguous states), $124.73 (Alaska), or $114.70 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2019 plan year should review these affordability safe harbors when analyzing the cost for the coming year.

Proposed Rule Expands Required Electronic Filing of IRS Forms

Published: June 5, 2018

Currently, employers must file certain types of forms electronically (not via paper) only if they file 250 or more of the same type of form (e.g., Forms W-2 and 1095-C are evaluated separately). In a recently issued proposed rule, the IRS announced it intends to require aggregation of all information returns to determine the 250-return threshold.

Example

An employer files only two types of forms for 2018 in early 2019:

- 200 Forms W-2 with the SSA; and
- 100 Forms 1095-C and one Form 1094-C with the IRS.

The employer can file by paper because it has less than 250 of each type of filing.

However, if the proposed rule is finalized, the employer will have to file electronically because it has 301 **total** filings.

Specifically, the proposed rules states that "if during a calendar year a person is required to file a total of 250 or more information returns **of any type** covered by §301.6011-2(b), the person is required to file those information returns electronically" (emphasis added).

Forms covered by §301.6011-2(b) include (but are not limited to):

- Form W-2
- Form 1094-C
- Form 1095-C
- Form 1099

Additionally, the proposed rule provides that if the information returns originally filed for the calendar year are required to be filed electronically, any correction to those forms must also be filed electronically. This means, for instance, if an employer files 1,000 Forms 1095-C electronically with the IRS and later needs to correct 10 of those forms, the submission of the 10 corrected forms must be electronic.

If finalized, these rules would apply to information returns required to be filed after December 31, 2018 and any corrected returns filed after that date. Thus, this rule change may affect calendar year (CY) 2018 Forms W-2 and CY 2018 Forms 1094-C and 1095-C.

The proposed rule does not amend the existing regulations allowing persons who are required to file returns electronically to request a waiver of the electronic-filing requirement.

Employers with less than 250 forms can always voluntarily file electronically and the vast majority of employers do so.

Employer Action

- Employers that have not electronically filed in the past should be aware of this proposed rule and prepare to carefully review the number of forms submitted on an aggregated basis to determine whether they will be subject to electronic filing of CY 2018 forms.
- Affected employers that handle these IRS forms internally (without a third-party provider) will need to understand and prepare with IT as the filing process is complicated. Alternatively, it may be time to review a third-party vendor solution. If interested, we can help in this process.
- Employers can consider submitting comments to the IRS regarding this proposed regulation.

NJ Governor Signs Bills to Stabilize Individual Market

Published: June 12, 2018

New Jersey Governor Phil Murphy signed two bills into law in response to the repeal of the federal Individual Shared Responsibility Mandate under the Affordable Care Act (effective January 1, 2019). The bills are intended to stabilize the state's individual health insurance market.

This legislation will directly impact residents of NJ and indirectly affect employers with employees residing in the state.

State Individual Mandate

The New Jersey Health Insurance Market Preservation Act will require all New Jersey residents to have Minimum Essential Coverage (MEC) beginning January 1, 2019, or pay a penalty.

NJ's mandate is scheduled to take effect on January 1, 2019, making NJ the second state, after Massachusetts, to enact an individual mandate. The mandate includes an annual penalty of 2.5% of a household's income or $695 per adult and $347 per child – whichever is higher. The maximum penalty is based on household income and will not exceed the average yearly premium of a bronze plan.

A "hardship exemption" will be available for individuals who cannot afford coverage, determined by the State Treasurer. NJ expects to collect between $90 million and $100 million in penalties. This money, along with additional federal funding, will be used on a reinsurance program, which Murphy also signed into law.

Reinsurance Program

The New Jersey Health Insurance Premium Security Act authorizes NJ to apply for, accept, and receive federal funds to implement and sustain market stabilization programs, by applying for a federal waiver (Section 1332 waiver). Contingent on federal approval, NJ will establish a program to provide funding for health carriers to make claims payments that exceed a certain threshold. If approved, the program intends to reimburse health insurance carriers in the individual market for some of the cost associated with high-cost enrollees and is expected to reduce premiums by 10-20%.

It appears that if NJ does not receive approval from the federal government for funding of this program, the state may consider relief from the individual mandate for NJ residents.

Employer Action

While these bills do not directly affect employer sponsored plans, the individual mandate requirement for NJ residents will likely require education for employees. As residents in NJ will now be required to obtain health coverage to avoid a state income tax penalty, employers may see an increase in plan enrollment. Unlike Massachusetts which requires specific coverage components, the NJ law only requires that coverage be MEC. Thus, most traditional employer-sponsored group health plans should meet this definition. However, coverage for only dental benefits, certain medical indemnity policies and vision benefits are likely not sufficient for purposes of avoiding the state tax. For now, employers with employees who reside in New Jersey may wish to educate employees at Open Enrollment that by January 1, 2019 health coverage will be required for NJ residents to avoid a penalty.

Another issue to watch for is whether NJ will provide relief for residents who do not have coverage as of January 1, 2019, but have access to employer-sponsored coverage that runs on a non-calendar year, and enroll in that coverage when available (e.g., for a February 1 plan year, enroll February 1, 2019).

The ACA Undergoes a New Legal Challenge

Published: June 20, 2018

Several states have lodged a legal challenge to the entire Affordable Care Act ("ACA") on the basis that the lack of an Individual Mandate tax makes the remaining provisions unconstitutional. While the Administration is not intervening, several other states are, defending the ACA's sustainability without the Individual Mandate tax. No resolution to the legal questions is expected imminently, although the uncertainty that it causes could result in higher premiums now.

Background

One of the ACA's major provisions is that Americans must have health insurance or pay a penalty. That provision was challenged and, on June 28, 2012, the Supreme Court ruled that the Individual Mandate is not a valid exercise of Congress' power under the Commerce Clause (i.e. the federal government cannot force individuals to buy insurance), but nevertheless upheld it due to Congress' power under the Taxing Clause (i.e., the federal government has broad authority to monetarily penalize individuals).

Numerous efforts to repeal the ACA have all failed. However, in December 2017, Congress, through the Tax Cuts and Jobs Act, changed the Individual Mandate Penalty to $0, beginning January 1, 2019.

New Challenge

In a renewed effort to strike down the ACA, on February 26, 2018, Texas Attorney General Ken Paxton and 19 other Republican state attorneys general filed a lawsuit which charged that Congress' changes to the law in last year's tax bill rendered the entire ACA unconstitutional. The reasoning is as follows:

- **Step One:** If the Individual Mandate, per the Supreme Court, is only constitutional because it constitutes a tax, and if that tax has effectively been eliminated, then the mandate sans tax that remains on the books is therefore unconstitutional.

- **Step Two:** Invalidating the mandate should invalidate the whole ACA because the law cannot function the way Congress intended without the mandate in place.

Administration's Inaction

On June 7, 2018, in a departure from the Justice Department's custom of fighting to uphold all reasonable laws, U.S. Attorney General Jeff Sessions indicated in a brief that it will not participate in the defense of this law suit. While the Administration does call on the court to invalidate the Individual Mandate, guarantee issue requirement, and community rating requirement, it indicates that the remaining provisions should stand.

Defense

In May 2018, the court allowed the attorneys generals from Democratic-leaning states to "intervene" in the case and defend the law. California Attorney General Xavier Becerra is leading the challenge with 15 other states and the District of Columbia and filed a preliminary injunction on June 7, 2018. They refute the Republican attorneys' general claim, noting that the ACA and its Individual Mandate have already survived two reviews by the Supreme Court and over 70 unsuccessful repeal attempts in Congress.

What to Expect

While the complaint requests that the ACA be dismantled as of January 1, 2019, it is likely that litigation will extend well beyond that time and perhaps return before the Supreme Court. Whether the Republican-led repeal efforts will be successful is uncertain. In King v. Burwell (the most recent case before the Supreme Court challenging the validity of the ACA), Chief Justice Roberts alluded that the Court's current majority favored keeping the law intact:

> *"Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter."*

In the meantime, increased uncertainty may cause insurers to pull out of the Marketplace or increase premiums. If the ACA is invalidated, obviously, this would significantly impact employers who, among other things, would no longer have to evaluate affordability, define full-time employees as those working at least 30 hours per week, limit their waiting periods to 90 days, or file Forms 1095-C.

We will continue to keep you apprised of further developments.

Association Health Plans Final Rules

Published: June 28, 2018

The Department of Labor published a final rule on June 21, 2018 creating flexibilities for employers and working owners to band together to sponsor a single Association Health Plan (AHP). The final rule allows multiple employers to jointly sponsor a single group health plan by expanding ERISA's definition of "employer." An AHP may provide coverage to the owners and employees of participating employers and their families.

By collectively forming a single plan, multiple employers may avoid small group market rating, maintain greater flexibility in benefits, and reduce premiums and administrative expenses. An AHP is a multiple employer welfare arrangement (MEWA) and is subject to the same federal and state rules as any other MEWAs.

Applicability of the Final Rules

The Department outlines a rolling applicability period (i.e., effective dates) in order to allow states time to modify and/or implement rules in reaction to the federal changes.

- All associations (new or existing) may establish a fully insured AHP on September 1, 2018.
- Existing self-insured association programs established before June 21, 2018 and comply with federal rules prior to the final regulations, may rely on these rules January 1, 2019.
- New self-insured AHPs formed pursuant to this rule may rely on the guidance as of April 1, 2019.

Any AHP arrangement permitted before the final rules will remain valid. The final rules merely relax the definition of "employer" allowing more arrangements to qualify as a single plan.

Under existing law, most existing association programs do not qualify as a "single plan" under ERISA and each employer accessing coverage through the arrangement is treated as a single ERISA plan. This also means the size of

each employer (and not the aggregate size of the plan) controls how the plan is rated by insurance companies for purposes of premiums and benefits. For example, an insured association plan with an employer that has 30 employees would be required to comply with the ACA's small market rules (e.g., EHBs, age-banded rates, bronze level of coverage) even if, when looked at in the aggregate, the number of employees getting coverage through the association would otherwise qualify as a "large group."

Nothing in these rules change any existing state laws that may impose limitations, restrictions or prohibitions on creating these arrangements on a fully insured or self-funded basis. So, while federal law has become more relaxed, it will be up to each state (and applicable carriers) whether to follow along.

Ahp Formation

A bona fide group or association ("association") may form an AHP if:

- all employer members are engaged in the same trade, industry, line of business, or profession; or
- have a principle place of business in the same state or metropolitan area.

The association sponsoring the AHP must be a viable entity in the absence of providing health coverage and demonstrate a substantial business purpose for existing such as educating its members or promoting an industry. The rules specifically exclude certain entities from controlling an AHP including a health insurance issuer, subsidiary or affiliate, a provider network, health care organization, or other part of a health delivery system.

Association members must sufficiently control the association and the AHP in form and substance, but not necessarily conduct the day-to-day affairs. Members may demonstrate sufficient control over the AHP by regularly nominating and electing the officials who operate the governing body, retaining authority to remove those officials with or without cause; and maintaining approval and veto power over decisions regarding plan design, amendments or plan termination.

Eligible Participants

An employee or former employee of a current employer association member, working owner (one that works 20 hours/week or 80 hours/month), sole proprietor, partner, and their beneficiaries (e.g., spouses and dependent children) may all be eligible participants in an AHP. Independent contractors, such as those working in the "gig" economy, that possess a sufficient relationship with the association may aggregate their hours to allow participation in the AHP. Once members (including working owners) cease membership in the association, they can no longer be covered by the AHP because they have lost a significant connection to the group.

Keep in mind, these rules did not change the tax implications when group coverage is provided to certain self-employed individuals. Sole proprietors, partners and independent contractors who obtain coverage through a group plan will have the same tax restrictions and consequences that existed prior to the DOL guidance. Individuals holding greater than 2% of shares in an S-corporation and their family members, sole proprietors, partners, non-employee directors, non-employee independent contractors will continue to be restricted from participating in a Section 125 cafeteria plan (pre-tax premium payments). Contributions made by an employer toward the cost of group coverage to these individuals is generally taxable.

Plan Coverage

These rules do not require the underlying medical coverage to be of a "Bronze" level. This means, assuming it is permissible under state law, an AHP could offer a plan that does not meet minimum value. This could include "skinny" coverage (e.g., preventive care only). Applicable large employers (ALEs) considering coverage through an AHP should be mindful as to the potential penalty implications in the event the coverage does not meet minimum value requirements.

Nondiscrimination

AHPs are subject to the same HIPAA nondiscrimination rules as other large group health plans. The AHP cannot discriminate in eligibility, benefits or premiums against individuals within a group of similarly situated individuals based on a health factor. The AHP may make distinctions between groups of individuals based on bona-fide employment-based classification consistent with the employer's usual business practices. Notably, absent a bona fide business classification, all employers within an AHP will have the same benefits, premiums and eligibility rules. The Department's rule does not allow experience rating at each employer level.

Examples

Example 1

Association A offers group health coverage to all members. According to the bylaws of Association A, membership is subject to the following criteria: All members must be restaurants located in a specified area. Restaurant B, which is located within the specified area, has several employees with large health claims. Restaurant B applies for membership in Association A, and is denied membership based on the claims experience of its employees.

In this Example 1, Association A's exclusion of Restaurant B from Association A discriminates on the basis of claims history, which is a health factor. Association A does not meet the definition of a bona fide group or association of employers.

Example 2

Association F offers group health coverage to all plumbers working for plumbing companies in a state, if the plumbing company employer chooses to join the association. Plumbers employed by a plumbing company on a full-time basis (which is defined under the terms of the arrangement as regularly working at least 30 hours a week) are eligible for health coverage without a waiting period. Plumbers employed by a plumbing company on a part-time basis (which is defined under the terms of the arrangement as regularly working at least 10 hours per week, but less than 30 hours per week) are eligible for health coverage after a 60-day waiting period.

In this Example 2, making a distinction between part-time versus full-time employment status is a permitted distinction between similarly-situated individuals provided the distinction is not directed at individuals. Accordingly, the requirement that plumbers working part time must satisfy a waiting period for coverage is a rule for eligibility that is permissible under the nondiscrimination rules.

Example 3

Association G sponsors a group health plan, available to all employers doing business in Town H. Association G charges Business I more for premiums than it charges other members because Business I employs several individuals with chronic illnesses.

The employees of Business I cannot be treated as a separate group of similarly-situated individuals from other members based on a health factor of one or more individuals. Therefore, charging Business I more for premiums based on one or more health factors of the employees of Business I does not satisfy these requirements.

Example 4

Association Q is a retail industry association. It sponsors a group health plan that charges employees of employers different premiums based on their occupation: Cashier, stockers, and sales associates. The distinction is not directed at individual participants or beneficiaries based on a health factor.

The premium distinction is permissible because it is not based on a health factor and is not directed at individual participants and beneficiaries based on a health factor.

ERISA Reporting and Disclosure Requirements

An AHP is treated as a single plan with the association as the plan sponsor. Existing rules generally require AHPs to file both a Form M-1 and Form 5500 with the DOL. Small AHPs (generally under 100 participants) are not eligible for the filing exemption available for insured and unfunded plans with fewer than 100 participants.

AHPs will likely have to put in place appropriate safeguards for handling plan assets. To the extent participant and employer contributions are being transmitted to the association, who then pays benefits out of the AHPs assets or forwards them to the insurance carrier, those contributions are considered plan assets and must be held in a trust.

An AHP must comply with all ERISA disclosure requirements such as maintaining a written plan document and providing disclosures to plan participants including, but not limited to, a Summary Plan Description (SPD) and a Summary of Benefits and Coverage (SBC). Also, each member employer of the AHP must ensure new hires receive a Marketplace notice as required by the Fair Labor Standards Act.

Application of other Federal and State Laws

AHPs remain subject to all ACA requirements that would otherwise apply to a plan of the same size and funding method. As stated earlier, ALEs remain subject to Employer Shared Responsibility rules and risk penalty if the AHP does not provide minimum essential coverage that is affordable and meets minimum value requirements.

The Mental Health Parity and Addiction Equity Act (MHPAEA) and Mental Health Parity Act (MHPA) (collectively known as the “Mental Health Parity” laws) apply to employers with more than 50 employees. Mental Health Parity laws will apply to an AHP if the number of employees across all member employers in the preceding calendar year exceeds 50 in the aggregate.

COBRA continuation coverage requirements generally apply to employers with 20 or more employees. It is unclear whether all AHP member employers will be required to offer COBRA if the number of employees exceed 20 in the aggregate across all employers. No IRS guidance has been announced yet.

State Involvement

States are permitted to regulate self-insured and fully-insured AHPs to the extent the AHP is marketing to employers within the state. AHPs are subject to the same regulatory requirements, funding concerns, and state licensing restrictions which may have hindered formation at the state level in the past. States may require an AHP obtain a certification or license to operate in the state. The state may also require the AHP to purchase an insurance policy from another state-licensed insurance company. Careful review of state rules will be important if considering establishing an AHP.

Conclusion

We anticipate existing associations, carriers and TPAs will carefully review these rules to determine whether to establish AHPs. Additionally, industry groups currently not providing an insurance option to its employer population may consider creating one of these AHPs. Further analysis is needed on a state-by-state level to understand the state laws that may affect the establishment and administration of these programs.

Also, the Attorneys General ("AGs") in New York and Massachusetts have initiated a lawsuit against the administration challenging the validity of these rules. Depending on how quickly the AGs move, the effective dates outlined above could be affected.

Health & Welfare Plan Reporting & Disclosure Obligations

Published: June 29, 2018

The checklist below provides simple explanations of the various required reporting & disclosure obligations of employer-sponsored health & welfare plans (federal law).

All Welfare Benefit Plans The following are required for all employer-sponsored health and welfare plans (these usually include life and disability plans along with medical and dental, etc.)		
Any Size	SPD	Summary of employee rights and benefits under an employer-sponsored plan. All participants should receive a copy of this within 90 days of becoming covered by the plan and then at least every 5 years after that. Must meet certain content requirements.
Any Size	SMM	Describes material modifications to a plan and reflects changes made to the SPD before the SPD is revised. No later than 210 days after the end of the plan year in which the change is adopted, unless a revised SPD is provided.
Any Size	Notification of Benefit Determination	Claims notices or EOBs.
Any Size	Plan Documents	Must be maintained by the plan administrator (usually the employer) and provided within 30 days of a written request. A copy must be available at the business location. Generally includes, among other things, most recent SPD (and any interim SMMs) and Form 5500 filing, and any contracts or other instruments governing the plan and the plan's operations. This should be updated annually.

All Welfare Benefit Plans The following are required for all employer-sponsored health and welfare plans (these usually include life and disability plans along with medical and dental, etc.)		
Generally, 100+ participants	Form 5500	Generally, applies to employee welfare plans covering 100 or more employees at the beginning of the plan year must submit this electronically to the DOL by the end of the 7th month after the end of the plan year. A one-time 2½ month extension is available by submitting Form 5558 to the IRS by the date the Form 5500 would have otherwise been due.
Generally, 100+ participants	SAR	Narrative summary of information on Form 5500. Distributed to all participants within 9 months of the end of the plan year, or 2 months after the Form 5500 is due. Not required for a plan under which benefits are paid solely from the general assets of the employer or employee organization.
Group Health Plans The following are required for group health plans only, which generally refer to medical, dental, and/or vision plans:		
Any Size	Summary of Material Reduction in Covered Services or Benefits	Summary of group health plan amendments, provided within 60 days of adoption of material reduction in benefits, unless earlier notice is required pursuant to ERISA fiduciary obligation. Consistent with the SBC requirements (see below), any advance notification of a material modification to the SBC will satisfy this requirement.
20+ employees	**COBRA Notices:** If you have a COBRA administrator, it is probably handling all these notices on your behalf. However, you should be familiar with the requirements as the employer is ultimately responsible for COBRA compliance. These notification requirements include the following:	
	COBRA Reasonable Procedures	Included in the SPD and General COBRA Notice.
	General COBRA Notice (Initial Notice)	No later than 90 days after the date on which such individual's coverage under the plan commences.
	COBRA Election Notice	Within 44 days after the qualifying event date or loss of coverage if provided by the plan.
	Notice of Unavailability of COBRA	Notice that individual is not entitled to COBRA coverage. Provided within 14 days after the plan administrator (employer) receives notice of a qualifying event.
	Notice of Early Termination of COBRA	As soon as practicable after determining that coverage will end.
	COBRA Conversion Notice	Where required, within 180 days of the end of the COBRA coverage period.
Any Size	**HIPAA Notices:** There are various required notifications and some are issued from the insurer although the ultimate responsibility for disclosure is the plan sponsor's.	
	Special Enrollment Rights	Include with enrollment materials.
	Notice of Privacy Rights	Include with initial enrollment materials; again within 60 days after a material change; upon request; send a reminder every three years. However, if health benefits are provided through an insurance contract with a health insurance issuer or HMO, the plan must merely maintain a notice and provide such notice upon request.
	Wellness Program Disclosure	Where required, within 180 days of the end of the COBRA coverage period.
Any Size	WHCRA Notice	This should be provided upon initial enrollment and on an annual basis.

Group Health Plans The following are required for group health plans only, which generally refer to medical, dental, and/or vision plans:		
Any Size	QMCSO or NMS	Includes various requirements when a medical child support order has been received and describes the plan's qualification process. Should be included in the certificate/SPD.
Any Size	NMHPA (Newborn's and Mother's Health Protection Act)	This should be included in the certificate/SPD.
Any Size	Michelle's Law	If a plan covers dependents past age 26 or certain dependents such as grandchildren based on student status, Michelle's Law will apply and the disclosure will be required. This disclosure should be included in the certificate and the SPD.
Any Size	Medicare Part D: Participant Notice	Discloses the "creditable" status of prescription drug coverage to participants. Must be provided in specific time frames, including annually and at initial enrollment. Your insurance carrier will let you know if your plan is Creditable or Non-Creditable. It is important to note that the font and page requirements for this notice are very specific, so it is best to use the sample notice from the government website.
Any Size	Medicare Part D: Disclosure to CMS	This disclosure must be sent through the CMS website within the first 60 days of the plan year; within 30 days after termination of the prescription drug plan; and 30 days after any change in creditable status of the prescription drug plan.
Any Size	MSP Reporting	This disclosure is to CMS for purposes of coordination of benefits for Medicare-enrolled individuals. Unless the plan is both self-funded and self-administered, the carrier or TPA will be doing this disclosure.
Any Size	CHIPRA	This notice must go out before the first day of the plan year on an annual basis. Usually included in the enrollment materials. Disclosure to the state Medicaid or CHIP programs must also be completed once model forms are available from the respective states.
51+	MHPA/MHPAEA	Employers claiming a cost exemption must provide notice to the DOL and participants.

Patient Protection And Affordable Care Act (PPACA) – Health Care Reform These notices generally apply to medical plans only.		
Any Size	Grandfathered Health Plans	This notice should be provided to all plan participants in all plan materials (including the SPD and enrollment materials).
Any Size	Patient Protection Disclosure	Non-grandfathered plans that require designation of a primary care provider; can be provided with the open enrollment materials.
Any Size	Claims, Appeals and External Review Process	Non-grandfathered plans are subject to new and additional requirements including, among other things, new notices of adverse benefit determinations and external review decisions. These changes should be documented in the certificate of insurance/SPD (self-insured plans need to coordinate with TPAs).
Any Size	Advance Notice of Rescissions	Notice of at least 30 calendar days is required to an individual before coverage may be retroactively cancelled (rescinded). Coverage may only be rescinded in limited circumstances (e.g., fraud).
Any Size	SBC and Uniform Glossary	This is a summary of the health plan benefits that must be provided to all participants and beneficiaries. The DOL provides a model template. Plans must provide to newly eligible individuals (e.g., new hires, special enrollees) and in connection with renewal.
Any Size	HHS Quality Reporting	Annual reporting requirement to HHS and participants on specific features of the group health plan. Further guidance is needed.

Patient Protection And Affordable Care Act (PPACA) – Health Care Reform These notices generally apply to medical plans only.		
Generally employers filing 250+ Form W-2	W-2 Reporting	Many employers will be required to report the value of health insurance coverage provided to employees on the employee's Form W-2. Employers that file fewer than 250 Form W-2s for the preceding calendar year are not subject to he report requirement in the current calendar year.
Any Size	Comparative Effectiveness/PCOR Fee	For self funded health plans (including HRAs), there is a fee to fund a Patient-Centered Outcome Research program that equals $1 in the first year ($2 in year two, $2.08 in year three) multiplied by the average number of lives insured under a group health plan policy. Form 720 should be filed each July 31 for the calendar year immediately following the last day of the plan year. The insurance carriers are responsible for paying and reporting this fee for fully-insured plans.
All Employers Subject to the FLSA	Notice of Coverage Options	Notice of the new Marketplace, regardless of whether the employer offers a health plan, to each new employee at the time of hire. For 2014, the DOL will consider a notice to be provided at the time of hire if the notice is provided within 14 days of an employee's start date.
Large Employers	6055/6056 Reporting	First effective in 2016 for the 2015 calendar year: • A report to the IRS and to a primary insured reporting which individuals are enrolled in minimum essential coverage for individual mandate purposes, handled by the carrier for an insured plan and by the employer for a self-funded plan; • An information return to the IRS and to all full-time employees that reports the terms and conditions of the employer-sponsored health plan coverage, handled by large employers for employer penalty purposes.
Employers with self-funded health plans	Reinsurance Fee Enrollment Count	Submit an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for the applicable benefit year to HHS by November 15. 2014 – 2016 only.

General Employment Law Notices Not required to be issued by group health plans specifically; not an exhaustive list.[1]		
15+ employees for 20+ calendar weeks (current or preceding year)	ADEA (20 employees) ADA PDA GINA	Usually posted.
50+ employees	FMLA Notices	If you have an FMLA administrator, it is probably handling all of these notices on your behalf. However, the employer is ultimately responsible for FMLA compliance. These notification requirements include the following:
	General Notice	In addition to the posted notice requirement, notice of employer and employee general rights and responsibilities with respect to FMLA.
	Nonpayment of Premiums	When an employee's premium payment is more than 30 days late and employer intends to drop coverage.
	Other Notices	Examples are: Eligibility notice, Rights and Responsibilities notice, Certification form, Designation notice.
Any Size	USERRA Notices	In addition to the posted notice requirement, this notice should be provided at the beginning of any leave for uniformed service and may be provided along with the COBRA election notice.

Other Document Requirements		
Any Size	Cafeteria Plans	Written plan document is required if offering benefits on a pre-tax basis. Annual nondiscrimination testing must be performed.
Any Size	Self-Insured Reimbursement Plans	Any self-insured reimbursement plan (e.g., major medical, dental, FSA, HRA) must have a written plan document and is subject to nondiscrimination rules under Code Section 105(h).
Any Size	HIPAA Privacy & Security Policies	All self-insured health plans and fully insured group health plans that create or receive PHI/e-PHI (other than summary information) must implement privacy and security procedures. Does not apply to fully-insured plans that to not create or receive PHI/e-PHI.
Any Size	HIPAA Privacy and Security Plan Amendments	For plans subject to the HIPAA privacy and security rule (see above), ensure plan documents contain information on privacy and security rules rule.
Any Size	HIPAA Business Associate Agreements	Health plans should have business associate agreements with their business associates who use and disclose PHI/e-PHI for certain health plan functions including claims processing, legal advice, consulting and actuarial determinations.
Any Size	Medicare Part D Application for Subsidy	Applies only to retiree health plans providing prescription drug coverage. Plans may apply for a retiree subsidy from CMS within 90 days from the start of the plan year.
Any Size	Record Retention	ERISA plans are subject to record retention requirements. General rule is to retain records for 8 years.
Any Size	Record Retention – Grandfathered Plans	Grandfathered group health plans must retain record of grandfathered status for as long as the plan claims that status.

1 Discuss these notices with your employment counsel.

New Jersey Out-of-Network Bill

Published: July 26, 2018

On June 1, 2018, New Jersey Gov. Murphy passed the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the "OON Act"). In general, the OON Act applies to emergency services and other care provided by out-of-network physicians in in-network settings (i.e. hospital-based physicians). It takes effect on **September 1, 2018**.

The Act provides reforms to several aspects of the state's health care system involving disclosures of out-of-network (OON) charges, arbitration for billing disputes, and provider network adequacy audits. The bill applies to fully-insured plans and does not apply to self-insured plans unless they choose to opt-in.

The Act requires that a covered patient be responsible only for "in-network" amounts when receiving care at an in-network facility, but may be receiving care from an OON provider. The Act prohibits out-of-network health care providers from directly or indirectly waiving or paying all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider.

Health care professionals and health care facilities are required to provide disclosures of out of network status and obtain specific, knowing and voluntary consent from patients who wish to receive out of network services at the out of network cost. The health care providers and insurance carriers will look to negotiate or go to arbitration for a disputed fee amount. However, the providers cannot seek payment from the patient for payment of out of network balances unless the patient has given a specific consent to do so.

Employers should connect with their carriers for specific direction and questions on this new law.

House Passes Legislation to Improve HSAs

Published: August 7, 2018

The House of Representatives passed two pieces of legislation that, among other things, purport to improve and "modernize" health savings accounts ("HSAs").

The two bills are:

- H.R. 6199, Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018 (for a copy, visit https://www.congress.gov/115/bills/hr6199/BILLS-115hr6199eh.pdf)
- H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018 (for a copy, visit https://www.congress.gov/115/bills/hr6311/BILLS-115hr6311eh.pdf)

While the bills call for significant changes to the current rules affecting HSAs, the specific details are very different.

Summary of Proposed Changes

H.R. 6199 would:

- Exclude a direct primary care service arrangement from being treated as a disqualifying coverage for purposes of HSA eligibility. This would apply so long as the aggregate fees for all services do not exceed $150/month (or $250/month for coverage for more than one individual).
    - This would not include: procedures that require anesthesia, prescription drugs (other than vaccines), and laboratory services not typically administered in a primary care setting.
    - This would permit reimbursement from the HSA on a tax-free basis for direct primary care service arrangements subject to the monthly dollar limits described above. However, such fees are reportable for information purposes on the Form W-2.

- Permit individuals to maintain HSA eligibility when, in connection with employment, the individual (or the individual's spouse) receives (or is eligible to receive) "qualified items and services" at:
  - A health care facility located at a facility of the employer operated primarily for the benefit of the employer's employees (e.g., an onsite clinic)
  - Health care facilities located within supermarkets, pharmacies, or similar retail locations
  - For purposes of the above, "qualified items and services" are limited to the following:
    - Physical examinations,
    - Immunizations,
    - Drugs other than prescribed drugs,
    - Treatment for injuries occurring during employment,
    - Drug testing as a requirement of employment.
    - Hearing and visions screenings, and
    - Other similar items and services that do not provide significant medical benefits.
  - Treat a spouse's traditional health FSA coverage as non-disqualifying coverage for purposes of an employee's HSA eligibility in certain instances.
  - Create additional flexibility for health FSA and HRA conversions to fund HSAs including a conversion to HSA compatible arrangements for the remainder for the year.
  - Expand the definition of a qualified expense for purposes of health FSA, HRA, and HSA reimbursement to include certain menstrual care products and qualified sports and fitness expenses up to $500 (or $1,000 family) (e.g., gym memberships).

H.R. 6311 would:

- With respect to HSAs:
  - Expand HSA eligibility to age-based Medicare Part A eligible individuals (i.e., individuals age 65 and older).
  - Increase the maximum annual HSA contribution to match the out-of-pocket limit (as opposed to an IRS defined limit usually well below the maximum out of pocket).
  - Permit both spouses to make catch-up contributions to a single HSA (as opposed to requiring each spouse to have his/her own HSA to make a catch-up contribution).
  - Permit Bronze and Catastrophic plans to qualify as a high deductible health plan ("HDHP") for purposes of HSA eligibility.
  - Permit reimbursement of qualified medical expenses incurred within a 60-day period prior to the establishment of the HSA.
- Create a "Premium Copper Plan" in the individual Marketplace.
- Increase the health FSA carryforward from a maximum of $500 to the remaining account balance at the end of the year.
- Delay reinstatement of the Annual Fee on Health Insurance Carriers until January 1, 2022.

Both pieces of legislation have been sent to the Senate for consideration. Whether the Senate will take up these bills, let alone approve them "as is," remains uncertain. There appears to be some bi-partisan appetite to loosen the current HSA rules, which means it is possible that we may see changes to these arrangements, which could be effective as early as January 1, 2019. We will continue to keep you apprised.

NYC Mandates Employers Allow Temporary Schedule Changes

Published: August 14, 2018

As of July 18, 2018, employers in New York City must allow their employees to request two temporary schedule changes per calendar year for "personal events." The law requires alteration in the hours, times, or location of work, including, but not limited to using short-term unpaid leave, paid time off, working remotely, or swapping or shifting working hours with a coworker.

"Personal events" include:

- The need to provide care to a minor child or care recipient;
- The need to attend a legal proceeding or hearing for subsistence benefits; or
- Any circumstance that would constitute a basis for safe time or sick time pursuant to New York City's Earned Sick and Safe Time Act.

Please note, that the new law does exempt certain employees including:

- Employees employed for fewer than 120 days;
- Employees who do not work at least 80 hours in a calendar year in NYC;
- Certain employees covered by a collective bargaining agreement that waives the provisions of this law and addresses temporary changes to work schedules;
- Certain employees in motion picture, television, and live entertainment industries;
- Employees of federal, state, or local government.

Employers must post the Notice "You have a Right to Temporary Changes to Your Work Schedule" which can be found on the NYC Consumer Affairs website, linked below.

For more information on the NYC Temporary Schedule law, please visit the NYC Consumer Affairs website or view the NYC Frequently Asked Questions.

Time Spent in Connection with Wellness Programs Is Not Compensable

Published: September 13, 2018

Often, employers question whether they should be paying employees for time spent related to completing certain wellness activities such as:

- attending an in-person health education class and lecture (e.g., nutrition or diabetes management);
- taking an employer-facilitated gym class or using the employer-provided gym;
- participating in telephonic health coaching and online health education classes through an outside vendor facilitated by the employer;
- participating in Weight Watchers;
- voluntarily engaging in a fitness activity (e.g., going to personal gym, exercising outdoors, participating in a Fitbit challenge);
- getting a biometric screening; and
- attending a benefit fair.

The answer is not specifically addressed by the Fair Labor Standards Act ("FLSA") and seems particularly unclear when the employer uses incentives such premium discounts to encourage participation in the wellness program.

Under the FLSA, time is compensable when employees perform duties predominantly for the benefit of the employer. Time is not compensable for "off-duty" periods when the employee:

- is completely relieved from duty; and
- has a long enough amount of time that enables him or her to use the time effectively for his or her own purposes.

On August 28, 2018, the Department of Labor ("DOL") concluded in an information letter that when the employer does not require attendance, even when attendance results in reduced medical plan contributions, participation in the wellness activities is "voluntary." Assuming there is no direct financial benefit to the employer, attendance predominantly benefits the employee. Therefore, under these circumstances, the DOL stated that the time spent by the employees related to wellness activities does not have to be paid.

Medicare Part D Notification Requirements

Published: September 20, 2018

Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is “creditable” or “non-creditable.” This notification must be provided prior to October 15th each year. Also, following the plan’s annual renewal, the employer must notify the Centers for Medicare & Medicaid Services (“CMS”) of the creditable status of the drug plan.

This information serves to summarize these requirements in more detail.

Employer Action

If you have not already done so, make sure to send these notices no later than October 15, 2018.

What are the Notification Requirements?

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Also, the employer must annually notify CMS as to whether or not the employer plan is creditable.

Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html (notices last updated by CMS for use on or after April 1, 2011).

These model notices, when appropriately modified, will serve as a proper notice for purposes of this requirement. Spanish notices are also provided at the above link.

To Whom Should the Participant Notice Be Sent?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to October 15th each year (or next working day);
- Prior to an individual's Initial Enrollment Period for Part D;
- Prior to the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, prior to the ACEP each year (October 15th or next working day for 2011 and subsequent years), CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should provide the participant notice to new hires and newly eligible individuals under the group health plan.

How Should the Participant Notice Be Sent?

Entities have flexibility in the form and manner they provide notices to participants.

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements 29 CFR § 2520.104b-4(c)(1)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open Enrollment Materials

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

> If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
>
> Please see page xx for more details.

Personalized Notices

A personalized notice is only provided upon request of the beneficiary. If an individual requests a copy of a disclosure notice, CMS recommends that entities provide a personalized notice reflecting the individual's information.

For more information on the participant disclosure requirement, visit: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

CMS Notice

When and How Should Notification Be Given to CMS?

Employers will also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (March 1, 2019 for a 2019 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

Notice must be submitted electronically by completion of a form found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

Additional guidance on completing the form including screen shots is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/2009-06-29_CCDisclosure2CMSUpdatedGuidance.pdf

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CredCovDisclosureCMSInstructionsScreenShots110410.pdf

How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected amount of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

Simplified Determination

Most entities will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
  - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
  - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
  - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- a combined plan year deductible for all benefits under the plan,
- a combined annual benefit maximum for all benefits under the plan, and/or
- a combined lifetime benefit maximum for all benefits under the plan.

Guidance Proposes to Broaden HRA Rules

Published: November 7, 2018

The Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments") issued proposed guidance that, if finalized, creates a mechanism for employers to offer Health Reimbursement Arrangements (HRAs) in connection with individual health insurance coverage.

The proposed regulations add two new HRA options for employers to consider:

- **HRA integrated with individual health insurance coverage.** Beginning with the first plan year on or after January 1, 2020, permit integration of an HRA with individual health insurance coverage provided certain conditions are met.

- **Excepted Benefit HRA.** Beginning with the first plan year on or after January 1, 2020, employers that offer traditional group health plan coverage may consider offering an Excepted Benefit HRA with a maximum annual benefit amount of $1,800.

The above options are in addition to the already existing options of (i) HRA integrated with group health plan coverage, (b) retiree-only HRA, (c) limited purpose dental and vision HRA, and (d) qualified small employer HRA (QSEHRA).

Additionally, the proposed rules provide helpful clarifications including:

- Individual health insurance policies purchased through an HRA (as allowed by this rule) or through a QSEHRAs do not become part of an ERISA plan, provided certain conditions are met.

- While premiums for individual health insurance coverage purchased through the Marketplace, referred to as a qualified health plan, may not be paid for by the employer pursuant to pre-tax salary reductions under a Section 125 Cafeteria plan, the rule permits employees to purchase non-qualified health plans (e.g., individual health insurance coverage not sold in the Marketplace) on a pre-tax basis, if the employer's cafeteria plan includes that option.

- The availability of premium tax credits (PTC) when the individual has access to an HRA that can be integrated with individual health insurance coverage.

- Special enrollment opportunity provided to purchase individual health insurance coverage (both inside and outside of the Marketplace) for individuals who gain access to an employer-based HRA that is integrated with individual health insurance coverage.

Currently, employers do not need to do anything with respect to their existing HRAs or coverage options. The guidance seeks comments on a variety of issues and is proposed to take effect for plan years beginning on or after January 1, 2020.

Nothing in these proposed rules overrides state insurance laws that prohibit employer contributions toward individual health insurance coverage.

The following summary highlights some of the important aspects of these rules and how they may affect employers looking to implement this type of arrangement.

Background

There is a lot of regulatory history that sets the stage for the changes included in the proposed rule. In a nutshell, the law has generally barred employers from offering (and paying for) individual health insurance policies.

Notably, the Affordable Care Act (ACA) and subsequent regulatory guidance:

- require that HRAs be integrated with group health plan coverage;

- prohibit integration of an HRA with individual health insurance coverage; and

- bar employers from paying for (or reimbursing) the purchase individual health insurance policies on behalf of an employee.

Noncompliance with this general prohibition could result in penalties of $100/per affected individual/per day ($36,500 for one individual per year).

At the time, the regulators required integration with group health plan coverage because, standing alone, an HRA could not meet the ACA requirements that (1) prohibit lifetime and annual dollar limits on essential health benefits (EHBs) (as HRAs have an annual dollar limit and reimburse EHBs) and (2) mandate preventive care services be covered without cost sharing. By integrating the HRA with otherwise ACA-compliant group health plan coverage, the HRA could be deemed to meet the ACA market rules.

The 21st Century Cures Act (the "Cures Act") was enacted in 2016 and, among other things, created QSEHRAs, HRAs that are not integrated with group health plan coverage available to certain small employers.

Integration Of An HRA With Individual Health Insurance Coverage

The rules expand HRA integration to allow integration with individual health insurance subject to the following conditions:

- Participants and any dependents covered by the HRA must be enrolled in individual health insurance coverage;

- A traditional group health plan may not be offered to the same participants;

- The HRA must be offered on the same terms to all participants within the same classification of employee;

- The participant who is otherwise eligible for the HRA must have the opportunity to "opt-out" and waive future reimbursements from the HRA at least annually;

- The participant must provide substantiation of individual health insurance coverage for the plan year; and

- Written notification describing the arrangement is provided at least annually.

Permitted classifications and "same terms" requirements

For this purpose, permitted classifications of employees are defined by the regulations and include;

- Full-time employees;
- Part-time employees;
- Seasonal employees;
- Collectively bargained employees;
- Employees who have not satisfied a waiting period;
- Employees who are under age 25 when the plan year begins;
- Non-resident aliens with no U.S. based income (generally foreign employees who work abroad); and
- Employees who work in the same geographic rating area for purposes of insurance underwriting.

Notably, a classification of salaried vs. hourly is not a permissible classification under these rules.

For purposes of defining "full-time employee," "part-time employee," and "seasonal employee", the proposed rule requires the use of either:

- The definitions under the employer mandate (Code Section 4980H); or
- The definitions as used in the nondiscrimination rules for self-insured health plans (Code Section 105(h)).

The elected definition must be included in the HRA plan document and consistent across all classifications (i.e., if the 4980H definition is used for full-time employees, it must be used for part-time and seasonal employees).

Additionally, under the proposed rule, the maximum dollar amount available for reimbursement to participants in a class of employees may be increased based on the following:

- As the age of the participant increases, so long as the same dollar amount is available to all participants in the classification who are the same age;
- The number of dependents who are covered under the HRA increases, so long as the same dollar amount is available to all participants in the classification who have the same number of dependents.

As varying HRA benefit amounts by age or number of dependents may give rise to discrimination issues under Code Section 105(h), the IRS is expected to provide a safe harbor to alleviate the discrimination issue if certain conditions are met.

Substantiation Requirements

The HRA must implement, and comply with, reasonable procedures to verify that participants and dependents are (or will be) enrolled in individual health insurance coverage for the plan year. To properly substantiate the participant may provide:

- A document from the carrier (or other third party) showing the participant and dependents covered by the HRA are (or will be) enrolled in individual health insurance (e.g., an insurance card, explanation of benefits (EOB)); or
- Attestation by the participant stating the participant and dependents covered by the HRA are or will be enrolled in individual health insurance coverage, the date coverage began (or will begin) and the name of the provider of the coverage.

Additionally, for each reimbursement request, the participant (and, if applicable, the dependent who received the medical care) must substantiate that he or she continues to be enrolled in individual health insurance

coverage for the month during which the medical care expense was incurred. The substantiation may be in the form of an attestation.

The employer offering the HRA may rely on the participant's documentation or attestation unless there is actual knowledge that any individual covered by the HRA is not (or will not be) enrolled in individual health insurance coverage for the plan year or the month, as applicable.

Notice requirements

The HRA must provide written notice at least 90 days prior to the start of the plan year that meets content requirements outlined by the regulation. The notice includes a description of the HRA, the maximum dollar amounts available, opt-out and waiver rights, effect of the coverage on availability of any premium tax credit, and the substantiation rules.

ERISA Implications

The proposed rule clarifies that ERISA generally will not apply to the underlying individual health insurance coverage that is purchased through the HRA so long as:

- The purchase of individual health insurance coverage is voluntary for participants and beneficiaries. The fact that the employer requires such coverage to be purchased as a condition for participation in the HRA does not make the purchase involuntary.
- The employer does not select or endorse any issuer or coverage. Providing general information regarding the availability of health insurance in a state or general health insurance educational information is not considered endorsement for this purpose.
- Reimbursement is limited solely to individual health insurance coverage.
- The plan sponsor receives no consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.
- Each plan participant is notified annually that the individual health insurance coverage is not subject to Title I of ERISA.

While the individual health insurance policies are not subject to ERISA if they meet these requirements, the HRA remains subject to all ERISA requirements (including COBRA).

Premium Tax Credit Implications

Under the proposed rule, an employee who is offered an HRA that is integrated with individual health insurance coverage is considered to have minimum essential coverage (MEC) under an eligible employer sponsored plan so long as the coverage is (1) affordable and (2) the employee does not opt-out and waive future reimbursements from the HRA. If the employee has MEC, he or she may not be eligible for a PTC. The proposed rules go into great detail regarding how affordability is determined for this purpose. As the guidance and comments develop, we will provide further clarification.

Employer Mandate Implications

To the extent Applicable Large Employers (ALEs) consider offering an HRA integrated with individual health insurance coverage, the IRS indicates subsequent guidance will include a safe harbor for purposes of determining whether an offer of such coverage is considered an affordable offer of minimum value coverage for purposes of 4980H (the employer mandate), regardless of whether the employee who was offered such coverage, declined the HRA, and claims a PTC.

Additionally, future guidance is expected to extend the existing affordability safe harbors (W-2, Rate of Pay, and Federal Poverty Level) to employers offering an HRA integrated with individual coverage.

State Law

Some state insurance laws bar employers from purchasing (directly or indirectly) health insurance coverage from the individual market on behalf of employees. Both Oregon

and Texas prohibit this practice. Nothing in these federal rules overwrites the state's authority to regulate individual insurance markets. Therefore, it appears prohibitions at the state level remain valid and may limit this HRA option in certain areas.

Excepted Benefit HRA

The regulations create a new, limited Excepted Benefit HRA (EB HRA). This type of HRA is different from an integrated group health plan HRA and subject to more restrictive conditions.

To be considered an EB HRA (or other account-based plan), the arrangement must meet the following conditions:

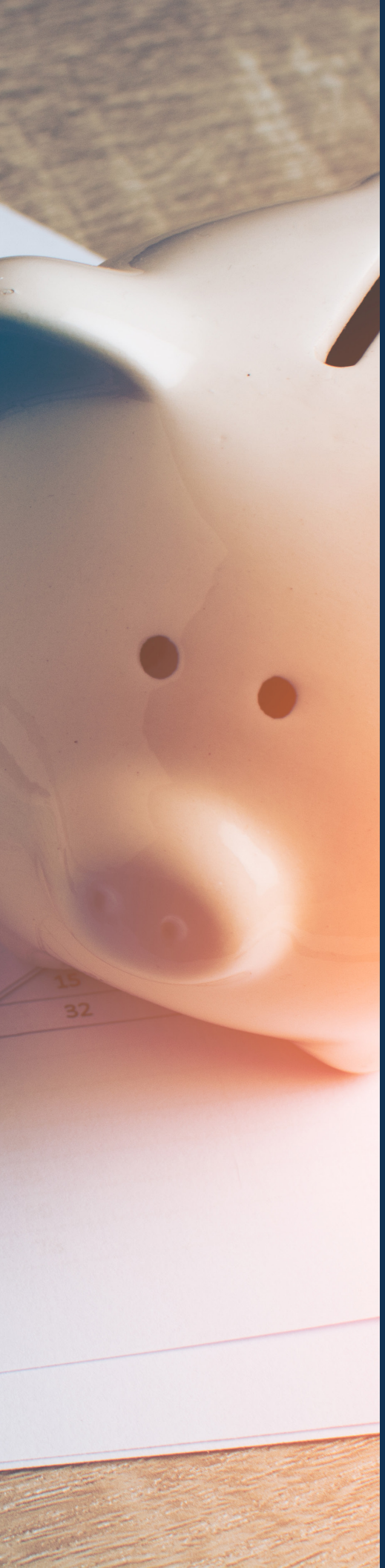
- There must be other group health plan coverage available for the plan year to participants that is not limited to excepted benefits and is not an HRA or other account-based plans.
- The benefit amount available each year cannot exceed $1,800. The $1,800 will have a cost-of-living adjustment annually beginning with the 2021 plan year.
- The arrangement cannot reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA premiums), or Medicare Part B or Part D premiums. There is an exception that would allow this arrangement to reimburse premiums for coverage that is an excepted benefit and otherwise eligible for reimbursement (e.g. short-term limited duration plans).
- The EB HRA (or other account-based group health plan) is made available under the same terms to similarly situated individuals regardless of any health factor.

Notably:

- While the EB HRA must be offered with other group health plan coverage, participants are not required to enroll in the group health plan coverage. Thus, a participant can decline the group health plan coverage but accept the EB HRA. This is a significant difference from integrated HRAs (which require group health plan coverage).
- If an employer offers an EB HRA, the employer may not offer a QSEHRA or HRA that is integrated with individual health insurance coverage.

Employer Action

- No action is required by employers as this rule is in proposed format and cannot be relied on at this point.
- If interested, employers and other stakeholders may provide comments to the Departments by December 28, 2018.
- Stay tuned for further guidance on this topic.



2019 Cost of Living Adjustments

Published: November 19, 2018

The IRS recently released cost of living adjustments for 2019 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

For plan years beginning in 2019, the dollar limitation under Section 125 for voluntary employee salary reductions for contributions to health flexible spending arrangements increases to **$2,700**.

The Affordable Care Act (ACA) amended Section 125 to place a $2,500 limitation under Section 125(i) on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Qualified Transportation Fringe Benefits

For calendar year 2019, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Section 132(f)(2)(B)) increases to **$265**.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Section 125 nondiscrimination testing) again increases to **$125,000** for 2019.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). Prop. Treas. Reg. 1.125-7(a)(9).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2019 increases to **$180,000**.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. Prop. Treas. Reg. 1.125-7(a)(10).

Non-Grandfathered Plan Out-Of-Pocket Cost-Sharing Limits

The 2019 maximum annual out-of-pocket limits for all non-grandfathered (NGF) plans are $7,900 for individual coverage and **$15,800** for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. The final regulations established that starting in the 2016 plan year, the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2019, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under § 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed **$5,150** ($10,450 for family coverage).

Health Savings Accounts

As announced in May 2018, the inflation adjustments for health savings accounts (HSAs) for 2019 were provided by the IRS in Rev. Proc. 2018-30.

Annual contribution limitation.

For calendar year 2019, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,500**. For calendar year 2019, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$7,000**.

High deductible health plan.

For calendar year 2019, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,350 for self-only coverage** or **$2,700 for family coverage,** and the **annual out-of-pocket expenses** (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $6,750 for self-only coverage** or **$13,500 for family coverage**.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-up contribution.

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.

New Prescription Drug Oversight, Transparency, and Opioid Abuse Legislation

Published: November 20, 2018

Throughout September and October 2018, the government enacted laws and issued proposed guidance aimed at the prescription drug market. These bills and regulatory actions follow the Trump administration's "American Patients First" blueprint, with the objective to bring down prescription drug prices and out-of-pocket costs, along with combatting the opioid epidemic.

The recent actions on prescription drugs seek to:

- Eradicate the use of "gag clauses" by PBMs and insurance carriers in contracts with pharmacists so information regarding pricing through insurance versus on a direct-buy basis is more readily available to consumers;
- Require pricing information in drug advertising; and
- Address opioid abuse.

Below is a discussion of the new laws and regulations on this topic. Except as it applies to "gag clauses," the direct effect of these changes will be felt predominantly in the Medicare and Medicaid marketplaces.

New Bills Prohibit "Gag Clauses" in Pharmacy Contracts

On October 10, 2018, President Trump signed legislation that would prohibit "gag clauses" in pharmacy contracts. Often the cash price of a prescription is lower than the copayment based on the plan's formulary. It has been a common practice for insurance plans and/or PBMs to have contractual language with their participating pharmacies that prohibited the pharmacist from disclosing the lower cash price to the enrollee (informally, a "gag clause"). The new legislation prohibits such clauses.

There are two bills that address this requirement:

- The Patient Right to Know Drug Prices Act applies to group health plans and health insurers offering group or individual coverage and is effective immediately.

- The Know the Lowest Price Act of 2018 applies to Medicare Part D plans and is effective for plan years beginning in 2020.

Group health plans sponsored by employers are subject to the Patient Right to Know Drug Prices Act. Generally, the group health plan and insurance carrier:

- cannot restrict any pharmacy that dispenses a prescription drug to an enrollee in the plan or coverage from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage; and

- must ensure any entity that provides pharmacy benefit management services under a contract with the health plan or the carrier does not violate the same provisions.

It is important to note however, that the legislation does not require the pharmacist to disclose the lower cash price; it simply prohibits the plan from penalizing the pharmacist from doing so. Consumers may still need to ask the pharmacist if there is a lower cash price when filling prescriptions.

Employer Action

Employers with self-funded health plans or self-funded prescription drug carve-outs managed by a PBM will want to discuss whether such gag clauses are included in contracts with participating pharmacy providers and have them removed as soon as possible.

Proposed Regulation to Require Drug Pricing Transparency on TV

In mid-October, the Centers for Medicare and Medicaid Services (CMS) released draft regulations that, if enacted, would include certain pharmacy pricing information in television advertisements.

Specifically, the draft regulations provide that CMS will publish an annual list of drugs which must provide pricing information if they are featured in a television commercial. Only drugs that are paid for by Medicare or Medicaid would be subject to this requirement.

If finalized, the advertisement must provide the drug's wholesale acquisition cost or "list price." Even though consumers rarely pay the list price of the drug at their pharmacy counter, CMS believes that sharing the list price will create transparency to the consumer as to how much drugs really cost compared to what they pay.

Interestingly, the proposed regulations state that the enforcement mechanism for drug companies that do not comply will be private lawsuits, not direct enforcement from CMS or other government agencies.

It is important to note that these regulations are not yet finalized and are not yet law; they are only in draft form. Therefore, there may be changes that can occur as the draft regulation continues through the regulatory process. Further updates may be available after the comment period closes in December 2018.

Newly Enacted Law Addresses the Opioid Crisis

On October 24, 2018, President Trump signed into law the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). This largely bi-partisan law includes the following objectives:

- Reduce use and supply of opioids;
- Encourage recovery for those with substance use disorders;

- Support caregivers and families impacted by substance use; and
- Drive innovation and long-term solutions (i.e., research for non-addictive painkillers and ensure parity for mental health and substance use disorders benefits).

While the objectives are global, in operation, the law primarily affects Medicare or Medicaid programs and healthcare providers. Group health plans are not directly affected. Some noteworthy provisions of the law are discussed below.

Few Implications for Employers and Group Health Plans

The final text of the bill provides little impact and/or changes for employers and employer-sponsored health plans.

However, in the early stages of the legislation, there was a provision that would have revised the Medicare Secondary Payer rules around payment for end-stage renal disease (ESRD) in order to generate revenue for the program by requiring group health plans to pay primary for an additional three months of care for ESRD patients before Medicare. This provision was not added as a part of the final regulations, and thus the Medicare Secondary Payer Rules are not changed by this law.

Separately, the Act provides that the Department of Labor (DOL) will establish an Advisory Committee on Opioids and the Workplace to review the impact of opioid use in the workplace and to support those in the workplace that abuse opioids.

Medicaid Coverage Expansions

The SUPPORT Act also has several provisions that expand Medicaid-covered services for substance use disorders. For example, the Act expands state Medicaid treatment for substance use disorders to include all FDA-approved drugs, counseling services, and behavioral therapy, beginning in October 2020 through 2025.

Medicare and Medicaid funding for Telemedicine

The Act expands the use of telemedicine for opioid and heroin use treatment and counseling. In the future, states will receive options for providing telehealth services to treat substance use disorders under Medicaid. Medicare coverage will be expanded for telehealth services for treatment of substance use and related mental health conditions.

Future regulations will be enacted for registration of providers to prescribe controlled substances via telemedicine in legitimate emergency situations.

Oversight on Providers and Pharmacists Providing Opioid Prescriptions

The Act also includes new measures of prescription drug oversight for doctors and providers that accept Medicaid. The Act requires states to have drug utilization safety measures to monitor issuing of opioid prescriptions and refills, and similar measures for antipsychotic prescriptions issued to children. There will also be additional federal funding available to states for implementation of prescription drug monitoring programs.

Additionally, the Department of Health and Human Services (HHS) must develop training programs and materials to train pharmacists on when they may refuse to fill a controlled substance prescription. Instances of refusal would include if there is suspicion of forgery, fraud or other prescription abuse.

The bill also seeks to promote communication with families of affected individuals during emergencies and overdoses. To promote this, providers will receive annual updates on privacy restrictions and laws describing what health information is allowed be shared with families and caregivers during an emergency.

Wellness Program Considerations for 2019

Published: November 29, 2018

Wellness programs have faced unique challenges and scrutiny in 2018. As the year winds down, it's important to review a few important areas as we launch into 2019. This article offers some updates on:

- The status of wellness program incentives when using medical exams, biometric testing, and health risk assessments; and
- The Department of Labor's enforcement activity on wellness programs tied to group health plans.

While this article is focused specifically on incentives and current litigation, there are additional requirements (e.g., reasonable alternatives, notification, and confidentiality) that may apply. This article is limited to a discussion on incentives and current litigation and does not address other important compliance issues.

ADA and GINA Incentive Rules Vacated

Beginning January 1, 2019, the incentive portions of the voluntary wellness program rules under the Americans with Disabilities Act ("ADA") and Genetic Information Nondiscrimination Act ("GINA") regulations are vacated. These rules generally apply to wellness programs that incentivize employees (or their spouses) to complete medical exams (e.g., get a physical or biometric testing) and/or answer disability-related inquiries (e.g., complete a health risk assessment).

It is important to note that the wellness program rules under HIPAA and the ACA are still in effect.

As a reminder, there are three sets of laws governing incentive limits and wellness programs currently in effect:

- **HIPAA/ACA rules.** When rewards are used in a group health plan to promote involvement in an activity (e.g., walking, diet, or exercise program) or are based on a certain outcome (e.g., not smoking or achieving certain results on biometric screenings), incentives cannot exceed 30% of the total cost of coverage under the group health plan (or 50% when the program is tobacco-related).

- **ADA rules.** A permissible reward in a wellness program involving an employee's medical test or disability-related inquiry cannot exceed 30% of the total cost of self-only coverage in the lowest cost plan option offered to an employee.

- **GINA rules.** Incentives related to a completion of a health risk assessment or medical exam are limited to 30% of the total cost of self-only coverage in the lowest cost plan offered by the employer. Incentives tied to participation of children are not permitted.

As a rule of thumb, if the incentive is set at generally no more than 30% of the total cost of coverage in the lowest cost self-only plan offered by the employer, the incentive would not violate the limit requirements under HIPAA/ACA, ADA and GINA rules.

However, as reported earlier, the decision in a recent lawsuit requires the Equal Employment Opportunity Commission ("EEOC") to re-issue regulations around the incentive limits under the ADA and GINA. The court indicated that the existing incentive limits would be vacated as of January 1, 2019 unless guidance is issued. In a status report to the court, the EEOC stated it did not anticipate regulations would be revised until 2020.

As a result, employers are in a state of confusion around these incentives for plan years beginning in 2019.

While no further guidance has been issued by the regulators, the following are some general comments that may be helpful as employers look to address wellness incentives for the upcoming year.

- The ADA and GINA rules only apply to wellness programs that reward employees (and/or their spouses) for:
  - annual physicals;
  - biometric screenings (e.g., blood draws);
  - completion of a health risk assessment; and
  - completion of a blood draw or mouth swab to determine smoker status.

To the extent a wellness program does not use incentives toward these activities, the challenged ADA and GINA incentive limits do not apply.

- To the extent the employer offers a wellness program that is subject to the ADA or GINA, the employer will want to determine what to do.
  - The most conservative approach would be to remove rewards associated with the completion of these activities. However, as many employers have been using incentives with these types of programs since before the 2016 EEOC rules were finalized, this may be an overly cautious tactic. Companies heavily invested in wellness, may be willing to ride out this time of uncertainty in favor of their wellness programs.

  - Many employers have decided to follow the "to be vacated" ADA/GINA guidelines on incentives (which are more restrictive than the existing rules under HIPAA) with respect to their wellness programs and take the risk that the EEOC will not challenge these arrangements until additional guidance is issued.

  - Employers should not take this opportunity to go more aggressive with their programs without consulting legal counsel.

Update on DOL Enforcement of Wellness Programs

Meanwhile, the Department of Labor ("DOL") has been actively pursuing cases involving group health plans with respect to HIPAA/ACA violations and breaches of fiduciary duty. The litigation primarily concerns outcome-based programs that fail to offer reasonable alternatives in line with the regulations. Following are some brief highlights from a few of the more interesting cases.

- **Acosta v. ChemStation International** (settled October 2018 for $59,189.90 - $53,122.00 in excess premiums withheld from participants and $6,067.90 in lost opportunity costs). The DOL alleged that the ChemStation wellness program required plan participants and beneficiaries who did not participate, or participated but did not achieve the specific number of health plan outcomes, to pay more in premiums than those who participated and achieved or maintained the outcomes. The DOL alleged the employer did not provide any alternative standard (reasonable or otherwise) by which plan participants and beneficiaries could obtain the discounted plan premiums offered to similarly-situated participants and beneficiaries who participated in the program and attained or maintained the specified number health outcomes.

- **Acosta v. Macy's** (pending motion to dismiss). DOL alleges, among other things, that Macy's wellness program failed to provide a reasonable alternative standard to stop paying a tobacco surcharge because tobacco users who completed a smoking cessation program were still paying the surcharge unless they certified non-tobacco user status for 6 months.

- **Acosta v. Dorel** (filed September 2018). DOL alleges, among other things, that the wellness program failed to provide a reasonable alternative standard to stop paying a tobacco surcharge because tobacco users who completed a smoking cessation program were still paying the surcharge unless they certified non-tobacco user status.

In each case, the documentation describing the program did not reflect a reasonable alternative standard for removing the surcharge was available.

These enforcement efforts highlight the importance of wellness program compliance, in particular around incentives and proper documentation and allowing employees who do not meet the standard to qualify for the reward another, reasonable way.

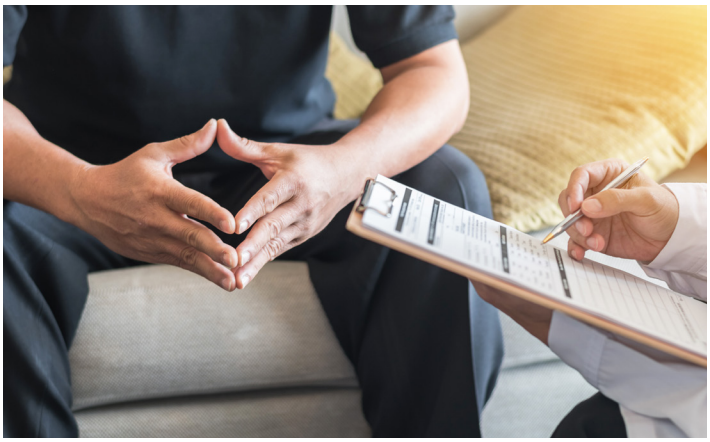
Employer Action

Employers with incentive-based wellness programs should:

- Review existing programs to determine whether they are subject to the ADA and/or GINA (require employees (and/or their spouses) to complete a medical exam, biometrics or a health risk assessment).

- If subject to the ADA and/or GINA, determine a strategy around incentives during an uncertain period while the EEOC works to reissue guidance. Any strategy will be based on the employer's risk tolerance and advice of counsel is recommended.

- HIPAA/ACA wellness rules remain in effect and are actively being looked at by the DOL. If an employer offers activity or outcome-based programs, they should ensure there are (among other things) reasonable alternative mechanisms to achieve the reward and appropriate notice is provided.



Extension of Deadline for 2018 Forms 1095-C

Published: November 30, 2018

On November 29, 2018, the IRS issued Notice 2018-94, which provides a limited extension of time for employers to provide 2018 Forms 1095-C to individuals. It also extends good-faith transition relief from certain penalties for the 2018 reporting year. The deadline for employers to provide Forms 1094-C and 1095-C to the IRS was not extended.

Q1: What was Extended?

2018 Forms 1095-C statements must be furnished to individuals by **March 4, 2019** (rather than January 31, 2019).
This extension of time also applies to carriers providing Forms 1095-B to individuals in insured plans.

Q2: Were the deadlines for reporting to the IRS extended?

No.

The 2018 Form 1094-C and all supporting Forms 1095-C (collectively, "the return") is due to the IRS by April 1, 2019 if filing electronically (or February 28, 2019 if filing by paper). These deadlines **were not extended** as part of the relief announced in Notice 2018-94. Per the Notice, the government determined there was no similar need for additional time for employers to file these Forms with the IRS.

As a reminder, employers that file at least 250 Forms 1095-C must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: Is there penalty relief?

Yes.

Notice 2018-94 extends transition relief from penalties to reporting entities that have made good-faith efforts to comply with the information reporting requirements for the 2018 reporting year, both for furnishing the Form 1095-C to individuals and for filing with the IRS. Specifically, this relief applies to missing or inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

No relief is available if the reporting entity does not make a good-faith effort to comply with the regulations or for a failure to file a return or furnish a statement by the applicable due dates.

This relief does not absolve an employer from correcting an incorrect Form if so instructed by the IRS

Q4: What if the submissions are late?

Employers that do not comply with these due dates are subject to penalties. However, employers should still furnish and file the forms and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q5: What if employees do not have Forms 1095-C (or Forms 1095-B from the carrier) before they file their tax returns?

Some taxpayers may not receive their Form 1095-C (or 1095-B from the carrier) by the time they are ready to file their personal tax return for 2018. Taxpayers do not need to wait until they receive their Form 1095-C (or 1095-B) to file their annual tax return, and may rely on other information from their employer (or carrier) for purpose of filing individual taxes. Individuals need not send this information to the IRS when filing their returns but should keep it with their tax records.

Q6: Will the IRS offer this relief for 2019 reporting?

According to the Notice, because the individual shared responsibility payment is reduced to zero for months beginning after December 31, 2018, the Departments are looking into whether the reporting requirements should change, if at all, for future years.

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