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2018: Fourth Quarter

# Compliance Digest

Compliance Bulletins Released October - December

# 2018 Compliance Bulletins

## November



# 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:

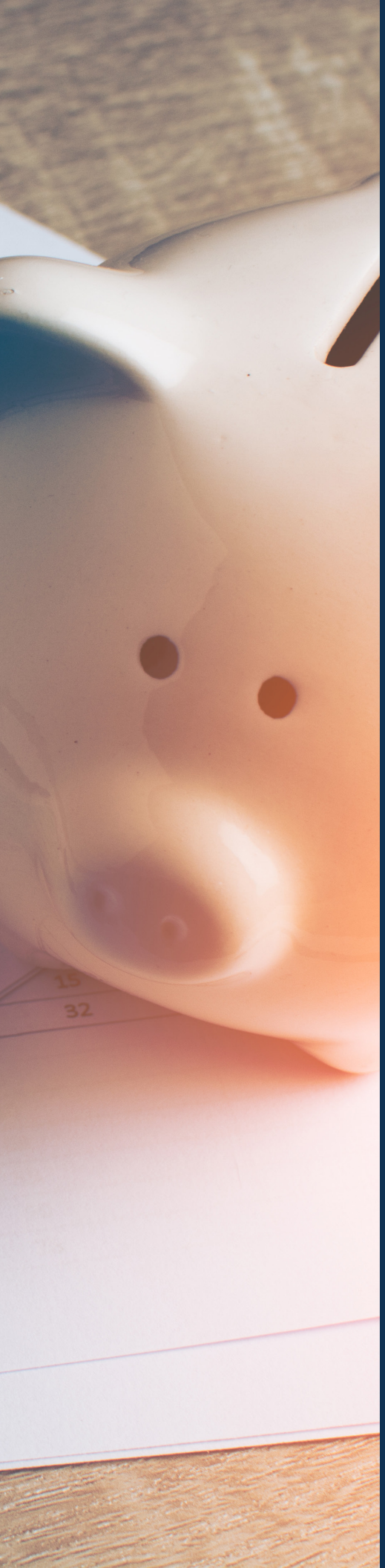
- There must be other group health plan coverage available for the plan year to participants that is not limited to excepted benefits and is not an HRA or other account-based plans.
- The benefit amount available each year cannot exceed $1,800. The $1,800 will have a cost-of-living adjustment annually 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.

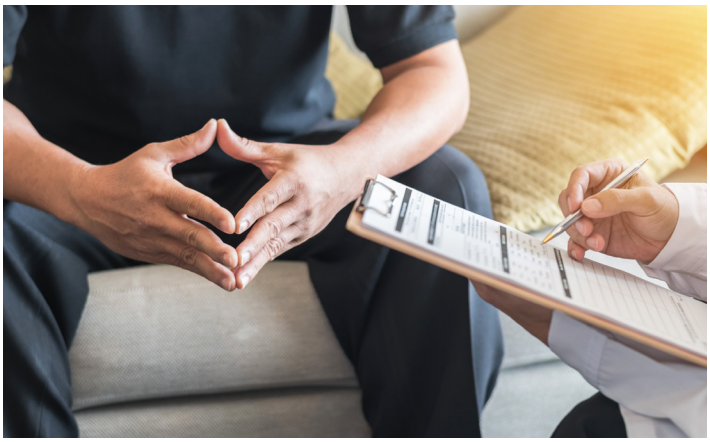
## Employer Action

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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