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2019: First Quarter

# Compliance Digest

Compliance Bulletins Released January-March

# 2019 Compliance Bulletins

## January



## February



## March




This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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# ACA Still In Force, But With Uncertain Fate

Published: January 18, 2019

On December 14, 2018, a Texas district court invalidated the entire Affordable Care Act ("ACA"). This includes the Individual Mandate, Employer Penalty, mandated benefits such as the prohibition against preexisting condition exclusions, taxes such as the PCOR fee, the establishment of the Marketplace and offering of subsidies, and reporting such as Form 1095-C reporting. The ruling does not constitute a final determination and the decision will be appealed. Therefore, there is no immediate impact.

Absent further direction, all provisions of the ACA remain in effect, including:

- The Employer Mandate and associated annual reporting on Forms 1094-C and 1095-C (due to employees by March 4, 2019 for calendar year 2018).
- Insurance market reforms, including the prohibition on preexisting condition exclusions, limitation on waiting periods, prohibition on lifetime and annual dollar limits, and coverage for children up to age 26.
- Availability of premium tax credits to assist certain low-to-middle income individuals in purchasing health insurance through the Marketplace.

This article summarizes this history of the challenges to the ACA and the potential effect a final ruling may have on its future.

## 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.

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.

On June 7, 2018, in a departure from the Justice Department's custom of fighting to uphold all reasonable laws, then U.S. Attorney General Jeff Sessions indicated in a brief that it would not participate in the defense of this lawsuit. While the Administration did call on the court to invalidate the Individual Mandate, guarantee issue requirement, and community rating requirement, it indicated that the remaining provisions should stand. It also asked the court to hold off on a broad ruling until after December 15, the end of this year's Marketplace open enrollment period, to avoid introducing "chaos in the insurance markets."

In May 2018, the court allowed the attorneys general from Democratic-leaning states to "intervene" in the case and defend the law. California Attorney General Xavier Becerra led the challenge with 15 other states and the District of Columbia. They refuted 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.

In addition, there is ongoing parallel litigation over the DOJ's decision not to defend the ACA.

## The December 14, 2018 Decision

In Texas v. Azar, Judge O'Connor, a George W. Bush appointee who sits in the Northern District of Texas, came to three conclusions:

- the plaintiffs had standing to sue so the case was properly before the court;

- with the penalty at $0, the Individual Mandate is no longer permissible under Congress' taxing power and is unconstitutional; and

- the Individual Mandate is essential to and inseverable from the entire ACA, meaning the entire ACA is invalid.

Judge O'Connor's ruling does not enjoin the ACA which means that the ACA's provisions remain in effect for the time being.

From here, the case will likely move to the Fifth Circuit Court of Appeals and then the Supreme Court where a final decision might not be made until 2020 or later.

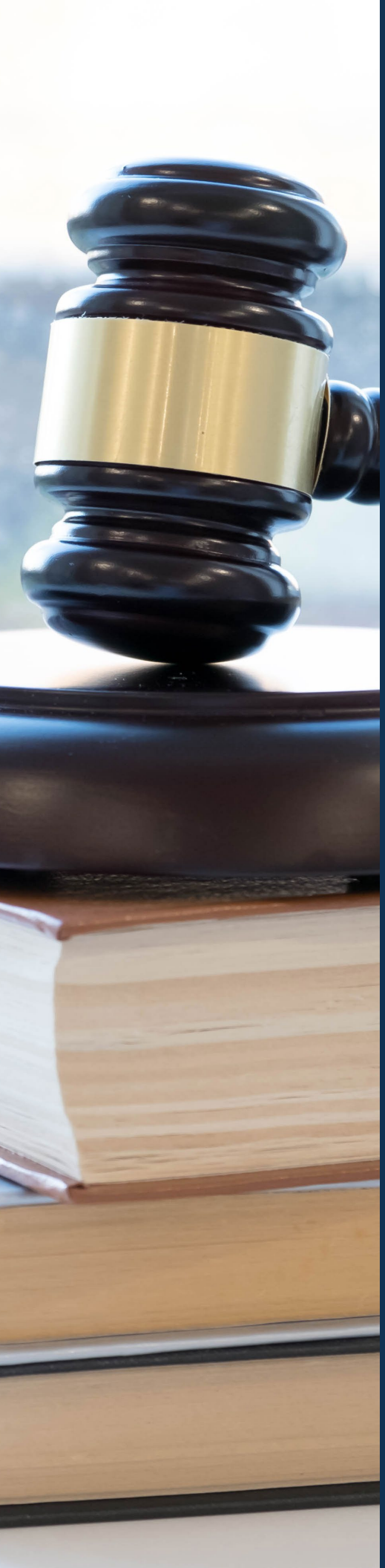
## Next Steps

While impossible to determine the final outcome, Judge O'Connor's arguments have been met with criticism, even by conservative legal scholars. 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.*

If the ACA is invalidated, the effects will be far-reaching, with the ACA touching almost every aspect of the American health care system (e.g., community rating and Medicaid expansion). In part, it 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 be monitoring this litigation and provide updates of further developments.



# Contraceptive Coverage Exemption Rules on Hold by Courts

Published: January 22, 2019

A federal district court in Pennsylvania has issued a nationwide injunction blocking revised rules set to be effective on January 14, 2019 regarding contraceptive services coverage in employer based health insurance. The revised rules would make it easier for private employers to refuse to provide coverage for contraceptive services as part of their health insurance plan for employees. Pending any appeal, the requirement to provide contraceptive services will remain in place for all entities that do not qualify for a religious objection exemption.

## Background

Under the Affordable Care Act ("ACA"), all non-grandfathered health plans must cover certain preventive items and services without cost-sharing, including contraceptive services. Churches, religious non-profits, and closely held for-profit organizations with religious objections can qualify for an exemption.

In October 2017, the Departments of Health and Human Services, Labor, and the Treasury (collectively "the Departments") released interim regulations permitting non-governmental employers, institutions of higher education, and individuals with religious or moral objections to cease providing coverage for some, or all, contraceptive services. Despite being effective immediately, these regulations were quickly put on hold by preliminary injunctions issued by two federal district courts. Appeals were filed in those cases.

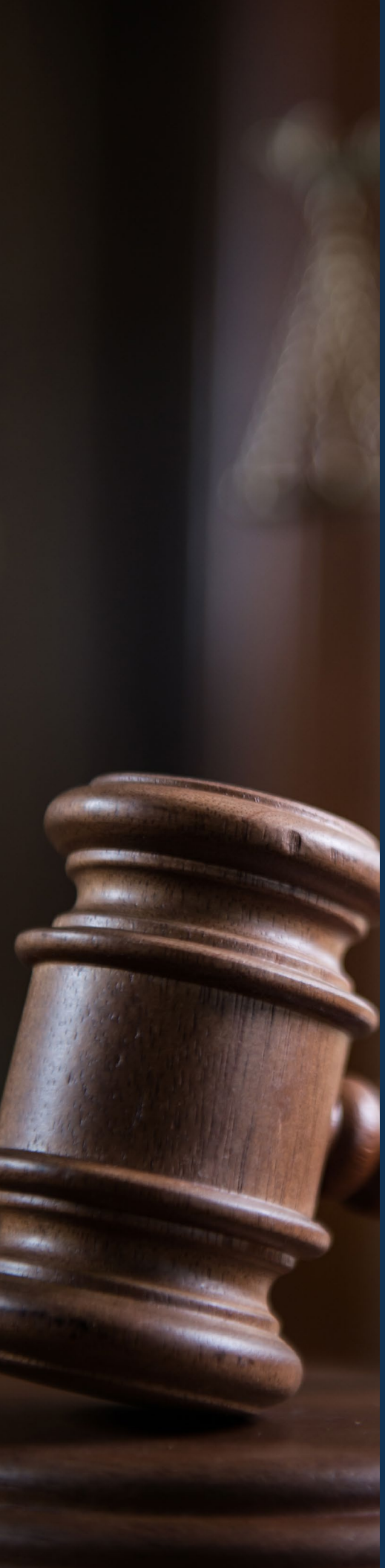
In November 2018, the Departments issued revised final regulations set to go into effect on January 14, 2019, which largely mirrored the October 2017 interim regulations. It is unclear how the publication of the revised final regulations affects the pending lawsuits over the October 2017 interim regulations.

## New Developments

Several states and the District of Columbia joined forces to challenge the November 2018 regulations in the same federal district courts in California and Pennsylvania that had issued injunctions against the October 2017 regulations because they were issued without a public comment period in violation of the rulemaking process. On January 13, 2019, the federal district court in California issued an injunction against the new rules, but limited that injunction to the specific states that had filed the lawsuit in that court. On January 14, 2019, the federal district court in Pennsylvania issued an injunction blocking the rules nationwide. The injunctions do not invalidate the regulations, but stop them from going into effect while the appeals process continues.

## Employer Considerations

It is expected that the Departments will appeal these latest injunctions. Employers should use caution and consult with counsel before implementing any changes related to contraceptive services that rely on the November 2018 or the October 2017 rules. As always, we will continue to monitor the progress of this issue and provide additional information when available.



# Proposed Settlement in Dave & Buster's ERISA Class Action Lawsuit

Published: January 23, 2019

A settlement has been preliminarily approved in the lawsuit filed against Dave & Buster's (D & B) by current and former employees alleging the company's nationwide reduction of employees' work hours was motivated by an intent to reduce costs for the company by restricting employee eligibility for the company health plan. D & B has reportedly agreed to pay more than $7.4 million to workers whose scheduled hours were cut.

## Background

The Affordable Care Act (ACA) became law on March 23, 2010. The ACA's employer mandate requires employers with more than 50 full time employees to offer health insurance to 95% of their full-time employees or pay penalties. The ACA defines "full time" as working 30 or more hours a week. Prior to the ACA, many employers offered health insurance to employees who worked at least 35 or 40 hours per week. Those employers were faced with the choice of expanding the eligibility criteria of their health plans, or risking penalties under the ACA.

The Employee Retirement Income Security Act of 1974 (ERISA) places certain duties on private employers that sponsor certain employee benefit plans. One of the protections under ERISA prevents anyone, including an employer, from discriminating against a plan participant for the purpose of interfering with a right or the attainment of a right protected by ERISA. Eligibility for health insurance is protected by ERISA.

## Marin v. Dave & Buster's, Inc.

According to the lawsuit filed in May of 2015, in response to the ACA employer mandate, D & B decided to manage its employee work schedules in order to restrict the number of hours employees could work per week. It was alleged that D & B reduced employees' scheduled work hours specifically to limit employee eligibility for health insurance for the purpose of minimizing costs imposed by the ACA. There were two outcomes of the schedule reductions that became the subject of the lawsuit:

- Some employees that were enrolled in D & B's group health plan lost eligibility
- Some employees that were eligible to enroll for D & B's group health plan lost eligibility

The lawsuit was significant because it alleged that D & B violated ERISA when it chose to reduce its employees' scheduled hours to avoid the ACA penalties, on the theory that intending to eliminate or prevent eligibility for the health insurance plan was prohibited interference under ERISA §510. Initially, D & B denied all the claims made in the lawsuit and tried to have the case dismissed. The Court denied the motion to dismiss and the parties proceeded with the litigation while negotiating a settlement. Ultimately, a settlement was reached and preliminarily approved by the court on December 18, 2018. A final approval hearing is scheduled in May of 2019.

## Employer Considerations

As with most settlements, there is unlikely to be any admission of wrongdoing on the part of D & B or any bright lines established by the court. However, the D & B litigation and preliminary settlement serve as an important reminder of the ERISA fiduciary rules and potential consequences when these rules aren't followed. While the employer mandate forced many employers to evaluate their plan eligibility rules to understand potential penalty exposure and risks, as the D&B case illustrates, careful consideration of the ERISA fiduciary rules should also be a part of this evaluation.

# 2019 Federal Poverty Guidelines Announced

Published: January 25, 2019

HHS recently announced the 2019 Federal Poverty Level (FPL) guidelines which, among other things, establish the FPL safe harbor for purposes of the Affordable Care Act (ACA) employer mandate. For 2019, the FPL safe harbor is **$102.62**/month in the lower 48 states, $128.18/month for Alaska, and $118.15/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect within 6 months before the first day of the plan year for purposes of affordability. As the FPL guidelines were announced after the start of the calendar year, plans beginning on January 1, 2019 use $99.75/month for the lower 48 states ($124.72 Alaska and $114.70 Hawaii). The increased threshold applies to plan years beginning on or after February 1, 2019.

## Background

Large employers may be subject to the employer penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees and at least one full-time employee receives a subsidy in the Marketplace. The FPL is relevant to this penalty in two ways:

1. **Affordability Safe Harbor**
   For affordability purposes, a large employer satisfies the FPL safe harbor with respect to an employee for a calendar month if the employee's required contribution for the large employer's lowest cost self-only coverage that provides minimum value does not exceed 9.5% (indexed at 9.86% for 2019) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2. **Subsidy Eligibility**
   An individual is only eligible for a subsidy in the Marketplace if he or she is within 100-400% of the FPL and is not offered affordable, minimum value group coverage.

## Indexed Amounts

The following are the 2019 HHS poverty guidelines:

**2019 Poverty Guidelines for the 48 Contiguous States and DC**

| Persons in family/ household | Poverty guideline |
|---|---|
| 1 | $12,490 |
| 2 | $16,910 |
| 3 | $21,330 |
| 4 | $25,750 |
| 5 | $30,170 |
| 6 | $34,590 |
| 7 | $39,010 |
| 8 | $43,430 |

For families/households with more than 8 persons, add $4,420 for each additional person.

**2019 Poverty Guidelines for Alaska**

| Persons in family/ household | Poverty guideline |
|---|---|
| 1 | $15,600 |
| 2 | $21,130 |
| 3 | $26,660 |
| 4 | $32,190 |
| 5 | $37,720 |
| 6 | $43,250 |
| 7 | $48,780 |
| 8 | $54,310 |

For families/households with more than 8 persons, add $5,530 for each additional person.

**2019 Poverty Guidelines for Hawaii**

| Persons in family/ household | Poverty guideline |
|---|---|
| 1 | $14,380 |
| 2 | $19,460 |
| 3 | $24,540 |
| 4 | $29,620 |
| 5 | $34,700 |
| 6 | $39,780 |
| 7 | $44,860 |
| 8 | $49,940 |

For families/households with more than 8 persons, add $5,080 for each additional person.

## Affordability Safe Harbor and Subsidy Eligibility 2019 Results

Based on new 2019 levels:

- For affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $12,490 for a single individual for every state (and Washington D.C.) except Alaska or Hawaii. So, if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value is **$102.62** (9.86% of $12,490/12) or less, the employer meets the FPL safe harbor.

- For subsidy eligibility purposes, the applicable FPL is the FPL for the state in which the employee resides. 100 – 400% of the FPL is **$12,490 – $49,960 for a single individual and $25,750 – $103,000 for a family of four** for every state (and Washington D.C.), except Alaska or Hawaii.

# DOL Penalties Increase for 2019

Published: January 28, 2019

IThe Department of Labor (DOL) published the annual adjustments for 2019 that increase certain penalties applicable to employee benefit plans.

## Annual Penalty Adjustments For 2019

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

| Description | 2018 Penalty | 2019 Penalty |
|---|---|---|
| Failure to file **Form 5500** | Up to $2,140 per day | Up to $2,194 per day |
| Failure of a **MEWA** to file reports | Up to $1,558 per day | Up to $1,597 per day |
| Failure to provide **CHIP Notice** | Up to $114 per day per employee | Up to $117 per day per employee |
| Failure to disclose CHIP/Medicare Coordination to the State | $114 per day per violation (per participant/beneficiary) | $117 per day per violation (per participant/beneficiary) |
| Failure to provide **SBCs** | Up to $1,128 per failure | Up to $1,156 per failure |
| Failure to furnish **plan documents** (including SPDs/SMMs) | $152 per day $1,527 cap per request | $156 per day $1,566 cap per request |
| **Genetic information** failures | $114 per day | $117 per day |
| De minimis failures to meet genetic information requirements | $2,847minimum | $2,919 minimum |
| Failure to meet genetic information requirements – not de minimis failures | $17,084 minimum | $17,515 minimum |
| Cap on unintentional failures to meet genetic information requirements | $569,468 maximum | $583,830 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, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

# New Jersey Updates 2019 Individual Mandate Employer Reporting

Published: January 29, 2019

The state of New Jersey has posted information related to employer reporting under New Jersey's individual health insurance mandate that went into effect January 1, 2019. Initially, starting in early 2020 and relating back to 2019, certain employers with New Jersey employees must remit to the state the same Forms 1095-C and 1094-C provided to the Internal Revenue Service (IRS) for 2019.

## Background

The New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance, starting January 1, 2019. Failure to do so, absent an exemption, will result in an individual penalty imposed by the state when a person files his or her 2019 New Jersey Income Tax return. This New Jersey individual insurance mandate essentially replaces the individual mandate imposed under the Affordable Care Act (ACA), which was effectively eliminated starting in 2019 under the Tax Cuts and Jobs Act.

As with the ACA, the NJ Act requires certain employers and insurance carriers to report to covered individuals and to the state in affirming that such individuals had actual health coverage in a calendar year.

## What's New

Recently, the state of New Jersey updated its "Information for Employers" website with respect to the New Jersey Health Insurance Mandate. Notably, beginning with CY 2019, employers must provide the same Forms 1094-C and 1095-C to the state of New Jersey as they provide to employees (and perhaps other individuals otherwise covered under an employer-sponsored plan) and to the Internal Revenue Service (IRS) under the ACA. The Forms are to be sent to the New Jersey Division of Taxation by February 15, 2020. This deadline actually precedes the general deadline by which such Forms need to be filed with the IRS under the ACA.

Employer reporting under the NJ Act applies to all employers that withhold and remit New Jersey Gross Income Tax for New Jersey residents, including employers located outside of the state. However, the NJ Act employer reporting is optional for employers who are not required to submit IRS Forms 1095-C or 1095-B to employees. That would generally consist of any employer under 50 employees. However, pending further guidance, a small employer with a self-insured plan for any portion of the year may still be subject to reporting under the NJ Act.

Even though the ACA has not required employers with insured plans to report on actual coverage of individuals (a responsibility that falls on insurance carriers), the state still requires such employers to submit any Forms 1095-C they generate for individuals who are NJ residents.

## Employer Action

All employers with employees who are New Jersey residents should evaluate whether they will be subject to these new reporting requirements beginning in 2019. In many cases, such employers will already be generating the Forms required to be filed with the state.

Employers should be aware of the February 15, 2020 reporting deadline (as it is earlier than what is required under federal law).

Further, all such employers should watch for updates on the New Jersey website, particularly if the IRS changes the current Forms for 2019 reporting, and if NJ deploys its own separate forms.

# Proposed Rules Address Prescription Drug Pricing

Published: February 6, 2019

Last week, the Department of Health and Human Services ("HHS") released a proposed rule to lower prescription drug prices and out-of-pocket costs by encouraging manufacturers to pass discounts directly to patients and bring new transparency to prescription drug markets.

Briefly:

- **Nothing has changed. This is a proposed rule.**
- Even if finalized in its current form, the proposed rule **does not impact employer-sponsored plans unless** Pharmacy Benefit Managers ("PBMs") and pharmaceutical manufacturers adopt a new safe harbor (discussed below), which may provide additional transparency.

## Background

Under the federal Anti-Kickback Statute ("AKS"), the federal government may impose criminal and civil penalties on whoever "knowingly and willfully offers, pays, solicits or receives remuneration to induce or reward the referral of business reimbursable under any of the federal health care programs" (e.g., Medicare, Medicaid). Generally, employer-sponsored health plans are not "federal health care programs;" therefore, they are not directly subject to the AKS.

Because the statute had a broad reach, the law was subsequently amended when HHS developed regulations to create "safe harbors." The safe harbors specify various payment and business practices that, if followed, are not subject to sanctions under the AKS, even though such practices potentially could be capable of inducing payments that could trigger penalties under this law.

## How would this Proposed Rule Impact Employer-Sponsored Plans?

The proposed rule creates a new safe harbor under the federal AKS related to PBM service fees.

If followed, the safe harbor protects the pharmaceutical manufacturer's payment for certain services that a PBM furnishes to the manufacturer from anti-kickback claims. For this purpose, the term "health plan" includes employer-sponsored group health plans.

Briefly, to qualify for the safe harbor's protection as proposed:

1. The PBM and pharmaceutical manufacturer must have a **written agreement** that:
   a. Covers all of the services the PBM provides to the manufacturer in connection with the PBM's arrangements with health plans for the term of the agreement; and
   b. Specifies each of the services to be provided by the PBM to the manufacturer and the compensation for such services.

2. Compensation paid to the PBM must:
   a. Be consistent with fair market value in an arm's-length transaction;
   b. Be a fixed payment, not based on a percentage of sales; and
   c. Not be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties, or between the manufacturer and the PBM's health plans, for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs.

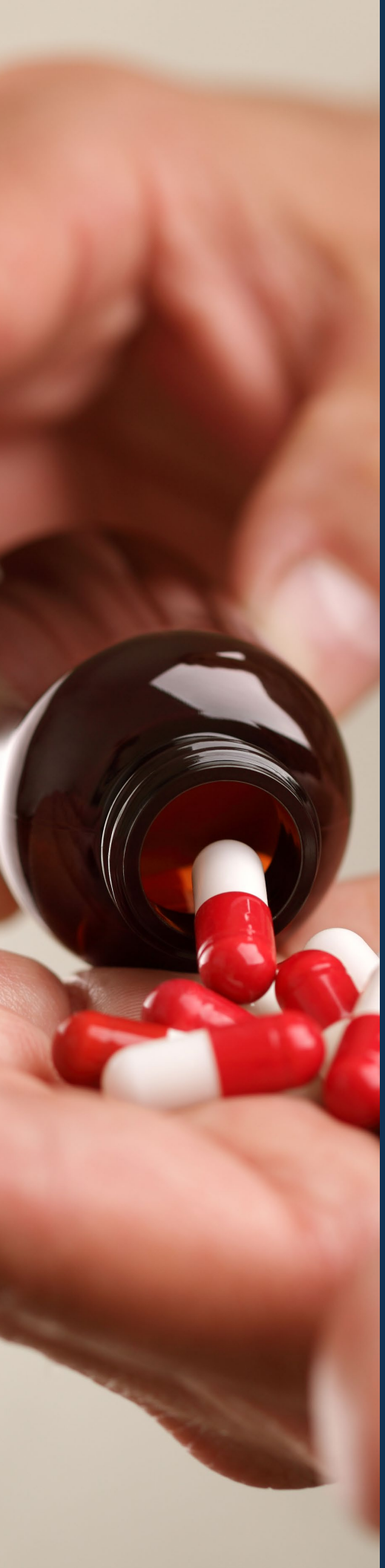
3. The PBM must disclose in writing, at least annually, to each health plan with which it contracts, and to HHS upon request, the services it rendered to each pharmaceutical manufacturer that are related to the PBM's arrangements with that health plan and associated costs for such services.

The proposed rule establishes a clear pathway for the pharmaceutical manufacturer and PBM to follow and reduce their potential exposure to federal anti-kickback claims. If they opt to use the safe harbor, then the employer-sponsored plan will receive more transparency through the new annual reporting obligation (described in (3) above) and may have favorable cost impact in a fixed fee pricing model (as described in (2) above).

However, nothing in the proposed rule requires the manufacturer and PBM to follow the safe harbor. HHS states that certain types of remuneration manufacturers may pay to PBMs either (1) would not implicate the AKS or (2) could be protected under another existing safe harbor. However, according to the proposed rule, following the safe harbor significantly reduces the risk of anti-kickback claims (which have both criminal and civil penalties).

## Employer Action

This is a **proposed rule**. Nothing in here is final and at this point there are no changes affecting health plans that contract with PBMs and any government programs. There is a 60-day comment window and any final (or interim final guidance) will come at a later date and may not reflect what is currently included in the proposed rule. Employers should expect various stakeholders to voice challenges to these rules. We will continue to monitor developments in this area and will keep you posted of relevant updates.



# Medicare Part D
## CMS Notification Reminder

Published: February 8, 2019

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, 2019) must complete this reporting no later than March 1, 2019.**

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

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

# Deadlines Extended for 2018 Forms 1095-C

Published: February 8, 2019

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 to provide Forms 1094-C and 1095-C to the IRS was not extended. This is very similar to the relief extended last year for 2017 Forms 1095-C (Notice 2018-06).

## 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 announced relief.

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

# M-1 Reporting Requirements

Published: February 12, 2019

The administrator of a multiple employer welfare arrangement (MEWA) must file a Form M-1 with the Department of Labor (DOL) for every calendar year, or portion thereof, that the MEWA offers or provides medical benefits to the employees of two or more employers (including one or more self-employed individuals). The annual M-1 filing for 2018 is due no later than **March 1, 2019** (unless an extension is requested).

## What is a MEWA?

Briefly, a MEWA is an arrangement that offers health and other benefits to the employees of two or more different employers (including one or more self-employed individuals).

A MEWA does not include a plan or other arrangement that is established and maintained:

- pursuant to one or more collective bargaining agreements (as determined by the Secretary),
- by a rural electric cooperative, or
- by a rural telephone cooperative association.

A plan that provides coverage to two or more trades or businesses (whether incorporated or not) within the same controlled group is considered a single employer, and not a MEWA. A determination of whether or not two employers are within the same controlled group is based on the rules contained in Internal Revenue Code § 414(c) and the applicable regulations (26 CFR § 1.414(c)-2). However, the definition of common control shall not be based on an interest of less than 25%.

Ownership interests that do not satisfy these requirements will not be viewed collectively as a single-employer plan, and thus will likely be considered a MEWA. Employers should seek the advice of legal counsel to determine whether or not their particular arrangement meets the controlled group requirements in order to avoid MEWA issues.

## Who Must File the Form M-1?

The administrator of a MEWA that provides benefits for medical care to the employees of two or more employers (including self-employed individuals) must file the Form M-1 with the DOL.

There are a number of exceptions to the Form M-1 requirements. In particular, a MEWA that provides coverage consisting solely of excepted benefits (most standalone dental and vision benefits are considered excepted benefits) is not required to file a Form M-1. However, if the MEWA provides coverage that consists both of excepted benefits and other benefits for medical care that are not excepted benefits, the administrator must still file the M-1.
Also, a Form M-1 is not required when:

- The MEWA is licensed or authorized to operate as a health insurance issuer in every state in which it offers or provides coverage for medical care to employees.
- The MEWA is a group health plan (or provides coverage through a group health plan) that is not subject to ERISA, including a governmental plan, church plan, or plan maintained only for the purpose of complying with workers' compensation laws.
- The MEWA provides coverage to the employees of two or more employers that share a common interest of at least 25% at any time during the plan year (determined under Code § 414(b) or (c)).

- There is a change in control of a business (e.g., merger or acquisition) as long as the reason for the change in control was not to avoid the M-1 filing requirement and it is temporary in nature (it does not extend beyond the end of the plan year following the plan year in which the change in control occurs).
- The MEWA provides coverage to persons (excluding spouses and dependents) who are not employees or former employees of the plan sponsor (e.g., nonemployee members of the board of directors or independent contractors), and the number of these individuals does not exceed 1% of the total number of employees or former employees covered under the arrangement, determined as of the last day of the year to be reported or, in the case of a 90-day origination report, determined as of the 60th day following the origination date.

## How is the Form M-1 Filed?

The Form M-1 must be filed electronically. The system may be accessed at http://www.askebsa.dol.gov/mewa/. Paper filings are no longer permitted.

## When is the Annual Filing Deadline?

The Form M-1 must be filed no later than **March 1** following any calendar year for which a filing is required.

However, administrators may request an automatic 60-day extension. To request an extension, the administrator must:

- complete Parts I and II of the Form M-1 (and check Box B(3) in Part I);
- electronically sign, date, and provide the administrator's name at the end of the form; and
- electronically file this request for extension no later than the normal due date for the Form M-1 (by March 1, 2019).

When filing the completed Form M-1, a PDF copy of this request for extension must be attached to the completed Form M-1 when filed.

## Is a Form M-1 Required At Other Times Besides the Annual Filing Requirement?

In addition to the annual filing requirement, administrators of both plan and non-plan MEWAs must file the Form M-1 within a certain time upon the following five registration events:

- 30 days prior to operating in any state.
- Within 30 days of knowingly operating in any additional state or states that were not indicated on a previous Form M-1 filing.
- Within 30 days of operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA.
- Within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year.
- Within 30 days of experiencing a material change as defined in the Form M-1 instructions.

## Are there Filing Requirements other than the Form M-1 that Apply?

Possibly. MEWAs that are employee benefit welfare plans (a plan MEWA) are required to file a Form 5500 regardless of size. Part III of the Form 5500 (Form M-1 Compliance Information) requests information regarding M-1 compliance, and requests the Form M-1 Receipt Confirmation Code from the last-filed M-1.

## Are there Penalties for Not Reporting?

The DOL may assess a civil penalty for failure to file a Form M-1, failure to file a completed Form M-1 and for late filings. In the event of no filing, an incomplete filing or a late filing, a penalty of up to $1,597 a day for each day that the administrator fails to comply with the requirement may apply. In addition, changes under health care reform also may impose criminal penalties on any person who knowingly submits false statements or false representations of fact in filing reports required under the rule (including Form M-1).

There is no voluntary compliance program available for delinquent Forms M-1.

## Help with Completing the Form M-1

For questions on completing the Form M-1, contact the Employee Benefits Security Administration's (EBSA's) Form M-1 help desk at (**202) 693-8360**.

For inquiries regarding electronic filing capability, contact the EBSA computer help desk at **(202) 693-8600.**

For inquiries regarding the Form M-1 filing requirement, contact the Office of Health Plan Standards and Compliance Assistance at (**202) 693-8335**.

## Additional Information

For the Form M-1 Online Filing System (and additional information), visit http://www.askebsa.dol.gov/mewa/.

MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation (revised August 2013) https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

# IRS Helps Employers Recover Mistaken HSA Contributions

Published: February 25, 2019

The Internal Revenue Service (IRS) has released Information Letter 2018-0033 which lists seven new examples of situations where an employer can obtain a return of contributions made to an employee's health savings account (HSA).

Employers should review the examples of mistaken HSA contributions in the Information Letter (as discussed below), and implement procedures to prevent any of the mistakes from taking place. If the employer does in fact make a mistaken HSA contribution, it should contact the HSA trustee or administrator to request a return of the money, using one or more of the IRS examples as justification.

## Background

Individuals have a "nonforfeitable" interest in the balance of their HSA. Under this general rule, an employer (or other third party, such as creditor) may not access an employee's HSA to obtain funds, including a return of employer contributions.

The IRS previously released Notice 2008-59, which contains three examples illustrating how the general rule operates in different situations. Two of the three examples in Notice 2008-59 relax the general rule, at least in part.

| Examples in Notice 2008-59 | IRS Conclusion |
|---|---|
| An employer contributes amounts to an employee's HSA that exceed the maximum annual contribution allowed by law due to an error | The employer may correct the error by contacting the HSA financial institution to obtain a return of the contribution to the employer; if the employer does not recover the money by the end of the taxable year, the contribution is treated as taxable income to the employee on Form W-2 |
| An employer contributes to the HSA of an employee who was never eligible for HSA contributions | Same as above |
| An employer contributes to the HSA of an employee who was eligible for HSA contributions at the start of the year, but who ceases to be eligible for HSA contributions during the year | The employer cannot recoup any contribution from the employee's HSA |

## IRS Information Letter 2018-0033

The latest Information Letter contains seven new examples of situations where an employer may recover contributions made to an employee's HSA.

The IRS states, in the Information Letter, that if there is "clear documentary evidence" demonstrating that an administrative or process error occurred, then the financial institution holding the employee's HSA contributions can return them to the employer, provided that the correction puts the employer and employee in the same position that they would have been in had the error not occurred.

The Information Letter lists the following examples of "errors which may be corrected" by allowing the employer to recover contributions made to an employee's HSA.

The examples set forth below are listed in the Information Letter, while the recovery amounts are based on our analysis of what the employer's and employee's position would have been without the administrative or process error:

| Examples in Information Letter 2018-0033 | Recovery Amount |
|---|---|
| An amount withheld and deposited in an employee's HSA for a pay period that is greater than the amount shown on the employee's HSA salary reduction election | The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election |
| An amount that an employee receives as an employer contribution that the employer did not intend to contribute but was transmitted because an incorrect spreadsheet is accessed or because employees with similar names are confused with each other | The employer may obtain a return of the entire amount of the employer contribution |
| An amount that an employee receives as an HSA contribution because it is incorrectly entered by a payroll administrator (whether in-house or third-party), causing the incorrect amount to be withheld and contributed | The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election |
| An amount that an employee receives as a second HSA contribution because duplicate payroll files are transmitted | The employer may obtain a return of the second or duplicate HSA contribution |
| An amount that an employee receives as an HSA contribution because a change in employee payroll elections is not processed timely so that amounts withheld and contributed are greater than what the employee elected | The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's payroll election (in accordance with the change in the employee's payroll election) |
| An amount that an employee receives because an HSA contribution is calculated incorrectly, such as a case in which an employee elects a total amount for the year that is allocated by the system over an incorrect number of pay periods | The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election<br>(as correctly calculated) |
| An amount that an employee receives as an HSA contribution because the decimal position is set incorrectly, resulting in a contribution greater than intended | The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election, with the decimal point set correctly |

## Timing

The changes outlined in Notice 2008-59 permit the employer to recover funds so long as the recovery occurs while the applicable tax year is open. For example, if an employer contributed to the HSA of an employee who was never HSA eligible in 2018, the employer may seek to recoup its incorrect HSA contribution in 2018. If the amount is not recovered in 2018, then the employer is to treat the impermissible employer contribution as taxable income reflected on the 2018 Form W-2.

Unfortunately, Information Letter 2018-0033 did not include guidance as to the proper timing to recover mistaken or incorrect employer HSA contributions. While it may be reasonable to follow the guidance in Notice 2008-59 (which is generally to correct in the open tax year or treat as additional taxable on the Form W-2 if not recovered), further clarification on this point would be helpful.

## Employer Action

Employers should review the examples of mistaken HSA contributions discussed above, and implement procedures to prevent any of the mistakes from taking place.

When a mistaken contribution is made to an employee's HSA that fits one of the examples listed in the Information Letter or in Notice 2008-59, the employer should contact the HSA trustee or administrator (usually the bank) to recover the contribution. The employer should maintain documentation to support its assertion that a mistaken contribution occurred, in case of any future IRS inquiry.

The following FAQs address some other questions that may arise.

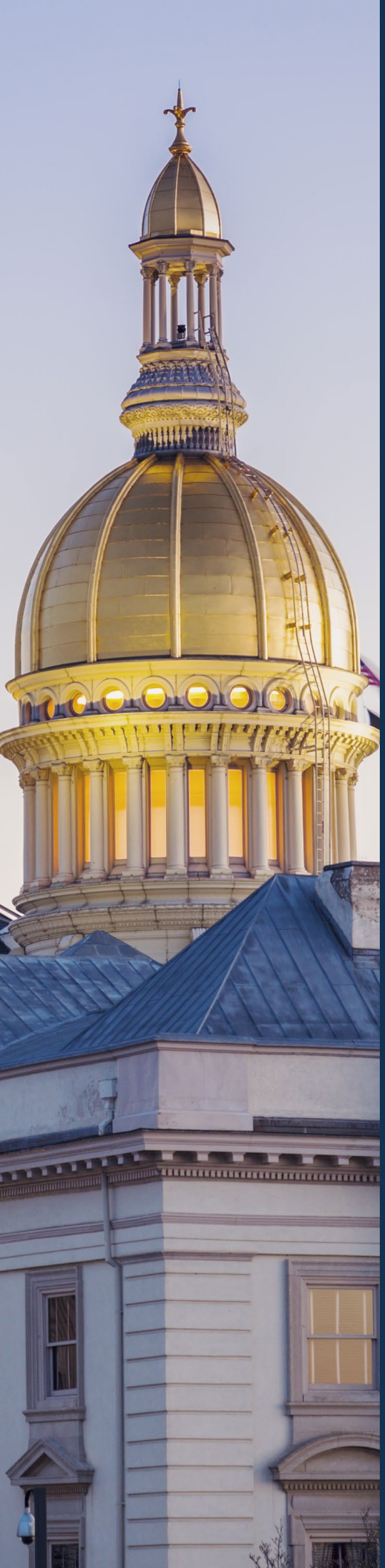
**Frequently Asked Questions**

**Q1:** Is the HSA trustee or administrator obligated to allow the employer's recovery of mistaken HSA contributions in accordance with the Information Letter and Notice 2008-59?

This issue is not addressed in the IRS guidance. Employers should review their contract with the HSA trustee or administrator in advance, to determine whether the contract permits recoupment in certain circumstances.

**Q2:** What if the mistaken contribution does not fit into one of the IRS examples?

IRS acknowledges in the Information Letter that the examples in the Information Letter and in Notice 2008-59 are not intended to provide an exclusive set of circumstances in which contributions made to an HSA may be returned to an employer. However, the HSA trustee or administrator may refuse the employer's request to recover contributions made to an employee's HSA unless the facts of the situation fit into one of the IRS examples.



# New Jersey Small Employer Stop Loss Bill

Published: March 6, 2019

A bill has been introduced in New Jersey in both the Senate and Assembly that, if passed, would prohibit insurance carriers or other insurers subject to the insurance laws of New Jersey or any other state from offering, issuing or renewing any stop loss insurance policy of any kind to small employers. Stop loss insurance provides reimbursement for catastrophic, excess or unexpected expenses and is used by small employers to self-insure part of the health insurance coverage they provide for employees. Under New Jersey law, in connection with a group health plan, a small employer means an employer with 2-50 eligible employees on business days during the preceding calendar year. If passed, the bill would become effective three months after it is enacted.

S3270 was introduced to the Senate on February 14, 2019 and A5095 was introduced to the Assembly on February 25, 2019, but they are far from becoming law at this point. As background, when a bill is introduced into the Senate or Assembly, it must be introduced to committee. If it is approved in the committee, it goes back to the Senate/Assembly to be debated and voted on. In order for a bill to pass the Senate/Assembly, a majority of the Senate/Assembly must vote in favor of it (which requires 21 votes for the Senate and 41 votes for the Assembly). If the bill is approved by both the Senate and Assembly, it then goes to the Governor. If he signs it, it then becomes law.

The Senate bill passed the Senate House Committee on March 4 by a 3-2 vote. At this point, it will go back to the Senate for debate and vote. The Assembly bill has been referred to committee.

We are following this legislation and will continue to keep you apprised.

# Proposed Changes to Out-of-Pocket Maximums and Prescription Drug Coverage

Published: March 12, 2019

On January 24, the U.S. Department of Health and Human Services ("HHS") published its Annual Notice of Benefit and Payment Parameters for 2020. This guidance is a proposed rule that addresses certain provisions of the Affordable Care Act ("ACA"). This is just a proposed rule. Any changes will be formalized in a final rule (and may be different from what is below).

**Briefly, the proposed rule includes:**

- Likely caps on out-of-pocket dollar limits for 2020 non-grandfathered group health plans.
- A possible change to the definition of Essential Health Benefit that, if finalized as written, may permit some employer group health plans to impose an annual and/or lifetime dollar limit on certain brand-name prescription drugs when a generic is available and medically appropriate.

## Background

HHS issues its Annual Notice of Benefit and Payment Parameters on a yearly basis, first in proposed form, and then as a final rule. While the proposed rule primarily addresses the ACA insurance exchanges or marketplaces, it does include some changes that would affect employer-sponsored health plans if finalized.

## Change in the Out-of-Pocket Maximum

If the proposed rule becomes final, non-grandfathered group medical plans are likely to see an increase in the out-of-pocket maximum from $7,900 for self-only coverage and $15,800 for other than self-only coverage in 2019, to $8,200 for self-only coverage and $16,400 for other than self-only coverage in 2020. (Note that different out-of-pocket limits apply to high-deductible health plans, for purposes of making contributions to a health savings account.)

HHS calculated the new dollar limits based on a proposed change in the methodology for determining the annual premium adjustment percentage. Beginning in 2020, HHS has proposed to use an alternative premium measure that captures increases in individual market premiums, in addition to increases in employer-sponsored insurance premiums, to calculate the premium adjustment percentage.

## Exclusion of Brand Name Drugs from Essential Health Benefits

Because of increased prescription drug costs, HHS has proposed to allow individual and group medical plans that cover both brand name drugs and their generic equivalent to exclude the brand name drug as an "essential health benefit" ("EHB") if the generic equivalent is available and medically appropriate for the enrollee. This would become effective in 2020.

In addition, HHS proposes that if an enrollee purchases the brand name drug when the generic equivalent is available and medically appropriate, the plan would be permitted to ignore the difference in price between the brand name drug and the generic equivalent in calculating the individual's deductible and out-of-pocket maximum (or other cost-sharing). This would be true even though the individual paid the higher price for the brand name drug. Under the proposed rule, plans would still have an obligation to count the price of the generic drug towards the individual's deductible and out-of-pocket maximum (or other cost-sharing).

HHS is also considering an alternate proposal that would allow a plan to exclude the entire amount that an enrollee paid for a brand name drug (for which there is a medically appropriate generic equivalent) from the individual's deductible and out-of-pocket maximum (or other cost-sharing).

Finally, if the proposed rule becomes final, plans could impose lifetime and annual dollar limits on brand name drugs, because they would no longer be considered "essential health benefits."

## Employer Action

This is a proposed rule. Nothing in this guidance is final, and at this point there are no changes affecting health plans.

Any final (or interim final) guidance will come at a later date and may not reflect what is currently included in the proposed rule.

We will continue to monitor developments in this area and will keep you posted of relevant updates.

# ERISA Preempts Certain State Wage Withholding Laws

Published: March 25, 2019

A recently-released U.S. Department of Labor (DOL) letter, dated December 4, 2018, restates the DOL's long-held position that ERISA preempts state laws that require employers to obtain written consent before withholding amounts from employees' wages for contributions to an ERISA-covered plan.

Generally, most private sector employers offering health and welfare benefits are subject to ERISA regardless of size. Plans sponsored by government entities (federal and state), tribal governments and church plans are generally not subject to ERISA.

Specifically, the letter responds to the question of whether ERISA would preempt a state law if the law prohibits employers from adopting and implementing automatic enrollment arrangements under which the employer automatically enrolls eligible employees in a disability benefit plan and contributes part of the employee's wages as contributions to the plan, unless the employee affirmatively elects not to participate.

Referencing prior DOL Advisory Opinions, the Department restates its position that a state law would be preempted by ERISA to the extent the law is interpreted to limit, prohibit, or regulate an employer's adoption of automatic enrollment arrangements in connection with a disability benefit plan or other ERISA welfare benefit plan covered, or making related deductions from wages for contribution to such a plan. The letter includes two important restrictions:

- If a state criminal law prohibits deductions from employees' wages under an automatic enrollment arrangement, then employers in that state must obtain an employee's written authorization before withholding contributions from the employee's wages to pay for coverage under the ERISA plan.

- The letter does not address the types of notice and disclosure requirements that a plan fiduciary would need to adopt and implement for an automatic enrollment arrangement to be operated in a manner that is consistent with the fiduciary's prudence and loyalty obligations under ERISA.

## Employer Action

- Nothing in this letter or the guidance requires an employer to do away with the employee approval of wage withholding for certain ERISA covered benefits. In fact, it is a best practice to have employees sign off on any wage withholding associated with their benefit elections as it provides documentation that the employee elected to participate in (or waive) the programs. The letter simply provides that, as it relates to an ERISA benefit plan, a state law cannot generally require employee authorization of wage withholding to pay for ERISA covered benefits, which is a helpful clarification when an employer has an automatic enrollment process.

- Not all benefits offered by an employer will benefit from ERISA's preemption power. For example, dependent care flexible spending accounts, commuter transit programs (e.g., parking and transit passes) and certain voluntary benefits not subject to ERISA. Thus, state wage withholding laws will continue to control when dealing with non-ERISA benefits.

- Benefit programs sponsored by government and church entities must comply with state payroll laws requiring them to obtain an employee's written authorization before withholding contributions from wages to pay for coverage (ERISA preemption is not available).

- If an employer is an applicable large employer, subject to the Employer Mandate, generally the employer must allow employees the opportunity to opt-out of health insurance coverage that is not of a minimum value and not affordable coverage. Employers with an automatic enrollment process will want to ensure there is a meaningful opportunity to "opt-out" of health insurance coverage.

# Federal Government Eyes Paid Leave

Published: March 26, 2019

Currently, six states and the District of Columbia have implemented paid family leave laws, including New York, New Jersey and California. Recently, there have been several efforts to expand this type of leave at the federal level.

The budget proposal recently introduced by President Trump includes six weeks of paid leave for new parents. The proposed plan calls for $750 million in funding to aid in the creation of paid leave programs at the state level that are "most appropriate for their workforce and economy." While the President has discussed paid family leave several times in the past, this appears to be the first time a budget line item has been dedicated to the idea.

Additionally, both political parties have introduced competing legislation establishing federal paid leave programs. The following chart highlights some of the details from these bills

| | FAMILY Act | Healthy Families Act | CRADLE Act |
|---|---|---|---|
| | **Senator Kirsten Gillibrand (D-N.Y.)** | **Senator Patty Murray (D-Wash.) and Representative Rosa DeLauro (D-Conn.)** | **Joni Ernst (R-Iowa) and Mike Lee (R-Utah)** |
| **Paid Sick Leave** | Yes | Paid if Employer has more than 15 employees. Unpaid for smaller groups | No |
| **Paid Parental Leave** | Yes | See above | Yes |
| **Paid Family Leave** | Yes | See above | No |
| **Sick leave for employee only or also for sick loved ones?** | Yes | See above | No |
| **Length of Leave** | 12 weeks | 7 days | Up to three months |
| **Accrual or immediate?** | Unknown | Accrued at 1 hour for every 30 hours worked. | Unknown |
| **Who pays?** | Employer and Employee | Employer | Federal Government (parent must agree to post-pone Social Security benefits) |

These proposed plans are very much in their infancy. However, there appears to be both support from the President and bipartisan interest in a paid leave benefit, opening the door for possible agreement and future legislation.

Employers should be aware of the federal interest in a paid leave program and identify whether employees work in states that are already subject to state paid leave requirements.

We will continue to keep you apprised of any developments.

# New Jersey to Require Pre-Tax Commuter Benefits

Published: March 27, 2019

On March 1, 2019, New Jersey established a transit benefit ordinance that requires employers to offer employees pre-tax commuter transit benefits, consistent with certain "qualified transportation fringe" benefits, as defined in Section 132(f) of the Internal Revenue Code.

## Background

Qualified transportation fringe benefits under Section 132(f) of the Internal Revenue Code allow an employer to provide commuter and transit benefits to their employees that are tax-free up to a certain limit. This employer-provided voluntary benefit program allows employees to effectively reduce their monthly commuting or transit costs. In 2019, the monthly limit is $265 for any commuter benefit or transit pass. While such benefits provide a tax benefit to employees, under the 2017 Tax Cuts and Jobs Act, employers are no longer allowed a federal income tax deduction for qualified transportation fringe benefits. The Act also requires tax-exempt employers to pay unrelated business income taxes on such benefits.

## New Jersey Requirements

Covered employers in New Jersey will be required to offer a "pre-tax transportation fringe benefit" to their employees. It appears that "covered employers" means employers with at least 20 employees, regardless of whether they all work in the State of New Jersey; however, clarification from the regulators on this would be helpful.

An employee under the new law is identified as anyone hired or employed by the employer and who reports to the employer's work location, and mirrors the definition used in the unemployment compensation law. Certain temporary or limited exceptions exist for employees covered by a collective bargaining agreement and those employed by the federal government.

Some of the details regarding implementation of the program are still outstanding and the Commission of Labor and Workforce Development will adopt rules and regulations concerning the administration and enforcement of the benefit. Civil penalties will apply for non-compliance with this new law.

## Employer Action

While the ordinance takes effect immediately, it will not be enforced until final rules and regulations are released. The earliest enforcement is anticipated to be March 1, 2020, but is subject to change. Employers should determine whether their current employee demographic would require these benefits to be offered to their employees. Employers currently offering transportation fringe benefits to employees should review their current program to ensure compliance with the final rules and regulations in New Jersey once those are released.

# Reminder

## San Francisco HCSO & FCO Reporting Due April 30

Published: March 29, 2019

As a reminder, covered employers under the San Francisco Health Care Security Ordinance (HCSO) and/or the Fair Chance Ordinance (FCO) need to complete the 2018 Employer Annual Reporting Form by **Monday, April 30, 2019**. The form can be submitted electronically via the website below. Covered employers may have received information from the Office of Labor Standards Enforcement (OLSE) regarding the annual reporting requirement in January.

The HCSO requires San Francisco's OLSE to collect information on an annual basis from covered employers regarding their health care expenditures. To avoid penalties, covered employers must complete the Employer Annual Reporting Form to report these expenditures.

Please note that the penalty for failing to timely submit the Employer Annual Reporting Form is $500 per quarter.

If you were not covered by the HCSO and/or the FCO in any quarter of calendar year 2018, you do not need to submit the form, and no further action is required.

**To determine whether you are required to submit the form, fill out the short survey on the first page of the Form** (https://etaxstatement.sfgov.org/OLSE/). Employers who were not covered by the HCSO or the FCO in 2018 will be directed to a page indicating that they do not need to submit. Covered employers will be directed to the appropriate online form.

In addition, if you haven't already done so, make sure to post the updated 2019 official HCSO Poster in a conspicuous place at any workplace or job site where covered employees work. The notice is available in 6 languages at https://sfgov.org/olse/sites/default/files/Document/HCSO%20Files/2019%20HCSO%20Poster%20Final.pdf.

For more information, visit the HCSO website at http://www.sfgov.org/olse/hcso.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