

Health and Welfare Compliance Guide

2020



COMPLIANCE & LEGAL



ABOUT THE HEALTH AND WELFARE COMPLIANCE GUIDE

Updated December 10, 2019

TIG Advisors has arranged for this guide to be created for our clients by Marathas Barrow Weatherhead Lent LLP (“MBWL”), a premiere employee benefits, executive compensation and employment law firm. Located in the heart of Boston’s financial district, MBWL has a national reach. We work with clients from Alaska to Florida and from Maine to California and everywhere in between. We assist our multinational clients with employment, benefits and compensation issues around the world. Our attorneys have experience in every aspect of employee benefits law and deal with employee benefits issues for some of the nation’s best-known employers. The attorneys at MBWL are recognized by clients, consultants, lawyers and national ranking services as among the best.

TIG Advisors and its affiliates provide advice and consulting on insurance and benefit issues, which may have important tax or legal implications; we do not provide tax or legal advice. This Guide is designed to provide general information with respect to Health and Welfare Plan compliance. No representation is made that the information provided is comprehensive or anything more than an overview. The information contained in this Guide is not intended, and should not be viewed as, legal advice. Specific questions about the tax or legal implications of your policy or related matters should be referred to a qualified ERISA and employee benefits attorney.

This Guide was last updated as of December 2, 2019 to reflect guidance in connection with the Patient Protection and Affordable Care Act of 2010 (the “ACA”) and other changes to federal law prior to December 2018. Neither Marathas Barrow Weatherhead Lent nor the broker who has provided this Guide to you has any obligation to update any information provided herein. The information contained in this Guide is accurate as of December 2, 2019. No responsibility is assumed for guidance published after that date and users are encouraged to monitor for any compliance developments and changes in the law. Users of this Guide must obtain advice from qualified ERISA counsel on all information contained herein.

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1. HEALTH AND WELFARE PLAN COMPLIANCE GUIDE DISCLAIMER

This Compliance Guide generally describes the legal requirements that apply to health and welfare employee benefit plans and is designed to help you evaluate your plans' compliance with these requirements. Each employer's situation is unique and not all of the requirements described in this Guide may apply to your health and welfare plans. This Guide is not designed to provide comprehensive coverage on any legal issue. There may be other significant compliance issues applicable to your plans that are not covered by this Guide. Always consult with an ERISA attorney for legal advice.

This Compliance Guide is not intended to provide legal advice and should not be relied upon as such. You should consult with legal counsel to design compliance procedures applicable to your unique situation.

2. GLOSSARY OF TERMS & GRANDFATHERED PLANS

This Guide has been updated as of November 1, 2019 to include guidance in connection with certain provisions of the Patient Protection and Affordability Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (combined “PPACA” or “ACA”). Not all provisions of the ACA are covered by this Guide. Select mandates applicable to employer-sponsored group health plans that are applicable during the first few years following the passage of the ACA are included; many mandates with later effective dates are not addressed (or are only addressed in a limited manner). In addition, because the Trump Administration has vowed to “repeal and replace” the ACA, users of this Guide should monitor for compliance developments and changes in the law. This Guide is not and should not be viewed as a comprehensive review of the ACA or any other applicable law.

NOTE: Special rules may apply to health plans maintained pursuant to a collective bargaining agreement. This Guide does not address these rules unless specifically noted.

GLOSSARY OF ACA TERMS

The purpose of this glossary is to assist you in becoming familiar with commonly used terms in the Affordable Care Act (ACA).

- \$2,000 Penalty***: Assessed annually if an Applicable Large Employer fails to offer coverage to at least 95% of its Full time Employees (and their children up to age 26) and at least one Full time Employee receives a Premium Credit for Exchange coverage. The requirement is only to offer coverage—no employer contribution or minimum plan design is necessary to avoid this penalty—just the offer of coverage. *Penalties are indexed for inflation after 2014:
 - 2015: \$2,080
 - 2016: \$2,160
 - 2017: \$2,260
 - 2018: \$2,320
 - 2019: \$2,500 (est.)
 - 2020:

- \$3,000 Penalty***: Assessed annually if an Applicable Large Employer offers coverage to at least 95% of its Full time Employees (and their children up to age 26), but the coverage offered is either not Affordable or does not provide Minimum Value and at least one Full time Employee receives a Premium Credit for Exchange coverage. *Penalties are indexed for inflation after 2014:
 - 2015: \$3,120
 - 2016: \$3,240
 - 2017: \$3,390
 - 2018: \$3,480
 - 2019: \$3,750 (est.)
 - 2020:

- Administrative Period**: A period of time of up to 90 days in between the Look-Back Measurement Period and the corresponding Stability Period for the employer to perform administrative functions such as enrolling eligible employees in coverage. Certain restrictions apply to the length of administrative periods to New Employees (an administrative period cannot operate to delay coverage past the first day of the thirteenth month following the employee’s date of hire).

- Affordable/Affordability**: Coverage is affordable if an employee’s contribution for single coverage does not exceed 9.5% of the employee’s household income. Employers may use a “safe harbor” to make this determination based on “W-2 Wages,” the “Federal Poverty Level” or an employee’s “Rate of Pay.” The affordability percentage is indexed for inflation after 2014:
 - 2015: 9.56%
 - 2016: 9.66%
 - 2017: 9.69%
 - 2018: 9.56%
 - 2019: 9.86%
 - 2020: 9.78%

- Affordable Care Act (ACA):** The Affordable Care Act is the shorthand term for the collection of laws that comprise national health care reform. ACA was signed into law on March 23, 2010, and contains sweeping changes to the U.S. health care system. This is also referred to as the “Patient Protection and Affordable Care Act” or “PPACA.”
- Applicable Large Employer (ALE):** An employer (determined on a Controlled Group basis) that employed 50 or more Full-time Employees, including Full-time Equivalent Employees, on business days during the preceding calendar year.
- Code:** The United States Internal Revenue Code of 1986, as amended.
- Community Rating:** Strict rules under ACA permit individual and small group policies to vary premiums only by age, tobacco use, single/family status, and geographic area. Factors traditionally used to develop premiums such as health status and gender are no longer allowed. Under community rating, premiums tend to rise for young, healthy individuals and decrease for individuals in poor health.
- Controlled Groups:** A “Controlled Group” is determined under Section 414 of the Internal Revenue Code (the “Code”). Controlled Group status is important to consider in the context of employee benefit plans for, among other things, coverage purposes (e.g., determining whether a health plan is a Multiple Employer Welfare Arrangement), testing (e.g., nondiscrimination testing is generally performed on a Controlled Group basis), and whether an entity is an Applicable Large Employer under the ACA. While actual determination should be made with the assistance of counsel, in general 80% common ownership between entities may be sufficient to establish controlled group status. A controlled group also exists if the same 5 or fewer individuals collectively own at least 80% of each entity, and effectively control at least 50% of each entity (taking into account the ownership of each person only to the extent such ownership interest is identical with respect to each individual).
- Essential Health Benefits:** A list of ten broad categories of benefits mandated under ACA including emergency services, hospitalization, maternity and newborn care, mental health care, and prescription drugs. Group health plans for large employers are not required to offer coverage for all Essential Health Benefits; however, they are prohibited from imposing annual or lifetime dollar limits on any covered Essential Health Benefits.
- Essential Health Benefits Package:** Non-grandfathered individual and small group insurance plans must contain the Essential Health Benefits Package, which includes coverage for all Essential Health Benefits categories.
- Exchange/Marketplace:** Every state must establish a health insurance Exchange for use by the uninsured (or default to a federally-facilitated Exchange). The Exchange offers fully insured contracts that provide Essential Health Benefits at different levels of coverage (i.e. platinum, gold, silver and bronze).
- Full-time Employee:** An employee who is reasonably expected to work full time at time of hire, or an employee who has worked, on average, at least 30 hours per week (or 130 hours per month) during the employer’s Look-Back Measurement Period.
- Full-time Equivalent Employee or “FTE”:** This concept applies only for determining Applicable Large Employer status. To determine the number of FTEs for a month, take the monthly hours of all part-time employees (up to 120 hours per employee) and divide them by 120. The total for each month is then added together and divided by 12 for each year. This number is then added to the number of Full-time Employees to determine the total number of FTEs.
- Individual Mandate:** The requirement that all adults maintain Minimum Essential Coverage (health insurance) for themselves and their dependents. Some exceptions apply based on income or immigration status or other factors. The penalty under the Individual Mandate has been set to \$0 starting January 1, 2019.
- Initial Measurement Period:** A period of 3 to 12 months chosen by the Applicable Large Employer to make an initial measurement of a Variable Hour Employee’s hours to determine whether he/she will be considered a Full-time Employee.

- Look-Back Measurement Period:** A period of 3 to 12 months chosen by an Applicable Large Employer to measure employees' hours to determine if they will be considered Full-time Employees during the employer's Stability Period. New Employees have an initial look-back measurement period based on their date of hire, whereas Ongoing Employees have a standard look-back measurement period that is the same for all ongoing employees.
- Medical Loss Ratio (MLR) Rule:** Requires insurance companies to provide an annual rebate to policyholders if the insurer fails to spend at least 85% of premium dollars on health care and related service (80% in the small group or individual market; or higher, based on state regulations).
- Minimum Essential Coverage:** Any health insurance coverage offered by an employer to an employee that is available in the small or large group market. Also includes Medicare, Medicaid, and individual insurance policies.
- Minimum Value:** A plan provides minimum value if it designed to pay, on average, at least 60% of participants' covered medical expenses. **NOTE:** the plan must also cover inpatient and physician services.
- New Part-Time, Seasonal, or Variable Hour Employees:** Have not yet worked for their employer for one complete standard Measurement Period and therefore have "initial" Look-Back Measurement and Stability Periods based on their date of hire until they become Ongoing Employees.
- Nondiscrimination Provisions:** Rules under ACA designed to prevent employers from favoring highly compensated employees with respect to eligibility or benefits under a non-grandfathered plan. Compliance with these provisions is currently delayed pending further guidance.
- Ongoing Employees:** Have worked for their employer for at least one complete standard Measurement Period.
- "Pay or Play" Mandate:** An Applicable Large Employer must offer Affordable, Minimum Value health insurance coverage to its Full time Employees and their dependent children up to age 26.
- Premium Credits:** Income-based subsidies from the federal government to help individuals purchase coverage through an Exchange. Available to individuals with household income below 400% of the federal poverty level who are without access to affordable employer coverage or Medicaid. These are advanceable, refundable subsidies that are paid by the federal government directly to the insurance companies.
- Seasonal Employee:** There are two (2) definitions of a "Seasonal Employee" under the ACA. For purposes of determining ALE status, an employee who is employed no more than 120 days (or four months) during the preceding calendar year (not required to be consecutive days) and who is a seasonal employee based on a reasonable, good faith interpretation of existing DOL guidance on seasonal employees may be excluded from the Applicable Large Employer determination (this exclusion applies to employers that would not be Applicable Large Employers but for their Seasonal Employees). For purposes of an ALE's treatment of a "Seasonal Employee" as a Variable Hour Employee, a Seasonal Employee is one who is customarily employed for a period of six (6) months or less, which generally begins at the same time each year.
- SHOP Exchange:** SHOP is the Small Business Health Options Program for employers with 100 or fewer employees. Employers purchasing coverage through a SHOP may pay for the Exchange premiums on a pre-tax basis if it is purchased through an employer's cafeteria plan. The Federal government continues to delay nation-wide application of the "employee choice" model in Federal SHOP Exchanges, under which employees may choose any qualified health plan available in the Exchange. Some federally funded states have implemented the employee choice model, but several other states are unable to. In these states, employers are limited to offering one qualified benefit plan to employees. State Exchanges may, but are not required to, delay application of the "employee choice" model as well.

- **Small Business Tax Credit:** Credit available under ACA designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. The maximum tax credit is 50% of premiums paid by eligible small employers who participate in a SHOP Exchange. The maximum credit goes to smaller employers with 10 or fewer Full time Equivalent Employees paying annual average wages of \$25,000 or less. The tax credit phases out at 25 employees and \$50,000 in average annual wages. It's available only to employers in the SHOP Exchange, and for a maximum of two consecutive tax years.
- **Stability Period:** A period of at least 6 months that is no shorter than the corresponding Look-Back Measurement Period (unless the employee measured part-time, in which case the stability period cannot exceed the look-back period). An employee's status as Full-time (or not Full-time) is based on the Look-Back Measurement Period, and is fixed for the duration of the Stability Period as long as the employee remains employed.
- **Variable Hour Employee:** A variable-hour employee is an employee with respect to whom, based on the facts and circumstances at his/her start date, it cannot be determined whether he/she is reasonably expected to work, on average, at least 30 hours per week. A new employee who is expected to work initially at least 30 hours per week may be a variable-hour employee if, based on the facts and circumstances at the start date, the period of employment at more than 30 hours per week is reasonably expected to be of limited duration and it cannot be determined that the employee is reasonably expected to work, on average, at least 30 hours per week over the Initial Measurement Period.

GRANDFATHERED PLANS

“Grandfathering” is a key concept under PPACA. A grandfathered plan is a group health (or individual) plan that was in place and provided benefits to at least one individual as of March 23, 2010. Grandfathered plans are exempt from some, but not all, of the PPACA mandates, for as long as they maintain grandfather status. Some of the PPACA mandates that grandfathered plans are exempt from while they maintain that status are as follows:

PPACA Mandates	Guide Section
Revised ERISA claims procedures	3.9
Code Section 105(h) nondiscrimination rules for fully insured plans (delayed)	9
Zero-dollar co-pay for certain preventive services	12.13
Choice of health care professional	12.16
Coverage for out-of-network emergency services	12.17
Out-of-pocket limits on essential benefits	12.28

The foregoing is an incomplete list of the mandates avoided by grandfathered plans as long as they maintain that status. **NOTE:** that a majority of the PPACA mandates apply to group health plans, whether grandfathered or not. In this Guide, when a mandate is discussed upon which the grandfathering rules have an impact, we will indicate the rules for both grandfathered and non-grandfathered plans. If a PPACA mandate is being discussed and there is no discussion of grandfathered status, the grandfathering rules do not have an impact.

Theoretically, grandfathering may be maintained for the life of a plan. Adding new members or new dependents will not eliminate grandfathered status (but see discussion below on “Anti-abuse rules”). The grandfathering rules apply separately to each “benefit package” made available under a grandfathered health plan. Losing grandfathered status for one “benefit package” offered under a health plan will not cause the entire plan to lose its grandfathered status.

PPACA and the federal agencies do not define the term “benefits package.” The regulations describe different benefits options as being “benefit packages.” Informal guidance from the federal regulators indicates that an arrangement is a separate benefit package if there is separate enrollment for that arrangement.

The following is a checklist which summarizes the requirements that must be satisfied in order for a plan to maintain “grandfathered” status. For special rules regarding fully insured plans maintained pursuant to a collective bargaining agreement ratified before March 23, 2010, see Section 4.

NOTE: The following rules apply separately to each benefit package available under the plan.

SECTION 1. ELIGIBILITY FOR GRANDFATHERED STATUS

1. YES / NO: Was the plan in effect on March 23, 2010?
2. YES / NO: Has the plan had at least one participant at all times since March 23, 2010?
3. YES / NO: Has the plan satisfied its disclosure requirement (i.e., starting with its 2011 plan year, has the plan included a statement, in any plan materials describing benefits, that it considers itself to be grandfathered and provided contact information for questions and complaints)?
4. YES / NO: Has the plan maintained records and any other information necessary to document its terms in effect on March 23, 2010, and made such records and information available for examination upon request?
5. YES / NO: After March 23, 2010, has the plan refrained from entering into a new policy, certificate, or contract of insurance that is effective before November 15, 2010?

If the answers to questions 1 – 5 are **YES**, then proceed to Section 2.

If any answer above is **NO**, then the plan is not grandfathered. Contact benefits counsel; do not proceed with the checklist.

SECTION 2. MAINTENANCE OF GRANDFATHERED STATUS

NOTE: With respect to numbers 2-6 below, all changes are measured against the plan design and employer contribution in effect on March 23, 2010 cumulatively, not year-over-year.

1. YES / NO: Has the plan eliminated all or substantially all benefits to diagnose or treat a particular condition?
2. YES / NO: Has the plan made any increase to percentage cost sharing (e.g. increased employee coinsurance from 20% to 30%)?

3. YES / NO: Has the plan increased a deductible or out-of-pocket maximum by more than 15% plus medical inflation?¹
4. YES / NO: Has the plan increased any copayment by more than the greater of \$5 plus medical inflation or 15% plus medical inflation?
5. YES / NO: For employers that contribute based on the cost of coverage (e.g., the employer contributes a percent of premium, such as 75%), has the contribution rate (determined by tier and based on the applicable COBRA rate) decreased by more than 5 percentage points (e.g., from 75% to less than 70%)?
6. YES / NO: For employers that contribute based on a formula (e.g. the employer contributes \$2 toward premiums for every hour worked), has the contribution rate decreased by more than 5 percent (e.g., from \$2 per hour to less than \$1.90 per hour)?
7. YES / NO: For a plan that had no overall annual or lifetime limit on the dollar value of all benefits in effect on March 23, 2010, has the plan added an overall annual or lifetime limit on the dollar value of benefits?
8. YES / NO: For a plan that had an overall lifetime limit (but no annual limit) on the dollar value of all benefits in effect on March 23, 2010, has the plan added an overall annual limit that is lower than the dollar value of the overall lifetime limit?
9. YES / NO: For a plan that had an overall annual limit on the dollar value of all benefits in effect on March 23, 2010 (regardless of whether the plan also imposed a lifetime limit), has the plan decreased the annual limit?

If the answers to questions 1 – 9 are **NO**, then proceed to Section 3.

If any answer above is **YES**, then the plan is not grandfathered. Contact benefits counsel; do not proceed with the checklist.

SECTION 3. ANTI-ABUSE RULES

1. YES / NO: After March 23, 2010, was the employer involved in a corporate transaction, the principal purpose of which was to cover new individuals under the plan?
2.
 - A. YES / NO: After March 23, 2010 were employees transferred into the plan from a plan under which they were covered on March 23, 2010 (the transferor plan); and
 - B. YES / NO: Would the plan, if treated as an amendment of the transferor plan, cause the transferor plan to lose grandfather status under Section 2, above; and
 - C. YES / NO: Was there no “bona fide employment-based reason”² for the transfer (for this purpose, concern of cost of coverage is not a bona fide employment-based reason)?

¹Medical inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) published by the Department of Labor. To calculate the medical inflation factor, follow these [instructions](#) found in the regulation on page 34565, Federal Register Vol. 75, No. 116, June 17, 2010. The most recent CPI-U can be found [here](#).

²Circumstances that constitute “bona fide employment-based reasons” include, but are not limited to:

- When a benefit package is being eliminated because the carrier is exiting the market;
- When a benefit package is being eliminated because the carrier no longer offers the product to the employer (for example, because the employer no longer satisfies the carrier’s minimum participation requirement);
- When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;
- When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or
- When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

If the answer to question 1 and at least one answer to 2(a) through (c) is NO, then the plan is grandfathered. Proceed to Section 4 if the plan is subject to a collective bargaining agreement.

If the answer to question 1 or the answers to each of 2(a) through (c) is YES, then the plan may not be grandfathered. Contact benefits counsel for further guidance.

SECTION 4. RULES FOR COLLECTIVELY BARGAINED PLANS

1. YES / NO: Was the collective bargaining agreement (CBA) ratified before March 23, 2010?
2. YES / NO: Has the plan remained fully insured since March 23, 2010?

If the answers to questions 1 and 2 are **YES**, the plan is grandfathered at least until the date on which the last CBA relating to the plan that was in effect on March 23, 2010 terminates. Upon expiration, evaluate the plan under Sections 2-3, above. **NOTE:** This permits an insured collectively bargained plan to change insurance carriers during the CBA period and not lose grandfathered status upon expiration of the CBA, even if the change in carriers was effective before November 15, 2010.

If the answer to either question 1 or 2 is **NO**, this Section 4 does not apply to the plan. Evaluate the plan under Sections 1 – 3, above.

SECTION 5. ADDITIONAL GUIDANCE FOR GRANDFATHERED PLANS

1. **Wellness Plans.** Introducing a wellness plan after March 23, 2010 may cause a loss of grandfathered status if the penalty for non-participation causes the plan to lose grandfathered status under Section 2, above.
2. **Good Faith Compliance.** The agencies will consider good-faith efforts to comply with a reasonable interpretation of the requirements and may disregard changes to the plan that only modestly exceed the requirements of Section 2, to the extent they occurred before June 14, 2010.
3. **Revocation of Changes.** The agencies will not consider the plan to lose grandfathered status if changes are revoked or modified effective as of the first day of the plan year beginning on or after September 23, 2010, and the terms of the plan on that date would not cause the plan to cease to be grandfathered.
4. **Restructuring Rate Tiers.** The grandfather plan requirements in (5) and (6) of Section 2, above apply on a tier-by-tier basis. As a result, if a plan modifies the rate tiers in place on March 23, 2010 (for example, from single and family to a multi-tiered structure of single, single-plus-one, and family), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. For example, using the tiers above, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than single (i.e., single-plus-one) must be within 5 percentage points of 50% (i.e., at least 45 percent).
5. **Adding a Coverage Tier for a New Class.** If a plan adds one or more new rate tiers without eliminating or modifying any previous tiers and those new rate tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of (5) and (6) of Section 2, above. For example, if a plan with only a single rate tier added a family rate tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status.
6. **Prescription Drugs.** A reclassification of a brand name drug into a higher cost-sharing tier because a generic alternative has been released does not cause a plan to lose grandfathered status.

DOCUMENTARY REQUIREMENTS

Employers claiming grandfathered status for their plans must provide a specific notice in every plan material provided to a participant or beneficiary describing the benefits provided under the plan. The notice requirement is not met by simply providing one notice to employees. As indicated, all documents (including websites) that describe benefits must include this notice. The notice essentially states that the plan sponsor believes its plan is grandfathered and that certain federally mandated benefits are not available in the plan because of that status. In addition, the notice must provide contact information for questions or complaints regarding the plan's grandfathered status. The federal agencies have issued a model notice, as follows:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from a grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the [Employee Benefits Security Administration, U.S. Department of Labor](#) at 1-866-444-3272. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plan, insert: You may also contact the [U. S. Department of Health and Human Services](#).]

This notice can be found [here](#).

Additionally, the employer must maintain records documenting the terms of the plan as in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be made available for examination upon request by a government agency with oversight over the rules governing the plan. Moreover, a participant, beneficiary, or individual policy subscriber must be able to inspect these documents to verify the status of the plan or health insurance coverage as a grandfathered health plan. A plan or issuer must maintain these records and make them available for examination for as long as the plan or issuer takes the position that the plan or health insurance coverage is a grandfathered health plan.

3. PLAN DOCUMENT REQUIREMENTS

3.1 WRITTEN PLAN DOCUMENT

The Employee Retirement Income Security Act of 1974 (ERISA) requires that every employee benefit plan, including welfare benefit plans, be established and maintained pursuant to a written plan document that describes the benefit structure and guides the plan's day-to-day operations.

The document must list one or more named fiduciaries for the plan. The named fiduciary can be identified by office or by name. For some plans, it may be an administrative committee or a company's board of directors. The plan document must be provided to participants and beneficiaries no later than 30 days after a written request.

The plan document is the legal document that establishes the plan. The plan can be separate from the summary plan description or can be combined into one document.

The Plan Document must include the following information

- Plan operation details
- Name of the plan administrator; if no plan administrator is named, the company/employer will be the plan administrator and also will be a "named fiduciary"
- Plan administration procedures and any delegation of responsibilities to other parties (e.g., claims review)
- Funding policy and procedure
- Plan amendment and termination procedures
- Explanation of how and when payments will be made under the plan
- If the plan is grandfathered under PPACA (see Section 2 above), the disclaimer described in Section 2 must appear on the plan document

PLAN DOCUMENT CHECKLIST

- Must be made available to participants for inspection
- A copy must be provided upon participant request

3.2 SUMMARY PLAN DESCRIPTION (SPD)

The SPD summarizes the terms of a plan and must be provided to participants and beneficiaries by all ERISA welfare plans, regardless of the number of participants. The SPD must be written in “plain language” so that it can be easily understood by all participants. ERISA provides that the SPD “shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.”

The plan administrator must distribute the SPD within 90 days after a person becomes a plan participant or beneficiary. A new plan must distribute the SPD to participants and beneficiaries within 120 days after becoming subject to ERISA. If a participant or beneficiary submits a written request for the SPD, the plan administrator must provide it to them within 30 days of the request. The SPD should be updated every five years if there are amendments to the plan, and every ten years if there are no amendments.

ERISA has very specific requirements relating to the content of SPDs. The Summary Plan Description (SPD) must include the following information:

- Name of the plan(s).
- Name and address of the employer.
 - In the case of a single employer plan, the employer whose employees are covered by the plan.
 - In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan, and the employers.
 - In the case of a plan maintained by two or more employers, the parent or most significant employer of the group of employers contributing to the plan.
- Employer Identification Number (EIN).
- Type of plan (medical, dental, etc.) and plan number (e.g., 501, 502, etc.).
- Beginning and ending dates of the plan year.
- Name, business address and telephone number of the plan administrator.
- Type of administration (insured, self-insured).
- Name and address of the designated legal agent.
- Eligibility and benefits requirements, including requirements for participation (waiting period, class eligibility) and a description of the benefits available under the plan. A general description of benefits is permissible, if the SPD refers the participants to the other documents that contain the detailed information and those documents are available to the participants without charge.
- Sources of plan contributions and any cost sharing provisions (premiums, deductibles, coinsurance, copays, etc.).
- The name and address of the insurer and the insurer’s role (whether providing insurance or only administrative services).
- Description of loss of benefits. The document must clearly identify the circumstances that may result in disqualification from the plan, ineligibility for benefits and the denial, loss, forfeiture or suspension of benefits, including subrogation and coordination of benefits provisions.
- Provisions regarding plan amendment and termination, including the rights of participants in the event of a plan termination.

- Statement of rights under ERISA. A model statement is included in the U. S. Department of Labor (DOL) Regulations; the statement of rights can, however, be rewritten as long as the information is consistent with the model.
- COBRA rights. All SPDs for group health plans must include language on COBRA rights. Group health plans subject to COBRA should include a description of the rights and obligations of participants and beneficiaries with respect to continuation of coverage, information pertaining to qualifying events, premium payments, notice and election requirements and duration of coverage.
- If the plan is fully insured, a statement must be included that if maternity benefits are provided, the plan may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the newborn or mother to less than 48 hours following a normal, vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance carrier for prescribing a length of stay not in excess of the above periods.
- Information must be included explaining the HIPAA special enrollment rules.
- Information must be included explaining the qualified medical child support order (QMCSO) procedures.
- Notice of the Women’s Health and Cancer Rights Act must be included.
- Disclosure of the office of the DOL through which plan participants may seek information regarding the provisions of HIPAA.
- Complete description of the plan’s claims procedures.
- If the plan is grandfathered under PPACA (see Section 2 above), the disclaimer described in Section 2 must appear on the document.

SUMMARY PLAN DESCRIPTION (SPD) CHECKLIST

- Copy of SPD must be provided to each participant and each beneficiary.
- SPD can be provided to employees with enrollment materials.
- SPD must be provided within 120 days after a plan first becomes subject to ERISA.
- SPD must be provided within 90 days after an individual becomes a participant.
- SPD must be provided every five years if there have been any changes to the plan during the five-year period.
- SPD must be provided every ten years if there have been no changes to the plan.
- If material modification is made to plan, a summary of material modification (SMM) must be provided no later than 210 days after the end of the plan year in which the change is adopted (an updated SPD can be provided instead of the SMM).
- If material reduction in covered services is made to plan, notice of the reduction must be provided within 60 days after the adoption of the change (unless SPDs are issued at least every 90 days).
- Participants and beneficiaries may also make written request for a copy of the SPD.
- If the plan is grandfathered under PPACA (see Section 2 above), the disclaimer described in Section 2 must appear on the document.

SUMMARY PLAN DESCRIPTION (SPD) FOREIGN LANGUAGE CHECKLIST

- The following plans must include a prominently displayed notice, in the non-English language common to the plan's participants, offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to the plan's participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights under the plan.
 - A plan that covers fewer than 100 participants at the beginning of a plan year, and in which 25 percent or more of all plan participants are literate only in the same non-English language, or
 - A plan that covers 100 or more participants at the beginning of the plan year, and in which the lesser of (i) 500 or more participants, or (ii) 10% or more of all plan participants are literate only in the same non-English language, so that a summary plan description in English would fail to inform these participants adequately of their rights and obligations under the plan.

3.3 SUMMARY OF MATERIAL MODIFICATION (SMM)

The SMM describes material changes to the Plan and must be distributed to participants and beneficiaries by all ERISA welfare plans. Examples of material changes include changes in the eligibility requirements, benefits, plan name, or the name of the plan sponsor. The SMM must generally be provided to participants no later than 210 days after the close of the plan year in which the plan sponsor adopted the material modification. Distribution of an updated SPD will satisfy the SMM requirement.

SUMMARY OF MATERIAL MODIFICATION (SMM) CHECKLIST

- Copy of SMM must be provided to each participant and each beneficiary no later than 210 days after the end of the plan year in which the change is adopted.
- No prescribed format for SMM.
- SMM can be in letter, memo, or other format.
- An updated SPD can be provided instead of the SMM.
- SMM may be combined with other documents.
- Plan identifying information should be included.

3.4 NOTICE OF MATERIAL REDUCTION IN COVERED SERVICES OR BENEFITS

If a plan sponsor reduces health benefits, the plan administrator must notify participants and beneficiaries of the reduction in covered services or benefits. The plan administrator must provide the notice to participants and beneficiaries no later than 60 days after the adoption of the change, or at regular intervals of not more than 90 days.

NOTICE OF REDUCTION IN COVERED SERVICES OR BENEFITS CHECKLIST

- Notice must be provided to each participant and each beneficiary no later than 60 days after the change is adopted.
- No prescribed format for notice.
- Notice can be in letter, memo, or other format.
- Notice may be combined with other documents.
- Plan identifying information should be included.
- An updated SPD can be provided instead of the notice IF SPDs are provided at regular intervals of not more than 90 days.

3.5 SUMMARY OF BENEFITS AND COVERAGE (SBC)

BACKGROUND

On February 9, 2012, the Departments of Labor, Health and Human Services, and the Treasury (the “Departments”) released final regulations that provide standards for use by group health plans and health insurance carriers in compiling and providing a summary of benefits and coverage (SBC) and a uniform glossary of commonly used health insurance and medical terms, as required by PPACA. The Departments also released templates, instructions, and related materials to assist with development of the SBC and disclosure of the uniform glossary.

Under the final regulations, the SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font. The SBC is accompanied by the four-page uniform glossary of health insurance and medical terms, which also will be available on the government websites. A group health plan or health insurance carrier also must provide participants with a new SBC each year when the policy is renewed (if renewal is automatic, the SBC must be provided at least 30 days prior to renewal). The SBC requirement may be satisfied electronically, provided the distribution complies with ERISA’s electronic disclosure rules. The SBC requirement first became effective for open enrollments and plan years beginning on or after September 23, 2012.

In addition, the regulations provide that if a material modification is made to the terms of the plan (other than in connection with a renewal of coverage – e.g., mid-year) that would affect the content of the SBC, and such modification is not reflected in the most recently provided SBC, then the plan or carrier must provide notice of the modification to enrollees no later than 60 days prior to the date on which such modification will become effective.

ADDITIONAL GUIDANCE

The Departments subsequently released several sets of answers to frequently asked questions (FAQs) on implementation issues associated with SBCs, and a proposed rule modifying 2012's final rule was published in December of 2014.

On June 16, 2015, the Departments released an **updated** final rule that consolidates the original rule and subsequent guidance. The final rule breaks very little new ground and importantly does not include new sample language for SBCs. The new requirements are effective for plan years beginning on or after September 1, 2015. In February 2016, the Agencies proposed further changes to the SBC template and related materials initially proposed in December 2014. A request for comments on these materials was also issued with the expectation of finalizing the materials “expeditiously.” The agencies made good on their promise to finalize the SBC materials “expeditiously,” releasing final versions in April 2016. Use of the revised SBC template and related materials is required starting with the first day of the first open enrollment period that begins on or after April 1, 2017 with respect to coverage for plan years beginning on or after that date. Thus, for calendar-year plans, the updated materials will be used for the 2017 open enrollment period relating to coverage beginning on or after January 1, 2018. For plans that do not use an annual open enrollment period, these materials must be used beginning on the first day of the first plan year that begins on or after April 1, 2017. The following summarizes the SBC requirements under the **updated** final rule.

What plans are subject to the SBC requirement?

The SBC rules apply to all fully insured and self-insured health plans including, regardless of grandfathered status. The SBC rules do not apply to health savings accounts (HSAs) or HIPAA-excepted benefits, which include “retiree-only” plans, stand-alone dental or vision plans, and most FSAs. If an HRA is integrated with other major medical coverage, then it does not have to separately satisfy the SBC rules; the effects of employer allocations to an HRA account can be denoted in the SBC for the other major medical plan. Although an HSA is not subject to the SBC rules, an SBC prepared for a high deductible health plan associated with an HSA can mention the effects of the employer contributions to such an HSA.

Which participants in a group health plan must receive an SBC?

An SBC must be provided to each participant or beneficiary who is enrolled in a group health plan. However, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form), unless the plan or insurer has knowledge of a separate address for a beneficiary (e.g., a spouse or adult dependent).

May the SBC be delivered electronically?

Yes, the rules permit plans to electronically deliver the SBC to participants and beneficiaries in accordance with ERISA's electronic disclosure requirements with one modification. In this regard, a distinction is made between a participant or beneficiary who is already covered under the group health plan, and a participant or beneficiary who is eligible for coverage but not enrolled in a group health plan. With regard to the latter group, plans may send a paper postcard electronically or through regular mail to provide instructions for accessing the SBC online, provided the format is readily accessible through an internet posting and a paper copy is provided free of charge upon request.

The FAQs add an additional safe harbor, under which SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. **NOTE:** that these rules differ from ERISA's electronic disclosure requirements, so consideration should be given if the SBC is intended to suffice as a summary of material modification (SMM) under ERISA. In other words, if a plan chooses to communicate material modifications via the SBC, their distribution must comply with ERISA's electronic disclosure requirements or a separate SMM may be required.

As noted above, plans may provide the SBC to an employee on behalf of a beneficiary, and may do so electronically, unless the plan has knowledge of a separate address for the beneficiary.

When must an SBC be provided to participants in a group health plan?

- Upon application. If a plan distributes an enrollment application, the SBC must be provided as part of those materials. If the plan does not distribute an enrollment application, the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage.
- Within 90 days of a "special enrollment." An SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided, which is 90 days from enrollment.
- Upon renewal. If a plan requires participants to affirmatively elect to maintain coverage during open enrollment, or provides them with the opportunity to change coverage options during open enrollment, the plan must provide the SBC at the same time it distributes open enrollment materials. If elections automatically renew and there is no opportunity to change coverage options, the SBC must be provided no later than 30 days prior to the first day of the new plan year (or, if coverage has not yet been renewed, as soon as practicable but in no event later than seven business days after issuance of the new insurance contract, or upon confirmation of intent to renew, whichever is earlier).
- Upon request. The SBC must be provided as soon as practicable to participants and beneficiaries upon their request, and in no event later than seven business days from the date of such request.

Who is responsible for developing the SBC?

For fully insured plans, health insurers are responsible for developing the SBC. For self-insured plans, the plan sponsor (or designated administrator) is responsible for developing the SBC. A plan administrator that uses two or more insurers or service providers with respect to a single group health plan may synthesize the information into a single SBC, or may contract with one of its insurers or service providers to perform that function.

What is the penalty for failure to provide an SBC?

A group health plan or insurer that willfully fails to provide an SBC is subject to a fine of not more than \$1,128 per enrollee (or beneficiary if they reside at a known address that is different than the participant) per failure.

Must plans provide advance notice of changes?

Plans must notify participants no later than 60 days prior to the effective date of any material modification that would affect the content of the most recently provided SBC, unless the change is made in connection with a renewal or reissuance of coverage. This is a change from the rules under ERISA, which provide that notice of a material reduction in group health plan benefits must be communicated to participants within 60 days of being adopted by the plan, and that a material modification (other than a reduction) be communicated within 210 days after the end of the plan year in which the change is adopted.

Must the SBC be provided on a stand-alone basis?

The SBC may be provided as either a stand-alone document or in combination with other documents, as long as the SBC is prominently displayed at the beginning of such other documents.

How should the SBC be drafted if the plan design does not fit the SBC template?

The SBC instructions provide that to the extent a required SBC element cannot be reasonably described consistent with the template and the instructions, the plan is required to accurately describe the plan's terms while using its best efforts in a manner that is still consistent with the instructions and template.

What is the foreign language requirement?

Plans must include a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or insurer for the English versions of SBCs sent to an address in a county in which 10% or more of the population is literate only in a non-English language. A plan can voluntarily include the statement in the SBC for use in counties that do not meet the 10% non-English language threshold.

Are group health plans primarily for expatriates required to provide an SBC?

Yes, although in lieu of providing an SBC, a plan may provide an internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. The Departments will not take any enforcement action against a plan for failing to provide an SBC with respect to expatriate coverage during the first year that the rules apply. **NOTE:** that to the extent coverage or benefits are available within the United States, the plan is still required to provide a compliant SBC.

What key provisions were added in the June 2015 regulations?

Online Access to Individual Underlying Policy or Group Certificate. The Regulations clarify that all insurance issuers must include an Internet web address where a copy of the actual policy or group certificate of coverage can be reviewed and obtained before someone signs up for coverage. For fully insured employer-sponsored plans, because the actual "certificate of coverage" is not available until after the plan sponsor has negotiated the terms of coverage with the insurer, the insurer may post a sample group certificate of coverage for each applicable product. After the actual certificate of coverage is executed, it must then be posted and made available to the plan sponsor, participants, and beneficiaries on the Internet.

Safe Harbor for Sponsors That Use Vendors. The Agencies confirmed that a prior proposed safe harbor for plan sponsors that contract with others to deliver the SBCs will still be available if:

1. the plan sponsor monitors performance by the vendor under the contract;
2. if the plan sponsor has knowledge that the SBC is not being provided in a manner that satisfies the requirements and the plan sponsor has all information necessary to correct the noncompliance, the plan sponsor corrects the noncompliance as soon as practicable; and
3. if the plan sponsor has knowledge the SBC is not being provided in a satisfactory manner and the plan sponsor does not have all information necessary to correct noncompliance, the plan sponsor communicates with the affected participants and beneficiaries regarding the noncompliance and begins taking steps as soon as practicable to avoid future violations.

Timing and Delivery of SBCs Remains the Same. The Agencies continue to attempt to take a common-sense approach to the timing and the delivery of SBCs, including:

1. not requiring a new SBC be provided to participants who were provided an SBC prior to the start of a plan year but before the insurance contract is finalized (as long as there have been no changes to the required information);
2. allowing participants whose coverage is automatically renewed to be provided with an SBC for that coverage option by the start of the plan year (although they may request and must receive SBCs for other coverage options within seven days of the request); and
3. permitting electronic posting of SBCs for those enrolling online.

Which templates and associated documents should be used on or after April 1, 2017?

The Final SBC template and associated documents, released in March of 2016, were required to be used for open enrollments occurring on or after April 1, 2017. For calendar year plans, the 2018 open enrollment was the first open enrollment requiring use of the new SBC template. Employers should review SBCs to ensure they have been changed to reflect the new rules. Templates, instructions, and related materials for the new SBCs can be found on the Department of Labor website – links are provided below.

SBC TEMPLATES, INSTRUCTIONS, AND CERTAIN RELATED MATERIALS:

[DOL.gov - SBC Template](#)

[DOL.gov - SBC Completed Example](#)

[DOL.gov - SBC Instruction Guide for Group Coverage](#)

[DOL.gov - SBC Instruction Guide for Individual Health Insurance Coverage](#)

[DOL.gov - SBC What this Plan Covers & What You Pay for Covered Services: Yes Answers](#)

[DOL.gov - SBC What this Plan Covers & What You Pay for Covered Services : No Answers](#)

[DOL.gov - Glossary of Health Coverage and Medical Terms](#)

Additional materials may be found at:

[DOL.gov - Summary of Benefits and Coverage and Uniform Glossary](#)

[CMS.gov - Summary of Benefits and Coverage and Uniform Glossary](#)

3.6 SUMMARY ANNUAL REPORT (SAR)

This report summarizes financial information and other items reported on the Form 5500. The SAR is a narrative summary of the Form 5500. ERISA welfare plans exempt from filing a Form 5500 (for example, small unfunded or insured plans with less than 100 participants) are not required to distribute an SAR. In addition, totally unfunded welfare plans (regardless of size) are also exempt from distributing the report. When an SAR is required, it must be provided to plan participants and beneficiaries receiving benefits within nine months after the close of the plan year (i.e., September 30 for a calendar year plan year). If an extension has been granted for filing the plan's Form 5500, the summary annual report must be provided within two months after the extended filing date.

SUMMARY ANNUAL REPORT (SAR) CHECKLIST

- Prescribed format.
- SAR must be provided by the end of the ninth month after the close of the plan year (September 30 for calendar year plans).
- Extension of two months granted if Form 5558 timely completed and submitted.
- Most software programs used to prepare Form 5500 filings will also produce SARs.

3.7 CLAIMS REVIEW PROCEDURES

All employee benefit plans (both grandfathered and not grandfathered) governed by ERISA must establish reasonable claims procedures that address claim filings, notification of benefit determinations, and steps to obtain a full and fair review of an adverse benefit determination. In order for a claims procedure to be “reasonable,” it must meet the following requirements (**NOTE:** Non-grandfathered plans must also meet the requirements set forth at Section 3.8 below):

- The claims procedures must contain administrative processes and safeguards designed to ensure that:
 - benefit determinations are made in accordance with plan documents; and
 - plan provisions have been applied consistently with respect to similarly situated claimants.
- The claims procedures cannot contain any provision or be administered in any way that unduly inhibits or hampers the participant's ability to obtain benefits, such as requiring fees for filing claims or appeals.
- The claims procedures must allow a claimant's authorized representative to act on his or her behalf.
- The summary plan description (SPD) must include a description of the claims and appeals procedures and applicable time frames (unless the SPD explicitly states that the claims procedures will be provided in a separate document without charge).

The claims review time frames differ depending upon the type of claim involved.

For group health plans:

- Urgent care claim decisions (involving immediate medical care to avoid seriously jeopardizing the life or health of the claimant) must be decided no later than 72 hours after receipt of the claim; a maximum of 72 hours is permitted for the review of an adverse determination.
- Pre-service claims (involving requests for approval of benefits in advance of receiving medical care) must be decided no later than 15 days from the receipt of a claim; a maximum of 30 days is permitted for the review of an adverse benefit determination.
- Post-service claims (involving requests for approval of benefits after receiving medical care) must be decided no later than 30 days after receipt of the claim; a maximum of 60 days is permitted for the review of an adverse benefit determination.
- Any decision (other than by plan amendment or employment termination) to terminate or reduce benefits that have already been granted must be treated as an adverse benefit determination.
- Any request for an extension of a course of treatment involving urgent care must be made within 24 hours after receipt of the claim if the claim was made at least 24 hours before the coverage was due to end.

For disability plans:

- Initial disability decisions must be made no later than 45 days after receipt of the claim; a maximum of 75 days is permitted for review of an adverse benefit determination.

INFORMATION REQUIRED UPON CLAIM DENIAL

When issuing an adverse benefit determination, plans must provide the claimant with the specific reasons for the denial, including identifying and providing access to all guidelines, rules, and protocols relied upon in making the adverse determination, at no cost to the claimant.

A denial notice must include:

- the specific reason(s) for the adverse benefit determination;
- a reference to the specific plan provision on which the determination is based;
- a description of any additional material or information necessary to fix the claim and an explanation of why such material or information is necessary;
- a description of the review procedures, including a statement of the claimant's right to bring a lawsuit following an adverse benefit determination on review;
- either the specific rule or guideline used in making the benefit determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment or a statement that such explanation will be provided free of charge upon request; with respect to claims for disability benefits filed under a plan from January 18, 2017 through December 31, 2017 only:
 - i. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

- ii. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- with respect to claims for disability benefits filed under a plan after April 1, 2018:
 - i. a discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
 - the views presented by the health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;
 - ii. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - iii. either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist; and
 - iv. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Denial letters for disability benefits are required to be culturally and linguistically appropriate. This means that if a claimant's address is in a county where 10% or more of the population is literate only in the same non-English language, such letters must include a prominent statement in that language about the availability of language services. Furthermore, the plan must provide a copy of the applicable letter or notice in that language upon request, and it must provide oral language services.

APPEALS

The time frames and standards for the appeal of group health and disability claims include:

- Claimants are entitled to at least 180 days to file an appeal following receipt of a notification of an adverse benefit determination.
- If the denial was based (in whole or in part) on a medical judgment, the decision on appeal must be reached in consultation with a health care professional who (i) has appropriate training and experience in the field of medicine, (ii) was not involved in the initial determination, and (iii) is not a subordinate of the decision-maker.
- The identity of medical or vocational experts whose advice was obtained from the plan must be given, regardless of whether the advice was relied upon in making the determination.

APPEAL DETERMINATION NOTICE

Claimants must be provided with a notice of decision on appeal, which must include the following:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision on which the benefit determination is based;
- a statement that the claimant is entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered, or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the plan concerning the claim without regard to whether the statement was relied on;
- either the specific rule or guideline used in making the benefit determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the plan to the claimant's medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the plan's optional appeals procedures, and the claimant's right to receive information about such procedures, as well as the right to bring a lawsuit and, with respect to claims for disability benefits filed under a plan after April 1, 2018, any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency;" and
- with respect to claims for disability benefits filed under a plan after April 1, 2018, a discussion of the decision including an explanation of the basis for disagreeing with or not following:
 - i. The views presented by the health care professionals treating the claimant and vocational professionals who evaluated the claimant;
 - ii. The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
 - iii. A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

Disability benefit claimants are not barred from suing due to failure to exhaust the plan's claims procedures where the plan itself failed to comply with its claims procedures (except for certain minor failures). Also, retroactive rescissions of coverage are considered benefit denials that trigger the plan's appeals procedures.

ACCESS TO “RELEVANT DOCUMENTS”

Plans must provide claimants access to all documents, records, and other information relevant to the benefit determination, regardless of whether the plan relied on the material in making the decision. Documents, records, and other information will be considered “relevant” to a given claim if:

- they were relied on by the plan in making the benefit determination;
- they were submitted, considered, or generated in the course of making the benefit determination (even if the plan didn’t rely on them);
- they demonstrate that, in making the determination, the plan complied with its own processes for ensuring appropriate decision making and consistency (e.g., documents produced during an internal audit); or
- the information constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

3.8 CLAIMS PROCEDURES TIME CHART

Time Limits	Type of Claim			
	Urgent Health Care	Pre-Service Health Care (permission needed before obtaining care) (non-urgent)	Post-Service Health Care	Disability
To make initial claim determination	24 hours if not grandfathered / 72 hours if grandfathered	15 days (depending on medical circumstances)	30 days	45 days
Extension (if proper notice and delay is beyond plan control)	None	15 days	15 days	30 days, plus another 30 days
To request missing information from claimant	24 hours	5 days	30 days	45 days
For claimant to provide missing information	48 hours	45 days	45 days	45 days
For claimant to request appeal	180 days	180 days	180 days	180 days
To make determination on appeal	72 hours (depending on medical circumstances)	30 days (or 15 days, if plan requires two appeals)	60 days (or 30 days, if plan requires two appeals)	45 days (or up to 45 days more in special circumstances)

3.9 SPECIAL CLAIMS RULES APPLICABLE TO NON-GRANDFATHERED HEALTH PLANS

All group health plans governed by ERISA must follow the rules set forth in Sections 3.7 and 3.8. In addition, once a plan loses its grandfathered status (see Section 2 above), the following additional rules will apply with respect to claims for benefits:

- **Use of Broader Definition of “Adverse Benefit Determination”** Claims that may not otherwise have been subject to EBSA’s claims procedure regulations will now be subject to both those procedures and the new claims procedures. The new regulations include a rescission of coverage within the definition of “adverse benefit determination,” which broadens the claims that are subject to the claims procedures. Claim denials will be subject to the existing and new claims regulations if based upon a group health plan’s determination that the individual is not eligible to participate in a plan, a benefit is not covered by the terms of a plan, the plan imposes a preexisting, source-of-injury, network, or other exclusion on otherwise covered benefits, or a benefit is experimental, investigative, or not medically necessary or appropriate. An adverse benefit determination includes both pre-service and post-service claims, and any rescission of coverage whether or not there is an immediate adverse effect on any particular benefit.
- **Additional Criteria to ensure a Claimant Receives a Full and Fair Review** In addition to complying with the existing EBSA claims procedures, group health plans must provide a claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim. This information must be provided sufficiently in advance to allow a claimant time to respond prior to the adverse benefit determination. Further, any new rationale for denying a claim on appeal or review must be disclosed to the claimant sufficiently in advance to allow the claimant time to respond prior to the adverse benefit determination on appeal or review.
- **Additional Criteria to Avoid Conflicts of Interest by Decision Makers** The interim final regulations mandate additional precautions to ensure that claims and appeals are decided independently and impartially. Accordingly, plans cannot hire, promote, or terminate claims reviewers based on the likelihood that an individual will support a denial of benefits. For example, bonuses based on the number of claims denied are strictly forbidden. Similarly, a plan cannot contract with a medical expert based on the expert’s reputation for outcomes in contested cases rather than the expert’s professional qualifications.
- **External Claim Review** The new claims procedures require group health plans to provide an effective external review process by Independent Review Organizations (“IROs”), by requiring plans to provide information to IROs regarding final adverse benefit determinations. The new claims procedures set forth standards for state external review processes and provide an outline of the federal external review process, the final details of which will be forthcoming. Due to preemption, most claims under self-insured ERISA-covered plans will be subject to the federal external review process. For plans providing health insurance coverage that is subject to a state external review process, these plans will not need to comply with the federal external review process if the state external review process meets the minimum consumer protection in the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act, upon which the federal external review process will be based. Decisions by IROs under the external review processes will be binding on the plan and claimant, except to the extent other remedies are available under state or federal law.
- **Notice Standards** Notices to individuals must be provided in a “culturally and linguistically appropriate manner.” Depending on the number of non-English speaking plan participants, written communications may be required in their native language. In addition to the existing notice standards under ERISA’s standard claims procedures, group health plans must provide:
 - information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes;
 - the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the plan’s standard, if any, that was used to deny the claim.

For notices of final internal adverse benefit determinations, the description must include a discussion of the decision;

- a description of available internal appeals and external review processes, including how to initiate an appeal; and
- the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.
- **Strict Adherence Required or Deemed exhaustion of Internal Claims and Appeals Procedures**
If group health plans do not strictly adhere to all requirements of the internal claims and appeals process, claimants will be deemed to have exhausted the internal claims and review process regardless of whether the plan substantially complied with these requirements or any error committed is “de minimis.” This is a different standard than the one applied under EBSA regulations. Accordingly, non-compliance with the new claims procedures could turn a claimant into a plaintiff empowered to seek external review or immediate judicial review of the benefit denial. Moreover, claims that incur a claims procedure failure are deemed denied on review without the exercise of discretion by an appropriate fiduciary. This could cause the plan to lose deference to its claim determination and lead a court to apply the de novo standard on judicial review.
- **Continued Coverage Requirement** Group health plans must provide continued coverage pending the outcome of an internal appeal. An ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

3.10 ELECTRONIC DISCLOSURE RULES

SUMMARY PLAN DESCRIPTION (SPD) ELECTRONIC DISCLOSURE CHECKLIST

The DOL permits certain disclosures required under Title I of ERISA to be made through electronic media. The electronic disclosure rules extend to the following documents:

- Summary Plan Descriptions (SPD)
- Plan Amendments
- COBRA Notices
- HIPAA Special Enrollment Rights Notice
- Women’s Health and Cancer Rights Act (WHCRA) Notice
- Qualified Medical Child Support Order (QMCSO)
- Explanation of Benefits (EOB)
- Financial Reporting (Form 5500, Summary Annual Report (SAR))

The basic requirements for electronic disclosures include:

- The steps taken for furnishing the documents are reasonably calculated to result in the actual receipt of the documents (e.g., using return-receipt or notice of undelivered e-mail features or conducting periodic reviews or surveys to confirm receipt).
- The plan must take reasonable and appropriate steps to safeguard the confidentiality of personal information related to an individual's accounts and benefits.
- The electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document.
- Each time an electronic document is furnished, a notice (electronic or paper) must be provided to each recipient describing the significance of the document.
- A paper version of the electronic document must be available on request.

Once the basic requirements are satisfied, ERISA documents may be furnished to two classes of potential recipients:

- Participants who have the ability to access documents through their employer's electronic information system that is located where they are reasonably expected to perform duties as employees (i.e., employees working from home or on travel are covered, but distribution through a kiosk in a common area in the workplace does not comply with the requirements).
- Participants (including retirees and terminated participants with elected COBRA continuation coverage), beneficiaries, and others who affirmatively consent to receive the documents electronically and who provide an electronic address and reasonably demonstrate their ability to access documents in electronic form.

Please **NOTE:** that the electronic disclosure rules are complex. We recommend that employers consult with benefits counsel prior to instituting procedures with regard to the electronic distribution of ERISA-required disclosures.

3.11 DOCUMENT RETENTION RULES

In general, employee welfare benefit plan documents and documents required by ERISA must be retained for not less than six years after the filing date of the Form 5500 that is based on those records (or six years after the date on which such documents would have been filed but for an exemption or simplified reporting requirement). To accommodate extended Form 5500 filings (and provide some cushion), it is a good practice to retain employee welfare benefit plan documents for eight years. However, there may be other reasons, such as a benefit claim statute of limitations period that is longer than eight years, that could warrant a longer retention period.

Materials should be preserved in a manner and format that permits ready retrieval. All records including annual reports, disclosures, amendments and resolutions should be retained. The responsibility to retain these records lies with the plan administrator, even if a third-party administrator administers the plan. The following should be retained:

- Original signed plan documents and amendments.
- Corporate resolutions and/or committee actions related to the plan(s).
- Plan disclosures and communications to participants (including Summary Plan Descriptions and Summary of Material Modifications).

- Financial reports, audits, and related statements.
- Form 5500s.
- Trust documents.
- Nondiscrimination and coverage testing results.
- Disputed claim records in the event of future litigation.
- Payroll and census data used to determine eligibility and contributions.

NOTE: It is a good internal practice for the official plan documents to be retained for the life of the plan, so that the plan sponsor has a paper trail of the plan from its inception.

4. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

4.1 LAWS AND REGULATIONS

Under COBRA, employers that maintain a group health plan and have 20 or more employees must offer COBRA continuation coverage to qualified beneficiaries who have lost health care coverage as a result of certain qualifying events. If there are 20 or more employees for at least 50 percent of the normal business days in the prior year, COBRA must be offered by the employer the following year. Employers are not required to pay for the cost of the coverage, but are required to make it available to the beneficiaries. The employee or qualified beneficiary may be charged 102% of the applicable premium for this benefit.

NOTE: Many states have “mini-COBRA” rules that apply to smaller plans and these rules can be different from the federal COBRA rules.

Group Health Plan: A group health plan is a plan that is maintained by an employer and that provides health care to employees (and former employees). A group health plan includes both insured and self-insured plans, and includes: medical, dental, vision and prescription drug coverage. In addition, COBRA may apply to a health flexible spending account and to certain employee assistance plans.

New rules allow an employee to pay COBRA premiums due to a different plan sponsor than the sponsor of the cafeteria plan. This will allow the employee to make a pre-tax election at a new employer to pay for COBRA premiums due to his previous employer.

Qualifying Event: A qualifying event is a loss of coverage under a group health plan due to one of the following events:

- A covered employee’s termination of employment (other than for gross misconduct).
- A covered employee’s reduction in hours of employment.
- A covered employee’s death.
- Divorce or legal separation from a covered employee.
- A child ceasing to be a dependent under the terms of the plan.
- A covered employee’s entitlement to Medicare.
- Employer bankruptcy (retiree plans only).

Qualified Beneficiary: A qualified beneficiary is a person who is covered under a group health plan immediately before the qualifying event and who is one of the following:

- A covered employee,
- the covered employee’s spouse, or
- the covered employee’s dependent child.

In general, any dependent children of a covered employee at the time of a qualifying event are considered qualified beneficiaries. A child born or adopted during a period of COBRA coverage also will be entitled to elect COBRA coverage. In addition, a qualified medical child support order (QMCSO) may require the plan to provide COBRA coverage for a covered employee’s child, even though the child may not meet the plan’s definition of “dependent.” (QMCSOs are explained in Section 12.6).

4.2 LENGTH OF COBRA COVERAGE

The maximum period that COBRA coverage must be provided is generally 18 months if the coverage is triggered by the employee's termination or reduction in hours of employment (and this period can be extended to 29 months if a qualified beneficiary is disabled). The maximum period COBRA coverage must be provided for all other qualifying events (including any multiple qualifying events) is 36 months.

Disability Extension: If during the first 60 days of COBRA coverage, a qualified beneficiary is determined by the Social Security Administration to be disabled, an 18-month period of COBRA coverage will be extended to a maximum of 29 months if the qualified beneficiary notifies the plan administrator of his or her disability before the end of the original 18-month maximum coverage period and within 60 days after the latest of (1) the date of the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the qualified beneficiary would lose coverage under the plan; and (4) the date on which the beneficiary is notified of his or her obligation to provide notice of his or her disability to the plan administrator.

Multiple Qualifying Event: If, after a qualifying event that is a termination of employment or reduction in hours of employment, a second qualifying event occurs during the initial 18-month coverage period (or a 29-month disability extension period), the maximum coverage period for the spouse or dependent child who is a qualified beneficiary is extended to a total of 36 months (measured from the date on which the 18-month period began).

A second qualifying event is one of the following events, if the event occurs during the initial 18-month coverage period, and if the second qualifying event would have caused a loss of coverage for the qualified beneficiary if it had occurred first:

- A covered employee's death.
- Divorce or legal separation from a covered employee.
- A child ceasing to be a dependent under the terms of the plan.
- A covered employee's entitlement to Medicare.

Medicare Extension: The COBRA rules involving Medicare are complex and usually require the assistance of legal counsel.

- **Medicare Entitlement Before Qualifying Event.** In general, if a covered employee becomes entitled to Medicare while still employed and then within the 18-month period beginning on the date of his or her Medicare entitlement, the employee has a qualifying event that is either a termination or a reduction in hours of employment, the employee's spouse and dependent children (but not the employee) become entitled to COBRA coverage for a maximum period ending 36 months measured from the date the employee became entitled to Medicare. The employee is entitled to COBRA coverage for a maximum period of 18 months measured from the date of the qualifying event. (**NOTE:** This rule assumes that entitlement to Medicare does not cause a loss of coverage under the Plan.)
- **Medicare Entitlement After Qualifying Event.** In general, if a covered employee becomes entitled to Medicare after experiencing a qualifying event that is either a termination or a reduction in hours of employment, the employee's COBRA coverage can be terminated. The spouse and dependent children continue COBRA coverage until the end of the original 18-month coverage period—no extension applies. (**NOTE:** This rule assumes that entitlement to Medicare does not cause a loss of coverage under the Plan.)
- **USERRA.** The COBRA health care coverage continuation rights are separate from continuation coverage rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). In certain circumstances USERRA provides health care coverage continuation rights for qualifying military service for up to 24 months.

4.3 COBRA NOTICE REQUIREMENTS

There are several different notice obligations under COBRA:

Initial Notice: This notice informs participants and their spouses about continuation coverage available to them under COBRA. Generally, the Initial Notice must be provided to each covered employee and to the employee's spouse (if covered under the plan) no later than the earlier of: (1) either 90 days from the date on which the covered employee or spouse first becomes covered under the plan or, if later, the date on which the plan first becomes subject to the COBRA requirements; or (2) the date on which the plan administrator is required to provide a qualifying event notice and election form to the employee or to his spouse or dependent. The Initial Notice must include the name of the plan and a person to contact (name, address and phone number) for further information. (Notice to a spouse covers all dependents residing with that spouse.)

The Initial Notice has been updated to reflect the availability of alternative coverage on the Exchange. An updated model (referred to as the "COBRA Model General Notice") is available in English and Spanish [here](#) under the tab "For Employers and Advisers" after expanding the "Regulations" tab.

Qualifying Event Notice and Election Form: This notice informs former participants and their covered dependents of their right to elect continuation coverage under COBRA. The employer must notify the plan administrator within 30 days after a qualifying event that is triggered by:

- a covered employee's termination,
- a covered employee's reduction in hours of employment,
- a covered employee's death,
- a covered employee's entitlement to Medicare, or
- the employer's initiation of bankruptcy.

NOTE: If the plan states that COBRA continuation coverage begins on the date of loss of coverage (as opposed to the date of the qualifying event), the employer must notify the plan administrator within 30 days of the date the beneficiary actually loses coverage under the plan.

The Qualifying Event Notice has been updated to reflect the availability of alternative coverage on the Exchange. An updated model (referred to as the "COBRA Model Election Notice") is available in English and Spanish [here](#) under the tab "For Employers and Advisers" after expanding the "Regulations" tab. The DOL has released an FAQ that states that a plan administrator may include additional information about Exchange change in or with the election notice (such as, how to get help with Exchange enrollment, availability of financial assistance, information about the Exchange website or contact information, general information about Exchange products and other "information that may help qualified beneficiaries choose between COBRA and other coverage options." The updated Qualifying Event Notice also reflects changes mandated by the ACA's prohibition on preexisting condition exclusions and eliminates the prior model language relating to the Health Coverage Tax Credit, which expired January 1, 2014.

The plan administrator then must issue the COBRA Qualifying Event Notice and Election Form to covered employees and dependents within 14 days of receiving the notice of the qualifying event from the employer. The notice must be in writing and be written in a manner that can be easily understood by the average plan participant. Plans may tailor the election notice to particular groups of qualified beneficiaries so long as the information is not too long or complicated. If the employer is the plan administrator, then the employer has 44 days to provide the COBRA Qualifying Event Notice and Election Form.

The employer must give the qualified beneficiaries at least 60 days to elect continuation coverage.

Required Notice by Employee: COBRA requires employees to notify the plan administrator when certain qualifying events occur. The qualified beneficiary (employee or his/her spouse or dependent) must provide notice to the plan administrator of a divorce, legal separation, child losing dependent status, second qualifying event, or Social Security disability determination.

The plan must establish reasonable procedures for the qualified beneficiaries to use in giving the required notices. The procedures must:

- be described in the SPD;
- specify the individual or entity designated to receive the notices;
- explain how the notice must be given to the plan; and
- describe the information required to be given in the notice.

The employer must give the qualified beneficiary at least 60 days to provide notice of a one of these qualifying events. The 60-day period begins to run from the latest of: (1) the date of the qualifying event; (2) the date on which there is a loss of coverage; or (3) the date on which the qualified beneficiary is informed, through the plan's SPD or the initial COBRA notice, of his or her obligation to provide notice (including the procedures the qualified beneficiary is required to use to provide notice to the employer).

The plan administrator in turn must notify the qualified beneficiary of his/her COBRA rights within 14 days after receipt of the notice from the qualified beneficiary. (Notice to a spouse covers all dependents residing with that spouse.)

Notice of Unavailability (Denial) of Coverage: A plan administrator must provide a notice of unavailability (denial) of COBRA continuation coverage if the administrator receives notice of a qualifying event from a beneficiary and determines that the individual is not entitled to continuation coverage. The plan administrator also must give notice of coverage denial to those individuals who are not eligible for COBRA continuation coverage at the time of any other qualifying event (e.g., an employee who is fired for gross misconduct).

The plan administrator must provide the denial of coverage notice to the individual within 14 days of receipt of any qualifying event notice from either the employer or a beneficiary.

Termination Notice: A plan administrator also must provide notice of early termination of COBRA continuation coverage. This notice requirement is triggered when a plan cancels a beneficiary's coverage prior to the maximum coverage period, such as for nonpayment of premiums, or when the employer ceases to offer health care coverage. The notice must include the reason the coverage has terminated early, the date of coverage termination, and any conversion rights the beneficiary might have. The COBRA regulations specify that the notice must be provided "as soon as practicable" following the plan administrator's determination that COBRA coverage is terminating.

Insufficient Payment Notice: A COBRA premium payment that is insufficient by only a small amount will have to be accepted as full payment by a plan unless the plan administrator notifies the qualified beneficiary of the amount of the deficiency. The plan administrator must send an insufficient payment notice to the qualified beneficiary notifying him or her that the payment was deficient and that the plan will not accept partial payment as payment in full. The notice must give the qualified beneficiary a reasonable time to correct the deficiency before the plan administrator can terminate coverage. A 30-day grace period generally will be considered reasonable.

SPD Notice: ERISA requires each group health plan to disclose in its summary plan description (SPD) the "reasonable procedures" that must be used by covered employees and qualified beneficiaries to provide notices to the plan.

Conversion Privileges: Plans that include an option for conversion to individual coverage are required to make this option available to qualified beneficiaries during the 180-day period ending on the date that their maximum coverage period expires, if the plan offers the conversion option. This option must be explained to qualified beneficiaries in the COBRA Qualifying Event Notice. Although not required, a plan administrator might consider sending a conversion notice to qualified beneficiaries during the last 180 days of COBRA coverage.

NOTE: Some states mandate that individuals be provided an option to purchase a conversion policy that provides coverage after COBRA continuation coverage has expired. Notice requirements and other employer obligations vary from state to state.

COBRA Record keeping: The employer must keep detailed records of COBRA notifications, including the dates sent, and detailed records of COBRA rejections or acceptance. Failure to comply with the law subjects the employer to excise taxes, in addition to damages under ERISA, as well as possible attorneys' fees and the liability for any of the beneficiary's medical expenses that were incurred during the gap in coverage.

4.4 COBRA NOTICE CHECKLIST

- Initial Notice
- Qualifying Event Notice and Election Form
- Notice from qualified beneficiary to employer (divorce/legal separation, child ceasing to be a dependent, second qualifying events, and Social Security disability determinations)
- Notice of Unavailability (Denial) of Coverage
- Notice to qualified beneficiary of extension of COBRA coverage period (second qualifying events and disability)
- Conversion notice (required if group health plan has a conversion option)
- Notice of Early Termination
- Notice of COBRA coverage expiration (recommended – not required)
- Insufficient Payment Notice (if using the insignificant premium underpayment procedure)

COBRA PROCEDURES CHECKLIST

- Insignificant premium underpayment procedure
- Accurate disclosure to health care providers
- Verification of elections
- Documentation of date each notice sent
- Documentation of COBRA dates (notices, elections, maximum coverage periods)
- Documentation of events reported to the employer/plan administrator for divorce, child ceasing to be a dependent, second qualifying events, and disability determinations
- Establishment of procedures for qualifying beneficiaries to use in providing required notices to plan
- Establishment and/or maintenance of a COBRA record keeping process
- Check relevant state laws

4.5 MINI-COBRA STATE LAWS

COBRA is a federal law that applies to all states. State Mini-COBRA laws are state laws enforced by each state's insurance department that expand upon the federal COBRA law. Please review any state Mini-COBRA laws, which may also be called "state continuation."

5. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA was designed to improve the portability of health care coverage and increase the privacy and security of health care coverage. HIPAA's portability requirements generally apply to group health plans with two or more covered employees. HIPAA also permits state and local (i.e., non-federal) governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Group health plans with 50 or more participants must also comply with HIPAA's privacy standards and security requirements.

5.1 HIPAA PORTABILITY PROVISIONS

The HIPAA portability and special enrollment requirements were designed to make health care coverage more available to people when they change jobs by placing restrictions on the ability of health plans to impose preexisting condition exclusions on new enrollees and by requiring plans to allow certain special mid-year enrollments. The HIPAA portability provisions applied to all group health plans with two or more covered employees.

Beginning in 2014, the ACA eliminated all preexisting condition limitations and exclusions in group health plans. Likewise, some states have passed additional protections for preexisting conditions.

Notice of Special Enrollment Rights: Plans must provide special enrollment rights, which allow employees to enroll outside of the initial or open enrollment periods, to employees and their dependents who do not enroll in the plan when they first are eligible because they have other health care coverage, and they later lose the other coverage because:

- The other coverage was COBRA continuation coverage and that coverage was exhausted.
- The individual lost eligibility for the other coverage.
- Employer contributions for the other coverage ceased.

A plan that provides coverage for dependents must also give special enrollment rights to employees who initially decline to enroll in the plan but later acquire a new dependent as a result of marriage, birth, adoption or placement for adoption. The special enrollment right applies to the employee, the employee's spouse, and the newly acquired dependent.

Plan administrators must notify potential participants of the plan's special enrollment rights at the time the employee is offered an opportunity to enroll in the plan. This information should also be included in the plan's SPD. The special enrollment period must be at least 30 days from the date the employee lost the other coverage or gained a new dependent.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) provides for a premium assistance subsidy under an employer health plan for CHIP-eligible individuals provided that the employer pays at least 40% of the cost of plan coverage. Group health plans must permit a new special enrollment if an eligible employee or dependent loses eligibility under Medicaid or CHIP and must also permit special enrollment for those who become eligible for government assistance under CHIP or Medicaid. Unlike the normal special enrollment period of 30 days, the CHIP special enrollment period for both of these events is 60 days.

Each employer that maintains a group health plan in a state that provides Medicaid or CHIP assistance must provide each employee written notice about premium assistance programs. The Health and Human Services and the Department of Labor ("HHS/DOL") issued model notice is available [here](#).

5.2 HIPAA PORTABILITY CHECKLIST

- Provide notice of special enrollment rights at time of enrollment (to all new hires or others upon first becoming eligible)**
 - Forms must be updated to reflect CHIP special enrollment rights.
- Provide CHIP Notice**
 - Notice is due annually by the first day of plan year (e.g., may be sent with open enrollment materials).

5.3 HIPAA PRIVACY STANDARDS

HIPAA PRIVACY STANDARDS

HIPAA's privacy standards impose rules for the use and disclosure of protected health information (PHI). PHI is individually identifiable health information that is maintained or transmitted by a health plan or other covered entity. The scope of these rules will depend on whether the plan is insured and the extent to which the plan has access to PHI. A group health plan may avoid most of HIPAA's privacy requirements if the plan is fully insured and the sponsor does not have access to PHI (other than summary health information and enrollment information).

USE AND DISCLOSURE RULES

All health plans must obtain authorizations from individuals for most types of uses or disclosures of PHI except for uses and disclosures for treatment, payment and health care operations. All authorizations must be informed and voluntary. The authorization must include the name of the person(s) or class of person(s) authorized to use or disclose the PHI; a description of the information to be used or disclosed, the purpose of the requested use or disclosure and an expiration date for the authorization. The authorization must be dated and signed by the individual whose PHI will be disclosed. A separate authorization must be signed by each individual whose PHI will be disclosed.

PRIVACY NOTICE

If a group health plan is self-funded, or it is insured and the plan sponsor wishes to receive PHI from its insurance companies, the group health plan will have more onerous compliance obligations. For example, these plans must distribute a notice to individuals explaining the participant's privacy rights, the plan's legal duties with respect to the participant's PHI, and the plan's uses and disclosures of protected health information. The notice must be provided to any individual whose PHI will be used or maintained by the plan. Participants must be provided with a privacy notice when they begin participation in the plan and again within 60 days of a material revision to the notice. In addition, every three years the plan must notify participants that a privacy notice is available and explain how to obtain a copy. The notice may be provided by paper or electronic delivery (if the use of the computer is a regular part of the participant's job or the participant has agreed to the electronic distribution). If the employer's or group health plan's website provides information about the plan's benefits then notice must also be posted on the website.

BUSINESS ASSOCIATES

If any of the plan's business associates, including third party administrators, attorneys, accountants, and consultants, engage in transactions with the plan that involve the use or disclosure of PHI, the business associate and the plan must enter into a "business associate contract" that imposes many of the HIPAA privacy rules on the business associate.

A group health plan may enter into a business associate contract with an insurance agent/broker that allows the agent/broker to have access to PHI and electronic PHI for the purpose of placing the plan's coverage with the agent/broker. If the agent/broker is a business associate of the plan, then the agent/broker is permitted to receive PHI and electronic PHI from the health plan for the purpose of placing a contract for insurance.

5.4 HIPAA/HITECH OMNIBUS FINAL RULE

The 563-page HIPAA Omnibus Rule, released January 25, 2013 (which generally became effective September 23, 2013) makes a long list of significant changes to existing regulations. These include, among others:

- modification to the standard for reporting breaches of unsecured personal health information (PHI);
- extension of HHS enforcement authority over business associates;
- expansion of the definition of the term business associate to include Health Information Organizations, E-prescribing Gateways, entities that provide data transmission services for PHI and which require routine access to such PHI, and personal health record vendors;
- modifications to the requirements for business associate agreements;
- new obligations for business associates to enter into business associate agreements with their own subcontractors;
- the removal of limitations on the liability of covered entities for the acts and omissions of business associates;
- changes to the requirements for notices of privacy practices;
- new limitations on the sale of PHI;
- new limitations on and clarifications concerning the use and disclosure of PHI for marketing;
- relaxation of certain limitations on the use of PHI for fundraising; and
- improvement to the regulations concerning authorizations for the use or disclosure of PHI for research.

Except as noted below with respect to provisions related to the requirements for business associate agreements and arrangements relating to the sale of PHI, the deadline for complying with the amended HIPAA regulations was September 23, 2013. In recent enforcement actions by HHS' Office of Civil Rights ("OCR"), covered entities and business associates have been assessed penalties for failing to comply with the Omnibus Rule.

Below is a review of the changes implemented in the Omnibus Rule in greater detail, and a checklist for covered entities and business associates to review their compliance with those changes.

PROVISIONS OF THE OMNIBUS RULE RELATING TO HEALTH PLANS

1. Tougher Breach Reporting Standard Adopted

Section 13402 of the HITECH Act requires covered entities to provide notification to affected individuals and to the Secretary of HHS following the discovery of a breach of unsecured protected health information. HITECH requires the Secretary to post on an HHS Web site a list of covered entities that experience breaches of unsecured protected health information involving more than 500 individuals. The Omnibus Rule substantially alters the definition of breach. Under the August 24, 2009 interim final breach notification rule, breach was defined as the “acquisition, access, use, or disclosure of protected health information in a manner not permitted under [the Privacy Rule] which compromises the security or privacy of the protected health information.” The phrase “compromises the security or privacy of [PHI]” was defined as “pos[ing] a significant risk of financial, reputational, or other harm to the individual.”

According to HHS, “some persons may have interpreted the risk of harm standard in the interim final rule as setting a much higher threshold for breach notification than we intended to set. As a result, we have clarified our position that breach notification is necessary in all situations except those in which the covered entity or business associate, as applicable, demonstrates that there is **a low probability that the protected health information has been compromised...**” To demonstrate that there is a low probability that PHI has been compromised, a covered entity or business associate must perform a risk assessment that addresses, at a minimum, the following factors:

- the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- the unauthorized person who used the protected health information or to whom the disclosure was made;
- whether the protected health information was actually acquired or viewed; and
- the extent to which the risk to the protected health information has been mitigated.

While these factors are similar to those recommended by HHS in the preamble to the interim final rule for use in assessing the risk of harm, HHS contends that the former “risk of harm” standard resulted in an analysis that was too subjective. Accordingly, HHS indicates that under the Omnibus Rule, the risk assessment analysis should be an objective test focusing on whether PHI has been “compromised.” Nevertheless, other than listing the risk assessment factors, the Omnibus Rule does not define the term “compromise” or explain what it means for PHI to be compromised. HHS did note in the preamble, however, that it will issue additional guidance “to aid covered entities and business associates in performing risk assessments with respect to frequently occurring scenarios.” To that end, in response to an alarming increase in the number of ransomware attacks in early 2016, OCR issued a fact sheet addressing numerous HIPAA privacy, security, and breach notification issues. The fact sheet is available [here](#).

According to the fact sheet, ransomware is a type of malware that “attempts to deny access to a user’s data, usually by encrypting the data with a key known only to the hacker who deployed the malware, until a ransom is paid. After the user’s data is encrypted, the ransomware directs the user to pay the ransom to the hacker (usually in a cryptocurrency, such as Bitcoin) in order to receive a decryption key.”

According to OCR, when ePHI is encrypted as the result of a ransomware attack, an unauthorized disclosure occurs because unauthorized individuals have taken possession or control of ePHI in a manner that is not permitted under the HIPAA privacy rule. Thus, the entity victimized by the ransomware attack must conduct the full breach analysis to determine whether breach notification is required.

2. Expansion of HHS Enforcement Authority over Business Associates and Related Changes to Requirements for Business Associate Agreements

As expressly required by HITECH, the Omnibus Rule amends 45 C.F.R. § 164.104 to make certain HIPAA privacy and security rules directly applicable to business associates, but only where those rules so provide. The rules that are made applicable to business associates under this provision are: 45 C.F.R. § 164.306 pertaining to security standards, 45 C.F.R. § 164.308 pertaining to administrative safeguards, 45 C.F.R. § 164.310 pertaining to physical safeguards, 45 C.F.R. § 164.312 pertaining to technical safeguards, 45 C.F.R. § 164.316 pertaining to policies and procedures, 45 C.F.R. § 164.502 pertaining to disclosures of PHI, and 45 C.F.R. § 164.504 pertaining to organizational requirements.

The Omnibus Rule also requires business associates to agree in business associate agreements to comply with the requirements imposed on them under HIPAA. In addition, under the Omnibus Rule, business associate agreements now must require business associates to enter into business associate agreements with subcontractors who will receive, create, or transmit PHI on their behalf. HHS has released a new model form business associate agreement that includes revisions pursuant to the requirements of the Omnibus Rule. The model form is available [here](#).

3. Expansion of Definition of Business Associate

The Omnibus Rule broadens the definition of business associate to include, in addition to those entities that would qualify as business associates under the preexisting regulations, the following entities: (1) a Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity that requires routine access to such protected health information; and (2) a person who offers a personal health record to one or more individuals on behalf of a covered entity. As a result, these entities are subject to the requirements imposed on business associates under HIPAA including various requirements under the Security Rule, and the new requirement to enter into business associate agreements with subcontractors. They also are subject to direct enforcement action by HHS. HHS, however, has declined to define the term “Health Information Organization,” noting that “the type of entities that may be considered Health Information Organizations continues to evolve.” HHS has provided on its website the following examples of business associates in the health plan context:

- A third-party administrator that assists a health plan with claims processing.
- An attorney whose legal services to a health plan involve access to protected health information.
- A pharmacy benefits manager that manages a health plan’s pharmacist network.

With respect to what it means to require access to PHI on a “routine basis,” HHS distinguishes entities that require access to PHI on a “routine basis” from entities that serve as “mere conduits.” HHS cautions, however, that the “mere conduit” exception is intended to be narrow and to apply only to courier services such as the Postal Service “and their electronic equivalents, such as Internet service providers (ISPs) providing mere data transmission services.” HHS also notes that “an entity that maintains [PHI] on behalf of a covered entity is a business associate and not a conduit, even if the entity does not actually view the [PHI].”

4. Additional Requirements Related to Business Associate Subcontractors

According to the Omnibus Rule, a subcontractor is “a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.” The Omnibus Rule provides that there must be an agreement between the business associate and its subcontractor that provides that the subcontractor is subject to the same HIPAA requirements for access and use of PHI as the business associate. In effect, the Omnibus Rule places the subcontractors of business associates in the same position that business associates were in before HITECH made business associates directly subject to certain HIPAA requirements. Specifically, business associates’ subcontractors are contractually obligated to comply with certain HIPAA requirements, but not directly subject to HHS enforcement authority.

5. Expanded Liability of Covered Entities and Business Associates for Acts of Their Agents

Prior to the promulgation of the Omnibus Rule, 45 C.F.R. § 160.402 established civil monetary penalty liability for covered entities under HIPAA based on the acts and omissions of their agents, including workforce members, but exempted covered entities from liability for the acts of their business associates if the following conditions were met: (1) the relevant business associate agreement requirements; (2) the covered entity did not know of a pattern or practice of the business associate in violation of the business associate agreement; and (3) the covered entity did not fail to act as required by the HIPAA Privacy or Security Rule with respect to such violations. The Omnibus Rule provides that covered entities are liable under the “federal common law of agency” for the acts and omissions of their business associates, and eliminates the exception to such liability that was included previously in 45 C.F.R. § 160.402. The Omnibus Rule also provides that like covered entities, business associates may be held liable under the “federal common law of agency” for the acts and omissions of their subcontractors.

The preamble to the Omnibus Rule discusses two contexts in which covered entities and business associates may be held liable for the acts of their agents: (1) when they “delegate out” obligations under HIPAA to another party; and (2) when they retain authority to give interim instructions concerning a particular task, such as where a business associate agreement provides that the business associate must make available PHI based on instructions to be provided by the covered entity. Imposing agency liability in both these contexts would appear to leave little ground uncovered, as it indicates that covered entities and business associates may be liable for the acts of third parties both when they retain control of the performance of a certain task, and when they do not. The preamble, however, does provide a number of examples of situations where a covered entity or business associate will not be subject to agency liability. These include a business associate hired by a small health care provider to perform de-identification. The preamble explains that such an arrangement should not give rise to agency liability because the provider would be unable to provide guidance to the business associate. HHS cites a business associate who performs credentialing for a covered entity where the covered entity lacks the authority to award accreditation as another example of an arrangement that would not give rise to agency liability. The common thread in these two examples appears to be the lack of ability for the business associate to control or direct the performance of its agent.

In sum, the elimination of a bar to liability for the acts of business associates represents a significant expansion of HHS’s enforcement authority. When negotiating business associate agreements, covered entities and business associates should consider carefully how decisions to delegate responsibility for tasks such as handling breach notification and their retention of authority to provide instructions to their business associates and contractors with respect to certain tasks affects their exposure to liability.

6. Additional Requirements for Notices of Privacy Practices

As a result of the Omnibus Rule, Notices of Privacy Practices (NPPs) for all covered entities must include the following additional information: (1) that the sale of protected health information and the use of such information for paid marketing require authorization from the individual; (2) that other uses and disclosures not described in the NPP will be made only with authorization; (3) that covered entities must notify affected individuals of breaches of their PHI; and (4) that individuals can restrict disclosures to their health plan for services for which they pay “out of pocket.”

In addition, NPPs for health plans that underwrite (excluding certain long-term care plans) must state that the plan cannot use or disclose genetic information for underwriting purposes. NPPs for covered entities that intend to contact individuals for fundraising also must note that individuals have a right to opt out of receiving fundraising communications from the covered entity. Finally, entities that maintain psychotherapy notes must note in their NPPs that most uses and disclosures of such notes require authorization.

The Omnibus Rule also eliminates one existing requirement relating to NPPs: whereas NPPs previously had to state that the covered entity may contact individuals to provide appointment reminders or information about treatment alternatives or other health-related benefits, such a statement is no longer required. It is worth noting, though, that authorization will generally be required for the use or disclosure of PHI for marketing activities that are supported by payments from third parties.

The Omnibus Rule also includes important provisions concerning requirements for distributing revised NPPs. Specifically, the Omnibus Rule provides that health plans that post their NPPs on their Web sites must post material changes on their Web sites by the effective date of the change, and provide information about the change in their next mailing to covered individuals. Plans that do not post their NPPs on their Web sites must provide information about any material change to their NPP to covered individuals within 60 days of the material revision to the NPP. These provisions are intended to enable health plans to avoid the cost of having to make a separate mailing of their revised NPPs, which would have been required under preexisting regulations.

7. Limitations on the Sale of PHI

The sale of PHI without authorization is prohibited under the Omnibus Rule. The “sale of [PHI],” however, is defined to exclude disclosures for public health purposes, for treatment and payment for health care, for the sale, transfer, merger, or consolidation of all or part of a covered entity and for related due diligence, to a business associate in connection with the business associate’s performance of activities for the covered entity, to a patient or beneficiary upon request, and as required by law. In addition, the disclosure of PHI for research purposes or for any other purpose permitted by HIPAA will not be considered a “sale” if the only remuneration received by the covered entity or business associate is “a reasonable, cost-based fee to cover the cost to prepare and transmit the protected health information for such purpose or a fee otherwise expressly permitted by other law.” Notably, under the Omnibus Rule, an authorization to sell PHI must state that the disclosure will result in remuneration to the covered entity.

8. Limitation on the Use of PHI for Paid Marketing

Under preexisting regulations, covered entities are required to obtain authorization to use or disclose PHI for marketing purposes, but not for activities that constitute treatment or health care operations. Marketing is defined as “a communication about a product or service that encourages recipients . . . to purchase or use the product or service.” However, prior to the implementation of the Omnibus Rule, no prior authorization was required to make communications related to treatment and health care operations. The practical effect was that covered entities could use PHI to conduct marketing for a variety of purposes, such as recommending alternative therapies, without obtaining authorization from the patient or beneficiary.

The Omnibus Rule limits the ability of covered entities to make such communications. Specifically, under the Omnibus Rule, covered entities must obtain authorization to use PHI to make any treatment and health care operations communications if they receive financial remuneration for making the communication from a third party whose product or service is being promoted. HHS notes that the authorization requirement applies even when a business associate will receive the remuneration for making a communication, and the covered entity will not receive direct remuneration.

There are several important limitations to this requirement. First, “refill reminders” are excluded, so long as the remuneration for making such a communication is “reasonably related to the covered entity’s cost” for making the communication. The preamble notes that permissible costs that can be reimbursed do not include indirect costs, and are limited to labor, supplies, and postage. The preamble also notes that communications about generic equivalents and adherence communications reminding patients to take medication as directed are both considered to be “refill reminders.” Additionally, for self-administered drugs and biologics, communications about all aspects of the delivery system (such as a communication about an insulin pump) are considered to be “refill reminders” as well.

Second, face-to-face marketing communications are not subject to the authorization requirement. Permissible face-to-face communications can include handing someone written material such as a pamphlet.

Third, promotional gifts of nominal value are not subject to the authorization requirement.

Additionally, for purposes of determining whether authorization is required to use PHI to make a paid marketing communication, financial remuneration does not include nonfinancial benefits, such as in-kind payments, and payments for a purpose other than making a communication, such as payments to implement a disease management program.

HHS also notes in the preamble that authorizations from patients and beneficiaries need not be limited to a single product or service or the products or services of a single entity, but can allow subsidized communications more generally.

9. Additional Modifications to HIPAA Regulations

The Omnibus Rule includes a number of additional noteworthy changes. Although they are of somewhat lesser import than those highlighted above, they are not inconsequential. They include:

- a provision requiring covered entities to agree, upon request, to restrict disclosures to health plans of PHI when the PHI pertains to items or services for which an individual has paid “out of pocket.” As a result, covered entities will have to implement procedures for complying with such requests;
- a requirement for covered entities to provide access to PHI in electronic format upon request if they maintain information in designated record sets electronically;
- a requirement for covered entities to comply with requests by individuals to transmit copies of PHI to third persons when such requests are made in writing;
- a provision allowing covered entities to disclose PHI to family members of a deceased patient who were involved with the patient’s care or payment for their care, so long as such disclosure is not contrary to “any prior expressed preference of the individual that is known to the covered entity,”
- establishment of a 50-year limit on the obligation to protect the PHI of deceased individuals;
- a provision allowing covered entities to disclose immunization records to a school if the school is required by law to obtain such records prior to admission and the covered entity obtains and documents the agreement to the disclosure from the parent or individual as applicable; and
- a provision implementing requirements of the Genetic Information Nondiscrimination Act of 2008 (“GINA”) by prohibiting the use of genetic information for underwriting purposes, such as eligibility determinations and the computation of premiums.

5.5 HIPAA PRIVACY STANDARDS COMPLIANCE CHECKLIST

- Determine whether any state privacy laws apply to the group health plan.
- Identify group health plan’s current uses and disclosures of protected health information, including the individuals who have access to protected health information.
- Determine which current uses and disclosures are permitted and under what circumstances.
- Determine whether group health plan documents need to be amended in order to (or continue to) receive protected health information for plan administrative purposes.
- Identify service providers who are business associates.
- Determine whether business associate service provider contracts need to be amended to comply with privacy rules.
- Appoint a privacy officer.

- Establish privacy policies and draft related procedures.
- Distribute privacy notice.
- Train workforce on privacy policies and procedures.
- Establish appropriate safeguards for protecting PHI from accidental or intentional use in violation of the privacy standards.
- Amend business associate agreement, as necessary, to reflect GINA requirements (see Section 12.9 of this Guide).

5.6 HIPAA SECURITY STANDARDS

HIPAA's security standards impose rules for the protection of electronic PHI. Employers that electronically maintain or transmit PHI must implement policies and procedures to protect the security of, and access to, the electronic PHI and to ensure that the electronic transmission of this data is not subject to disclosure other than as required by law or necessary for the plan's administration. Employers should consult with legal counsel to evaluate the current measures in place to protect this information and to establish a formal policy to adhere to the requirements in the security standards.

- Attorney's review of HIPAA Privacy and Security Standards

5.7 GAP ANALYSIS

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards for group health plans and health insurance issuers to protect against threats to the security or integrity of personal health information from unauthorized uses or disclosures.

For purposes of the privacy rules, employers are not covered entities; however, employers are responsible for ensuring that their group health plans, which are covered entities, and the entities that provide services to their group health plans (called business associates in the HIPAA rules) comply with the HIPAA rules.

In general, group health plans must be HIPAA privacy and security compliant. Some employers have missed the compliance deadline and should consider implementing a compliance program now. For those with existing programs in place, we review their programs and either validate what is in place or work with them to implement compliant changes.

MARATHAS BARROW WEATHERHEAD LENT (MBWL) IS READY TO ASSIST OUR CLIENTS WITH THEIR COMPLIANCE EFFORTS BY OFFERING THE FOLLOWING SERVICES:

Conduct a Privacy and Security Assessment & Gap Analysis.

MBWL can assist your company with a privacy and security assessment designed to (i) determine whether your company needs to be HIPAA compliant and (ii) if so, identify specific areas in current operations that need to be addressed or updated for HIPAA compliance.

Deliverable. Based on the security and privacy assessment and gap analysis, MBWL will work with you to create a compliance work plan. We will assist you to prioritize tasks based on the sensitivity of the information involved and specify the tasks and responsible parties, and set target completion dates.

Assist with the Appointment of a Privacy Officer & Assist the Privacy Officer.

The privacy rules require covered entities to appoint a privacy officer, who will be in charge of creating and implementing the policies and procedures to make your company HIPAA compliant. Your Privacy Officer should possess good attention to detail, be intelligent and have good common sense and, most of all, be patient. He or she is going to have a steep learning curve for several months.

- The Privacy Officer's tasks include:
- Having a working knowledge of the HIPAA privacy regulations
- Providing for the training of the rest of the staff
- Determining which entities are "business associates"
- Helping prepare office protocols
- Handling the day-to-day issues that will inevitably arise when the privacy regulations are fully activated

Deliverable. **MBWL** will assist your company in identifying the proper person to act as Privacy Officer and will assist your Privacy Officer with his or her compliance efforts.

Convene a Privacy Committee.

For small employers, a sole privacy officer may be sufficient to implement the privacy rules. But a privacy committee may be needed to develop and implement the HIPAA programs of a mid- to large-size company.

Deliverable. **MBWL** will help you to determine whether as single privacy officer or a committee (that reports to a privacy officer) is appropriate. If a committee is appropriate, **MBWL** will assist in its formation and help you identify those individuals who should participate.

Adopt Forms, Policies and Procedures.

Federal law requires companies sponsoring group health plans to adopt and use particular forms (such as privacy notices, etc.), policies, and procedures to guide the company's implementation of the HIPAA privacy rules.

Deliverable. **MBWL** can assist you with the development of a compliance manual that will include forms, policies and procedures customized to fit the particular needs and circumstances of your company.

Contract Review.

A key component of the privacy assessment is the identification of business associates and ensuring contracts with business associates are HIPAA compliant.

Deliverable. **MBWL** can help you to identify your business associates, review existing agreements and update for HIPAA compliance and create new contracts where existing contracts do not exist.

Security Review.

The HIPAA Security rules require any entity receiving electronic protected health information to establish security protocols both with respect to their computer systems and with respect to the procedures established for those accessing this information.

Deliverable. The **MBWL** team has worked with many employers of all sizes, assisting them with security implementation. We will assess your compliance needs and work with your team to implement compliant protocols and procedures.

MBWL has worked with many public and private companies across the country, assisting them with the implementation and review of their HIPAA compliance efforts. Our experience in the field is superior. MBWL's extensive experience allows them to work quickly and keep compliance costs low. For friends and clients of the agency providing this Guide, the first over the phone consultation is free. During this consultation MBWL will be able to help you identify whether you need to implement a compliance program. MBWL will then be able to provide you with an estimate of the cost of review or HIPAA implementation.

For assistance, contact Peter Marathas (pmarathas@marbarlaw.com) at (617) 830-5456 or Stacy Barrow (sbarrow@marbarlaw.com) at (617) 830-5457.

5.8 HIPAA PRIVACY & SECURITY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") includes "administrative simplification" provisions that require the U.S. Department of Health and Human Services to develop uniform standards for, among other things, protected health information ("PHI") and for the security of electronically transmitted PHI ("ePHI").

The HIPAA requirements impose significant duties on the health care industry, including health plans and their sponsors, third-party health plan administrators, health care providers, and health care information clearinghouses. The HIPAA Team at MBWL is ready to assist you with your compliance efforts.

The regulations include specific requirements for group health plans regarding disclosure or other use of the PHI of individuals covered by the plan. Key compliance considerations are outlined below.

COVERED ENTITIES

Health Plans, Providers, and Clearinghouses. HIPAA does not regulate employers as employers, but becomes applicable to employers through their group health plans. A group health plan is any individual or group plan that pays the cost of health care. Worker's Compensation, disability and life insurance plans are not "health plans" for these purposes. Medical reimbursement account plans or employee assistance plans that reimburse or pay for treatment are, in general, "health plans."

PROTECTED HEALTH INFORMATION

PHI includes all “individually identifiable health information” which generally comprises of any data created or received by a health plan that relates to an individual’s physical or mental health or condition, including information related to health condition or payment and it must directly identify someone.

NOTE: If the information does not include at least one of 18 identifiers, information is not PHI.

USE AND DISCLOSURE OF PHI

PHI may be disclosed, with authorization, as necessary for treatment, payment, or health care operation (also called “TPO”).

A health plan must not permit a health insurance issuer or HMO with respect to the group health plan to disclose PHI to the plan sponsor except as permitted by regulations.

MINIMUM NECESSARY STANDARD

A HIPAA regulated entity must identify and then implement reasonable measures to limit the use or disclosure to the minimum amount necessary to accomplish the intended purpose of the use or disclosure.

“Minimum Necessary Standard” - Health Plans must implement policies and procedures regarding compliance and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

AMENDMENT TO HEALTH PLANS

To disclose PHI to the plan sponsor or to provide for or permit the disclosure of PHI to the plan sponsor by a health insurer or HMO with respect to the group health plan, the group health plan documents must specifically restrict disclosures and uses of such information by the plan sponsor in a manner that is consistent with the regulations.

Plan sponsor must **certify** to health plan that the plan documents have been amended to incorporate the following provisions and that the plan sponsor agrees:

- not to use or further disclose the information other than as permitted or required by the plan documents or as required by law;
- to ensure that any agents, including a subcontractor, to whom it provides protected health information received from the group health plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;
- not to use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
- to report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- to make available PHI only in accordance with the regulations;
- to make available to individuals PHI for correction or incorporate any correction to PHI in accordance with the regulations;
- to provide an accounting of PHI disclosures to the individual;
- to make its internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the secretary of HHS for purposes of determining compliance by the group health plan with the HIPAA administrative simplification requirements;
- if possible, to return or destroy all PHI received from the group health plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, but if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- to ensure that a Firewall exists between the health plan and the employer to provide for adequate separation between the group health plan and the plan sponsor.

The plan documents must:

- describe the employees or classes of employees or other persons who are to be given access to the PHI to be disclosed, and identifying any employee or person who receives PHI relating to payment under, health care operations of, or other matters relative to the group health plan in the ordinary course of business;
- restrict the access to and use by such employees and other persons to the plan administration functions that the plan sponsor performs for the group health plan; and
- provide an effective mechanism for resolving any issues of noncompliance by such persons.

PHI DISCLOSURE TO BUSINESS ASSOCIATES

- Business associates of a covered entity are defined as persons, other than workforce members, who perform or assist in the performance of a function on behalf of, or provide services to, a covered entity and such function or service involves the use or disclosure of PHI.
- Rules recognize legitimate need to disclose PHI to Business Associates.
- Must obtain “Satisfactory Assurances” that Business Associate will appropriately safeguard PHI; the rules require that a written agreement be in place.
- If a health plan knows of breach, must take steps to cure.
- If breach is not cured, the health plan must terminate contract.
- Each Business Associate contract must include a provision permitting termination.

PRIVACY NOTICE

Plans must provide Privacy Notices to all employees, and within three (3) years of the date they first provide the Privacy Notice, they must provide employees with a notice about the availability of the Privacy Notice.

The Privacy Notice must describe:

- use and disclosure of PHI;
- individual's rights; and
- the plan's obligations .

NOTE: Self-insured health plans must provide the notice to participants. Insurance companies or HMOs must provide notices for fully-insured plans, but if a health plan creates or receives PHI, it must maintain privacy notices and provide to employees on request.

INDIVIDUAL PRIVACY RIGHTS

HIPAA provides individuals the right to:

- access and review PHI;
- amend PHI;
- receive an accounting of PHI disclosures, but not disclosures related to TPO;
- request privacy restrictions; and
- be notified of breaches of unsecured PHI;

ADMINISTRATIVE REQUIREMENTS

HIPAA regulated entities must:

- appoint Privacy Official and Privacy Contact;
- conduct Privacy Training,
- prepare policies and procedures, and
- have certain security measures.

STEPS SPONSOR OF HEALTH PLANS MUST TAKE

A health plan sponsor must:

- designate a HIPAA privacy official and task force;
- analyze the current flow of health information to determine how that information moves and is used or disclosed ;
- identify which disclosure practices qualify as treatment, payment, or operations (which may continue if the privacy requirements described herein are met), and which disclosure practices qualify for an exception to the authorization rules (e.g., disclosures required under workers compensation laws);
- identify which employees need access to PHI to carry out health plan functions and identify the type of PHI needed;
- amend health plan documents to permit disclosure of PHI consistent with the requirements of HIPAA;
- create privacy policies and procedures consistent with the requirements of HIPAA; and
- identify business associates and review all existing contracts and determine revisions necessary to bring the agreements into compliance with HIPAA.

HIPAA SECURITY, IN GENERAL

HIPAA governs how covered entities such as health care plans must safeguard the individually identifiable health information they maintain regarding certain individuals, e.g., patients, plan participants, etc. In particular, HIPAA requires covered entities that maintain or transmit this information electronically to comply with the regulations for safeguarding electronic protected health information, or “ePHI.” In order to comply, group health plans and the other covered entities must employ reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity and availability of the ePHI against reasonably anticipated risks. This means that covered entities, such as health plans, must assess their electronic systems to determine how they measure up against the requirements set forth in the Security Rule. The first step in this process of compliance is to identify the systems using, storing, transmitting, etc., ePHI and to determine whether those systems employ safeguards that meet the requirements set forth in the Security Rule.

The Security Rule under HIPAA covers a lot of ground, from basic steps such as password protection to more elaborate forms of protection such as encryption. In many cases, the particular safeguard is required; in others, the safeguard is “addressable.” Addressable requirements are not synonymous with “optional.” Rather, addressable requirements require additional evaluation to determine the extent to which a covered entity such as a group health plan must comply. A good place to start the analysis is a review of the covered entity’s current policies, procedures, and practices regarding their electronic data. Of course, all of the review, evaluation, analysis, and other steps taken to assess the degree of compliance of the system, and the degree of additional safeguards required, must be documented and periodically reassessed. HIPAA requires this type of review and record.

Failure to comply with the requirements of the Security Rule can result in civil or criminal penalties. Civil penalties are \$100 per violation but are capped at \$50,000 per year. Criminal penalties range from \$25,000 to \$1,500,000 in fines and up to 10 years in jail. State attorneys general may sue to enforce individual rights. Individuals harmed by violations may receive part of the penalty payments.

This is a very general outline of the HIPAA privacy standards and is not intended nor should be deemed to be legal advice. Plan Sponsors are encouraged to call Peter Marathas (617) 830-5456 or Stacy Barrow (617) 830-5457 for assistance with their HIPAA privacy compliance efforts.

5.9 AUTHORIZATION TO RELEASE INFORMATION

An individual authorization for the use or disclosure of protected health information is required whenever the use or disclosure is not otherwise permitted under the privacy rule. Below is a sample form that is intended to comply with HIPAA's content requirements. A valid authorization form may include elements or information in addition to the required elements, provided that they are consistent with HIPAA. The sample form does not address any law other than HIPAA. Many state laws impose additional requirements for valid authorizations, which may require the modification of this form.

Sample – Authorization to Release Information

I authorize the release to [the human resources professionals responsible for the administration of the company's group health plan] of [company name] and [] portions of my medical record that relate to any claims for benefits that I may have under such plan, which such payment of benefits have either been delayed or denied by the health plan, including, but not limited to: diagnosis, duration of the condition, clinical course, prognosis, treatment and other information that may help with the resolution of any claim.

I authorize the health plan, and any physician or other care provider to disclose this information to [the human resources professional responsible for the administration of the company's group health plan] of [company name] and [], for the following purposes only: to assist me with resolution of any such claim and to conduct any plan operations related thereto.

I understand that, if my information is disclosed to someone who is not required to comply with state or federal privacy laws, then such information may be redisclosed and will no longer be protected by these regulations.

This authorization shall continue until such time as I am no longer a participant in [company's health plan]. I understand that I have the right to revoke this authorization at any time. I am aware that my revocation is not effective to the extent that anyone, including the insurer or my physician and/or the company, has acted in reliance upon this authorization. I understand that my revocation must be submitted in writing to:

[HIPAA Compliance Officer]

[Address]

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment nor affect my eligibility for benefits.

Signature

Date

Print Name:

If the form is signed by a personal representative, complete the following information:

Printed name of the participant's personal representative:

Relationship to the participant, including authority to act as personal representative:

A COPY OF THE SIGNED AUTHORIZATION SHOULD BE PROVIDED TO THE PARTICIPANT and kept in the plan's records in the event of an audit.

6. WELLNESS PROGRAMS

A wellness program must be designed to promote health and prevent disease, and is an exception to HIPAA's nondiscrimination rules (see Section 7). The HIPAA wellness rules have been substantially updated under the ACA and under Proposed (released November 20, 2012) and Final Regulations (released June 3, 2013) (combined, the "Regulations"). **NOTE:** that final regulations issued under the ADA (released May 17, 2016) in connection with wellness programs that include disability-related inquiries and/or medical examinations (whether offered in or outside of a group health plan) differ in certain respects from the HIPAA wellness rules. Likewise, recent court cases have further modified the wellness program regulations.

6.1 GENERAL RULES

The Regulations identify and clarify the five requirements for wellness programs as described below.

Initial Note: The prior and proposed regulations divided wellness programs into two categories: participatory wellness programs and health-contingent wellness programs. In general, participatory wellness programs do not condition receipt of a reward on achievement of a health standard. Health-contingent wellness programs condition receipt of an award on an individual's satisfaction of a standard related to a health factor or attaining or maintaining a specific health outcome. Consistent with prior guidance, the Regulations provide that health-contingent wellness programs are subject to the same five basic requirements discussed below, but participatory wellness programs are not.

The Final Rules further divide the category of health-contingent wellness programs into two subcategories: activity-only wellness programs and outcome-based wellness programs.

- A. Activity-Only Wellness Programs.** Under the Regulations, an activity-only wellness program requires an individual to perform or complete an activity that is related to a health factor before the individual can obtain a reward. An activity-only program does not require the individual to attain a specific health-related outcome. Examples of activity-only wellness programs include walking, diet, or exercise programs.
- B. Outcome-Based Wellness Programs.** Under the Regulations, an outcome-based wellness program requires an individual to attain or maintain a specific health outcome to obtain a reward. Generally, outcome-based wellness programs have two tiers. The first tier is a certain measurement, test, or screening as part of an initial standard. The second-tier targets individuals who do not meet the initial standard. For those individuals who do not initially achieve the specific outcome, compliance with a program or activity may be offered as an alternative mechanism of achieving the same reward. The Regulations make clear that the provision of this alternative mechanism of achieving the same reward does not mean that the program is not an outcome-based wellness program. As long as a measurement, test, or screening is used as part of an initial standard, and those who meet the initial standard receive the reward, the program is categorized as an outcome-based wellness program.

Programs that test individuals for certain conditions or risk factors, such as high blood pressure, high cholesterol, abnormal BMI (body mass index), or high glucose levels, and rewards employees who are determined to be within a normal range or at low risk for a certain medical condition are examples of outcome-based wellness programs. If employees are determined to be not within a normal range or at a high risk for a certain medical condition, they are then required to take additional steps (such as meeting with a health coach, taking a health or fitness course, following a "health improvement action plan," or complying with a health care provider's care plan) to achieve the reward.

6.2 THE FIVE REQUIREMENTS:

- 1. Frequency of Opportunity to Qualify.** For both activity-only and outcome-based wellness programs, eligible individuals must be given the opportunity to qualify for the program at least once per year.
- 2. Amount of Reward.** The reward must not exceed 30% of the cost of coverage—if dependents may participate, reward limit is measured as 30% of the cost of the family coverage. Rewards include financial rewards (e.g., premium discounts, rebates, or modifications of otherwise applicable cost-sharing amounts such as copays, deductibles, or coinsurance) and non-cash rewards (e.g., gift cards, thermoses, or sports gear). If tobacco use prevention is part of the program, the reward may be as high as 50% of the cost of coverage. (**NOTE:** that the reward for the non-tobacco use portion of the program cannot exceed 30% of the cost of coverage).

For example, an employer sponsors a group health plan. The annual premium for employee-only coverage is \$3,600 (of which the employer pays \$2,700 per year and the employee pays \$900 per year). The annual premium for family coverage is \$9,000 (of which the employer pays \$4,500 per year and the employee pays \$4,500 per year). The plan offers a wellness program with an annual premium rebate of \$360. The program is available only to employees.

In this example, the program satisfies the above rule because the reward for the wellness program, \$360, does not exceed 30 percent of the total annual cost of employee-only coverage, \$1,080. ($\$3,600 \times 30\% = \$1,080$.) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 30 percent of the cost of family coverage, \$2,700. ($\$9,000 \times 30\% = \$2,700$.)

If the wellness program includes a tobacco cessation program, the maximum discount for individual only coverage for the insurance described above would be \$1,800 annually ($\$3,600 \times 50\% = \$1,800$) or \$4,500 ($\$9,000 \times 50\% = \$4,500$) if family coverage is elected and the tobacco program is offered to the family.

- 3. Reasonable Design.** Both activity-only and outcome-based programs must be reasonably designed to promote health or prevent disease. This requirement is satisfied if the program “has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and is not overly burdensome, is not a subterfuge for discrimination based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.” While not required, using evidence-based clinical standards, such as those found in the Center for Disease Control’s Guide to Community Preventive Services, may be an encouraged best practice. “Reasonable design” will also require the provision of “reasonable alternative standards” as described more fully below.
- 4. Uniform Availability.** The same, full reward under health-contingent wellness programs (both activity-only and outcome-based) must be available to all “similarly-situated individuals.” In certain circumstances, compliance with this requirement will necessitate the provision, upon request, of a reasonable alternative standard (“RAS”) (or waiver of the original standard). The Regulations clarify what will qualify as an RAS.

For activity-only wellness programs, the program must provide a RAS for an individual for whom it is unreasonably difficult to satisfy the original standard due to a medical condition or for whom it is medically inadvisable to try to satisfy the original standard. If reasonable, a plan or issuer may seek verification from an individual’s physician that a health factor makes it medically inadvisable or unreasonably difficult to attempt to satisfy the original standard.

Outcome-based wellness programs must provide a RAS regardless of whether the original standard was unreasonably difficult due to a medical condition or medically inadvisable to try and satisfy. Additionally, it is never reasonable for an outcome-based program to seek physician verification of difficulty in meeting the original standard.

If the RAS itself constitutes an activity-only program, it must satisfy all the applicable requirements of activity-only programs. If the RAS constitutes an outcome-based program, it must satisfy all the applicable requirements of outcome-based programs. If the RAS for an outcome-based program

constitutes an outcome-based program, the RAS may not require the individual to meet a different level of the same standard without additional time to comply. For example, if the original standard is to meet a BMI less than 30, the RAS cannot require an individual to meet a BMI less than 31 as of the same measurement date (but could provide an alternate standard such as reducing BMI by a small amount over a realistic period of time, such as one year). Furthermore, if the RAS for an outcome-based program constitutes an outcome-based program, an individual must be provided with the chance to comply with his or her physician's recommendations as a second RAS, as long as the physician "joins" the individual's request, and the physician is permitted to adjust his or her recommendations at any medically appropriate time.

The time commitment required for the RAS on the part of the individual must also be reasonable. A wellness program must accommodate the recommendations of an individual's physician regarding the medical appropriateness of any plan standard.

All facts and circumstances will be taken into account when determining whether a program has provided an RAS; individual or class-based waivers may be provided in lieu of an RAS; and no particular RAS must be established prior to an individual's request.

- 5. Notice of Availability of Reasonable Alternative Standard.** For both outcome-based and activity-only wellness programs, the plan or issuer must disclose in all plan materials describing the terms of the program the availability of an RAS to qualify for the reward (or the potential for a waiver). The notice must include applicable contact information and a statement that the recommendations of an individual's personal physician will be accommodated. The Regulations provide the following sample language that plans may use (once tailored to its program) to satisfy this notice requirement.

The final regulation provides the following sample language:

"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

Two other approved sample statements included in examples provide:

"Your health plan wants to help you take charge of your health. Rewards are available to all employees who participate in our Cholesterol Awareness Wellness Program. If your total cholesterol count is under 200, you will receive the reward. If not, you will still have an opportunity to qualify for the reward. We will work with you and your doctor to find a Health Smart program that is right for you."

"Fitness Is Easy! Start Walking! Your health plan cares about your health. If you are considered overweight because you have a BMI of over 26, our Start Walking program will help you lose weight and feel better. We will help you enroll. (If your doctor says that walking isn't right for you, that's okay, too. We will work with you [and, if you wish, your own doctor] to develop a wellness program that is.)"

6.3 PROGRAMS EXEMPT FROM WELLNESS RULES

The Regulations define and illustrate programs that comply with the nondiscrimination requirements without having to satisfy any additional standards under HIPAA (assuming participation in the program is made available to all similarly situated individuals).

Such programs are those under which none of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor or under which no reward is offered. While these programs may not have to comply with additional requirements under HIPAA, they may have to comply with other laws. For instance, programs that have disability-related inquiries or a medical exam must still comply with the ADA rules discussed below.

The Regulations include the following list to illustrate the wide range of programs that would not have to satisfy any additional standards under HIPAA to comply with the nondiscrimination requirements:

- Program that reimburses costs of fitness center membership.
- Diagnostic testing program that provides reward for participation, not outcome.
- Program that encourages preventative care through waiver of co-payment/deductible for certain activities (e.g., pre-natal or well-baby visits).
- Program that reimburses employees for the costs of smoking cessation programs without regard to whether employees quit.
- Program that provides reward for attending a monthly health education seminar.
- Program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment.

Only programs under which any of the conditions for obtaining a reward is based on an individual satisfying a standard related to a health factor must meet the five additional requirements described above in Section 6.2.

NOTE: that some wellness incentives have tax consequences. For example, if cash or a cash-equivalent reward, such as a gift card, is given, it is considered taxable income that must be reported on the employee's W-2 and federal employment taxes must be paid on it. However, certain incentives provided as part of a health benefit plan are not taxable. The rules are complicated and employers should consult with their tax counsel regarding tax consequences of wellness incentives.

6.4 GINA CONSIDERATIONS

The Genetic Information Nondiscrimination Act of 2008 ("GINA") must be considered with respect to the implementation of any wellness program.

Title I of GINA -applicable to group health plans and health insurers, and Title II primarily applicable to employers – impact employer-sponsored group health plans and wellness programs and prohibit discrimination against individuals on the basis of their genetic information.

Title I has three main rules: (1) prohibition on genetic information-based discrimination in rate setting (i.e., plans may not increase group premiums or contribution amounts based on genetic information); (2) limitation on genetic testing requests or requirements (i.e., plans may not request or require genetic testing of a covered individual or family member, subject to certain exceptions); and (3) certain prohibitions on the collection of

genetic information (i.e., plans generally may not request, require, or purchase genetic information prior to or in connection with enrollment or at any time collect or use genetic information for underwriting purposes).

“Genetic information” includes information about (1) an individual’s genetic tests, (2) the genetic tests of an individual’s family members, (3) the manifestation of a disease or disorder in an individual’s family member (i.e., family medical history); and (4) an individual’s request for, or receipt of, genetic services.

“Underwriting purposes” include, with respect to group health plan coverage, rules for and determination of eligibility (including enrollment and continued eligibility), and computation of premium and contribution amounts. The federal regulators have clearly stated that “underwriting purposes” for purposes of GINA is intended to be a broad concept and includes changing deductibles or other cost-sharing mechanisms, or providing discounts, rebates, payments in kind, or other differential mechanisms in return for activities such as completing a health risk assessment (“HRA”) or participating in a wellness program.

DESIGNING TITLE I-COMPLIANT HRAS

Title I does not prohibit a wellness program design that either (1) uses inducements for participants to provide information that is not genetic information, or (2) requests participants to provide genetic information where there is no cost or eligibility (or otherwise implicates underwriting or enrollment matters).

Employers can design a Title I-compliant HRA in one of two ways:

- **HRAs that do not request genetic information** – Such HRAs must not request an individual’s genetic information (i.e., that relate to the individual’s family medical history, or any information about genetic testing, genetic services, genetic counseling, or genetic disease relating to the individual or the individual’s family member), or
 - Include the model statement instructing the individual not to divulge any genetic information described in the GINA Title II regulations model language regarding inadvertent acquisition of information to protect against a GINA Title II violation
 - Do not just rely on the model statement but make clear by additional means (e.g., in written HRA instructions) that the individual should only answer medical questions about him or herself (and not about any family members, including a spouse) and not to divulge any information about genetic testing or genetic services.
- **HRAs that contain optional questions regarding genetic information** – Such HRAs should make the participant’s provision of genetic information strictly optional and free from inducement (i.e., no incentive or penalty is applied, and no benefit is offered or denied, based on whether or not the participant complies with the request for genetic information).
 - Consider bifurcating the form into separate sections to avoid confusion about which questions are optional.
 - **NOTE:** that an employer sponsoring a wellness program that acquires genetic information will also need to satisfy the conditions for the applicable exception from the GINA Title II prohibition, including those related to voluntariness and obtaining prior written authorization, discussed further below.

Additional restrictions and limitations may apply to the HRA under GINA Title II (limiting an employer’s ability to offer inducements to an employee’s spouse who completes an HRA), HIPAA (restricting a wellness program that is part of a group health plan from discrimination on the basis of a health factor), and the ADA (limiting an employer’s ability to offer inducements to an employee who completes an HRA).

DESIGNING A GINA TITLE II-COMPLIANT WELLNESS PROGRAM

GINA Title II, among other things, prohibits employers from basing employment decisions on genetic information and acquiring the genetic information of their employees and the family members of their employees, except in limited situations. These requirements may impact the benefit plans and programs (whether or not they are group health plans) that employers offer to their employees.

Two exceptions that are the most relevant to employee welfare plans are the inadvertent acquisition exception and the exception for plans or program that offer health or genetic services (including wellness programs). If an employer makes a lawful request for medical information other than genetic information (e.g., in a health risk assessment), its request will generally not be considered inadvertent for the exception unless the person from whom the medical information is requested was instructed not to provide any genetic information.

The regulations provide the following model language that can be used to help preserve the inadvertent acquisition exception when making requests for non-genetic information:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

In general, Title I of the ADA (discussed below) and Title II of GINA limit the amount of inducements (whether financial or in-kind, and no matter how de minimis) that may be offered to an employee or his or her spouse in connection with a wellness program that includes disability-related inquiries or a medical examination. On May 17, 2017, the EEOC issued final regulations that provide guidance regarding whether inducements offered to encourage participation in an employer-sponsored wellness program will cause the program to not be considered “voluntary” under the ADA and whether (and to what extent) incentives may be offered to an employee’s spouse without violating GINA Title II’s prohibition against requesting, requiring or purchasing genetic information. The EEOC published Q&As regarding the EEOC’s final rule on employer wellness programs and GINA [here](#).

In general, a wellness program cannot induce a participant to provide genetic information in connection with a wellness program by offering an incentive or imposing a penalty (whether financial or in-kind and no matter how de minimis). However, inducements are permissible for:

1. Completion of an HRA that either (1) does not ask for genetic information, or (2) includes inquiries about genetic information but informs the participant, in clear language reasonably likely to be understood, that he or she will receive the inducement regardless of whether or not responses to the genetic information questions are provided; and/or
2. An employee for the employee’s spouse to provide information about the spouse’s manifestation of a disease or disorder, subject to the requirements described below. (Prior to the final regulations, there was concern that because GINA defines “family member” to include a spouse, that providing for completion of an HRA by a spouse would violate GINA if a reward was offered because information about a spouse’s current medical condition could be considered genetic information.)

Title II permits a wellness program that includes a disability-related inquiry or medical examination to offer an inducement to an employee for the employee’s spouse to provide information about the spouse’s manifestation of a disease or disorder, subject to the following conditions:

- The program meets the general requirements for wellness programs that involve genetic information with respect to reasonable design, voluntariness, prior written authorization, and use and disclose limitations, and specifically:
 - The program is “reasonably designed to promote health or prevent disease” of the spouse. For example, collecting information on an HRA without providing any follow-up information or advice to the spouse would not be reasonably designed to promote health or prevent disease.
 - The spouse provides prior, knowing, voluntary, and written authorization in accordance the form that meets the requirements set forth in the final regulations and the authorization describes confidentiality protections and restrictions on disclosure of genetic information.
- The amount of the incentive for the spouse’s information does not exceed 30% of the cost of self-only coverage under the applicable group health plan, where the applicable plan is determined as follows:
 - If the wellness program is offered only to participants in an employer-sponsored group health plan (or the wellness program is a stand-alone group health plan), then that group health plan is the applicable plan.
 - If the wellness program is not connected with participation in a particular plan, then the employer’s group health plan (if any) is the applicable plan (and if more than one such plan is offered, then it is the plan with the lowest cost).
 - If the employer does not offer group health plan coverage, then the applicable plan is the second-least-costly Silver Plan on the ACA Exchange for the location of the employer’s principal place of business (based on coverage for a 40-year-old nonsmoker).

Title I of the ADA discussed below applies a separate 30% inducement cap for information voluntarily provided by an employee (subject to the rules described above in the last bullet).

The final rules also prohibit wellness programs from offering inducements to provide either genetic information or manifestations of a disease or disorder regarding an employee’s **children** (even if the children are adults and even if the children participate in the program).

Other GINA Title II rules under the final regulations include:

- The program may not penalize an employee’s spouse (or the employee) based on medical information collected from the spouse (e.g., by denying an inducement because the spouse has high blood pressure).
- Employers may not deny access to health benefits or retaliate against an employee based on a refusal by the employee’s spouse to provide his or her medical information.
- Employers may not require or induce wellness program participants to agree to the sale, exchange, sharing, transfer, or other disclosure of their genetic information (except for purposes of program administration or pursuant to the limited disclosures permitted by law) or to waive confidentiality protections application to genetic information.

6.5 ADA CONSIDERATION

Medical questionnaires and medical examinations often make up a large part of an employer’s wellness program. However, the ADA places significant limits on an employer’s ability to make disability-related inquiries or to require medical examinations. As a general rule, to be permitted under the ADA, disability-related inquiries and medical examinations must be “job-related and consistent with business necessity.” To meet these requirements, an employer must have a reasonable belief based on objective evidence that either (1) an employee’s ability to perform an essential job function will be impaired by a medical condition, or (2) an employee will pose a direct threat due to a medical condition.

Wellness programs are implemented “across the board” and questions are asked—typically through a Health Risk Assessment (“HRA”)—without regard to an employer’s reasonable belief of either of the two concerns described above. Therefore, a wellness program that makes disability-related inquiries or requires medical examinations will violate the ADA unless it meets an exception under the ADA.

The ADA includes an exception for voluntary wellness programs, under which an employer does not have to show that the disability-related inquiries or medical examinations are job-related and consistent with business necessity if the wellness program is “voluntary.” According to the EEOC, in order for the program to be voluntary, an employer may not require participation nor penalize employees who do not participate.

The ADA also provides an insurance safe harbor that may apply to wellness programs if the program is a “bona fide benefit plan.” This safe harbor states that the ADA is not to be construed to prohibit or restrict “a person or organization covered by this chapter from establishing, sponsoring, observing, or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law...” The EEOC rejects the idea that the safe harbor could apply to employer wellness programs, since employers are not using information to determine whether employees with certain health conditions are insurance or to set insurance premiums. The ADA final regulations contain a new provision explicitly stating that the safe harbor provision does not apply to wellness programs even if they are part of an employer’s health plan. However, since these regulations were issued, a number of lawsuits have expressed divergent views and a proposed bill released by the House Committee on Education and the Workforce supports maintaining the insurance safe harbor

DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS DEFINED

The ADA only applies to wellness programs if such programs make disability-related inquiries or conduct or request medical examinations.

The EEOC defines a “disability-related inquiry” to mean a question (or series of questions) that is likely to elicit information about a disability. A disability-related inquiry includes obvious questions, such as asking an employee whether he or she has (or ever had) a disability or how he or she became disabled. However, a disability-related inquiry also includes asking questions relating to an employee’s genetic information (including the employee’s family medical history), asking whether the employee is currently taking any prescription drugs or medications, and asking broadly worded questions about an employee’s impairments that are likely to elicit information about a disability. On the other hand, general questions regarding an employee’s well-being, whether the employee has been drinking, the employee’s current illegal use of drugs, or a request for contact information for the employee in the case of a medical emergency are not disability-related inquiries.

The EEOC defines a “medical examination” as a procedure or test that seeks information about an individual’s physical or mental impairments or health. Whether a particular test or procedure is a medical examination will be determined based on several factors, but the EEOC has determined that certain tests, including blood pressure screenings and cholesterol tests, are medical examinations for purposes of the ADA.

The broad range of questions and tests covered under the EEOC’s definitions of “disability-related inquiry” and “medical examinations” makes it very unlikely that a health risk assessment (provided as part of a wellness program) would not be subject to the ADA’s requirements concerning these restrictions. An example of a program that would not be considered to ask any disability-related questions or conduct any medical examinations is a smoking cessation program that is available to any employee who smokes and only asks employees to disclose how much they smoke.

EEOC FINAL RULE

On May 17, 2016, the EEOC released final regulations to provide guidance on designing wellness programs that would comply with the ADA. The new notice requirement and incentive rules apply for plan years starting on and after January 1, 2017. The EEOC states that all other provisions, such as the confidentiality requirements, are clarifications of existing obligations; so those provisions were effective immediately. The final regulations apply to all workplace wellness programs, including those offered to employees or their family members that do not require participation in a particular health plan.

The EEOC published Q&As on the EEOC's final rule on Employer wellness programs and Title I of the ADA [here](#).

The final rule has five essential elements.

First, an employee health program, including any disability-related inquiries or medical examinations that are part of such programs, must be reasonably designed to promote health or prevent disease. To comply with this element, a wellness program must have a reasonable chance of improving the health of, or preventing disease in, participating employees and must not be overly burdensome. In addition, the program must not be a subterfuge for violating the ADA or other laws preventing employment discrimination, or highly suspect in the method chosen to promote health or prevent disease. A wellness program will not be "reasonably designed" if the employer collects health information without giving any feedback to the employees or spouse who provide it, or without using the information to design a program that addresses at least a subset of conditions identified. Nor will it be "reasonably designed" if it simply shifts health costs from the employer to targeted employees based on health.

The second element of the EEOC Final Rule is that the wellness program must be voluntary. The EEOC Final Rule states that a wellness program is not voluntary if an employee is required to participate. Furthermore, an employee cannot be denied coverage under any group health plan or particular benefit packages within a group health plan for non-participation, nor can benefits be limited for employees who do not participate. This requirement clearly makes programs that condition eligibility on whether an employee completes a health risk assessment or undergoes biometric screenings impermissible. It also prohibits programs that prevent employees from enrolling in particular plan options if they do not undergo a medical examination or a disability-related inquiry. Finally, an employer cannot take any adverse employment action or retaliate against, interfere with, coerce, intimidate, or threaten employees for not participating.

The Final Rule requires an employer to provide employees a written notice that:

- is written in language reasonably likely to be understood by the employee from whom medical information is being obtained;
- describes the type of medical information that will be obtained and the specific purposes for which the medical information will be used;
- describes the restrictions on the disclosure of the employee's medical information, the employer representatives or other parties with whom the information will be shared, and the methods the employer uses to prevent improper disclosure of medical information (including whether it complies with certain HIPAA rules).

The EEOC has issued a sample notice that may be tailored for an employer's program. A copy of the sample notice for employer-sponsored wellness programs can be found [here](#).

The EEOC published questions and answers about the sample notice [here](#).

The third element of the EEOC Final Rule requires that incentives must not exceed 30 percent of the of the total cost of an employee-only health plan (including both the employer's and the employee's contributions) for participation in a wellness program that includes disability-related inquiries and/or medical examinations without running afoul of the ADA's requirement that such programs be "voluntary."

The Final Rule differs from the HIPAA rules in several ways. First, the 30 percent cap applies regardless of whether an employer’s wellness program is considered a participatory program (for example, completing a health risk assessment without any further action required by the employee based on the results) or a health-contingent programs (for example, a program that requires an employee to meet a health-related goal in order to obtain an incentive), if such programs include medical inquiries or exams. Second, the ADA incentive limitations do not allow the additional 20 percent incentive that HIPAA allows for programs that are designed to prevent or reduce tobacco if the program includes a disability-related inquiry or medical exam (such as a blood test for nicotine). However, employers offering wellness programs that include smoking cessation components that do not include medical inquiries or exams but merely ask employees whether or not they use tobacco (or whether they have ceased doing so at the end of the program) may offer incentives as high as 50 percent of the cost of employee coverage for participation in such a program, consistent with current HIPAA guidance as amended by the ACA (though any smoking cessation program that includes a medical inquiry or exam would be subject to the 30 percent cap). Third, the Final Rule uses different rules for identifying the self-only coverage used to calculate the 30 percent limit as follows:

Wellness Program Design	Reward Limit
Wellness program offered only to employees enrolled in the employer’s group health plan	30% of the total cost of coverage under the benefit option in which the employee has enrolled (e.g., HMO, PPO, POS, HDHP)
Wellness program offered to all employees regardless of health plan participation	30% of the total cost of coverage under the least expensive benefit option offered by the employer
Wellness program offered to all employees; employer does not offer a group health plan	30% of the cost of self-only coverage under the second lowest cost Silver Plan for a 40-year-old nonsmoker on the Exchange in the employer’s principal place of business

Under the fourth element of the EEOC Final Rule, reasonable accommodations must be provided, absent undue hardship, to enable employees with disabilities to earn whatever financial incentive an employer offers (regardless of whether a wellness program includes disability-related inquiries or a medical examination). For example, an employer that offers a reward for completing a biometric screening that includes a blood draw would have to provide an alternative test so that an employee with a disability that makes drawing blood dangerous can participate and earn the incentive.

The final element of the EEOC Final Rule requires that confidentiality be observed with regard to the medical information collected in connection with the wellness program. In general, except as permitted under existing EEOC regulations or as needed to administer the health plan, information obtained from disability-related inquiries and medical examinations may only be provided to an employer in aggregate terms that do not disclose, or are not reasonably likely to disclose, the identity of an employee. In addition, the Final Rule states that an employer cannot require an employee to agree to the sale, exchange, sharing, transfer, or other disclosure of medical information (except to the extent permitted by the rules to carry out specific activities related to the wellness program); or to waive any confidentiality protections under the ADA regulations as a condition for participating in a wellness program or for earning any incentive the employer offers in connection with such a program.

While the U.S. District Court for the District of Columbia ruled in late 2017 in *AARP v. EEOC* that the 30% incentive limits under the EEOC’s Final Rule are vacated effective January 1, 2019, the EEOC has indicated that it is unlikely that they can implement a new regulation before 2021, and informally indicated that it has no plans to change enforcement guidance anytime soon. In the meantime, it’s arguable that vacating the safe harbor should not require employers to reduce incentives for 2019 based on activities performed in 2018. It is worth noting that previous enforcement action targeted very aggressive plans with incentives far outside of the 30% limit. Employers are advised to consult with ERISA counsel when designing and implementing wellness programs.

6.6 GUIDANCE ON WELLNESS PROGRAMS AND “AFFORDABILITY” UNDER ACA’S EMPLOYER MANDATE

Final regulations on certain provisions relating to the federal premium tax credits that eligible individuals may use to purchase subsidized health insurance coverage from public exchanges address the effect of incentives under a nondiscriminatory wellness program for purposes of determining affordability under the ACA’s employer mandate.

The regulations are important for employers that are subject to the Affordable Care Act’s (ACA’s) employer shared responsibility provisions because they affect the determination of whether coverage offered by employers is “affordable.” Coverage is “affordable” if the employee’s annual contribution for self-only coverage under the plan does not exceed 9.5% (as indexed) of the individual’s household income. Employers owe a tax if they fail to provide affordable coverage and full time employees purchase subsidized coverage from a public exchange.

Under the final regulations, incentives under a nondiscriminatory employer-provided wellness program that reduces the amount employees have to pay for employer-sponsored coverage are not treated as reducing the employee’s required contribution for purposes of determining whether coverage is “affordable”, except in the following situation:

Wellness Programs Related to Tobacco Use. An employer may assume that all employees will pay the contribution rate for non-tobacco users (i.e., the “participating,” or lower rate) or for employees who complete a tobacco-related wellness program.

7. HIPAA NONDISCRIMINATION RULES

HIPAA's nondiscrimination provisions generally prohibit a group health plan or group health insurance issuer from denying an individual eligibility for benefits based on a health factor and from charging an individual a higher premium than a similarly situated individual based on a health factor.

These rules apply to all group health plans with two or more employees, whether fully insured or self-insured. Certain exceptions exist for limited scope dental and vision plans (i.e., the dental or vision plan is not connected to the medical plan), most healthcare flexible spending accounts, self-insured non-federal government plans, and certain church plans.

A group health plan may not establish rules for eligibility that are based on a health status-related factor. The following items are considered health status-related factors:

- Health status.
- Medical condition (both physical and mental).
- Claims experience.
- Receipt of health care (except for permitted pre-existing condition limitations).
- Medical history.
- Genetic information.
- Evidence of insurability, which includes conditions arising from acts of domestic violence, as well as participation in high risk activities (e.g., motorcycling, snowmobiling, horseback riding, skiing, etc...).
- Disability.

For example, an employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

In this example, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates HIPAA's nondiscrimination rule.

In another example, employees who enroll in their employer's group health plan during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

In this example, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates HIPAA. However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate HIPAA, because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

7.1 UNIFORM APPLICATION

Plans can exclude/limit benefits as long as the exclusions are applied on a uniform basis for all “similarly situated individuals” and not directed at individual participants based on a health factor.

Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants.

For example, a group health plan applies a \$2 million lifetime limit on all benefits. However, the \$2 million lifetime limit is reduced to \$10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

In this example, the lower lifetime limit for participants and beneficiaries with congenital heart defects violates HIPAA because benefits under the plan are not uniformly available to all similarly situated individuals and the plan’s lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

In another example, a group health plan has a \$2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. A participant files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a \$10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

The facts of this example strongly suggest that the plan modification is directed at the participant based on his claim. Absent outweighing evidence to the contrary, the plan violates HIPAA.

7.2 SOURCE OF INJURY RULES

If an injury results from a medical condition or act of domestic violence, a plan may not deny benefits for the injury (if plan otherwise covers such injury). A plan may exclude/limit coverage for high-risk activities (e.g., bungee jumping) but cannot exclude an individual from enrollment for coverage due to the individual’s participation in such high-risk activities.

For example, a group health plan generally provides medical/surgical benefits, including benefits for hospital stays that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Because of depression, Individual D attempts suicide. As a result, D sustains injuries and is hospitalized for treatment of the injuries. Under the exclusion, the plan denies D benefits for treatment of the injuries.

In this example, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of D’s injuries violates HIPAA because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

In another example, a group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant E sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for E’s head injury.

In this example, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible and does not violate HIPAA. However, if the plan did not allow E to enroll in the plan (or applied different rules for eligibility to E) because E frequently participates in bungee jumping, the plan would violate HIPAA.

7.3 SIMILARLY SITUATED INDIVIDUALS DETERMINATION

Distinctions among groups must be based on bona fide employment-based classifications consistent with an employer's usual practice and cannot include health factors.

Bona fide employment-based classifications can include:

- Part-time and full time.
- Geographical location.
- Date of hire and length of service.
- Current and former employees.
- Different occupations (e.g., faculty vs. staff).
- Different groups can have different eligibility, benefits, and cost provisions (e.g., age limits for dependent children).
- Participants and their beneficiaries may be in different groups.

For example, a group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

In this example, the plan's preexisting condition exclusions violate HIPAA because they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. Under HIPAA's nondiscrimination provisions, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.

7.4 NON-CONFINEMENT PROVISIONS

Plans may not delay or deny eligibility, benefits, or effective date of coverage, or set individual premium rates based on a person's confinement to a hospital or other health care facility.

The final rules clarify the interaction with states' extension of benefits laws to deal with insurance laws that require the prior carrier to continue coverage throughout the hospital stay, inasmuch as state law cannot change the legal obligation of the succeeding carrier under HIPAA, but any state law designed to prevent more than 100% reimbursement, such as state coordination of benefits laws, continue to apply.

For example, in previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer A. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer B. Under Issuer B's policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

Issuer B violates HIPAA because the group health insurance coverage restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer. Additionally, conclusions that under state law Issuer A may also be responsible for providing benefits to such a dependent; and that in a case in which Issuer B has an obligation under HIPAA to provide benefits and Issuer A has an obligation under state law to provide benefits, any state laws designed to prevent more than 100% reimbursement, such as state coordination-of-benefits laws, continue to apply.

7.5 ACTIVELY-AT-WORK PROVISIONS

Plans may not refuse to provide benefits because an individual is not actively at work on the day that individual would otherwise become eligible for benefits unless an individual is absent due to health factors that is treated as “actively-at-work.”

An exception to this rule is the “first day at work limitation.” For example, under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

In this example, the plan violates HIPAA. However, the plan would not violate HIPAA if, under the plan, an absence due to any health factor is considered being actively at work.

In another example, under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

In this example, the plan violates HIPAA because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate HIPAA if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

Also, some stop-loss carriers include actively-at-work provisions in the umbrella policy—the DOL believes this practice is illegal.

7.6 “SUPPLEMENTAL PLAN” SAFE HARBOR

Supplemental health insurance plans include any plan or policy that is provided under a separate insurance policy or contract to provide Medicare supplemental health insurance, TRICARE supplemental coverage or other similar coverage.

These plans are designed to fill a gap in the participant’s primary coverage and may provide coverage for payments of deductibles and coinsurance.

Certain types of these plans are exempt from the HIPAA nondiscrimination rules. Some providers have been exploiting this exception as a means to offer risk-based coverage to employees and avoid the HIPAA requirements.

The U.S. Department of Labor has expressed concern that supplemental health plans provide more than just supplemental coverage – that they are established to avoid the HIPAA requirements. Accordingly, the DOL issued safe harbor requirements to specify which types of supplemental health insurance plans will qualify for exemption from the HIPAA nondiscrimination requirement.

These rules clarify that if a supplemental health plan does not meet the safe harbor, then the plan is required to satisfy the HIPAA nondiscrimination provisions.

The safe harbor has four requirements:

1. the supplemental coverage must be provided by a separate policy, certificate, or contract of insurance;
2. the supplemental coverage must be specifically designed to fill gaps in primary coverage and may not include a provision that it becomes secondary only in case of a coordination of benefits;
3. the cost of the supplemental coverage may not exceed 15% of the cost of the primary coverage; and
4. the supplemental coverage may not provide different eligibility provisions, benefits, or premiums based on a health factor of the participant and/or dependent.

8. MILITARY LEAVE (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (“USERRA”) applies to all employers and protects an employee’s job status, promotion and benefits while the employee is on qualified leave. A group health plan must offer up to 24 months of continuation coverage for current health benefits to the employee (and his or her covered dependents) while the employee is serving in the “uniformed services.” Service in the “uniformed services” includes active or reserve duty, whether voluntary or involuntary, and time off for training or instruction.

Under USERRA, a group health plan is any insurance policy or contract or other arrangement under which health services are provided. This broad definition of group health plan includes not only plans providing medical, dental, vision and prescription drug coverage, but also includes health flexible spending accounts and health reimbursement arrangements (HRAs).

USERRA requires employers to develop reasonable procedures for employees to use in electing continuation coverage, but the statute does not require any particular election procedure. The statute also does not specify the time within which the election must be made, whether the election must be in writing ,or who may make an election on behalf of a covered employee.

If the period of coverage is less than 31 days, the plan may not require the employee to pay more than his or her regular premium payment. If the period of coverage is 31 days or more, the plan may charge the employee up to 102% of the applicable premium for this coverage. USERRA does not provide any time period within which premiums must be paid.

Employers must provide employees entitled to rights and benefits under USERRA a notice of their rights, benefits and obligations under USERRA by posting a notice provided by the DOL. The notice must be posted where the employer usually posts employee notices. The poster may be found on the DOL website at: U.S. Department of Labor -- Veterans’ Employment and Training Service (VETS) -- Understanding Your Rights Under USERRA.

USERRA CHECKLIST

- Develop reasonable procedures for employees electing military leave.
- Provide notice of military leave rights by posting USERRA notice.

8.1 EMPLOYER OBLIGATIONS WITH RESPECT TO MILITARY SERVICE LEAVE

INTRODUCTION

America's strong sense of patriotic pride is sometimes demonstrated by the record numbers of men and women enlisting in the Armed Forces or signing up for Reserve or National Guard duty. Based on the extent of the anticipated military buildup, leave requests to perform military service may become common in the workplace. In order for Employers to be prepared for such requests and to comply with applicable law, we have set forth below a brief summary of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). USERRA is codified at 38 U.S.C. §4301 et seq.

PROTECTIONS UNDER USERRA

Following the Gulf War, Congress enacted USERRA to provide protection for members of the Armed Forces who leave employment to perform military service, including Reserve duty. USERRA prohibits employment discrimination against an employee who takes leave for military service, and it protects the employee's job status. Significantly, USERRA requires that returning service personnel must be reemployed in the same or similar position that they would have attained if they had not been absent for military service. Employers also are obligated to maintain certain benefits or offer their continuation.

SCOPE AND COVERAGE OF USERRA

USERRA applies to all employers, large and small alike, regardless of the number of employees on their payroll. USERRA also covers the workplace of an employer in a foreign country, if the foreign entity is incorporated or otherwise organized in the United States or is controlled by an entity organized in the United States.

USERRA protects any employee performing uniformed service in the Armed Forces (Army, Navy, Marine Corps, Air Force, or Coast Guard), including Reserve duty. USERRA also covers service in the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time duty with the National Guard, as well as service in the commissioned corps of the Public Health Service. In addition, there is a catch-all provision that allows the President to designate any other category of persons to be protected.

RIGHT TO REINSTATEMENT

For leave periods of 90 or fewer days, the employer must reinstate the employee to the position the employee would have attained or held had he or she been continuously employed and not taken the leave, provided that the employee is qualified for the position. For leaves of more than 90 days, the employee must be returned to the position the employee would have attained or held had he or she been continuously employed and not taken the leave, or a position of like seniority, status, and pay, provided the employee is qualified for the position.

Significantly, this means that an employee returning from military service must be given all promotions and pay increases that the employee would have received by virtue of seniority or employment service, just as if he or she had not taken leave to perform military service.

If a returning employee would have been promoted, the employer has the obligation to attempt to qualify the employee for the new position by providing training or education. If the returning employee is not qualified to perform that job, and cannot be qualified, he or she must be returned to the position held at the commencement of military service.

EXCEPTIONS TO REINSTATEMENT

Only employees who receive an “honorable discharge” are entitled to reinstatement and protection under USERRA. Additionally, under certain limited exceptions, employers may be exempt from the reinstatement requirement where:

1. the employer’s circumstances have so changed that reinstatement would be “impossible or unreasonable;”
2. the employer can prove “undue hardship,” but only in connection with certain types of reinstatement; or,
3. the employment from which the person leaves for military service was to be for a brief, non-recurrent period and there was no reasonable expectation that such employment would continue indefinitely or for a significant period.

OBLIGATIONS OF THE EMPLOYEE

Employees are required under USERRA to give employers “advance written or verbal notice” of their military service obligations unless, under the circumstances, such notice is impossible or unreasonable. In addition, an employee must request to return to work within certain time limits depending upon the length of military service in order to fully protect his or her right to reinstatement. USERRA establishes the following categories:

1. Service of 1 to 30 days: The employee must report to his or her employer by the beginning of the first full regularly scheduled work day that would fall 8 hours after returning home following completion of service (allowing a reasonable period for safe transportation from site of service).
2. Service of 31 to 180 days: An employee must submit an application for reemployment within 14 days after completion of service or, if that submission is not possible, on the first full calendar day that submitting an application is possible.
3. Service of more than 180 days: An employee must submit an application for reemployment within 90 days after completion of service.
4. Hospitalized or convalescing employee: An employee may have up to two years to submit an application.

EMPLOYMENT DISCRIMINATION PROHIBITED

Employment discrimination based on past, current ,or future military obligation is prohibited with respect to any term, condition, or benefit of employment. USERRA also prohibits retaliation against any person who has exercised his or her rights protected under USERRA.

LIMITATION ON RIGHT TO TERMINATE EMPLOYEE FOLLOWING RETURN FROM LEAVE

USERRA imposes a significant restriction on an employer's right to terminate an employee who would otherwise be employed "at will." For up to a one-year period following reinstatement (depending on the length of military service), an employer may terminate an employee only "for cause." Employees who return from more than 180 days of military service may be terminated only "for cause" for a one-year period from the date of reinstatement. Employees who return from leave after serving 31 to 180 days may be terminated only "for cause" for a 180-day period from the date of reinstatement.

BENEFIT CONTINUATION AND PROTECTION

Health Benefits. Employees on leave for fewer than 31 days are entitled to have their health benefits (including dependent coverage) continued at the employer's normal expense for the period of the leave. In addition, once the employer-provided health coverage lapses, employees are entitled to purchase coverage on terms similar to COBRA. Upon reinstatement, employees are entitled to coverage without exclusions or waiting periods.

Pension. Returning employees are entitled to full credit during periods of military service for purposes of vesting and accrual of benefits under retirement plans, including defined benefit plans, defined contribution plans and profit sharing and retirement plans. Periods of service may not be treated as a break-in-service for purposes of forfeiture. Employers are responsible for making the necessary contributions to pension funds for any liabilities that accrue as a result of benefit accrual during military service covered by USERRA. However, the employee is responsible for any employee-required contributions.

Vacation. Vacation benefits do not continue to accrue during military leave, unless the employer separately provides for such continued accrual under other types of leave. An employee cannot be forced to use vacation time or other paid leave during a period of military leave. However, an employee is permitted, upon request, to receive accrued vacation pay while on military leave.

Seniority. Seniority, and other rights and benefits determined by seniority, continue to fully accrue during military leave to the same extent they would have accrued if the person had remained continuously employed, provided the employee returns to work following the leave.

Other Benefits. With respect to other rights and benefits not determined by seniority, such as sick pay, clothing allowances, or employer training, the employee is treated as being on a leave of absence and is entitled to receive the same rights and benefits that the employer would otherwise provide to employees on other types of leave from employment.

OTHER PROTECTIONS UNDER USERRA

Employees are entitled to protection under USERRA for leaves involving a cumulative length of absence of up to five years, or longer in some circumstances. Employers that violate the discrimination, reinstatement, or retaliation provisions of USERRA can face significant liability, including court ordered reinstatement, payment of lost wages and benefits, liquidated damages for willful violations (equal to the amount of compensation), attorneys' fees, expert witness fees, and other litigation expenses. Interestingly, an employer that prevails in court against an employee cannot recover fees or costs from the employee.

USERRA preempts state laws to the extent any state law provides for less protection than that afforded under the federal law as discussed above. However, states are permitted to enact laws that provide for greater protections than those afforded under the USERRA. Accordingly, employers should check with counsel to determine whether existing state law or pending legislation may impose additional obligations on the employer.

9. CODE SECTION 105(H) NONDISCRIMINATION RULES

Section 105(h) of the Internal Revenue Code of 1986, as amended (the “Code”) has traditionally applied to self-insured plans. Under PPACA, Code Section 105(h) will apply to fully insured plans as of the later of the first plan year after September 23, 2010, or when the plan loses grandfathered status. As of the date of this guide, the federal regulators had not released substantive guidance on the application of Code Section 105(h) to non-grandfathered fully insured plans (see below).

NOTE: that on December 22, 2010, the IRS deferred application of the nondiscrimination requirements applicable to non-grandfathered insured group health plans under PPACA. The IRS guidance provides that compliance with the nondiscrimination requirements is not required (and thus any sanctions for failure to comply do not apply) until future guidance is issued. This means that plan sponsors will not be required to file IRS Form 8928 (requiring employers to self-report any failure to meet certain group health plan requirements) or to pay any excise tax associated with failure to comply with PPACA’s nondiscrimination requirements as applied to non-grandfathered fully insured plans until future guidance is issued. As noted above, as of the date of this guide, no such guidance has been issued. Thus, our analysis in this Guide is limited to application of the rules to self-insured plans.

9.1 GENERAL RULES

Under Code §105(h) a plan cannot discriminate in favor of highly compensated individuals (“HCEs”) as to eligibility to participate (referred to as the “Eligibility Test”) and the benefits provided under the plan cannot discriminate in favor of participants who are HCEs (referred to as the “Benefits Test”).

For these purposes, an individual is a Highly Compensated Employee (“HCE”) if he or she is:

- one of the five highest paid officers;
- a shareholder who owns more than 10 percent of the employer’s stock; or
- among the highest paid 25 percent of all employees (other than employees subject to the exclusions noted below who do not participate in any plan sponsored by the employer).

There is no limit on the number of individuals who may be classified as HCEs for this purpose.

9.2 PENALTIES

For self-insured plans, the penalty for a violation of the Code Section 105(h) is the inclusion into income of the premium value into the affected HCEs income, according to the IRS.

9.3 ELIGIBILITY TEST

The Code §105(h) Eligibility Test consists of three alternative tests:

- a 70% test

A plan satisfies the Eligibility Test if it “benefits” 70% or more of all non-excludable employees; or

- a 70%/80% test

The plan satisfies this test if it “benefits” 80% or more of all non-excludable employees who are eligible to benefit under the plan and 70% or more of all non-excludable employees are eligible to benefit under the plan; or

- a nondiscriminatory classification test.

If a plan cannot pass either of the percentage tests described above, it may still pass Code §105(h) by establishing different “plan groups” using a nondiscriminatory reasonable classification. To qualify, the plan must benefit such employees as qualify under a classification of employees set up by the employer which is “found by the Internal Revenue Service not to be discriminatory in favor of highly compensated individuals.” According to IRS regulations, this determination may be made based upon the facts and circumstances of each case, “applying the same standards as are applied under Code §410(b)(1)(B) (relating to qualified pension, profit-sharing and stock bonus plans), without regard to the special rules in Code §401(a)(5) concerning eligibility to participate.” The use of this test is complex and its application is unclear because the regulatory reference above is to a section of the Code that was repealed and replaced, and (2) the nondiscriminatory classification test for qualified retirement plans operates on fundamentally different principles, policies and definitions, which have changed from the time that Code §105(h) was enacted (in 1978) and regulations thereunder were issued (in 1981).

NOTE: Excludable Employees

In applying the Code §105(h) nondiscrimination rules, employers may exclude employees who are not eligible for the plan and who:

- have less than three years of service;
- are under age 25;
- are “part-time” or “seasonal employees”; or
- belong to a union or who are nonresident aliens.

For these purposes, “part-time” employees are those whose customary weekly employment is less than 35 hours, if other employees have substantially more hours; provided, however, that any employee whose customary weekly employment is less than 25 hours may be considered as a part-time employee.

NOTE: Aggregation Rules

These tests (both the eligibility and benefits test) are determined on a “controlled group” basis. The controlled group rules are complex. A common myth is that if an employer establishes a separate entity with a separate EIN it can avoid aggregating plans of different companies, thus permitting the employer to place all of its HCEs in one company. THIS IS NOT TRUE. An employer segregating its workforce in this manner will not avoid testing these groups together if they are considered a single employer under the controlled group rules. Employers should seek the direct advice of competent counsel on the application of the controlled group rules.

9.4 BENEFITS TEST

The Code §105(h) Benefits Test consists of two sub-tests:

- the plan violates the Benefits Test unless all the benefits provided to any one HCE is provided to all other participants on the same basis; and
- the plan must also not discriminate in favor of HCEs in actual operation.

Essentially, if any benefit is provided to an HCE that any other participant did not receive, the plan will fail the Benefits Test. For these purposes, “benefits” include not only the benefits provided in the plan but also benefits provided by the employer with respect to the plan, such as premium contribution and plan availability.

Example: If an employer pays a greater percentage of premium for any of its HCEs than for any other participant, the plan will fail the Benefits Test. Similarly, if an employer extends the post-termination COBRA or other coverage for an HCE and does not provide the same extension to all other participants, the plan will fail this test.

10. FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an employer employs 50 or more employees (including part-time employees) each working day during 20 or more calendar weeks in the current or preceding calendar year, the employer must comply with the FMLA. A covered employer must grant an eligible employee up to a total of 12 weeks (or 26 weeks, as applicable) of unpaid leave in a 12-month period for one or more of the following reasons:

- For incapacity due to pregnancy, prenatal medical care, or childbirth.
- To care for the employee's child during the first 12 months after the birth or placement with the employee of a child for adoption or foster care.
- To care for an immediate family member (spouse, child, or parent – but not a parent “in-law”) with a serious health condition.
- When the employee is unable to work because of a serious health condition.

MILITARY LEAVE ENTITLEMENT:

The FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of unpaid leave in a 12-month period to care for a spouse, son, daughter, parent, or next-of-kin who qualifies as a “covered service member.” A “covered service member” means a member of the Armed Forces (including a member of the National Guard or Reserves) who, due to a serious injury or illness incurred in the line of duty that may render the service member medically unfit to perform his or her duties, is (1) undergoing medical treatment, recuperation, or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list. A “covered service member” also means a veteran (who was a member of the Armed Forces, including the National Guard or Reserves) who was discharged under conditions other than dishonorable within the five-year period before an employee first takes military caregiver leave to care for that veteran who is undergoing medical treatment, recuperation, or therapy for a qualifying serious injury or illness. An employee is not entitled to receive more than 26 weeks of unpaid FMLA leave (for any reason) in a 12-month period. As with all FMLA leave, the leave is unpaid and employers may require employees (or employees may elect) to use any accrued paid time off.

Eligible employees with a spouse, son, daughter or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain “qualifying exigencies.” Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

Employee eligibility: All employees who work at a location where at least 50 employees of the company are employed within 75 miles of each other, and who have been employed for at least one year and completed at least 1,250 hours of service during the 12-month period immediately preceding the commencement of leave, are eligible for FMLA leave.

Serious Health Condition: A “serious health condition” is an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility.
- A period of incapacity requiring absence of more than three calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provider.
- Any period of incapacity due to pregnancy or for prenatal care.

- Any period of incapacity (or treatment therefore) due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc...).
- A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's, stroke, terminal diseases, etc...).
- Any absences to receive multiple treatments (including any period of recovery from the treatments) by, or on referral by, a health care provider for a condition that likely would result in incapacity of more than three consecutive days if left untreated (e.g., chemotherapy, physical therapy, dialysis, etc...).

Determining the 12-Month Period: Employers may select one of four options for determining the 12-month period:

- The calendar year.
- Any fixed 12-month "leave year" such as a fiscal year, a year required by state law, or a year starting on the employee's "anniversary" date.
- The 12-month period measured forward from the date any employee's first FMLA leave begins.
- A "rolling" 12-month period measured backward from the date an employee uses FMLA leave.

Substitution of Paid Leave: Employees may choose to use, or employers may require the employee to use, accrued paid leave or vacation to cover some or all of the FMLA leave taken. The substitution of accrued sick or family leave is limited by the employer's policies governing the use of such leave.

Maintenance of Health Benefits: A covered employer is required to maintain group health insurance coverage, including family coverage, for an employee on FMLA leave on the same terms as if the employee continued to work.

Where appropriate, arrangements will need to be made for employees taking unpaid FMLA leave to pay their share of health insurance premiums. **An employer must continue to pay its share of the premiums while the employee is on FMLA leave.**

For example, if the group health plan involves contributions by the employer and the employee, an employee on unpaid FMLA leave must make arrangements to pay his or her normal portion of the insurance premiums to maintain insurance coverage. Such payments may be made under any arrangement voluntarily agreed to by the employer and employee. **Again, the employer must continue to pay its share of the premiums during the FMLA leave period.**

An employer's obligation to maintain health benefits under FMLA stops if and when an employee informs the employer of an intent not to return to work at the end of the leave period, or if the employee fails to return to work when the FMLA leave entitlement is exhausted. The employer's obligation also stops if the employee's premium payment is more than 30 days late and the employer has given the employee written notice at least 15 days in advance advising that coverage will cease if payment is not received.

In some circumstances, the employer may recover premiums it paid to maintain health insurance coverage for an employee who fails to return to work from FMLA leave.

FMLA Notice Requirements: An employer covered by the FMLA must provide a notice to employees explaining:

- That the leave will be counted against their annual FMLA leave entitlement;
- Any requirements for the employee to furnish medical certification of a serious health condition, and the consequences of failing to provide certification;
- The employee's right and/or obligation to substitute paid leave for unpaid leave;
- Requirements and procedures for paying health care premiums during leave;

- Any requirement for employees to present fitness-for-duty certificates to be restored to employment, for employees who are themselves seriously ill;
- The employee's status as a "key employee," if applicable, and the potential consequence that restoration may be denied following FMLA leave, explaining the conditions required for such denial;
- The employee's right to restoration to the same or an equivalent job on returning from leave; and
- The employee's potential liability for reimbursing the employer for his or her share of health care premiums if the employee fails to return to work and the failure to return to work is not due to reasons beyond the employee's control.

Employers must provide the FMLA Notice of Eligibility and Rights & Responsibilities as well as the applicable Certification form within 5 business days of the employee giving notice of the need for leave. Employees should be provided at least 15 calendar days to return the completed Certification. Once the employer receives the Certification, the employer must provide the Designation Notice within 5 business days.

Employers are required to post a notice for employees in the workplace, that outlines the basic provisions of FMLA and are subject to a civil money penalty for willfully failing to post such notice.

The poster may be found on the DOL's website at U.S. Department of Labor — Employment Standards Administration (ESA) — Wage and Hour Division (WHD) — Family and Medical Leave Act (FMLA) Poster.

Employers should also have a written FMLA policy.

NOTE: Many states have family leave rules that apply to group health plans and these rules can be different from the federal rules.

Employee Notice Requirements: When the need for FMLA leave is foreseeable, employees must provide at least 30 days' notice. When not foreseeable, employees should be instructed to comply with the employer's normal call-in procedures.

Job Restoration: Upon return from leave, employees are generally entitled to the same position or a position with equivalent status, pay, benefits, and other employment terms. However, an employee has no greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the FMLA leave period. Employer policies should include a statement that, if an approved FMLA leave extends beyond 12 weeks (or 26 weeks, if applicable), the employee's former job and salary cannot be guaranteed.

10.1 FMLA CHECKLIST

- Determine 12-month period that will apply to FMLA leave.
- Decide whether to substitute paid leave.
- Make arrangements for employees to pay their portion of health insurance premium.
- Employer must continue to pay its portion of health insurance premium.
- Implement process to determine when FMLA ends.
- Determine whether employer has a right to recover premiums paid if employee does not return to work.
- FMLA notice posted in the workplace and written FMLA policy distributed to employees.
- FMLA notices must be provided:
 - Notice of Eligibility and Rights & Responsibilities and applicable Certification form: provided within 5 business days after employee gives notice of need for FMLA leave
 - Designation Notice: provided within 5 business days after the employee provides completed Certification form
 - Notice should be mailed to employee if leave has already begun
- Check relevant state law regarding family leave.

10.2 RELEVANT STATE FAMILY AND MEDICAL LEAVE REGULATIONS

Although the federal government mandates certain conduct under the Family Medical Leave Act (FMLA), some states have chosen to expand upon the FMLA. Always determine whether the employee is entitled to leave under an applicable state law (which may have requirements that differ from the FMLA).

10.3 FMLA AND CAFETERIA PLANS

Generally, an employer must either allow an employee on unpaid FMLA leave to revoke coverage, or continue coverage but allow the employee to discontinue payment of his or her share of the premium for group health plan coverage (including a health flexible spending account (FSA)) under a cafeteria plan for the period of the FMLA leave.

FMLA does not require that an employer allow an employee to revoke coverage if the employer pays the employee's share of premiums. If the employer continues coverage during an FMLA leave, the employer may recover the employee's share of the premiums when the employee returns to work.

FMLA also provides the employee a right to be reinstated in the group health plan coverage (including a health FSA) provided under a cafeteria plan upon returning from FMLA leave if the employee's group health plan coverage terminated while on FMLA leave (either by revocation or due to nonpayment of premiums). Such an employee is entitled, to the extent required under FMLA, to be reinstated on the same terms as prior to taking FMLA leave (including family or dependent coverage), subject to any changes in benefit levels that may have taken place during the period of FMLA leave.

10.4 FMLA & CAFETERIA PLANS – PAYMENT OPTIONS

A cafeteria plan may offer one or more of the following payment options, or a combination of these options, to an employee who continues group health plan coverage (including a health FSA) while on unpaid FMLA leave.

These options are referred to as pre-pay, pay-as-you-go, and catch-up.

Pre-pay: Under the pre-pay option, a cafeteria plan may permit an employee to pay, prior to commencement of the FMLA leave period, the amounts due for the FMLA leave period. However, FMLA provides that the employer may not mandate that an employee pre-pay the amounts due for the leave period.

Contributions under the pre-pay option may be made on a pre-tax salary reduction basis from any taxable compensation (including from unused sick days or vacation days). Contributions under the pre-pay option may also be made on an after-tax basis.

Pay-as-you-go: Under the pay-as-you-go option, employees may pay their share of the premium payments on the same schedule as payments would have been made if the employee were not on leave.

Contributions under the pay-as-you-go option are generally made by the employee on an after-tax basis. However, contributions may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation (e.g., from unused sick days or vacation days) that is due the employee during the leave period.

An employer is not required to continue the group health coverage of an employee who fails to make required premium payments while on FMLA leave, provided that the employer follows the notice procedures required under FMLA. However, if the employer chooses to continue the health coverage of an employee who fails to pay his or her share of the premium payments while on FMLA leave, FMLA permits the employer to recoup the premiums (to the extent of the employee's share).

Catch-up: Under the catch-up option, the employer and the employee may agree in advance that the group coverage will continue during the period of unpaid FMLA leave, and that the employee will not pay premiums until the employee returns from the FMLA leave. Where an employee is electing to use the catch-up option, the employer and the employee must agree in advance of the coverage period that: the employee elects to continue health coverage while on unpaid FMLA leave; the employer assumes responsibility for advancing payment of the premiums on the employee's behalf during the FMLA leave; and these advance amounts are to be paid by the employee when the employee returns from FMLA leave.

When an employee fails to make required premium payments while on FMLA leave, an employer is permitted to utilize the catch-up option to recoup the employee's share of premium payments when the employee returns from FMLA leave.

Contributions under the catch-up option may be made on a pre-tax salary reduction basis from any available taxable compensation (including from unused sick days and vacation days) after the employee returns from FMLA leave. The cafeteria plan may provide for the catch-up option to apply on a pre-tax salary reduction basis if premiums have not been paid on any other basis (i.e., have not been paid under the pre-pay or pay-as-you-go options or on a catch-up after-tax basis).

Contributions under the catch-up option may also be made on an after-tax basis.

Exceptions: Whatever payment options are offered to employees on non-FMLA leave must be offered to employees on FMLA leave, with the following exceptions:

- FMLA does not permit the pre-pay option to be the sole option offered to employees on FMLA leave. However, the cafeteria plan may include pre-payment as an option for employees on FMLA leave, even if such option is not offered to employees on non-FMLA leave-without-pay.
- FMLA allows the catch-up option to be the sole option offered to employees on FMLA leave if and only if the catch-up option is the sole option offered to employees on non-FMLA leave-without-pay.
- If the pay-as-you-go option is offered to employees on non-FMLA leave-without-pay, the option must also be offered to employees on FMLA leave. The employer may also offer employees on FMLA leave the pre-pay option and/or the catch-up option.

In addition to the aforementioned payment options, an employer may voluntarily waive, on a nondiscriminatory basis, the requirement that employees who elect to continue group health coverage while on FMLA leave pay the amounts the employees would otherwise be required to pay for the leave period.

As an example, an employer allows employees to pay premiums for group health coverage during an FMLA leave on an after-tax basis while the employee is on unpaid FMLA leave. Under the terms of the employer's cafeteria plan, if an employee elects to continue health coverage during an unpaid FMLA leave and fails to pay one or more of the after-tax premium payments due for that coverage, the employee's salary after the employee returns from FMLA leave is reduced to cover unpaid premiums (i.e., the premiums that were to be paid by the employee on an after-tax basis during the FMLA leave, but were paid by the employer instead).

In this example, the employer's cafeteria plan satisfies the cafeteria plan requirements. The employer's cafeteria plan would also satisfy the cafeteria plan requirements if the plan provided for coverage to cease in the event the employee fails to make a premium payment when due during an unpaid FMLA leave.

11. MEDICARE PART D – MEDICARE MODERNIZATION ACT (MMA)

MEDICARE PART D CREDITABLE COVERAGE

The Medicare Modernization Act (MMA) requires plan sponsors (e.g., employers) to notify Medicare eligible participants whether their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage. There are generally two disclosure requirements:

1. Annual Report of Prescription Drug Creditable Coverage to Centers for Medicare and Medicaid Services (CMS)

A group health plan must annually file a report with the CMS stating whether the prescription drug coverage under the plan is creditable. A creditable coverage report also must be filed when the plan's prescription drug coverage ceases to be creditable.

The creditable coverage disclosure notice must be provided within 60 days after the beginning of each plan year. Additionally, the disclosure notice must be amended and resubmitted within 30 days of the termination of a prescription drug plan or within 30 days after any change in the creditable coverage status of a prescription drug plan.

The notice must be completed and submitted electronically via the CMS website, located [here](#).

2. Participant Notice of Creditable Coverage

Employers must provide participants with a creditable coverage notice (1) before the Medicare Part D annual coordinated election period (October 15-December 7), (2) within 12 months before the individual's Medicare Part D Initial Enrollment Period, (3) before the effective date of coverage under the group health plan if a Medicare Part D eligible employee enrolls in the group health plan, (4) when the prescription drug coverage is no longer creditable, and (5) at the request of the individual. A creditable coverage notice provided with the plan's open enrollment materials each year will satisfy the requirements to provide the notice before the Medicare Part D annual coordinated election period and within the 12 months before any individual's Medicare Part D Initial Enrollment Period.

As defined in the Medicare Part D regulations, coverage is considered creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage. This determination is important because employees who do not enroll in Medicare during their first open enrollment period must pay a late enrollment penalty of 1% per month if they go 63 days without creditable coverage before enrolling in Medicare Part D.

11.1 ANNUAL REPORT OF PRESCRIPTION DRUG CREDITABLE COVERAGE TO CMS

The electronic disclosure form available on the CMS website generally requires that the following information be provided:

- Information regarding the entity offering the coverage, including employer identification number, address and telephone number.
- The type of coverage and the number of benefit options offered under the plan.
- Aggregated creditable coverage (or, if applicable, aggregated non-creditable coverage) information for all of the benefit options offered under the plan.
- The period covered by the disclosure notice.
- The estimated number of Part D eligible individuals expected to be covered under the plan as of the beginning of the plan year.
- The estimated number of individuals expected to be covered through an employer/union group health retiree plan.
- The date the annual creditable coverage notice was provided to Part D eligible individuals.
- If the disclosure notice is being filed in response to a change in creditable coverage status, the date the amended creditable coverage notice was provided to Part D eligible individuals .
- The name, title, and e-mail address of the employee who is completing the form on the entity's behalf.

For entities with subsidiaries, one disclosure form may be submitted to CMS for the entire entity if the type of coverage and the plan year is the same for all subsidiaries. Alternatively, each subsidiary may submit its own form with subsidiary-specific information.

11.2 PARTICIPANT NOTICE OF CREDITABLE COVERAGE

As a result of the Medicare Modernization Act (MMA), employers that provide prescription drug coverage to active employees or retirees and their dependents who are covered by either Medicare Part A or Part B must provide them with a “creditable coverage” disclosure notice at specified times. Only employers that contract with a prescription drug plan (“PDP”) through Medicare, or that contract with Medicare to become a PDP, are exempt from this notice requirement. A disclosure notice is required regardless of whether the employer’s coverage is primary or secondary to Medicare.

The purpose of the disclosure notice is to inform the Medicare beneficiaries of whether or not the employer’s drug coverage is “as good as” the new Medicare Part D prescription drug coverage. This serves an important function because employees who do not enroll in Medicare during their first open enrollment period must pay a late enrollment penalty of 1% per month if they go 63 days without “creditable coverage” and then subsequently enroll in Medicare Part D. However, individuals who have creditable coverage through their employer’s health plan may opt to stay in that plan in lieu of participating in Medicare Part D. Those individuals would not be subject to late enrollment penalties.

The Centers for Medicare & Medicaid Services (“CMS”) recently published guidance on the technical details of the disclosure notices, as well as model notices, in both English and Spanish, designed to help eligible individuals decide whether or not to enroll in Medicare Part D. The most significant points regarding this new notice obligation include the following:

WHAT IS CREDITABLE COVERAGE?

Under the MMA, coverage will be considered creditable when the actuarial value (i.e., the expected amount of paid claims) of the employer’s prescription drug coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D.

This is true regardless of whether it is the employee or the employer who pays for the coverage. If a plan has multiple benefit options, the actuarial test must be performed separately for each option. CMS has indicated that coverage will be considered creditable if the following four tests are met:

1. the coverage is designed to pay, on average, at least 60% of participants’ prescription drug expenses;
2. the coverage covers both brand and generic prescriptions;
3. it provides reasonable access to retail providers and, optionally, to mail order coverage; and
4. it has a maximum annual benefit for prescription drug coverage that is at least \$25,000, or has an actuarial expectation that it will pay at least \$2,000 per Medicare-eligible employee in 2006.

In the case of health plans with integrated prescription drug and medical coverage, the fourth requirement above is replaced with the following three requirements:

1. the integrated health plan must have no more than a \$250 deductible per year;
2. the maximum annual benefit must be at least \$25,000; and
3. the lifetime combined benefit maximum must be no less than \$1,000,000.

If the employer is not applying for the MMA’s retiree drug subsidy, and its plan meets the applicable requirements set forth above, an actuarial certification of equivalence is not necessary. If the employer does not meet the applicable requirements set forth above, however, an actuarial certification may be required to prove creditable coverage.

WHO IS ENTITLED TO THE DISCLOSURE NOTICE?

Broadly, the disclosure notice must be provided to all Medicare Part D-eligible individuals who are covered under, or who apply for, the employer’s prescription drug coverage. This would, for example, generally include all active and retired employees who are Medicare beneficiaries, as well as Medicare beneficiaries who are covered as spouses under either the employer’s active or retiree coverage.

An individual is considered to be Medicare Part D-eligible if (1) he or she is entitled to Medicare Part A and/or is enrolled in Part B, as of the effective date of coverage under the Part D plan; and (2) the individual resides in the service area of a PDP or of a Medicare Advantage plan that provides prescription drug coverage. For this reason, individuals who are living abroad or who are incarcerated would not be considered Medicare Part D-eligible individuals.

WHAT INFORMATION MUST THE DISCLOSURE NOTICE CONTAIN?

CMS has published two model notices: a creditable coverage notice and a non-creditable coverage notice. An employer may choose not to use the applicable model disclosure notice. In that event, the employer drafted disclosure notice must contain the following components:

1. a statement that the employer has determined that the prescription drug coverage it provides is or is not creditable;
2. the definition of “creditable coverage”;
3. an explanation of why creditable coverage is important and either, as applicable, (i) a cautionary statement that even though coverage is creditable, the employee could be subject to payment of higher Part D premiums if he or she subsequently has a break in creditable coverage of 63 days or more before enrolling in a Part D plan; or (ii) an explanation that an individual may be subject to payment of higher Part D premiums if the person fails to enroll in a Part D plan when first eligible as a result of non-creditable coverage; and
4. for non-creditable coverage notices, a notification that the individual can only enroll in a Part D program at specified times each year.

CMS has also recommended, but not required, that certain elements be present in an employer-drafted notice of creditable coverage, including:

1. an explanation of the individual’s rights to the notice and when he or she can expect to receive such a notice;
2. an explanation of the options available to the individual (e.g., staying in the employer’s plan versus transferring to a Medicare Part D plan);
3. the consequences if an individual decides to transfer coverage to a Medicare Part D plan while he or she is participating in an integrated plan that covers both medical and prescription drug benefits;
4. the circumstances under which an individual could become re-enrolled in an employer’s plan after selecting Medicare Part D coverage; and
5. information on how to get extra help paying for a Medicare prescription drug plan, including the contact information for the Social Security Administration.

WHEN MUST THE NOTICE BE PROVIDED?

The disclosure notice must be provided, at a minimum, at the following five times:

1. prior to individual’s initial enrollment period for Medicare Part D;
2. prior to the annual Medicare Part D enrollment period from October 15 through December 7 of each year;
3. prior to the effective date of coverage for any Medicare eligible individual who joins the employer’s plan;
4. whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and
5. upon request.

So long as a disclosure notice is provided to all plan participants, CMS will consider items one and two to have been met. Additionally, “prior to” means that the notice must have been provided within the past twelve months.

HOW MUST THE NOTICE BE PROVIDED?

CMS has indicated that it will be flexible with regard to the form and manner of providing the notice disclosure.

Paper

The notice need not be sent as a separate mailing. Instead, it can be included with other plan participant information materials (such as summary plan descriptions and enrollment information), provided that the reference to the notice is prominent and conspicuous (i.e., at least 14-point font in a separate box, bolded or offset on the first page that begins the plan participant information being provided). A single notice will suffice for a covered Medicare eligible individual and all Medicare eligible dependent(s) covered under the same plan so long as it is not known that they live at a different address than the participant.

Electronic

An employer may provide a disclosure notice through electronic means, but only if the individual has indicated that he or she has adequate access to electronic information. Moreover, the individual must also be informed of (1) his or her right to the paper version, (2) how to withdraw his or her consent, (3) how to update his or her address information, and (4) any hardware or software requirements for accessing and retaining the disclosure notice.

If an individual consents to the electronic transfer of the notice, he or she must provide a valid e-mail address and his or her consent must be submitted electronically to the employer. The disclosure notice must also be posted on the employer's website, if applicable, with a link to the disclosure notice on the homepage.

If you have any questions about the new creditable coverage disclosure notice requirements or need assistance in ensuring compliance with the new requirements, please do not hesitate to contact Peter Marathas (pmarathas@marbarlaw.com) at (617) 830-5456 or Stacy Barrow (sbarrow@marbarlaw.com) at (617) 830-5457.

11.3 MEDICARE PART D – MODEL NOTICES

The Centers for Medicaid and Medicare Services have released notices for use by employers to employees and beneficiaries regarding creditable coverage under the group health plan (or the lack of creditable coverage). These Model Notices are typically updated annually. The most recent Model Notices can be found [here](#).

12. OTHER LAWS AND REQUIREMENTS

12.1 MENTAL HEALTH PARITY ACT (MHPA)

Group health plans that cover more than 50 employees are prohibited from imposing annual or lifetime coverage limits that are more restrictive for mental health benefits than other medical benefits. Although the MHPA requires “parity,” or equivalence, with regard to dollar limits, the MHPA does not require group health plans and their health insurance issuers to include mental health coverage in their benefits package. Group health plans that provide out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits. This requirement became effective beginning the first plan year on or after October 1, 2009.

12.2 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) prohibits a group health plan from applying financial requirements (e.g., deductibles, co-payments, coinsurance, and out-of-pocket maximums), quantitative treatment limitations (e.g., number of treatments, visits, or days of coverage), or non-quantitative treatment limitations (such as restrictions based on facility type) to its mental health and substance use disorder benefits that are more restrictive than those applied to the plan’s medical and surgical benefits. Regulations under the MHPAEA became effective for plan years beginning on or after July 1, 2014.

In December 2016, the 21st Century Cures Act required the federal agencies to improve mental health parity compliance by issuing additional guidance and soliciting feedback on a variety of mental health parity topics, including how to improve required disclosures. In connection with that law, the federal agencies issued an FAQ (Part 38) on mental health parity implementation that reiterates that the mental health parity rules apply to any benefit that a plan may offer for treatment of an eating disorder.

The agencies also issued a draft model disclosure form that is available [here](#) and a request for comments on the form and other mental health parity disclosure issues. Existing mental health parity rules provide that a plan or insurer must disclose the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider on request and must make available the reason for any denial of reimbursement or payment for services with respect to such benefits to the participant or beneficiary. If an employer receives this type of request (even if not on the DOL’s model form), it has just 30 days to respond. If an employer doesn’t respond in 30 days, penalties of up to \$110 per day may apply.

APRIL 23, 2018 FAQ GUIDANCE

On April 23, 2018, the Agencies released several more pieces of guidance on issues arising under the MHPAEA, including 2017 enforcement actions and guidance on mental health parity implementation.

The guidance includes:

- [Proposed FAQs \(Part 39\)](#) regarding non-quantitative treatment limitations (e.g., non-numerical limits on benefits, such as preauthorization requirements) and plan disclosure issues;
- An [updated draft model disclosure form](#) participants may use to request information from employer-sponsored health plans;
- A [self-compliance tool](#) for group health plans, plan sponsors, insurance carriers, State regulators and other parties to evaluate MHPAEA compliance by a group health plan or insurance carrier; and

PROPOSED FAQs (PART 39)

The April 2018 proposed FAQs provide additional guidance regarding non-quantitative treatment limitations (NQTs) and disclosure requirements under the MHPAEA. The proposed FAQs address whether specified plan designs are NQTs and, if so, whether the plan designs comply with the MHPAEA. Among other things, the FAQs clarify that health plans cannot:

- Deny claims for Applied Behavior Analysis therapy (which the plan classified as a mental health condition) as “experimental or investigative” when the NQTL standard, in practice, was applied more stringently to MH/SUD benefits than medical/surgical benefits;
- Reduce reimbursement rates for non-physician practitioners providing MH/SUD services without using a comparable process with respect to reimbursement of non-physician providers of medical/surgical services;
- Exclude coverage for inpatient, out-of-network treatment outside of a hospital for eating disorders such as a residential treatment center where it covers such treatments for medical/surgical conditions following physician authorization and a determination that the treatment is medically appropriate based on clinical standards of care; or
- Apply more stringent guidelines when setting dosage limits for prescription drugs to treat MH/SUD (e.g., buprenorphine to treat opioid use disorder).

Another proposed FAQ provides that the complete exclusion of coverage, including prescription drugs, for a particular condition (e.g., bipolar disorder) does not violate the MHPAEA, although it could raise issues under other laws, especially if the program is insured and subject to state mandate requirements.

The proposed FAQs also address ERISA disclosure requirements for MH/SUD benefits.

- If a plan uses a provider network and furnishes a provider directory with the plan’s summary plan description, it must make reasonable efforts to ensure the directory’s list of providers is accurate, current, and complete.
 - The provider list may be furnished in a separate document that is accompanied by the plan’s SPD if it is furnished automatically and without charge and the SPD contains a statement to that effect.
- If a plan uses a provider network, a hyperlink or URL for the provider directory may be used in enrollment and plan summary materials, subject to the DOL’s electronic disclosure safe harbor requirements.

Additional proposed FAQs address mental health treatment limitations involving provider licensure, network adequacy standards, emergency room care, and use of step therapy “fail first” protocols.

For more examples of plan provisions that could be red flags that a plan might be imposing an impermissible NQTL, see [Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations \(NQTLs\) that Require Additional Analysis to Determine Mental Health Parity Compliance](#).

UPDATED DRAFT MODEL DISCLOSURE FORM

The Departments have also issued an updated draft model disclosure form (initially released in June 2017) that plan participants can use to request MH/SUD-related information from their plan or insurer. Plan participants are not required to use the draft model form to request information about their MH/SUD benefits; plan sponsors and issuers must respond to participant requests for this information even if the model form is not used.

The updated form includes expanded background language and additional examples. For instance, the form now includes several examples of factors used in the development of a NQTL (e.g., excessive utilization and recent medical cost escalation) and evidentiary standards used to evaluate those factors.

SELF-COMPLIANCE TOOL

The guidance also includes an updated MHPAEA self-compliance tool that group health plans can use to determine whether they are compliant with the MHPAEA. The tool is the same audit checklist used by DOL investigators for enforcement purposes.

The updated self-compliance tool has significantly more comprehensive guidance regarding NQTLs and disclosure, along with additional examples of what parity is and what it is not.

The DOL has stated it will update the self-compliance tool every two years with additional guidance on MHPAEA’s requirements, as appropriate.

12.3 NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT (NEWBORNS’ ACT)

The Newborns’ Act provides protections for newborns and mothers regarding the minimum length of a hospital stay under federal law that applies to the plan. Group health plans that are subject to the Newborns’ Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The notice may be included in the plan’s SPD and does not have to be provided separately.

NOTE: Many states also have rules that apply to protect newborns and mothers and these rules can be different from the federal rules.

12.4 WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Group health plans that provide coverage for mastectomies are required to notify participants about the availability of coverage for breast reconstructive surgery. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. The plan administrator must provide this notification at the time of enrollment in the health plan and then annually thereafter. A model WHCRA Notice is included below.

MODEL WHCRA ENROLLMENT NOTICE

The following is language that group health plans may use as a guide when crafting the WHCRA enrollment notice:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymph edema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductible and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

12.5 NATIONAL MEDICAL SUPPORT (NMS) NOTICE

This is a notice used by a state agency responsible for enforcing the health care coverage provisions in a medical child support order. Within 40 days of receipt of the NMS (if this period is reasonable), the employer must complete certain sections of the NMS notice and transfer it to the plan administrator, after which the plan administrator must determine if the NMS notice is a QMCSO and notify the state agency of its determination. The plan administrator must promptly notify affected persons of receipt of the NMS and the procedures for determining its qualified status.

- Is your plan compliant with the NMS procedures?

12.6 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is a child support order that requires the plan to provide for health benefit coverage (including any coverage provided under COBRA) to the participant's child. A QMCSO may require a group health plan of the noncustodial parent (employee) to provide coverage to his or her child, even though the child may not meet the plan's definition of "dependent." The plan administrator must have in place procedures to determine if a medical child support order is qualified under ERISA and provide the procedures to participants upon request at no charge. The procedures may be included in the plan's SPD, but if not, the SPD must at least contain a statement that QMCSO procedures are available upon request at no cost.

12.7 MICHELLE'S LAW

Effective for the first plan year following October 9, 2009, all group health plans that cover dependents must extend coverage for dependent college students who take medically necessary leaves of absence. The coverage is available for up to one year or, if earlier, until the date on which the coverage would otherwise end under the plan. The extended coverage must provide the same benefits as if the child was not on a medically necessary leave of absence. Written certification must be provided by the child's treating physician stating the child is suffering from a serious illness or injury, and the leave (or change of enrollment) is medically necessary. The plan must include a description of the terms for continued coverage when sending any notice describing the plan's student certification requirements for coverage.

Under the Patient Protection and Affordable Care Act of 2010 ("PPACA"), all group health plans that offer coverage to dependents must offer coverage to children of covered employees, up to the age of 26 (see Section 12.10 of this Guide). As such, for the most part Michelle's Law will become irrelevant in most cases. However, Michelle's Law will remain applicable to those plans that offer coverage to dependents beyond the age of 26 who remain in college.

12.8 MEDICARE SECONDARY PAYER REPORTING REQUIREMENTS

Responsible Reporting Entities (RREs) (generally, insurers for fully insured plans and employers or TPAs for self-insured group health plans) must report to the Centers for Medicaid and Medicare Services ("CMS") secondary payer information. File submissions are required on a quarterly basis. Following registration, each RRE will be assigned to a group corresponding to one of the submission periods.

Plan sponsors should:

- If self-insured, confirm third-party administrator is meeting notice requirements.
- Discuss with third-party administrators or insurance company what additional information is needed.
- Collect required data for current participants and for future participants on an on-going basis.
- Review reimbursement and indemnity provisions of contracts with insurers or TPAs with respect to penalties.

12.9 GENETIC INFORMATION NONDISCRIMINATION ACT (“GINA”)

Effective for plan years beginning on or after May 21, 2009, GINA prohibits discrimination by group health plans, health insurance issuers, and employers against an individual based on the individual’s genetic information. Group health plans and health insurance issuers generally may not request, require, or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Group health plans and insurers are prohibited from setting premium and contribution rates for the employer group on the basis of genetic information of an individual enrolled in the plan.

GINA requires the HIPAA Privacy regulations to be amended, effective May 21, 2009, to treat genetic information as protected health information. GINA prohibits the use of genetic information for underwriting purposes and makes the definitions of genetic information and underwriting consistent with GINA.

Plan sponsors should:

- Review plan operations for all group health plans (including with insurers or TPAs) to make sure operations are in compliance.
- Revise HIPAA privacy policies and procedures and notices as necessary to conform with the treatment of genetic information as protected health information and prohibit use and disclosure for underwriting purposes.

12.10 AGE 26 COVERAGE REQUIREMENT (PPACA)

Under PPACA, group health plans that otherwise offer coverage to dependent children must offer coverage to any “child” of a participant, up to the age of 26. This requirement became effective as of the first day of the first plan year on or after September 23, 2010. This requirement applies whether or not the plan is grandfathered (see discussion at Section 2).

Unlike prior “dependency” rules, the PPACA age 26 coverage requirement does not permit a plan to condition eligibility on any schooling, financial, or dependency requirements; that is, under PPACA, children must be covered up to the age of 26 whether or not they are “dependents” of their parents, whether or not they live in the same home or even the same state, whether or not they are employed and whether or not they are married. However, under PPACA, a plan is not required to offer coverage to a child’s spouse or the child’s children. In addition, a plan cannot vary the coverage provided to children under age 26 based on age.

PPACA does not define the term “child.” Final regulations clarify that a plan will not fail to satisfy the age 26 requirement if dependent coverage is offered only to children under age 26 would fall within the Code Section 152(f)(1) definition of a child. Under that definition, a “child” includes a natural born child, an adopted child or one placed for adoption, a stepchild, or an eligible foster child. That definition does not include grandchildren, nieces or nephews and they are not required to be offered coverage (however, a sponsor may voluntarily extend coverage, subject to carrier/stop loss carrier approval, and impose conditions other than the relationship between the participant and the child on such coverage.)

12.11 ELIMINATION OF LIFETIME LIMITS (PPACA)

Historically, many group health plans established a lifetime maximum on the value of benefits that could be provided under the plan terms. These lifetime maximums were typically \$1 million, \$2 million or even higher. When employees and their dependents reached the limit, benefits were no longer available under the plan.

Under PPACA, effective beginning as of the first day of the first plan year on or after September 23, 2010, all individual and group health plans were required to eliminate lifetime limits on the dollar value of essential benefits for any participant or beneficiary. This means that plans are no longer permitted to cap benefits to pre-established dollar amount. The law prohibits group health plans from imposing lifetime dollar limits on the value of essential health benefits and does not make a distinction between in-and out-of-network benefits. The government agencies have made clear that any lifetime limits on the dollar value of EHBs, whether in-or out-of-network, are problematic under the law. Essential health benefits (EHBs) include:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance abuse.
- Prescription drugs.
- Rehabilitative and devices.
- Laboratory services.
- Preventive and wellness services.
- Pediatric services, including oral and vision care.

The plan sponsor is not prohibited by this requirement from excluding all benefits for a condition. An exclusion of all benefits for a condition is not considered to be a lifetime dollar limit. However, if any benefits are provided for a condition, then the prohibition on lifetime dollar limits applies.

Plans may define EHBs by reference to any of the 51 benchmark plans identified by the states or the District of Columbia, or one of the three largest Federal Employees Health Benefits Program plan options. Since a state's base-benchmark plan may not reflect all EHBs in the state and supplementation may be required, the final regulations define EHBs as benefits covered by a state's benchmark plan, including certain state-required benefit mandates, or benefits covered by one of the three federal options.

This mandate applies whether or not the plan is "grandfathered" (see Section 2 of this Guide).

Mandate Inapplicable: This mandate does not apply to retiree-only plans, health flexible spending accounts or health savings accounts. This mandate also does not apply to HIPAA-excepted benefits such as free-standing dental and vision benefits (i.e., offered under a separate policy, certificate, or contract of insurance), long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance, or Medicare supplemental health insurance. Likewise, dental and vision benefits that are "not an integral part" of a group health plan are HIPAA-excepted benefits that are not subject to the health care reform mandate rules. Generally, dental and vision benefits are "not an integral part" of a group health plan if: (1) the participant has a right to decline coverage; or (2) claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

Special Note: Interplay Between Removal of Lifetime Dollar Limits and Mental Health Parity Requirements

The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) prohibits a group health plan from applying financial requirements (e.g., co-pays) or treatment limitations (e.g., number of annual visits) to its mental health and substance use disorder benefits that are more restrictive than those applied to the plan’s medical and surgical benefits. The health care reform law does not supersede the requirements of MHPAEA. Accordingly, while lifetime visit or other limitations may be permitted under PPACA, these limitations must also meet all applicable MHPAEA requirements. Always consult with qualified benefits counsel to ensure that any limits imposed on mental health or substance use disorder benefits comply with MHPAEA.

Special Note: Stop-Loss Carriers

PPACA applies to group health plans and group health insurance products. Stop-loss carriers typically characterize their products as “risk insurance.” They, therefore, do not believe that they must eliminate lifetime maximums from their contracts. As of the date of this guide, no guidance has been issued that applies health care reform mandates to stop-loss carriers to the same extent as they apply to the underlying health insurance coverage. Sponsors of self-funded group health plans with stop-loss coverage should still review their stop-loss coverage since they may include exclusions, limitations, and enrollment restrictions are prohibited in the underlying health insurance coverage and the sponsor may have exposure to such excess liability.

12.12 ELIMINATION OF ANNUAL LIMITS (PPACA)

Historically, group health plans had established annual limits on the value of benefits that could be provided under the plan terms. When employees and their dependents reached these annual limits, benefits were no longer available under the plan for that plan year.

Beginning in plan year 2014, PPACA prohibited group health plans, regardless of their grandfathered status, from imposing annual dollar limits on the value of essential health benefits. Essential health benefits are described in Section 12.11 above.

Plans are still permitted to exclude all benefits for a particular condition. However, if any benefits are provided for a condition, then the prohibition on annual dollar limits applies.

Mandate Inapplicable: This mandate does not apply to retiree-only plans, health flexible spending accounts, or health savings accounts. This mandate also does not apply to HIPAA-excepted benefits such as free-standing dental and vision benefits (i.e., offered under a separate policy, certificate or contract of insurance), long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance. Likewise, dental and vision benefits that are “not an integral part” of a group health plan are HIPAA-excepted benefits that are not subject to the health care reform mandate rules. Generally, dental and vision benefits are “not an integral part” of a group health plan if: (1) the participant has a right to decline coverage, or (2) claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.

Special Note: Interplay Between Removal of Annual Dollar Limits and Mental Health Parity Requirements

The Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) prohibits a group health plan from applying financial requirements (e.g., co-pays) or treatment limitations (e.g., number of annual visits) to its mental health and substance use disorder benefits that are more restrictive than those applied to the plan’s medical and surgical benefits. The health care reform law does not supersede the requirements of MHPAEA. Accordingly, while annual visit or other limitations may be permitted under PPACA, these limitations must also meet all applicable MHPAEA requirements. Always consult with qualified benefits counsel to ensure that any limits imposed on mental health or substance use disorder benefits comply with MHPAEA.

Special Note: Stop-Loss Carriers

PPACA applies to group health plans and group health insurance products. Stop-loss carriers typically characterize their products as “risk insurance.” They therefore do not believe that they must eliminate annual maximums from their contracts. As of the date of this guide, no guidance has been issued that applies health care reform mandates to stop-loss coverage to the same extent as they apply to the underlying health insurance coverage. Sponsors of self-funded group health plans with stop-loss coverage should still review their stop-loss coverage since they may include exclusions, limitations, and enrollment restrictions are prohibited in the underlying health insurance coverage and the sponsor may have exposure to such excess liability.

12.13 ZERO CO-PAY/OUT-OF-POCKET FOR PREVENTIVE SERVICES (PPACA)

Commencing on the later of the first day of the first plan year on or after September 23, 2010, or the date a plan loses its grandfathered status (see Section 2 of this Guide), plans must include certain preventive services and not charge plan participants co-payments, co-insurances or deductibles for these services when they are delivered by an in-network provider.

A non-grandfathered plan must provide benefits for and prohibit the imposition of cost-sharing requirements (including co-payments, co-insurance, or deductibles) with respect to:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved. (For a complete list of “A” and “B” Recommendations of the Task Force click [here](#).)
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force). HHS released guidelines that are effective for plan years beginning on or after August 1, 2012 that include coverage for a broad range of items and services.

The complete list of recommendations and guidelines for preventive services that are required to be covered under PPACA can be found [here](#). Any future changes to a recommendation or guideline for a preventive service by the above-referenced agencies should also be noted at this website.

GUIDANCE ON TOBACCO USE INTERVENTIONS

As described in DOL FAQ XIX, a group health plan will be in compliance with the requirement to cover tobacco use counseling and interventions, if it covers without cost-sharing:

- Screening for tobacco use; and,
- At least two cessation attempts per year, each of which includes coverage for:
 - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephonic, group, and individual counseling) without prior authorization; and

- All FDA-approved tobacco cessation medications (including both prescription and OTC) for a 90-day treatment regimen when prescribed by a provider without prior authorization.

PREVENTIVE HEALTH SERVICES NOT RECOMMENDED

Non-grandfathered plans may continue to impose cost-sharing requirements to cover those preventive services that are not required to be covered by PPACA. Moreover, nothing prohibits the imposition of cost-sharing requirements for treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

The preventive service coverage or cost-sharing requirements are not applicable for any item or service that has ceased to be a recommended preventive service. However, other federal or state requirements may apply in connection with the discontinuance of preventive services or the changing of cost-sharing requirements for any such item or service (e.g., PPACA requires that the participants receive 60 days' advanced notice of any material modification before it becomes effective under the group health plan or health insurance policy).

COST-SHARING WHEN PREVENTIVE SERVICES PROVIDED AS PART OF OFFICE VISIT

The following are a series of rules and examples on how to apply the cost-sharing requirement for office visits during which recommended preventive services are rendered.

- **Cost-Sharing for Office Visit Allowed.** If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit where the primary purpose of the visit was for preventive services, then non-grandfathered plans may impose a cost-sharing requirement with respect to the office visit.
- **Cost-Sharing for Office Visit Not Allowed.** If recommended preventive services are not billed separately (or are tracked as individual encounter data) from an office visit and the primary purpose of the visit was the delivery of a recommended preventive service or item, then non-grandfathered plans may not impose cost-sharing requirements for such visit.
- **Cost-Sharing for Office Visit Allowed.** Regardless of whether recommended preventive services are billed separately (or are tracked as individual encounter data) from an office visit, if the primary purpose of the office visit was not to provide a recommended preventive service or item, then a cost-sharing requirement may be imposed on the office visit. In addition, a plan could, in this case, exclude coverage for the office visit entirely to the extent otherwise permitted under applicable law.
 - **Example 1.** An individual covered by a non-grandfathered group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of "A" or "B" in the current recommendations of the Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.
 - **Example 2.** Same facts as Example 1. As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations noted above. Because the treatment is not included in the recommendations, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

- **Example 3.** An individual covered by a non-grandfathered group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of “A” or “B” in the current recommendations of the Task Force with respect to the individual. The provider bills the plan for an office visit. The blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver recommended preventive items or services. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.
- **Example 4.** A child covered by a non-grandfathered group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the HRSA. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the HRSA, nor otherwise included in the recommendations noted above. The provider bills the plan for an office visit. The service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the HRSA. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

COST-SHARING PERMITTED FOR OUT-OF-NETWORK PROVIDERS

Non-grandfathered plans that offer coverage through a network of providers are not required to provide coverage for recommended preventive services delivered by an out-of-network provider and may impose cost-sharing requirements for the delivery of such services by an out-of-network provider.

REASONABLE MEDICAL MANAGEMENT TECHNIQUES PERMITTED

If a recommendation or guideline for a preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the non-grandfathered plans can use “reasonable medical management techniques” to determine any coverage limitations.

ADDITIONAL WOMEN’S HEALTH PREVENTIVE CARE REQUIREMENTS AND GUIDELINES

In August 2011, HHS issued detailed guidelines regarding women’s health care services that group health plans and health insurance policies must cover without cost-sharing pursuant to Section 2713 of PPACA [here](#). Women’s Preventive Services Guidelines. They can be found [here](#).

ADDITIONAL GUIDANCE ON WOMEN’S PREVENTIVE CARE

On May 11, 2015, the Departments of Health and Human Services, Labor, and Treasury, jointly released FAQs to clarify group health plans’ and insurance carriers’ responsibilities to cover contraceptives and other preventive services. The guidance contained in these FAQs was effective for plan years beginning on or after July 10, 2015 (January 1, 2016 for calendar year plans).

Specifically, the Departments have clarified that insurance carriers and group health plans must cover without cost sharing at least one of each of the methods (currently 18) identified by the FDA in its current birth control guide, which include emergency contraception such as Plan B and Ella. The FDA's current birth control guide can be found [here](#).

Plans and carriers may continue to use reasonable medical management techniques (e.g., a plan may impose cost sharing to encourage use of other items and services within the chosen contraceptive method). For example, a plan may impose cost-sharing on brand name pharmacy items when a generic equivalent is safe and available. Likewise, a plan may use cost sharing to encourage use of one of several FDA-approved devices within one of the 18 approved contraceptive methods. However, if the participant's doctor recommends a particular service or FDA-approved item based on a determination of medical necessity, the plan must cover that service or item without cost sharing, and must defer to the determination of the participant's doctor with regard to medical necessity, which may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service.

If a plan intends to utilize reasonable medical management techniques within a specified method of contraception, it must have an easily accessible, transparent, and expedient exception process that is not unduly burdensome. The exception process must take into account any medical exigencies involved for a claim involving urgent care (i.e., the process should not delay provision of an emergency contraceptive).

The FAQs provide additional clarification on related issues:

- The FAQs clarify that women must be offered preventive screening and genetic testing for breast cancer susceptibility gene (BRCA)-related cancer when recommended by a doctor (e.g., due to family history), even women who previously had breast, ovarian, or other cancer.
- Preventive services must be provided as recommended by the participant's physician, regardless of the sex assigned to the participant at birth, gender identity, or gender recorded by the plan or carrier.
- Plans and carriers must provide recommended preventive services to covered dependents of enrollees (age appropriate as determined by the dependent's physician). This includes services related to pregnancy, such as preconception and prenatal care.
- Plans and carriers must cover anesthesia for a preventive colonoscopy, without cost sharing, if determined to be medically appropriate by the participant's physician.

TRUMP ADMINISTRATION ON WOMEN'S PREVENTIVE CARE

In November 2018, the Trump Administration finalized regulations allowing certain employers with religious or moral objections to opt-out of providing contraceptive coverage as required under the ACA. The interim final rules, which largely resemble the final rules, but expanded the religious exemption to include all non-governmental employers (not just closely-held employers), were the target of lawsuits in late 2017 that effectively prevented their implementation by the U.S. Department of Health and Human Services. Employers seeking to avail themselves of the religious or moral exemptions contained in the final rules should consult with ERISA counsel for direct legal advice given the ongoing litigation.

12.14 PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS AND LIMITATIONS (PPACA)

Under the ACA, a group health plan, including a grandfathered plan, is prohibited from applying a preexisting condition exclusion (PCE) to any participant. This requirement was effective beginning on or after January 1, 2014.

Under final regulations effective for plan years beginning on or after January 1, 2017, a PCE is “a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial).” Thus, the prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition. A preexisting condition can be a serious medical condition, such as cancer, diabetes, high blood pressure, or something relatively minor, such as acne.

The definition also provides that a PCE includes any limitation or exclusion based on information relating to an individual’s health status, “such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.” An exclusion of benefits for a condition regardless of when the condition arose relative to the effective date of coverage is not considered a PCE, but the requirements of other federal or state laws may prohibit such an exclusion.

Prior to the ACA, group health plans were required to issue HIPAA certificates of creditable coverage to all individuals who lost coverage under a group health plan or who would have lost coverage but for an election to take COBRA continuation coverage. Individuals used these certificates to demonstrate creditable coverage to a subsequent plan so that a PCE period could be reduced or eliminated. With the enactment of ACA’s prohibition on pre-existing condition exclusions, these certificates became obsolete.

12.15 PROHIBITION ON RESCISSIONS OF COVERAGE (PPACA)

A group health plan, including a grandfathered plan, may not terminate coverage retroactively (i.e., rescind coverage) except in the case of fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A group health plan or health insurance issuer must provide at least 30 days’ advance written notice to each participant who would be affected before coverage may be rescinded in accordance with PPACA. The prohibition on rescission became effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar year plans).

A retroactive termination of coverage is not a “rescission” for these purposes to the extent the retroactive termination is attributable to a failure to pay timely premiums towards coverage (including COBRA premiums). A cancellation or discontinuance of coverage is not a rescission if:

1. it has only a prospective effect;
2. is initiated by the individual and the employer/plan sponsor or insurer does not, directly or indirectly, take action to influence the individual’s decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual; or
3. it is initiated by an Exchange.

Example 1: An employer sponsors a group health plan that provides coverage for full time employees. A full time employee covered under the plan is reassigned to a part-time position; however, the plan mistakenly continues coverage. After a routine audit, the plan discovers that the employee no longer works full time. The plan rescinds the employee's coverage effective as of the date that the employee changed from full time to part-time status. This rescission violates PPACA because there was no fraud or an intentional misrepresentation of material fact; however, the plan may cancel the employee's coverage prospectively, subject to other applicable state and federal and laws.

Example 2: If a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, a plan's termination of coverage retroactive to the divorce is not a rescission of coverage. (Of course in such situations, COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.)

NOTE: A showing of "fraud or intentional misrepresentation" is a high standard to meet. Employers should ensure that their summary plan descriptions, enrollment and other plan communications documents are carefully reviewed by qualified counsel to determine whether any ambiguous terms or provisions could provide the basis for an assertion that a representation was merely inadvertent and not intentional. For example, if the term "spouse" is not defined, an employee with a common-law spouse could claim that the inclusion of the common-law spouse was inadvertent and not an intentional misrepresentation, even in states where common-law marriage is not recognized.

A rescission of coverage under an ERISA plan subject to the prohibition is an "adverse benefit determination" triggering the application of ERISA's claims procedures (even if there is no adverse effect on any particular benefit at the time of the rescission).

12.16 CHOICE OF HEALTH CARE PROFESSIONAL (PPACA)

If a group health plan requires participants to designate a primary care provider, participants must be permitted to designate any participating primary care provider who is accepting new patients. With respect to a child, any participating physician who specializes in pediatrics (allopathic or osteopathic) can be designated as the child's primary care provider. In addition, a group health plan may not require authorization or referral for obstetrical or gynecological care provided by a participating OB/GYN specialist. **NOTE:** that group health plans that have not negotiated with any provider for the delivery of health care (i.e., have not created networks of coverage) but merely reimburse participants for certain medical expenses are not subject to this requirement.

Notice Requirements: A group health plan that requires participants to designate a primary care provider must notify them of their right to designate any participating primary care provider whenever the plan provides a summary plan description or other similar description of benefits available under the plan. The notice must state that with respect to a child, any participating physician who specializes in pediatrics can be designated as the child's primary care provider. In addition, the plan must notify participants that it may not require authorization or referral for obstetrical or gynecological care provided by a participating OB/GYN specialist.

12.17 COVERAGE FOR OUT-OF-NETWORK EMERGENCY SERVICES (PPACA)

If a group health plan provides any benefits with respect to emergency hospital services, it must do so without requiring prior authorization or higher cost sharing amounts, even for services provided out-of-network, and it must do so without regard to any other requirement except applicable cost-sharing and other permitted exclusions (e.g., waiting periods, coordination of benefits, etc...). In other words, coinsurance and copayment amounts must be the same in-network and out-of-network emergency services, although out-of-network providers may “balance bill” participants (i.e., the provider may charge the excess of the out-of-network provider rate over the amount the plan pays). Also, the plan must pay an amount equal to the greatest of three possible amounts:

- The median of all negotiated rates with network providers for the emergency service furnished, excluding any participant cost sharing amounts;
- The amount for the plan pays for out-of-network benefits (e.g., the usual, customary, and reasonable amount (“UCR”)), reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency services were provided in-network; and
- The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant.

In addition, cost-sharing requirements other than copayments or coinsurance (such as a deductible or out-of-pocket maximum) may apply to out-of-network emergency services to the extent that such deductible or out-of-pocket maximum would apply to non-emergency out-of-network services.

To calculate the median rate described above, consider the following example: if for a given emergency service a plan negotiated a rate of \$100 with three providers, a rate of \$125 with one provider, and a rate of \$150 with one provider; the amounts taken into account to determine the median would be \$100, \$100, \$100, \$125, and \$150; therefore, the median is \$100.

To determine the UCR amount, consider the following example: if a plan generally pays 70% of the UCR amount for out-of-network services, the plan may charge 100% of the UCR amount reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency services were provided in-network.

Determining a plan’s coverage requirement for out-of-network emergency services is perhaps best illustrated by example:

Example. A group health plan provides coverage for out-of-network emergency services. The plan has agreements with in-network providers for certain emergency services in the following amounts: one has agreed to accept \$85, two have agreed to accept \$100, two have agreed to accept \$110, three have agreed to accept \$120, and one has agreed to accept \$150. In this example, the participant receives care from one of the out-of-network providers that charges \$120. Under the agreement, the plan agrees to pay the providers 80% of the agreed amount, with the participant responsible for the remaining 20%. In this example, the median is \$110; therefore, the amount calculated under the first bullet above is 80% of \$110 (\$88).

With respect to the second bullet above, the plan generally reimburses participants for 50% of the UCR amount (for purposes of this example, the UCR amount is \$116). Subtracting the 20% in-network coinsurance from \$116 leaves \$92.80. With respect to the third bullet above, the Medicare payment is \$80. In this example, the greatest amount is \$92.80; therefore, the participant is responsible for the difference between the \$120 charged and the \$92.80 paid by the plan (\$27.20).

12.18 MEDICAL LOSS RATIO REQUIREMENTS (PPACA)

Beginning January 1, 2011, insurers were required to annually calculate their medical loss ratio (MLR) and provide rebates to policyholders if their MLR (percent of premium revenue spent on claims/medical care) is less than 85% for large groups (51+ employees during the preceding calendar year) and 80% (or higher, based on state regulations) for small groups (50 or fewer employees during the preceding calendar year, unless a state elects to extend the cutoff to 100 employees) or individuals.

The rebates are not calculated separately for each employer group health plan's experience. Even if an employer's particular plan's MLR was below the applicable required standard, a policyholder will not receive a rebate unless the particular insurance product purchased in the policyholder's market size in its state qualifies for an MLR rebate.

The MLR requirement does not apply to self-insured plans or insurers of only excepted benefits. Nor does it apply to insurers in the individual or group insurance markets in the five U.S. territories (U.S. Virgin Islands, Northern Mariana Islands, Guam, American Samoa, and Puerto Rico). On December 2, 2011, the Department of Health and Human Services released final regulations on the MLR rule, and the DOL issued Technical Release No. 2011-04, which provides rebate guidance to employer-sponsored group health plans subject to ERISA.

Under the final regulations, insurers apportion and pay rebates directly to policyholders. Rebates must be paid by September 30 of each year. If provided in accordance with the final rule, rebates are not subject to taxes.

The Technical Release, which applies to ERISA plans, clarifies that ERISA's fiduciary duty and plan asset rules govern treatment of insurer rebates. Any portion of a rebate that is attributable to employee contributions must be used for the exclusive benefit of plan participants and beneficiaries (e.g., via reductions in future contributions or benefit enhancements), and ERISA fiduciary principles must be followed in choosing how to use that portion of the rebate. MLR rebates must be used to pay premiums or provide refunds within **three months** of receipt, or the employer is required to hold the rebates in trust, per DOL rules.

12.19 "SIMPLE" CAFETERIA PLANS (PPACA)

Effective beginning January 1, 2011, PPACA has permitted eligible small employers to offer cafeteria plans to their employees without having to satisfy the cafeteria plan nondiscrimination requirements or the nondiscrimination requirements for group term life insurance and health care and dependent care flexible spending accounts. A cafeteria plan is a separate written plan under which employees are permitted to choose between at least one permitted taxable benefit (e.g., unreduced cash compensation), and at least one qualified benefit (e.g., health insurance).

Under the so-called "safe harbor" from the nondiscrimination testing requirements, the cafeteria plan and the underlying benefits will be treated as meeting the specified nondiscrimination requirements if the plan satisfies minimum eligibility and participation requirements and minimum contribution requirements.

ELIGIBLE EMPLOYER

An eligible employer is an employer that employed an average of 100 or fewer employees on business days during either of the two preceding years. If an employer was an eligible employer for any given year, then the employer remains an eligible employer until the employer employs an average of 200 or more employees during any year preceding any such subsequent year. **NOTE:** IRS tax controlled group rules under Code Section 52 apply (which differ in certain respects from the rule that apply for other nondiscrimination testing purposes). Determining whether an employer is part of a controlled group can be complex and very fact specific and should be performed by qualified counsel.

ELIGIBILITY REQUIREMENTS

The eligibility requirement is met only if all employees (other than excludable employees) are eligible to participate, and each employee eligible to participate can elect any benefit available under the plan. Excludable employees for purposes of a simple cafeteria plan are those who:

- have not attained age 21 (or a younger age selected by the employer) before the end of the plan year;
- have not completed one year of service (or a shorter period of service selected by the employer) as of any day during the plan year;
- are covered by a collective bargaining agreement, if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer; or
- certain nonresident aliens working outside the U.S.

MINIMUM CONTRIBUTION REQUIREMENTS

Simple cafeteria plans require “true” employer contributions. The minimum contribution requirement is met if the employer provides a minimum contribution for each non-highly compensated employee (HCE) **in addition to** any salary reduction contributions made by the employee. The minimum must be able to be applied toward the cost of any qualified benefit (other than a taxable benefit) offered under the plan. The contribution must be equal to:

- A uniform percentage (not less than 2%) of the employee’s compensation for the plan year, or
- An amount which is not less than the lesser of:
 - 6% of the employee’s compensation for the year, or
 - 2x the amount of employees’ salary reductions (employers cannot favor HCEs with respect to contribution rate).

12.20 EMPLOYER-SPONSORED HEALTH COVERAGE INFORMATIONAL REPORTING ON W-2 (PPACA)

FORM W-2

Under the ACA, certain employers must report the cost of employer-sponsored health coverage on each employee's annual Forms W-2 (using box 12, code DD).

BACKGROUND

The purpose of the reporting requirement is to provide useful and comparable consumer information to employees on the cost of their health coverage. It does not cause otherwise excludable employer-provided health coverage to become taxable. For these purposes, the amount reported includes both the employer's and the employee's contributions towards coverage, regardless of whether the employee paid for the coverage on a pre-tax or after-tax basis.

WHEN WAS THE REQUIREMENT FIRST EFFECTIVE, AND TO WHOM DOES IT APPLY?

The reporting requirement was first effective starting with the 2012 Forms W-2 (the Forms W-2 for calendar year 2012 that employers are generally required to furnish to employees in January 2013). (Reporting for the 2011 calendar year was optional.)

The requirement applies to most employers, including federal, state, and local government entities (except with respect to plans maintained primarily for members of the military and their families), churches and other religious organizations, and employers that are not subject to continuation coverage requirements under COBRA, to the extent such employers provide applicable employer-sponsored coverage under a group health plan (although employers who only sponsor self-funded group health plan coverage that is not subject to COBRA are not required to report the cost of the coverage on Form W-2). Notice 2012-9 clarifies that, until further notice, the exemption for federally recognized Indian tribal governments is expanded to include employers that are tribally chartered corporations wholly owned by federally recognized Indian tribal governments.

Third-party sick-pay providers that provide the Forms W-2 to the employees of the employers with which they have contracted do not have to report the cost of coverage. However, a Form W-2 provided by the employer to the employee must report the cost of coverage regardless of whether that Form W-2 includes sick pay or whether a third-party sick pay provider is furnishing a separate Form W-2 reporting the sick pay.

Also, to the extent an employer chooses to honor the request of an employee who terminated employment during the year to receive his/her Form W-2 before the end of that calendar year, the employer is not required to include the reportable cost of coverage with respect to that employee in Box 12, Code DD.

Small Employer Exemption. Small employers (those that are required to file fewer than 250 Forms W-2 for the calendar year prior to the reporting year) are not subject to the reporting requirement for 2012 Forms W-2, nor subsequent years, until further guidance is issued. The Notice clarifies that if an employer filed fewer than 250 Forms W-2 only because the employer used an agent to file the forms, the exemption does not apply. For purposes of this relief, the employer is determined without the application of any aggregation rules for related employers (i.e., controlled group rules).

NOTE: that employers who are in a professional employer organization (“PEO”) relationship or who use employee leasing organizations should consult with legal counsel to determine how the reporting requirement applies to them.

Multi-employer Plans. An employer that contributes to a multiemployer plan is not required to report the cost of coverage under that multiemployer plan. If the only applicable employer-sponsored coverage provided to an employee is provided under a multiemployer plan, the employer is not required to report any amount with respect to that employee.

WHICH LINES OF COVERAGE ARE REPORTED?

The reporting requirement applies to employer-sponsored group health plans (whether fully insured or self-funded), which generally include major medical plans and limited benefit plans (e.g., so-called “mini-med” plans). A determination of whether a particular arrangement constitutes a group health plan may require a review of the relevant facts and circumstances.

WHICH LINES OF COVERAGE ARE NOT REPORTED?

The following lines of coverage are not included when reporting of the cost of coverage:

- Employee assistance program (EAP), wellness program, or on-site medical clinic coverage if the employer does not charge a premium to COBRA qualified beneficiaries with respect to that type of coverage; however, an employer may include these lines of coverage if desired, provided such coverage is applicable employer-sponsored coverage;
- Dental or vision coverage, to the extent it qualifies as a HIPAA-excepted benefit;
- Long-term care, and accident-only or disability coverage;
- Specified disease or illness and hospital indemnity or other fixed indemnity insurance, to the extent that the cost of coverage is paid by the employee on an after-tax basis and the coverage is offered as an independent, non-coordinated benefit;
- Contributions made to an Archer medical savings account (MSA) or a health savings account (HSA) because they are reported separately in box 12 using code R for MSAs and code W for HSAs;
- Employee’s contributions to a health flexible spending account (FSA). Notice 2012-9 clarifies that the value of an employer-funded FSA is only reported if the amount of the FSA for the plan year exceeds the salary reduction elected by the employee for the plan year (in other words, the requirement does not apply to FSA coverage if contributions occur only through employee salary reduction elections); and
- Coverage under a health reimbursement arrangement (HRA); however, an employer may include it if desired.

The guidance clarifies that to the extent an employer offers a benefit that includes otherwise reportable coverage as an incidental part of the benefit, the employer is not required to include either the reportable

or non-reportable portion of benefit. Similarly, an employer may, but is not required to, include the non-reportable portion of otherwise reportable coverage if the non-reportable portion is an incidental part of the benefit, notwithstanding the prohibition on reporting coverage that is not applicable employer-sponsored coverage.

12.21 PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE FEE (PCORI FEE) (PPACA)

The Patient-Centered Outcomes Research Institute Fee (a/k/a/ the Comparative Effectiveness Research Fee) (the “Fee”) is used to research, evaluate, and compare health outcomes and the clinical effectiveness of medical treatments, including protocols for treatment, care management, and other strategies or items being used in the treatment, management, and diagnosis/prevention of illness or injury.

The Fee is effective for policy and plan years after September 30, 2012 and before October 1, 2019 (i.e., for calendar year policies/plans, the fees would apply for calendar policy/plan years 2012 through 2018). Grandfathered-status of the plan is irrelevant for purposes of the Fee.

Generally, all group health plans that cover U.S. residents are subject to the Fee, except for benefits that are “excepted benefits” under HIPAA. “Excepted benefits” include dental and vision plans that are issued under a separate contract of insurance from the group health plan. With respect to dental and vision plans that are self-funded, such benefits are HIPAA-excepted if the participant has the right to opt-out of the coverage.

The amount of the Fee is equal to the number of individuals covered during the policy year or plan year multiplied by the applicable dollar amount for the year. A chart of the PCORI fee due dates and applicable rates is available [here](#).

With respect to fully insured group health plans, the Fee will be paid by the applicable insurance company. With respect to self-funded group health plans, the plan sponsor is responsible for payment. **NOTE:** that because the PCORI fee is assessed on the plan sponsor of a self-insured plan, it generally should not be included in the premium equivalent rate that is developed for self-insured plans if the plan includes employee contributions. However, an employer’s payment of PCORI fees is tax deductible as an ordinary and necessary business expense.

Insurers and plan sponsors must report and pay these fees annually on IRS Form 720, which are due by July 31 of each year. A return will generally cover policy or plan years that end during the preceding calendar year. In other words, fees for a plan year are due by July 31 of the calendar year following the calendar year containing the plan year-end. Form 720 may be filed electronically. The most recent version of the form is available [here](#) and includes a section in Part II for payment of the PCORI Fee.

Plan sponsors and policy issuers cannot reduce the PCORI fee due July 31 for any overpayment from a prior year. If a plan sponsor or policy issuer overpaid the PCORI fee reported on a previously filed Form 720, it should file Form 720X, Amended Quarterly Federal Excise Tax Return, for an overpayment of a previously filed PCORI liability. Form 720X is available on IRS.gov. Similarly, corrections to a previously filed Form 720 need to be made, for example, because the employer determined a fee using an incorrect applicable dollar limit, it should also use Form 720X.

APPLICATION OF THE FEE TO COMMON TYPES OF HEALTH COVERAGE OR ARRANGEMENTS

Type of Insurance or Arrangement	Subject to the Fee?	Person Responsible for Paying and Reporting the Fee
Accident and health coverage or major medical insurance coverage	Yes	<ul style="list-style-type: none"> The issuer if insured The plan sponsor if self-insured
Retiree-only health or major medical coverage	Yes	<ul style="list-style-type: none"> The issuer if insured The plan sponsor if self-insured
Health or major medical coverage under multiple policies or plans	Yes	<ul style="list-style-type: none"> Each issuer or plan sponsor Special rules apply for coverage under multiple applicable self-insured health plans (see below)
COBRA coverage	Yes	<ul style="list-style-type: none"> The issuer if insured The plan sponsor if self-insured
Health Reimbursement Arrangement (HRA)	Yes, unless it meets the requirements for being treated as an excepted benefit	<ul style="list-style-type: none"> The plan sponsor Special rules apply for coverage under multiple applicable self-insured health plans and special counting rules for HRAs
Flexible Spending Arrangement (FSA)	No, as long as it's a HIPAA-excepted benefit (most FSAs will be HIPAA-excepted and thus avoid the fee).	N/A
Stand-alone dental or vision coverage	No	N/A
Group insurance policy or health plan designed specifically to cover primarily employees who are working and residing outside of the U.S.	No	N/A
Medicare Advantage and Medicare Part D	No	N/A
Medigap and Medicare supplemental plans	No	N/A
Health Savings Arrangements (HSAs)	No	N/A
Archer Medical Savings Accounts (MSAs)	No	N/A
Stop-loss or indemnity reinsurance	No	N/A

Type of Insurance or Arrangement	Subject to the Fee?	Person Responsible for Paying and Reporting the Fee
EAPs, disease management programs and wellness programs	No, provided the program does not provide significant benefits in the nature of medical care or treatment.	N/A
Accident and health coverage or major medical insurance coverage	Yes	<ul style="list-style-type: none"> • The issuer if insured • The plan sponsor if self-insured
Retiree-only health or major medical coverage	Yes	<ul style="list-style-type: none"> • The issuer if insured • The plan sponsor if self-insured
Health or major medical coverage under multiple policies or plans	Yes	<ul style="list-style-type: none"> • Each issuer or plan sponsor • Special rules apply for coverage under multiple applicable self-insured health plans (see below)
COBRA coverage	Yes	<ul style="list-style-type: none"> • The issuer if insured • The plan sponsor if self-insured
Health Reimbursement Arrangement (HRA)	Yes, unless it meets the requirements for being treated as an excepted benefit	<ul style="list-style-type: none"> • The plan sponsor • Special rules apply for coverage under multiple applicable self-insured health plans and special counting rules for HRAs
Flexible Spending Arrangement (FSA)	No, as long as it's a HIPAA-excepted benefit (most FSAs will be HIPAA-excepted and thus avoid the fee).	N/A
Stand-alone dental or vision coverage	No	N/A
Group insurance policy or health plan designed specifically to cover primarily employees who are working and residing outside of the U.S.	No	N/A
Medicare Advantage and Medicare Part D	No	N/A
Medigap and Medicare supplemental plans	No	N/A
Health Savings Arrangements (HSAs)	No	N/A
Archer Medical Savings Accounts (MSAs)	No	N/A
Stop-loss or indemnity reinsurance	No	N/A

Type of Insurance or Arrangement	Subject to the Fee?	Person Responsible for Paying and Reporting the Fee
EAPs, disease management programs and wellness programs	No, provided the program does not provide significant benefits in the nature of medical care or treatment.	N/A
HIPAA-excepted benefits such as accidental death and dismemberment benefits	No	N/A
Disability income coverage	No	N/A
Automobile medical payment coverage	No	N/A
Workers' compensation or similar coverage	No	N/A
On-site medical clinic	No	N/A

RESPONSIBLE PARTY FOR PAYMENT

For an insured plan, the insurer is responsible for paying the fee, regardless of whether the plan is maintained by a single employer or multiple employers, or is a multiemployer plan.

The responsible payor for a self-insured plan is the “plan sponsor,” which varies by the type of plan. For example, the employer or employee organization is the “plan sponsor” of a plan established or maintained by a single employer or employee organization. For a multiemployer plan, the joint board of trustees is the plan sponsor; and for a multiple employer welfare arrangement, the committee (if any) is the plan sponsor. In the case of a plan that is not sponsored by one of the entities specifically mentioned in the proposed regulations (for example, a plan maintained by two or more employers that is not a multiemployer plan), the plan sponsor is the person identified as such under the terms of the plan, or the person designated by the terms of the plan as the plan sponsor for purposes of this requirement, provided that the designation and acceptance is completed by the filing due date. Furthermore, if no designation has been made, then each employer that maintains the plan is the plan sponsor (with respect to that employer’s employees).

This rule is particularly noteworthy because the regulations do not include controlled group rules that would treat related entities as a single entity for purposes of paying the fee (which, again, is imposed on the sponsor of a self-insured health plan). Therefore, if a plan is adopted by multiple members of a controlled group for the benefit of each company’s employees, employers should make sure the plan documentation clearly states which entity is the plan sponsor for purposes of paying this fee. If the documents do not specify a plan sponsor, each controlled group member could owe a fee for its covered employees (and their dependents).

COUNTING COVERED LIVES/PARTICIPANTS

The fees imposed by the PCORI regulations are based upon the average number of lives covered by the policies, and the average number of lives covered by the self-insured plans, respectively. Lives include all persons covered, including employees, spouses, dependents, domestic partners, and retirees, unless an exception applies. There are different methods for counting the number of covered lives under insurance policies and self-insured plans.

Counting Methods for Insurance Policies. Insurers may choose from four different methods to determine the average number of lives covered, as described below:

- **Actual Count method:** Insurers may calculate the sum of lives covered for each day of the policy year and then divide that sum by the number of days in the year.
- **Snapshot method:** Insurers may calculate the sum of the lives covered on one date in each quarter of the policy year (or an equal number of dates in each quarter) and then divide that number by the number of days on which a count was made. The dates used in the second, third, and fourth quarters must be within three days of the date in that quarter that correspond to the date used for the first quarter. Moreover, all dates used must fall within the same policy or plan year.
- **Member Months method:** Insurers may determine the average number of lives covered based on the “member months” reported on the National Association of Insurance Commissioners Supplemental Health Care Exhibit (the “Exhibit”) divided by 12.
- **State Form method:** An insurer that is not required to file the Exhibit may use data in any form that is equivalent to the Exhibit that is filed with the applicable state if the state form reports lives covered in the same manner as member months reported on the Exhibit.

Counting Methods for Self-Insured Plans. Plan sponsors can choose from three different methods to determine the average number of lives covered by the plans, as described below:

- **Actual Count method:** Plan sponsors may calculate the sum of the lives covered for each day in the plan year and then divide that sum by the number of days in the year.
- **Snapshot method:** Plan sponsors may calculate the sum of the lives covered on one date in each quarter of the year (or an equal number of dates in each quarter) and then divide that number by the number of days on which a count was made. The number of lives covered on any one day may be determined by counting the actual number of lives covered on that day or by treating those with self-only coverage as one life and those with coverage other than self-only as 2.35 lives. The dates used in the second, third, and fourth quarters must be within three days of the date in that quarter that correspond to the date used for the first quarter. Moreover, all dates used must fall within the same policy or plan year.
- **Form 5500 method:** Sponsors of plans offering self-only coverage may add the number of employees covered at the beginning of the plan year to the number of employees covered at the end of the plan year, in each case as reported on Form 5500, and divide by 2. For plans that offer more than self-only coverage, sponsors may simply add the number of employees covered at the beginning of the plan year to the number of employees covered at the end of the plan year, as reported on Form 5500.

NOTE: Applicable self-insured health plans that provide accident/health coverage through fully insured options and self-insured options may disregard the individuals covered solely under the fully insured options for purposes of the fees. Of course, the disregarded individuals would still be counted by the issuer in determining fees due for the applicable insurance policy.

Special counting rules apply to FSAs and HRAs. In general, the plan sponsor of an HRA or an FSA that is not HIPAA-exempted (and therefore, subject to the fees discussed herein) may treat each participant’s HRA or FSA as covering a single covered life for counting purposes, and therefore, the plan sponsor is not required to count any spouse, dependent or other beneficiary of the participant. If the plan sponsor maintains another self-insured health plan, participants in the HRA or non-exempted FSA who also participate in the other self-insured health plan only need to be counted once for purposes of determining the fees applicable to the self-insured plans.

Special rule for coverage under multiple applicable self-insured health plans. Generally, separate fees apply for lives covered by each specified health insurance policy or applicable self-insured health plan. However, two or more applicable self-insured health plans may be combined and treated as a single applicable self-insured health plan for purposes of calculating the PCORI fee but only if the plans have (1) the same plan sponsor and (2) the same plan year.

For example, if amounts in an HRA may be used to pay deductibles and copays under a specified health insurance policy, the HRA (an applicable self-insured health plan) and the policy would be subject to separate PCORI fees. However, an HRA that may be used to pay deductibles and copays under the applicable self-insured health plan is not subject to a separate fee (and the fee will apply only to the applicable self-insured health plan) if both the HRA and the applicable self-insured health plan have the same plan sponsor and the same plan year.

12.22 FORM 8928 REPORTING (IRS)

This requirement was effective starting with the 2010 tax year, and requires employer to self-report certain failures by group health plans, and pay the applicable excise tax.

The following types of failures that must be reported include the following:

Failure to provide the required level of pediatric vaccine coverage.

- Failure to offer COBRA continuation coverage to a qualified beneficiary.
- Failure to comply with HIPAA's limitations on pre-existing condition exclusions.
- Failure to provide HIPAA certificates of creditable coverage.
- Failure to comply with HIPAA's special enrollment requirements.
- Failure to comply with nondiscrimination in eligibility to enroll and premium contributions (i.e., HIPAA's nondiscrimination rules related to health factors).
- Failure to permit 48-hour and 96-hour hospital length of stay in connection with childbirth for mothers and newborns.
- Failure to provide parity in mental health benefits and substance use disorder benefits.
- Failure to make comparable Health Savings Account ("HSA") contributions.
- Failure to comply with the ACA's coverage mandates and market reforms.

The amount of the excise tax is generally \$100 per individual per day of noncompliance (failure to make comparable HSA contributions generally results in a 35% excise tax on all employer HSA contributions).

Certain reportable HIPAA and COBRA failures that are due to "reasonable cause and not willful neglect" may not be subject to the excise tax, provided that any such failures (1) were undiscovered despite exercising reasonable diligence, and (2) were corrected within 30 days after discovery (or the date on which the failure should have been known). However, once a plan receives notice that the IRS intends to examine the plan, the "reasonable cause" exception is limited. In such cases, the following excise taxes apply:

- \$2,500 per affected individual for de minimis violations; and
- \$15,000 per affected individual for violations that are not de minimis

Under these circumstances, the tax is limited to 10 percent of the aggregate amount paid by the group health plan during the preceding year, and potentially limited by other caps provided on the Form. Failures that are not due to "reasonable cause" are generally not subject to the limits described above.

If an employer must file Form 8928, it generally must do so no later than the company's income tax return due date for the applicable year (regardless of any extensions. Note, however, that an automatic 6-month extension may be obtained by filing Form 7004 by the regular due date (along with the taxes).

A late filing results in a penalty of 5% of the unpaid tax for each month (or fraction thereof) the return is not filed (up to 25%). Additional penalties apply if the tax is not timely paid (one-half of one percent of the unpaid tax for each month (or fraction thereof) the tax is not paid (up to 25%), unless the failure to file or pay was due to reasonable cause and not to willful neglect (as described above). These penalties are in addition to the interest charge imposed on unpaid taxes at the rate set by the IRS.

12.23 HEALTH INSURANCE EXCHANGES (PPACA)

Each State was required to have a Health Insurance Exchange (an “Exchange”) for its individual market established and operational by January 1, 2014, which was required to include a Small Business Health Options Program (a “SHOP Exchange”). HHS has also provided for a Federally-Facilitated SHOP (FF-SHOP) in states that do not established a state-based Exchange.

On May 15, 2017, the Centers for Medicare and Medicaid Services announced in a press release that it was planning to essentially end the FF-SHOP exchange, which covers 33 states, as of the end of 2017 because “insurance company and agent/broker participation, as well as overall enrollment in the Federally-Facilitated SHOP Marketplace has been lower than anticipated and, at its current pace, is unlikely to reach expectations and, at its current pace, is unlikely to reach expectations.” In the announcement, HHS indicated its intention to issue proposed regulations that would change the enrollment process for small employers purchasing plans in the FF-SHOP. According to the announcement, for plan years beginning on or after January 1, 2018, the proposed regulations would eliminate the FF-SHOP’s enrollment function, and small employers instead would enroll directly with an insurer offering SHOP plans or with the assistance of an agent or broker registered with the FF-SHOP. The announcement states that employers would still use the Healthcare.gov website to obtain a determination of eligibility. This proposal would change the way the FF-SHOP operates. HHS also anticipates that state-based SHOPS would be able to provide for online enrollment, or opt to direct small employers to insurers and SHOP-registered agents and brokers to directly enroll in SHOP plans.

The SHOP Marketplace is generally open to employers with 1-50 full time-equivalent employees (FTEs) (generally, those working 30 or more hours per week on average). (In some states, for example, Virginia, the FF-SHOP Marketplace is open to employers with 1-100 FTE employees.) Employers with fewer than 25 employees may qualify for a tax credit if they buy insurance through the SHOP Marketplace.

Employer eligibility for a SHOP Exchange is based partially on state law. Plans available through the Exchanges are classified along the so-called “precious metal” spectrum, each with a corresponding actuarial value: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90% actuarial value of benefits provided under the plan).

To be eligible to participate in an Exchange, an employer must have its primary office in the Exchange service area and offer all its employees coverage through that SHOP, or offer coverage to each eligible employee through the SHOP servicing the employee’s primary worksite. If a qualified employer ceases to be qualified solely because of an increase in the number of employees, HHS proposed regulations require the SHOP to continue treating the employer as qualified until the employer either fails another eligibility requirement or elects to no longer purchase coverage for its employees through the SHOP.

The ACA requires each SHOP to provide the “employee choice model,” in which the employer chooses a level of coverage and a contribution amount and employees then select any plan at that level. On March 8, 2016, the Department of Health and Human Services (HHS) published a final rule taking the next step in implementing “employee choice” in the SHOP. “Employee choice” provides employers the opportunity to allow employees to choose any health plan at the actuarial value or “metal” level selected by the employer. HHS finalized the addition of a new “vertical choice” model for Federally-facilitated SHOPS (FF-SHOPS) and State-based Exchanges using the Federal platform for SHOP eligibility and enrollment (SBE-FP). For plan years beginning on or after January 1, 2017, employers will be able to offer qualified employees a choice of all plans across all available actuarial value levels of coverage from a single issuer.

Small business markets differ from state-to-state. In order to provide for State-specific evaluations of the impact of vertical choice on adverse selection and resulting changes in plan pricing, and to provide for more uniform small group market coverage options both on and off-Exchange, HHS provided states with additional flexibility by allowing State Insurance Commissioners to recommend that the FF-SHOP in their state not implement vertical choice. Similarly, States with SBE-FPs utilizing the Federal platform for SHOP enrollment functions will be able to opt out of making vertical choice available in their States.

In States where vertical choice is available, a qualified employer would have a choice of three coverage options for both Qualified Health Plans (QHPs) and stand-alone dental plan (SADPs): a single plan, all available plans at a single level of coverage (horizontal choice, as required by the statute), and a choice of all plans offered by a single issuer across all levels of coverage (vertical choice). In States where vertical choice is not an available option for qualified employers, the single plan option and horizontal choice option would continue to be available to qualified employers.

Under the final rule, HHS recommended that a State with an FF-SHOP that wished to recommend against offering vertical choice in that State submit a letter to HHS in the summer before the following year, describing and justifying the State's recommendation, based on the anticipated impact vertical choice would have on the small group market and consumers. A stat-based exchange using the federal enrollment platform (SBE-FP) for SHOP enrollment functions may decide against offering vertical choice by notifying HHS of that decision prior to the beginning of the QHP certification process each year. A list of all states with a FF-SHOP or SBE-FP using the federal platform for eligibility and enrollment functions can be found [here](#) and provides information on whether vertical choice will be available to SHOP consumers for the 2020 plan year. In total, 34 states with a FF-SHOP or an SBE-FP state using the federal platform for eligibility and enrollment functions allowed for vertical choice for plan year 2020.

12.24 EMPLOYEE NOTICE OF EXCHANGE AVAILABILITY (PPACA)

On May 8, 2013, the United States Department of Labor (DOL) released welcomed guidance (Technical Release No. 2013-02) about the "Exchange Notice" requirement under the PPACA.

The ACA requires states to establish an exchange (or "Marketplace") through which insurance carriers will offer insurance coverage to individuals (and small businesses (under 100 or under 50 employees, depending on state law)).

Employers subject to the Fair Labor Standards Act (FLSA) must provide notice of the availability of Marketplace coverage to all employees. Employees hired on or after October 1, 2013 must be given the notice within 14 days of their start date. Two model notices were issued by the DOL – one [for employers who offer health care coverage to some or all employees](#) and one [for employers who do not](#).

NOTICE TO ALL EMPLOYEES

The Technical Release requires employers to provide the Marketplace notice to all employees, regardless of plan enrollment or eligibility status or of part-time or full time status. However, employers are not required to provide a separate notice to spouses or dependents eligible for coverage under the plan.

FORM AND CONTENT OF THE NOTICE

The Marketplace notice must inform employees of the existence of the Marketplace as well as contact information and description of the services provided by a Marketplace. The notice must also inform the employee that the employee may be eligible for a premium tax credit (subsidy) if he or she does not have access to affordable coverage and purchases qualified coverage through the Marketplace. Employees must also be informed that the purchase of health coverage through a Marketplace will terminate eligibility for employer premium contributions (if any) to any health benefits plan offered by the employer and that all or a portion of those employer contributions may be excludable from the employee's income for Federal income tax purposes.

There is one model for employers that do not offer a health plan and another model for employers who offer a health plan to some or all employees. Employers may use one of these models, as applicable, or a modified version, provided the notice meets the content requirements described above.

TIMING AND DELIVERY OF NOTICE

Employers are required to provide the new Marketplace notice to each new employee on the start date or within 14 days of the start date.

Hand delivery, delivery by first-class mail or in accordance with the DOL's electronic disclosure requirements (found at 29 CFR 2520.104b-1(c)) is acceptable.

MODEL NOTICES

In addition to the information described above, the model Marketplace notice must include information employees will need to apply for coverage through a Marketplace, including:

- Employer name and Employer Identification Number;
- Employer address and phone number;
- The name, phone number, and email address of an employer contact who can discuss employee health coverage with Marketplace officials;
- Information about any health coverage offered by the employer, including whether health coverage is offered to some or all employees, eligibility criteria, and availability of dependent coverage; and
- Whether the employer coverage meets the ACA's 60% minimum value standard, and whether the cost of this coverage to the employee meets the "affordability test" under the ACA.

12.25 EMPLOYER SHARED RESPONSIBILITY TRANSITION RELIEF (“PAY OR PLAY”) (PPACA)

Prior to 2016, there was various transition relief from the Pay or Play penalties. Currently, there is none.

12.26 APPLICABLE LARGE EMPLOYER REPORTING REQUIREMENTS (PPACA)

The ACA added Sections 6055 and 6056 to the Internal Revenue Code (the “Code”). These new sections require employers, plan sponsors, and health insurance issuers to report health coverage information to the IRS and to employees annually.

Code Section 6055 requires insurance issuers, self-insured health plan sponsors, governmental agencies, and any other entities that provide minimum essential coverage (e.g., multi-employer plans) to report information on that coverage to the IRS and covered individuals.

The Code Section 6056 reporting requirements apply to “applicable large employers” (ALEs) – generally employers with 50 or more full time equivalent employees (FTEs) – and require reporting of health care coverage provided to the employer’s full time employees.

Appendix A includes a comprehensive guide to the ACA reporting for employer reviewing the forms and instructions for the most recent reporting year (i.e., 2018).

12.27 WAITING PERIODS AND ORIENTATION PERIODS (PPACA)

Final regulations (“Final Regulations”) issued by regulatory agencies in charge of health care reform guidance (the Departments of Labor, Treasury, and Health and Human Services) clarifying the relationship between a group health plan’s eligibility provisions and the Affordable Care Act’s (ACA) 90-day limit on waiting periods. Specifically, the Final Regulations address an employer’s ability to require new employees to satisfy a “reasonable and bona fide employment-based orientation period” before starting a group health plan’s waiting period.

The Final Regulations on orientation periods are effective for plan years beginning in 2015.

90-DAY LIMIT ON WAITING PERIODS

The ACA prohibits group health plans from requiring otherwise eligible employees to wait longer than 90 days for coverage to be effective once an employee is eligible to enroll under the terms of the plan. This requirement became effective starting with plan years beginning in 2014. Being “otherwise eligible” to enroll means having met the plan’s substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan’s terms). Thus, under the waiting period rules, once an individual is determined to be otherwise eligible for coverage under a group health plan’s terms,

any waiting period for coverage may not extend beyond 90 days. All calendar days are counted, including weekends and holidays. In other words, coverage must be effective no later than the start of the 91st day after the employee becomes eligible.

FINAL REGULATIONS ON ORIENTATION PERIODS

Final Regulations allows plans to use “orientation periods” of up to one month in addition to a 90-day waiting period as long as the period is a reasonable and bona fide employment-based orientation period. They clarify that orientation periods are “reasonable” and “bona fide” based on all relevant facts and circumstances. Employers should review the terms of their group health plans and work with qualified ERISA counsel to ensure that any orientation period is reasonable, bona fide and employment-based, and not merely a subterfuge for the passage of time.

The Final Regulations provide little explanation or guidance as to the circumstances under which an orientation period might satisfy these requirements; however, they clarify that the one-month limit on orientation periods is determined by adding one calendar month and subtracting one calendar day, measured from an employee’s start date in a position that is otherwise eligible for coverage.

For example, if an employee’s start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee’s start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee’s start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee’s start date is August 31, the last permitted day of the orientation period is September 30.

COMPLIANCE WITH THE EMPLOYER MANDATE

The Final Regulations note that compliance with the orientation period and waiting period rules is not determinative of whether an employer has complied with the ACA’s “Pay or Play” employer mandate. An employer subject to the mandate may be exposed to tax penalties if it fails to offer affordable minimum value coverage to certain newly-hired full time employees by the first day of the fourth full calendar month of employment.

For example, an employer that has a one-month orientation period may comply with both the waiting period rules and the employer mandate by offering coverage no later than the first day of the fourth full calendar month of employment. However, the employer would not be able to impose the full one-month orientation period and the full 90-day waiting period without potential exposure to a penalty under the employer mandate. For example, if an employee is hired as a full time employee on January 6, a plan may offer coverage May 1 (first day of the fourth full month of employment) and comply with both the orientation period and waiting period provisions. However, if the employer starts coverage May 6, which is one month plus 90 days after date of hire, the employer may be exposed to a penalty under the employer mandate.

Employers should consider application of the Pay or Play mandate when structuring eligibility and waiting periods to ensure that coverage is offered to new full time employees no later than the first day of the fourth full calendar month of employment.

12.28 OUT-OF-POCKET LIMITS (PPACA)

Under the ACA, all non-grandfathered group health plans must ensure that annual out-of-pocket (OOP) cost sharing (e.g., deductibles, coinsurance and co-payments) for in-network essential health benefits does not exceed certain limits, as shown below:

ACA OOP Maximums on Essential Health Benefits

ACA OOP Maximums on Essential Health Benefits			
	Plan years beginning in 2017	Plan years beginning in 2018	Plan years beginning in 2019
Individual (Self-only)	\$7,150	\$7,350	\$7,900
Family	\$14,300	\$14,700	\$15,800

INDIVIDUAL LIMIT APPLIES TO FAMILY PLAN

HHS clarified that the ACA’s out-of-pocket limits apply to each individual, even those enrolled in family coverage if the plan’s family OOP maximum exceeds the ACA’s OOP limit for self-only coverage (i.e., “embedded” individual maximums on essential health benefits).

For example, if an employee is enrolled in family coverage and one member of the family reaches the individual OOP maximum on essential health benefits (\$7,900 in 2019), that family member cannot incur additional cost-sharing expenses on essential health benefits, even if the family has not collectively reached the family maximum (\$15,800 in 2019).

OUT-OF-POCKET LIMITS APPLY TO ALL PLANS – LARGE GROUP & SELF-INSURED

The DOL has confirmed that HHS’ clarification applies to all non-grandfathered group health plans, including large group and self-insured plans. Meaning all non-grandfathered plans must contain an embedded individual out-of-pocket limit for family coverage. For these purposes, family coverage includes any tier of coverage other than employee-only.

OUT-OF-POCKET LIMITS APPLY TO HIGH-DEDUCTIBLE PLANS

The federal agencies have confirmed that these rules apply to high-deductible health plans (HDHPs). The embedded out-of-pocket limit rules do not impact HSA-qualified HDHPs, as a family HDHP will not be required to start paying medical claims under the ACA out-of-pocket rule until the minimum annual deductible for family HDHP coverage is satisfied. In other words, by the time the embedded individual out-of-pocket limit is reached, the employee will have satisfied the minimum annual deductible for HDHP coverage. Therefore, one family member could incur expenses above the HDHP self-only OOP maximum (\$6,750 in 2019).

For example, assume that a spouse incurs expenses of \$10,000, \$7,900 of which relate to essential health benefits, and no other family member has incurred expenses. The spouse has not reached the HDHP maximum (\$13,500 in 2019), which applies to all benefits, but has met the self-only embedded ACA maximum (\$7,900 in 2018), which applies only to essential health benefits. Therefore, the spouse cannot incur additional OOP expenses related to essential health benefits and the plan pays the remaining \$2,100 of the \$10,000 charge; however, the spouse can incur OOP expenses on non-essential health benefits up to the HDHP family maximum (factoring in expenses incurred by other family members).

Minimum deductibles for HDHPs and contribution and out-of-pocket limits for HSAs are shown in the table below:

HDHP/HDSA Limits			
	Minimum Annual Deductible for HDHP 2019	Maximum Annual HSA Contribution 2019	Maximum Annual Out-of-Pocket 2019
Individual	\$1,350	\$3,500	\$6,750
Family	\$2,700	\$7,000	\$13,500

12.29 THE CADILLAC TAX (40% TAX ON HIGH-COST HEALTH COVERAGE)

The “Cadillac Tax” (governed under IRC §4980I) imposes a 40% tax on the aggregate cost of “applicable employer-sponsored coverage” (including employer-sponsored group health plan and multiemployer plan coverage) in excess of certain “applicable dollar limits” adjusted annually for inflation. The Cadillac Tax was initially scheduled to take effect in 2018 but subsequent legislation has delayed it until 2022. The law sets the annual limit to \$10,200 for self-only coverage and \$27,500 for family coverage, with the limits set to increase by the consumer price index (CPI) plus 1 percentage point in 2019 and 2020, and by the CPI thereafter.

The 40% tax is imposed on the “coverage provider,” which is the health insurance carrier in the case of an insured group health plan, the employer with respect to a health savings account or Archer medical savings account, or in all other cases, the “person that administers the plan benefits.” However, it is anticipated that the cost would be passed through to health plan participants. The tax is intended to raise revenue and control health care costs by reducing excessive health care spending.

In February 2015, the IRS released the first notice, Notice 2015-16, which focused on three major issues affecting administration of the Cadillac Tax, namely: what types of coverage constitute “applicable employer-sponsored coverage” potentially subject to the Cadillac Tax; how the “cost” of applicable coverage is determined; and how the annual dollar limits are applied. Also, while the Cadillac Tax was originally non-tax deductible, changes in the law that occurred in December 2015 make it tax deductible for employers who pay it.

WHAT CONSTITUTES APPLICABLE COVERAGE SUBJECT TO CADILLAC TAX

The Cadillac Tax applies to excess benefits received by an employee under “applicable employer-sponsored coverage.” The February Notice confirms that applicable employer-sponsored coverage is determined without regard to whether the employer or the employee pays for the coverage, whether on a pre- or post-tax basis, or whether the coverage is insured or self-insured.

Additionally, the Notice confirms that applicable coverage includes, but is not limited to, health FSAs, HSAs, Archer MSAs, and multiemployer plans. The IRS anticipates that future proposed regulations will provide that employer contributions to HSAs and Archer MSAs, including salary reduction contributions, will be included in applicable coverage, and after-tax contributions will be excluded. Also included is coverage for on-site medical clinics, although the IRS may provide an exception for clinics that offer only de minimis medical care (e.g., first aid) to employees.

The Notice acknowledges an issue regarding self-insured dental and vision coverage that was a particular concern for many employers. Under the statute, only insured dental and vision benefits are specifically excluded from the Cadillac Tax. The Notice indicates that the IRS is considering adopting an approach under which both insured and self-insured dental and vision benefits are excluded from the Cadillac Tax, provided that the benefits are offered under stand-alone plans that otherwise satisfy the revised rules on expected benefits.

THE COST OF APPLICABLE COVERAGE

By statute, the cost of coverage for Cadillac Tax purposes is determined using rules “similar to” those for defining applicable premiums of COBRA coverage. The February Notice addresses the COBRA rules likely to inform the IRS as it proposes rules applicable to the Cadillac Tax, while at the same time indicating possible changes to the rules under Cobra.

- Under COBRA, the applicable premium is based on the cost of coverage for similarly situated non-COBRA beneficiaries. The IRS indicates that it will adopt a similar standard for purposes of the Cadillac Tax, and it invites comments on an approach under which a group of similarly situated employees would be determined by starting with all employees covered by a particular benefit package, then subdividing that group based on mandatory disaggregation rules (based on whether an employee is enrolled in self-only coverage or other-than-self-only coverage), and then allowing further subdivision based on permissive disaggregation rules (based on the number of individuals covered in addition to the employee, and potentially other distinctions traditionally made in the group insurance market).
- Regarding permissive disaggregation, the IRS is considering whether disaggregation should be permitted based on (a) a broad standard (such as a bona fide employment-related distinction like job category or nature of compensation, or (b) a more specific standard (such as a list of specific categories for which disaggregation is allowed). If a more specific standard is preferable, the IRS invited comments on which specific criteria should be permitted.
- Notably, the IRS confirmed that the Cadillac Tax rules do not require that the cost of coverage be determined separately based on the number of individuals who are receiving coverage in addition to the employee. Therefore, the IRS is considering an approach whereby employers would be permitted to use just one cost of coverage for other-than-self-only coverage (even if the actual cost of such coverage varies depending on how many individuals other than the employee are covered). The approach being considered by the IRS appears to suggest that it would be permissible to have only two costs of coverage for purposes of the Cadillac Tax (self- and other-than-self-only), even if under COBRA the costs of the same coverage were broken down further into how many individuals other than the employee were covered (e.g., employee plus one, employee plus two, family, etc.).
- The COBRA regulations provide two methods for self-insured plans to use when developing the COBRA-applicable premium – the actuarial basis method and the past cost method. Concerned about the possibility of abuse in a plan that switches between these methods frequently, the IRS is considering, for purposes of the COBRA regulations and the Cadillac Tax, rules that would generally require a plan to use its chosen valuation method for at least five years. The IRS invites comments on whether these approaches should be adopted for the Cadillac Tax.

The Notice also addresses a number of other issues concerning the cost of applicable coverage:

- The Notice clarifies that the applicable cost of applicable coverage refers to coverage in which an employee is enrolled, and not coverage that is merely offered to the employee.
- The Notice confirms that any coverage under a multiemployer plan is treated as other-than-self-only coverage for purposes of the Cadillac Tax.
- The Notice confirms that the cost of applicable coverage for health FSAs equals the sum of salary reduction contributions and also any reimbursements under the arrangement in excess of the salary reduction contributions, such as employer flex credits.
- The IRS also indicated that a Health Reimbursement Arrangement (HRA) constitutes applicable coverage. The IRS is considering various methods of determining the cost of coverage for HRAs, including: (i) basing it on the amounts made newly available to a participant each year; (ii) adding together all claims and administrative expenses attributable to HRAs for a particular period and dividing that sum by the number of employees covered for that period; and (iii) using the actuarial basis method. Comments also were requested on issues relating to whether the cost of applicable coverage should not include (i) an HRA that can be used only to fund the employee contribution toward coverage, and/or (ii) an HRA that can be used to cover a range of benefits, some of which would not be applicable coverage.
- The IRS also invited comments on whether alternative methods for calculating the cost of applicable coverage would be consistent with the statute. This is response to certain stakeholder suggestions that the cost of applicable coverage be determined by reference to similar coverage elsewhere (e.g., on the Health Insurance Marketplace).

THE APPLICABLE DOLLAR LIMIT

There are two applicable dollar limits – self-only coverage (estimated at \$10,200 in 2018) and other-than-self-only coverage (estimated at \$27,500 in 2018). In Notice 2015-16, the IRS addresses certain related issues:

- Acknowledging the potential for an employee simultaneously to have different types of coverage to which different dollar limits apply, the IRS is considering determining the applicable dollar limit based on whether an employee's primary coverage/major medical coverage (i.e., the type of coverage that accounts for the majority of the aggregate cost of applicable coverage) is self-only or other-than-self-only coverage. Alternatively, a composite dollar limit could be determined by prorating the dollar limits for each employee according to the ratio of the cost of the self-only coverage and the cost of the other-than-self-only coverage. The IRS invited comments on these approaches.
- Under the statute, an additional amount is added to the dollar limits for an individual “who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunication lines” (including a retired employee who satisfied these requirements for at least 20 years). The IRS requested comments on how to determine whether the majority of employees covered by the plan are so engaged, what the term “plan” means for this purpose, how to make the 20-year determination, and whether further guidance on the definition of a “high-risk profession” is needed.
- Under the statute, the applicable dollar limits may be increased by an age and gender adjustment if the age and gender characteristics of a particular employer are less favorable than the national workforce. The IRS invited comments on whether it would be desirable or possible to develop safe harbors to assist employers in adjusting the dollar limits for their particular workforce.

ADDITIONAL GUIDANCE ISSUED ON JULY 30, 2015

On July 30, 2015, the IRS issued Notice 2015-52 to supplement Notice 2015-16 (discussed above). The new IRS guidance proposes additional approaches related to (1) identification of the coverage provider (i.e., the person or entity responsible for paying the tax), (2) determining the cost of applicable coverage, (3) age and gender adjustments to the applicable dollar limit and (4) notice and payment of the Cadillac Tax. Below is a summary of the key approaches described by the IRS in Notice 2015-52.

The IRS emphasized that Notice 2015-52 is not guidance on which taxpayers may rely. Although this latest notice (like Notice 2015-16 before it) is not formal guidance for Section 4980I purposes, it is likely that the issues addressed in the Notice will ultimately be reflected in proposed regulations under Section 4980I (assuming attempts to legislatively repeal the provision are unsuccessful). For that reason, employers and their advisors may wish to familiarize themselves with positions the IRS has taken in its two notices and offer comments to shape the upcoming proposed regulations. As one example, some of the proposals regarding capturing age and gender characteristics could involve a fair amount of administrative complexity for employers.

IDENTIFICATION OF THE COVERAGE PROVIDER

The coverage provider is easily identified in the case of an insured plan or a health savings account. However, in all other cases, the coverage provider is the “person that administers the plan benefits.” Because neither the ACA nor ERISA contains guidance on identifying the person or entity that administers plan benefits, the IRS has proposed two approaches to assist in identifying the coverage provider.

Under the first approach, the coverage provider would be the person or entity responsible for performing day-to-day functions related to administration of the plan (e.g., processing claims or handling participant inquiries). In many cases, this would be a third-party benefits administrator. Under the second approach, the coverage provider would be the person or entity that has the ultimate authority or responsibility with respect to administration. Usually, this would be the plan administrator that is defined in the plan, such as a benefits administration committee that has been delegated administrative duties.

Either approach will present challenges for employers. For example, a single third-party rarely administers all benefits considered “applicable coverage” under Code Section 4980I. It is not uncommon to have separate administrators for medical benefits, pharmacy benefits, mental health and substance abuse benefits and flexible spending benefits. Employers would need to determine which portion of the 40% Cadillac Tax should be allocated to each administrator.

CALCULATION OF THE COST OF APPLICABLE COVERAGE

- **Timing Issues.** In order to timely pay the 40% Cadillac Tax, coverage providers must determine the cost of applicable coverage shortly after the taxable period (which the IRS indicated will likely be the calendar year for all taxpayers, regardless of plan year). This presents challenges for self-insured plans that cannot determine the cost of coverage until claims incurred prior to the end of the taxable period are submitted. Therefore, the IRS requested comments on whether a claims run-out period would be appropriate. Additionally, experience-rated insurance policies often provide payments or discounts following a policy year. The IRS has requested comments on how these payments or discounts should be applied to the cost of applicable coverage.
- **Excluding Income Tax Reimbursements from the Cost of Applicable Coverage.** If an entity other than the plan sponsor is responsible for paying the 40% Cadillac Tax, that entity will likely pass the cost of the

tax through to the plan sponsor in the form of increased service fees. Code Section 4980I provides that the cost of applicable coverage does not include amounts attributable to the 40% Cadillac Tax. However, Code Section 4980I does not address what happens when the same parties that pass on the cost of the 40% Cadillac Tax also seek reimbursement of income taxes incurred due to the receipt of additional service fees. This raises an important question – should the amount passed-through in the form of increased service fees to reimburse for income taxes (in addition to the 40% Cadillac Tax reimbursement) be excluded from the cost of applicable coverage? The IRS has requested comments on administrable methods for excluding income tax reimbursements, including what tax rate to use. The IRS anticipates that Cadillac Tax and income tax reimbursements will be excludable from the cost of applicable coverage only if separately billed and identified.

- **Annual Contributions to Account-Based Plans.** The cost of applicable coverage includes employer and employee contributions to account-based plans, such as health savings accounts. The IRS recognized that annual contributions (as opposed to contributions made monthly or per pay period) could trigger a 40% Cadillac Tax in the month of contribution because the cost of applicable coverage is determined on a monthly basis. To avoid this result, the IRS indicated that it is considering an approach that would allow employers to apply annual contributions on a pro rata basis over the course of the taxable period when determining the cost of applicable coverage.
- **Flex-Credits and Carry-Overs under Flexible Spending Arrangements.** The cost of applicable coverage for benefits provided through a flexible spending arrangement (FSA) is the greater of the employee's contribution to the FSA or the total reimbursements made from the FSA. The IRS stated that when an employer contributes non-elective flex credits to an FSA on behalf of an employee, the cost of applicable coverage includes (1) the employee's contributions, and (2) the amount of non-elective flex credits actually used for reimbursements. This would prevent unused non-elective flex credits from being included in the cost of applicable coverage. The IRS also stated that it is considering a safe harbor approach for amounts carried-over from prior years to prevent double counting. Under this safe harbor, amounts carried-over from previous years will not be included in the cost of applicable coverage. The IRS plans to restrict the availability of this safe harbor if non-elective flex credits are available.
- **Inclusion of Amounts Taxable under Code Section 105(h).** Code Section 105(h) provides that the value of a discriminatory self-insured benefit provided to a highly compensated employee must be included in the employee's income. However, under 2012 guidance related to disclosing the cost of coverage for Form W-2 purposes, the IRS provided that the amount included in income should be excluded. Addressing this discrepancy, the IRS stated that it is the "coverage," not the resulting tax benefit that constitutes "applicable coverage" under Code Section 4980I. In other words, although a highly-compensated employee is taxed on the value of the discriminatory coverage, that coverage must be included in the cost of applicable coverage under Code Section 4980I.

OTHER PROPOSED APPROACHES

The IRS also described potential regulatory approaches related to the following:

- **Age and Gender Adjustments to the Applicable Dollar Limit.** The applicable dollar limits used to determine whether there is an excess benefit may be increased upward based on the age and gender characteristics of all employees of an employer. The IRS is considering rules allowing employers to determine these characteristics based on a "snapshot" on the first day of the plan year. The IRS also indicated that it is developing age and gender adjustment tables to assist employers in applying the adjustment.
- **Notice and Payment of the 40% Cadillac Tax.** Under Code Section 4980I, employers are required to calculate the 40% Cadillac Tax and notify the coverage provider and the Treasury of the amount of the tax, if any. The IRS has not yet determined the form of this notice but has indicated that coverage providers will likely pay the 40% Cadillac Tax using Form 720. Form 720 is a quarterly-filed form, but similar to payment of the PCORI fee, the 40% Cadillac Tax will only be paid once per year.

PREPARING FOR THE CADILLAC TAX

While the Cadillac Tax remains controversial and there is limited guidance as to how it will be implemented, assuming it is not repealed, below are steps that an employer can take to prepare for the Cadillac Tax and may wish to consider to reduce coverage costs:

- Monitor legislative and regulatory developments that would delay or repeal the tax;
- Review health care budgets and assess current coverage offerings to determine if they could be deemed high-cost in 2022 based on existing, limited guidance;
- If current coverage design is high-cost, consider:
 - separating coverage lines, such as ancillary dental and vision policies, that are exempt from taxable plans to reduce the total overall cost of coverage;
 - implementing high-deductible health care plans and guide employees to that coverage;
 - offering comprehensive voluntary insurance benefit options such as supplement insurance or other income replacement policies to employees (coverage for specified disease or hospital indemnity insurance must be paid for with after-tax dollars to avoid application of the Cadillac Tax) in lieu of current coverage;
 - shifting employee contributions from pre-tax to after-tax where after-tax contributions are excluded from the tax's calculation (e.g., for HSAs);
 - limiting or excluding spousal coverage or lower the cost of family coverage;
 - changing benefits (e.g., adding preauthorization, network or telemedicine provisions); and
 - increasing cost-sharing features such as deductibles and coinsurance; and
- Strengthen wellness options to improve overall health

Any changes, specifically, to cut benefits, should consider the impact on any potential employer mandate penalty as well as timing and potential labor issues (e.g., if employees are part of a collective bargaining unit). In addition, when negotiating insurance policies, administrative service agreements, and other third-party service agreements, employers should consider the potential tax (e.g., will it be passed to the employer and, if so, will an income tax reimbursement be added to the amount passed through) and whether the service provider's role in helping to determine the tax.

12.30 TRANSITIONAL REINSURANCE FEE

Employers with self-insured major medical plans were required to report their membership count to the U.S. Department of Health and Human Services ("HHS") via the pay.gov website each November 15 as part of the Affordable Care Act's ("ACA") transitional reinsurance fee (the "Fee"). The Fee was assessed on both insured and self-insured group health plans and applied on a calendar year basis from 2014-2016. The fee was \$63 per covered life in 2014, \$44 in 2015, and \$27 in 2016. Carriers offering group health insurance and sponsors of self-insured medical plans were required to pay the Fee to support payments to carriers in the individual market that cover high-cost claimants. Carriers paid the fee on behalf of fully insured plans; employers were responsible for paying the fee for a self-insured plan.

12.31 ACA NONDISCRIMINATION PROVISIONS (SECTION 1557)

In May 2016, the Department of Health and Human Services (HHS) published a final rule implementing Section 1557 of the Affordable Care Act (ACA), which prohibits discrimination on the basis of, among other grounds, sex (including gender identity) in certain health programs and activities. Specifically, entities covered under the rule cannot deny, cancel, limit or refuse to issue health coverage; deny or limit a claim; or impose additional cost sharing based on race, color, national origin, sex, age or disability.

The rule has broad implications for the provision of transgender- and gender transition-related medical treatment. It effectively requires many group health plans and employers to cover health care services provided to transgender individuals. The extent to which the rule may apply to a particular plan or employer involves some analysis; however, it is clear that HHS intends to encourage coverage of health care services for transgender individuals in the broadest manner possible.

The rule became effective for plan years beginning on or after January 1, 2017. Some aspects of the rule that require notices and accommodations for individuals with disabilities or limited English language skills became effective 90 days after the July 18, 2016 effective date of the final rule.

NONDISCRIMINATION REQUIREMENTS

With respect to transgender health benefits, a covered entity may not deny or limit coverage or impose additional cost sharing or other limitations for sex-specific health services provided to transgender individuals because the individual's gender identity or recorded gender is different from the one to which such health services are ordinarily provided. For example, when a plan covers medically appropriate pelvic exams, coverage cannot be denied for an individual for whom a pelvic exam is medically appropriate because the individual either identifies as a transgender man or is enrolled in the health plan as a man.

In addition, covered entities are prohibited from categorically excluding coverage for services related to gender transition. Exclusion of transition-related treatment as experimental or cosmetic is also prohibited. Transition-related services, which include treatment for gender dysphoria, are not limited to surgical treatments and may include, but are not limited to, services such as hormone therapy and psychotherapy, which may occur over the lifetime of the individual.

Covered entities may still use reasonable medical-management techniques and are not required to cover any particular treatment or procedure. However, they will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.

COVERED ENTITIES

The rule is sweeping in its coverage and scope. It applies to all health programs and activities that receive federal financial assistance through HHS, including Medicaid/CHIP, most providers that accept Medicare, student health plans, and issuers of Marketplace plans.

Therefore, the rule will apply directly to many health insurance issuers as well as hospitals, health clinics, state Medicaid agencies, community health centers, physician's practices and home health care agencies. These entities may not discriminate in the operation of their employee health benefit programs.

Employers who aren't principally engaged in providing health care or health coverage will be subject to these rules directly if they sponsor an employee health benefit program that receives federal funding through HHS, such as a retiree medical plan that participates in the Medicare Part D retiree drug subsidy program.

If they have not done so already, covered entities should determine whether there are plan exclusions or coverage limitations related to sex, gender dysphoria or sexual orientation. This would include categorical exclusions of gender-transition services. These exclusions should be removed for plan years beginning on or after January 1, 2017. In most cases, the cost of this additional coverage will be low, particularly because the number of participants for whom these benefits will be provided is likely to be very low.

Even employers that do not receive federal funding from HHS for a health program or activity can be affected by these rules through their health insurance carrier or third-party administrator (TPA), many of whom will be subject to Section 1557 directly.

It is important to note that Section 1557 can affect employers even if they're not subject to the rules directly. For example, if an employer has a plan design that is discriminatory under Section 1557 but HHS does not have jurisdiction (e.g., because the employer is not receiving any federal funding), HHS may refer the matter to the EEOC, who can pursue a claim under federal laws including Title VII and the Americans with Disabilities Act, both of which require that employee benefits be provided in a non-discriminatory manner.

EXEMPTIONS

The rule doesn't contain a new blanket religious exemption, although HHS has stated that the rule doesn't displace existing protections for religious freedom and conscience that already exist in federal laws such as the Religious Freedom Restoration Act. HHS also declined to exempt benefits that are excepted from the ACA's market reforms and portability requirements (e.g., limited scope dental and vision plans) from the Section 1557 final regulations. According to HHS, many excepted benefits are a "health program and activity" for Section 1557 purposes. Wellness programs are covered as an employee health benefit program whether or not they are part of the employer's health benefit plan as are employer-provided health clinics.

IMPLICATIONS

While many employers will not be subject to Section 1557 directly, it will impact their plan design if their carrier or TPA is a covered entity. Employer sponsors of self-insured plans should consult with their TPA to determine if the TPA is a covered entity and whether any plan design changes are recommended.

AFFORDABLE CARE ACT SECTION 1557 – NONDISCRIMINATION CHECKLIST

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities any part of which are receiving Federal financial assistance administered by the Department of Health and Human Services ("HHS").

If an employer sponsors a self-insured group health plan (the "Plan") that receives Federal funding from HHS (i.e., the retiree drug subsidy). It is not entirely clear whether an employer or the Plan is considered the "covered entity" subject to this law, although there is a reasonable argument that it is the Plan. Accordingly, the employer will need to ensure that the Plan complies with Section 1557.

The following chart highlights the requirements of the regulations that are applicable to the Plan.

Requirement	Satisfied?
<p>1. Nondiscrimination. The Plan may not discriminate on the basis of race, color, national origin, sex, age or disability (“protected groups”). Related requirements provide that the Plan:</p> <ul style="list-style-type: none"> A. May not have or implement a categorical coverage exclusion or limitation for all health services related to gender transition. B. May not deny or limit coverage or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. C. May not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual. D. May not deny, cancel, limit or refuse to issue or renew health coverage, or impose additional cost sharing or other limitations or restrictions on coverage on the basis of a protected group. E. May not directly or through contract utilize criteria or methods in the administration of the Plan that have the effect of discriminating. F. May not limit services to only one sex unless the limitation substantially related to the achievement of an important health or scientific objective. 	
<p>2. Designation of Responsible Employee & Adoption of Grievance Procedures. These requirements are only applicable to covered entities with 15 or more employees.</p>	
<p>3. Notice Requirements. The Plan must take initial and continuing steps to notify beneficiaries, enrollees, applicants and members of the public of the Section 1557 compliance.</p> <ul style="list-style-type: none"> A. A notice containing the information below must be provided in all significant Plan-related communications (e.g., SPD, open enrollment materials, SMMs, COBRA initial notice and election forms, claims and appeal notices, etc.), and must be posted on any website containing Plan information: <ul style="list-style-type: none"> i. A statement that the Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability with respect to administration of the Plan; ii. A statement that the Plan provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities; iii. A statement that the Plan provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency; 	

- i. How to obtain the aids described in (ii) and (iii) above;
- ii. How to file a complaint with the HSS Office of Civil Rights.

The notice described above must have taglines (i.e., a statement regarding where participants can get more information) at least in the top 15 languages spoken in the relevant state. A Plan that serves people in multiple states can aggregate the top languages spoken in the relevant states for purposes of determining the notice requirements (i.e., it does not need to have separate taglines for each state).

- B. The notice requirement in (a) above does not apply to small communications, such as a post card or tri-fold brochure. Instead, a notice containing only the language in (a)(i) and taglines for the top 2 languages spoken in the state must be included.
- C. This requirement became effective 90 days after July 18, 2016.

Sample notices and taglines, including translated documents, can be found [here](#).

4. Access for Individuals with Limited English Proficiency. The Plan must provide language assistance services free of charge, and such services must be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency.

- A. When oral communication is a reasonable step to provide meaningful access to an individual with limited English proficiency, the Plan must offer a qualified interpreter.
- B. When translating written content in paper or electronic form, a qualified translator must be used.
- C. The Plan must not (i) require that the individual pay for an interpreter or translator, (ii) rely on an adult accompanying the individual in lieu of offering an interpreter or translator (except in the case of an emergency or when the individual requires that the accompanying adult assist, (iii) rely on a minor in lieu of offering an interpreter or translator (except in the case of an emergency); or rely on unqualified staff to interpret or translate.
- D. If a qualified interpreter is provided remotely via video, appropriate software must be used and the speed must be sufficient (i.e., no choppy, burry, or grainy images).

5. Accessibility of Electronic and Information and Information Tech. Plan programs that are provided through electronic and information technology must be accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. If Plan information is posted on a website or intranet, the site should comply with Title II of the ADA (see ADA Tool Kit – Website Accessibility).

13. HEALTH SAVINGS ACCOUNTS (HSAs)

Generally, an HSA is a savings account that permits an eligible individual who participates in a High Deductible Health Plan (HDHP) to make tax-deductible contributions and to receive tax-free distributions for medical expenses.

TRUST OR CUSTODIAL ACCOUNT

An HSA must be established under a trust or custodial account. The trustee or custodian of the account must be a bank or insurance company or another person approved by the IRS to serve as trustee or custodian. Except for rollover contributions, HSA contributions must be in cash. The assets of the HSA may not be forfeitable, may not be invested in life insurance and may not be pledged as security for a loan. HSAs are subject to the prohibited transaction rules of the Internal Revenue Code that apply to individual retirement accounts.

ELIGIBILITY

An individual is eligible to make deductible contributions to an HSA if he or she has health coverage under an HDHP. An HDHP is a health plan that:

- for self-only coverage has an annual deductible of at least \$1,350 for 2019 and a maximum out-of-pocket expense limit for in-network expenses of no more than \$6,750 for 2019; or
- for family coverage, has an annual deductible of at least \$2,700 for 2019 and a maximum annual out-of-pocket expense limit for in-network expenses of no more than \$13,500 for 2019.

ELECTIONS

Cafeteria plans offering HSAs must permit participants to change their salary reduction amounts prospectively on at least a monthly basis and must permit an ineligible participant to revoke his election prospectively.

PREVENTIVE CARE

The HSA rules permit an HDHP to exclude “preventive care” from the otherwise applicable minimum annual deductible amount. Thus, an individual can make deductible HSA contributions even though the individual has “first dollar” preventive care coverage (or preventive care coverage with a separate annual deductible that is lower than the minimum annual deductible otherwise applicable to an HDHP). Preventive care includes the following:

- Periodic health care evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
- Routine prenatal and well-child care
- Child and adult immunizations

- Tobacco cessation programs
- Obesity weight-loss programs
- Certain screening services

A **draft** version of an executive order by the President Trump that was released in June 2017 directs the IRS to update existing regulations to allow individuals enrolled in high-deductible health plans coupled with a health savings account to access care for chronic conditions before they meet the deductible. This provision would be optional.

CONTRIBUTIONS

For 2019, the maximum annual HSA contribution for self-only coverage increases to \$3,500, \$7,000 for family coverage.

The above contribution maximums do not apply to rollover contributions from another HSA. A maximum of one HSA rollover per year is permitted.

Individuals age 55 or older may make “catch-up” contributions in excess of the foregoing limits. The maximum catch-up contribution is fixed at \$1,000 and does not increase in future years.

Contributions may be made by the account owner or by his or her employer. Contributions may be made through a cafeteria plan.

Generally, contributions by individuals are deductible to the HSA account owner unless the account owner may be claimed as a dependent on another person’s tax return. Employer contributions are not taxable to the individual. Under a proposed rule, upon which employers can rely, employers would not have to make contributions for employees who have not set up HSAs by year-end, as long as certain notice requirements are met. This rule would also allow employers to accelerate HSA contributions for employees with high medical expenses.

DISTRIBUTIONS

HSA distributions that are used to pay qualified medical expenses of the individual and the individual’s spouse and dependents for the year are excluded from the individual’s gross income. Qualified medical expenses generally include expenses for which a deduction would otherwise be available under Section 213(d) of the Internal Revenue Code.

For individuals who are not eligible for Medicare, qualified medical expenses do not include health insurance premiums (with exceptions for long-term care insurance, COBRA continuation coverage and coverage during certain periods of unemployment). For individuals who are eligible for Medicare, health insurance premiums (other than supplemental Medicare or Medigap insurance premiums) are qualified medical expenses.

Under the Patient Protection and Affordable Care Act of 2010, over the counter drugs (other than insulin) may not be reimbursed from an HSA without a prescription.

13.1 HSA ENHANCEMENTS

HSAs first became available to taxpayers in 2004 as part of Congress's attempt to expand health care coverage and control costs through consumer-directed programs. HSAs are tax-favored investment accounts that may be used to pay for an individual's current or future health, vision and dental expenses. To set up an HSA, an individual must be covered by a "high deductible health plan" (HDHP) and satisfy certain other eligibility rules. Within the statutory limits, employer contributions to an HSA are not taxable, and the individual may make tax-deductible contributions to the HSA. Employers have been slow to adopt HSAs and, among those that have, employees have been reluctant to enroll. The enhancements added by Congress, some effective immediately, are an attempt to encourage the growth of HSAs.

FSA GRACE PERIOD MAY NOT PREVENT HSA ELIGIBILITY

Generally, an individual may not participate in both an HSA and an FSA because FSA coverage is not a high deductible health plan. According to the IRS, this restriction continues during any "grace period" after the end of the plan year during which unused FSA amounts are available to pay new medical expenses, even if there was no money left in the FSA. However, individuals with a zero balance in their FSA at year end may contribute to an HSA at the start of the new year.

EARLIER NOTICE OF COST OF LIVING ADJUSTMENTS

The Treasury Department will make future cost of living adjustments to the contribution limits and HDHP requirements by June 1st of the preceding year.

FULL-YEAR CONTRIBUTION ALLOWED FOR MID-YEAR ENROLLEES

Individuals who enroll in a high deductible plan after the start of the year may make a full HSA contribution for the year. However, if the individual does not remain eligible for the high deductible plan during the testing period (the period beginning with the last month of the taxable year and ending on the last day of the twelfth month following such month), then an amount equal to the HSA deduction during the period that the individual was treated as eligible is included in income, and an additional 10% tax applies to the amount includible.

14. HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

An HRA is an arrangement that (1) is financed or paid for solely by the employer, (2) is not provided pursuant to an employee salary reduction election or otherwise under a Section 125 cafeteria plan, and (3) reimburses only:

- Code Section 213 medical expenses
- Expenses incurred after the HRA is adopted and after an individual's coverage begins
- Expenses that are substantiated (e.g., such as a health care provider's receipt or bill)
- Expenses that are not deducted by the employee under Code Section 213 and not reimbursed by another plan

The HRA must have been adopted by the employer and the individual must have enrolled in the HRA prior to incurring the expense.

Reimbursements of expenses from an HRA are generally excludable from the employee's income. However, to qualify for this exclusion, an HRA may only provide benefits that reimburse expenses for medical care under Code Section 213(d). Allowable reimbursements under Code Section 213(d) include reimbursements for:

- Medical, dental, and vision expenses
- Premiums for accident or health insurance coverage, including COBRA premiums
- Long-term care premiums

An HRA may not be used to pay for disability insurance premiums. Employers that sponsor HRAs can further limit the expenses that are eligible for reimbursement. For example, some HRAs exclude certain expenses that are difficult to administer, such as expenses that could be for personal as well as medical reasons. Due to the administrative expense involved with substantiating claims and HIPAA privacy concerns, many employers hire third-party administrators (TPAs) to substantiate HRA claims.

FINANCING HRA COVERAGE

Employees have individual HRA accounts to which the employer credits hypothetical dollars amounts. Amounts credited to an HRA must be provided solely by the employer and may not be attributable, directly or indirectly, to employee salary reductions. There are no dollar limits on the amount that the employer can credit under an HRA. Amounts may be contributed in a lump sum (such as at retirement or on an annual basis) or periodically based on the employee's payroll period.

ELIGIBILITY RULES

As a general rule, an employer may allow any common law employee (or former employee) to participate in its HRA. While individuals who are not considered employees, such as self-employed individuals, partners in a partnership and more than 2 percent shareholders in a Subchapter S corporation, can sponsor an HRA for their employees, these self-employed individuals cannot participate in an HRA on a tax-favored basis.

Employers may decide that they only want certain groups of employees to be eligible for the HRA (for example, employees who work in a specific geographical location). While an HRA can be designed to only

cover a portion of the employer's workforce, an employer needs to consider Internal Revenue Code Section 105(h) nondiscrimination rules and the ACA's integration rules (discussed below) when designing an HRA.

- HRAs are subject to the Section 105(h) nondiscrimination rules for self-funded health plans. These rules prohibit self-insured plans from discriminating in favor of highly compensated individuals (HCIs) with respect to eligibility or benefits.
- HRAs that are subject to the ACA's market reforms must satisfy the integration rules described below. This generally means that the HRA can only reimburse the medical expenses of individuals (including dependents) who are actually enrolled in the non-HRA group health plan coverage.

In addition to covering employees (and former employees, including retirees), HRAs may be designed to reimburse the eligible medical care expenses of an employee's spouse (opposite sex and same-sex) and tax dependents. Due to the ACA, this also includes children who are under age 27 as of the end of the taxable year. However, unless a domestic partner qualifies as a tax dependent under the federal tax law, an HRA cannot reimburse a domestic partner's medical care expenses on a tax-favored basis, even if the employer offers domestic partner coverage under its group health plan.

Employers may require new employees to satisfy a waiting period before they are allowed to participate in the HRA. However, for HRAs that are subject to the ACA, this waiting period cannot exceed 90 days.

COORDINATING HRA COVERAGE WITH OTHER GROUP HEALTH PLANS

In general, a medical expense may not be reimbursed from a health FSA if the expense has been reimbursed or is reimbursable under another health plan. Therefore, if an HRA is offered in addition to a health FSA, and both plans cover the same medical expenses, amounts available under an HRA must be exhausted first before reimbursements may be made from the health FSA.

UNIFORM COVERAGE RULE

Because the uniform coverage rule does not apply to HRAs, the maximum amount that may be reimbursed by the HRA may be limited to the current balance of the HRA. Employers may establish an HRA that allows employees access to HRA amounts only as those amounts are credited to the account (i.e., uniform coverage is not required) and the HRA is not required to use a 12-month coverage period. Therefore, the annual use-it-or-lose-it rule applicable to health FSAs is not required for HRAs and any unused HRA amounts may continue to be carried forward from year to year until they are used by the employee.

HRA ACCOUNTS AND TERMINATION OF EMPLOYMENT

When an employee terminates employment (including at retirement and death), the HRA either may provide that the employee forfeits the balance in his or her HRA account or may continue to reimburse qualifying medical expenses incurred after termination. If the termination is caused by the employee's death, the employer may allow the employee's surviving spouse and dependents to use up the balance in the HRA account, and the estate may also claim reimbursement for pre-death expenses incurred by the employee. However, the federal tax rules strictly prohibit HRAs from "cashing out" HRA balances (that is, paying some or all of an individual's HRA balance in cash or other taxable benefits).

LIMITATION ON REIMBURSEMENTS FROM HRA

Under the Patient Protection and Affordable Care Act of 2010, over the counter drugs (other than insulin) may not be reimbursed from an HRA without a prescription.

HRAS AND THE INDIVIDUAL MARKET/ACA

Effective for plan years beginning on or after January 1, 2014, most stand-alone HRA are prohibited. HRAs that are “integrated” with other group health plan coverage do not violate the ACA’s market reforms and continue to be permissible. Specifically, the regulatory agencies have announced that HRAs are not considered “integrated” with individual health insurance policies for purposes of satisfying the ACA’s prohibition on annual dollar limits on essential health benefits. An HRA (other than QSEHRAs discussed below, which are not subject to the ACA’s market reforms) that reimburses medical expenses but is not “integrated” with a group health plan will have to remove annual limits or qualify for an exception (e.g., be an excepted benefit, such as a dental or vision HRA or a retiree-only HRA).

There are two ways for an HRA to be considered “integrated” with another group health plan. One method imposes a minimum value requirement on the non-HRA group health plan coverage. The other method limits the types of expenses that can be reimbursed under the HRA. Under both methods, integration does not require the HRA and the coverage with which it is integrated to share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. Under both integration methods, the following four requirements must be met:

1. The employer sponsoring the HRA must sponsor a group health plan (other than the HRA) that does not only provide excepted benefits.
2. Employees (and their spouses and dependent children) who are covered under the HRA must be enrolled in another group health plan that does not only provide excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage).
3. The HRA must be available only to employees (and their spouses and dependent children) who are enrolled in the non-HRA group coverage, regardless of whether the employer sponsors the plan.
4. Employees (and former employees) must be offered the opportunity to permanently opt out and waive future reimbursements from the HRA at least annually. On termination of employment, the remaining amounts in the HRA must be forfeited or the employee must be permitted to permanently opt out of and waive future reimbursements.

If the non-HRA group health plan coverage described in the first three requirements above meets the ACA’s minimum value requirement, the HRA may reimburse any type of permitted medical care expense. However, if the minimum value standard is not met by the non-HRA group health plan coverage, the HRA can only reimburse copayments, coinsurance, deductibles and premiums under integrated non-HRA group coverage, as well as medical care that does not constitute essential health benefits.

QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT (“QSEHRA”)

On December 7, 2016, the Senate passed the 21st Century Cures Act (“Cures Act”), an omnibus measure that includes the Small Business Healthcare Relief Act (“Relief Act”), which significantly expands small employers’ options for providing health coverage. The law is effective for plan years beginning on or after January 1, 2017.

The HRA Relief Act allows small employers—defined as those who are not applicable large employers (“ALEs”)—to establish a qualified health reimbursement arrangement (“HRA”) that reimburses eligible employees and their family members for medical expenses, including individual health insurance premiums, up to a specified annual limit. In general, an employer is an ALE if it employed at least 50 full time equivalent employees on average in the prior calendar year.

Eligible Employers

An eligible employer cannot be an ALE and cannot offer a group health plan to any of its employees. A qualified HRA must be funded solely by employer contributions (i.e., no salary reduction contributions) and must be available to all “eligible employees.”

Eligible Employees

“Eligible employees” include all employees of the employer, except for employees in the following categories, who may be excluded:

- those who have not completed 90 days of service;
- those under the age of 25;
- part-time and seasonal employees;
- those covered by a collective bargaining agreement, if accident and health benefits were the subject of good faith negotiations; and
- nonresident aliens with no U.S.-source income from the employer.

To participate, eligible employees must demonstrate that they and any participating family members have enrolled in minimum essential coverage (“MEC”).

Annual Limit

Amounts available under a qualified HRA cannot exceed \$5,150 / \$10,450 (for 2019) if the HRA also covers family members). The annual limits are prorated for partial years of coverage. The employer’s annual contribution must be the same for all eligible employees; however, certain variations are permitted with respect to HRA funds that are available for reimbursement of individual market coverage. Employer contributions to a qualified HRA may vary in accordance with the price of an individual market health insurance policy based on the age of the eligible employee (and the age of covered family members) or the number of an eligible employee’s covered family members. For example, an employer contribution equivalent to 80% of the cost of age-banded coverage up to \$5,150 per year would be permissible.

Notice Requirements

Employers must notify eligible employees of the availability of a qualified HRA at least 90 days prior to the beginning of the plan year or upon eligibility for employees who become eligible during the year. The notice must state: (1) the amount available under the HRA for the year; (2) that employees receiving federally subsidized coverage must disclose the HRA contribution to the Marketplace; and (3) that if the employee does not have MEC, an individual mandate penalty may apply and any reimbursement from the HRA may be included in gross income that month.

Failure to provide the notice as required may result in a penalty of \$50 per employee, not to exceed \$2,500 per year. The penalty may be waived if it is shown that the failure was due to reasonable cause and not willful neglect.

On February 27, 2017, the IRS delayed the initial notice deadline pending its issuance of further guidance. IRS Notice 2017-67 provided a new deadline for the initial qualified HRA notice. An eligible employer that provides a qualified HRA during 2017 or 2018 must provide the initial written notice to eligible employees by the later of (1) February 19, 2018, or (2) 90 days before the first day of the qualified HRA’s plan year. Subject to this rule, notice must be given to newly eligible employees on or before the date they become eligible to participate. Notice may be provided electronically.

Notice 2017-67 provides further guidance on a wide range of topics for qualified HRAs, including the criteria for qualified HRAs, the same terms requirement, the impact on eligibility for health savings account contributions, and the MEC requirement.

Federal Premium Subsidy Reduction

Employees participating in a qualified HRA will have their monthly federal premium subsidy for Marketplace coverage reduced by 1/12th of the employer's annual HRA contribution. For example, if an employee's subsidy is \$250 per month and 1/12th of the employer's annual HRA contribution is \$200, the employee's subsidy will be reduced to \$50 per month.

In addition, if the HRA provides "affordable" coverage, the employee's subsidy will be reduced to zero that month. An HRA provides affordable coverage in any month where the difference between the cost of coverage under the second-lowest-cost silver plan in the Marketplace and the employer's HRA contribution does not exceed 9.5% (9.86%, as indexed for 2019) of the employee's household income.

Example: In 2019, if the second-lowest cost silver plan in the employee's Marketplace is \$300 per month, 1/12th of the employer's annual HRA contribution is \$100 and the employee earns \$2,100 per month, the employee will not be eligible for a federal premium subsidy because $\$2,100 \times 9.86\% = \207 , which exceeds the \$200 difference between the applicable Marketplace plan and the employer's monthly HRA contribution.

Reporting Requirements

The Relief Act requires employers to report amounts available under a qualified HRA on employees' Form W-2. Presumably, it will be reported for informational purposes in box 14. Employees will also be required to report the amount available under a qualified HRA, likely as part of their subsidy application.

Effect on Other Laws

Under the Relief Act, qualified HRAs will not be considered group health plans under ERISA and, with the exception of the PCORI tax and the Cadillac tax, which is currently scheduled to go into effect in 2022, will not be subject to the ACA's market reforms, including ACA reporting for self-insured plans. Thus, qualified HRAs will not be subject to COBRA continuation requirements.

15. FLEXIBLE SPENDING ACCOUNTS (FSAS)

15.1 DEBIT CARDS

Initially, health FSA debit or credit cards could only be used for expenses incurred at providers that were assigned health-related merchant codes. The IRS has expanded this rule to allow electronic reimbursement for items purchased from general merchants. To qualify, the card processor must provide a system for approving and rejecting card transactions using inventory control information (e.g., stock keeping units “SKUs”). The system compares the inventory control information for the items purchased against a list of items that qualify as reimbursable medical expenses. The medical expenses are totaled, and the system approves the use of the card only for the amount of the medical expenses subject to coverage under the health FSA.

Health FSA debit cards may not be used at drug stores or pharmacies unless 1) the store participates in the inventory information approval system, or 2) on a limited basis, 90% of the store’s gross receipts during the prior taxable year consisted of items that qualify as expenses for medical care.

New rules also provide that a debit card may be used for reimbursements to former employees, so long as COBRA continues. The debit card must be terminated when the former employee ceases to be a participant in the plan, not when the individual ceases to be an employee, as was the case under the prior rule.

SUBSTANTIATION

If the employer’s health plan has co-payments in specific dollar amounts, and the dollar amount of the transaction at a health care provider (as identified by its merchant category code) equals an exact multiple of not more than five times the dollar amount of the co-payment for the specific service (i.e., pharmacy benefit co-payment, co-payment for a physician’s office visit, etc.) under the accident or health plan (i.e., the major medical plan, health maintenance organization, etc.) covering the specific employee-cardholder, then the charge is fully substantiated without the need for submission of a receipt or further review.

In addition, if a health plan has multiple co-payments for the same benefit, (e.g., tiered co-payments for a pharmacy benefit), exact matches of multiples or combinations of the co-payments (but not more than the exact multiple of five times the maximum co-payment) will similarly be fully substantiated without the need for submission of a receipt or further review. If the dollar amount of the transaction at a health care provider exceeds a multiple of five or more times the dollar amount of the co-payment for the specific service, the transaction must be treated as conditional pending confirmation of the charge by the submission of additional third-party information.

In the case of a plan with multiple co-payments for the same benefit, if the dollar amount of the transaction exceeds five or more times the maximum co-payment for the benefit, the transaction must also be treated as conditional pending confirmation of the charge by the submission of additional third-party information. Similarly, if the dollar amount of the transaction is not an exact multiple of the co-payment (or an exact match of a multiple or combination of different co-payments for a benefit in the case of multiple co-payments for the same benefit), the transaction must be treated as conditional pending confirmation of the charge, even if the amount is less than five times the co-payment. In these cases, the employer must require that additional third-party information, such as merchant or service provider receipts, describing (1) the service or product, (2) the date of the service or sale, and (3) the amount, be submitted for review and substantiation.

The co-payment schedule required under the health plan must be independently verified by the employer (i.e., the co-payment amount must be substantiated by a third-party; statements or other representations by the employee are not sufficient).

Though substantiation is required prior to payment, new regulations allow advance orthodontia payments that are “required” to be reimbursed even though services have not yet been provided.

LIMITATION ON REIMBURSEMENTS

Under the Patient Protection and Affordable Care Act of 2010, over the counter drugs (other than insulin) may not be reimbursed from a health flexible spending account without a prescription.

LIMITATION ON EMPLOYEE CONTRIBUTIONS

For plan years beginning on or after January 1, 2019, the maximum employee salary reduction election to a health FSA is \$2,700. Also, due to the ACA’s prohibition on annual dollar limits, all health FSAs must qualify as “HIPAA-excepted.” To be HIPAA-excepted, the employer must offer other non-excepted health coverage to the employee for the plan year, and the maximum amount available under the FSA for reimbursement cannot be more than the greater of \$500 or two-times the employee’s salary reduction election.

15.2 HEALTH FSA CORRECTION PROGRAMS

Cafeteria plan rules provide that after an expense for a qualified benefit has been incurred under a health FSA, it must first be substantiated before the expense is reimbursed. For paper reimbursement requests, the substantiation process always occurs before the expense is reimbursed. However, when a health FSA offers participants the use of a debit card, an expense may be incurred and paid via the debit card before it is substantiated (i.e., at the point of service). There are certain limited situations where health FSA claims are automatically substantiated at the point of service (e.g., under the copayment matching system), but in general the rules require employees to substantiate expenses within a reasonable amount of time after the transaction.

FSA CORRECTION PROCEDURES

Cafeteria plans are required to have the following procedures in place in the event employees do not timely substantiate health FSA expenses reimbursed through a debit card:

1. The debit card must be deactivated until the claim is substantiated or the improper payment recovered (the employee may continue to submit paper claims);
2. The employer must demand that the employee repay the plan;
3. If the employee fails to repay plan after the employer’s demand per (ii) above, the employer must withhold the amount from the employee’s pay, to the full extent allowed by law;
4. If neither (ii) nor (iii) above result in full repayment, the employer must apply an offset against properly substantiated claims incurred during the same plan year; and
5. If neither (ii), (iii) nor (iv) above result in full repayment, the employer may treat the improper payment as it would any other business indebtedness. In other words, it may include the improper payment in the employee’s gross income.

IRS Memorandum Number 201413006 notes that the above correction procedure for debit cards may be applied to improper payments from a health FSA (e.g., an expense that is later identified as an ineligible expense).

EXHAUSTION OF CORRECTION METHODS REQUIRED BEFORE EXPENSE IS INCLUDED IN INCOME

The memorandum clarifies that an employer may alter the order of the above correction procedures as long as it does so consistently for all participants. However, the memorandum requires exhaustion of correction procedures (ii) through (iv) above before an employer may apply correction procedure (v) and include the improper payment in the employee's income. The IRS notes that including the improper payment in employees' gross income should be the exception rather than a routine occurrence, and that repeated inclusion in income of improper payments suggests that proper substantiation procedures are not in place or that payments may be a method of cashing out unused FSA amounts.

CORRECTIONS OCCURRING AFTER THE END OF THE PLAN YEAR

The memorandum clarifies that in the event correction procedures (ii) through (iv) were not applied during the plan year in which the improper payment occurred, the employer should report the improper payment as wages on a Form W-2, which are subject to withholding for income tax, FICA and FUTA. Form 1099 should not be used for this purpose.

15.3 CARRYOVERS

On October 31, 2013, the Internal Revenue Service (IRS) released Notice 2013-71 (Notice), which modifies the "use or lose" rule for health flexible spending accounts (health FSAs) to allow a \$500 annual carryover of unused contributions, provided that the cafeteria plan offering the health FSA does not incorporate the "grace period" rule. The Notice does not extend the carryover provisions to dependent care FSAs.

As to the "use-or-lose" rule, the Notice is intended to encourage employees to participate in health FSAs by watering down the strict "use-or-lose" rule familiar to health FSA participants, and reduce unnecessary spending at the end of the year to avoid forfeiture of contributions. Offering the carryover is optional and is an alternative to offering the health FSA grace period.

BACKGROUND

In general, a cafeteria plan may not provide for the deferral of compensation from one year to the next (e.g., a pre-tax contribution made in one year may not be used to purchase a benefit that will be provided in a subsequent year). With respect to health FSAs, this concept manifests in the form of the so-called "use-or-lose" rule, which requires that contributions not used by the end of the plan year (or any applicable "grace period") be forfeited. In 2005, the IRS modified the "use-or-lose" rule to permit cafeteria plans to allow up to a 2½-month grace period, during which employees could continue to be reimbursed for qualified medical expenses incurred during the "grace period" with funds remaining from the prior plan year.

The Affordable Care Act (ACA) also changed the rules for health FSAs, including limiting elective employee contributions to health FSAs to \$2,500 per plan year starting in 2013, as indexed for inflation (\$2,700 in 2019) (prior to the ACA, there was no federal limit on health FSA contributions). In light of the ACA's limit on health FSAs, the IRS has concluded that it is appropriate to offer additional administrative relief beyond that provided by the grace period rule. Thus, the Notice modifies the "use-or-lose" rule applicable to health FSAs to permit an annual carryover of up to \$500.

\$500 CARRYOVER PERMITTED

The Notice permits, but does not require, an employer to amend its Internal Revenue Code Section 125 cafeteria plan to allow for a carryover of up to \$500 of any amount remaining unused at the end of a health FSA's plan year. The carryover does not count against or otherwise affect the indexed \$2,500 salary reduction limit applicable to each plan year (\$2,700 for 2019). Employers may specify a carryover limit lower than \$500 or decline to permit any carryover at all. An employer may also require a minimum balance (e.g., \$25) for carryovers. An employer adopting the carryover must amend its cafeteria plan to remove any grace period that applies to the health FSA by the end of the plan year from which amounts will be carried over (e.g., before the start of the first plan year in which the carryover will be available).

The carryover amount may be used to pay claims incurred during the entire plan year to which it is carried over. Amounts remaining at the end of the plan year that are available for carryover are net of reimbursements made during the plan's run-out period (the period of time following the end of the plan year during which claims incurred during that plan year may continue to be submitted for reimbursement). Any unused amounts relating to a health FSA may not be cashed out or converted to any other taxable or nontaxable benefit. Any unused amount in excess of \$500 remaining at the end of the plan year (after adjustments for run-out claims) is forfeited.

Employers may continue to use run-out periods following the end of a plan year; however, amounts reimbursed during the run-out period effectively will reduce the amount available for carryover (e.g., if there is \$700 available at the end of the 2018 plan year and an employee submits \$500 in claims during the run-out period that were incurred in 2018, the amount available for carryover after the run-out period is \$200). Importantly, the Notice clarifies that the carryover amount does not have to be spent in the year following the year for which it was created. That is, once the carryover amount is established for a year, it could remain available for an indefinite number of future years as illustrated by the following examples.

Example 1:

An employer offers a health FSA on a calendar year basis with an annual run-out period from January 1–March 31 in which participants can submit claims incurred during the prior year. The plan has a \$2,650 annual limit and has been amended to adopt the \$500 carryover; therefore, there is no grace period.

- Unused amount in employee's health FSA on December 31, 2017: \$800
- Employee's 2018 health FSA election: \$2,650
- Employee submits a claim for \$350 in March 2018 that was incurred in 2017
 - Employee's unused amount is reduced to \$450 (\$800-\$350)
- If no other claims are submitted by March 31, 2017: \$450 carries over to 2018
- Employee has \$3,100 available for claims incurred in 2018
- Employee submits a claim for \$2,800 incurred July 15, 2018
- Plan pays the claim (\$2,650 from 2018, plus \$150 from the 2017 unused amount)

- Employee's unused amount is now reduced to \$300 (\$450-\$150)
- If no other claims are incurred in 2018: \$300 carries over to 2019

Example 2:

Same facts as above. This example illustrates the carryover rules when an employee incurs claims in 2017 but waits to submit them until after being reimbursed for claims incurred in 2018.

- Unused amount in employee's health FSA on December 31, 2017: \$800
- Employee's 2018 health FSA election: \$2,650
- Employee submits a claim for \$2,800 incurred January 15, 2018
- Plan pays the claim (\$2,650 from 2017, plus \$150 from the 2017 unused amount)
 - Employee's unused amount is reduced to \$650 (\$800-\$150)
- Employee submits a claim for \$350 in March 2018 that was incurred in 2017
 - Employee's unused amount is reduced to \$300 (\$650-\$350)
- If no other claims are submitted by March 31, 2018: \$300 carries over to 2018
- If no other claims are incurred in 2018: \$300 carries over to 2019

PLAN AMENDMENT REQUIRED; GRACE PERIOD MUST BE REMOVED

To utilize the new carryover option, a cafeteria plan offering a health FSA must be amended on or before the last day of the plan year from which amounts may be carried over. The amendment may be made retroactively to the first day of that plan year, provided that the employer informs participants of the carryover provision.

The Notice prohibits cafeteria plans from incorporating both a carryover provision and a grace period. For example, a plan permitting a carryover to 2019 of unused 2018 health FSA amounts would not be permitted to have a grace period in 2019 but would be permitted to have had a grace period during the first 2½ months of 2018. The grace period also must be eliminated by the end of the plan year from which amounts may be carried over.

The Notice does not appear to permit retroactive amendment of a plan to remove a grace period. Therefore, it appears that an employer wishing to add a carryover option in 2019 of unused 2018 amounts will need to amend its cafeteria plan by the end of the 2018 plan year to remove the grace period. However, such action may raise ERISA or state law issues and an employer wishing to do so should consult with ERISA counsel.

CARRYOVER COMPATIBILITY WITH HSAS

IRS Memorandum number 201413005 includes the following clarifications relating to the \$500 health FSA carryover and its effect on employees' health savings accounts (HSAs):

- An individual who is covered by a general-purpose health FSA is not HSA eligible, even if the coverage is solely as the result of a carryover from the prior year. Moreover, an individual covered by a general-purpose health FSA solely as the result of a carryover may not contribute to an HSA even for months in the plan year after the health FSA no longer has any amounts available to pay or reimburse medical expenses.

- However, an individual who elects to enroll in HSA-compatible FSA coverage in the following plan year may elect to have general purpose FSA funds carried over to a limited purpose FSA (i.e., an HSA-compatible FSA) in order to preserve the individual's HSA eligibility for that next plan year. An individual may also elect to decline or waive a carryover for the following year.
- Plans may apply the HSA-compatible carryover automatically for an individual who elects coverage in an HDHP for the following plan year.
- Carryover amounts may not be carried over to a non-health FSA or another type of cafeteria plan benefit.
- If an individual elects to carry over unused amounts from a general-purpose health FSA to a limited-purpose FSA, the carryover amount is available after the general-purpose FSA's run-out period.

COBRA AND CARRYOVERS

Internal Revenue Service (IRS) Notice 2015-87, released December 16, 2015, addresses issues related to offering COBRA continuation for healthcare FSAs that include carryover amounts.

Healthcare FSAs are considered group health plans and are subject to COBRA. However, a special limited COBRA obligation may apply for employees who have "overspent" (been reimbursed more than contributed to date) their accounts. For employees who have not overspent their account, the limited COBRA coverage stops at the end of the plan year in which COBRA was first offered. If a healthcare FSA does not meet all the requirements to offer limited COBRA coverage, then COBRA continuation must still be offered, but coverage would continue for 18 months or longer, depending on the qualifying event.

In order to calculate COBRA eligibility and premiums, employers need to determine:

- The maximum benefit employees are entitled to receive for the remainder of the year as a benefit under the healthcare FSA – i.e., the remaining balance in their account as the day before the qualifying COBRA event, including carryover amounts; and
- The cost of the premium needed to pay for COBRA continuation – i.e., the maximum amount required to be paid for COBRA does not include the unused amount carried over from prior years. This carryover amount is not part of the salary reduction for the current year. The applicable premium is based solely on the sum of the employee's salary reduction election for the year and any non-elective (employer) contributions.

Examples illustrating these rules are below:

Maximum benefit. Employee elects \$2,500 for the current plan year and has \$500 carried over from the previous plan year. In addition, she has been reimbursed \$1,100 and contributed \$1,250 as of the day prior to her termination of employment on July 1. The maximum benefit she is entitled to receive for the remainder of the plan year under the healthcare FSA, including the amounts carried over, is \$1,900. $((\$2,500 + \$500) - \$1,100)$.

COBRA premium. The maximum premium required for COBRA (that is, 102 percent of the applicable premium) does not include amounts carried over from previous plan years. The premium amount is \$212.50 per month for the remaining six months of the plan year. $((\$2,500 - \$1,250 / 6) \times 1.02)$.

COBRA Continuation into New Plan Year

Healthcare FSAs are not required to allow COBRA beneficiaries to elect additional amounts at the beginning of a new plan year or access to any employer contributions, following the plan year of COBRA eligibility. However, any funds (up to \$500) remaining at the end of the plan year, are carried over to the new plan year for an active COBRA beneficiary as of the last day of the qualifying-event plan year. The applicable premium for carryover funds for the new plan year is zero. The carryover is also limited to the appropriate, generally 18 month, COBRA continuation period. That could span more than one open enrollment for beneficiaries.

Example: During the Healthcare FSA plan year, an employee experiences a qualifying event as of June 1, 2017, elects COBRA continuation, and pays the required premiums for the rest of the plan year. At the end of the plan year, there is \$500 of unused benefits remaining.

The beneficiary can continue to submit expenses under the same terms as similarly situated non-COBRA beneficiaries in the next plan year, up to \$500. The premium for the carryover during the new plan year is zero; however, the available coverage period is 18 months and terminates at the end of November 2018. COBRA coverage ends and the Healthcare FSA need not reimburse any expenses incurred after that date.

Carryover Flexibility

2015-87 allows some flexibility in features of carryover provisions.

- A Healthcare FSA may limit the availability of the carryover of unused amounts (subject to the \$500 limit) to individuals who elect to participate in the Healthcare FSA in the next year.
- Employers may even set a minimum amount of salary reduction elections to the Healthcare FSA for the next year. For example, employers can condition the carryover of funds to employees electing at least \$50 or more to the Healthcare FSA. Therefore, only employees electing \$50 or more for new plan years have their remaining funds (up to \$500) carried over to the new plan year. Employees not electing the Healthcare FSA would forfeit leftover funds as of the end of the plan year.
- A Healthcare FSA may also limit the timeframe that unused amounts may be used. For example, a Healthcare FSA can limit the ability to carry over unused amounts to one year. If a participant carried over \$25 and did not elect any additional amounts for the next year, the Healthcare FSA may require forfeiture of any amount remaining at the end of that next year.

16. DEPENDENT CARE ASSISTANCE PLANS (DCAPS)

Under a dependent care assistance plan (“DCAP”), employees can exclude from their income amounts paid for certain types of care provided to children and other dependents. The maximum reimbursement under a DCAP is generally \$5,000 or \$2,500 for married employees who file separate tax returns.

To be eligible, expenses must be for dependent care must be employment related, meaning that the care must be provided so that the employee (and spouse, if married) can be at work. Generally, employees cannot participate in DCAPs unless their spouses are employed on either a full time or a part-time basis.

There is an optional provision that would allow a terminated employee to be reimbursed for dependent care expenses that are incurred after their termination date but before the end of the plan year (or the 2½ month grace period if the plan adopts the grace period). Reimbursements may only be made up to the amount that had been deducted from their pay at the time of termination. If the employer chooses to offer this benefit, it must be described in the cafeteria plan document.

Debit cards are now allowed to be used for the reimbursement of dependent care expenses, though these services may not be reimbursed before they are provided. An administrator may make funds available on a regular schedule based on a documented provider payment schedule.

Examples of eligible expenses include day care services, general purpose day camp (primary reason for being there must be the care and well-being of the child and be custodial in nature, not educational), babysitters and pre-school. Examples of ineligible expenses include costs of food and transportation (if itemized), educational expenses such as private schools, kindergarten, sports camps and overnight camps.

The following are eligible dependents:

- A person who is the participant’s dependent child under the age of 13, who lives in the participant’s home for more than half the year, and who receives more than half of his or her support from the participant for the year
- A person who is the participant’s disabled dependent, who lives in the participant’s home for more than half the year, who receives more than half of his or her support from the participant for the year, and who regularly spends at least 8 hours a day in the participant’s home
- A person who is the participant’s disabled spouse, who lives in the participant’s home for more than half the year, and who regularly spends at least 8 hours a day in the participant’s home
- Generally, the following would be considered eligible dependent day care providers:
 - State licensed day care center
 - Friend or neighbor (must have SSN or Tax ID)
 - A relative who is not the participant’s dependent

16.1 CHANGE IN STATUS RULES FOR DCAPS

The following are considered qualified change in status events that would allow a participant to change his/her election mid-year:

- Change in marital status (such as marriage, divorce or death of spouse)
- Change in the number of dependents (such as birth or adoption of a child, or death of a dependent)
- Change in employment status of the participant, his/her spouse, or dependents
- Dependent satisfies or ceases to satisfy an eligibility requirement
- Change in residence of the participant his/her spouse, or dependent
- Change due to event when an independent, third party provider (other than a relative) significantly increases or decreases the cost of dependent care or when there has been a coverage change (e.g., a change in providers)

17. FILING REQUIREMENTS

17.1 FORM 5500 AND RELATED SCHEDULES

This annual return/report is used to report detailed information concerning the plan to the Internal Revenue Service (IRS) and the Department of Labor (DOL). Form 5500 and its related schedules must be filed with the Employee Benefits Security Administration by the last day of the seventh month after the end of the plan year (for a calendar year plan year, the filing date is July 31).

If needed, the plan administrator may obtain a two and one-half month filing extension by submitting Form 5558 to the IRS on or before the original due date.

Insured and/or self-funded welfare plans covered by ERISA that have fewer than 100 participants on the first day of the plan year, and certain church and government plans are exempt from filing Form 5500.

For the purposes of filing Form 5500, dependents and children are not counted as participants (therefore the plan generally must have 100 participating employees to have a filing obligation).

A cafeteria plan is considered only a funding vehicle and is not an ERISA welfare benefit plan. This means that cafeteria plans do not need to file a Form 5500. However, any component benefit plan that is an ERISA welfare benefit plan (e.g., health care FSAs, health care, dental, long-term disability, AD&D, and group term life) will be required to file a Form 5500 (unless an exemption applies as described in the preceding paragraph).

Employers may file a single Form 5500 with respect to all welfare plans and component plans if the employer has adopted a “wrap around” plan document explaining that for ERISA purposes, all of the employer’s welfare plans are combined into one welfare benefit plan. (See Tab 20 for a description of “wrap around” plan documents.)

In general, a welfare benefit plan filing Form 5500 will be required to attach one or more of the following schedules, as applicable:

- Schedule A – Insurance Information, to report insurance contracts held by the plan.
- Schedule C – Service Provider Information, to list service providers who received \$5,000 or more in direct or indirect compensation payable by the plan, and any terminated accountants or actuaries. Generally, Schedule C is only applicable to Plans with ERISA “plan assets.”
- Schedule D – D/F/E Participating Plan Information to list any of the following in which the plan participated during the plan year: master trust investment account, common/collective trust, pooled separate account, 103-12 investment entity, or group insurance arrangement.
- Schedule G – Financial Transaction Schedule, to report loans or fixed income obligations in default or determined to be uncollectible as of the end of the plan year, and any nonexempt transactions.
- Schedule H – Financial Information for large plans (covering 100 or more participants as of the beginning of the plan year).
- Schedule I – Financial Information for small plans (covering fewer than 100 participants as of the beginning of the plan year).

Form 5500 with schedules and instructions explaining in detail each schedule and filing requirements are available [here](#) under the Electronic Filing Requirement heading.

To complete the Form 5500, you will need the following information:

- Plan Name
- Plan Year
- Plan Number
- Employer identification number (EIN)
- List of all benefits provided under the plan
- Any insurance premiums paid
- Any commissions paid (and a list of payees)
- Number of plan participants

17.2 FORM 5500 CHECKLIST

- Form 5500 must be filed if plan is insured and has 100 or more participants on the first day of the plan year.
- Form 5500 must be filed by the end of the seventh month after the close of the plan year (July 31 for calendar year plans).
- Extension of 2½ months granted if Form 5558 completed.
- Cafeteria plans are not required to file Form 5500.
- Health care flexible spending account plans, health care plans, dental plans, long-term disability plans, AD&D plans and group term life plans are required to file Form 5500.
- Dependent care flexible spending account plans funded with only salary reductions are not ERISA welfare benefit plans and are not required to file Form 5500.

FORM 5500, SCHEDULES AND ATTACHMENTS (NOT APPLICABLE FOR FORM 5500-SF FILERS)

	Large Welfare Plan	Small Welfare Plan
Form 5500	Must complete.	Must complete. ²
Schedule A – Insurance Information	Must complete if plan has insurance contracts for benefits or investments.	Must complete if plan has insurance contracts for benefits or investments. ¹
Schedule C – Service Provided Information	Must complete Part I if service provider was paid \$5,000 or more, Part II if a service provider failed to provide information necessary for the completion of Part I, and Part III if an accountant or enrolled actuary was terminated. Generally, Schedule C is only applicable to Plans with “plan assets.”	No required.
Schedule D – D/F/E Participating Plan Information	Must complete Part I if a plan participates in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if a plan participates in a CCT, PAS, MTIA, or 103-12 IE.
Schedule G – Financial Transaction Schedules	Must complete if Schedule H, lines 4b, 4c, or 4d are “Yes.” ^{3,4}	Not required. ²
Schedule H – Large Plan and D/F/E Financial Information	Must complete. ^{2,4,5}	Not required.
Schedule I – Small Plan Financial Information	Not required.	Must complete. ¹
Schedule MB – Actuarial Information	Not required.	Not required.
Schedule R – Pension Plan Information	Not required.	Not required.
Schedule SB – Actuarial Information	Not required.	Not required.
Accountant’s Report	Must attach. ⁴	Not required.

1. Do not complete if filing the Form 5500-SF instead of the Form 5500.
2. Unfunded, fully insured and combination unfunded/insured welfare plans covering fewer than 100 participants at the beginning of the plan year that meet the requirements of 29 CFR § 2520.104-20 are exempt from filing an annual report.
3. Must also complete schedules of assets and reportable (5 percent) transactions if Schedule H, lines 4i or 4j, are marked “yes” but use of computer scannable form is not required.
4. Must also complete to report any nonexempt transactions even if Schedule H is not required.
5. Unfunded, fully insured and combination unfunded/insured welfare plans covering 100 or more participants at the beginning of the plan year that meet the requirements of 29 CFR § 2520.104-44 are exempt from the accountant’s report requirement and completing Schedule H.

The IRS added compliance questions to Forms 5500, 5500-SF, 5500-EZ and Schedules H, I and R. The IRS has decided that filers should not answer these questions for the 2015 and the 2016 plan years.

17.3 PROPOSED CHANGES TO FORM 5500

Reserved. Significant changes to Form 5500 reporting were expected to start with plan years beginning in 2019; however, as of the date of this guide, the rules proposing such changes have not been finalized. Therefore, it does not appear that the new forms or expanded reporting requirements will apply to plan years beginning in 2019. The DOL has released advance copies of the 2018 [Form 5500](#) and [instructions](#)

17.4 FORM M-1 (MEWAS)

Form M-1 (Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming exception (ECEs)): Administrators of multiple employer welfare arrangements (MEWAs) and certain other entities that offer or provide coverage for medical care to employees of two or more employers are generally required to file the Form M-1 (Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)). The Form M-1 is due no later than March 1, following any calendar year for which a filing is required. A two-month extension is available.

For additional guidance about the Form M-1 reporting requirements, see the [Reporting and Disclosure Guide for Employee Benefit Plans](#) on the DOL website.

17.5 FORM W-2 (WAGE AND TAX STATEMENT)

This form is used to report wages, as well as taxable benefits such as group legal services contributions or benefits, premiums for group term life insurance above \$50,000, employer payments for domestic partner benefits, employer contributions to medical savings accounts, and employer payments under adoption assistance plans. The employer must file it with the Social Security Administration before March 1st of the calendar year following the contributions or payments.

17.6 EFAST2 FILING

EFAST2 is an all-electronic system designed by the Department of Labor, Internal Revenue Service, and Pension Benefit Guaranty Corporation to simplify and expedite the submission, receipt, and processing of the Form 5500 and Form 5500-SF. These forms must be electronically filed each year by employee benefit plans to satisfy annual reporting requirements under the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code. Under EFAST2, filers choose between using EFAST2-approved vendor software or the DOL's website (IFILE) to prepare and submit the Form 5500 or Form 5500-SF. Completed forms are submitted via the Internet to EFAST2 for processing. More information is available [here](#).

17.7 MEWA STATEMENT ON FORM 5500

The administrator of an employee welfare benefit plan that provides benefits wholly or partially through a Multiple-Employer Welfare Arrangement (MEWA) must file a Form 5500, unless otherwise exempt. Plans required to file a Form M-1, Report for Multiple-Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs), are not eligible for the filing exemption in 29 CFR 2520.104-20. Such plans are required to file the Form 5500 regardless of the plan size or type of funding.

Generally, a Form M-1 must be filed each year by March 1st following the calendar year in which a plan operates subject to the Form M-1 filing requirement. (For example, a plan MEWA that was operating in 2018 should file the 2018 Form M-1 annual report by March 1, 2019.) In addition, Form M-1 filings are necessary in the case of certain registration, origination, or special events.

17.8 PENALTIES FOR NONCOMPLIANCE WITH FORM 5500 REPORTING

For calendar year plans, the Form 5500 must be filed by July 31 of the following year (subject to extension of 2½ months granted if Form 5558 completed).

- IRS penalties for late filing are \$25 per day up to a maximum of \$15,000.
- DOL penalties:
 - Late filers: \$50 per day (no maximum);
 - Non-filers: \$300 per day (up to \$30,000 per year);
 - Civil Penalty: up to \$2,140 per day (no maximum) for failing or refusing to file a complete and accurate Form 5500;
 - Willful Violations: up to a \$100,000 fine and/or imprisonment up to 10 years.

Penalties may be waived if the noncompliance was due to reasonable cause. The DOL typically sends a Notice of Intent to Assess a Penalty to notify filers of a proposed DOL penalty due to a late or incomplete annual return. The CP 283 Notice is sent to notify filers of a proposed IRS penalty due to a late or incomplete Form 5500, 5500-SF or 5500-EZ return.

17.9 CORRECTION PROGRAM AVAILABLE FOR DELINQUENT FORM 5500S

If a plan is late in filing a 5500 form or a plan never filed a 5500 form because the sponsor was unaware that the plan had to do so, the DOL has a correction program to file late forms with reduced penalties.

Penalties under the DOL's Delinquent Filer Voluntary Compliance Program:

- Small Plans (fewer than 100 participants):
 - Penalty is \$10 per day not to exceed \$750.
 - If there are multiple late Form 5500s for the same plan, the maximum penalty is \$750 for each plan year, not to exceed \$1,500 per plan.
- Large Plans (100 or more participants):
 - Penalty is \$10 per day not to exceed \$2,000.
 - If there are multiple late Form 5500s for the same plan, the maximum penalty is \$2,000 for each plan year, not to exceed \$4,000 per plan.

A [DOL Fact Sheet](#) and [FAQs about the Delinquent Filer Voluntary Correction Program](#) are available.

18. FIDUCIARY RESPONSIBILITIES

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a welfare plan and their beneficiaries.

EMPLOYEE CONTRIBUTIONS

Although all plan assets must be held in a trust, there are exceptions to this rule for certain welfare plans. Employee contributions that are deposited or sent to the insurance company within 90 days of the withdrawal from employees' paychecks are not required to be held in a trust. Employers must ensure that they deposit the contributions or send the contributions to the insurance company within the 90-day time period to avoid the requirement to hold plan assets in a trust. In addition, amounts contributed to health FSAs are considered to be plan assets, but the DOL will not enforce the trust requirement for these amounts (or any pre-tax salary reductions for health care premiums) as long as (1) the health FSA and premium reimbursement plans are part of a cafeteria plan; and (2) all participant contributions are held as part of the employer's general assets (and not in any separate fund).

FIDELITY BONDS

A fidelity bond is required for all plan fiduciaries and other persons who handle plan funds or other plan property. The bond amount must be at least 10% of the funds handled, with a minimum of \$1,000 and a maximum of \$500,000. These bonds should be reviewed and updated annually.

18.1 NONDISCRIMINATION RULES

SECTION 125/CAFETERIA PLAN NONDISCRIMINATION REQUIREMENT

A cafeteria plan may not discriminate in favor of highly compensated individuals as to eligibility, and highly compensated participants as to contributions or benefits. Highly compensated individuals and participants include officers, 5% or more shareholders or owners, individuals who are highly compensated, or spouses or dependents of highly compensated individuals or participants. In addition, the plan may not provide more than 25% of the non-taxable benefits under the plan to "key" employees. A separate test also applies to contributions for health benefits offered under the plan. If the plan is discriminatory, the benefits provided under the plan must be treated as taxable income to the highly compensated individuals, highly compensated participants and/or "key" employees.

Employers must perform nondiscrimination testing as of the last day of the plan year and must include any non-includible employees who were employees at any time during the year. There are safe harbors for cafeteria plans that provide health benefits and for premium-only plans that satisfy certain requirements.

Notably, the regulations specify that employer contributions made to an HSA through a cafeteria plan are subject to cafeteria plan nondiscrimination rules rather than the otherwise applicable comparability rules of Code Section 4980G.

SELF-FUNDED MEDICAL PLAN NONDISCRIMINATION REQUIREMENT

A self-funded medical plan, under Section 105(h) of the Code, may not discriminate in favor of highly compensated individuals as to eligibility nor as to benefits provided under the plan. A highly compensated individual is one of the five highest paid officers, a shareholder who owns 10% or more of the value of the stock of the employer, or one of the highest paid 25% of all employees (other than excludable employees). To pass the eligibility test (1) at least 70% of all nonexcludable employees must actually participate in the plan, (2) at least 70% of all nonexcludable employees are eligible to participate in the plan and at least 80% of those who are eligible actually participate, or

(3) the plan must be offered to a nondiscriminatory class of employees.

To pass the benefits test, all the benefits provided to the highly compensated individuals must be provided to all other plan participants. If the plan fails the benefits test, then the full amount of the benefit provided under a self-insured plan must be included as taxable income to the highly compensated individuals. If the plan fails the eligibility test, then only a portion of the amount reimbursed to the highly compensated individual will be included as taxable income.

NOTE: The Internal Revenue Service has rules that “benefits” include not just coverage under the plan but also includes any type of benefit outside of the plan. Accordingly, employers who provide favorable terms to its highly compensated individuals, including, for example, by paying a higher contribution premium, waiving waiting periods, extending COBRA coverage period, or paying a part of COBRA premium when the same is not paid for every non-highly compensated individual, violates Code Section 105(h) and its nondiscrimination rules.

FULLY INSURED PLANS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (“PPACA”)

See full discussion at Section 9.

Prior to 2010, the nondiscrimination rules of Code Section 105(h) described above did not apply to fully insured plans. Under PPACA, effective upon the later to occur of the first plan year following September 23, 2010, or when the plan loses its grandfathered status, the nondiscrimination rules described above shall apply to fully insured plans. (For a discussion of grandfathering status under PPACA, see Section 2 of this Guide.)

The benefits and eligibility tests and rules described above generally apply to full insured plans, as and when described next above. However, the penalty for violating Code Section 105(h) nondiscrimination rules for fully insured plans is a penalty of \$100 per day per affected person, up to a maximum of \$500,000. Under federal law, employers are required to self-report any violation of these rules.

The application of this requirement to non-grandfathered fully insured plans has been delayed until further guidance is released by the federal regulatory agencies. As of the date of this guide, the federal agencies had not published guidance on this requirement. Check with qualified ERISA counsel for more information.

DEPENDENT CARE ASSISTANCE NONDISCRIMINATION REQUIREMENT

The contributions or benefits provided under a dependent care assistance plan may not discriminate in favor of highly compensated employees or their dependents. To satisfy this requirement, the average benefits provided to non-highly compensated employees must be at least 55% of the average benefits provided to highly compensated employees. In addition, not more than 25% of the amounts paid or incurred by the plan

sponsor for dependent care assistance may be paid to 5% or more shareholders or owners (or their spouses or dependents). If the plan is discriminatory, the highly compensated employees and/or the 5% or more shareholders and owners lose the tax benefit of the dependent care assistance plan.

LIFE INSURANCE NONDISCRIMINATION REQUIREMENT

A group term life insurance plan may not discriminate in favor of “key” employees as to benefits under the plan or as to eligibility for benefits under the plan. A “key” employee is an officer having annual compensation greater than \$135,000 per year; a 5% or more owner of the company; or a 1% or more owner of the company with annual compensation greater than \$150,000. If the group term life insurance plan is discriminatory, the “key” employee may not exclude the value of the first \$50,000 in life insurance coverage from his or her gross income. A group term life insurance plan with a level dollar amount of coverage, which is the same for all covered employees, does not discriminate in favor of “key” employees as to benefits.

HRA NONDISCRIMINATION REQUIREMENT

Because an HRA is not an insured benefit, it will be subject to nondiscrimination testing under Code Section 105(h). In general, Code Section 105(b) would require the HRA to (1) not discriminate in favor of highly compensated individuals as to eligibility to participate, and (2) provide benefits that do not discriminate in favor of highly compensated individuals. This means that a self-insured HRA may not base the maximum reimbursement amount on compensation, age, or years of service. IRS guidance received so far does not explain how a plan sponsor should test an HRA for nondiscrimination. However, informal comments by IRS officials indicate that it is probably permissible to test based on the annual increment credited to the HRA, rather than the HRA’s total account balance (which would include carryovers).

HSA COMPARABILITY REQUIREMENT

If the employer fails to contribute the same dollar amount or the same percentage of the annual deductible under the HDHP for all employees with comparable coverage, the employer is subject to an Cadillac Tax equal to 35% of the aggregate amount contributed by the employer to the HSAs of its employees for the period. (Comparability is determined separately for part-time employees.) The IRS may waive the Cadillac Tax where the failure is due to reasonable cause and not to willful neglect and the Cadillac Tax would be excessive relative to the failure involved. These rules do not apply to an employer’s HSA contributions made “through” a cafeteria plan.

18.2 MISCELLANEOUS ISSUES

BENEFIT ELECTIONS/PAY REDUCTION AGREEMENT

Each year before the open enrollment period, employers should communicate available benefit options for the upcoming plan year to employees and remind employees to make changes if they wish. This is especially important if the plan does not allow changes during the plan year absent special circumstances. If employees make contributions for benefits, employers should obtain an agreement from each participant to reduce the employee's pay for these contributions.

SECTION 125/CAFETERIA PLAN

Generally, elections must be made before the earlier of the first day of the plan year or period of coverage or when benefits are first currently available. Elections may be made electronically by employees. New employees or current employees who fail to make an election may be enrolled in a default election. It is permissible to make a new employee's cafeteria plan election retroactive up to 30 days, if this is incorporated in the plan document, but salary reductions may only be taken from compensation that is not yet currently available. However retroactive coverage is not allowed for an employee who returns to work after a termination or unpaid leave of less than 30 days. It is permissible for a cafeteria plan that offers dental and vision plans to require two-year election locks as an exception to the prohibition on the deferral of compensation, but the premiums must be paid no less frequently than annually and salary reductions from one year may not be used to pay premiums for the next year.

If employees are required to pay all or part of the premium for any fully-insured or self-funded benefits and are permitted to do so on a pre-tax basis, or if the employer pays additional compensation to employees who waive coverage under a group health plan, the Employer must maintain an Internal Revenue Code Section 125 Plan, commonly known as a "cafeteria plan." The plan must be in writing and signed before the plan may take effect. The written plan document must:

- Set forth the rules for eligibility to participate and the procedures for making elections
- Provide that all elections are irrevocable (except to the extent the plan incorporates the optional change in status rules)
- State how employer contributions may be made under the plan (for example, salary reduction or nonelective employer contributions)
- Describe all the benefits offered under the cafeteria plan, which may be satisfied by incorporating by reference separate plans that describe the benefits
- Identify the maximum amount of elective contributions
- Define the plan year
- Specify that only employees may participate in the cafeteria plan
- Include provisions complying with the uniform coverage rule, and the use-or-lose rule (formerly, the "use-it-or--lose-it" rule) if the plan includes a flexible spending arrangement, the ordering rule for use of paid time off, if used, and the optional 2½ month grace periods or carryover feature, if used
- Describe HSA salary reduction rules if an HSA is offered through the cafeteria plan.

The cafeteria plan “change in status” rules allow plans to offer employees an option to revoke a cafeteria plan election (other than a health FSA election) to purchase a qualified health plan through a Marketplace. There are two specific situations in which a plan can allow an employee to do so:

- **Reduction in hours.** If an employee had been reasonably expected to average at least 30 hours of service per week, but there was a later change in the employee’s status so that the employee actually averages fewer than 30 hours of service per week, then, even if the reduction does not result in the employee ceasing to be eligible under the group health plan, the employee may revoke coverage. The revocation is only permitted if the individuals losing coverage because of the revocation receive coverage under another plan that provides minimum essential coverage, and the new coverage must be in place by the first day of the second month following the month in which the prior coverage is revoked. The cafeteria plan may rely on the employee’s reasonable representation that he or she (and any related individuals who are revoking coverage) has enrolled or will enroll in another health plan that provides minimum essential coverage within the required timeframe.
- **Enrollment in the Marketplace/Exchange.** If an employee qualifies for a “Special Enrollment Period” to enroll in the Marketplace/Exchange, or if an employee chooses to enroll in the Marketplace/Exchange during the Exchange’s annual open enrollment, then the group health plan coverage may be revoked for the employee and his/her dependents, and the individual(s) may enroll in the Marketplace/Exchange and may choose coverage that is effective no later than the day immediately following the last day of the prior coverage that was revoked. A cafeteria plan may rely on the employee’s reasonable representation that the employee and any related individuals who are revoking coverage have enrolled or will enroll in coverage through the Marketplace within the required timeframe.

FLEXIBLE SAVINGS ACCOUNTS

The employer should remind flexible spending account (FSA) participants to budget health and dependent care expenses carefully to avoid forfeiture at the end of the plan year (or at the end of two and one-half months after the end of the plan year, if selected by the plan sponsor) under the “use or lose” rule. To aid in budgeting and making elections for the upcoming plan year, employees should be reminded that health care FSAs may include over-the-counter medications (other than insulin) as reimbursable expenses only if they are prescribed (so long as the plan document provides for such reimbursement).

DISABILITY BENEFITS

Disability benefits funded by the employer or purchased with pre-tax dollars are subject to federal income tax, FICA and FUTA. If employees pay the entire cost of disability benefits with after-tax funds, all benefits received by the employee are excludable from the employee’s gross income.

GROUP TERM LIFE BENEFITS

Include the value of employer-paid group term life insurance in excess of \$50,000 in W-2 earnings. Determine the value of this coverage using IRS Table I rates (minus after tax employee contributions, if any, without taking salary reductions into consideration). These amounts are subject to FICA withholding (but not federal income tax or FUTA withholding). Life insurance benefits payable upon the employee’s death are excludable from the employee’s income regardless whether the employee pays the premiums on a pre-tax or after-tax basis.

LONG-TERM CARE BENEFITS

In general, long-term care insurance is treated as accident and health insurance. This means that the employee can deduct any premiums paid for the coverage and the benefits are excludable from the employee's income regardless whether the employee pays the premiums on a pre-tax or after-tax basis.

SUBSIDIZED DOMESTIC PARTNER BENEFITS

Domestic partners are not eligible for the special tax treatment under the Internal Revenue Code, including the tax benefits under cafeteria plans and flexible spending accounts unless the domestic partner qualifies as a tax dependent of the employee. If the plan sponsor subsidizes any portion of the domestic partner's benefits, the plan sponsor must include the value of this coverage in the employee's income (and report it).

19. SUBROGATION & REIMBURSEMENT

The U.S. Supreme Court unanimously ruled in *Sereboff v Mid Atlantic Medical Services* that a medical plan may be reimbursed for medical claims it paid, but only from damage awards or settlements (“funds”) received by the participant or beneficiary. No reimbursement is allowed from the participant’s personal assets. Further, reimbursement is only allowed (a) if the Plan document imposes a constructive trust or equitable lien on the funds, and (b) the funds are within the beneficiary’s control or possession.

Group health plan documents should include a provision that clearly explains the plan’s procedures regarding subrogation and that clearly outlines the plan’s right to first recovery of any funds obtained by the participant from third parties relating to payments made by the plan on the participant’s behalf.

Self-funded group health plan documents should also contain a clause specifically providing that the federal common law “make whole doctrine” shall not apply to any recovery the participant may receive from third parties. Without such a provision, the plan might be prohibited from recovering any funds from the participant until the participant has been “made whole” for any losses and this could potentially cause significant loss of subrogation recoveries and legal fees to the plan.

Another important step is for plan sponsors to review their TPA agreements. TPA agreements should be amended to require that the TPA either notify the client of potential recovery situations, or properly handle recovery situations to preserve the plan’s right of recovery.

20. WRAP PLAN DOCUMENTS

[Agency] has entered a partnership agreement with a nationally recognized law firm, Marathas Barrow Weatherhead Lent LLP.

This firm was selected by [Agency] due to their expertise in employee benefits and employment law. Our partnership with this law firm will offer your company value added legal, compliance and legislative services and educational opportunities.

Upon request, Marathas Barrow Weatherhead Lent will provide estimated fees for SPD/Wrap services and will finalize proposed services and documents directly with your company. [Agency] is not compensated in any manner for this service and will work with any law firm your company chooses to assist you with your compliance program.

21. ONLINE ACCESS / GOVERNMENTAL CONTACTS / BENEFITS COUNSEL

21.1 STATE AND FEDERAL GOVERNMENT WEBSITE LISTINGS

- [U.S. Department of Labor Employer Site](#)
- [U.S. DOL Pension and Welfare Benefits Administration](#)
- [Social Security Administration](#)
- [Internal Revenue Service](#)
- [U.S. Department of Health & Human Services \(HIPAA\) Site](#)
- [HIPAA Privacy](#)
- [Northeast Human Resources Association](#)
- [Employee Benefits Adviser](#)
- [National Association of Insurance Commissioners](#)
- [Understanding the Affordable Care Act](#)

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22. EMPLOYER SHARED RESPONSIBILITY PROVISION (“PAY OR PLAY” MANDATE)

22.1 OVERVIEW

The ACA’s employer shared responsibility provision (“ESRP”) requires an applicable large employer (“ALE”) to offer health insurance to its full time employees and their dependent children or be exposed to a penalty if a full time employee receives a premium tax credit to help purchase coverage through the Health Insurance Marketplace (“Marketplace”) because the employer failed to offer the employee access to affordable, minimum value coverage. An ALE is an employer (determined on a controlled group basis) that employed 50 or more full time employees, including full time equivalent employees, on business days during the preceding calendar year. Each member of a controlled group of corporations with its own Employer Identification Number (“EIN”) is considered an ALE Member and is responsible for offering coverage to its full time employees and completing the applicable ACA reporting (Forms 1094-C and 1095-C) on their behalf. The controlled group as a whole is referred to as an Aggregated ALE Group for ESRP and ACA reporting purposes.

In general, there are two potential penalties (both non-deductible for tax purposes) that could be imposed on an employer for failure to satisfy the mandate. The first penalty, known as the “no coverage” penalty, is based on whether an employer fails to offer group health plan coverage to its full time employees and their dependents. In this case, the annual penalty is \$2,000 (as indexed) per full time employee (minus 30 full time employees) if at least one employee receives a premium tax credit for Marketplace coverage. The second penalty, known as the “unaffordability” penalty, applies when an employer offers coverage that fails to meet certain affordability and minimum value requirements. In that case, the annual penalty is \$3,000 (as indexed) for each full time employee who receives a premium tax credit for Marketplace coverage, but no more than what the “no coverage” penalty would be if it applied. Employers may avoid the “no coverage” penalty by offering coverage to all but 5% of their full time employees and their dependents. However, if any full time employee who is not offered coverage (or who is offered unaffordable coverage) receives a premium tax credit for Marketplace coverage, the employer will be required to pay the “unaffordability” penalty for that employee.

22.2 EXECUTIVE SUMMARY

The Final Regulations ([79 FR 8543](#)) cover the relevant issues by addressing three basic topics:

- **Applicable Large Employers (ALEs).** The Final Regulations define which employers are applicable large employers, and therefore subject to the rules. Generally, these are employers that employ 50 or more full time employees, including full time equivalent employees. The Final Regulations explain the rules for identifying full time employees and full time equivalent employees.
 - **NOTE:** ALE status is determined on a tax-controlled group basis.
- **Full time Employees.** An employer is potentially subject to a penalty only with respect to its “full time employees,” which do not include full time equivalents (such as part-time employees). Therefore, the Final Regulations include detailed rules to help employers make these judgments.
- **Shared Responsibility Payments.** The Final Regulations explain how to calculate any penalties and the circumstances under which they are imposed. The Final Regulations also explain how penalties are assessed and collected by the Internal Revenue Service.

In general, the type of employer that should be most concerned with the possibility of an ESRP penalty is one with employees who are considered full time under the mandate (using a 30 hour per week or 130 hour per month standard), but are not offered employer-sponsored health coverage, or are offered coverage that is either unaffordable or does not provide minimum value.

22.3 IDENTIFYING THOSE EMPLOYERS SUBJECT TO THE MANDATE

The starting point for understanding the ESRP is to understand which employers are potentially liable for a penalty. The Final Regulations refer to these employers as “applicable large employers.”

APPLICABLE LARGE EMPLOYER

An employer is an applicable large employer for a calendar year if it employed an average of at least 50 full time employees on the employer’s business days during the preceding calendar year. Solely for purposes of determining applicable large employer status (but not for penalty purposes), the hours of service of full time equivalent employees (e.g., part-time employees) are included in the calculation.

Example: During each month of 2018, an employer has 20 full time employees, each of whom averages 35 hours of service per week, and 40 part-time employees, each of whom averages 90 hours of service per month. In this example, each of the 20 employees who average 35 hours of service per week count as one full time employee for each month. To determine the average number of full time equivalent employees for each month, take the total hours of service of the part-time employees (up to 120 hours of service per employee) and divide by 120. The result is that the employer has 30 full time equivalent employees each month ($40 \times 90 \div 120 = 30$). By adding the two categories of employees together, the employer would have 50 full time and full time equivalent employees. Therefore, the employer is an applicable large employer for 2019.

The ESRP applies to all common law employers, including tax exempt entities and government entities (such as Federal, State, local or Indian tribal government entities). However, for purposes of determining applicable large employer status, and for penalty purposes, hours worked outside of the United States are disregarded, provided that the associated compensation constitutes foreign source income.

Treatment of Employees in U.S. Territories: The Secretary of Health and Human Services provided guidance on various issues concerning employees in the U.S. territories (Puerto Rico, American Samoa, Guam, Northern Mariana Island, and U.S. Virgin Islands) in a letter to governors on December 10, 2012.

In the letter, HHS recognizes that although the Act’s insurance market reforms (e.g., coverage for adult children, elimination of lifetime limits, and essential health benefits) generally apply to the territories, certain tax provisions (including premium tax credits and the employer mandate) do not automatically apply to the territories. The letter provides guidance on these and other issues, although each territory’s tax code must be analyzed to determine which of the Affordable Care Act’s tax provisions may apply.

LIMITED EXCEPTION FOR SEASONAL EMPLOYEES

Seasonal employees' hours are included when determining applicable large employer status; however, an employer will not be an applicable large employer if it employed 50 or more full time employees for no more than 120 days in the preceding calendar year, and the employees causing it to reach or exceed the 50 (or 100) full time employee threshold were seasonal employees employed no more than 120 days during the preceding calendar year. For these purposes, four calendar months may be treated as the equivalent of 120 days. The four calendar months and the 120 days are not required to be consecutive.

Example: An employer employs 40 full time employees for all of 2018. In addition, the employer also has 80 seasonal full time employees who work from September through December 2018. The employer has 40 full time employees during each of eight calendar months of 2018, and 120 full time employees during each of four calendar months of 2018, resulting in an average of 66 full time employees (rounding fractions down). However, the employer's workforce equaled or exceeded 50 full time employees (including seasonal workers) for no more than four calendar months in 2018, and the number of full time employees would be less than 50 during those months if seasonal workers were disregarded. Accordingly, the employer is not an applicable large employer for 2019.

CONTROLLED GROUPS

For purposes of determining applicable large employer status, all members of a tax controlled group are treated as a single employer. However, each member of a controlled group is treated as a separate entity for purposes of determining the liability for, or amount of, a penalty.

Example: In 2018 and 2019, corporation P owns 100 percent of all classes of stock of corporations S and T. For every calendar month in 2018, P has 10 full time employees, S has 40 full time employees and T has 60 full time employees. P, S, and T are a controlled group of corporations. Because P, S and T have a combined total of 110 full time employees during 2018, they are each potentially liable for an ESRP penalty in 2019.

For 2019, S offers coverage to its full time employees, whereas P and T do not. P has 3 full time employees who receive a premium tax credit to pay for the cost of the employee's coverage purchased through an Marketplace. P's penalty is based on P's full time employees. P's employee's receipt of a premium tax credit does not trigger a penalty on T with respect to T's full time employees.

Other rules regarding application of the penalty to controlled groups are discussed below.

SUCCESSOR EMPLOYERS

The Final Regulations provide that for purposes of determining applicable large employer status an employer includes a predecessor employer; however, the Final Regulations do not address the specific rules for identifying a predecessor employer, or the corresponding successor employer. Until further guidance is issued, employers may rely upon a reasonable, good faith interpretation of existing IRS guidance on predecessor (and successor) employers for purposes of determining applicable large employer status. The guidance also clarifies that for purposes of assessment and collection of an ESRP penalty (but not for determining applicable large employer status), State law may provide for liability of a successor employer for a penalty which has been, or could have been, imposed on a predecessor employer. In that case, the liability could be assessed, paid, and collected from the successor employer in accordance with IRS rules on transferred assets.

Successor Liability in Corporate Transactions: Under the Final Regulations, liability for a penalty is determined after the end of each calendar year. Therefore, an employer should consider the possibility of post-closing liability in any transaction, and ensure that the transaction document contains the appropriate representations and allocates responsibility for any ESRP penalties accordingly.

NEW EMPLOYERS

The Final Regulations provide that an employer not in existence during an entire preceding calendar year is an applicable large employer for the current calendar year if it is reasonably expected to employ an average of at least 50 full time employees (taking into account the hours of part-time employees) on its business days during the current calendar year.

Example: On January 1, 2018, Corporation B has three employees. However, its owners purchased a factory intended to open later that year that will employ approximately 100 employees. By March 15, 2018, Corporation B has more than 75 full time employees. Because Corporation B can reasonably be expected to employ on average at least 50 full time employees on business days during 2018, and actually employs an average of at least 50 full time employees on its business days during 2018, Corporation B is an applicable large employer for 2018.

22.4 IDENTIFYING EMPLOYEES WHO ARE FULL TIME UNDER THE MANDATE

Once it is clear that an employer is an applicable large employer, the employer must identify those full time employees whose coverage (or lack of coverage) would trigger a possible penalty. For this purpose, full time employee equivalents are not counted. Penalties are applied only with respect to actual full time employees. “Employee” is defined by the common law standard and, as such, certain individuals such as “leased employees” are excluded. Also, penalties apply on a monthly basis which, technically, requires employers to identify full time employees for each month. Because this can be a very cumbersome and burdensome process, the Final Regulations use special rules to identify full time employees. These rules are different from the rules for determining whether an employer is an applicable large employer.

HOURS OF SERVICE RULES

Under the mandate, a full time employee is an employee who is employed on average at least 30 hours of service per week or 130 hours per month. Hours of service include paid time off due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. An employee’s hours worked outside of the United States are disregarded, provided that the compensation for those hours of service constitutes foreign source income. Also, benefits paid from disability coverage purchased by the employee on an after-tax basis or hours paid solely to comply with a workers’ compensation law are not treated as hours of service.

With respect to part-time employees whose hours are not tracked, the Final Regulations require an employer to use one of two available “equivalency methods” to estimate an employee’s hours of service. Under the equivalency methods, an employer may either credit 8 hours of service per day if an employee works at least one hour, or credit 40 hours of service per week if an employee works at least 1 hour per week, provided that the hours credited generally reflect the actual hours worked. However, the Final Regulations prohibit use of the days-worked or weeks-worked equivalency methods if the result would be to substantially understate

an employee's hours of service in a manner that would cause that employee not to be treated as a full time employee. For example, an employee who worked 12 hours per day for 3 days one week could be credited with 40 hours that week, but could not be credited with only 8 hours of service per day under an equivalency method (because that would make it look like the employee only worked 24 hours during that week).

As discussed below, these credited hours will be averaged to determine whether the employee works (or is credited with) an average of at least 30 hours of service per week during a "look-back measurement period."

LOOK-BACK MEASUREMENT METHOD FOR IDENTIFYING FULL TIME EMPLOYEES

To assist employers in identifying full time employees and to ease the difficulties on employers, employees and the Marketplaces that would be created by determining eligibility for coverage on a monthly basis, the Final Regulations provide an optional look-back measurement method so that an employer can assess its potential for liability under the mandate. Under the look-back measurement method, there is an "initial" measurement period for new employees and a "standard" measurement period for "ongoing employees." Ongoing employees are employees who have worked for the employer for at least one "standard" measurement period (defined below).

1. Ongoing Employees

For ongoing employees, consistent with prior IRS guidance, the Final Regulations provide that an employer may determine whether an employee worked an average of at least 30 hours of service per week by looking back at a defined period of 3 to 12 consecutive calendar months, as chosen by the employer (the "standard measurement period"). If an employee is determined to work full time during a standard measurement period, then the employee is treated as full time during the "standard stability period" so long as he remains employed during that period and regardless of the hours actually worked. In general, the standard stability period must be the longer of six months following the standard measurement period or the number of months in the measurement period (taking into account any applicable "administrative period" as discussed below).

Employers have flexibility when choosing the measurement, stability and administrative periods for ongoing employees, provided that the determination is made on a uniform and consistent basis for all employees in the same category. For these purposes, the four permissible categories are: collectively bargained employees and non-collectively bargained employees; each group of collectively bargained employees covered by a separate collective bargaining agreement; salaried employees and hourly employees; and employees whose primary place of employment are in different States.

Example: An employer uses a calendar year standard stability period and a 12-month standard measurement period that begins each October 15, so that it can use an administrative period from October 15 through December 31 of each year to determine which employees worked full time during the measurement period. The plan's eligibility provisions require employees to work on average at least 30 hours per week during the standard measurement period to be eligible for coverage during the standard stability period. As of January 1, 2019, Employee A and Employee B have been employed by their employer for several years. Employee A worked full time during the October 15, – October 14, standard measurement period. Employee B did not work full time during that same period.

In this example, Employee A and Employee B are ongoing employees with respect to the calendar year 2019 stability period because they were employed during the entirety of the standard measurement period. Employee A is eligible for coverage for the entire 2019 stability period because he worked full time during the measurement period. However, Employee B is not required to be offered coverage in 2019 (including the October 15, 2019 – December 31, 2019 administrative period, because Employee B did not work full time during the measurement period.

2. Administrative Period for Ongoing Employees

An administrative period is available to accommodate employers that might need some time between the standard measurement period and the standard stability period in order to determine which employees are eligible for coverage and for other administrative purposes. The administrative safe harbor is a period of not more than 90 days between the end of the standard measurement period and the start of the standard stability period and may neither reduce nor lengthen the measurement period or the stability period.

To prevent an administrative period from creating a potential gap in coverage, it must overlap with the prior stability period, so that ongoing full time employees will continue to be offered coverage during the administrative period. For example, an employee entitled to coverage for a stability period that is calendar year 2019 will be covered during any administrative period in 2019 (see Employee A in the example above – he is covered during the administrative period from October 15, 2019 through December 31, 2019, because he is a full time employee for purposes of the 2019 calendar year stability period).

3. New Full time Employees

If a new employee is reasonably expected to work full time at date of hire and is not a seasonal employee, then at least for the first three months following an employee's date of hire, an employer will not be liable for a penalty solely by reason of failing to offer coverage to the employee during that three-month period. This coordinates with the Act's rule limiting waiting periods to no greater than 90 days.

Coordination with 90-day limit on waiting periods: A group health plan may not apply a waiting period greater than 90 days once the employee meets the plan's substantive eligibility conditions (such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms).

If, based on the facts and circumstances at time of hire, it cannot be determined that an employee is reasonably expected to work on average at least 30 hours per week, the employee is a variable hour employee. A new employee who is expected to work full time initially may be a variable hour employee if, based on the facts and circumstances, the period of full time employment is reasonably expected to be of limited duration and it cannot be determined that the employee is reasonably expected to work full time on average over the initial measurement period.

For example, a variable hour employee would include a retail worker hired full time for the holiday season who is reasonably expected to continue working after the holiday season but is not reasonably expected to work full time for the portion of the initial measurement period remaining after the holiday season, so that it cannot be determined at the time of hire that the employee is reasonably expected to work full time during the initial measurement period.

NOTE: that new full time hourly employees are measured monthly until they become "ongoing." They do not enter an initial measurement period if they change from full time to part-time before becoming ongoing (the initial measurement period is only for new part-time, seasonal or variable hour employees). In that situation, the employee may be treated as part-time for ACA reporting purposes for any month in which he or she works less than 130 hours. In other words, a new full time employee who changes to part-time before entering a standard stability period may be treated as part-time (i.e., coverage may be terminated and COBRA offered) without penalty exposure, as long as the employee continues to work part-time.

4. New Part-Time, Seasonal or Variable Hour Employees

If an employer uses the look-back measurement method for its ongoing employees, it may also do so for its new part-time, seasonal and variable hour employees in a manner consistent with the rules for ongoing employees. However, the initial measurement and administrative periods combined may not extend beyond the end of the month beginning on or after the employee's one-year anniversary (totaling, at most, 13 months and a fraction of a month). **NOTE:** that an employer may use an initial measurement period that is shorter than the initial stability period and still comply with the general rule that the initial measurement period and administrative period combined may not extend beyond the last day of the first month beginning on or after the employee's one-year anniversary. For example, an employer that wishes to use a 12-month stability period for new variable hour employees and an administrative period that exceeds one month may use an

11-month measurement period and still comply with the general rule that the initial measurement period and administrative period combined may not extend beyond the last day of the first month beginning on or after the employee's one-year anniversary.

5. Administrative Period for New Variable Hour and Seasonal Employees

As is permitted for ongoing employees, an employer may use an administrative period before the start of the initial stability period following an employee's initial measurement period. The administrative period must not exceed 90 days in total and includes all periods between the new employee's date of hire and the employee's eligibility date, other than the initial measurement period. Thus, for example, if the employer begins the initial measurement period on the first day of the month following a new variable hour or seasonal employee's date of hire, the period between the employee's start date and the first day of the next month must be taken into account in applying the 90-day limit on the administrative period. Similarly, if there is a period between the end of the initial measurement period and the date the employee is first offered coverage under the plan, that period must be taken into account in applying the 90-day limit on the administrative period.

In addition, the initial measurement period and administrative period together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee's date of hire. For example, if an employer uses a 12-month initial measurement period for a new variable hour employee, and begins that initial measurement period on the first day of the first calendar month following the employee's start date, the period between the end of the initial measurement period and the offer of coverage must not exceed one month (assuming the variable hour employee works full time during the initial measurement period).

6. Special Rules for Initial Stability Periods

An employee determined to work full time during the initial measurement period must be treated as a full time employee for the entire initial stability period, even if the employee is determined to be a part-time employee during the following standard measurement period. In that case, the employer may treat the employee as a part-time employee only after the end of the initial stability period. In other words, an employer must continue to offer coverage to an employee during the employee's initial stability period, even if the initial stability period overlaps with a standard stability period during which the employee would not be considered full time.

Example: An employer uses a 12-month initial measurement period for an employee hired July 1, 2017. If the employer's standard stability period operates on a calendar year basis, the employee's first standard stability period starts January 1, 2019. The employee works an average of at least 30 hours per week during the initial measurement period, but not during the standard measurement period. Based on the initial measurement period, the employee is eligible for coverage from August 1, 2018 through July 31, 2019, even though the standard measurement period indicates that the employer would not have to offer coverage at any time during the 2019 standard stability period.

If there is a period between the end of the initial stability period and the beginning of the first standard stability period as an ongoing employee, the employee's treatment as full time or not full time during the initial stability period continues to apply until the employee's first standard stability period as an ongoing employee.

Example: An employer uses a 12-month initial measurement period for an employee hired October 20, 2017 that runs from November 1, 2017 through October 31, 2018 for an initial stability period of December 1, 2018 through November 30, 2019. The employer's standard measurement period runs from October 15 – October 14 of each year. In this example, the employee's first standard stability period starts January 1, 2020 because the employee was not hired until after October 15, 2017, which means the first standard measurement period to apply begins October 15, 2018. Therefore, if the employee works full-time during the initial measurement period the employee's initial stability period will continue an additional month until January 1, 2020.

7. Change to Full time During the Initial Measurement Period

The Final Regulations address the treatment of new part-time, seasonal or variable hour employees who have a change in employment status during the initial measurement period (e.g., a promotion into a position in which employees are reasonably expected to be employed on average 30 hours of service per week). A new part-time, seasonal or variable hour employee who has a change in employment status during an

initial measurement period is generally treated as a full time employee as of the first day of the fourth month following the change in employment status (or by the start of the initial stability period, if sooner and the employee worked full time during the initial measurement period).

8. Change to Part-Time During the Standard Stability Period

A change in employment status for an ongoing employee does not change the employee's status as a full time employee or non-full time employee during the stability period, except when the special "3-month rule" applies. Under the 3-month rule, an employer using the look-back measurement method to determine the full-time employee status of an employee may apply the monthly measurement method to that employee beginning on the first day of the fourth full calendar month following the calendar month in which the employee experiences a change in employment status such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected not to be employed on average at least 30 hours of service per week (for example, the employee has changed to a part-time position of only 20 hours of service per week).

This rule only applies with respect to an employee to whom the employer continuously offered minimum value coverage no later than the end of the third full calendar month of employment, and only if the employee actually averages less than 30 hours of service per week for each of the three full calendar months following the change in employment status. Under this rule, an employer may apply the monthly measurement method to the employee even if the employer does not apply the monthly measurement method to the other employees in the same permitted category of employees (for example, under this method an employer could apply the monthly measurement method to an hourly employee, even if the employer uses the look-back measurement method to determine full-time employee status of all other hourly employees). The employer may continue to apply the monthly measurement method through the end of the first full measurement period (and any associated administrative period) that would have applied had the employee remained under the applicable look-back measurement method.

REHIRED EMPLOYEES OR EMPLOYEES RETURNING FROM A LEAVE OF ABSENCE

The IRS recognizes that an employee might work for the same employer on and off during different periods (e.g., due to unpaid leaves of absence, or when an employee is terminated and later rehired). The Final Regulations permit an employer to treat a returning employee as a new employee if the employee returns to work after a period of at least 13 consecutive weeks (26 consecutive weeks for employees of educational institutions) where no hours of service were credited.

Alternatively, if the period with no credited hours of service is between 4 and 13 weeks and is longer than the employee's term of employment, an employer may treat a returning employee as a new employee. For example, if an employee works three weeks, terminates employment, and is rehired by that employer ten weeks after terminating employment, the rehired employee is treated as a new employee because the ten-week period with no credited hours of service is longer than the immediately preceding three-week period of employment.

An employee treated as a continuing employee (as opposed to an employee who is treated as terminated and rehired), will return to the measurement and stability period that would have applied had the employee not experienced the period of leave. An employee who returns to work during a stability period where the employee would be treated as a full time employee must be offered coverage upon resumption of services, or, if later, as soon as administratively practicable.

SPECIAL UNPAID LEAVE

For periods of unpaid leave subject to FMLA or USERRA, and for unpaid leave on account of jury duty (“special unpaid leave”), the Final Regulations require an employer to determine the average hours of service per week for the employee during the applicable measurement period excluding special unpaid leave period and use that average as the average for the entire measurement period.

Alternatively, the employer may choose to treat employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.

EMPLOYEES OF EDUCATIONAL INSTITUTIONS

Additional requirements apply to employment break periods for employees of an educational organization. For this purpose, an employment break period is a period of at least four consecutive weeks (disregarding special unpaid leave) during which an employee is not credited with an hour of service.

The Final Regulations require applicable large employers that are educational organizations to treat employment break periods related to non-working weeks or months under the academic calendar as periods of special unpaid leave, as described above. Accordingly, an educational organization must either determine the average hours of service per week for the employee during the measurement period excluding the employment break period and use that average as the average for the entire measurement period, or treat employees as credited with hours of service for the employment break period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of an employment break period. In no event must an educational organization credit an employee with more than 501 hours of service in any calendar year for any employment break period (disregarding any periods of special unpaid leave subject to FMLA or USERRA, or on account of jury duty).

The Final Regulations contain anti-abuse rules designed to prevent the application of this rule (e.g., an employee’s hours of service during an employment break period are disregarded if they would prevent an employee from otherwise being treated as a full time employee in accordance with the rules for employees of educational institutions).

TEMPORARY STAFFING AGENCIES

The Final Regulations do not provide specific relief for temporary staffing agencies, which may face difficulty determining full time employee status due to the nature of their employees’ work schedules. The regulators recognize that although many employees of temporary staffing agencies will likely be variable hour employees, such employees are not inherently variable hour employees (e.g., highly-skilled technical or professional workers on long term assignments). It is anticipated that the rules discussed above regarding unpaid leaves of absence will resolve some issues.

MULTIEMPLOYER PLANS

The Final Regulations provide that an employer that is required by a collective bargaining (or participation) agreement to contribute to a multiemployer plan will not be treated, with respect to employees for whom the employer is required to contribute to the plan, as failing to offer full time employees (and their dependents)

the opportunity to enroll in minimum essential coverage (i.e., for the purposes of the “4980H(a) penalty” which may apply if an employer does not offer a specified percentage of its full time employees (and their children) insurance coverage) and will not be subject to a penalty for failing to offer affordable, minimum value coverage (i.e., for the purposes of the “4980H(b) penalty” which may apply if an employer does not offer affordable coverage that reimburses claims at least at a 60% level — so-called, minimum value coverage — to its full time employees) as long as the following conditions are met:

- the multiemployer plan offers dependent coverage;
- the multiemployer plan provides minimum value coverage; and
- the coverage is affordable.

The preamble to the Final Regulations provides that employers can treat multiemployer plan coverage as affordable using any of the safe harbor tests set forth in the final regulations (i.e., the “Rate of Pay,” “W-2” or “Federal Poverty Level” safe harbors). In addition, coverage is affordable if the employee’s required contribution toward self-only coverage does not exceed 9.5% (as indexed) of the wages reported to the multiemployer plan (using actual wages or an hourly wage rate under the agreement requiring contributions).

22.5 IDENTIFYING AN EMPLOYER’S LIABILITY FOR SHARED RESPONSIBILITY PAYMENTS

An applicable large employer may be liable for an ESRP penalty if it fails to satisfy either the Coverage Test or the Affordability Test.

- **Coverage Test.** An employer will fail this test if it does not offer “minimum essential coverage under an eligible employer sponsored plan” to at least 95 percent of its full time employees and their dependents, and at least one full time employee receives a premium tax credit. For “smaller” applicable large employers (less than 50 full time employees), an offer of coverage to all but 5 or fewer full time employees and their dependents will suffice.
- **Affordability Test.** An employer that offers “minimum essential coverage under an eligible employer sponsored plan” to all full time employees (or to at least 95 percent of its full time employees and their dependents), but has at least one full time employee who receives a premium tax credit because coverage was not offered to that employee or the coverage offered was not “affordable” or did not provide “minimum value.”
 - “Minimum essential coverage under an eligible employer sponsored plan” includes coverage offered under any self-insured group health plan and any health insurance coverage offered by an employer to an employee that is offered in the small or large group market (excluding limited scope dental or vision benefits offered under a separate insurance contract), regardless of whether the coverage offered is affordable to the employee or provides minimum value.
 - Coverage is “affordable” if the employee’s required contribution for self-only coverage does not exceed 9.5% (as indexed) of the employee’s household income for the year (see below for several alternatives available to employers other than household income, one of which permits an employer to substitute an employee’s annual wages, as reported in Box 1 of Form W-2, in lieu of household income).
 - A health plan provides “minimum value” if its share of the total allowed costs of benefits provided under the plan is at least 60 percent of those costs. Employer contributions to an HSA and amounts newly made available under an HRA may be taken into account in determining minimum value. **NOTE:** plans must cover inpatient hospitalization and physician services to provide minimum value (discussed further below).

- “Dependent” means an employee’s child under age 26 and includes natural and adopted children. Spouses, stepchildren and foster children are excluded from the definition of dependent for these purposes.

NOTE: Employers are not required to offer spousal coverage, and the receipt of a premium tax credit by an employee’s spouse or dependent will not result in a penalty.

Penalty Amounts

The annual penalty for failing the Coverage Test is equal to the number of full time employees (minus 30 full time employees) multiplied by \$2,000 (as indexed), if at least one full time employee receives a premium tax credit. The annual penalty for failing the Affordability Test is equal to the number of full time employees who receive a premium tax credit multiplied by \$3,000 (as indexed). The penalty for failing the Affordability Test cannot exceed the penalty for failing the Coverage Test – in other words, the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer any coverage. Penalties are calculated on a monthly basis.

Annual Open Enrollment Requirement

To avoid potential penalties, an employer must permit employees to enroll (or decline coverage) at least once each plan year. In addition, an employer may not render an employee ineligible for a premium tax credit by requiring employees to enroll in unaffordable coverage (as determined by reference to the federal poverty level safe harbor) or coverage that does not provide minimum value. However, an employer will not be treated as failing to offer coverage if that coverage is terminated due to the employee’s failing to make a timely payment of the employee portion of the premium. For this purpose, the Final Regulations incorporate certain of the COBRA rules regarding when premium payments are timely made.

Controlled Groups

The 30-full time employee reduction under the Coverage Test is allocated across each member company (i.e., on an EIN-by-EIN basis) based on size.

Example: Employers A and B are members of the same tax controlled group. Employer A employs 40 full time employees each month of the year. Employer B employs 35 full time employees in each month. Employer A does not offer any group health plan coverage and becomes liable for a penalty due to a full time employee receiving a premium tax credit. Employer B complies with the employer mandate. In this example, Employer A is subject to a penalty of \$48,000, which is equal to $24 \times \$2,000$ (40 full time employees reduced by 16 (its allocable share of the 30-employee offset $((40 \div 75) \times 30 = 16)$) and then multiplied by \$2,000 (as indexed)).

Under the Affordability Test, if an employee is employed by more than one member of a controlled group during a calendar month, the liability for the penalty is allocated to the member for whom the employee has the greatest number of hours of service for that calendar month.

Affordability Safe Harbors

An employer that complies with the Coverage Test and the minimum value portion of the Affordability Test may use one or more of the following safe harbor alternatives in lieu of household income when assessing whether coverage is affordable.

1. Form W-2 Safe Harbor

Coverage is affordable under the W-2 safe harbor if an employee’s required contribution for self-only coverage (excluding COBRA coverage) does not exceed 9.5% (as indexed) of the employee’s Form W-2 wages (as reported in Box 1). Application of this safe harbor is determined after the end of the calendar year and on an employee-by-employee basis, taking into account the Form W-2 wages and the required employee contribution for that year.

To qualify for the W-2 safe harbor, the employee’s required contribution must remain a consistent amount or percentage during the year, meaning that an employer is not permitted to make discretionary adjustments to the required employee contribution for a pay period. However, an employer may require a

contribution that is based on a consistent percentage of all Form W-2 wages and subject to a dollar limit specified by the employer (e.g., an employer may set the contribution for self-only coverage at 9.5% of wages up to \$200). The W-2 safe harbor is prorated for partial periods of coverage.

2. Rate of Pay Safe Harbor

Coverage is affordable under the rate of pay safe harbor if an employee's required monthly contribution for self-only coverage does not exceed 9.5% (as indexed) of an amount equal to 130 hours multiplied by the employee's hourly rate of pay. For salaried employees, monthly salary is used instead of 130 multiplied by the hourly rate of pay.

3. Federal Poverty Line Safe Harbor

Coverage is affordable under the Federal poverty line safe harbor if the employee's required monthly contribution for self-only coverage does not exceed 9.5% of a monthly amount determined as the Federal poverty line for a single individual for the applicable calendar year, divided by 12. For this purpose, the applicable Federal poverty line is the Federal poverty line for the State in which the employee is employed.

COBRA Qualified Beneficiaries

Under the Final Regulations, a failure to offer COBRA coverage could potentially trigger a penalty on an employer under the Coverage Test or the Affordability Test (in addition to any COBRA penalty for the failure). Although a failure to offer COBRA coverage in one instance may not trigger a penalty under the Coverage Test if the employer otherwise offers coverage to at least 95 percent of full time employees, a penalty under the Affordability Test could apply if the qualified beneficiary is not offered coverage or it is unaffordable.

Employer Reporting Obligation

The IRS will contact employers after the end of each calendar year to inform them of their potential liability and provide an opportunity for a response. Employers are required to file information returns identifying their full time employees and describing the coverage offered, if any. (See Appendix A for more information about employer reporting obligations).

NOTE: This Compliance Guide is provided as a service to clients and friends of Marathas Barrow Weatherhead Lent LLP. It is designed only to give general information on the material actually covered. It is not intended to be a comprehensive summary of the law or on recent developments in the law, treat exhaustively the subject matter covered, provide legal advice or tender a legal opinion. Questions concerning legal compliance should always be discussed with a licensed attorney with the requisite experience in the practice area of concern.

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APPENDIX A

Employer's Guide to ACA Reporting: A Review of the Forms and Instructions for 2019

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INTRODUCTION

As part of the Tax Cuts and Jobs Act (TCJA), the Affordable Care Act's (ACA) individual mandate penalty has been repealed effective January 1, 2019; however, the TCJA did not repeal the employer mandate nor its reporting requirements. Employers should be prepared to respond to IRS Employer Shared Responsibility Provision (ESRP) penalty letters and continue to prepare for 2019 reporting, which will occur in the first quarter of 2020.

The IRS has released the draft versions of its employer and provider reporting forms and instructions for 2019. Links to the forms and instructions are below:

- [Form 1094-C](#)
- [Form 1095-C](#)
- [Form 1094-C / 1095-C Instructions](#)
- [Form 1094-B](#)
- [Form 1095-B](#)
- [Form 1094-B / 1095-B Instructions](#)

Additional IRS guidance can be found here:

- [Forms and Instructions for Prior Years](#)
- [IRS Tool for Determining ALE Status and Potential Penalty Exposure](#)
- [Q/A's on Reporting by Health Coverage Providers \(Section 6055\)](#)
- [Q/A's on Reporting of Offers of Health Coverage by Employers \(Section 6056\)](#)
- [Q/A's about Information Reporting by Employers on Form 1094-C and Form 1095-C](#)
- [Q/A's on Employer Shared Responsibility Provisions Under the ACA](#)

This guide reviews the 2019 forms and instructions and notes relevant changes from 2018. It also addresses IRS guidance on the solicitation of social security numbers ("SSNs") or taxpayer identification numbers ("TINs") and the treatment of cash "opt-out" payments for reporting purposes. It also provides guidance for employers that receive Letter 226J, Notice of a proposed Employer Shared Responsibility Payment, Letter 5699, Request for ACA Reporting Forms, or Letter 972CG, Late Filing, Missing/Incorrect TIN, or Failure to File Electronically Forms.

The reporting requirements are complex, due in part to how the health care reform law was drafted. The Affordable Care Act added two sections to the Internal Revenue Code: Sections 6055 and 6056. The sections are found next to each other in the Code; however, they apply to different types of entities. Section 6055 applies to providers of health insurance, such as health insurance carriers and employers that sponsor self-insured plans. Section 6056 applies to "applicable large employers" or "ALEs", which are employers with 50 or more full-time equivalent employees in the prior calendar year.

To further complicate things, the reporting forms come in two different "series" – the B-Series and the C-Series forms. Employers may use either or both sets depending on their company size and whether their group health plan is self-insured or fully insured. Our goal with this guide is to provide some clarity and best practices for employers.

BACKGROUND

The Affordable Care Act (“ACA”) added Sections 6055 and 6056 to the Internal Revenue Code (the “Code”). These sections were first effective for calendar year 2015 and require employers and providers of health insurance coverage to report certain information to the IRS, full-time employees, and other plan participants each year. The Section 6055 reporting requirements apply to providers of health insurance coverage, such as insurance companies, employers that sponsor self-insured group health plans, and other entities that provide coverage, such as multiemployer plans. The Section 6056 reporting requirements apply to “applicable large employers” or “ALEs” and require reporting of health care coverage offered to the employer’s full-time employees (an ALE is an employer that employed 50 or more full-time equivalent employees on average in the prior calendar year).

Moreover, Section 6056 reporting applies at the “ALE Member” level, meaning that each member company of a controlled group of corporations files its own “authoritative” transmittal (Form 1094-C) and is responsible for reporting on its full-time employees. In other words, parent companies do not report on employees of their subsidiaries or affiliates, although each ALE Member will list the other ALE Members on Part IV of Form 1094-C as being a part of the same “Aggregated ALE Group.”

Reporting under Sections 6055 and 6056 involves one or both of two sets of forms: the “B-Series” forms (Forms 1094-B and 1095-B) and the “C-Series” forms (Forms 1094-C and 1095-C). Each set of forms includes a transmittal form (Forms 1094-B and 1094-C), which serves as a cover page to the individualized forms (Forms 1095-B and 1095-C), which are prepared for each employee for whom the employer is required to report. The B-Series forms are used to report whether individuals have minimum essential coverage (“MEC”) and, therefore, are not liable for the individual shared responsibility payment (which has been eliminated for months after December 2018). The C-Series forms are used to report information about offers of health coverage and enrollment in health coverage for employees, to determine whether an employer owes an employer shared responsibility payment, and to determine the eligibility of employees for the premium tax credit. However, ALEs that sponsor self-insured plans will perform their Section 6055 and 6056 reporting using only the C-Series forms when reporting on full-time employees.

The forms that must be filed and distributed depend on whether the employer is an ALE and the type of coverage provided. The following chart summarizes the filing and distribution requirements for the relevant reporting entities:

	Fully-Insured Plan	Self-Funded Plan
Non-ALE	Not required to file.	Forms 1094-B and 1095-B.
ALE	Forms 1094-C and 1095-C (Part III will not be completed).	Forms 1094-C and 1095-C for employees. Either B-Series or C-Series forms for non-employees.
Insurance Provider	Forms 1094-B and 1095-B.	Not applicable.

There is also Form 1095-A, which is provided by the Marketplace and is used by individuals who receive Marketplace coverage to reconcile premium tax credits. A general overview of the filing deadlines and other requirements relevant to the B-Series and C-Series forms is provided below.

WHAT'S NEW FOR 2019?

The forms and instructions are largely unchanged from 2018. The Plan Start Month box continues to be optional on Form 1095-C for 2019. Parts I and III of Form 1095-C include separate fields for each individual's first name, middle initial, and last name (a similar change is made to Parts I and IV of Form 1095-B.) Penalty amounts for reporting failures reflect indexed increases. The instructions reiterate, as in prior years, that the 250-return threshold that triggers mandatory electronic filing with the IRS applies separately for each type of form (i.e., separately for Form 1095-B and 1095-C) and for original and corrected returns.

2019 FILING DEADLINES AND EXTENSIONS

Forms 1095-C for the 2019 calendar year must be furnished to individuals by January 31, 2020. Forms 1094-C and 1095-C must be filed with the IRS by February 28, 2020, or March 31, 2020, if filing electronically. An automatic 30-day extension of time to file the forms with the IRS is available by completing [Form 8809](#). The form may be submitted on paper, or through the [FIRE System](#) either as a fill-in form or an electronic file. No signature or explanation is required for the extension. However, it must be filed on or before the due date of the returns to get the 30-day extension. Under certain hardship conditions an additional 30-day extension may apply; however, requests for additional extensions of time to file information returns are not automatically granted and the automatic extension of time to file and any approved requests for additional time will only extend the due date for filing the information returns with the IRS. **NOTE:** The automatic extension for filing with the IRS does not extend the due date for furnishing statements to individuals.

Employers may request a 30-day extension of time to furnish the statements to recipients by sending a letter to the IRS that includes identifying information about the employer and which states the reason for delay.

ELECTRONIC FILING

Electronic filing under the [AIR system](#) is required by entities that are required to file 250 or more information returns, otherwise a penalty will apply. The threshold applies separately to each type of form filed and separately for original and corrected returns. For example, if an entity has 500 Forms 1095-B and 100 Forms 1095-C, it must file Forms 1095-B electronically, but is not required to file Forms 1095-C electronically. If the entity has 150 Forms 1095-C to correct, it may file on paper because the corrected returns fall under the threshold. However, if there are 300 Forms 1095-C to correct, they must be filed electronically. The IRS encourages electronic filing by employers of all sizes. The electronic filing requirement does not apply if the entity applies for and receives a hardship waiver ([Form 8508](#)). Also, entities that are required to file electronically can file up to 250 returns on paper; those returns will not be subject to a penalty for failure to file electronically.

FURNISHING FORMS TO PARTICIPANTS

Statements to participants must be furnished on paper by mail (or hand delivered), unless the recipient affirmatively consents to receive the statement in an electronic format. **NOTE:** that the consent must relate specifically to receiving the Form 1095-C electronically. Consent may be provided on paper or electronically; however, if consent is on paper, the recipient must confirm the consent electronically. Statements reporting expatriate coverage, however, may be furnished electronically unless the recipient explicitly refuses to consent to receive the statement in an electronic format.

SUBSTITUTE STATEMENTS TO RECIPIENTS

If you are not using the official IRS form to furnish statements to recipients, see [Pub. 5223](#), which explains the requirements for format and content of substitute statements to recipients. Employers may develop forms themselves or buy them from a private printer. Substitute statements furnished to recipients may be in portrait format; however, substitute returns filed with the IRS using paper must be printed in landscape format.

REPORTING PENALTIES

The IRS has granted temporary relief from accuracy-related penalties for reports filed for the 2015-2018 calendar years for reporting entities that can show a good faith effort to comply. In determining good faith, the IRS will consider whether employers have made reasonable attempts to comply with the requirements (e.g., gathering and transmitting the necessary data to an agent or testing its ability to transmit information) and the steps that have been taken to prepare for next year's reporting. It does not appear that this temporary relief extends to 2019 filings.

The following table reflects penalties for returns filed in the applicable year (i.e., the 2020 penalty is for returns filed in 2020 for calendar year 2019), based on information found in [Rev. Proc. 2017-58](#), as modified by [Rev. Proc. 2018-18](#). **NOTE:** that failure to provide Form 1095-C to an employee and the IRS may result in two penalties, as each are supposed to receive the form (doubled for willful failures, with no cap on the penalty). The instructions also make clear that each employer is responsible for satisfying its reporting obligation, regardless of its use of third parties to assist with the reporting process.

Penalty Description	2021 Penalty	2020 Penalty	2019 Penalty
Failure to file an information return or provide a payee statement	\$280 for each return with respect to which a failure occurs	\$270 for each return with respect to which a failure occurs	\$270 for each return with respect to which a failure occurs
Annual penalty limit for non-willful failures	\$3,392,000	\$3,339,000	\$3,275,500
Lower limit for entities with gross receipts not exceeding \$5M	\$1,130,500	\$1,113,000	\$1,091,500
Failures corrected within 30 days of required filing date	\$50	\$50	\$50
Annual penalty limit when corrected within 30 days	\$565,000	\$556,500	\$545,500
Lower limit for entities with gross receipts no exceeding \$5M when corrected within 30 days	\$197,500	\$194,500	\$191,00
Failures corrected by August 1	\$110	\$110	\$100
Annual penalty limit when corrected by August 1	\$1,696,000	\$1,669,500	\$,637,500
Lower limit for entities with gross receipts no exceeding \$5M when corrected by August 1	\$565,000	\$556,500	\$545,500
Failure to file an information return or provide a payee statement due to intentional disregard	\$560 per return with respect to which a failure occurs (no cap)	\$550 for each return with respect to which a failure occurs (no cap)	\$540 for each return with respect to which a failure occurs (no cap)

EMPLOYER SHARED RESPONSIBILITY PENALTIES, AFFORDABILITY

As discussed, the C-Series forms are used to determine whether employers owe a shared responsibility payment and whether employees are eligible for the premium tax credit (i.e., whether the employees were offered “affordable” coverage). Both the employer shared responsibility penalties and the 9.5% affordability factor are indexed to inflation.

Code Section	490H(a)	490H(b)	36B(b)(3)(A)(i)
Description	Coverage not offered to 95% (or all but 5) of full-time employees.	Coverage offered, but unaffordable or is not minimum value.	Premium credits and affordability safe harbors.
2020*	\$2,570	\$3,860	9.78%
2019*	\$2,500	\$3,750	9.86%
2018	\$2,320	\$3,480	9.56%
2017	\$2,260	\$3,390	9.69%
2016	\$2,160	\$3,240	9.66%
2015	\$2,080	\$3,120	9.56%
2014**	\$2,000	\$3,000	9.50%

*Section 4980H(a) and (b) penalties for 2019 are projected.

**No employer shared responsibility penalties were assessed for 2014.

EMPLOYER SHARED RESPONSIBILITY PENALTIES, LETTER 226J

In November 2017, employers across the country began receiving penalty notices related to their calendar year 2015 reporting. Enforcement of calendar year 2017 began in the fall of 2018. Employers started receiving letters for calendar year 2018 in the summer of 2019, and continue to receive them into quarters 3 and 4.

The general procedure the IRS uses to propose penalties is described in [Letter 226J](#), which is the initial proposal of the penalty that may be owed. The IRS has published [Understanding your Letter 226J](#) for employers to understand what they need to do and what they may want to do if they receive Letter 226J.

Letter 226J will be issued if the IRS determines that, for at least one month in the year, at least one of the employer’s full-time employees was enrolled in subsidized coverage through the Marketplace and the employer did not qualify for an affordability safe harbor (or other relief for the employee). The determination of whether an employer may be liable for a penalty and the amount of the proposed penalty in Letter 226J are based on information from Forms 1094-C and 1095-C filed by the employer and the individual income tax returns filed by the employer’s employees.

The letter will include, among other things, the following:

- a brief explanation of the pay-or-play provisions;
- a table itemizing the proposed penalty by month and whether the liability is under the “no coverage” provision, the “unaffordability” provision or neither;
- an employer shared responsibility response form ([Form 14764 – ESRP Response](#));
- a list of full-time employees who received subsidized Marketplace coverage each month ([Form 14765 – Employee Premium Tax Credit List](#)) and for whom the employer did not qualify for an affordability safe harbor or other relief;
- a description of the actions the employer should take if it agrees or disagrees with the proposed payment amount in Letter 226J; and
- a description of the actions the IRS will take if the employer does not respond timely.

The response to Letter 226J will be due by the response date shown on that letter, which generally will be 30 days from the date of Letter 226J. The letter will contain the name and contact information of a specific IRS employee that the employer should contact if it has questions about the letter.

EMPLOYER RESPONSE TO LETTER 226J

Employers will have an opportunity to contest any proposed penalty notices. Employers that receive a Letter 226J may respond to the IRS about the proposed payment. The letter will provide instructions for how the employer should respond in writing, either agreeing with the proposed penalty amount or disagreeing with all or a portion of it. Employers may allow someone to contact the IRS on their behalf so long as they send the IRS a Form 2848 (Power of Attorney and Declaration of Representative) that states specifically the year and that it is for the Section 4980H Shared Responsibility Payment.

If an employer agrees with the penalty determination, it must complete and return a Form 14764, ESRP Response, that is enclosed with the letter, and include full payment by check or money order for the penalty amount assessed (or, if enrolled in the Electronic Federal Tax Payment System (EFTPS), pay electronically).

If an employer disagrees with the penalty determination, it must complete and return a Form 14764, ESRP Response, and include a signed statement explaining the basis for the disagreement. The ALE may include documentation with the supporting statement. The statement must also include what changes the ALE would like to make to the Forms 1094-C. Any changes to the Forms 1095-C should be made on Form 14765, Employee PTC Listing. The employer should not file a corrected Form 1094-C or 1095-C. The Letter 226J includes additional, specific instructions on making changes to the Employee PTC Listing.

If the ALE responds to Letter 226J, the IRS will acknowledge the ALE’s response with one of five versions of Letter 227 (which, in general, acknowledge the ALE’s response and describe further actions the ALE may need to take). If, after receipt of Letter 227, the ALE disagrees with the proposed or revised employer shared responsibility payment amount, it may request a pre-assessment conference with the IRS Office of Appeals. The ALE should follow the instructions provided in Letter 227 and [Publication 5](#) for requesting a conference with the IRS Office of Appeals. A conference should be requested in writing by the response date shown on Letter 227, which generally will be 30 days from the date of Letter 227.

If the ALE does not respond to either Letter 226J or Letter 227, the IRS will assess the amount of the proposed penalty and issue a notice and demand for payment (Notice CP 220J). Notice CP 220J will include a summary of the ALE’s payment responsibility and will reflect payments made, credits applied, and the balance due, if any. The notice will instruct the ALE how to make payment, if any. ALEs will not be required to include the employer shared responsibility payment on any tax return that they file or to make payment before notice and demand for payment. ALEs may have the ability to make installment payments, as described in [Publication 594](#).

REQUEST FOR ACA REPORTING FORMS, LETTER 5699

The IRS has also begun sending letters to employers it believes were ALEs and should have filed Forms 1094-C / 1095-C for 2015 or a subsequent year. Employers receiving Letter 5699 have 30 days to respond to the IRS and indicate whether they:

- Offered coverage for the year in question and already submitted forms (if so, they'll need to indicate employer name, EIN and filing date);
- Were an ALE for the year in question and have submitted their forms with the response letter (not available for employers that must file electronically);
- Were an ALE for the year in question and will submit their forms within the next 90 days (if more than 90 days, an explanation is required); or
- Were not an ALE for the year in question.

If none of the above apply, the employer must indicate in writing why they haven't filed and what actions they plan to take. Employers that receive Letter 5699 should consult with ERISA counsel for assistance with obtaining an extension of time to respond and/or preparing a response.

LATE FILING, INCORRECT/MISSING TIN, OR FAILURE TO ELECTRONICALLY FILE, LETTER 972CG

In the fall of 2019, the IRS began to send letter to employers that filed 1094/1094-C forms late, had the incorrect TIN (tax identification number), or failed to file electronically for 2017 filings. There are 5 types of penalties that can occur as part of this letter:

- TIN: penalty applies to returns with a missing or incorrect tax identification number.
- Failure to File Electronically: penalty applies for each form over 250 that were filed by paper instead of electronic.
- Tier 1: penalty applies to returns filed after the due date but within 30 days.
- Tier 2: penalty applies to returns filed after the due date and after 30 days but before August 1.
- Tier 3: penalty applies to returns filed after August 1.

Employers receiving Letter 972CG will generally have 45 days to respond to the IRS from the date the notice was sent. Within Letter 972CG is a response sheet, where the employer can indicate if they are in full agreement, partial agreement, or total disagreement with the penalty. If the employer partially or totally disagrees with the penalty, the employer is required to submit a signed statement with the reasons why it disagrees and any other supporting documentation. Employers should consult with legal counsel before responding.

The IRS will respond to an appeal and the employer will need to respond accordingly. This could include the IRS accepting the explanation and waiving, partially accepting the explanation and issuing a lower penalty, or not accepting the explanation and requiring the employer to pay the penalty. If the employer disagrees with the IRS' assessment, it should consult with ERISA counsel to determine the next best course of action.

GUIDANCE ON ERROR MESSAGES, SSN/TIN SOLICITATION

In general, employers that report under Section 6055 (i.e., those that sponsor self-insured plans) and insurance carriers must obtain SSNs or TINs for their covered participants. Under Section 6055, the requirement to obtain an SSN or TIN may be satisfied by making an initial solicitation when the individual first enrolls. If an SSN or TIN is not provided at the time of initial enrollment, a second solicitation (the first annual solicitation) must be made at a reasonable time thereafter (generally within 75 days). If the second solicitation is unsuccessful, a third solicitation (the second annual solicitation) must be made by December 31 of the year following the initial solicitation.

Employers reporting on full-time employees under Section 6056 have an existing requirement to collect an employee's SSN at time of hire (a discussion of which exceeds the scope of this client guide). Therefore, the guidance above regarding when to make an SSN or TIN solicitation applies in the context of obtaining an SSN or TIN from an enrollee in a group health plan.

That said, the following IRS guidance on soliciting SSNs or TINs based on the AIRTN500 error message, which indicates that an SSN or TIN provided on the return do not match IRS records, applies regardless of whether the employer is reporting under Section 6055 and/or Section 6056. In these situations, a filing status of "accepted with errors" due to an AIRTN500 message does not trigger an additional SSN or TIN solicitation requirement. An AIRTN error message is neither a Notice 972CG (Notice of Proposed Civil Penalty), nor a requirement that the employer must solicit an SSN or TIN in response to the error message³. Therefore, an employer is not required to make additional SSN or TIN solicitations if the previous solicitation produced an AIRTN500 message, unless the employer receives Notice 972CG from the IRS.

B-SERIES FORMS AND INSTRUCTIONS

In general, most employers will not file the B-Series forms for their employees. Employers that will file the B-Series forms are those who have self-insured plans but are not ALEs, or ALEs that provide self-insured coverage to non-employees (e.g., retirees or COBRA participants in the years following termination) and prefer to use the B-Series forms over the C-Series forms to report on those non-employees who are covered under the self-insured plan (the instructions allow self-funded ALEs the option of using the B-Series or C-Series forms to report coverage for individuals who were not employees at any point during the year).

The B-Series forms are typically used by insurance companies to report months of "minimum essential coverage" or "MEC" to covered individuals. For example, all employees who are enrolled in a fully insured group health plan will receive a Form 1095-B from the insurance company. If the employees work full-time for an ALE, they will also receive a Form 1095-C from their employer. Any government coverage through the Children's Health Insurance Program (CHIP), Medicaid, or Medicare (including Medicare Advantage) is reported by the government sponsors of those programs.

³81 FR 50671 at 50676, footnote 2 (<https://www.federalregister.gov/d/2016-18100>).

B-SERIES FORMS – DETAIL

As noted above, only certain non-ALEs and self-funded employers (including level-funded employers) might use Form 1095-B to report MEC for certain covered individuals. For example, a non-ALE will report self-insured coverage for employees on Form 1095-B, and a self-insured ALE has the option of reporting coverage for any individual who was not a full-time employee for any month of the year on Form 1095-B or Form 1095-C (see below for reporting of non-full-time employees on the C-Series forms).

Non-ALEs reporting self-funded (or level-funded) coverage on Form 1095-B use code B on line 8, leave Part II blank, and enter their relevant company information in Part III as the “provider” of self-funded coverage. Part I contains the participant’s information and Part IV reports the months of coverage for the participant and any covered family members. Only insurance companies entering codes A or B on line 8 will complete Part II.

When completing Part IV, employers may enter a date of birth in column (c) only if an SSN or other TIN isn’t entered in column (b). When checking the box in column (d) or boxes in column (e), an individual is treated as being covered in a month if the individual was covered on at least one day in that month.

B-SERIES FORMS – CORRECTIONS

In general, employers should file corrected returns as soon as possible after an error is discovered. Errors on Form 1095-B that require correction include mistakes regarding the responsible individual’s name, origin of coverage (line 8), SSN or TIN, employer information (Part II), coverage provider information (Part III), and covered individuals (Part IV).

When correcting a Form 1095-B that was previously filed with the IRS, complete the form and enter an “X” in the CORRECTED checkbox when furnishing to the participant. When correcting a Form 1095-B that was previously furnished to a participant, but not the IRS, write, print or type CORRECTED on the new Form 1095-B furnished to the recipient (enter an “X” in the CORRECTED checkbox only when correcting a Form 1095-B previously filed with the IRS). Then, file a Form 1094-B with the IRS along with the corrected Form(s) 1095-B (do not file a corrected Form 1094-B).

GUIDANCE FOR EMPLOYERS WITH HRAS

The instructions for the B-Series forms contain guidance on an employer’s obligation to report when an employee is covered under more than one form of MEC. If, for any month, an individual is covered by more than one form of MEC that is provided by the same employer, the employer is required to report only one of the coverages for that month. For example, an insurance company offering a Medicare or TRICARE supplement for which only individuals enrolled in Medicare or TRICARE are eligible is not required to report coverage under the Medicare or TRICARE supplement.

However, for this rule to apply to employer-sponsored coverage, the employer must sponsor both types of coverage. For example, if an employer offers a health reimbursement arrangement (“HRA”) that is only available to employees who enroll in its fully insured group health plan, the employer is not required to report the employee’s coverage under the HRA for the months in which the employee is enrolled in both plans. If, however, an employer offers an HRA to employees who enroll in coverage sponsored by another employer (such as spousal coverage), the employer sponsoring the HRA must report that coverage.

Considering the application of this rule to employers, it is not clear whether employers must report under Section 6055 if they offer retiree HRAs that require the retiree to be entitled to Medicare to participate. Further guidance from the IRS on this issue would be welcome.

C-SERIES FORMS AND INSTRUCTIONS

As mentioned, applicable large employers or “ALEs” (i.e., employers with 50 or more full-time equivalent employees in the previous year) use Forms 1094-C and 1095-C to report information about offers of health coverage. Form 1094-C is used to report summary information to the IRS and Form 1095-C is used to report information about each full-time employee to the IRS and to the employee. ALE Members that offer self-insured coverage also use Form 1095-C to report information to the IRS and to employees about covered individuals.

FORM 1094-C – DETAIL

Form 1094-C provides a summary of aggregate, employer-level data to the IRS. It’s essentially a “cover page” for the Forms 1095-C that are sent to the IRS. Information required on Form 1094-C includes:

- employer information and information on the ALE Member’s controlled group;
- whether the employer is using simplified reporting methods (discussed below);
- information about whether an offer of coverage was made to 95% (or all but five) of full-time employees and their dependents (70% for 2015 plan years);
- total number of Forms 1095-C issued to employees;
- full-time employee count by month; and
- total employee count by month.

FORM 1094-C, PART I

The first 16 lines of Form 1094-C request standard employer information. Line 17 is reserved, and Line 18 requests the total number of Forms 1095-C that will be transmitted along with the Form 1094-C being completed. Line 19, however, can be a source of confusion for employers. As noted above, Form 1094-C is prepared at the ALE Member level, meaning that each member of a controlled group of corporations files its own “authoritative” Form 1094-C by checking the box on line 19. An ALE Member may file multiple Forms 1094-C, although they must mark one (and only one) as the authoritative transmittal. Many employers will file one Form 1094-C, which will be their authoritative transmittal.

NOTE: Each ALE Member must file its own Forms 1094-C and 1095-C under its own separate Employer Identification Number (“EIN”), even if the ALE Member is part of an Aggregated ALE Group. No Authoritative Transmittal should be filed for an Aggregated ALE Group.

FORM 1094-C, PART II

Lines 20-22 are completed only on the authoritative transmittal. Line 20 requests the total number of Forms 1095-C that will be filed by the ALE Member. Employers filing one Form 1094-C will have the same number in both lines 18 and 20. Line 21 (Aggregate ALE Group) should be checked by employers that are part of a controlled group of corporations during any month of the reporting year. If line 21 is checked, the employer must also complete the “Aggregated Group Indicator” in Part III, column (d), and then complete Part IV to list the other members of the Aggregated ALE Group.

Line 22 – Certifications of Eligibility – can also be confusing for employers. There are two possible choices on line 22, and an employer may select all, some, or none, depending on the facts. The two Certifications of Eligibility are discussed below.

Line 22, Box A – Qualifying Offer Method

An employer will check this box if they are making a “Qualifying Offer” and are using code 1A in line 14 of Form 1095-C to report that offer, or they are using an alternative method to furnish Form 1095-C to employees.

To be eligible to use the Qualifying Offer Method, the employer must have made a Qualifying Offer to at least one full-time employee for all months during the year in which the employee was a full-time employee for whom an employer shared responsibility payment could apply. A Qualifying Offer is an offer of MEC providing minimum value to a full-time employee, with a required employee contribution that does not exceed 9.5% (as adjusted) of the mainland single federal poverty line (“FPL”) in effect within six months before the start of the plan year, divided by 12, provided that the offer includes an offer of MEC to the employee’s spouse and dependents (if any).

For plan years beginning in 2019, the required employee contribution percentage is 9.86%, which limits the monthly employee contribution to \$99.75 ($\$12,140 \text{ mainland FPL} \div 12 \times 9.86\%$) if an employer wishes to make a Qualifying Offer.

When an employer uses the Qualifying Offer Method, it must not complete Form 1095-C, line 15 (Employee Required Contribution), for any month for which a Qualifying Offer is made. Instead, it enters code 1A on Form 1095-C, line 14, for any month for which the employee received a Qualifying Offer (or in the “all 12 months” box, if applicable). The instructions provide that employers making a Qualifying Offer need not complete Form 1095-C, line 16 (safe harbor codes) because a Qualifying Offer is, by definition, affordable and therefore no penalty could apply. **NOTE:** that use of the Qualifying Offer method is not mandatory for employers who qualify; they instead may complete Part II of Form 1095-C with the applicable offer code and required employee contribution.

In addition, an employer that is eligible to use the Qualifying Offer Method may use an alternative method of furnishing Form 1095-C for certain employees. The alternative method is available only for a full-time employee who: (1) received a Qualifying Offer for all 12 months of the calendar year, and (2) did not enroll in employer-sponsored coverage under a self-insured plan. In lieu of furnishing Form 1095-C for these employees, the employer may provide a statement that contains the following information:

- Employer/ALE Member name, address, and EIN;
- Contact name and telephone number at which the employee may receive information about the offer of coverage and the information on the Form 1095-C filed with the IRS for that employee;
- Notification that, for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and therefore are not eligible for a premium tax credit; and
- Information directing the employee to see Pub. 974, Premium Tax Credit (PTC), for more information on eligibility for the premium tax credit.

The alternative method of furnishing Form 1095-C may be of limited usefulness to employers, as the employer is still required to prepare a Form 1095-C for transmission to the IRS.

Line 22, Box B – Reserved

Box B on Line 22 of Form 1094-C is no longer applicable after 2015.

Line 22, Box C – Reserved

Box C on Line 22 of Form 1094-C is no longer applicable after 2016.

Line 22, Box D – 98% Offer Method

To be eligible to check box D and use the 98% Offer Method, the employer must have offered affordable, minimum value coverage to at least 98% of its employees for whom it is required to file a Form 1095-C and offered MEC to those employees' dependents. For these purposes, coverage may be affordable under any of the three affordability safe harbors (W-2, Rate of Pay, and Federal Poverty Line). Under this method, the employer is not required to complete the "full-time employee count" in Part III, column (b) of Form 1094-C.

This method provides limited relief to most employers, although for certain employers it can be very helpful. Employers that only offer coverage to full-time employees will obviously know how many employees were full-time each month, so the 98% Offer Method is of limited use to them. Likewise, employers with fully insured plans will only need to report on full-time employees. However, employers with self-insured plans must report on full-time employees as well as any other individual who are covered under the self-insured plan. A self-insured employer that offers coverage to part-time employees may not bother to track which employees are full-time for ACA purposes, because they offer part-time employees affordable coverage as well. Therefore, this method may be of interest to those employers because it allows them to forgo completing the "full-time employee count" in Part III, column (b) of Form 1094-C.

NOTE: If an ALE member uses the 98% offer method, it is not required to complete the "full-time employee count" in Part III, column (b) of Form 1094-C.

FORM 1094-C, PART III

Part III of Form 1094-C, lines 23-35, reports monthly information for the ALE Member. Column (a) reports whether the employer offered MEC to at least 95% (or all but five) of its full-time employees and their dependents. Employers can use Line 23 to report on the entire calendar year. Otherwise, Lines 24 through 35 should be used to report the answer for each applicable month. For purposes of column (a), an employee in a limited non-assessment period ("LNAP") such as a waiting period or initial measurement period is not counted in determining whether MEC was offered to at least 95% of the employer's full-time employees and their dependents. In our experience, it appears that if full-time employees are reported for each month of the year (as opposed to Line 23—All 12 Months), the IRS expects the MEC Offer Indicated marked for those months as well (rather than using Line 23)

NOTE: As mentioned in the LNAP section below, an employee in an LNAP is not a full-time employee those months, even if coverage is offered before the end of the LNAP.

Column (b) reports the employer's full-time employee count by month, excluding employees in an LNAP. The instructions note that an employee should be counted as full-time for any month in which the employee was full-time under the monthly measurement method or the look-back measurement method, as applicable, on any day of the month.

Column (c) reports the employer's total employee count, including full- and part-time employees and employees in an LNAP. The total employees count may be determined by choosing one of the following days of the month: (1) the first day of each month; (2) the last day of each month; (3) the 12th day of each month; (4) the first day of the first payroll period that starts during each month; or (5) the last day of the first payroll period that starts during each month (provided that for each month that last day falls within the calendar month in which the payroll period starts).

Column (d) is completed only if the employer checked “Yes” on line 21, indicating that it was a member of an Aggregated ALE Group. If an ALE Member enters an “X” in one or more months in column (d), it must also complete Part IV.

Column (e) is no longer applicable after 2016 and has been marked as “reserved.”

FORM 1094-C, PART IV

An employer must complete this section if it checks “Yes” on line 21. If the employer was a member of an Aggregated ALE Group (a tax-controlled group) for any month of the calendar year, it will enter the names and EINs of the other members (other than itself). Special rules apply when listing more than 30 controlled group members in Part IV. ALE Members with no full-time employees are not required to prepare the C-Series forms.

FORM 1095-C – DETAIL

Form 1095-C is the individual, employee-specific return to be filed with the IRS and distributed to employees. This form reports information about the employer’s offer of coverage, if any, to full-time employees and whether a safe harbor for employer shared responsibility penalties applies.

Each full-time employee must receive only one Form 1095-C from his or her employer. However, an employee who works for more than one ALE Member that is a member of the same Aggregated ALE Group must receive a separate Form 1095-C from each ALE Member. When an employee works for more than one ALE Member in the same month, only one ALE Member is treated as the employer of that employee for reporting purposes that month (generally, the ALE Member for whom the employee worked the greatest number of hours of service).

The operative portion of Form 1095-C is Part II, which requires employers to insert specified codes describing the type of offer, if any, made to an employee, and other information about the coverage. Information required on Form 1095-C includes:

- whether the employee received an offer of MEC providing minimum value, and whether that offer was also extended to his or her spouse and/or dependents, if any;
- the required employee contribution each month for lowest-cost self-only minimum value coverage;
- any affordability safe harbor used by the employer; and
- whether other relief from the employer mandate applies for an employee.

NOTE: that if the employer sponsors a self-insured plan, Form 1095-C, Part III must be completed to report information that would otherwise be reported on the B-Series forms.

Part I of Form 1095-C contains standard employer and employee information. A new field added at the end of 2015 – Plan Start Month – remains optional for 2019 reporting, as it was for prior years. Employers choosing to enter a date in this field would enter the two-digit number indicating the month in which their plan year began.

FORM 1095-C, LINE 14

Employers use line 14 to enter one or more of the “offer of coverage” codes, as described below. If the same code applies for all 12 calendar months, the employer may enter the applicable code in the “All 12 Months” box.

NOTE: Do not leave line 14 blank for any month, including months when the individual was not an employee.

Offer of Coverage – Code Series 1	
1A	Qualifying Offer: MEC providing minimum value is offered to the employee at a cost that does not exceed the FPL safe harbor, and at least MEC is offered to spouse and dependents. Code 1A may be used for certain months even if the employee did not receive a Qualifying Offer the entire year.
1B	Offer of MEC providing minimum value to employee only.
1C	Offer of MEC providing minimum value to employee and at least MEC offered to dependent children (not spouse).
1D	Offer of MEC providing minimum value to employee and at least MEC offered to spouse (not dependent children).
1E	Offer of MEC providing minimum value to employee and at least MEC offered to spouse and dependent children.
1F	Offer of MEC NOT providing minimum value offered to employee, regardless of whether coverage is also offered to spouse and dependent children.
1G	Used for an individual who was not a full -time employee for any month of the calendar year and who enrolled in self-insured coverage for one or more months. Code 1G must be used for the entire year if it applies (i.e., the employer must enter it on line 14 in the “All 12 Months” column or in each separate monthly box).
1H	No offer of coverage (use this code unless the employee was offered MEC that would have been in effect for every day of the month).
1I	Reserved (not applicable after 2015).
1J	MEC providing minimum value offered to employee and at least MEC conditionally offered to spouse (MEC not offered to dependent children).
1K	MEC providing minimum value offered to employee; at least MEC offered to dependent children; and at least MEC conditionally offered to spouse.

If the type of coverage, if any, offered to an employee was the same for all 12 months in the calendar year, enter the Code Series 1 indicator code corresponding to the type of coverage offered either in the “All 12 Months” box or in each of the 12 boxes for the calendar months.

Codes 1J and 1K were first added in 2016 and represent a conditional offer of coverage to a spouse. A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee’s spouse only if the spouse is not eligible for coverage under his or her own employer’s plan). An employer may use these codes to report a conditional offer to a spouse, regardless of whether the spouse meets the condition. In other words, an employer may use codes 1J or 1K to report a conditional offer to a spouse even if the spouse has access to other coverage and is not eligible to enroll.

FORM 1095-C, LINE 15

Complete line 15 only to the extent code 1B, 1C, 1D, 1E, 1J, or 1K is entered on line 14 either in the “All 12 Months” box or in any of the monthly boxes. Enter the employee share of the monthly cost for the lowest-cost self-only minimum value coverage that is offered to the employee, which should include any cents. If the employee is offered coverage but the required contribution is zero, enter “0.00” (do not leave blank).

NOTE: that the amount entered in line 15 will not reflect the amount the employee is paying for coverage if the employee enrolls in any option other than employee-only coverage under the lowest cost minimum value plan.

For non-calendar year plans, an employer may divide the total cost to the employee for the plan year by the number of months in the plan year. This monthly amount of the employee’s share of the cost would then be reported for any months of that plan year that fall within the calendar year being reported.

Example: For a plan year beginning July 1, 2019, an employer may determine the amount to report for January through June 2019 by taking the total annual employee cost for the plan year ending June 30, 2019 and dividing by 12 (and reporting that amount for January through June 2019). Then, the employer may determine the monthly amount for July through December 2019 by taking the total annual employee cost for the plan year ending June 30, 2020 and dividing by 12 (and reporting that amount for July through December 2019).

Wellness Incentives

Incentives under a wellness program are not treated as reducing the employee’s required contribution for purposes of Line 15, except for incentives relating to tobacco use. An employer may treat all employees as paying the contribution rate for non-tobacco users, even if the individual is a tobacco user or does not otherwise participate in wellness. All other incentives, however, are treated as unearned for purposes of Line 15.

Federal Poverty Level Safe Harbor

Employers using the FPL safe harbor may set a required employee contribution that does not exceed 9.5% (as adjusted) of the mainland single federal poverty line (“FPL”) in effect within six months before the start of the plan year, divided by 12, provided that the offer includes an offer of MEC to the employee’s spouse and dependents (if any).

Code Section	490H(a)	490H(b)	36B(b)(3)(A)(i)
Calendar Year	FPL in Effect 6 Mos. Before Plan Year	Affordability Safe Harbor	FPL Safe Harbor
2020	\$12,490	9.78%	\$101.79
2019	\$12,140	9.86%	\$99.75
2018	\$12,060	9.56%	\$96.08
2017	\$11,880	9.69%	\$95.93
2016	\$11,770	9.66%	\$94.75
2015	\$11,670	9.56%	\$92.97
2014	\$11,450	9.50%	\$90.96

FORM 1095-C, LINE 16

An employer will use line 16 to report to the IRS the reason, if any, why it should not be subject to an employer shared responsibility penalty with respect to the employee on whom it's reporting. Reasons an employer would not be subject to a penalty with respect to an employee include:

- The employee was not employed or was not a full-time employee;
- The employee enrolled in the MEC offered;
- The employee was in a "limited non-assessment period" or "LNAP" such as a waiting period or initial measurement period;
- The employer met one of the three affordability safe harbors with respect to the employee; or
- The employer was eligible for multiemployer interim rule relief for this employee (i.e., the employer was contributing to a multiemployer plan on behalf of the employee).

For each month, an employer should enter the applicable code, if any, from Code Series 2 (described below). If the same code applies for all 12 calendar months, the employer may enter the code in the "All 12 Months" box and not complete the monthly boxes.

NOTE: If none of the codes apply for a month, leave line 16 blank for that month.

In some circumstances, more than one indicator code could apply to the same employee in the same month. For any month in which an employee enrolled in MEC, in general, code 2C is used instead of any other code that could also apply (certain exceptions apply for reporting coverage under a multiemployer plan or post-employment coverage such as COBRA or retiree medical). Special ordering rules apply for employees who did not enroll in health coverage, as described below.

Safe Harbor and Other Relief – Code Series 2	
2A	Employee not employed on any day of the calendar month.
2B	Employee not a full-time employee that month. Also use for employees who terminates mid-month if they were offered coverage that would have continued through the end of the month, had they remained employed.
2C	Employee enrolled in health coverage offered for each day of the month, regardless of whether any other code might also apply. Do not enter code 2C when using: multiemployer plan relief (enter code 2E); code 1G in line 14 (leave blank); or any month in which a terminated employee is enrolled in COBRA or other post-employment coverage (enter code 2A).
2D	Employee in a limited non-assessment period ("LNAP"), such as an initial measurement period or waiting period. Do not enter code 2D when using multiemployer plan relief (enter code 2E).
2E	Multiemployer interim rule relief applies. Use this code over any other for any month in which it applies.
2F	W-2 affordability safe harbor applies for this employee for the year. If used, it must be used for all months of the year for which the employee is offered health coverage.
2G	Federal poverty line ("FPL") safe harbor applies for any month(s).

2H	Rate of pay safe harbor applies for this employee for any month(s).
2I	Reserved (not applicable after 2015).

NOTE: Do not enter an affordability safe harbor code (2F, 2G or 2H) for any month in which the employer did not offer MCE to at least 95% (or all but five) of its full-time employees and their dependents.

REPORTING COBRA AND POST-EMPLOYMENT COVERAGE

The instructions provide that an offer of COBRA is reported differently depending on whether the offer is made to a former employee (i.e., due to an employee's termination of employment) or to an active employee (i.e., due to a reduction in hours).

In the months following termination of employment, an employer should report offers of COBRA to a former employee (or to a former employee's spouse or dependents) due to termination of employment using code 1H (no offer of coverage) on line 14 and code 2A (employee not employed) on line 16, without regard to whether COBRA is elected. In the month of termination, the employer may use code 2B if the offer of coverage would have continued through the end of the month, had the employee remained employed. The employer may use code 2C if the employee remains enrolled in coverage through the end of the month of termination.

Like COBRA, other post-employment coverage such as retiree medical should not be reported as an offer of coverage on line 14. Instead, the employer would use codes 1H/2A on lines 14 and 16, respectively (1E/2B or 1H/2B in the month of termination, unless the employee has remained enrolled through the end of the month, in which case code 1E/2C is used).

However, when an offer of COBRA is made to an employee who remains employed, it is reported as an offer of coverage, but only to those individuals offered COBRA.

Example: An employer offers employees the opportunity to enroll in family coverage. An employee enrolls in employee-only coverage effective January 1. On July 1, the employee experiences a reduction in hours that results in loss of eligibility under the terms of the plan. The employer terminates coverage and offers COBRA to the employee, but not any spouse or dependents because they were not enrolled in the plan on the day before the qualifying event.

In this example, the employer should enter code 1E (offer of family coverage) on line 14 for January – June and should enter code 1B (offer of employee-only coverage) on line 14 for July – December.

For purposes of the employer share responsibility provision, an employer is still treated as having made an offer to the employee's dependents for an entire plan year as long as they had an opportunity to enroll at least once for the plan year, even if the employee declined to enroll the dependents in the coverage and, as a result, the dependents later did not receive an offer of COBRA.

FORM 1095-C, LINES 17-22

Part III of Form 1095-C spans lines 17-22 and is completed only by employers that sponsor self-insured coverage. If the employee for whom the employer is preparing the Form 1095-C has enrolled in self-insured coverage offered by the employer, the employer will enter “X” in the check box in Part III and will list the employee on line 17 (if enrolled in self-insured coverage) and any other family members who enrolled in coverage offered to the employee should be listed on subsequent lines.

NOTE: For purposes of completing Part III, an individual is considered covered for a month if the individual was covered on at least one day.

All employee family members that are covered individuals through the employee’s enrollment must be included on the same form as the employee. If two or more employees employed by the same employer are spouses or an employee and his or her dependent, and one employee enrolled the spouse or dependent in coverage, the enrollment information should be reflected only on Form 1095-C for the employee who enrolled in the coverage and would list the other employee family members as covered individuals.

Employers reporting coverage under a self-insured plan may use the B-Series or the C-Series forms to report coverage for individuals who were not employees for any month of the year, such as non-employee directors, employees who retired in a previous year, employees receiving COBRA (or any other form of post-employment coverage) who terminated employment during a previous year, and a non-employee COBRA beneficiary who independently elected COBRA. In these situations, Part II of Form 1095-C must be completed by using code 1G in the “All 12 Months” box or the separate monthly boxes for all 12 calendar months. The employer must complete Form 1095-B if it chooses not to use Form 1095-C to report non-employee coverage under a self-insured health plan.

Part III should be completed for each individual enrolled in the plan, including the employee reported on line 1. Employers may disregard the continuation sheet if reporting fewer than seven covered individuals.

REPORTING OPT-OUT PAYMENTS

In [Notice 2015-87](#), the IRS clarified several issues regarding the “affordability” of employer-sponsored health coverage, including how to treat various cash opt-out payments for purposes of ACA reporting. Under that guidance, “unconditional” opt-out payments are treated as increasing an employee’s cost of coverage for purposes of line 15 of Form 1095-C, although transition relief is available for certain arrangements that were in effect prior to December 16, 2015.

UNCONDITIONAL OPT-OUT PAYMENTS

A cash opt-out payment is “unconditional” when employees may receive it without having to show proof of other coverage, such as enrollment in a spouse’s plan. Unless they qualify for transition relief, payments under an unconditional opt-out arrangement are treated as increasing an employee’s cost of coverage. With unconditional opt-out payments, an employee must make the regular employee contribution and forgo the opt-out payment to enroll in coverage. Therefore, they must be added to the employee’s cost of coverage.

Example: An employer offers employee-only coverage for \$125 per month but pays employees \$25 each month if they decline coverage. The opt-out payment is treated as increasing the required employee contribution because the employee must forgo the opt-out benefit in addition to making the regular contribution to obtain coverage (line 15 of Form 1095-C would be \$150).

ELIGIBLE OPT-OUT ARRANGEMENTS

Until final regulations are issued, employers may treat unconditional opt-out payments as employer contributions for ACA reporting purposes **as long as they were adopted or in effect prior to December 16, 2015** and not substantially increased thereafter (“Eligible Opt-Out Arrangements”). Employers with Eligible Opt-Out Arrangements are not required to treat the payment as increasing the employee’s cost of coverage. For example, if an employer charges \$100 per month for coverage and offers a \$50 per month unconditional opt-out payment, the employer may report the employee’s cost of coverage as \$100 instead of \$150.

NOTE: that the IRS encourages employers to report the cost of coverage as including the opt-out payment (i.e., \$150 in this example) and claim relief for Eligible Opt-Out Arrangements under Notice 2015-87 if assessed a shared responsibility penalty. The IRS prefers this approach as it’s more likely an employee will obtain a premium credit if the higher cost is reported, and the true cost to the employee is \$150 in this example when the opt-out payment is not conditioned on enrollment in other coverage.

CONDITIONAL OPT-OUT PAYMENTS

A cash opt-out payment is “conditional” when made only to employees who show proof of enrollment in other coverage, such as that of a spouse’s employer. It does not increase the employee’s cost of coverage. In these situations, the opt-out payment is conditioned on an employee satisfying a meaningful requirement related to the provision of health care to employees. In other words, an employee is not entitled to the opt-out benefit simply by declining the employer’s health coverage.

Example: An employer offers employee-only coverage for \$125 per month but pays employees \$25 per month if they opt-out in favor of a spouse’s plan. The opt-out is not treated as increasing the required employee contribution because it is subject to a meaningful condition related to the provision of health care to employees (line 15 of Form 1095-C would be \$125).

SERVICE CONTRACT ACT AND DAVIS BACON ACT EMPLOYEES

Until further guidance is provided, employers may treat “cash-in-lieu” payments as employer contributions toward the cost of health coverage, to the extent the amount of the payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the Service Contract Act (“SCA”) or Davis Bacon Act (“DBA”).

Example: An employer offers SCA or DBA employees the choice of coverage under a group health plan or \$500 per month. For the employee, \$500 per month does not exceed the amount required to satisfy the employer’s fringe benefit requirements. The required employee contribution is \$0 per month, although the employee may consider the required employee contribution to be \$500 per month for purposes of the premium tax credit.

The IRS encourages employers not to reduce the amount of an SCA or DBA employee’s required contribution by the amount of the fringe benefit payment and claim relief under Notice 2015-87 if contacted by the IRS regarding an assessable payment.

CAFETERIA PLAN FLEX CREDITS

Employer contributions towards flex credits under a cafeteria plan that are available to purchase MEC in addition to other cafeteria plan benefits are not treated as an opt-out payment, even if employees waiving health coverage may collect the credit as taxable cash compensation. However, unless the flex credit is a “health flex credit,” meaning that it can only be used to pay for medical care or the employer’s group health plan premiums, it will be treated as an unconditional opt-out payment for affordability purposes.

Example: An employer offers employees the choice of a \$480 health FSA contribution or \$480 toward the cost of medical, dental or vision coverage under the employer’s plan. The \$480 is a health flex credit and is treated as reducing the required employee contribution (line 15 of Form 1095-C would be reduced by \$40 per month reflecting the \$480 health flex credit). If the employee could take the \$480 as cash or spend it on any non-health benefit it would not qualify as a health flex credit.

C-SERIES FORMS – CORRECTIONS

In general, employers should file corrected returns as soon as possible after an error is discovered. Errors on Form 1094-C that require correction include a mistake in the name or EIN of the employer, information about the employer’s Aggregated ALE group membership, offer of MEC indicator, full-time employee count, and transition relief indicator (for 2015 and 2016 returns). Employers correcting Form 1094-C should prepare a new authoritative Form 1094-C, enter an “X” in the “CORRECTED” box at the top of the form, and submit the standalone corrected Form 1094-C (no Forms 1095-C).

Errors on Form 1095-C that require correction include name, SSN, company EIN, offer of coverage, employee required contribution, Section 4980H Safe Harbor and other relief codes, and information regarding covered individuals.

When correcting a Form 1095-C that was previously filed with the IRS, complete the form and enter an “X” in the CORRECTED checkbox when furnishing to the participant. When correcting a Form 1095-C that was previously furnished to a participant, but not the IRS, write, print or type CORRECTED on the new Form 1095-C furnished to the recipient (enter an “X” in the CORRECTED checkbox only when correcting a Form 1095-C previously filed with the IRS). Then, file a Form 1094-C with the IRS along with the corrected Form(s) 1095-C (do not file a corrected Form 1094-C).

If an employer eligible to use the Qualifying Offer Method had furnished the employee an alternative statement, the employer must furnish the employee a corrected statement if it filed a corrected Form 1095-C correcting the employer’s name, EIN, address or contact name and telephone number. If the employer is no longer eligible to use an alternative furnishing method for the employee, it must furnish a Form 1095-C to the employee and advise the employee that the Form 1095-C replaces the statement it had previously furnished.

DE MINIMIS ERRORS ON LINE 15 OF FORM 1095-C

The instructions for Forms 1094-C and 1095-C include additional information for employers that have errors on Forms 1095-C. Specifically, the instructions indicate that Forms 1095-C filed with incorrect dollar amounts for Employee Required Contributions (line 15) may fall under a de minimis error safe harbor. The safe harbor generally applies if no single amount in error differs from the correct amount by more than \$100. If the safe harbor applies, employers will not have to correct Form 1095-C to avoid penalties. However, if the recipient elects for the safe harbor not to apply, the employer may need to issue a corrected Form 1095-C to avoid potential penalties.

TIPS AND TRICKS

Below are a couple of approaches to consider that may help control costs or ease the administrative burden associated with reporting.

OFFERS OF COBRA TO EMPLOYEES IN A STABILITY PERIOD

An offer of COBRA coverage to an active employee who has experienced a reduction in hours is still an “offer of coverage” for purposes of line 14 of Form 1095-C – it’s just likely to be unaffordable. Employers have a choice as to how they structure their group health plan to handle situations where employees move to part-time status while being treated as full-time in a stability period. In general, they can continue coverage through the end of the applicable stability period, or they can terminate coverage immediately, offer COBRA, and have exposure to 1/12th of the \$3,000 “unaffordable coverage” penalty for each month in which the employee is required to be treated as full-time and receives subsidized Marketplace coverage. The potential employer shared responsibility penalty may be less than the cost of continuing “affordable” coverage for an employee who is no longer working full-time.

Also, the months of exposure to an unaffordable coverage penalty will be limited to three months in certain situations. There is a special rule (known as the “three-month rule”) that allows employers to terminate coverage during a stability period for full-time employees who make a move to part-time employment that is intended to be permanent, and who have been offered minimum value coverage continuously by the end of their third full calendar month of employment (i.e., it is unavailable for employees who experienced an initial measurement period of greater than 3 months). Under these conditions, an employee who is in a stability period as full-time and who works less than 130 hours for the three consecutive months following a change to part-time may be measured using the monthly measurement method after the end of the third calendar month until the end of the next standard measurement period (and associated administrative period) to begin following the change to part-time. This effectively allows the employee to be treated as part-time after the end of the third full calendar month following the change to part-time. Employers who terminated coverage immediately upon the change to part-time will have exposure to only three months of the unaffordable coverage penalty, for any employee who qualifies under the three-month rule. This rule allows the employer to use the monthly method to determine full-time status for the employee even though other employees in that classification (e.g., hourly) are measured using the look-back method.

USING LIMITED NON-ASSESSMENT PERIODS (“LNAP”)

Employers should not overlook the limited non-assessment period, or LNAP. The LNAP generally refers to a period during which an ALE Member will not be subject to an assessable payment for a full-time employee, regardless of whether that employee is offered health coverage during that period. The LNAPs are described in detail in the instructions, and generally include periods such as the employer’s waiting period or initial measurement period.

With respect to new, full-time employees, the LNAP generally extends through the end of the third full calendar month of employment, regardless of the length of the waiting period. Moreover, employers may use the entire LNAP even if coverage is offered before the end of the LNAP.

Example: An employer offers minimum value coverage effective on the date of hire if the employee timely enrolls. An employee is hired September 2, 2019 and enrolls in coverage. Form 1095-C is not required for the employee in 2019 because for every month of the year the employee is either not employed (January through August) or in an LNAP (September through December).

NOTE: that if the employee enrolled in self-insured coverage during his months of employment in 2019, reporting under Section 6055 would apply and the employee could receive either Form 1095-C or 1095-B.

A new part-time, seasonal or variable hour employee who reaches the end of the year before the end of their initial measurement period will not be considered a full-time employee that year and is not required to be provided a Form 1095-C (assuming the employee hasn't enrolled in self-insured coverage during that time). Likewise, an employee who terminates employment during their initial measurement period (and associated administrative period) is not a full-time employee and is not required to be provided a Form 1095-C.



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