A person with collar shirt

Description generated with high confidence

The Compliance Question of the Week is posted on the UBA Wisdom and Compliance Communities to help Partners stay up to date on benefits compliance topics that may affect their clients. This is a recap of questions and answers from the past year, by topic.

**Please note that this document is for Partner information only and should not be given to clients.**

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| Cafeteria and Account-Based Plans (FSAs, HSAs, HRAs) |

**Question:** Under the new health reimbursement arrangement (HRA) final rules, what types of HRAs can an employer offer? When can an employer start offering these new HRAs?

**Answer:** Under the final rules, employers can start offering individual coverage HRAs and excepted benefit HRAs starting on January 1, 2020.

The Department of the Treasury (Treasury), Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, the Departments) released their [final rules](https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-12571.pdf) regarding health reimbursement arrangements (HRAs) and other account-based group health plans. The DOL also issued a [news release](https://www.dol.gov/newsroom/releases/ebsa/ebsa20190613), [frequently asked questions](https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/health-reimbursement-arrangements.pdf), [model notice](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/HRA-Model-Notice-PDF.pdf), and [model attestations](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/HRA-Model-Attestations-PDF.pdf).

The final rules’ goal is to expand the flexibility and use of HRAs to provide individuals with additional options to obtain quality, affordable healthcare. According to the Departments, these changes will facilitate a more efficient healthcare system by increasing employees’ consumer choice and promoting healthcare market competition by adding employer options.

To do so, the final rules expand the use of HRAs by:

* Removing the prohibition against integrating an HRA with individual health insurance coverage (individual coverage HRA)
* Expanding the definition of limited excepted benefits to recognize certain HRAs as limited excepted benefits if certain conditions are met (excepted benefit HRA)
* Providing premium tax credit (PTC) eligibility rules for people who are offered an HRA integrated with individual coverage
* Assuring HRA and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) plan sponsors that reimbursement of individual coverage by the HRA or QSEHRA does not become part of an ERISA plan when certain conditions are met
* Changing individual market special enrollment periods for individuals who gain access to HRAs integrated with individual coverage or who are provided QSEHRAs

The final rules will be published in the Federal Register on June 20, 2019, be effective on August 19, 2019, and generally apply for plan years beginning on or after January 1, 2020.

Our UBA Advisor “[Tri-Agency Final Rules on Health Reimbursement Arrangements](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=ScG8Ut8Eggk%3d)” provides reviews the final rules in more detail.

**Question:** We have an employer that offers health savings accounts (HSAs) to its employees. The employer’s contributions and employees’ contributions are run through a cafeteria plan. For those employees who elected to make contributions to their HSAs, the employer has been making deductions from their paychecks. Some of these employees have not opened an HSA, despite the employer’s repeated efforts to get them to open an HSA. What should the employer do?

**Answer:** The employer should refund all of the employees’ HSA payroll deductions as taxable income subject to withholding and payroll taxes. Employees will forfeit any employer contributions that would have been made if the employees had established an HSA.

As a best practice and in the future, the employer should have a written policy to accept contributions only after an employee has established an HSA (for example, after an employee has completed and signed an HSA trust or custodial agreement with a bank or insurance company).

The employer may consider using the model notice from [Treas. Reg. §54.4980G-4](https://www.govinfo.gov/content/pkg/CFR-2009-title26-vol17/pdf/CFR-2009-title26-vol17-sec54-4980G-4.pdf), Q/A-14(c) in drafting a written policy. Because the model notice applies to HSAs with contributions run outside of a cafeteria plan, the employer should consult with its attorney about adapting the model notice language for its use.

**Question:** If employees underspend their flexible spending account (FSA) funds, how may an employer use those forfeited funds?

**Answer:** The IRS provides specific options for an employer to use in distributing forfeited funds. To determine which options are available, an employer should look to the plan document (or cafeteria plan document) which may specify how forfeitures must be applied. If the plan document or cafeteria plan document describes how forfeitures must be applied, then an employer / plan sponsor would need to follow the document’s terms. An employer should carefully document its actions regarding the forfeitures.

If an employer is not subject to ERISA, then an employer may use the following options, including retaining the funds (this means that an employer could mingle the funds with its general accounts and use the funds for the employer’s purposes):

1. Defray plan administration expenses
2. Reduce salary reduction amounts for the following year
3. Increase the annual coverage amount
4. Return funds in the form of cash to employees on a reasonable and uniform basis

If an employer chooses the cash distribution option, the cash distribution would be considered taxable income and reported on Form W-2.

If an employer is subject to ERISA, then an employer cannot retain the funds (for example, an employer cannot comingle the funds with its general accounts). ERISA’s fiduciary duties (for example, duty of loyalty, exclusive benefit rule, no prohibited transactions, etc.) would also apply to the handling of the funds.

**Question:** Depending on an employer’s corporate structure, generally who can participate in a cafeteria plan and who cannot participate in a cafeteria plan?

**Answer:** Only an employer’s current and former employees can participate in a cafeteria plan. If contributions are run through a cafeteria plan, then the following categories of people cannot participate in the cafeteria plan:

* Sole proprietors who do not have dual status as employees
* Directors of a Subchapter C corporation who do not have dual status as employees
* Partners or more-than-2% shareholders in a Subchapter S corporation
* Spouse, children, parents, and grandparents of a more-than-2% shareholder in a Subchapter S corporation
* General partners in a general or limited partnership
* Limited partners of a limited partnership who are not employees of the partnership
* Limited partners of a limited partnership who are employees of the partnership and receive guaranteed benefits from the partnership
* Members of an LLC who are treated as partners in a partnership or treated as self-employed
* Members of an LLC, unless the LLC has elected to be taxed as a Subchapter C corporation
* Partners in an LLP

**Question:** When would a domestic partnership be a permitted election change event?

**Answer:** Under Section 125, in most cases qualifying as a domestic partner would not be a permitted election change event. For an event to be the permitted election change event of “change in marital status,” it would usually need to include marriage, divorce, spousal death, legal separation, or annulment.

However, if a domestic partner’s status changes so that the domestic partner is now an employee’s tax dependent, then that event would be a permitted election change event of “change in number of dependents.”

From our UBA Advisor “[Cafeteria Plans: Qualifying Events and Changing Employee Elections](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=c4ILhGQ9ZFo%3d)”:

**Change in Marital Status**

Both same-sex and opposite-sex marital status changes are qualifying events. Legal separations (unless the legal separation leads to loss of eligibility under the plan) and the commencement and termination of a domestic partnership are not. There is a narrow exception if a domestic partnership changes an individual’s tax status. If a domestic partner qualified as a tax dependent for health coverage purposes, this could trigger a qualifying event.

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| **Example** | **Permitted election change event?** |
| Jessica gets married to Timothy. | Yes |
| Timothy gets married to Christopher. | Yes |
| Jennifer enters into a domestic partnership (with either a same or opposite sex individual). | No, unless the domestic partnership changes an individual’s tax status. If the domestic partner becomes a tax dependent, it could trigger a qualifying event. |

**Question:** If a parent wants to drop a child (age 23) from the parent’s plan because the parent no longer wants to pay for the child’s coverage, would this be considered a qualifying event for the child to join the child’s employer’s plan? Is the parent allowed to drop the child from coverage for this reason outside of open enrollment?

**Answer:** Yes, if the child loses group health plan coverage, then the child has a HIPAA special enrollment right to join his employer’s group health plan.

However, a parent’s unwillingness to continue paying for a child’s coverage is not a permitted election change event under the Section 125 cafeteria plan rules. This means that a parent cannot drop a child’s coverage mid-year based on the reason that the parent doesn’t want to pay for the child’s coverage.

Our UBA Advisor “[Cafeteria Plans: Qualifying Events and Changing Employee Elections](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=c4ILhGQ9ZFo%3d)” describes HIPAA special enrollment rights at page 9.

**Question:** Under what circumstances would an executive reimbursement plan be permitted?

**Answer:** While executive reimbursement plans are disfavored and self-funded executive reimbursement plans are likely prohibited, it *may* be permissible to have an executive reimbursement plan if it is fully insured and not run through a cafeteria plan. A plan sponsor who is considering an executive reimbursement plan should consult with its attorney before proceeding.

Please be aware that, under the Patient Protection and Affordable Care Act (ACA), the Section 105(h) rules are to apply to fully insured, non-grandfathered plans. In late 2010, the government delayed enforcement of Section 105(h) against fully insured, non-grandfathered plans until the first plan year beginning after regulations are issued. To date, no regulations have been issued so there is currently no penalty for noncompliance. This means that if the IRS issues regulations, then an executive reimbursement plan sponsor could face enforcement because the arrangement would likely be prohibited.

Further, in discussions with other Partner Firm members, there are some carriers who run Section 105(h) nondiscrimination testing on all their fully insured, non-grandfathered plans because that is what the ACA says applies to those plans, despite the IRS’ statement that it will hold off enforcement until after it issues regulations.

**Question:** Can an employee be HSA-eligible if the employee’s spouse is enrolled in Medicare?

**Answer:** Yes. To be an eligible individual and qualify for an HSA, you must meet the following requirements:

* You must be covered under a high deductible health plan (HDHP) on the first day of the month.
* You are not enrolled in Medicare.
* You cannot be claimed as a dependent on someone else’s tax return for the year.
* You have no other disqualifying health coverage except what is permitted.

| **Disqualifying Coverage** | **Acceptable Secondary Coverage** |
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| Health flexible spending account (FSA)  (unless it is limited-purpose or post-deductible) | Discount cards for prescription drugs (so long as the plan does not pay benefits prior to the deductible being satisfied) |
| Health reimbursement arrangement (HRA) (unless it is limited-purpose, retirement, or post-deductible) | Dental coverage (so long as it doesn’t provide medical benefits) |
| Medicaid | Accident, business travel coverage, accidental death and disability (AD&D), disability |
| Medicare | Disease specific coverage (so long as the principal health coverage is through the HDHP) |
| On-site clinics (unless they provide nominal benefits such as flu shots, Band-Aids, and aspirin) | Wellness programs (so long as it doesn’t provide significant benefits in the nature of medical care or treatment) |
| Telemedicine (unless there is a co-pay and it does not provide significant benefits in the nature of medical care or treatment) | Workers’ compensation |
| TRICARE | Vision coverage |
| VA Medical Benefits (unless it is hospital care or services for a service-connected disability) | Preventive care |

**Question:** How are health savings account (HSA) contributions calculated?

**Answer:** HSA contributions are calculated by month. In 2018, if an individual moves from family coverage to single coverage, the individual’s maximum contribution amount is calculated as  
(X / 12 x $6,900) + (Y / 12 x $3,450) = $\_\_\_\_.

X represents the number of months the individual was eligible under family coverage; Y represents the months the individual was eligible under single coverage.

The dollar figures used in the formula will change annually based on IRS contribution limits.

**Question:** If a person used health savings account (HSA) funds for an expense that she believed was a qualified medical expense, but later discovered that the expense was fully paid by the insurer, then may the person return the distribution to her HSA?

**Answer:** Yes, the person is allowed to return the mistaken distribution to her HSA, if she believed that the expense was a qualified medical expense when she requested and received reimbursement for the expense from the HSA.

If the person returns the mistaken distribution to the HSA by April 15 following the first year when she knew or should have known that the distribution was a mistake, the distribution is not taxable and not subject to additional tax or the excess contributions excise tax.

However, the HSA trustee is not required to allow the person’s mistaken distribution to be returned to the HSA. If the person is not allowed to return the mistaken distribution to the HSA, then the distribution should be included in the person’s gross income and is generally subject to an additional 20% tax.

Our UBA Advisor "[Health Savings Accounts: What You Need to Know](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=QHhxUXIZgZU%3d)" describes distributions at pages   
6-7.

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| COBRA |

**Question:** Can a person's COBRA coverage period run from the coverage loss date, rather than the qualifying event date?

**Answer:** Yes. The default rule is that COBRA coverage runs from the date of the COBRA qualifying event, whether the coverage loss occurs at that time or later.

However, COBRA coverage can run from the coverage loss date if a plan document specifically states that:

* the COBRA continuation coverage period will be counted from the coverage loss date, and
* the employer's period for notifying the plan administrator of certain COBRA qualifying events (such as the employee's death, employment termination, reduction of hours, Medicare entitlement, or employer's start of bankruptcy proceedings involving certain retirees) will begin with the coverage loss date.

**Question:** For employers with employees affected by the current federal furlough, will the employees’ health benefits discontinue and would the furlough be considered:

* unpaid leave for purposes of applying the ACA’s employer shared responsibility provisions?
* a reduction of hours under the cafeteria plan regulations?
* a COBRA qualifying event?

For purposes of the answers below, the employer is an applicable large employer and the employer is subject to COBRA.

**Answer – regarding federal employees**: For federal employees who receive Federal Employees Health Benefits (FEHB) coverage, FEHB coverage continues even when the employees don’t receive a paycheck. According to the U.S. Office of Personnel Management’s [Fact Sheet: Pay and Benefits Information for Employees Affected by the Lapse in Appropriations](https://chcoc.gov/content/fact-sheet-pay-and-benefits-information-employees-affected-lapse-appropriations), an employee’s share of premiums will accumulate and be withheld later when the lapse ends and employees can be paid.

On Friday, January 11, 2019, Congress passed a bill that would provide back pay to furloughed federal employees when the furlough ends. It appears that the President will sign the bill. If the bill becomes law, then the furlough would be considered paid leave. For now, it appears that employees of government contractors are not included in the bill that will pay furlough back pay.

Under the Patient Protection and Affordable Care Act (ACA), any hour for which an employee is paid or entitled to payment must be counted as an hour of service. Our UBA Advisor “[Perfect Attendance! How to Handle Leaves of Absence under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=A4X_NiBBBaY%3d)” that further describes how leaves of absence should be treated.

A furlough would not necessarily be a COBRA qualifying event. Although a furlough may cause a reduction of hours for an employee, the reduction in hours would only be a COBRA qualifying event if the reduction in hours results in a loss of group health plan coverage. For federal employees who are on furlough, their FEHB coverage continues so there is no loss of group health plan coverage and no COBRA qualifying event.

A furlough with back pay would not likely fit the definition of the permitted election change event of reduction of hours.

**Answer – regarding employees who are not considered to be federal employees:** For employees who aren’t considered to be federal employees, the answer may be yes to each question, depending on the facts of each employee’s case.

If an employer is using the monthly measurement method, then the reduction in hours of a furloughed employee may result in loss of eligibility for group health plan coverage and trigger a COBRA qualifying event. If an employer is using the lookback measurement method, then the employer must offer coverage through the stability period to employees who have full-time status based on their prior measurement period. When an employee’s hours are calculated during the contemporaneous measurement period, the unpaid leave will count as zero hours of service.

If an employee experiences a COBRA qualifying event, then the employee may make election changes for any group health plans subject to COBRA (including FSAs). If an employee has the permitted election change event of reduction in hours, then the employee may make changes for group health plans (excluding FSAs) that provide minimum essential coverage. Please see pages 4-5 of our UBA Advisor “[Cafeteria Plans: Qualifying Events and Changing Employee Elections](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=c4ILhGQ9ZFo%3d)” that describe which benefits can be changed mid-year when an employee has a permitted election change event.

**Educational Information**

From the Wolters Kluwer *Employee Benefits Answer Book*:

**Q 6:42 What is a qualifying event?**

A qualifying event is any one of the following events (but only if the event results in a loss of group health plan coverage):

* 1. The death of a covered employee;
  2. Termination of a covered employee’s employment for any reason other than gross misconduct;
  3. Reduction in the number of hours a covered employee is employed;
  4. Divorce or separation of a covered employee and his or her spouse;
  5. Medicare entitlement of a covered employee;
  6. A child of the covered employee ceasing to meet the group health plan’s definition of a dependent child; or
  7. Commencement of a bankruptcy proceeding concerning an employer from whose employment the covered employee retired.

Also, see our UBA Advisor “[What Qualifying Events Trigger COBRA?](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=1WxNmVQQyhc%3d)” that describes qualifying events.

From our UBA Advisor “[Perfect Attendance! How to Handle Leaves of Absence under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=A4X_NiBBBaY%3d):”

Under the ACA, any hour for which an employee is paid or entitled to payment must be counted as an hour of service. …

**Unpaid Leave**

If the employee is on an unpaid leave of absence (except unpaid FMLA) and in a stability period, the employee must be offered coverage through the stability period. When the employee’s hours are calculated during the contemporaneous measurement period, the leave of absence will count as zero hours of service.

**Question:** May a COBRA participant change plans during open enrollment?

**Answer:** Yes, at open enrollment, the plan must give a COBRA participant the same opportunity to change plans as it gives to active employees. This means that if active employees may select a different group health plan, then COBRA participants must also have the same opportunity to select a different group health plan.

As a best practice, when the plan sends enrollment forms and related documents to active employees, the plan should send these documents to COBRA participants to ensure that they have the opportunity to make open enrollment decisions.

**Question:** Can a plan provide for a longer coverage continuation period than what federal COBRA provides?

**Answer:** Yes, a plan can provide for a longer coverage continuation period than what federal COBRA provides. Federal COBRA sets the maximum period for which group health plan coverage is required to be continued. However, a plan can provide for a longer continuation period.

Please be aware that if a plan sponsor wants to lengthen the coverage continuation period, then the carrier (if the plan is fully insured) or stop-loss carrier (if the plan is self-funded and uses stop-loss insurance) may not agree to the longer coverage continuation period. The plan sponsor would need to negotiate this issue with the carrier before providing for a longer coverage continuation period than what federal COBRA provides.

**Question:** If an employer is subject to COBRA, would the employer need to offer COBRA on an Employee Assistance Program (EAP)?

**Answer:** Generally, an EAP will be subject to COBRA if it provides medical care.

If an EAP is referral-only and does not provide medical care, then COBRA will not apply.

**Question:** How does an employer handle COBRA continuation coverage when an employee alerts the plan administrator that the employee divorced several months (or years) ago and the employee’s former spouse wasn’t taken off the plan after the divorce?

**Answer:** Presuming that the initial COBRA notice or the plan’s summary plan description (SPD) provided reasonable procedures for the covered employee to furnish notice of the divorce, the plan is not required to offer the qualified beneficiary (former spouse) the opportunity to elect COBRA continuation coverage because the employee did not provide notice by the deadline provided in the initial COBRA notice or plan’s SPD.

If the plan sponsor receives a late qualifying event notice, then the plan sponsor must provide a notice of unavailability of COBRA coverage.

Also, the plan administrator/trustee may have a fiduciary duty to file a court action against the employee for failing to notify the plan of the divorce so that the plan can seek reimbursement for claims paid on behalf of the former spouse.

If a former spouse remains on the group health plan due to lack of notice, there could be coverage issues with the insurer (or stop-loss carrier, if it’s a self-insured plan with stop-loss coverage) over claims paid for an ineligible individual.

Also, there may be a retroactive cancellation prohibition issue, depending on when the plan sponsor decides to cancel coverage. The plan sponsor should consult with its attorney on how to proceed with cancellation and the cancellation effective date.

**Question:** In an acquisition or merger, does the buyer or seller have an obligation to offer COBRA continuation coverage?

**Answer:** If the seller and buyer negotiated their COBRA liability by contract as part of the sale, then the contract will determine who has an obligation to offer COBRA coverage.

If the contract is silent on COBRA coverage obligations, then the seller's group health plan has the duty to offer COBRA coverage as long as the seller maintains a group health plan post-sale.

If the seller doesn't maintain a group health plan post-sale, then the answer depends on whether it's a stock sale or an asset sale.

In a stock sale, if the seller doesn't maintain a group health plan post-sale, then the buyer is responsible for offering COBRA coverage.

In an asset sale, if the seller doesn't maintain a group health plan post-sale and the group health plan's termination is connected with the asset sale, then the buyer is responsible for offering COBRA coverage if the buyer continues business operations associated with the assets purchased without interruption or substantial change.

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| ERISA |

**Question:** When the plan changes, when should I give notice to participants?

**Answer:** Depending on the change that is made, an employer must provide notice within one of three time frames:

* 60 days prior to the change
* No later than 60 days after the change (or, within 60 days of the change)
* Within 210 days after the end of the plan year

For changes to the Summary Plan Description (SPD) that are a material reduction in covered services or benefits, notice is required within 60 days of adoption of the material reduction in group health plan services or benefits. For example, a decrease in employer contribution would be a material reduction in covered services or benefits so notice should be provided within 60 days of the change in employer contribution. As a best practice, an employer should give advance notice of the change. For practical purposes, employees should be told prior to the first increased withholding.

If a plan makes a material modification in any of the plan terms that would affect the content of the Summary of Benefits and Coverage (SBC) (that is not reflected in the most recently provided SBC), then notice must be provided no later than 60 days prior to the date when the modification will become effective.

However, if the change is part of open enrollment, assuming you communicate the change during open enrollment, the open enrollment communication is considered acceptable notice, regardless of whether the SBC or the SPD, or both, are changing. Open enrollment is essentially a safe harbor for the 60-day prior/60-day post notice requirements.

Finally, changes that do not require more immediate notifications, because they do not affect the SBC and are not a material reduction in benefits, must be communicated through a summary of material modifications or an updated summary plan description within 210 days after the end of the plan year.

**Question:** When completing Form 5500 Schedule A, how may an employer look up a carrier’s NAIC code and EIN?

**Answer:** The employer / plan administrator can search <http://freeerisa.benefitspro.com> for the carrier’s employer ID number (EIN). The plan administrator can look up the NAIC code on pages 78-80 of the [2018 Instructions for Form 5500](https://www.dol.gov/sites/default/files/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2018-instructions.pdf). If the plan administrator is unable to determine the correct EIN and NAIC code from the resources above, then the plan administrator should ask the carrier for the correct NAIC code and EIN.

**Question:** What is the status of the Department of Labor’s (DOL’s) association health plans (AHPs) final rule under the recently issued court decision?

**Answer:** On March 28, 2019, the U.S. District Court for the District of Columbia (Court) [found](https://www.courtlistener.com/recap/gov.uscourts.dcd.198818/gov.uscourts.dcd.198818.79.0_1.pdf) that the DOL’s final rule exceeded the statutory authority delegated by Congress under ERISA and that the final rule unlawfully expands ERISA’s scope. In particular, the Court found the final rule’s provisions – defining “employer” to include associations of disparate employers and expanding membership in these associations to include working owners without employees – are unlawful and must be set aside.

The Court’s [order](https://www.courtlistener.com/recap/gov.uscourts.dcd.198818/gov.uscourts.dcd.198818.78.0_1.pdf) vacates the specific provisions of the DOL’s final rule regarding “bona fide group or association of employers,” “commonality of interest,” and “dual treatment of working owners as employers and employees.” The order sends the final rule back to the DOL to consider how the final rule’s severability provision affects the final rule’s remaining portions.

The Court’s order does not affect employers who formed AHPs under the DOL’s previous guidance regarding the definition of “employer.” Both existing and new employer groups or associations that meet the DOL’s pre-rule guidance can continue to sponsor an AHP.

This Court order stops employers from sponsoring new self-insured AHPs under the final rule beginning on April 1.

For an employer that relies on the final rule’s expanded definition of “employer” to currently sponsor a fully-insured AHP or existing self-insured AHP, the employer should consult with its attorney as soon as possible. If the employer can meet the DOL’s pre-rule guidance, then it can continue to sponsor an AHP.

However, if the employer cannot meet the DOL’s pre-rule guidance, then the employer should consult with its attorney to determine whether it can amend its structure and plan document to meet the DOL’s pre-rule guidance. If it cannot meet the DOL’s pre-rule guidance through plan amendment, then the employer should consult with its attorney on how to proceed because the AHP will no longer qualify as an ERISA plan and may be subject to the ACA’s individual market and small group market rules as well as state regulation.

The DOL has not indicated how it will proceed. The DOL could revise its final rule or the DOL could appeal the decision. Employers in AHPs should keep apprised of future developments in this case.

See our Advisor “[Update on DOL’s Association Health Plans Final Rule](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=_F-ZUqI1lwQ%3d)” for more information.

**Question:** How long should I keep reporting and disclosure records?

**Answer:** Generally, reporting and disclosure records should be retained for six years from their filing date, although it’s best practice to keep such records for eight years. Benefits determination records are subject to the open-ended retention requirement of ERISA Section 209, so these records should be kept as long as they may be relevant to benefit entitlement determination.

Beyond these time frames, if a company is on notice that any matter may become the subject of litigation or an audit (for example, receiving notice that a lawsuit is being filed, notice of a DOL or EEOC charge, an attorney demand letter, or an internal complaint), the company must keep all documents related to that matter until the case has come to a conclusion. In this type of case, the company should seek legal advice from its attorney about document retention.

Last, an employer should also consult with its attorney on state laws regarding document retention.

**Question:** How does an employer request an extension for filing Form 5500?

**Answer:** An employer may request an extension of up to 2.5 months after the Form 5500 due date by filing [Form 5558](https://www.irs.gov/pub/irs-pdf/f5558.pdf) (Application for Extension of Time to File Certain Employee Plan Returns) with the IRS. If an employer files Form 5558 on or before the normal due date of the Form 5500, then its extension request will be automatically granted.

**Question:** If a health and welfare benefit plan has fewer than 100 participants, then does it need to file a Form 5500?

**Answer:** If a plan is self-funded and uses a trust, then it is required to file a Form 5500, no matter how many participants it has.

Currently, group welfare plans generally must file Form 5500 if:

* The plan is fully insured and had 100 or more participants on the first day of the plan year (dependents are not considered "participants" for this purpose unless they are covered because of a qualified medical child support order).
* The plan is self-funded and it uses a trust, no matter how many participants it has.
* The plan is self-funded and it relies on the Section 125 plan exemption, if it had 100 or more participants on the first day of the plan year.

There are several exemptions to Form 5500 filing. The most notable are:

* Church plans defined under ERISA Section 3(33)
* Governmental plans, including tribal governmental plans
* Top hat plans which are unfunded or insured and benefit only a select group of management or highly compensated employees
* Small insured or unfunded welfare plans. A welfare plan with fewer than 100 participants at the beginning of the plan year is not required to file an annual report if the plan is fully insured, entirely unfunded, or both.

A plan is considered unfunded if the employer pays the entire cost of the plan from its general accounts. A plan with a trust is considered funded.

For smaller groups that are self-funded or partially self-funded, you'd need to ask them whether the plan is funded or unfunded. If the employer pays the cost of the plan from general assets, then it is considered unfunded and essentially there is no trust. If the employer pays the cost of the plan from a specific account (in which plan participant contributions are segregated from general assets), then the plan is considered funded.

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| Fees & Taxes |

**Question:** How does an employer pay its Patient Centered Outcomes Research Initiative (PCORI) fee when it moves from a non-calendar plan year to a calendar year plan using a short plan year? The employer had a self-funded plan from 7/1/2017 to 6/30/2018, and a short plan year from 7/1/2018 to 12/31/2018. Now the employer is on a calendar year plan.

**Answer:** The employer would use the $2.45/person PCORI fee on the six-month short plan year (7/1/18-12/31/18). The employer would use the $2.39/person PCORI fee on the 12-month plan year (7/1/17-6/30/18). The PCORI fee for the short plan year and 12-month plan year would be filed on the same Form 720 that is due by July 31, 2019.

**Educational Information**

From the IRS’ [Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377) Questions and Answers](https://nam02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.irs.gov%2Faffordable-care-act%2Fpatient-centered-outcomes-research-trust-fund-fee-questions-and-answers&data=02%7C01%7Ctleger%40atlasinsurance.com%7C675868910c7b4ef825b308d6df3ff3af%7C5261cf5386c547be8e4cee60505d0312%7C0%7C0%7C636941863794237875&sdata=Kvx3HyFnfR%2FTVq9vTj8zgvuu8rt2EAR0nFCzdRDq20A%3D&reserved=0):

**Q12. Does the PCORI fee apply to an applicable self-insured health plan that has a short plan year?**

A12. Yes, the PCORI fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

**Q13. What is the PCORI fee for the short plan year?**

A13. The PCORI fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year. Thus, for example, the PCORI fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2013, and ends on Dec. 31, 2013, is equal to the average number of lives covered for April through Dec. 31, 2013, multiplied by $2 (the applicable dollar amount for plan years ending on or after Oct. 1, 2013, but before Oct. 1, 2014).

**Q14. What is the PCORI fee due date for the short plan year?**

A14. The due date for the PCORI fee is July 31 of the year following the last day of the plan year (including a short plan year).

From our UBA Advisor “[Frequently Asked Questions about the Patient-Centered Outcomes/Comparative Effectiveness (PCORI) Fee](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=SIR6_0_m1_c%3d)”:

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| **Plan/Policy Year** | **Year Fee Is Due ($2.39, indexed/**  **person)** |  | **Plan/Policy Year** | **Last Year Fee Is Due ($2.45, indexed/ person)** |
| Nov. 1, 2016 - Oct. 31, 2017 | July 31, 2018 |  | Nov. 1, 2017 - Oct. 31, 2018 | July 31, 2019 |
| Dec. 1, 2016 - Nov. 30, 2017 | July 31, 2018 |  | Dec. 1, 2017 - Nov. 30, 2018 | July 31, 2019 |
| Jan. 1, 2017 - Dec. 31, 2017 | July 31, 2018 |  | Jan. 1, 2018 - Dec. 31, 2018 | July 31, 2019 |
| Feb. 1, 2017 - Jan. 31, 2018 | July 31, 2019 |  | Feb. 1, 2018 - Jan. 31, 2019 | July 31, 2020 |
| March 1, 2017 - Feb. 28, 2018 | July 31, 2019 |  | March 1, 2018 - Feb. 28, 2019 | July 31, 2020 |
| April 1, 2017 - March 31, 2018 | July 31, 2019 |  | April 1, 2018 - March 31, 2019 | July 31, 2020 |
| May 1, 2017 - April 30, 2018 | July 31, 2019 |  | May 1, 2018 - April 30, 2019 | July 31, 2020 |
| June 1, 2017 - May 31, 2018 | July 31, 2019 |  | June 1, 2018 - May 31, 2019 | July 31, 2020 |
| July 1, 2017 - June 30, 2018 | July 31, 2019 |  | July 1, 2018 - June 30, 2019 | July 31, 2020 |
| Aug. 1, 2017 - July 31, 2018 | July 31, 2019 |  | Aug. 1, 2018 - July 31, 2019 | July 31, 2020 |
| Sept. 1, 2017 - Aug. 31, 2018 | July 31, 2019 |  | Sept. 1, 2018 - Aug. 31, 2019 | July 31, 2020 |
| Oct. 1, 2017 - Sept. 30, 2018 | July 31, 2019 |  | Oct. 1, 2018 - Sept. 30, 2019 | July 31, 2020 |

**Question:** Who must pay the Patient-Centered Outcomes Research Institute (PCORI) fee and when is the fee due? Is there a penalty for failure to file or pay the PCORI fee? How does a plan sponsor correct a previously filed Form 720?

**Answer:** The fee must be determined and paid by:

* The insurer for fully insured plans (although the fee likely will be passed on to the plan)
* The plan sponsor of self-funded plans, including HRAs
  + The plan’s TPA may assist with the calculation, but the plan sponsor must file IRS [Form 720](https://www.irs.gov/pub/irs-pdf/f720.pdf) and pay the applicable fee
  + If multiple employers participate in the plan, each must file separately unless the plan document designates one as the plan sponsor

The fee is due by July 31 of the year following the calendar year in which the plan/policy year ends. For example:

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| **Plan/Policy Year** | **Year Fee Is Due** ($2.26, indexed/ person) |  | **Plan/Policy Year** | **Year Fee Is Due** ($2.39, indexed/  person) |
| Nov. 1, 2015 - Oct. 31, 2016 | July 31, 2017 |  | Nov. 1, 2016 - Oct. 31, 2017 | July 31, 2018 |
| Dec. 1, 2015 - Nov. 30, 2016 | July 31, 2017 |  | Dec. 1, 2016 - Nov. 30, 2017 | July 31, 2018 |
| Jan. 1, 2016 - Dec. 31, 2016 | July 31, 2017 |  | Jan. 1, 2017 - Dec. 31, 2017 | July 31, 2018 |
| Feb. 1, 2016 - Jan. 31, 2017 | July 31, 2018 |  | Feb. 1, 2017 - Jan. 31, 2018 | July 31, 2019 |
| March 1, 2016 - Feb. 28, 2017 | July 31, 2018 |  | March 1, 2017 - Feb. 28, 2018 | July 31, 2019 |
| April 1, 2016 - March 31, 2017 | July 31, 2018 |  | April 1, 2017 - March 31, 2018 | July 31, 2019 |
| May 1, 2016 - April 30, 2017 | July 31, 2018 |  | May 1, 2017 - April 30, 2018 | July 31, 2019 |
| June 1, 2016 - May 31, 2017 | July 31, 2018 |  | June 1, 2017 - May 31, 2018 | July 31, 2019 |
| July 1, 2016 - June 30, 2017 | July 31, 2018 |  | July 1, 2017 - June 30, 2018 | July 31, 2019 |
| Aug. 1, 2016 - July 31, 2017 | July 31, 2018 |  | Aug. 1, 2017 - July 31, 2018 | July 31, 2019 |
| Sept. 1, 2016 - Aug. 31, 2017 | July 31, 2018 |  | Sept. 1, 2017 - Aug. 31, 2018 | July 31, 2019 |
| Oct. 1, 2016 - Sept. 30, 2017 | July 31, 2018 |  | Oct. 1, 2017 - Sept. 30, 2018 | July 31, 2019 |

Although the PCORI statute and its regulations do not include a specific penalty for failure to report or pay the PCORI fee, the plan sponsor may be subject to [penalties](https://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleF-chap68-subchapA-partI-sec6651.pdf) for failure to file a tax return because the PCORI fee is an excise tax. The plan sponsor should consult with its attorney on how to proceed with a late filing or late payment of the PCORI fee.

The PCORI regulations note that the penalties related to late filing of Form 720 or late payment of the fee may be waived or abated if the plan sponsor has reasonable cause and the failure was not due to willful neglect.

If the plan sponsor already filed Form 720 (for example, for a different excise tax), then the employer / plan sponsor can make a correction to a previously filed Form 720 by using [Form 720X](https://www.irs.gov/pub/irs-pdf/f720x.pdf).

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| General ACA |

**Question:** For employers with employees affected by the current federal furlough, will the employees’ health benefits discontinue and would the furlough be considered:

* unpaid leave for purposes of applying the ACA’s employer shared responsibility provisions?
* a reduction of hours under the cafeteria plan regulations?
* a COBRA qualifying event?

For purposes of the answers below, the employer is an applicable large employer and the employer is subject to COBRA.

**Answer – regarding federal employees**: For federal employees who receive Federal Employees Health Benefits (FEHB) coverage, FEHB coverage continues even when the employees don’t receive a paycheck. According to the U.S. Office of Personnel Management’s [Fact Sheet: Pay and Benefits Information for Employees Affected by the Lapse in Appropriations](https://chcoc.gov/content/fact-sheet-pay-and-benefits-information-employees-affected-lapse-appropriations), an employee’s share of premiums will accumulate and be withheld later when the lapse ends and employees can be paid.

On Friday, January 11, 2019, Congress passed a bill that would provide back pay to furloughed federal employees when the furlough ends. It appears that the President will sign the bill. If the bill becomes law, then the furlough would be considered paid leave. For now, it appears that employees of government contractors are not included in the bill that will pay furlough back pay.

Under the Patient Protection and Affordable Care Act (ACA), any hour for which an employee is paid or entitled to payment must be counted as an hour of service. Our UBA Advisor “[Perfect Attendance! How to Handle Leaves of Absence under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=A4X_NiBBBaY%3d)” further describes how leaves of absence should be treated.

A furlough would not necessarily be a COBRA qualifying event. Although a furlough may cause a reduction of hours for an employee, the reduction in hours would only be a COBRA qualifying event if the reduction in hours results in a loss of group health plan coverage. For federal employees who are on furlough, their FEHB coverage continues so there is no loss of group health plan coverage and no COBRA qualifying event.

A furlough with back pay would not likely fit the definition of the permitted election change event of reduction of hours.

**Answer – regarding employees who are not considered to be federal employees:** For employees who aren’t considered to be federal employees, the answer may be yes to each question, depending on the facts of each employee’s case.

If an employer is using the monthly measurement method, then the reduction in hours of a furloughed employee may result in loss of eligibility for group health plan coverage and trigger a COBRA qualifying event. If an employer is using the lookback measurement method, then the employer must offer coverage through the stability period to employees who have full-time status based on their prior measurement period. When an employee’s hours are calculated during the contemporaneous measurement period, the unpaid leave will count as zero hours of service.

If an employee experiences a COBRA qualifying event, then the employee may make election changes for any group health plans subject to COBRA (including FSAs). If an employee has the permitted election change event of reduction in hours, then the employee may make changes for group health plans (excluding FSAs) that provide minimum essential coverage. Please see pages 4-5 of our UBA Advisor “[Cafeteria Plans: Qualifying Events and Changing Employee Elections](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=c4ILhGQ9ZFo%3d)” that describe which benefits can be changed mid-year when an employee has a permitted election change event.

**Educational Information**

From the Wolters Kluwer *Employee Benefits Answer Book*:

**Q 6:42 What is a qualifying event?**

A qualifying event is any one of the following events (but only if the event results in a loss of group health plan coverage):

1. The death of a covered employee;
2. Termination of a covered employee’s employment for any reason other than gross misconduct;
3. Reduction in the number of hours a covered employee is employed;
4. Divorce or separation of a covered employee and his or her spouse;
5. Medicare entitlement of a covered employee;
6. A child of the covered employee ceasing to meet the group health plan’s definition of a dependent child; or
7. Commencement of a bankruptcy proceeding concerning an employer from whose employment the covered employee retired.

Also, see our UBA Advisor “[What Qualifying Events Trigger COBRA?](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=1WxNmVQQyhc%3d)” that describes qualifying events.

From our UBA Advisor “[Perfect Attendance! How to Handle Leaves of Absence under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=A4X_NiBBBaY%3d):”

Under the ACA, any hour for which an employee is paid or entitled to payment must be counted as an hour of service. …

**Unpaid Leave**

If the employee is on an unpaid leave of absence (except unpaid FMLA) and in a stability period, the employee must be offered coverage through the stability period. When the employee’s hours are calculated during the contemporaneous measurement period, the leave of absence will count as zero hours of service.

**Question:** On December 14, 2018, the U.S. District Court for the Northern District of Texas (Court) [issued](https://www.courtlistener.com/recap/gov.uscourts.txnd.299449/gov.uscourts.txnd.299449.211.0.pdf) a declaratory order in ongoing litigation regarding the individual mandate and the Patient Protection and Affordable Care Act (ACA). The Court declared that the individual mandate is unconstitutional and declared that the rest of the ACA – including its guaranteed issue and community rating provisions – is unconstitutional. The Court did not grant the plaintiffs' request for a nationwide injunction to prohibit the ACA's continued implementation and enforcement.

What has happened recently in the court case?

**Answer**: On December 30, 2018, the Court issued two orders. The first [order](https://www.courtlistener.com/recap/gov.uscourts.txnd.299449/gov.uscourts.txnd.299449.220.0.pdf) grants a stay of its December 14 order. This means that the court’s order regarding the ACA’s unconstitutionality will not take effect while it is being appealed. The second [order](https://www.courtlistener.com/recap/gov.uscourts.txnd.299449/gov.uscourts.txnd.299449.221.0.pdf) enters the December 14 order as a final judgment so the parties may immediately appeal the order.

On December 31, 2018, the Court issued an order that stays the remainder of the case. This means that the Court will not be proceeding with the remaining claims in the case while its December 14 order is being appealed. After the appeal process is complete, the parties are to alert the Court and submit additional court documents if they want to continue with any remaining claims in the case.

At this time, the case's status does not impact employers' group health plans. However, employers should stay informed for the final decision in this case.

**Question:** What is the current status of the court case that is challenging the ACA’s constitutionality?

**Answer:** On December 14, 2018, the U.S. District Court for the Northern District of Texas (Court) [issued](https://www.courtlistener.com/recap/gov.uscourts.txnd.299449/gov.uscourts.txnd.299449.211.0.pdf) a declaratory order in ongoing litigation regarding the individual mandate and the Patient Protection and Affordable Care Act (ACA). The Court declared that the individual mandate is unconstitutional and declared that the rest of the ACA is unconstitutional.

As background, earlier this year, twenty states filed a [lawsuit](https://www.courtlistener.com/recap/gov.uscourts.txnd.299449/gov.uscourts.txnd.299449.1.0.pdf) asking the Court to strike down the ACA entirely. The lawsuit came after the U.S. Congress passed the Tax Cuts and Jobs Act in December 2017 that reduced the individual mandate penalty to $0, starting in 2019.

The plaintiffs argued that, without the penalty, the individual mandate is unconstitutional because it can no longer be considered a tax. The plaintiffs argued that the individual mandate is not severable from the rest of the ACA so if the individual mandate is unconstitutional, then the rest of the ACA is unconstitutional.

The U.S. Department of Justice (DOJ) responded that the individual mandate is unconstitutional without the penalty. The DOJ also argued that because the guaranteed issue and community rating provisions are inseverable from the individual mandate, the guaranteed issue and community rating provisions are also unconstitutional.

The individual mandate requires most people to have a certain level of health insurance coverage or pay a penalty (for 2018, the penalty is $695 per adult and $347.50 per child, or 2.5 percent of household income, whichever is greater). Guaranteed issue prohibits insurers from basing coverage eligibility on an individual’s medical history and from excluding preexisting conditions on new plans. In the individual and small group markets, adjusted community rating means that premiums cannot be based on medical history and can only vary based on age, tobacco use, and geographic area.

Although the DOJ asked the Court to declare the individual mandate, guaranteed issue, and community rating provisions to be unconstitutional as of January 1, 2019, the Court went further than the DOJ’s request.

The Court found that the individual mandate is unconstitutional without the penalty and that the individual mandate is inseverable from the rest of the ACA. Because of its findings, the Court declared that the individual mandate and the entire ACA – including its guaranteed issue and community rating provisions – are unconstitutional.

The Court did not grant the plaintiffs’ request for a nationwide injunction to prohibit the ACA’s continued implementation and enforcement. The Court’s declaratory judgment simply defines the parties’ legal relationship and rights under the case (for example, that the individual mandate is unconstitutional as applied to the individual plaintiffs) at this relatively early stage in the case.

On December 16, 2018, the Court issued an [order](https://www.courtlistener.com/recap/gov.uscourts.txnd.299449/gov.uscourts.txnd.299449.212.0_1.pdf) that requires the parties to meet and discuss the case by December 21, 2018, and to jointly submit a proposed schedule for resolving the plaintiffs’ remaining claims. The parties’ proposed schedule for resolving these remaining claims is due to the Court by January 4, 2019.

At this time, the case’s status does not impact employers’ group health plans. However, employers should stay informed for the final decision in this case.

UBA’s revised Advisor “[Status of Court Case Challenging ACA Constitutionality](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=HoZO8Hj2Epg%3d)” reviews the status of the case.

**Question:** The IRS proposed a rule to expand mandatory electronic filing for employers who are required to file at least 250 returns during the calendar year. If this proposed rule is adopted as a final rule, then will employers continue to have transition relief from the W-2 reporting requirement?

**Answer:** Yes, transition relief from the W-2 reporting requirement would still be available for an employer that was required to file fewer than 250 Forms W-2 for the preceding calendar year, without application of any aggregation rules. Our UBA Advisor “[Frequently Asked Questions about the W-2 Reporting Requirement](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=HB0g4fX37dA%3d)” describes this transition rule at Q&As 1 and 2.

Under the proposed rule, the IRS would aggregate an employer’s information returns to determine whether an employer would meet the 250-return threshold for mandatory electronic filing. Our UBA Advisor “[IRS Issues Proposed Rule to Expand Mandatory Electronic Filing](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=bxS-nr8zjfo%3d)” describes this proposed rule.

That Advisor also discusses the IRS [proposed rule](https://www.gpo.gov/fdsys/pkg/FR-2018-05-31/pdf/2018-11749.pdf) that would affect most employers who are required to file information returns, such as Forms W-2, Forms 1095-B, Forms 1095-C, and forms in the 1099 series:

**Current Non-Aggregation Rule**

Employers are not required to electronically file their returns with the IRS unless they are required to file at least 250 returns during the calendar year. The IRS uses a non-aggregation rule in applying this 250-return threshold. Essentially, it uses a separate total for each type of information return filed and each type of corrected information return filed. This means that if an employer files 150 Forms W-2 and 100 Forms 1095-C this year, then the employer is not required to file electronically.

Under current regulations, the IRS can waive the electronic filing requirement if an employer requests a waiver and demonstrates hardship related to the cost of electronic filing.

**Proposed Aggregation Rule**

Under the proposed rule, the IRS would determine whether an employer meets the 250-return threshold by aggregating its information returns. Using the example above, under the proposed rule, the employer would meet the 250-return threshold and would be required to electronically file its information returns.

Corrected returns would not be included in the calculation of whether an employer meets the 250-return threshold. However, the proposed rule would require an employer to electronically file its corrected returns if the original returns were electronically filed.

**Question:** Can an employer exclude children from coverage based on a child’s access to other coverage, employment status, or marital status?

**Answer:** No, if a group health plan provides dependent coverage, then the plan must generally make coverage available for children until age 26. These group health plans must not define dependent, for purposes of dependent coverage, in terms other than the relationship between the child and the plan participant.

This means that a plan cannot use items such as a child’s access to other coverage, employment status, marital status, tax dependent status, residency, or student status to define dependent.

Also, if the employer is an applicable large employer, then it must offer coverage to its full-time employees’ dependent children to avoid penalties under the employer shared responsibility provisions.

**Question:** Under the Patient Protection and Affordable Care Act (ACA), if an employer grows during the year, when must the employer offer coverage and report on coverage offered?

**Answer:** The employer will need to determine its average number of full-time / full-time equivalent employees for the calendar year. Under the ACA, an employer is an applicable large employer (ALE) for a calendar year if it employed an average of at least 50 full-time or full-time equivalent employees during the prior calendar year.

The ALE determination is a three-year cycle. For example, an employer's size, calculated at the conclusion of 2018 determines its obligations for 2019, which it reports on in 2020.

If 2018 is the first time that a company is an ALE, then the company will have until April 1, 2019, to offer coverage. If the company has individuals who are currently full-time employees and the company offers a group health plan, then the company must offer coverage to those full-time employees on January 1, 2019.

From our UBA Advisor “[The Play-or-Pay Penalty and Counting Employees Under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=kJJFzDUPXs0%3d)”:

**Q33: What happens if an employer grows during the year?**

A33: Large-employer status is on a calendar-year basis, based on the average number of employees during the prior calendar year. If an existing employer that was below the 50 (or 100) employee threshold grows during a calendar year, it will not have to offer coverage until the next calendar year.

In addition, if an employer first becomes “large,” it will have until April 1 following the year in which it becomes large to offer coverage. This special rule is only available once, even if the employer moves back and forth between large and small status.

**Question:** If a group offers dependent coverage of children, then how must the coverage be structured?

**Answer:** If a group offers dependent coverage of children, then the plan must cover children until they reach age 26.

Also, the plan cannot define dependent (for purposes of eligibility for dependent coverage of children) in terms other than the relationship between a child and the participant. This means, for example, that a plan may not deny or restrict dependent coverage for a child who is under age 26 based on:

* the presence or absence of the child's financial dependency upon the participant or any other person;
* residency with the participant or with any other person;
* whether the child lives or works in a network service area;
* marital status;
* student status;
* employment;
* eligibility for other coverage; or
* any combination of those factors.

Last, the coverage cannot vary based on age. For example, a plan cannot have a premium surcharge for children who are age 18 through 25.

**Question:** When the plan changes, when should I give notice to participants?

**Answer:** Depending on the change that is made, an employer must provide notice within one of three time frames:

* 60 days prior to the change
* No later than 60 days after the change (or, within 60 days of the change)
* Within 210 days after the end of the plan year

For changes to the summary plan description (SPD) that are a material reduction in covered services or benefits, notice is required within 60 days of adoption of the material reduction in group health plan services or benefits. For example, a decrease in employer contribution would be a material reduction in covered services or benefits so notice should be provided within 60 days of the change in employer contribution. As a best practice, an employer should give advance notice of the change. For practical purposes, employees should be told prior to the first increased withholding.

If a plan makes a material modification in any of the plan terms that would affect the content of the Summary of Benefits and Coverage (SBC) (that is not reflected in the most recently provided SBC), then notice must be provided no later than 60 days prior to the date when the modification will become effective.

However, if the change is part of open enrollment, assuming you communicate the change during open enrollment, the open enrollment communication is considered acceptable notice, regardless of whether the SBC or the SPD, or both, are changing. Open enrollment is essentially a safe harbor for the 60-day prior/60-day post notice requirements.

Finally, changes that do not require more immediate notifications, because they do not affect the SBC and are not a material reduction in benefits, must be communicated through a summary of material modifications or an updated summary plan description within 210 days after the end of the plan year.

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| General Compliance |

**Question:** How should employees pay premiums if they have a domestic partner and their children on their plan? Are those premiums paid on a pre-tax or after-tax basis? In this case, the employer doesn’t contribute toward the premiums of domestic partners or their children.

**Answer:** An employee would pay premiums post-tax for a domestic partner and the domestic partner’s children (unless the domestic partner or the domestic partner’s children qualify as tax dependents of the employee).

**Educational Information:** An employee can only pay pre-tax under a cafeteria plan for the health coverage of a spouse, child under age 27, or Code §105(b) dependent.

A cafeteria plan could be disqualified if it permits a participant to elect coverage on a pre-tax basis for a person who falls outside these categories. In addition to disqualifying the plan, the IRS may impose on the employer employment tax withholding liability and penalties for all employee pre-tax contributions and elective employer contributions. Also, all employees could be required to pay employment and income taxes and penalties on their pre-tax contributions and elective employer contributions.

When an employee pays with after-tax dollars for coverage for an individual who is neither a child under age 27 nor a Code §105(b) dependent, the coverage will not be taxable to the employee, provided that the employee pays at least the fair market value of the coverage. (An employee who pays less than the fair market value for the coverage is taxed on the difference.)

The employee will have no imputed income, and any health benefits paid on behalf of the individual under the plan will be tax-free to both the employee and the individual.

Where health coverage is provided on an after-tax basis for the individual but on a pre-tax basis for the employee, separate payroll slots must be maintained for pre-tax and after-tax coverage, and an allocation must be made as to the amount of premiums attributable to the individual's coverage.

**Question:** If a plan participant divorced over a year ago and failed to notify the plan administrator about the divorce until today, can the plan participant change the election/contribution from employee + spouse coverage to employee-only coverage mid-year under the IRS permitted election change event of "change in marital status"? The cafeteria plan document states that plan participants must inform the plan administrator of a permitted election change event within 30 days of the event. The plan sponsor is terminating the former spouse's coverage prospectively.

**Answer:** No, the late notice of divorce makes the employee unable to change the election/contribution under the permitted election change event of “change in marital status.”

However, there’s informal guidance regarding automatic loss of coverage. If the cafeteria plan document (or plan document or SPD) provides for automatic loss of coverage when there’s a failure to satisfy plan requirements (for example, when someone becomes ineligible for coverage), then the employer may be able to terminate the employee’s contribution mid-year. If the cafeteria plan document (or plan document or SPD) is silent on automatic loss of coverage, then the employer should consult with its attorney before proceeding.

There are a couple other issues to consider. First, if the plan is subject to ERISA, the plan administrator/trustee may have a fiduciary duty to file a court action against the employee for failing to notify the plan of the divorce so that the plan can seek reimbursement for claims paid on behalf of the former spouse.

Second, if the employer is subject to COBRA (and presuming that the initial COBRA notice or the SPD provided reasonable procedures for the covered employee to inform the plan administrator of the divorce), the plan is not required to offer the former spouse the opportunity to elect COBRA continuation coverage because the employee did not provide notice of the divorce by the deadline provided in the initial COBRA notice. However, if the plan sponsor receives a late qualifying event notice, then the plan sponsor must provide a notice of unavailability of COBRA coverage.

**Question:** What are the recently adjusted amounts of certain federal civil monetary penalties?

**Answer:** On January 23, 2019, the Department of Labor (DOL) issued its [Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2019](https://www.govinfo.gov/content/pkg/FR-2019-01-23/pdf/2019-00089.pdf) which is the DOL’s annual adjustment of federal civil monetary penalties.

Here are some of the adjustments:

* Form 5500: For failure to file, the maximum penalty increases from $2,140 to $2,194 daily for every day that the Form 5500 is late.
* Summary of Benefits and Coverage: For failure to provide, the maximum penalty increases from $1,128 to $1,156 per failure.
* Medicaid/CHIP notice: For failure to provide, the maximum penalty increases from $114 to $117 per day per employee.
* For failure to provide documents to the DOL upon its request, the maximum penalty increases to $156 per day, not to exceed $1,566 per request.

The adjustments are effective for penalties assessed after January 23, 2019, for violations occurring after November 2, 2015.

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| HIPAA |

**Question:** Under HIPAA, can a group health plan or health care provider send communications to employees’ homes by postcard, or must the communications be sent by sealed envelopes?

**Short Answer:** Generally, a covered entity (such as a group health plan or health care provider) may provide communications such as appointment reminders without a person’s HIPAA authorization. The covered entity should reasonably safeguard the person’s privacy by taking care to limit the amount of information disclosed.

However, the covered entity may not use a postcard or send the communication to a person’s home, or both, if the person requests that communications be mailed using a sealed envelope or an alternate address such as post office box.

**Educational Information**

From HHS’ [FAQs for Professionals](https://www.hhs.gov/hipaa/for-professionals/faq/286/are-appointment-reminders-allowed-under-hipaa-without-authorization/index.html):

Are appointment reminders allowed under the HIPAA Privacy Rule without authorizations?

Answer: Yes, appointment reminders are considered part of treatment of an individual and, therefore, can be made without an authorization.

From the OCR’s [Incidental Uses and Disclosures Frequently Asked Questions](https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveredentities/incidentalu%26d.pdf):

Q: May physician’s offices or pharmacists leave messages for patients at their homes, either on an answering machine or with a family member, to remind them of appointments or to inform them that a prescription is ready? May providers continue to mail appointment or prescription refill reminders to patients’ homes?

A: Yes. The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care. This includes communicating with patients at their homes, whether through the mail or by phone or in some other manner. In addition, the Rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual’s privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment, or ask the individual to call back.

A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual’s care, even when the individual is not present. However, covered entities should use professional judgment to assure that such disclosures are in the best interest of the individual and limit the information disclosed. See 45 CFR 164.510(b)(3).

In situations where a patient has requested that the covered entity communicate with him in a confidential manner, such as by alternative means or at an alternative location, the covered entity must accommodate that request, if reasonable. For example, the Department considers a request to receive mailings from the covered entity in a closed envelope rather than by postcard to be a reasonable request that should be accommodated. Similarly, a request to receive mail from the covered entity at a post office box rather than at home, or to receive calls at the office rather than at home are also considered to be reasonable requests, absent extenuating circumstances. See 45 CFR 164.522(b).

**Question:** What are some HIPAA resources available through UBA and through the U.S. Department of Health and Human Services (HHS)?

**Answer:** UBA sponsored an Employer Webinar on HIPAA in April 2017. The webinar recording and presentation are available on our Wisdom Network's Employer Webinar Series [webpage](http://wn4.ubabenefits.com/Sales/BrandingMarketing/EmployerWebinarSeries/tabid/1437/Default.aspx).

Our July 12, 2018, UBA Quarterly Compliance Call covered HIPAA business associate agreements. Both the presentation and recording are available on our Wisdom Network’s Quarterly Compliance Call [webpage](http://wn4.ubabenefits.com/Wisdom/ComplianceTopics/GeneralCompliance/tabid/1446/Default.aspx).

Our UBA Advisors “[How HIPAA Applies to Health and Welfare Benefit Brokers](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=cVvGUJ25JWE%3d)” and “[HIPAA Best Practices Guide](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=uLI5zSuhe_I%3d)” may be useful resources.

Outside of UBA, HHS has some free HIPAA training tools on its Training Materials [webpage](https://na01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hhs.gov%2Fhipaa%2Ffor-professionals%2Ftraining%2Findex.html&data=02%7C01%7Ckchong%40atlasinsurance.com%7C243e767e394342b3d15208d6705d1ec5%7C5261cf5386c547be8e4cee60505d0312%7C0%7C0%7C636819942599630961&sdata=jIpiY20Rz89%2BgkwqiEhT1xHPH8Tv8YkvEsnEVLNR5ag%3D&reserved=0).

**Question:** If a parent wants to drop a child (age 23) from the parent’s plan because the parent no longer wants to pay for the child’s coverage, would this be considered a qualifying event for the child to join the child’s employer’s plan? Is the parent allowed to drop the child from coverage for this reason outside of open enrollment?

**Answer:** Yes, if the child loses group health plan coverage, then the child has a HIPAA special enrollment right to join his employer’s group health plan.

However, a parent’s unwillingness to continue paying for a child’s coverage is not a permitted election change event under the Section 125 cafeteria plan rules. This means that a parent cannot drop a child’s coverage mid-year based on the reason that the parent doesn’t want to pay for the child’s coverage.

Our UBA Advisor “[Cafeteria Plans: Qualifying Events and Changing Employee Elections](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=c4ILhGQ9ZFo%3d)” describes HIPAA special enrollment rights at page 9.

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| Medical Loss Ratio |

**Question:** Our client recently received a medical loss ratio (MLR) rebate. How should the money be distributed?

**Answer:** If the plan document states how a rebate should be used, then the plan administrator should follow the plan document’s terms.

In the absence of plan document language on how a rebate should be used, please see the educational information below for how to distribute the rebate.

Regulatory agencies’ guidance on how employers should distribute rebates has been fairly general, so employers have some discretion on calculating and distributing the employees’ share. These general principles apply:

**How should the rebate be divided?**

Assuming both the employer and employees contribute to the cost of coverage, the rebate should be divided between the employer and the employees, based on the employer’s and employees’ relative share. Employers may divide the rebate in any reasonable manner – for example, the rebate could be divided evenly among the employees who receive it, or it may be divided based on the employee’s contribution for the level of coverage elected.

Employers are not required to precisely determine each employee’s share of the rebate, and so do not need to perform special calculations for employees who only participated for part of the year, moved between tiers, etc.

Using the example that the rebates are based on premiums paid to the carrier for calendar year 2017, the employer may pay the rebate only to employees who participated in the plan in 2017 and are still participating, only to current participants (even though the rebate relates to 2017), or to those who participated in 2017, regardless whether they are currently participating.

Insurers must send a notice to all employees who participated in the plan in 2017 stating that a rebate has been issued to the employer, so employers who choose to limit rebate payments to those who are currently participating should be prepared to explain why the rebate is only being paid to current participants. This might include the fact that since the rebate would be taxable income, the amount involved does not justify the administrative cost to locate former participants and issue a check.

**Are Former Plan Participants Entitled to Share in a Rebate?**

Whether former participants should be included in any rebate allocations depends on the type of plan involved. For ERISA plans, there is no requirement that former participants be included or excluded. However, the Department of Labor (DOL) Technical Release, in discussing fiduciary decisions regarding distribution of rebates, states that if a fiduciary determines that the cost of including former participants in a rebate distribution approximates the amount of the rebate, the fiduciary may properly decide to allocate the rebate only to current participants. Therefore, the plan fiduciaries should consider whether to include former participants and should make a prudent decision based on all of the facts and circumstances.

For non-federal governmental plans, the interim final regulations specifically require any portion of a rebate that is based on former participants' contributions to be aggregated and used for the benefit of current participants.

For nongovernmental, non-ERISA plans, the interim final regulations provide that if the rebate is paid to the policyholder (which is only permissible if the policyholder has given the insurer written assurance that meets the requirements of the regulations), the policyholder must allocate the rebate to current participants only, in the same way as a non-federal governmental plan. If the rebate is paid directly to participants by the insurer (because the policyholder has declined to provide a written assurance), the insurer must distribute the rebate equally among those who were participants during the MLR reporting year on which the rebate is based.

**How may the employer use the rebate?**

The employer may pay the rebate in cash, use it for a premium holiday, or use it for benefit enhancements. The rebate must be applied or distributed within 90 days after it is received.

A cash rebate is taxable income to the employee if it was paid with pre-tax dollars.

A premium holiday should be completed within 90 days after the rebate is received (or the rebate needs to be deposited into a trust).

Benefit enhancements include reduced copays or deductibles (which may not be practical due to the timing requirements) or wellness-type benefits that the employer would not have offered without the rebate, such as free flu shots, a health fair, a lunch and learn on nutrition or stress reduction, or a nurse line.

**How should the rebate be provided?**

The employer should consider the practical aspects of providing a rebate in a particular form.

Generally, the larger the amount that would be due to an individual, the more effort the employer should make to directly benefit the person (either through a cash rebate or premium holiday). While benefit enhancements are permissible, a large rebate should be used to provide a direct benefit enhancement, such as a reduced co-pay, and not for a general benefit, such as flu shots.

The agencies have not provided any details as to what amount is so small that it does not need to be returned to the employee. (Insurers are not required to issue a rebate check to individuals if the amount is less than $5.00.) A cash rebate is taxable income if the premium was paid with pre-tax dollars, so issuing a check that is very small after taxes should not be necessary. If an employer knows it costs $2.00 to issue a check, issuing a rebate check for $1.00 should not be necessary. However, an employer cannot simply keep the rebate if it determines that cash refunds are not practical – it will need to use the employee share of the rebate to provide a benefit enhancement or premium reduction.

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| Medicare |

**Question:** What is Medicare Section 111 mandatory reporting?

**Answer:** Under Section 111, group health plans are required to make disclosures to CMS. (The Section 111 disclosure is different than the Medicare creditable coverage disclosures to participants and CMS.) Both fully-insured plans and self-funded plans must complete the Medicare Section 111 online disclosure.

If it’s a fully-insured plan, the insurer should be making the online disclosure. If it’s a self-funded plan, then the plan administrator should be making the online disclosure. Hyperlinked below is CMS’ guide that provides detailed instructions on how a plan completes Section 111 mandatory reporting.

**Educational Information**

There is Medicare Secondary Payer (MSP) mandatory reporting for group health plan (GHP) responsible reporting entities (RREs). In most cases, the RRE will be the insurer or TPA. However, for self-funded plans, the RRE will usually be the plan administrator.

Per CMS’ [MMSEA Section 111 MSP Mandatory Reporting GHP User Guide](https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/MMSEA-Section-111-GHP-User-Guide-Version-52.pdf), on a quarterly basis, an RRE must submit GHP entitlement information about employees and dependents to the CMS Benefits Coordination & Recovery Center (BCRC). Then the BCRC provides the RRE with Medicare entitlement information for those GHP participants that can be identified as Medicare beneficiaries. This data exchange helps to assure that claims will be paid by the correct organization at first billing.

The [presentation](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=cJ_Uw8d5k5A%3d) from our UBA February Employer Webinar discusses Section 111 reporting at   
slides 22-24.

Also, from our UBA Advisor “[What You Need to Know About Medicare Secondary Payer Rules](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=lSRW0uVJqZk%3d)”:

**Q6. Are there any reporting requirements surrounding Medicare Secondary Payer rules?**

A6. Yes, under Medicare Section 111. Dependent on circumstances, a responsible reporting entity (RRE) can be an insurer, a third party administrator, or a plan administrator. The RRE is responsible for collecting data from plan sponsors and participants and reports to CMS quarterly. Failure to report this information can lead to penalties of $1,181 for each day of non-compliance. (See Question 12 for more.) …

**Q12. Generally speaking, what are the penalties for violating Medicare Secondary Payer or ACA premium reimbursement rules?**

A12. There are numerous penalties that exist for violation of Medicare Secondary Payer rules.

Medicare Civil Monetary Penalties: …

2. Failure on the part of a group health plan to fulfill reporting requirements under Section 111 to allow for the coordination of benefits can result in a civil monetary penalty of $1,181 a day for each day of non-compliance for each individual for which the information should have been submitted. …

**Question:** What are the penalties if an employer hasn’t followed the Medicare Part D creditable coverage disclosure requirements?

**Answer:** The Medicare Prescription Drug, Improvement and Modernization Act of 2003 doesn’t provide a specific penalty for not providing the disclosure. Further, CMS does not describe specific civil penalties for plans that do not comply with the Medicare Part D creditable coverage disclosure requirements (either the disclosure to CMS or the disclosure to Part D-eligible individuals). The only specified penalty relates to a retiree plan attempting to receive the retiree drug subsidy; the plan would be denied the subsidy if it had not complied with the required Medicare Part D notifications. CMS’ [webpage](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/index.html) provides more information regarding the Employer & Union Retiree Drug Subsidy.

Other laws, such as ERISA’s fiduciary obligations or Medicare Secondary Payer Rules, may apply depending on the facts. Those laws may provide penalties or sanctions when violations occur.

**Question:** Can an employee be HSA-eligible if the employee’s spouse is enrolled in Medicare?

**Answer:** Yes. To be an eligible individual and qualify for an HSA, you must meet the following requirements:

* You must be covered under a high deductible health plan (HDHP) on the first day of the month.
* You are not enrolled in Medicare.
* You cannot be claimed as a dependent on someone else’s tax return for the year.
* You have no other disqualifying health coverage except what is permitted.

| **Disqualifying Coverage** | **Acceptable Secondary Coverage** |
| --- | --- |
| Health flexible spending account (FSA)  (unless it is limited-purpose or post-deductible) | Discount cards for prescription drugs (so long as the plan does not pay benefits prior to the deductible being satisfied) |
| Health reimbursement arrangement (HRA) (unless it is limited-purpose, retirement, or post-deductible) | Dental coverage (so long as it doesn’t provide medical benefits) |
| Medicaid | Accident, business travel coverage, accidental death and disability (AD&D), disability |
| Medicare | Disease specific coverage (so long as the principal health coverage is through the HDHP) |
| On-site clinics (unless they provide nominal benefits such as flu shots, Band-Aids, and aspirin) | Wellness programs (so long as it doesn’t provide significant benefits in the nature of medical care or treatment) |
| Telemedicine (unless there is a co-pay and it does not provide significant benefits in the nature of medical care or treatment) | Workers’ compensation |
| TRICARE | Vision coverage |
| VA Medical Benefits (unless it is hospital care or services for a service-connected disability) | Preventive care |

**Question:** When must an employer provide a Medicare Part D Creditable Coverage Disclosure to an individual?

**Answer:** Disclosures to individuals must be made:

1. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) which runs from October 15 through December 7 of each year;
2. Prior to an individual’s Initial Enrollment Period (IEP) for Medicare Part D;
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
4. Whenever the plan no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and
5. Upon request by the individual.

If the creditable coverage disclosure notice is provided to all plan participants annually (for example, at open enrollment), CMS will consider items 1 and 2 above to be met.

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| Nondiscrimination |

**Question:** May a self-funded plan exclude high-cost, specialty drugs?

**Answer:** Generally, a self-funded plan may design its prescription drug plan to exclude or limit certain high-cost prescription drugs. However, a plan sponsor should evaluate its proposed prescription drug plan design to ensure that it doesn’t violate mental health / substance use disorder parity rules, violate the Americans with Disability Act’s prohibition of discrimination against the disabled, or discriminate based on sex, gender, sexual orientation, or gender identity (if the plan is subject to Section 1557’s nondiscrimination rules).

Our UBA Advisors “[Proposed FAQs about Mental Health and Substance Use Disorder Parity](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=LmTvSh424wE%3d)” and “[Update on Nondiscrimination Regulations Relating to Sex, Gender, Age, and More Finalized](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=kJixk3CrcCc%3d)” that describes these nondiscrimination concepts.

Also, under HIPAA’s nondiscrimination rules for eligibility and benefits, a plan sponsor should not amend a prescription drug plan to exclude or limit certain high-cost prescription drugs based on an individual participant’s health factors.

If a plan sponsor wants to amend its prescription drug plan to exclude or limit certain high-cost prescription drugs, then its amendment should:

* apply to all individuals in one or more groups of similarly situated individuals and
* the amendment should be effective no earlier than the first day of the first plan year beginning after the amendment is adopted.

**Question:** Under what circumstances would an executive reimbursement plan be permitted?

**Answer:** While executive reimbursement plans are disfavored and self-funded executive reimbursement plans are likely prohibited, it *may* be permissible to have an executive reimbursement plan if it is fully insured and not run through a cafeteria plan. A plan sponsor who is considering an executive reimbursement plan should consult with its attorney before proceeding.

Please be aware that, under the Patient Protection and Affordable Care Act (ACA), the Section 105(h) rules are to apply to fully insured, non-grandfathered plans. In late 2010, the government delayed enforcement of Section 105(h) against fully insured, non-grandfathered plans until the first plan year beginning after regulations are issued. To date, no regulations have been issued so there is currently no penalty for noncompliance. This means that if the IRS issues regulations, then an executive reimbursement plan sponsor could face enforcement because the arrangement would likely be prohibited.

Further, in discussions with other Partner Firm members, there are some carriers who run Section 105(h) nondiscrimination testing on all their fully insured, non-grandfathered plans because that is what the ACA says applies to those plans, despite the IRS’ statement that it will hold off enforcement until after it issues regulations.

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| Play or Pay and Reporting |

**Question:** Under the ACA, what are the indexed Penalty A and Penalty B for 2019 and 2020?

**Answer:** For 2019, Penalty A is $2,500 and Penalty B is $3,750. For 2020, Penalty A is $2,570 and Penalty B is $3,860. Our recently updated UBA Advisor “[The Play-or-Pay Penalty and Counting Employees](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=kJJFzDUPXs0%3d)” discusses penalties in more detail.

**Question:** For plan/policy years that end on October 31, 2018, through December 31, 2018, the PCORI fee is $2.45/person with a due date of July 31, 2019. I’m looking for a Form 720 with a field for plan/policy years ending during those dates. Has the IRS released its updated form for the PCORI fees that are due on July 31, 2019?

**Answer:** No, the IRS has not released an updated Form 720 yet. In the past, the IRS didn’t release the updated form until a week or two before the PCORI fee due date.

Our UBA Advisor “[Frequently Asked Questions about the Patient-Centered Outcomes/Comparative Effectiveness (PCORI) Fee](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=EFgcVL1CO6I%3d)” describes the PCORI fee.

**Question:** An applicable large employer is moving the start of its plan year from 12/1 to 1/1 and the employer would like to move its stability period to match the new plan year. How soon can the employer make the change to its measurement and stability periods?

**Answer:** The earliest that the employer can make the change is during the stability period that follows its upcoming stability period.

From our UBA Advisor “[Making Changes in Measurement and Stability Periods](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=XKUmfX7kXSQ%3d)”:

“ . . . an employer may change the measurement period or method (from or to the monthly measurement method, or in the length or start date) for one or more categories of employees. (The permitted categories are hourly and salaried, under a bargaining agreement or not under a bargaining agreement, covered under different bargaining agreements, and located in different states.) Employers that plan to change the dates of their measurement and stability periods must inform employees of the upcoming change, but cannot make the change until the stability period following the upcoming stability period.”

**Question:** Where can I find CMS’ minimum value calculator?

**Answer:** Highlighted below is the hyperlink to the minimum value calculator. From the Centers for Medicare & Medicaid Services’ (CMS’) [Regulations and Guidance](https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html):

**Minimum Value**

An employer-sponsored plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. See [Notice 2014-69](https://www.irs.gov/pub/irs-drop/n-14-69.pdf) for additional guidance regarding whether an employer-sponsored plan provides minimum value coverage if the plan fails to substantially cover in-patient hospitalization services or physician services. Under [proposed regulations](http://www.gpo.gov/fdsys/pkg/FR-2013-05-03/pdf/2013-10463.pdf) upon which taxpayers may rely, employers generally must use a [minimum value calculator](http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html) developed by HHS to determine if a plan with standard features provides minimum value. Plans with nonstandard features are required to obtain an actuarial certification for the nonstandard features. The proposed regulations also describe certain safe harbor plan designs that will satisfy minimum value. …

[Minimum Value Calculator](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-final-4-11-2013.xlsm) (XLSM – 598 KB)

[Minimum Value Calculator Methodology](https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-methodology.pdf) (PDF - 154 KB)

**Question:** What amount does an employer report on Form 1095-C for an employee who was on COBRA due to a reduction in hours? Does the employer include the COBRA 2% administration fee?

**Answer:** The employer reports the cost of employee-only coverage in Line 15. The employer does not include the COBRA 2% administration fee when reporting the cost.

For more information, please see page 2 of our UBA Advisor “[2018 IRS Reporting Tip 1 Reporting Offers of COBRA Coverage](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=Wckmm7JQRXk%3d)” describes the codes an employer would use to report an offer of COBRA coverage.

**Question:** How does an applicable large employer with a self-funded plan complete Form 1095-C for the following situations?

1. A person terminated employment mid-year and started COBRA on the first of the month mid-year
2. A person terminated employment mid-year and started COBRA mid-month mid-year
3. A person had COBRA coverage for the entire year and was not an employee for the entire calendar year

**Answer:** The employer would complete Form 1095-C with the following codes:

1. Line 14 1H, Line 15 blank, Line 16 2A for the months that the person was offered COBRA coverage
2. Line 14 1H, Line 15 blank, Line 16 2B for the month in which the person terminated employment with the ALE; Line 14 1H, Line 15 blank, Line 16 2A for the remaining months that the person was offered COBRA coverage
3. Line 14 1G under “All 12 Months,” Line 15 blank, Line 16 blank

Also, the employer would complete Part III indicating the months that the person was enrolled on the plan, including any period of COBRA coverage.

**Question:** If an applicable large employer has union employees who are enrolled in a fully-insured union plan, who has responsibility for completing Forms 1094-C and 1095-C?

**Answer:** The employer is responsible for completing Section 6056 reporting (Form 1094-C and Form 1095-C Parts I and II) for the union employees.

Our UBA Advisor “[IRS Releases Final Forms and Instructions for 2018 ACA Reporting](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=-uNcMrSLN0o%3d)” that summarizes an employer’s reporting responsibilities.

**Question:** Must an employer offer coverage to a full-time employee who is a student with an immigrant visa that provides post-graduation work authorization?

**Answer:** Yes, if the employer is an applicable large employer and the full-time employee is otherwise eligible for coverage, then the employer should offer coverage to the employee.

Presuming that the employee is eligible under the plan document’s provisions, being a noncitizen student is not an automatic bar to health plan coverage eligibility. For purposes of the employer shared responsibility provisions, noncitizens (such as those in the U.S. on most visas) who work in the U.S. have their hours counted for play-or-pay purposes. Further, all hours that a student employee works for payment (other than through a federal, state, or local work study program) must be counted as hours of service.

**Educational Information**

From our UBA Advisor “[The Play-or-Pay Penalty and Counting Employees Under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=kJJFzDUPXs0%3d)” which is attached:

**Q7: Are foreign workers counted?**

A7: Yes. All hours worked in the U.S. that generate U.S. source income for income tax purposes are counted. This means that hours worked in the U.S. by noncitizens (such as those here on most visas or who have a green card) are counted. The IRS has specifically said that workers holding H-2A and H-2B visas must be considered.

Further, according to Healthcare.gov’s [Immigration Status and the Marketplace](https://www.healthcare.gov/immigrants/immigration-status/), individuals with non-immigrant status, including student visas, qualify to use the Marketplace.

From Checkpoint EBIA:

**C. Penalty Tax Hinges on Whether Employer Offers Coverage to Full-Time Employees**

…

**ii. Student Employees**

Commenters to the proposed regulations requested special rules for determining the hours of service of employees who are also students of an educational organization. …

In response, the final regulations provide that “hours of service” do not include hours of service performed by students in positions subsidized through the federal work study program or a substantially similar program of a state or a political subdivision of a state. However, the final regulations do not include a general exception for student employees. All hours of service for which a student employee of an educational organization (or of an outside employer) is paid or entitled to payment in a capacity other than through the federal work study program (or a state or local government's equivalent) are required to be counted as hours of service.

**Question:** One of our clients recently received an Employer Shared Responsibility Payment (ESRP) letter. What should the employer do?

**Answer:** The employer should consult with its attorney as soon as possible about replying to the ESRP letter within the deadline on the letter. An employer would need its attorney to review its filings and determine what its response will be.

Our UBA Advisor "[Understanding Your IRS Play-or-Pay Penalty Assessment Letter](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=cG2imZF1LSo%3d)" answers common questions that an employer may have after it receives an ESRP letter.

Also, during our February 2018 Quarterly Compliance Call, one of our UBA Legal and Compliance Committee members presented on ESRP letters. Our presenter indicated that brokers generally shouldn't be preparing clients' responses to ESRP letters because these are essentially tax issues that should be handled by an employer's attorney. The presentation and Quarterly Compliance Call recording are available on our Wisdom Network's Quarterly Compliance Call [webpage](http://wn4.ubabenefits.com/Wisdom/ComplianceTopics/GeneralCompliance/tabid/1446/Default.aspx).

**Question:** Under the Affordable Care Act (ACA), if an employer grows during the year, when must the employer offer coverage and report on coverage offered?

**Answer:** The employer will need to determine its average number of full-time / full-time equivalent employees for the calendar year. Under the ACA, an employer is an applicable large employer (ALE) for a calendar year if it employed an average of at least 50 full-time or full-time equivalent employees during the prior calendar year.

The ALE determination is a three-year cycle. For example, an employer's size, calculated at the conclusion of 2018 determines its obligations for 2019, which it reports on in 2020.

If 2018 is the first time that a company is an ALE, then the company will have until April 1, 2019, to offer coverage. If the company has individuals who are currently full-time employees and the company offers a group health plan, then the company must offer coverage to those full-time employees on January 1, 2019.

From our UBA Advisor “[The Play-or-Pay Penalty and Counting Employees Under the ACA](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=kJJFzDUPXs0%3d)”:

**Q33: What happens if an employer grows during the year?**

A33: Large-employer status is on a calendar-year basis, based on the average number of employees during the prior calendar year. If an existing employer that was below the 50 (or 100) employee threshold grows during a calendar year, it will not have to offer coverage until the next calendar year.

In addition, if an employer first becomes “large,” it will have until April 1 following the year in which it becomes large to offer coverage. This special rule is only available once, even if the employer moves back and forth between large and small status.

**Question:** What are the penalties for failing to file a correct information return or failing to furnish a correct payee statement under the play-or-pay rules?

**Answer:** Generally, the penalty for failing to file an information return is $250 per return and the penalty for failing to provide a correct payee statement is $250 per statement.

From the IRS’ [Information Reporting by Applicable Large Employers](https://www.irs.gov/affordable-care-act/employers/information-reporting-by-applicable-large-employers):

**Information Reporting Penalties**

An ALE Member that fails to comply with the information reporting requirements may be subject to the general reporting penalty provisions under section 6721 (failure to file correct information returns) and section 6722 (failure to furnish correct payee statement).

* The penalty for failure to file an information return generally is $100 for each return for which such failure occurs. The total penalty imposed for all failures during a calendar year cannot exceed $1,500,000.
* For returns required to be filed after December 31, 2015, the penalty for failure to file an information return generally is increased from $100 to $250 for each return for which such failure occurs. The total penalty imposed for all failures during a calendar year after December 15, 2015 cannot exceed $3,000,000.
* The penalty for failure to provide a correct payee statement is $100 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed $1,500,000.
* The penalty for failure to provide a correct payee statement is increased from $100 to $250 for each statement for which the failure occurs, with the total penalty for a calendar year not to exceed $3,000,000. The increased penalty amount applies to statements required to be provided after December 31, 2015.
* Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to furnish a payee statement.

The waiver of penalty and special rules under section 6724 and the applicable regulations, including abatement of information return penalties for reasonable cause, may apply to certain failures under section 6721 or 6722.

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| Wellness |

**Question:** If an employer wants to have a wellness program that offers premium incentive to employees who get a medical exam and biometric screening from their doctor, does the employer have to pay the cost of the medical exam and biometric screening?

**Answer:** No, an employer is not required to pay for the medical exam and biometric screening. However, the employer needs to evaluate whether the cost would be overly burdensome. If there are significant costs related to the medical exams or biometric screenings, then the wellness program design may not meet the ADA’s and GINA’s reasonable design requirement.

From our UBA Advisor “[Understanding Wellness Programs and their Legal Requirements](http://wn4.ubabenefits.com/DNNGlobalStorageRedirector.ashx?egsfid=PUsrpW9C3zQ%3d)”:

**Reasonable Design**

Like the ADA, GINA requires wellness programs that collect genetic information to be reasonably designed. A program is considered reasonably designed to promote health or prevent disease if it:

* 1. Has a reasonable chance of improving the health of, or preventing disease in, the participating individual;
  2. Is not overly burdensome;
  3. Is not a subterfuge for discriminating on the basis of a health factor; and
  4. Is not highly suspect in its methods.

Wellness programs are not reasonable if they are designed to shift costs from an employer to employees based on their health, are used only to predict future health costs, are unreasonably intrusive, overly burdensome, or have significant costs related to medical exams. Wellness programs are not reasonable if health information is collected and is not used to provide results, follow-up information, or advice to participants.