Compliance Update for Employee Welfare Plans

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4.19.2018

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Agenda

- Affordable Care Act
- GOP Tax Bill
- Government Spending Bill
- Chronic Disease Management Act
- Recent Developments
  - Employer Mandate Penalties (2015) – IRS Letter 226J
  - HIPAA Privacy and Security
  - PPACA Section 1557: The Latest
- Leaves of Absence and Benefits Administration

Affordable Care Act

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- PPACA remains law of the land
- Continue to comply with PPACA provisions, including employer mandate (pay-or-play) and reporting
  - 2017 statements were due to individuals by March 2, 2018
  - ALEs filed 1094-C with copies of 1095-Cs by 2/28 (paper) or 4/2 (electronic)
- Individual coverage mandate still in effect (for now)

Tax Cuts and Jobs Act

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- Individual Mandate effectively repealed as of 1/1/2019
- Employer deduction for transportation fringe benefits eliminated
- Tax credit for paid FMLA leave (credit only available for wages paid in 2018 and 2019)
- Many, many other issues to discuss with corporate and personal tax advisors

Tax Cuts and Jobs Act

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- Not in the legislation:
  - Removal of exclusion for employer-provided tuition assistance
  - DCAP Limitations
  - Repeal of the employer mandate
  - Repeal of the Cadillac tax
  - Limitation on exclusion for employer-provided health coverage

Government Spending Bill

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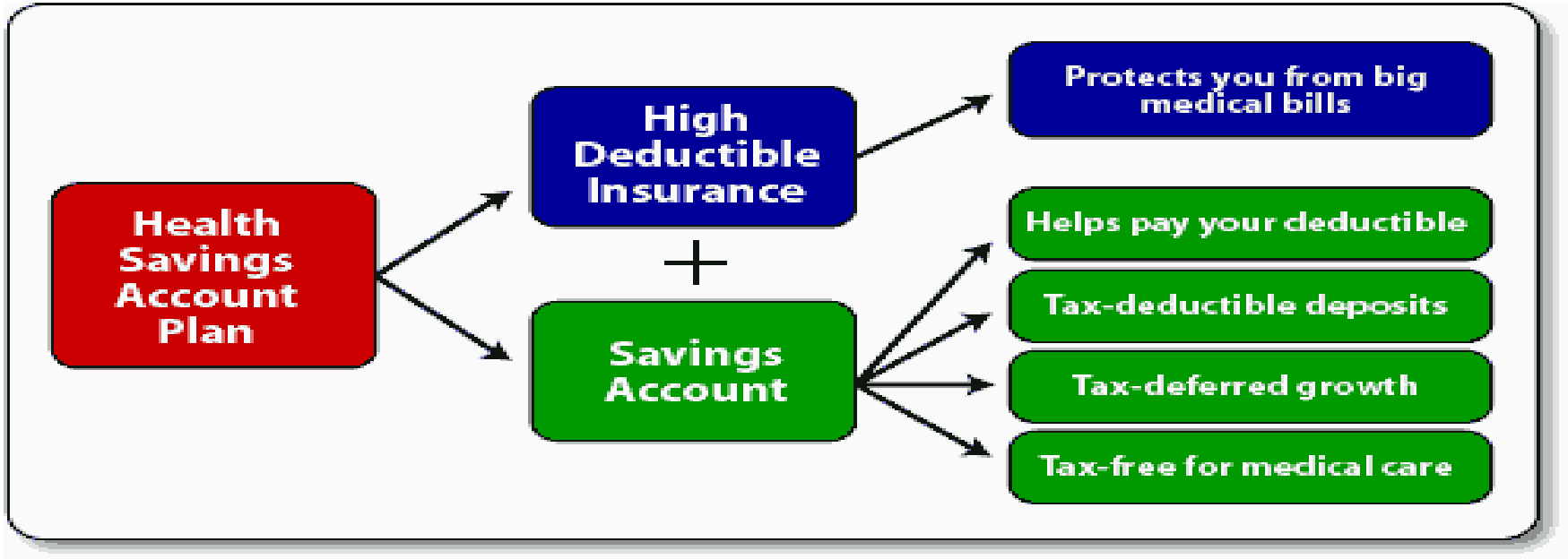
- Cadillac Tax
  - Enacted as IRC Section 4980I
  - Under PPACA, originally set to go into effect in 2018
  - In December 2015, delayed by Congress until 2020
  - On January 22, Congress further delayed the effective date until 2022
- Health Insurance Provider Fee
  - Applicable to fully-insured plans
  - Previous moratorium of 2017 fee
  - Fee still applies to 2018
  - New moratorium of 2019 fee

Chronic Disease Management Act

- Under current law, eligibility to contribute to an HSA is spoiled by any “disqualifying coverage”
- Preventive care is not disqualifying coverage
  - However, preventive care generally does not include treatment of an *existing* illness, injury, or condition
- (Bipartisan) Chronic Disease Management Act
  - Would permit qualifying HDHPs to provide treatment and prescription drugs without a deductible for certain chronic conditions without spoiling HSA contribution eligibility

HSA Refresher



HSA Refresher

- High-deductible health plan (HDHP)
  - $1,350/$2,700 minimum deductibles (2018)
  - Watch out for embedded single deductible within family umbrella
  - $6,650/$13,300 out-of-pocket maximums
- Eligibility determined on first day of each month
- Mid-year election changes more frequent

HSA Refresher

- No other “disqualifying coverage”
  - Any first dollar coverage spoils contribution eligibility
  - Medicare enrollment (but not merely turning 65)
  - Onsite clinics
  - Telemedicine
  - General purpose health FSA

HSA Refresher

- What is NOT disqualifying “other coverage”
  - Permitted insurance
    - Workers’ comp, tort/property liability, or auto insurance
    - Specified disease or illness (e.g., a cancer)
    - Fixed amount per day of hospitalization
  - Permitted coverage
    - Accident, disability, dental, vision, or long-term care (or a limited-purpose health FSA or HRA for such benefits)
  - Post-deductible coverage
    - E.g., post-deductible HRA or FSA

Recent Developments

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Miscellaneous

- 2018 HSA Maximums and Limits
  - Minimum annual deductibles: $1,350/$2,700
  - Maximum Out-of-Pocket: $6,650/$13,300
  - Contribution Limit: $3,450~~/$6,900~~ $6,850
- 2018 FSA Maximum: $2,650
- ACA Affordability Measure: 9.56%
- PCORI fee continues
- PPACA Out-of-Pocket Maximums
  - $7,350 self-only; $14,700 family

Employer Mandate Assessments

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- ESR Penalties: A Refresher
  - Headcount Penalty – 4980H(a)
    - Fail to offer MEC to 95% (70% in 2015) of FTEs and their children
    - Penalty: $2,080 in 2015 (indexed) each FTE minus 30 (80 for 2015) if just one FTE obtains subsidized coverage on the Exchange
    - Coverage need not be affordable or provide minimum value
  - Individualized Penalty – 4980H(b)
    - Fail to offer coverage that is both affordable and provides minimum value to a particular FTE
    - Penalty: $3,120 in 2015 (indexed) per year for THAT employee
    - Applies only to those FTEs who receive a premium tax credit

Employer Mandate Assessments

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IRS Letter 226J

- Notifies employer of preliminary IRS calculation of employer shared responsibility payment (ESRP) owed
- Uses information from filed Forms 1094 and 1095 to calculate penalty
- 30 day response deadline
- ESRPs are based on what the employer reported:
  - 4980H(a) penalties assessed based on reporting errors on Form 1094-C, Part III, column (a)
  - 4980H(b) penalties assessed based on affordability issues or a failure to accurately report an affordability safe harbor on Form 1095-C

Employer Mandate Assessments

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Form 14765, PTC Listing

Form **14765**
(April 2017)

Department of the Treasury - Internal Revenue Service

Employee Premium Tax Credit (PTC) Listing

Any month not highlighted is a month that the employee received a PTC and no safe harbor or other relief from the ESRP was applicable. The employee is an assessable full-time employee for that month.

Employer name										Employer ID number			Tax year		

Employee Name *(last, first)*	SSN *(last 4 digits)*	All 12 months Indicator Codes *(Form 1095-C, lines 14 and 16 combined)*	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Additional Information Attached
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Employer Mandate Assessments

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If disagree with penalty

- Return Form 14764, ESRP Response, by due date
- Include signed statement explaining why you disagree
- Can provide documentation
  - Describe changes to information you reported on 2015 Forms 1094-C and/or 1095-C
  - Make changes to Employee PTC listing (Form 14765)
  - Do NOT file corrected 2015 Forms

Employer Mandate Assessments

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If disagree with penalty (continued)

- After returning Form 14764, IRS will reply with Letter 227
- If employer disagrees with IRS after receipt of Letter 227, may request a pre-assessment conference with IRS Office of Appeals

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HIPAA Privacy and Security Overview and Agency Enforcement

HIPAA Privacy and Security

- General rule: a **covered entity** must not use or disclose **protected health information** unless permitted by the HIPAA privacy rules
- Covered entities
  - **Health plans**
    - Self-insured health plans
  - Health care providers
  - Health care clearinghouse

HIPAA Privacy and Security

- Protected Health Information (PHI)
  - Any medical information that can personally identify an individual and which is created or received by a covered entity
- Some information in the hands of the employer is NOT PHI:
  - Enrollment/disenrollment information
  - Employee health information received from sources other than the group health plan:
    - FMLA and sick leave requests
    - ADA reasonable accommodation requests
    - Workers' comp
    - Drug testing/fitness-for-duty

HIPAA Privacy and Security

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- HIPAA Privacy: Individual Rights
  - Right to access PHI held by group health plan
  - Right to Notice of Privacy Practices (NPP)
    - To new employees at time of enrollment
    - Within 60 days after a material revision (including required changes)
    - At any time upon request
    - At least once every three years, plan must notify covered individuals of the *availability* of the notice and how to obtain it

HIPAA Privacy and Security

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- HIPAA Privacy: Administrative Requirements
  - Designate privacy official and contact person
  - Conduct training
  - Adopt safeguards (administrative, physical, technical)
  - Adopt policies and procedures
  - Establish complaint procedure
  - Adopt and implement sanctions and mitigation
  - Prohibit retaliation

HIPAA Privacy and Security

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- HIPAA Security Rule
  - Purposes
    - Ensure confidentiality, integrity, and availability of ePHI
    - Protect against reasonably anticipated threats to ePHI
    - Protect against reasonably anticipated unauthorized uses or disclosures of ePHI
    - Ensure workforce compliance with security requirements
  - Applies to covered entities, business associates, and subcontractors
  - ONGOING OBLIGATION to assess, update, and document

HIPAA Privacy and Security

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- HIPAA Breaches
  - "Breach" is the acquisition, access, or disclosure of **unsecured** PHI in a manner **not permitted** by the Privacy Rule which compromises the security or privacy of PHI
  - Breach notification requirements
    - Notify each individual without unreasonable delay (not more than 60 days)
    - Notify HHS
      - If 500+ individuals affected, within 60 days
      - For all breaches, within 60 days from end of the plan year
    - Notify media
      - If 500+ individuals in one state affected
  - If business associate (BA) discovers breach, it must notify covered entity within 60 days of discovery
    - BA may notify affected individuals
    - BAA should address responsibility and logistics

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- Enforcement of HIPAA Rules
  - OCR enforcement entails:
    - Investigation
    - Resolution agreements
    - Potential penalties
  - Does self-reporting trigger an OCR investigation?
    - Very likely, especially for breaches with more than 500 individuals
    - To report on not report
      - Reporting may trigger investigation and penalties
      - On the other hand, no reporting = potential for substantial penalties
        - » Recent $475,000 assessment for report that was 61 days late

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- Enforcement of HIPAA Rules
  - OCR Activity
    - Collected fines in 2015: approximately $15,000,000
    - Collected fines in 2016: approximately $23,500,000

Monetary penalties for HIPAA violations

Violation category*	Each violation	All violations of an identical provision in a calendar year
Did not know	$100 to $50,000	$1.5 million
Reasonable cause	$1,000 to $50,000	$1.5 million
Willful neglect – corrected	$10,000 to $50,000	$1.5 million
Willful neglect – Not corrected	$50,000	$1.5 million

* Per 45 CFR §1176(a)(1)

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- OCR Enforcement Case Examples
  - OCR Activity
    - Alaska Dept. of Health and Social Services (2012)
      - Alaska's Medicaid provider
      - Unencrypted USB hard drive was stolen from employee's vehicle
      - No risk analysis, security measures, or training of employees was done
    - Penalty: $1.7 million
    - Takeaway: Didn't matter that there was no evidence that anyone used or disclosed the PHI

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- OCR Enforcement Case Examples
  - Triple S Management Corp. (2015)
    - Mailing vendor for insurance companies
    - Failure to terminate access to PHI when no longer needed
    - Failure to identify business associates or execute BAAs
    - Disclosed more than minimum necessary
    - Risk analysis didn't address all IT equipment and systems
    - Didn't implement adequate privacy and security safeguards
  - Penalty: $3.5 million and corrective action plan

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- OCR Enforcement Case Examples
  - North Memorial Healthcare; Raleigh Orthopaedic
    - Entities disclosed PHI to service providers without a BAA
      - North: gave access to entire database (289,000 individuals) to vendor for payment and healthcare operations
      - Raleigh: sent PHI to BA to transfer x-rays to electronic media
  - Penalty: $1.55 million (North Memorial); $750K (Raleigh)

HIPAA Privacy and Security

- HIPAA Privacy and Security Audit Program
  - HITECH Act requires HHS to conduct periodic audits to ensure covered entities and business associates are complying with the HIPAA Privacy and Security Rules and beach notification standards
  - OCR Phase 1 audits (2011-2012)
    - 115 entities audited
    - Random, not complaint-driven
    - Focused only on covered entities
    - 89% had deficiencies

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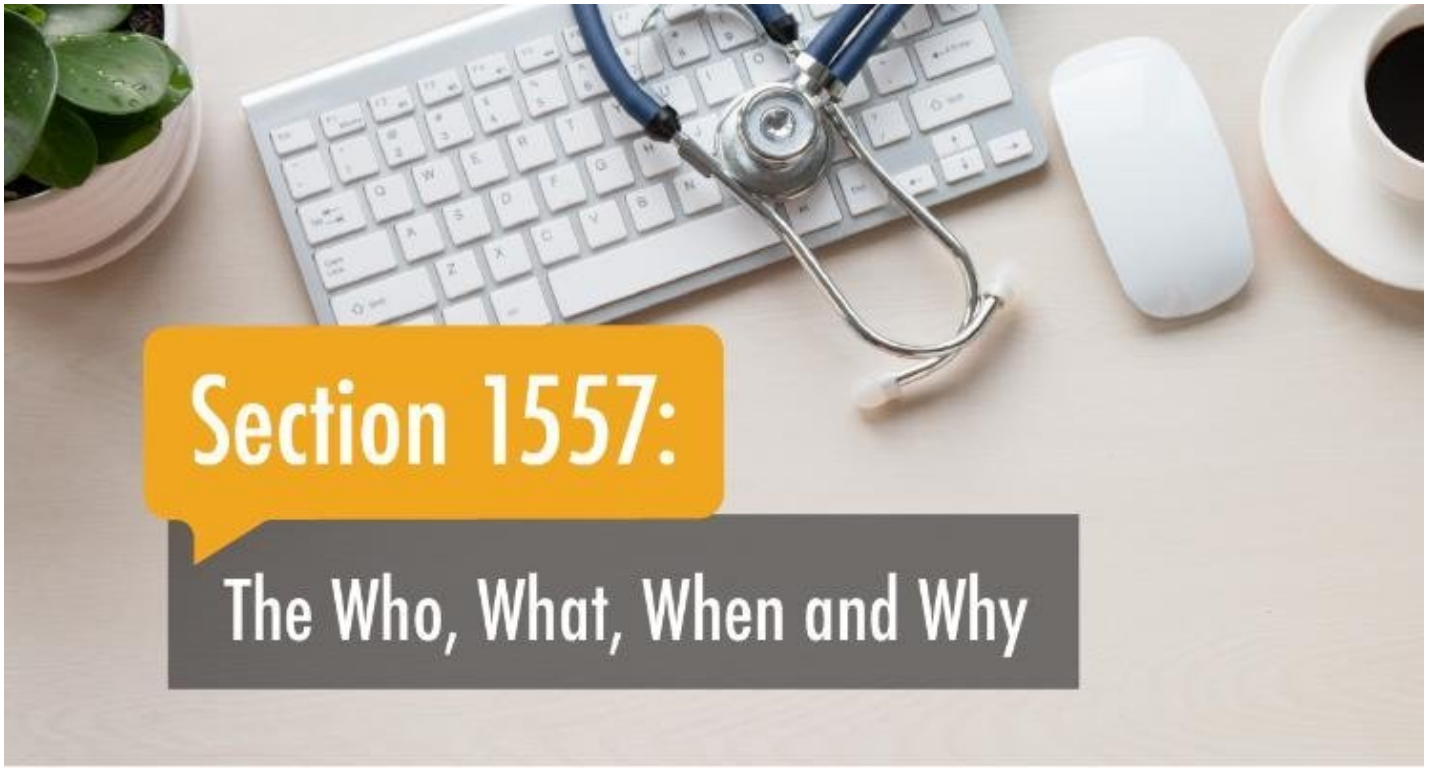
- HIPAA Privacy and Security Audit Program
  - OCR Phase 2 audits (ongoing)
    - 166 covered entities selected for desk audits
    - 1st round completed in September 2017
    - Key takeaways
      - Compliance was largely “inadequate”
        - » Access to Notice of Privacy Practices
        - » Content of breach notification letters
        - » Information security risk analysis



PPACA Section 1557

PPACA Section 1557

- Who Must Comply:
  - Health insurance marketplaces and all health plans offered by insurance companies that participate in the marketplace
  - **Health insurers, hospitals, and clinics that receive funding from HHS**
  - Group health plans that receive a retiree drug subsidy from CMS
  - Self-insured employer group waiver plans (EGWPs)

PPACA Section 1557

- Section 1557, PPACA's nondiscrimination provision, prohibits discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age, or disability
- May 18, 2016 – HHS Final rule implementing Section 1557

PPACA Section 1557

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- Final rule contains provisions addressing discrimination in the provision of health services related to gender transition:
  - No categorical or automatic exclusions from coverage, or limits on coverage for, all services related to gender transition
  - Can't otherwise deny or limit coverage for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual

PPACA Section 1557

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- Access to Individuals with LEP
  - Covered entities must provide meaningful access to individuals w/limited English proficiency who are eligible to be served or likely to be encountered in its health programs and activities
  - Language assistance services must:
    - Be provided free of charge
    - Be accurate and timely
    - Protect the privacy and independence of the individual
  - Cannot require an individual to provide his own interpreter

PPACA Section 1557

- Covered entities must provide nondiscrimination notices describing:
  - Its nondiscrimination policy;
  - Its policy on providing auxiliary aids;
  - Its provision of language assistance services;
  - The individual designated for investigating grievances under its grievance policy; and
  - How to file a discrimination complaint with HHS's Office of Civil Rights (OCR)
- Model notice: https://www.hhs.gov/sites/default/files/sample-ce-notice-english.pdf

PPACA Section 1557

- Enforcement
  - *Franciscan Alliance v. Burwell* (N.D. Tex. 2016)
    - Nationwide injunction on HHS's enforcement of Section 1557 on the basis of gender identity or termination of pregnancy (ONLY!)
    - Remainder of Section 1557 is still in place and now effective
  - EEOC: discrimination against transgender individuals is discrimination on the basis of "sex" in violation of Title VII of the Civil Rights Act of 1964

PPACA Section 1557

- *Baker v. Aetna Life Insurance Co.* (N.D. Tex.)
  - Employee who transitioned from male to female sued employer under both Section 1557 and Title VII for denying coverage of breast augmentation surgery
  - Court dismissed both claims in separate decisions:
    - February 2018 – Title VII claims dismissed
    - Helpful to employer:
      - Conservative venue
      - Employer's plan did cover hormone replacement therapy

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Employee Leaves of Absence: Rules for Benefits Administration

Written Plan Terms and Eligibility

- Plan document defines who is eligible, and who is not
  - Must be consistent with insurance policy (if fully-insured)
  - Typically, only full-time common law employees are eligible
- Plan documents typically do not provide continued coverage during a leave of absence (though they can)
  - FMLA and USERRA provide exceptions to the rule, and require continued eligibility
  - COBRA requires continuation rights upon a qualifying event
  - Workers' comp law and the ADA do NOT generally require continued benefit eligibility during a leave of absence

Written Plan Terms and Eligibility

- Insurance carrier or stop loss carrier under no obligation to insure employer’s acts of kindness, or even the promises made in employee handbooks

Written Plan Terms and Eligibility

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- HIPAA nondiscrimination rules impact eligibility
  - Cannot discriminate based on a health factor
    - Gaining Eligibility: individuals absent from work due to a health factor (e.g., absent due to sickness or disability) must be treated for plan purposes as being "actively at work" and the absence cannot be counted when calculating continuous service
  - **Example**: John Doe starts work on January 15. The plan's waiting period lasts until the first of the month following 30 days of work. John is hurt on the job on February 2 and is off work until March 28. He's not yet eligible for FMLA leave. Should he be offered coverage? If so, when?

Written Plan Terms and Eligibility

- HIPAA nondiscrimination rules impact eligibility
  - Cannot discriminate based on a health factor
    - Keeping Eligibility: HIPAA doesn't require an employer to keep coverage effective forever, just because an employee is absent due to a health condition.
  - **Example**: Instead of reporting back to the jobsite on March 28 as planned, John states that he won't return until July so that he can continue physical therapy sessions. The plan covers employees who regularly work 30 hours per week. Should John get to keep his coverage? For how long?

Written Plan Terms and Eligibility

- HIPAA nondiscrimination rules impact eligibility
  - Cannot discriminate based on a health factor
    - First-Day-of-Work Rules are Permissible: a plan may require an employee to actually begin work before coverage is effective IF that rule is applied regardless of the reason for the individual's absence (i.e., health-related or not), so long as all employees who fail to start work are treated similarly
  - **Example**: John Doe's first day of work is supposed to be March 18, but he has to delay his start date to April 1 due to an accident on March 17 in which he broke his wrist. The plan provides coverage as of the first day of employment. When is coverage offered to John?

FMLA Leave

- Family and Medical Leave Act of 1993
  - Covered Employers
    - Private employers with 50 or more employees for each working day in 20 or more workweeks in the current or preceding calendar year
    - Public agencies (regardless of the number of employees)
    - School districts (regardless of the number of employees)
    - Some state laws have different requirements (Kansas does not have an FMLA-style state law)
  - Eligible Employees
    - Those who have worked for a covered employer for at least 12 months and who have worked at least 1,250 hours during the 12-month period immediately before FMLA leave is to start

FMLA Leave

- Requires an employer to provide 12 weeks of *unpaid* leave to employees:
  - Who are unable to work due to a serious health condition
  - To care for a spouse, child, or parent with a serious health condition
  - To care for their child after the child's birth or adoption
  - With a "qualifying exigency" due to a spouse, child, or parent leaving for active military duty in a foreign country
  - Who are "next of kin" to a service member with a serous illness or injury (up to 26 weeks of leave in this case)

Benefits During FMLA Leave

- Coverage under group health plans must be maintained
- What do “group health plans” entail?
  - Group health coverage (including prescriptions)
  - Group dental coverage
  - Group vision coverage
  - Health FSA
  - Wellness plan
  - EAP (if it provides medical care)
- But not life, AD&D, dependent care, voluntary benefits
- Employees can choose to drop coverage, with one exception – the employer can require that coverage continue if the employee can stop paying for it (though employer can later require a “catch-up”)

Benefits During FMLA Leave

- Coverage must be maintained for the duration of the leave and under the same conditions as if the employee was not on leave
  - Employer must continue to pay its share of premiums
  - During FMLA leave employee must also pay his share of the premiums at the normal, active employee premium cost (FMLA is not COBRA)
- Employer may require employee to pay his share in any of the following ways:
  - "Pay-as-you-go"
    - Same schedule as payroll deductions
    - May not be feasible unless it's a paid leave
  - In advance (pre-paid), pursuant to the cafeteria plan
    - Cannot be the sole option
  - Another system agreed to by the employer and the employee (e.g., "catch-up")

Benefits During FMLA Leave

- Group health coverage can be terminated under any of the following situations:
  - If employee chooses to drop it during FMLA leave
  - Employee fails to pay share of the premium, but…
    - Special rules apply regarding notice and timing
      - A grace period of at least 30 days is required before coverage can be terminated for nonpayment
      - Notice must be mailed to employee at least 15 days before coverage can cease
  - When employment relationship terminates
  - When employee gives unequivocal notice of intent to not return
  - Employee fails to return
  - Employee continues leave after exhausting FMLA leave (ADA leave may apply)

FMLA and COBRA

- *Going* on FMLA leave is NOT a COBRA qualifying event
- What if employee fails to return to work following FMLA leave and loses coverage as a result?
  - This IS a COBRA qualifying event (either a reduction in hours or termination of employment which causes a loss of coverage)
  - COBRA qualifying event is when FMLA ends – not when it begins
- A lapse of coverage *during* the FMLA period (e.g., due to employee's failure to pay premiums) is irrelevant for COBRA purposes

FMLA and COBRA

"John hasn't worked here since June 2017, and he exhausted his FMLA, sick leave, and vacation pay months ago. But he hasn't been terminated, so we just kept covering him."

"John is on our LTD plan,
so we kept him on the health plan, too."

"John is entitled to workers' compensation benefits, so we just kept him on the health plan."

"The carrier never questions our eligibility file."

FMLA and COBRA

- Employees (and qualified beneficiaries) get COBRA continuation rights when there's a:

QUALIFYING EVENT + LOSS OF COVERAGE

- A leave of absence is a qualifying event (i.e., a reduction in hours, to zero) that will eventually cause a loss of coverage (e.g., after FMLA is exhausted and employee fails to return to work)

- Whether there's a loss of coverage is governed by plan terms

FMLA and COBRA

- What happens if you simply continue coverage for an employee when no longer eligible and they have exhausted FMLA leave?
  - Insurance carrier (or stop-loss carrier) is under no obligation to cover the employee
  - Creates more uncertainty when you actually get around to terminating coverage (“I’ve been covered for 6 months…what changed now?” “You covered John for his leave of absence…why not me?”)
  - COBRA obligations don’t go away, but how to provide COBRA becomes more uncertain

PPACA and Leaves of Absence

- Employers who use the look-back method to determine full-time status will find that certain employees are “locked in” to full-time status during a stability period
- An employee who was employed an average of at least 30 hours of service per week during an initial measurement period or standard measurement period must be treated as a full-time employee for the entire associated stability period
  - (at least, as long as he/she “remains an employee”)

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Questions?

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Thank you!

The intent of this presentation is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits issue. It does not necessarily fully address all your specific issues. It should not be construed as, nor is it intended to provide, legal or tax advice. Questions regarding specific issues should be addressed by your organization's general counsel, tax advisor, or an attorney who specializes in this practice area.