MORETON & COMPANY

Q2 Benefits Newsletter

House Passes Comp Time Bill

On May 2, 2017, the House of Representatives passed H.R. 1180, better known as The Working Families Flexibility Act. The bill proposes to amend the Fair Labor Standards Act ("FLSA") to permit private sector employees to "bank" overtime hours for later comp time use. (Currently, the FLSA prohibits private sector employers from using comp time.) For example, under H.R. 1180, an employee working 50 hours in a workweek could roll the 10 overtime hours into a comp time bank for later use instead of receiving 10 hours of overtime pay. Each hour banked would be banked at an overtime rate, meaning that those 10 overtime hours would be equivalent to 15 banked hours. Note that H.R. 1180 has only passed the House of Representatives. To become law, H.R. 1180 must still pass the Senate and be signed by the President.

Under H.R. 1180, comp time banking would be subject to the following limitations:

- Employees can only use comp time systems under a written agreement with their employer, and employees have the right to terminate the agreement at any time
- To be eligible for comp time, employees must have worked for at least 1,000 hours for their employer during a continuous 12-month period.
- Employees may use any available comp time within a reasonable period after making a request to the employer so long as the use of available comp time does not unduly disrupt the employer's operations.
- Employees may not accrue more than 160 hours in their comp time banks. No later than January 31st of each year (or 31 days after any other chosen twelve-month period), employers must pay out any unused comp time from the previous year at the employee's regular rate of pay (either at the time the comp time was earned, or at the employee's then regular rate, whichever is higher).
- Employers also have the option, at any time, to force payout of any accrued comp time that exceeds 80 hours, so long as they give the affected employee at least 30 days' notice.
- Similarly, employees may, at any time, request a payout of their accrued but unused comp time. Employers have 30 days in which to make these requested payments.
- Employees must receive pay for any accrued but unused comp time upon termination.

H.R. 1180 also carries with it penalties in the form of liquidated damages for any violations. Employees would be granted a private right of action to sue the employer for violations.

H.R. 1180 passed the House along party lines with a vote of 229 to 197. As noted above, the bill is now headed to the Senate for further consideration. President Trump's advisors have indicated that he will sign the bill if presented. Should the bill become law, it will have far-reaching impacts on nearly all employers in the private sector. However, be aware that employers in states with daily or other more stringent overtime requirements may not see much change at all, depending on their states' interplay with the FLSA. For example, California employers who are required to pay overtime for all hours over eight in one workday (in addition to weekly overtime) could not implement such a comp time schedule and still meet their obligations under state law. Moreton & Company will keep you posted on this issue.

EEOC Settles Wellness Case

The United States Equal Employment Opportunity Commission (EEOC)–the federal agency that oversees enforcement of the Americans with Disabilities Act (ADA) – has settled a case involving a wellness program that allegedly violated the ADA. The wellness plan at issue required employees enrolled in the employer's self-insured health plan to complete a health risk assessment, biometric screening, and blood draw, or pay 100% of the monthly premium. The employer had argued that its wellness program was allowed under a health plan safe harbor provision in the ADA that gives employer plans certain latitude with respect to underwriting.

The settlement followed a trial court decision that rejected the employer's argument about application of the underwriting safe harbor. However, the court upheld the program on other grounds, finding that though the penalty for non-participation was steep (no employer help with premiums), it was considered a voluntary program under ADA requirements in place at the time. (NOTE: After this lawsuit was brought, the EEOC issued new ADA wellness regulations. Under the new regulations, the employer's program likely would not be considered voluntary.) However, the court agreed to proceed with a trial on the employee's claim that the employer violated the ADA's anti-retaliation provisions by terminating her for criticizing the wellness program and refusing to complete a health risk assessment.

As part of the settlement, the employer agreed to **(1)** pay the employee $100,000, **(2)** not retaliate against any other employee who objects to the wellness program, **(3)** not maintain an involuntary wellness program in the future that poses disability-related inquiries or seeks medical examinations, **(4)** direct employees to send concerns about the wellness program to the HR department, and **(5)** train employees on the requirements of the ADA.

There is likely to be continued litigation over wellness programs and the reach of the new ADA wellness regulations. Stay tuned for further updates.

ON-SITE CLINICS & HSA PLANS

"Employers that offer HSA-eligible plans and provide an on-site clinic face unique challenges"

Offerings of HSA-eligible high-deductible health plans (HDHP) have more than doubled in the past five years. One national survey of employer-sponsored health plans found that more than half of large employers (53%) now provide this type of plan to their employees, and nearly a quarter of employees (24%) are enrolled. At the same time, there has also been steady growth in offerings of on-site and near-site medical clinics, especially among the largest employers.

Employers that offer HSA-eligible plans and provide an on-site clinic face unique challenges. Under the rules for HSA-eligible plans, only preventive services can be provided at no cost; employees need to pay the full cost of a non-preventive visit before they satisfy the plan deductible. Employers with on-site clinics who allow employees enrolled in HDHP coverage to access discounted clinic services before the employee has met their plan deductible may be unknowingly disqualifying employees from HSA eligibility, understating their own tax liability, and incorrectly filing employment tax forms. To remain HSA eligible, employees need to be charged fair market value for any on-site clinic services until the employee's deductible has been met.

Although lawmakers have discussed changes to HSA rules, it remains to be seen if lawmakers will loosen regulations to make coordinating clinics and HSA-eligible plans easier. Employers with on-site clinics that either have an HSA-eligible plan or are considering adding an HSA-eligible plan should review their clinic fee structure and billing practices to ensure clinic use is compliant with plan eligibility unless and until HSA regulations are changed.

IRS Announces 2018 HSA Contribution Limits,

HDHP Minimum Deductibles, and Out-of-Pocket Maximums

> "...some individuals may have to pay more out-of-pocket expenses without the benefit of the HSA tax break."

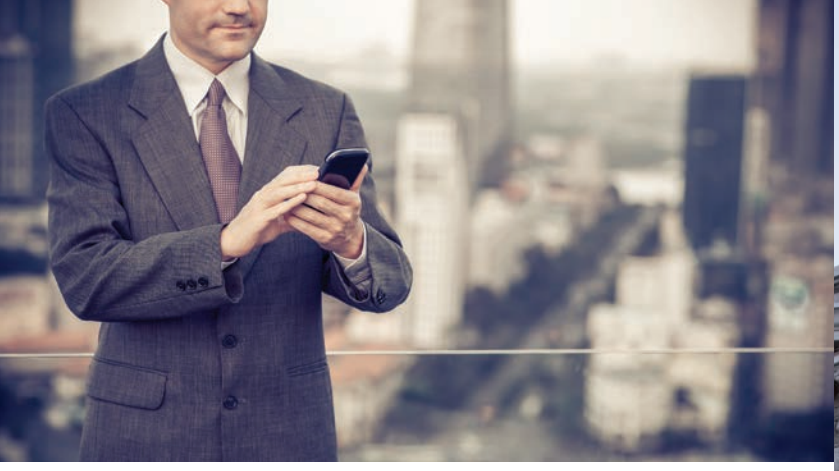
The IRS has released the 2018 cost-of-living adjusted limits for health savings accounts (HSAs) and high-deductible health plans (HDHPs). Here are the details:

HSA Contribution Limits: The 2018 annual HSA contribution limit for individuals with self-only HDHP coverage will be $3,450 (a $50 increase from 2017), and the 2018 limit for individuals with family HDHP coverage will be $6,900 (a $150 increase from 2017).

HDHP Minimum Deductibles: The 2018 minimum annual deductible for self-only HDHP coverage will be $1,350 (a $50 increase from 2017), and the 2018 minimum annual deductible for family HDHP coverage will be $2,700 (a $100 increase from 2017).

HDHP Out-of-Pocket Maximums: The 2018 limit on out-of-pocket expenses (including items such as deductibles, copayments, and coinsurance, but not premiums) for self-only HDHP coverage will be $6,650 (a $100 increase from 2017), and the 2018 out-of-pocket limit for family HDHP coverage will be $13,300 (a $200 increase from 2017).

In contrast to 2017, when only one of these amounts changed from the prior year, all of them are scheduled to increase for 2018. The HDHP minimum deductibles are increasing for the first time since 2015. Because the increases to the HDHP out-of-pocket maximums are larger than the increases to the HSA contribution limits, some individuals may have to pay more out-of-pocket expenses without the benefit of the HSA tax break.



Keeping COBRA Practices Compliant

Wal-Mart Stores, Inc. has become the latest large company sued in a class action for failure to provide adequate notices as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Even though your company may not be large enough to be at significant risk of class action litigation, the recent spate of COBRA class actions is a good reminder of the need to administer COBRA properly.

COBRA Notice and Content Requirements

COBRA requires companies with 20 or more employees that sponsor a group health plan to provide both a general notice within 90 days of starting coverage and a continuation coverage election notice within 14 days of learning that a qualifying event occurred. The general notice must inform covered employees and spouses of their COBRA rights. The general notice can be a separate document or included in the plan's Summary Plan Description (SPD). Caution should be exercised when relying on the SPD because of the DOL's timing and method of delivery requirements.

In addition to the timing and method of delivery requirements, there are content requirements for the general and qualifying event notices. The DOL has made model general and qualifying event notices available, and though employers should tailor the models to meet their individual needs, the DOL considers companies that use the model notice to be compliant.

Recent Lawsuits Due to Inadequate COBRA Notices

Wal-Mart is just one of several companies that have faced class action complaints as a result of allegedly inadequate COBRA notices. Examples of the types of claims made include:

- **Wal-Mart Stores Inc**. Among the allegations listed was that the required information was "piecemealed" throughout Wal-mart's notice, and the notice did not provide contact information for the plan administrator; the notice did not explain that a covered employee's spouse may elect continuation coverage on behalf of all other qualified beneficiaries; and the notice did not explain how electing continuation coverage would affect the qualified beneficiaries' future group health coverage rights.
- **Capgemini North America, Inc. & Capgemini Financial Services USA, Inc.** Capgemini's business practices allegedly involved transferring its employees between its operations in the United States and its operations in India. Employees lost health plan coverage on their transfer, and Capgemini failed to provide COBRA notices to these employees.
- **Shipcom Wireless, Inc.** Shipcom allegedly failed both to provide COBRA general notices and election notices.

Companies subject to COBRA should take this opportunity to review their procedures for compliance. Many companies outsource this obligation to a COBRA vendor. Employers should periodically review their process for notifying the COBRA vendor of new hires and terminations to ensure the vendor is getting timely and correct information. Doing so will ensure appropriate COBRA notifications are being sent in a timely manner.

Could Your Section 125 Cafeteria Plan Survive an Audit?

A Section 125 Cafeteria Plan is relatively easy to set up and extremely beneficial to both employers and employees, but they shouldn't be considered "set-it-and-forget-it plans." An increase in Department of Labor (DOL) audits warrants a much closer look at Section 125 Cafeteria Plans to ensure compliance and proper administration.

Under Section 125 of the IRS Code, employers can offer certain health & welfare benefits on a pre-tax basis. These include accident insurance, dependent care assistance, group-term life insurance (employee only), disability insurance, health savings accounts, and flexible spending accounts. Both employers and employees save money on taxes, but only if the Section 125 Cafeteria Plan is done right. Three things to watch for:

1. Understand which health & welfare benefits should be pre-taxed

Just because a benefit can be offered on pre-tax basis does not mean it's the most beneficial way to purchase it. One example is disability insurance. Employees can pay for disability coverage on a pre-tax basis, but doing so is a bad decision because then the benefit is taxable.

While there is no downside to offering most medical, dental, and vision benefits pre-tax, there are certain scenarios you should take into consideration when setting them up. Talk to your producer if you have further questions.

2. Test for nondiscrimination sooner rather than later

Because employers and employees get a tax break through Section 125 Cafeteria Plans, employers have to test for nondiscrimination rules to prevent plans from favoring highly compensated or key employees.

A test for nondiscrimination can be complicated but boils down to three basic (and potentially troublesome) areas:

- Eligibility: too many non-highly compensated or non-key employees are ineligible
- Availability of benefit: highly compensated or key employees have access to more or better benefits than others
- Utilization: highly compensated or key employees elect more health & welfare benefits under the plan

Employers should have no problem passing eligibility and availability tests if the plan was designed properly. However, plans (other than simple premium premium-only plans) should be tested annually.

3. Non-tax dependent domestic partners prompt tax confusion

Another scenario that can cause confusion is how to handle domestic partners coverage if your company offers it. While many employers allow employees to cover domestic partners on their plans, unless the domestic partner is also a tax dependent, the coverage provided is subject to different tax treatment than spousal coverage.

Employers should make sure they understand the tax issues involved in domestic partner coverage and set up policies to comply.

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