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# Q3 Benefits Newsletter

## What Happens to Employees' HSAs if They Drop or Lose Their HDHP Coverage?

Many employers have adopted an HSA compatible high deductible health plan option as part of their benefit offerings, and contribute to the HSAs of employees that choose the HDHP option. What happens to those employees' HSAs if they lose HSA eligibility in the future, either because the company drops its HDHP option or the employee leaves the company or changes to a non-HDHP plan?

Employees who establish HSAs always have a nonforfeitable right to their HSA account balances, including their own contributions and any contributions made on their behalf by employers or family members. So, if your employees cease to be HSA-eligible because they drop or lose their HDHP coverage, their existing HSA balances will be unaffected. Earnings on those balances will continue to accrue on a tax-free basis, and distributions to pay or reimburse qualified medical expenses will continue to be tax-free. HSA distributions made for other reasons will remain taxable and may be subject to a 20% excise tax.

The primary consequence of losing HSA eligibility is its effect on HSA contributions. The annual limit on HSA contributions is based on the account holder's months of actual or deemed HSA eligibility. An individual who is not HSA-eligible for a taxable year cannot exclude any employer contributions from income and cannot deduct any other contributions for that year. An individual who ceases to be HSA-eligible midyear may make or receive contributions only for months of eligibility. If an employee's HSA has not already received the maximum contribution for those months when HSA eligibility ends, additional contributions could be made up to the applicable limit, provided that those contributions are made no later than the federal tax return deadline (without extensions) for the year of partial eligibility. Contributions in excess of the maximum or made after the deadline are considered excess contributions that are neither excludable nor deductible. Excess contributions may also be subject to a 6% excise tax if they are not timely withdrawn.

One other potential consequence of losing HSA eligibility is that certain special tax rules that are contingent on maintaining HSA eligibility for a 13-month "testing period" will not be available. The testing period requirement applies to employees who use the "full-contribution rule" (which can increase the contribution limit for individuals who become HSA-eligible or switch to family HDHP coverage midyear, by allowing the annual contribution to be determined by the coverage in effect on December 1). If HSA eligibility is lost before the applicable testing period ends, funds that were contributed or rolled over to the individual's HSA will become taxable and may also be subject to a 10% additional tax.

# Common Questions

## Regarding Your Benefit Programs

Moreton & Company often fields questions regarding various provisions of your benefit plans (or the group insurance contracts that fund your employee benefit programs). Some of the most common questions are set forth below:

1. Disabled children may be able to remain covered under your health or other benefit plans beyond age 26 if they meet certain eligibility requirements. You may be required to provide proof of incapacity and dependency within 30 days of the effective date or the date the child reaches age 26.

2. Waiver of premium, conversion, and continuation/portability provisions in **life** and **disability** plans (not all plans have these provisions):
   - **Waiver of premium:** This provision may waive further premiums for an employee with a total disability or a terminal illness. This benefit is usually provided to those under age 60. You will need to file specific paperwork and documents in a timely manner to trigger this benefit. Once approved, this feature may allow continued coverage to the member without cost.
   - **Conversion Right:** This provision allows terminated employees to convert a portion of their current policy to a personal policy within 30 days of their coverage ending (cost will be higher). A notice informing the terminated employee of this option should be provided to each covered employee at termination. The most current form can be found on your carrier's website.
   - **Continuation/Portability:** This feature is less common, but if present it allows an employee to keep a portion of their current coverage on a personal level and pay the premiums directly to the carriers for a specific amount of time.

The provisions relating to waiver of premium and continuation/portability vary greatly between carriers. Consult your contract, carrier, or broker with any questions.


# Documented COBRA Procedures Can Protect Employers From Claims of Non-Receipt

As part of an employment discrimination lawsuit, a former employee alleged that her employer had failed to notify her of her COBRA rights following her resignation. Despite the employee's claim that she did not receive an election notice, the trial court found the employer had produced sufficient evidence that its third-party administrator (TPA) had mailed the notice and ruled in favor of the employer without a trial.

The employee appealed, primarily challenging the trial court's reliance on an affidavit from the TPA's delivery manager, who stated that the TPA provided record keeping services for the employer and COBRA notices to departing employees. The manager explained that the TPA did not retain hard copies of COBRA notices but did retain computer records and that, while he had not personally sent the notice to the employee, the TPA's computer system showed that a notice had been timely mailed. Based on the manager's status as a long-time TPA employee familiar with its record keeping procedures, the appellate court accepted his affidavit as written testimony and the accompanying screen shots of computer records as business records sufficient to prove the required notice had been provided.

In a lawsuit for failure to offer COBRA coverage, the plan administrator (typically the employer) must be able to prove that an election notice was properly sent. Proof of receipt is not required–the administrator need only prove that the notice was sent by means reasonably calculated to reach the recipient. While the best evidence may be a certificate of mailing or a certified mail receipt, many larger employers instead rely on comprehensive business records. Lawsuits often turn on the plan administrator's ability to produce written COBRA notice procedures and business records to prove the procedures have been consistently followed. Courts frequently cite the adequacy–or inadequacy–of the administrator's documentation as a factor in their rulings. Whether an employer/plan administrator handles its own COBRA notice obligations or delegates responsibility to a TPA, it is imperative to retain records sufficient to prove that adequate notice has been timely provided to each qualified beneficiary.

# Does Your Health Plan Have To Provide The SPD To Plan Participants Every Year?

Clients often ask if they must provide a copy of their health plan's Summary Plan Description (SPD) every year. The answer is that health and welfare plan SPDs do not have to be routinely provided every year. In general, health and welfare plan SPDs must be furnished to participants when they first become covered by a plan and then at specific intervals thereafter. ("Participants" for this purpose includes employees or former employees who are or may become eligible for benefits or whose beneficiaries are or may be eligible for benefits–including COBRA qualified beneficiaries and covered retirees.) Different deadlines apply in different situations; as discussed below, plan administrators may wish to furnish SPDs sooner than the outside limit. Here is an overview of the deadlines:

**Newly Covered Participants:** For a new participant in an existing plan, an SPD must be automatically furnished within 90 days after the participant first becomes covered.

**New Plans:** The plan administrator of a new plan must automatically furnish SPDs within 120 days after the plan is first established and becomes subject to ERISA.

**Five-Year Rule If Material Changes Made:** A plan administrator must automatically furnish an updated SPD at least every five years if any material changes were made within that five-year period. The updated SPD must be furnished no later than 210 days following the last day of the fifth plan year after a material change would have been reflected in the most recently distributed SPD, and must incorporate all the amendments that occurred during the five-year period (Meanwhile, the material changes must have been communicated via a Summary of Material Modification).

**Ten-Year Rule If No Material Changes Made:** If no material changes were made during the immediately preceding ten-year period, a copy of the most recently distributed SPD must be furnished by the plan administrator within 210 days following the last day of the tenth plan year after a material change would have been reflected in the most recently distributed SPD.

Because the SPD provides participants with important information about their rights and responsibilities under the plan, it may be advisable to furnish SPDs soon after coverage begins. If a participant has not been notified of plan requirements, such as the need to follow the plan's claims procedure, a court may not require the participant to comply with those obligations. Thus, furnishing SPDs as soon as practicable is generally in the plan's best interest.

Finally, keep in mind that group health plans are subject to a variety of disclosure requirements in addition to the SPD, many of which have different distribution rules. For example, the summary of benefits and coverage (SBC) required under health care reform must be furnished in connection with enrollment materials. And if the SPD is used to convey information that is subject to an annual notice requirement, then the SPD must be distributed annually. Also, SPDs are among the materials that must be furnished to participants (and certain others) upon request.

# Court Sends EEOC Wellness Regulations
## Back To Agency For Reconsideration

A federal court has concluded that the EEOC's final wellness regulations are arbitrary and capricious and sent them back to the agency for review. The regulations, which address the impact of the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) on employer-sponsored wellness programs, are effective for plan years beginning on or after January 1, 2017. Shortly before the regulations were to take effect, AARP sued the EEOC seeking to delay the effective date, but the court denied the request. Addressing the substance of its case, AARP argued that permitting incentives of up to 30% of the cost of coverage is an unreasonable interpretation of the term "voluntary" because the incentive is too high to give employees a meaningful choice whether to participate in programs requiring disclosure of ADA-protected information. It further argued that the EEOC's reversal of its prior position on the meaning of "voluntary" (which precluded incentives) was unsupported, inadequately explained, and thus, arbitrary and capricious.

> **"Note that this ruling does not affect HIPAA's wellness regulations, which remain effective and in force."**

The court has now ruled in AARP's favor, determining that the EEOC has not justified its conclusion that the 30% incentive level is a reasonable interpretation of voluntariness. Rejecting the EEOC's argument that 30% is appropriate because it harmonizes the EEOC regulations with HIPAA as amended by the ACA, the court explained that HIPAA's 30% incentive cap is not intended to serve as an interpretation of the term "voluntary" since voluntariness of participation is not an issue under HIPAA. Moreover, the court pointed out, the EEOC regulations are inconsistent with the HIPAA regulations in other respects. For instance, the EEOC regulations extend the 30% cap to participatory wellness programs to which the HIPAA cap does not apply. Addressing GINA, the court was troubled by the EEOC's justification for allowing incentives for information about a spouse's medical history–that employer discrimination was less likely since the spouse's medical history does not reveal actual genetic information about the employee–stating that an employer's concern about the spouse's increased health costs could still lead to discrimination. Based on these failings, the court held that the agency made its decision arbitrarily. However, noting that the regulations had been applicable for eight months and concerned over the impact of vacating them, the court remanded the regulations to the EEOC for reconsideration.

Although the court called out what it deemed serious failings by the EEOC, it appears to have overlooked additional salient points. For example, when the agencies established the original 20% incentive cap under HIPAA, they were concerned, at least in part, with the potential for large wellness incentives effectively to deprive some individuals of coverage. It is possible that the EEOC will delve into this background as it reconsiders the regulations. In the end, this court's "serious concerns" about the EEOC's reasoning were outweighed by the "potentially widespread disruption and confusion" of vacating final regulations already in effect. So, for now, the EEOC's final wellness regulations will remain in effect. Note that this ruling does not affect HIPAA's wellness regulations, which remain effective and in force.

# Trump Administration Halts Implementation

## of Enhanced EEO-1 Reporting Requirements

The Trump administration has halted implementation of the new EEO-1 reporting requirements–an Obama-era policy that aimed to close what economists call the wage gap. The new rules, which were to have gone into effect in Spring 2018, required businesses to record how much they pay employees of various genders, races, and ethnicities, and report such information to the EEOC. The new rule applied to employers with 100 plus employees, and federal contractors with 50 employees or more.

In a letter sent Tuesday to Victoria Lipnic, acting chair of the Equal Employment Opportunity Commission, Neomi Rao, administrator of the Office of Information and Regulatory Affairs, said the Office of Management and Budget had paused the government's pay data collection process to review it, citing concerns over whether the new requirements were unnecessarily burdensome for employers.

Employers with 100 plus employees are still subject to EEO-1 reporting, but will not be required to provide the additional information required under the new rule.

# IRS Releases Draft & Instructions

## 2017 ACA Form 1094/1095

**"... coverage providers, ALEs, and their advisors should diligently continue their efforts to prepare for filings for the 2017 tax year."**

The IRS has issued draft Form 1094/1095 information returns for the 2017 tax year (for filing in early 2018). Forms 1094-B and 1095-B are used by coverage providers to report health plan enrollment to enrollees. Forms 1094-C and 1095-C are used by applicable large employers (ALEs - employers subject to the pay or play penalty) to report information relevant to Code § 4980H employer shared responsibility penalties (ALEs sponsoring self-insured health plans are also coverage providers; they satisfy their health plan enrollment reporting obligation by reporting coverage information on Form 1095-C). The forms also provide information relevant to the individual shared responsibility penalty and premium tax credits.

The draft 2017 forms show few changes from 2016. Here are highlights:

**Form 1094-B:** Form 1094-B, which is the transmittal for Form 1095-B, is unchanged.

**Form 1094-C:** The only change is removal of the line 22 box for "Section 4980H Transition Relief." This relief was applicable only to the 2015 plan year; it remained on the 2016 form since some non-calendar-year plans qualified for this relief for months of the 2015 plan year falling in the 2016 calendar year.

**Forms 1095-B and 1095-C:** There are no substantive changes on the face of these forms. A new paragraph in the Instructions for Recipients entitled "Additional information" refers recipients to an IRS webpage that provides an overview of the provisions of the individual shared responsibility, employer shared responsibility, and premium tax credits along with contact information for the IRS Healthcare Hotline for questions.

Draft instructions have also been released. The draft instructions for the B Forms do not include any substantive changes that will affect completion of the forms. The draft instructions for the C Forms are largely unchanged, although references to transition relief available to non-calendar-year plans for certain months in 2016 have been eliminated now that this relief has expired. Citing IRS Notice 2017-9, the draft instructions observe that a safe harbor is available for de minimis errors in reporting dollar amounts on line 15 of Form 1095-C (required employee contributions), excusing the ALE from having to file a corrected return for minor errors, unless the individual recipient elects for the safe harbor not to apply. For purposes of determining affordability of employer-sponsored coverage, the draft instructions note inflation adjustments to the 9.5% threshold, increasing the percentage to 9.66% for plan years beginning in 2016 and 9.69% for plan years beginning in 2017. In addition, the draft instructions clarify that there is no specific code to enter on line 16 to indicate that an employee was offered coverage and declined the coverage. The deadlines to furnish statements to individuals and to file with the IRS have been updated from 2017 to 2018.

Coverage providers, ALEs, and their advisors should diligently continue their efforts to prepare for filings for the 2017 tax year.

# Court Affirms Use of Single Document

## As the SPD and Plan Document

A federal appellate court has affirmed a trial court's holding that a single document can serve as both the formal plan document and the summary plan description (SPD) for an ERISA plan. An individual covered under her husband's employer-sponsored health plan settled a medical malpractice claim relating to services paid for by the plan. The SPD included a reimbursement provision, but the individual refused to repay the covered expenses, claiming that the plan was not entitled to reimbursement because there was no ERISA-compliant written instrument in place when it paid the expenses. Although the SPD referenced an "official plan document" and indicated that the terms of the official plan document would control in the event of any conflict with the SPD, the SPD was the only document describing plan benefits, rights, and obligations, and was treated as the official plan document.

The individual asserted that the U.S. Supreme Court's *Cigna v. Amara* decision requires that plan documents and SPDs be separate documents, but the court noted that other courts have "consistently" rejected that reading of *Amara*. It distinguished *Amara*, which held that SPD terms are not enforceable over conflicting terms in a plan document, from this situation, where the issue was whether the SPD could function as the plan document in the absence of a separate written instrument. The court rejected the argument that the SPD lacked sufficient detail to comply with ERISA's written instrument requirement, concluding that the SPD adequately described required elements such as plan funding and amendment procedures. Nor was the court persuaded that the SPD was unenforceable because the employer "lied" about the existence of a formal document. There was no evidence that the employer misrepresented material facts or that any misrepresentation was detrimental to the covered individual.

According to the court, the SPD's erroneous reference to a formal plan document may have been sloppy, but it was not a breach of fiduciary duty and did not render the SPD unenforceable. The court ruled that the plan was entitled to reimbursement for the covered medical expenses, and to attorney's fees and court costs.

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Some courts have held that a combined plan document/SPD is unacceptable on the grounds that it is not possible for a document to summarize itself. Nevertheless, many plans, particularly welfare plans, use a combined document and will appreciate the confirmation that this approach is acceptable–at least where the document meets ERISA's stated criteria for both written instruments and SPDs.

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