Fall 2018 Benefits Newsletter

MORETON & COMPANY

Extending Benefits Outside of Eligibility Requirements

In family owned or closely-held businesses, or businesses that have grown quickly, it is not unusual to run into a situation where someone related to the owners – or close to them in one way or another – is on the health plan even though that individual does not work for the company at all, or certainly not the amount of hours required for health plan eligibility. (For example, one of the owners has a brother without access to other employer coverage, or an uncle or parent, or in some cases, a nanny or other domestic employee that wants health coverage.) This also happens with retired owners, e.g., one of the founders of the company is retiring but is below social security age and wants to remain on the employer's group health plan until they reach Medicare eligibility age. This owner/retiree may even still have an office with their name on it and collect some sort of paycheck. But in fact, the likelihood is that the retiree simply does not meet eligibility requirements.

It is always important to read the SPD/insurance contract/policy/certificate of coverage and limit enrollment to those eligible under the terms set forth in those documents. In general, most health plans/insurance policies limit coverage to "Employees" who are actively at work for a certain number of hours per week (generally 30 plus hours per week). Non-employees, or employees who are not working the required hours (even if an employee in name), should not be allowed to be enrolled or remain on the plan. Self-funded plans also generally incorporate this "active" employment requirement.

Allowing someone to enroll outside of eligibility guidelines may seem like the "nice" thing to do (Aunt Sally really needs health insurance), but in this area, no good deed goes unpunished. In the event of an insurance audit (either random or following a large claim or high utilization), if the carrier identifies ineligible individuals, the carrier can rescind coverage (even retroactively). This may leave the employer to essentially "self-insure" the coverage provided to that ineligible individual from the date of ineligibility. Even if the plan is self-funded, if an ineligible individual incurs claims in excess of stop loss limits, the stop loss carrier can deny the stop loss claim because the individual was allowed on the plan outside of eligibility guidelines.

IRS Sending Letters to Request Information on ACA Reporting

Some employers have received letters from the IRS requesting information about whether the employer satisfied their ACA reporting obligations for 2015 and 2016. Generally, the letter is entitled "Request for Employer Reporting of Offers of Health Insurance Coverage" or "Letter 5699."

Background

The ACA's employer mandate requires Applicable Large Employers ("ALEs") to offer affordable, minimum value health insurance coverage to all full-time employees (i.e., those working 30 hours or more per week). ALEs are employers with 50 or more full-time or full-time equivalent employees. In order to enforce the employer mandate, the ACA requires ALEs to file information returns (i.e., Forms 1094-C) with the IRS and to provide statements to their full-time employees (i.e., Forms 1095-C) relating to whether the employees and their dependents were offered health insurance from the employer and, if so, to provide certain details about that health insurance coverage. In general, ALEs were required to offer health insurance coverage to their full-time employees beginning in 2015 and begin filing the Forms with the IRS in 2016.

Letter 5699

The IRS began sending letters imposing employer mandates earlier this year. The IRS is now sending Letter 5699 to employers it believes were ALEs that may have failed to submit the required Forms. In particular, Letter 5699 requests that the employer confirm the name and Employer Identification Number it used when filing the Forms along with the date such filing was made. Letter 5699 also reminds employers that there are penalties for failing to file the Forms.

Responding to Letter 5699

Employers must respond to Letter 5699 within 30 days of receipt. ALEs that failed to file the Forms for 2016 can provide them to the IRS with their response to Letter 5699 or can commit to filing them within 90 days of the date of the letter. In either case, the ALE must also explain the reason for the late filing.

Employers that receive Letter 5699 may also respond by either (i) demonstrating that they were not an ALE for the year in question or (ii) explaining why they did not file the Forms and any actions they plan to take to remedy the failure.

Employer Takeaway

Employers that receive IRS Letter 5699 should carefully review the letter and any Forms that they filed for the year indicated in the letter. Employers should respond timely to such letters.

ACA and HSA Annual Indexing Adjustments-2019 Changes

The IRS has announced 2019 indexing adjustments for key ACA and HSA numbers, including the employer shared responsibility penalty, affordability percentage (the required employee contribution limit that determines "affordability" for purposes of the employer penalty), and HSA limits and requirements.

The changes for 2019 are reflected below:

	2018	2019
§4980H(a) Penalty	$2,320 ($193.33 a month)	$2,500 ($208.33 a month)
§4980H(b) Penalty	$3,480 ($290.00 a month)	$3,750 ($312.50 a month)
Affordability Percentage	9.56%	9.86%
FSA Limit	$2,650	$2,700*
Maximum OOPM	$7,350 Individual / $14,700 Family	$7,900 Individual / $15,800 Family

*Projected (final amount has not yet been announced)

HSA changes for 2019 are as follows:

	2018	2019
HSA Maximum Contribution	$3,450 Individual / $6,900 Family	$3,500 Individual / $7,000 Family
HSA Maximum OOP	$6,650 Individual / $13,300 Family	$6,750 Individual / $13,500 Family
HSA Minimum Deductible	$1,350 Individual / $2,700 Family	$1,350 Individual / $2,700 Family

The IRS Releases Draft Forms 1094 and 1095 and Related Instructions

The IRS has released draft Forms 1094/1095-B (B Forms) and Forms 1094/1095-C (C Forms) and related instructions for the 2018 tax year. As a reminder, the B Forms are filed by minimum essential coverage providers (mostly insurers and government-sponsored programs) to report coverage information in accordance with Code § 6055. The C Forms are filed by applicable large employers (ALEs) to comply with Code § 6056, providing information that the IRS needs to administer employer shared responsibility under Code § 4980H, as well as receipt of premium tax credits. (In addition to being filed with the IRS, Forms 1095-B and 1095-C are furnished to individuals.) ALEs with self-insured health plans also report coverage information on Form 1095-C.

The forms/instructions are largely unchanged from 2017. The Plan Start Month box will continue to be optional on Form 1095-C for 2018. Part III of Form 1095-C now includes separate fields for each covered individual's first name, middle initial and last name, rather than a single blank for the individual's full name. (This change is reflected in the C Forms' instructions; a similar change is made to Part IV of Form 1095-B.) Penalty amounts for reporting failures reflect indexed increases.

Both sets of draft instructions continue to explain that the 250-return threshold that triggers mandatory electronic filing with the IRS applies separately for each type of form and for original and corrected returns. According to an example, an entity filing 500 Forms 1095-B and 100 Forms 1095-C would have to file the Forms 1095-B electronically but could file the Forms 1095-C on paper.

Those responsible for preparing and filing these forms will undoubtedly welcome the absence of major changes for the 2018 tax year. With deadlines for furnishing forms to individuals and for filing with the IRS arising quickly after the end of the year and no indication so far of reporting relief, it is essential to have a strategy for collecting and organizing the required information.

To Review Drafts and Instructions for Forms 1094 & 1095, click the links below:

1. https://www.irs.gov/pub/irs-dft/f1094b--dft.pdf
2. https://www.irs.gov/pub/irs-dft/f1095b--dft.pdf
3. https://www.irs.gov/pub/irs-dft/f1094c--dft.pdf
4. https://www.irs.gov/pub/irs-dft/f1095c--dft.pdf
5. https://www.irs.gov/pub/irs-dft/i109495b--dft.pdf
6. https://www.irs.gov/pub/irs-dft/i109495c--dft.pdf

Courts Rule in Favor of Participants in Mental Health Parity Litigation

A health plan participant sued the plan's insurer to recover benefits for treatment she had received for an eating disorder, claiming that the insurer violated the federal mental health parity requirements by imposing arbitrary reimbursement penalties on psychotherapy provided by psychologists and masters' level counselors rather than by physicians. The insurer asked the court to dismiss the claim, arguing that the individual had not adequately alleged that its reimbursement processes for these behavioral health services were more stringent than processes used for comparable medical and surgical services.

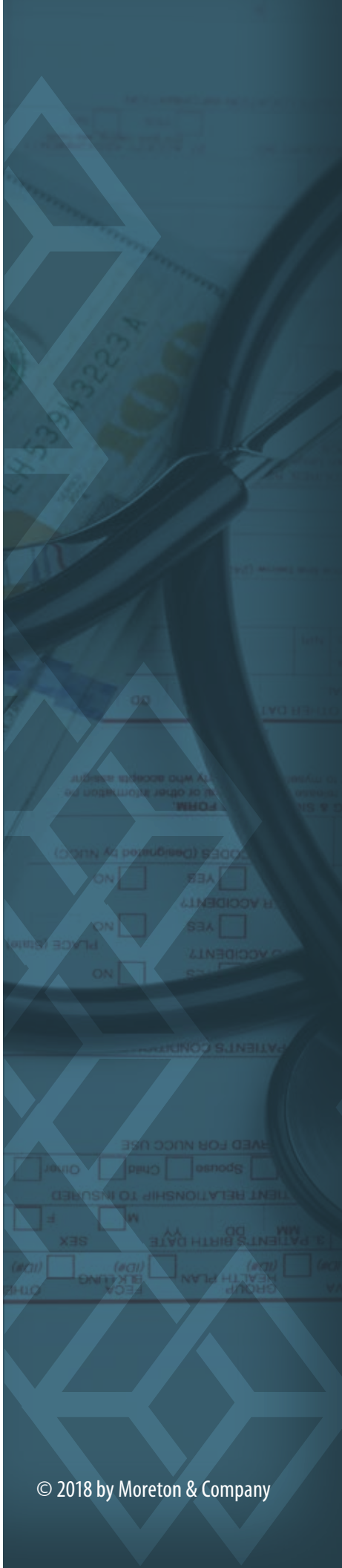
The court rejected the insurer's motion to dismiss the mental health parity claim. It explained that the insurer's restriction based on the provider's specialty was a treatment limitation subject to the mental health parity requirements. Pointing out that the insurer did not impose similar treatment limitations on medical and surgical benefits, the court held that at this stage of the case, the participant had adequately alleged that the restriction was a separate treatment limitation applied only to mental health or substance use disorder benefits and the case could proceed.

Health plan participants have ample guidance to lean on in bringing a federal mental health parity lawsuit based on a limitation on eating disorder benefits. The 21st Century Cures Act specifically provides that coverage for eating disorder benefits is subject to the parity requirements. Furthermore, agency guidance reiterates that eating disorders are mental health conditions and, therefore, treatment of an eating disorder is a mental health benefit.

In another case the court allowed mental health parity claims to proceed against an insurer that denied coverage for behavioral health care services provided in an outdoor residential treatment setting. An employee's 16-year-old daughter (who had been diagnosed with depression) filed a class action lawsuit against the insurer on behalf of the plan, claiming that the plan's "blanket exclusion" of coverage for wilderness therapy violated federal mental health parity requirements. The insurer asked the court to dismiss the case, arguing that the treatment was properly denied under the plan's "Counseling in the Absence of Illness" exclusion.

Denying the insurer's request for summary dismissal, the court explained that a mental health parity claim can be based on either "facial" or "as applied" violations. The plan did not violate the parity requirements "on its face" because its terms were neutral. But the court concluded the lawsuit adequately alleged that, in practice, the insurer categorically denied coverage for wilderness behavioral health care programs while covering medical and surgical services provided in analogous intermediate settings such as skilled nursing facilities and rehabilitation hospitals. The court found these allegations sufficient to allow the case to proceed forward.

As courts continue allowing these mental health parity claims to proceed to trial, the cases become increasingly costly for insurers to defend. It will be interesting to see the outcome, especially considering the DOL's recent statement that it is establishing dedicated mental health parity enforcement teams to conduct investigations of behavioral health organizations and insurance companies.



New Opinion Letters Regarding FMLA and FLSA

The Department of Labor (DOL) has released six new opinion letters on the Family and Medical Leave Act (FMLA) and the Fair Labor Standards Act (FLSA). Opinion letters respond to a specific inquiry from an employer or other entity to the DOL but represent the DOL's official position on the specific issue. Therefore, other employers may rely on these opinion letters as guidance.

The DOL issued two opinion letters on the FMLA:

- **FMLA2018-1-A:** The DOL found that an employer's no-fault attendance policy, under which attendance points that normally expire after 12 months are frozen for the duration of employee's FMLA leave, thereby remaining on the employee's record for longer than 12 months, did not violate the FMLA as long as the same policy is applied to other leaves.
- **FMLA2018-2-A:** The DOL concluded that voluntary organ-donation surgery and post-operative treatment can qualify as a "serious health condition" under the FMLA.

The DOL also issued four opinion letters on the FLSA:

- **FLSA2018-20:** The DOL found that an employee's voluntary participation during the workday in on-site biometric screenings and wellness activities not directly related to the employee's job predominantly benefits the employee, and therefore the time spent in such activities is not compensable worktime under the FLSA. Moreover, because the employee is relieved of all job duties during such activities, that time is also non-compensable "off duty" time.
- **FLSA2018-21:** The FLSA provides a potential exemption from overtime for certain employees of "retail and service" establishments, defined to mean an entity that (i) is recognized as providing retail sales and services in the particular industry; and (ii) 75% of the entity's sales of goods or services (or both) are retail (i.e., not for resale). In connection with this exemption, the DOL's opinion letter provides that in determining whether an entity is a retail and service establishment under the above conditions, (i) a business may make its sales primarily online; (ii) it is irrelevant whether the products are for either commercial or non-commercial use; and (iii) the fact that a purchaser uses the product to serve its own customers and may even raise prices to recover the purchase price does not make the product "wholesale" as opposed to resale.
- **FLSA2018-22:** In this opinion letter, the DOL discussed the distinction between a volunteer, who is not subject to the FLSA, and an employee. The DOL found that those who freely volunteer time without pressure or coercion to a non-profit organization are not employees, and acknowledged that the non-profit entity may pay for "travel, lodging, meals and other expenses incidental to volunteering without negating [the] volunteer status." In the opinion letter, the DOL found volunteer status even though the volunteers were members of the non-profit organization and had previously been treated as short-term employees receiving compensation for their service, given that the volunteers freely offered the services for charitable reasons, were highly compensated executives primarily employed by others, and the periods of service were no more than two weeks a year.
- **FLSA2018-23:** The FLSA exempts employees of motion picture theater establishments from its overtime requirements. The DOL found that the exemption applies to the food services operations of motion picture theaters, including in-theater dining and on-site restaurants that almost exclusively service theater-goers. The DOL stated the food service and movie operations constituted a single establishment because the two operations were incorporated as a single unit, pay taxes, maintain business records, order goods, pay invoices, and conduct banking as a single unit, and the employees perform services in both operations.

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