MORETON & COMPANY

# Fall 2019 Benefits Newsletter

## IRS Information Letter Emphasizes Continued Applicability of the Employer Shared Responsibility Mandate and Penalties

The IRS recently released an information letter on employer shared responsibility under Code § 4980H in response to a legislator's inquiry. The legislator asked whether employer shared responsibility penalties – which were added to the Code as part of the Affordable Care Act (ACA ) – may be waived or reduced based on hardship or other factors, and whether the IRS will extend transition relief for employers with fewer than 100 employees.

The letter provides background information on employer shared responsibility, noting that applicable large employers (ALEs) may be liable for penalties if they fail to offer adequate health insurance to full-time employees and their dependents. The letter explains that the law does not provide for a waiver of the penalties, but several forms of transition relief were available for 2015 and 2016. However, no transition relief is available for 2017 and subsequent years. The letter concludes with a reference to a January 2017 executive order directing federal agencies to exercise their discretion to waive, defer, grant exemptions from, or delay regulatory burdens imposed by the ACA. The letter points out that, notwithstanding the executive order, the ACA's legislative provisions remain in force until Congress changes them, so ALEs must follow the law and pay applicable penalties.

Enforcement of employer shared responsibility penalties got off to a slow start. Initial implementation of employer shared responsibility was delayed until 2015. And transition relief further delayed penalties for qualifying ALEs with fewer than 100 full-time employees until after the 2015 plan year. However, as noted in the information letter, available transition relief has expired, and enforcement has picked up. Many ALEs – rightly or wrongly – have received penalty notices. This information letter signals the IRS's position that, unless the ACA is changed, ALEs that fail to satisfy Code § 4980H will continue to be liable for employer shared responsibility penalties. Keep in mind that the penalty amounts increase with annual indexing. For 2018, the annual penalties (per applicable employee) are $2,320 under Code § 4980H(a) and $3,480 under Code § 4980H(b).

# Mental Health Parity – 2018 Enforcement Action

The United States Department of Labor (DOL) has issued a fact sheet summarizing its 2018 mental health parity enforcement activity. Released with recent FAQ guidance, the fact sheet and its accompanying introduction and appendix detail the agency's enforcement strategy, explain the investigation process, and describe examples of its 2018 enforcement actions. Here are highlights:

### Enforcement Strategy:

Noting its limited enforcement resources, the DOL explained that it works with insurers and other service providers (such as TPAs) to obtain voluntary global corrections when a violation relates to plan provisions or operations affecting multiple health plans. Thus, compliance is achieved for all the affected plans, not just the plan under investigation. The introduction also notes that the DOL uses specialized teams to evaluate compliance consisting of specialists in medical claims data review and analysis, economists, attorneys, and outside experts.

### Investigation Process:

The fact sheet explains that the DOL receives inquiries from plan participants who believe their mental health or substance use disorder benefits were improperly denied. If DOL staff are unable to obtain voluntary compliance, a formal investigation may be opened. During the investigation, plans are reviewed for compliance with all aspects of the parity rules including the requirements for quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs). If violations are found, the plan must remove non-compliant plan provisions and pay any improperly denied benefits.

### Examples of Enforcement Actions.

In 2018, the DOL closed 115 mental health parity investigations involving violations in six categories – annual dollar limits; aggregate lifetime dollar limits; provision of benefits in all six permitted classifications; cost-sharing requirements; treatment limitations (including NQTLs); and cumulative financial requirements and QTLs. The fact sheet contains five examples of the 21 mental health parity violations cited in 2018. In one case, a plan imposed a higher copayment for mental health and substance use disorder outpatient visits than for medical/surgical outpatient visits. The DOL required the plan to refund the difference to affected participants over a five-year period – resulting in $26,000 in reimbursements to 94 participants – and remove the impermissible financial requirement for future years. In another case, the DOL required a plan to reimburse claims it had denied due to a preauthorization requirement applicable only to mental health and substance use benefits. The plan paid over $20,000 to affected participants and removed the offending provision. And in another example, a plan was required to remove a provision requiring measurable goals and progress for continued coverage of mental health and substance use disorder treatment.

The DOL notes that while its global correction approach has resulted in fewer investigations than in previous years, those investigations have produced more impactful results. Also, because many investigations span more than a year and are reported only in the year in which they are closed, the 2018 report by itself does not provide a complete picture of the DOL's enforcement activity. Plan sponsors should take notice of the agency's steadfast commitment to mental health parity enforcement and take steps to ensure their plan is in compliance.


# Can Your Plan Terminate the Health Plan Coverage of an Employee on FMLA for Failure to Pay Premiums?

## QUESTION:

An employee on unpaid FMLA leave agreed to pay his share of premiums for coverage under our major medical plan by sending in personal checks, but he missed the due date for the first payment. May we drop him from coverage, and if so, when?

## ANSWER:

Your company's obligation to maintain the health coverage of an employee on FMLA leave generally ends when the employee's premium payment is more than 30 days late, unless you have an established policy of providing a longer grace period. Before dropping coverage, however, you must provide the employee with written notice that payment has not been received. The notice must be mailed to the employee at least 15 days before coverage is to end and must advise that coverage will be dropped on a specified date that is at least 15 days following the date of the letter, unless payment is received by that date. So, to drop the employee's coverage on the earliest possible date, the notice should be mailed at least 15 days before the end of the 30-day (or longer) grace period. If your company has established a policy regarding other forms of unpaid leave that provides for coverage to end as of the date an unpaid premium payment was due (i.e., retroactively), then the employee's coverage generally may be dropped retroactively in accordance with that policy. Otherwise, coverage may be terminated prospectively, effective at the end of the grace period.

When an employee loses coverage for non-payment of premiums, a COBRA election notice generally is not required. However, the employee's failure to return to work at the end of the FMLA leave is usually a COBRA qualifying event, even if coverage was dropped during the leave. Also, while healthcare reform's prohibition on rescission of coverage does not apply to the extent that a cancellation of coverage is attributable to a failure to timely pay premiums, a state law with stricter standards regarding when coverage may be rescinded or canceled may apply. Finally, if your employee's coverage is dropped because he failed to timely pay his share of the premium, but he later returns from the FMLA leave, his coverage generally must be restored.

# IRS Releases 2020 HSA Contribution Limits, HDHP Minimum Deductibles and HDHP Out-of-Pocket Maximums

The IRS has released the 2020 cost-of-living adjusted limits for health savings accounts (HSAs) and high-deductible health plans (HDHPs). Here are the details:

## HSA Contribution Limits:

The 2020 annual HSA contribution limit is $3,550 for individuals with self-only HDHP coverage (up from $3,500 in 2019), and $7,100 for individuals with family HDHP coverage (up from $7,000 in 2019).

## HDHP Minimum Deductibles:

The 2020 minimum annual deductible is $1,400 for self-only HDHP coverage (up from $1,350 in 2019) and $2,800 for family HDHP coverage (up from $2,700 in 2019).

## HDHP Out-of-Pocket Maximums:

The 2020 limit on out-of-pocket expenses (including items such as deductibles, copayments, and coinsurance, but not premiums) is $6,900 for self-only HDHP coverage (up from $6,750 in 2019), and $13,800 for family HDHP coverage (up from $13,500 in 2019).

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. The catch-up contribution limit (for HSA-eligible individuals age 55 or older) is set forth in Code § 223(b)(3) and remains at $1,000 for 2020.


# Plan Document Requests Under ERISA

Occasionally, an employer sponsoring an ERISA employee benefit plan will receive a written request from a participant or beneficiary (or their legal counsel) to provide plan related documents. Sometimes the request asks for specific documents and sometimes the request is broader, asking for all instruments under which the plan is established or operated, or words to that effect. Prompt response to such requests is important. In a recent decision from a federal court in North Carolina, the court assessed an employer a $41,140 civil penalty for failure to provide requested documents in a timely manner.

ERISA requires that upon written request of any participant or beneficiary, a plan administrator must furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instrument under which the plan is established or operated. ERISA also provides that if the administrator fails to provide requested documents within 30 days, a court may hold the administrator personally liable to the affected participant or beneficiary for up to $110 per day for each violation.

In the North Carolina case, the employer failed to fund the claims payment account for its self-funded group health plan and the claims administrator canceled its services, leaving several covered individuals with unpaid medical claims. In seeking the payment of benefits, certain plan participants requested that the plan's administrators (members of the employer's benefits committee) provided specific documents including the plan, summary plan description, contracts with medical providers, and any other instruments under which the employer's plan was established or operated. The administrators received the request on June 7, 2016 but did not provide the requested documents until July 25, 2018 (748 days after the 30 days allowed by law) and only after being sued by the participants.

The court awarded the participants $55 per day for 748 days for a total of $41,140. In deciding on the $55 per day penalty, the court noted that the participants were substantially prejudiced by the administrators' failure to provide the documents because they were essentially left in the dark on how to appeal the plan's refusal to pay their benefits. The court said the failure frustrated the participants' ability to litigate the benefits claim and concluded that the administrators' willingness to exploit the participants' lack of documents in the litigation evidenced their bad faith.

The court also said that even if the administrator previously (prior to the written request) provided participants with the documents (as claimed by the administrators), administrators were obligated to provide them again when they received the written request. It also noted that the purpose of the up to $110 per day penalty is not to compensate a plaintiff but to punish noncompliance with ERISA.

As this decision demonstrates, employers should pay attention to written requests for plan documents and respond in a timely manner. Significant penalties could await those who fail to do so.

# DOL Issues Final Regulations Increasing the Fair Labor Standard Act's Salary Threshold for White Collar Exemptions

The DOL has finalized regulations that increase the salary thresholds used to determine whether executive, administrative, and professional employees must be paid overtime. Generally, employees covered by the federal Fair Labor Standards Act (FLSA) must be paid at a rate not less than one and one-half their regular rate of pay for hours worked in excess of 40 in a workweek. Salaried employees who primarily perform executive, administrative, or professional duties, however, are exempt. DOL regulations adopted in 2004 apply that exemption to employees who satisfy a standard duties test and are paid at least $455 per week. Those regulations also exempt certain highly compensated employees whose total compensation exceeds $100,000 per year. Regulations adopted in 2016 increasing those dollar amounts were found invalid by a federal trial court, and an appeal of that decision was suspended by the Fifth Circuit pending the issuance of new regulations. New regulations were proposed in March, and they have now been issued in final form.

The final regulations – which take effect on January 1, 2020 – increase the minimum weekly salary under the standard salary level test to $684 per week ($35,568 per year for a full-time worker). This is a slight ($5 per week) increase over the amount in the proposed regulations. (Different weekly minimums apply in some U.S. territories and in the motion picture industry.) The final regulations also increase the highly compensated employee (HCE) salary threshold to $107,432 per year. This amount is significantly less than the proposed amount of $147,414 per year, largely because the DOL decided to base the final amount on the 80th percentile of full-time salaried workers nationally, rather than the 90th percentile. According to the DOL, the proposed higher HCE threshold would have resulted in "significant administrative burdens and compliance costs" without changing the exempt status of "the vast majority" of currently exempt HCEs. And it would have required overtime for employees who should be exempt, particularly in low-wage regions and industries. Like the proposed regulations, the final regulations allow up to 10% of the minimum weekly salary to be satisfied by annual or more frequent nondiscretionary bonuses, incentives, and commissions when applying the standard salary level test but not the HCE salary threshold. The final regulations also retain the special rule allowing the exemption threshold to be met by a year-end catch-up payment. The DOL has committed to periodic review and updating of the salary amounts, but the final regulations do not adopt any fixed schedule.

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