MORETON & COMPANY

Winter 2020 Benefits Newsletter

Failure to Provide Concrete Evidence of COBRA Procedures Sends COBRA Claim to Trial

A former employee claimed she did not receive timely notice of her COBRA rights upon employment termination and that she was unaware her health coverage had lapsed for almost a year. After contacting her employer, the employee allegedly declined COBRA coverage because she could not afford a lump-sum retroactive payment and her request for installment payments was denied. The employer asserted that upon terminations, resignations, or retirements, COBRA notifications were automatically generated and mailed to employees, and there was "no reason to believe that the ordinary process would not have been completed" for this employee. The employer further argued that even if it had not provided the notice, the employee could not prove damages because she had declined COBRA coverage. The employer asked the court to rule in its favor without a trial.

The court concluded that the employer's declaration regarding general business practices was insufficient to demonstrate it had met its notice obligations, specifically because the employer could not produce a copy of the letter or any documentation to back up its assertions that the notice had been mailed. Accordingly, the employer's motion was denied, and the case was set for trial.

In a lawsuit for failure to offer COBRA coverage, the plan administrator (typically the employer) bears the burden of proving the election notice was properly sent. Proof of receipt is not required–demonstrating that the notice was sent by means reasonably calculated to reach the recipient is sufficient. 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 such documentation as a factor in their rulings. This case demonstrates how important it is that employers retain records sufficient to prove that adequate notice has been timely provided to each qualified beneficiary.

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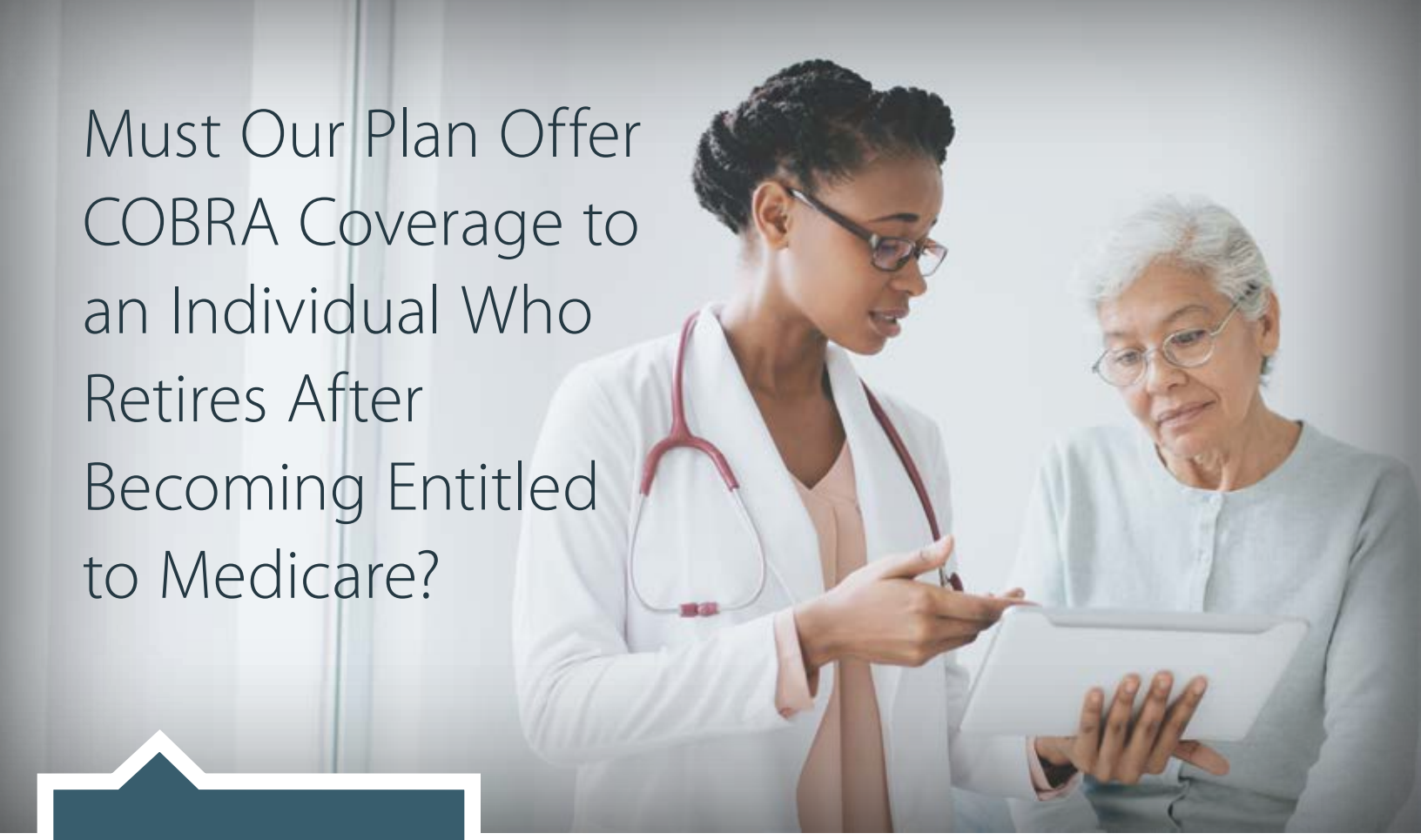
Must Our Plan Offer COBRA Coverage to an Individual Who Retires After Becoming Entitled to Medicare?



QUESTION: Company A has an employee who is retiring and will lose coverage under the company's major medical plan at the end of the month. She is 66 years old and already enrolled in age-based Medicare. Does Company A have to offer her COBRA?

ANSWER: Assuming Company A's plan is subject to COBRA, it will need to offer her COBRA coverage. The IRS COBRA regulations make clear that qualified beneficiaries who become entitled to Medicare benefits on or before the date of their COBRA election remain entitled to COBRA coverage. In contrast, for qualified beneficiaries who first become entitled to Medicare after electing COBRA, the COBRA statute and regulations generally permit a plan to terminate COBRA coverage early (i.e., before the end of the COBRA maximum coverage period). Thus, the date when Medicare entitlement occurs is critical. (Individuals are "entitled" to Medicare when they are enrolled in Medicare–mere eligibility to enroll does not constitute entitlement.)

Because this employee is already entitled to Medicare, she must be offered COBRA under Company A's plan when she experiences a qualifying event (her retirement). And if she elects COBRA, the plan may not terminate her COBRA coverage due to her Medicare entitlement before the end of the maximum coverage period (in this case, 18 months). Note that the Medicare Secondary Payer (MSP) rules often–but not always–permit plans providing COBRA coverage to pay secondary, with Medicare as the primary payer.

In addition, be aware that if a covered employee's qualifying event (i.e., termination of employment or reduction of hours) occurs within the 18-month period after the employee becomes entitled to Medicare, the employee's covered spouse and dependent children (but not the employee) are entitled to COBRA coverage for a maximum period that ends 36 months after the employee's Medicare entitlement.

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Does a Plan Have to Furnish SPDs in Languages other than English?

QUESTION: Company B employs a number of individuals who speak very little English. Does it have to furnish them with translated summary plan descriptions (SPDs) or summaries of material modifications (SMMs)?

ANSWER: ERISA does not require SPDs or SMMs to be translated into languages other than English, but if a plan covers a specified number of participants who are literate only in the same non-English language, the plan will be required to provide assistance in that language and to highlight the availability of the assistance in the SPD or SMM. Here is a summary of the requirements:

What Plans Must Provide Language Assistance?

A large plan (100 or more participants at the beginning of a plan year) must provide assistance in a non-English language if the lesser of (i) 10% of participants, or (ii) 500 participants (or more) are literate only in the same non-English language. A small plan (fewer than 100 participants) must provide non-English language assistance if 25% or more of the participants are literate only in the same non-English language. These rules apply ERISA's definition of "participant," meaning that a plan need only count employees or former employees (e.g., retirees) who are covered by the plan, and not other covered individuals (such as spouses).

What Information Must Appear in the SPD or SMM?

If a plan is required to provide language assistance, the SPD or SMM must contain a prominent statement, in the applicable non-English language, offering assistance and explaining how to obtain it. To comply with the prominence requirement, the statement should appear at the beginning of the SPD or SMM or on its cover.

What Language Assistance Must Be Available?

The assistance provided need not be in writing but must be "calculated to provide [participants] with a reasonable opportunity to become informed as to their rights and obligations under the plan." This will require a contact person fluent in the applicable non-English language and capable of accurately informing individuals of their rights and obligations under the plan. Because of the uncertainty inherent in oral communications of benefit plan information, some plans opt to prepare written materials in the non-English language, even though doing so is not expressly required.

Keep in mind that these rules do not apply to all types of plan-related materials. For example, the summary of benefits and coverage is subject to different standards for furnishing materials in languages other than English. And COBRA does not require notices to be translated into non-English languages.

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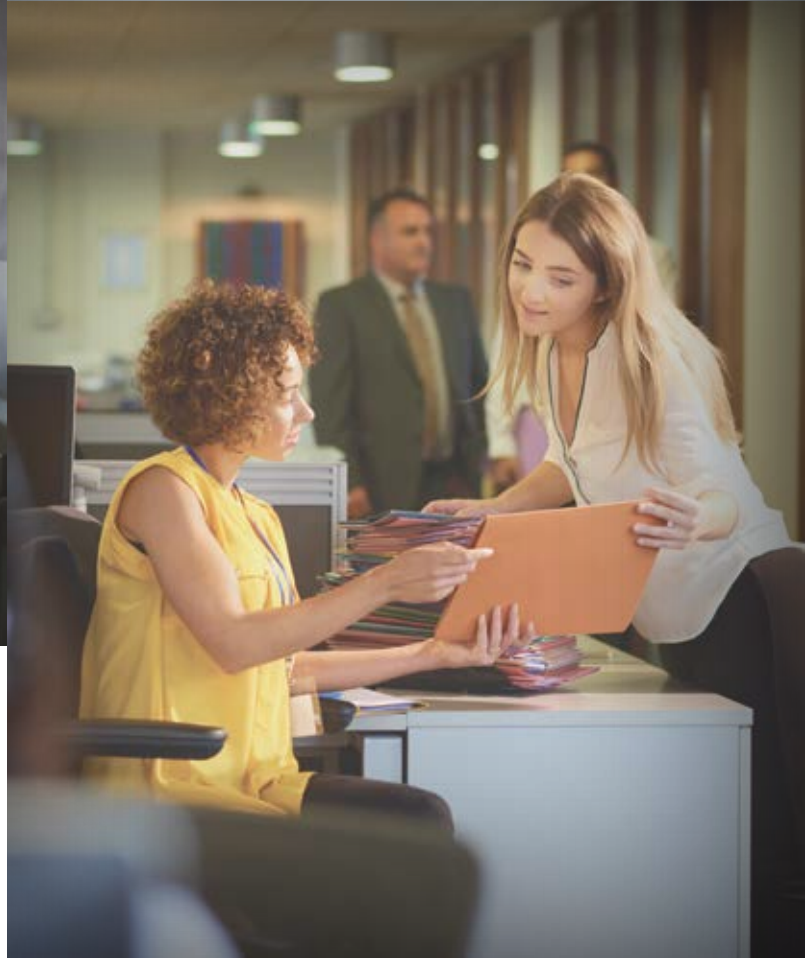

DOL Issues 2020 Adjusted Penalty Amounts

The DOL has announced the 2020 annual adjustments to the civil monetary penalties for a wide range of benefit-related violations. As background, legislation enacted in 2015 requires annual adjustments to certain penalty amounts by January 15 of each year. The 2020 adjustments are effective for penalties assessed after January 15, 2020, with respect to violations occurring after November 2, 2015. Here are highlights:

Form 5500:

The maximum penalty for failing to file Form 5500 (which must be filed annually for many ERISA plans) increases from $2,194 to $2,233 per day that the filing is late.

Summary of Benefits and Coverage (SBC):

The maximum penalty for failing to provide the SBC increases from $1,156 to $1,176 per failure.

Other Group Health Plan Penalties:

Violations of the Genetic Information Nondiscrimination Act (GINA), such as establishing eligibility rules based on genetic information or requesting genetic information for underwriting purposes, and failures relating to disclosures regarding the availability of Medicaid or Children's Health Insurance Program (CHIP) assistance, may result in penalties of $119 per participant per day, up from $117.

401(k) Plan Disclosure, Recordkeeping, and Reporting:

For plans with automatic contribution arrangements, penalties for failure to provide the required ERISA § 514(e) preemption notice to participants increase from $1,736 to $1,767 per day. Penalties for failing to provide blackout notices (required in advance of certain periods during which participants may not change their investments or take loans or distributions) or notices of diversification rights increase from $139 to $141 per day. And the maximum penalty for failure to comply with the ERISA § 209(b) recordkeeping and reporting requirements increases from $30 to $31 per employee.

Multiple Employer Welfare Arrangement (MEWA) Filing:

Penalties for failure to meet applicable filing requirements, which include annual Form M-1 filings and filings upon origination, increase from $1,597 to $1,625 per day.

Adjustments have also been made to other benefit-related DOL penalties, such as for failure to provide certain information requested by the DOL.

The increased penalties relate to a wide range of benefit plan compliance failures. But not all violations will result in the maximum permitted penalty. In some instances, the DOL has discretion to impose lower penalties, such as under programs designed to encourage Form 5500 filing.

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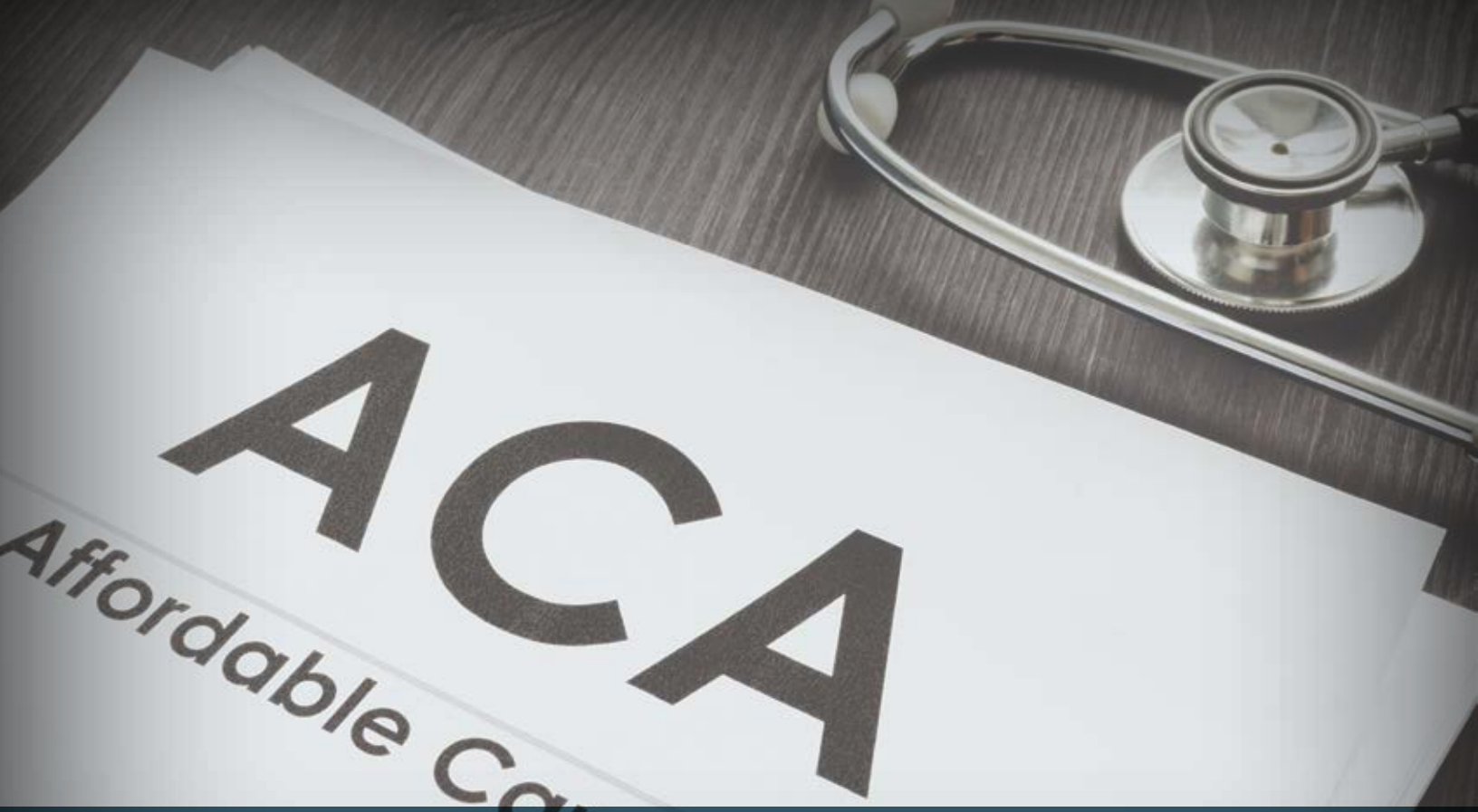

IRS Announces No Statute of Limitations for Employer Mandate Penalties

Recently the IRS released guidance indicating that there is not a statute of limitations (i.e., cut-off date) for assessing employer mandate penalties under the ACA.

As background, under the ACA, certain large employers (i.e., employers with 50 plus full-time or full-time equivalent employees) may be subject to penalties for:

- Failing to offer minimum essential coverage (MEC) to full-time employees and their dependents, if at least one full-time employee is certified for that month as having received a premium tax credit (PTC) for the ACA health insurance exchanges;
- Offering eligible employer-sponsored coverage that is not affordable or does not provide minimum value, if one or more full-time employees is certified to receive a PTC because the employer's coverage is unaffordable or does not provide minimum value.

To enforce these penalties, the IRS cross-references information reported by employers on IRS Forms 1094-C and 1095-C ("ACA employer information filings") with information reported by individuals on their Forms 1040.

The IRS' guidance addresses whether the ACA employer information filing triggers the general IRS three-year limitations period, precluding enforcement of the employer mandate more than three years after an employer completes its ACA employer information filing for a particular year. (Under the IRS Code, if an employer must make and report its liability on a return, generally a three-year limitations period applies.)

The IRS concluded that because the Forms 1094-C and 1095-C alone do not provide enough information to determine whether the penalty is applicable, ACA employer information filings are not "returns" that trigger the three-year limitations period. Unfortunately, this means employers will not have the benefit of a definitive limitations period for ACA employer mandate liability.

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