MORETON & COMPANY

Q4 BENEFITS NEWSLETTER

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MHPA Equity Act Enforcement is a Priority for Federal Agencies

The Department of Labor (DOL) has provided guidance on health plan provisions that, absent similar restrictions on medical or surgical benefits, may constitute impermissible limitations on mental health or substance use disorder benefits under the federal mental health parity rules. As background, the Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) require parity between medical or surgical benefits and mental health or substance use disorder benefits in the application of annual and lifetime dollar limits, financial requirements (such as deductibles, co-payments, coinsurance, and out-of-pocket maximums), and quantitative treatment limitations (such as number of treatments, visits, or days of coverage). Plans must also comply with parity-related requirements for non-quantitative treatment limitations (such as restrictions based on facility type) unless an exemption applies. Here are some of the plan provisions that the DOL has flagged as requiring careful analysis:

Preauthorization and Pre-Service Notification Requirements: Provisions requiring scrutiny include blanket preauthorization requirements for mental health or substance use disorder benefits, preauthorization requirements for admission to certain treatment facilities (e.g. a precertification requirement for mental health inpatient treatment), and medical necessity review or prescription drug preauthorization provisions.

Fail-First, Probability of Improvement, and Patient Noncompliance Provisions: Questionable provisions in this category include those that impose progress or treatment attempt requirements on substance use disorder benefits (e.g. a requirement that a patient attempt two forms of outpatient treatment before inpatient substance use disorder treatment is available). The DOL also highlights provisions that require a likelihood of improvement (e.g. coverage of substance use disorder services only if they result in measurable improvement within 90 days), and those that exclude services if the patient fails to comply with the treatment plan (e.g. exclusion of benefits if the patient ends treatment for chemical dependency against medical advice).

Written Treatment Plan: The DOL lists several provisions that require submission of a treatment plan for mental health or substance use disorder benefits (e.g. a requirement that an individualized treatment plan be submitted and updated every six months).

Residential, Geographical, and Licensure Requirements: Red flags are raised by provisions that limit residential treatment, impose geographical limitations on where treatment may be provided, or require certain licensure of facilities where these requirements are not also imposed on medical and surgical benefits.

This guidance provides a useful checklist of provisions that may be problematic under the mental health parity rules, but it is not intended to be an exhaustive list. And while the provisions described do not automatically violate the non-quantitative treatment limitation requirements, the DOL reminds plans and insurers that they must be prepared to provide evidence to substantiate parity compliance. You can access the Department's new guidance at: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

In addition, the DOL's April 2016 Affordable Care Act FAQs address, in part, mental health parity (see questions 8-11): https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf

New Wellness Decision
A Mixed Bag for Employers

In a much anticipated decision, a Wisconsin federal district court has found that Orion Energy Systems, Inc.'s wellness program did not violate the Americans with Disabilities Act (ADA). However, while the decision is a win for Orion, the Court's decision provides both good and bad news for employers.

In this case, Orion (the employer) waived the employee premium for its self-funded group health plan for those employees who participated in its wellness program (which required a health questionnaire, biometric screening, and a blood draw), but charged the full cost of the coverage to employees who chose not to participate. The Equal Employment Opportunity Commission (EEOC) challenged the program under the ADA. Orion defended the program by arguing (1) that the wellness program was lawful under the "safe harbor" provision under the ADA which allows an employer to establish, sponsor, and observe the terms of a bona fide benefit program or, (2) alternatively, that it was permissible as a voluntary wellness program. Earlier court decisions have upheld wellness programs under the first argument – that the program was lawful under the ADA's "safe harbor" provision. Here, the Court found that the EEOC's new ADA wellness regulation, which specifically states that the "safe harbor" provision does not apply to wellness programs, applied retroactively.

Importantly, the court went on to find that even absent the new EEOC regulation, the ADA's "safe harbor" did not apply in any event because wellness programs are "unrelated to basic underwriting and risk classification."

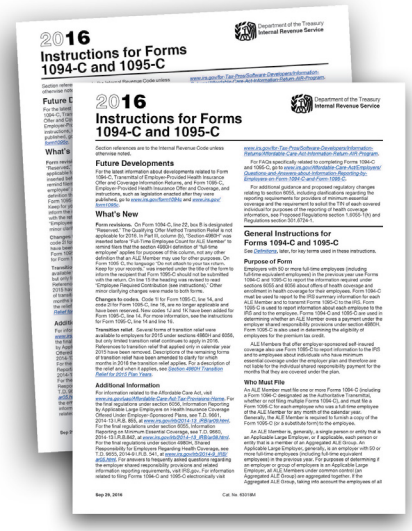
However, in a surprising move, the Court concluded, contrary to the EEOC's position, that despite the significant cost imposed on those failing to participate, the wellness program was voluntary and therefore passed ADA scrutiny. Although the Court briefly mentioned the 30% cap on financial incentives found in the EEOC's new ADA wellness regulations, because the EEOC did not argue that the cap applied retroactively, the Court did not consider its effect on Orion's wellness program. Note that if the Court had applied the EEOC's new wellness regulations, this wellness program would have not qualified as voluntary.

Only time will tell whether the Court's ruling is followed by other federal courts. Look for more information on this in the near future.

IRS Releases Final Instructions for 2016:
Forms 1094-C and 1095-C

Following up on the release of draft 2016 Forms 1094-C and 1095-C (see Moreton & Company client alert dated August 2, 2016 at http://www.moreton.com/wp-content/uploads/2016/08/CLIENT-ALERT_-2016-Draft-ACA-Reporting-Form_Final.pdf), the IRS has now released the 2016 instructions for Forms 1094-C and 1095-C (the C Forms). As background, the C Forms are filed by Applicable Large Employers (ALEs). The new C Form instructions generally follow the final 2015 instructions, but contain some important clarifications and additions. Here some are highlights:

Aggregated ALE Groups: The instructions contain an expanded discussion for filings made by ALE members that are part of an aggregated ALE group (i.e., employers in a controlled group or affiliated service group), and emphasize that each ALE member must file its own Form 1094-C (and associated 1095-Cs) under its own separate Employer Identification Number (EIN).



Multi Employer Plan Relief Extended for 2016: The instructions for Form 1095-C, Part II, line 14 extend the existing interim relief for multi employer plans for another year.

New Codes for Conditional Offers of Spousal Coverage: The instructions explain the addition of two new codes available for Form 1095-C, Part II, line 14 (codes 1J and 1K) to reflect conditional offers of coverage to an employee's spouse. A conditional offer is one that is subject to one or more reasonable, objective conditions (e.g. spouses are eligible only if the spouse is not eligible for coverage from their own employer).

COBRA and Other Post-Employment Coverage: The instructions clarify certain reporting situations regarding the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage including (1) how to report for the month in which an employee terminates with an ALE member and (2) whether and when to report that COBRA coverage was offered to dependents.

Full-Time Employee Count: The final instructions clarify that either the monthly or look-back measurement method and no other methods or full-time employee definitions—may be used to determine full-time status.

Definitions: A new definition is included for "Employee Required Contribution," which notes that additional rules apply when an ALE member makes certain employer contributions or payments, including HRA contributions and opt-out payments.

Expiration of Certain 2015 Transition Relief: Those forms of transition relief that applied only for 2015 have been omitted from the 2016 instructions.

Enrollment by Non-Full-Time Employees: As in 2015, self-funded ALEs will use Code 1G to report enrollment of individuals that are not full-time employees. A note has been added to the final instructions to emphasize that Code 1G applies either for the entire year or not at all.

Non-MEC Enrollment: The final instructions include a reminder not to use enrollment code 2C if the employee's coverage is not Minimum Essential Coverage (MEC) (i.e. the coverage consists solely of certain excepted benefits).

Affordability "Safe Harbors": The final instructions caution that ALEs should not enter an affordability "safe harbor" code on line 16 of Form 1095-C for any month in which they offer MEC to fewer than 95% of their full-time employees (as reported on Form 1094-C).

ALE members and their advisors will want to study the changes and clarifications in the C Form instructions for 2016. It is important to note that the "good faith" penalty relief for incorrect or incomplete returns or statements will not be available, since it was limited to filings made in 2016 (reporting 2015 information). The 2016 Instructions for Forms 1094-C and 1095-C are available at https://www.irs.gov/pub/irs-pdf/i109495c.pdf.

HHS Provides HIPAA Guidance On Ransomware Attacks

> "Ransomware is malware (malicious software) that encrypts data and makes it inaccessible to the targeted organization until a ransom is paid."

The Department of Health and Human Services (HHS) has issued guidance on the role that the Health Insurance Portability and Accountability Act (HIPAA) has in helping covered entities and business associates prevent and recover from ransomware attacks. Ransomware is malware (malicious software) that encrypts data and makes it inaccessible to the targeted organization until a ransom is paid. It can infect devices and systems through spam, phishing messages, websites, and email attachments when a user clicks on the malicious link or opens the attachment. The guidance provided by HHS includes a list of HIPAA-required security measures that can help organizations prevent, detect, and respond to ransomware threats. These include conducting a risk analysis to identify threats and vulnerabilities to electronic protected health information (ePHI), implementing procedures to safeguard against malware, training authorized users on detecting and reporting malware, limiting access to ePHI to persons or programs requiring access, and maintaining an overall contingency plan that includes disaster recovery, emergency operations, data backups, and test restorations.

HHS explains that the presence of ransomware (or other malware) on an organization's computer systems is a security incident under the HIPAA security rule and should trigger security incident response and reporting activities. Furthermore, a ransomware attack usually results in a breach under the HIPAA breach notification rule, requiring the notification of individuals whose information is involved in the breach as well as HHS and, in some cases, the media. However, breach notification would not be required if the organization can demonstrate—by conducting HIPAA's four-factor risk assessment plus other considerations set forth in the guidance—that there is a low probability that protected health information (PHI) has been compromised. And if the organization has encrypted the ePHI in a manner consistent with HHS guidance, then the breach notification provisions will not apply (i.e. the organization need not determine whether there is a low probability of compromise, and breach notification is not required). But, the guidance cautions that additional analysis may be necessary to determine whether the file with the ePHI was decrypted when accessed by the ransomware; if this is the case, the breach notification rule will apply. For example, if full disk encryption is the only encryption solution in place, ransomware may be able to access the file containing ePHI.

It is interesting to note that an HHS blog post reports that ransomware attacks are on the rise and are considered one of the biggest threats to health information privacy. This guidance will help covered entities and business associates understand their HIPAA obligations in the event of a ransomware attack, and ensure that they are taking appropriate steps to safeguard their data from the threat.

HHS Fact Sheet on Ransomware and HIPAA (July 2016):

http://www.hhs.gov/sites/default/files/RansomwareFact-Sheet.pdf

DOL Increases Penalties for Health Plan Violations

The Department of Labor (DOL) has issued regulations that increase the civil monetary penalties for a wide range of benefit-related violations. Recognizing that many penalties were becoming less effective as deterrents because the penalty amounts had not kept pace with inflation, Congress enacted legislation in 2015 that required an initial "catch-up" adjustment to the specified penalty amounts, followed by annual adjustments. These regulations establish the catch-up amounts. Future adjustments will be made by January 15 of each year, starting in 2017. Here are highlights of the changes:

Form 5500: The maximum penalty for failing to file Form 5500 which must be filed by most Employee Retirement Income Security Act (ERISA plans) will increase from $1,100 to $2,063 per day that the Form 5500 is late.

Group Health Plans: The maximum penalty for failing to provide the Summary of Benefits and Coverage (SBC) required under health care reform will increase from $1,000 to $1,087 per failure. Violations of the Genetic Information Nondiscrimination Act (GINA), such as establishing eligibility rules based on genetic information or requesting genetic information for underwriting purposes, may result in penalties of $110 per participant per day, up from $100. Maximum penalties relating to disclosures regarding the availability of Medicaid or Childs Health Insurance Program (CHIP) assistance, including failure to disclose to a state, on request, relevant information about the employer's plan, will also increase from $100 to $110 per day.

Benefit-related violations increase penalties ranging from $100-$963 per day

401(k) Plans: For plans with automatic contribution arrangements, penalties for failure to provide the required ERISA § 514(e) preemption notice to participants will increase from $1,000 to $1,632 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 will increase from $100 to $131 per day. And the maximum penalty for failure to comply with the ERISA § 209(b) record keeping and reporting requirements will increase from $11 to $28 per employee.

Multiple Employer Welfare Arrangements (MEWAs)**:** Penalties for failure to meet applicable filing requirements, which include annual Form M-1 filings and filings upon origination, will increase from $1,100 to $1,502.

Other penalties increased by the regulations include those for failure to provide certain information requested by the DOL, failures not corrected within specified time periods, and defined benefit plan compliance failures. The increases apply to penalties assessed after August 1, 2016 with respect to violations occurring after November 2, 2015. Penalty assessments made before August 1, 2016 (including those relating to violations after November 2, 2015) and assessments at any time relating to violations on or before November 2, 2015 will reflect the lower pre-adjustment amounts.

These changes affect a wide range of compliance issues. Keep in mind that not all violations will result in the highest permitted penalty; for example, DOL programs designed to encourage Form 5500 filing allow for lower penalties in certain circumstances. Note also that the DOL has not increased the penalty for failure to furnish certain information requested by participants or beneficiaries under ERISA § 502(c)(1).

IRS Confirms Taxability of Wellness Rewards

The IRS recently released a Chief Counsel Advice (CCA) memorandum (available at www.irs.gov/pub/irs-wd/201622031.pdf) analyzing the tax treatment of certain wellness incentives, including cash rewards and reimbursements of wellness program premiums that were paid on a pre-tax basis. The CCA examines three factual scenarios, all involving wellness programs that provide health screenings and other health benefits and generally qualify as health coverage that can be excluded from an employee's gross income under Code § 106(a). In one scenario, the program is provided at no cost to employees. In the other two scenarios, employees electing to participate in the wellness program must pay a premium on a pre-tax basis through a Code § 125 cafeteria plan. All three programs offer rewards for participation in the form of cash or other benefits that do not qualify as Code § 213(d) medical expenses. However, one of the programs also rewards participants with reimbursements of all or a portion of their wellness program premiums. Here are the highlights:

Cash Rewards: The CCA explains that any reward, incentive, or other benefit that is not medical care is included in an employee's income unless it is an excludable fringe benefit under Code § 132(e) which defines an excludable de minimis fringe benefit as "any property or service the value of which is so small as to make accounting for it unreasonable or administratively impracticable". But cash benefits are never excludable as de minimis benefits, so cash wellness rewards, regardless of the amount, must be included in the employee's gross income. The IRS has previously stated that, under this rule, gift cards are treated the same as cash.

Gym Fees and Other Non-excludable Rewards: The CCA explains that there may be rewards, such as T-shirts, that qualify as de minimis rewards that can be excluded from income. Payment of an employee's gym membership fees, however, would not be excludable from income because it is a non-excludable cash benefit. The fair market value of any non-excludable reward must be included in income and subject to employment taxes.

Reimbursement of Premiums Paid Tax-Free Through a Cafeteria Plan: The CCA notes that in Revenue Ruling 2002-3, the IRS addressed the reimbursement of health insurance premiums paid by salary reduction and concluded that the exclusions for health coverage and health benefits would not apply. The CCA concludes that the result is no different if the premium reimbursements come in the form of rewards under a wellness program.

> "Employers who are offered any scheme to save on taxes by implementing a wellness program should consult legal counsel."

Recently, certain wellness program designs have been promoted as a way to provide tax-free payments to employees. The details vary, but often they involve taking employee salary reductions as wellness program premiums and then returning some or all of the premiums to employees as untaxed "premium reimbursements" or other rewards. These, and similar arrangements (a new twist of the classic "double-dipping" scheme), have been informally rejected by the IRS, and this CCA reinforces and explains that position. Employers who are offered any scheme to save on taxes by implementing a wellness program should consult legal counsel.

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