COMMONWEALTH BENEFITS GROUP

Benefits and Employment Briefing

QUARTERLY NEWSLETTER

Fall 2017

2018 Updates to IRS Limits

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Texas Clears the Way for Telemedicine

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DOL Delays Effective Date of New Disability Claims Procedures

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HHS Expands Exemption from Contraceptive Mandate

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EEOC Wellness Update on Incentive Limitations

Despite efforts by the U.S. Equal Employment Opportunity Commission (EEOC), designing a wellness plan that complies with Title I of the Americans with Disabilities Act (ADA) and Title II of the Genetic Information Nondiscrimination Act (GINA) remains unclear as the EEOC final regulations are now under review.

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2018 Updates to IRS Limits

The chart below highlights the annual cost of living adjustments for certain limitations in the Internal Revenue Code that impact the maximum benefits and contributions to employee benefit plans. These limits are in effect beginning January 1, 2018, and the chart indicates whether the amount is increased from 2017. Employers will want to be sure and update their Summary Plan Descriptions and other materials highlighting the annual dollar limits.

Retirement Benefits

Updated Limit	2018 Limit Amount	Change
Basic limit on elective deferral amounts	$18,500	Previously $18,000
Limitation on catchup contributions for participants over age 50	$6,000	No change
Elective deferral limit for SIMPLE plans	$12,500	No change
Limitation on catchup contributions for participants over age 50	$3,000	No change
IRA maximum contribution limit	$5,500	No change
Limitation on catchup contributions for participants over age 50	$1,000	No change
457 elective deferral limit	$18,500	Previously $18,000
Annual dollar limit on includable compensation	$275,000	Previously $270,000
Annual additional dollar limit on contributions	$55,000	Previously $54,000

Additionally, with traditional IRAs, the amount that can be contributed may be reduced depending on filing status and income. Below are the phase-out ranges for 2018.

- For single taxpayers covered by an employer retirement plan, the phase-out range is $63,000 to $73,000, up from $62,000 to $72,000.
- For married couples filing jointly, where the spouse making the IRA contribution is covered by an employer retirement plan, the phase-out range is $101,000 to $121,000, up from $99,000 to $119,000.
- For an IRA contributor who is not covered by an employer retirement plan and is married to someone who is covered, the deduction is phased out if the couple's income is between $189,000 and $199,000, up from $186,000 and $196,000.
- For a married individual filing a separate return who is covered by an employer retirement plan, the phase-out range is not subject to an annual cost-of-living adjustment and remains $0 to $10,000.

Welfare Plans and Fringe Benefits

Updated Limit	2018 Limit Amount	Change
Health FSA limit	$2,650	Previously $2,600
DCAP limit		
Unless married and filing separately	$5,000	No change
Married and filing separately	$2,500	No change
HDHP minimum annual deductible		
Self-only coverage	$1,350	Previously $1,300
Family coverage	$2,700	Previously $2,600
Updated Limit	2018 Limit	Change

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	Amount	
HDHP Out-of-pocket maximum		
Self-only coverage	$6,650	Previously $6,550
Family coverage	$13,300	Previously $13,100
HSA maximum contribution limit		
Self-only coverage	$3,450	Previously $3,400
Family coverage	$6,900	Previously $6,750
Catch-up contribution for participants over age 50	$1,000	No change
Dollar limitation for definition of a “key employee”		
Officer group	$175,000	No change
More-than-1% owner	$150,000	No change
Dollar limitation for definition of a “highly compensated employee”	$120,000	No change

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Texas Clears the Way for Telemedicine

As of late, one of the quickest growing benefit trends has been free or low cost “telemedicine” programs to provide employees easy and affordable access to medical care. However, some states, including Texas, have been less than supportive of the trend. The term “telemedicine” generally refers to health-related services delivered over the telephone or internet to employees and their dependents and cover services ranging from non-specific wellness information about health conditions to primary care diagnosis and advice with prescription drug services.

Texas and Telemedicine

In 2015, the Texas Medical Board attempted to pass regulations which would have required patients to have a face-to-face encounter with a healthcare professional to establish a provider-patient relationship before dispensing a prescription. A Texas telemedicine provider challenged the restrictions and alleged that the Board was violating antitrust laws. As the legal issues proceeded through the Federal Courts, the Federal Trade Commission (FTC) initiated an investigation into whether the Board had engaged in anti-competitive measures by restricting the ability of telemedicine providers to operate in Texas.

In response, Texas legislators negotiated a telemedicine law for about a year, and in May 2017 passed a law removing the face-to-face requirement and prohibiting any Texas agency from adopting rules that would impose a higher standard of care for telemedicine than it has for in-person care. The law includes certain patient protections such as requiring telemedicine providers to provide appropriate follow-up care and copies of medical records to patients within 72 hours of their consultation. Providers also can receive reimbursements for services provided through telemedicine from the state Medicaid program without prior approval and no claims for reimbursements can be denied solely because the service was provided through telemedicine.

As a result of the passage of the new law, the FTC ceased its investigation of the Board and the legal proceedings are now over. However, the Board still retains jurisdiction to adopt rules relating to telemedicine, which it released this month. Despite the Board’s initial attempts to curtail telemedicine in Texas, the recently issued rules actually expand the telemedicine offerings in Texas to mental health services, but do prohibit the treatment of chronic pain with scheduled drugs via telemedicine. Finally, the Texas law also prohibits healthcare providers from prescribing any abortion-inducing drugs or devices through telemedicine. Twenty other states have such a telemedicine restriction and those laws have been challenged, so employers should continue to monitor their specific state laws and future developments in this area.

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Federal Laws and Telemedicine

As a reminder to all employers, a telemedicine program that provides primary care or prescription drug services would also qualify as group health plan under ERISA, COBRA, HIPAA and other federal laws, such as the ACA. Consequently, employers should be cautious about establishing stand-alone telemedicine programs since such programs could run afoul of these laws and expose employers to various penalties, including a $100 per day per participant penalty for ACA violations. A better practice is to ensure that the employer's telemedicine program is offered in conjunction with its group health plan.

Further, if the telemedicine program goes beyond offering preventative care, there is the risk that employees could be disqualified from participating in a health savings account (HSA) unless paying fair market value for the services. In order to remain eligible for an HSA, an employee must have coverage under a high deductible health plan (HDHP) and cannot receive subsidized health care before meeting the deductible unless the care is preventative care, consists of excepted benefits (such as dental or vision benefits) or is specifically permitted insurance like workers' compensation.

Employers considering offering telemedicine options should remain aware of the potential state and federal legal requirements and continue to monitor future developments to avoid penalties and unintended tax consequences for their business or employees.

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DOL Delays Effective Date of New Disability Claims Procedures

Just as employers were gearing up to change their administrative claims procedures and plan documents to reflect the U.S. Department of Labor's new rule boosting procedural protections for disability claimants, the DOL has put on the brakes, at least temporarily. The final rule strengthening disability claims procedures became effective in January this year with a full implementation date of January 1, 2018, for all claims filed on or after that date regardless of plan or policy year. However, on October 12, 2017, the DOL issued a proposed rule which would delay the applicability of the disability rule to April 1, 2018. It appears the DOL is concerned that the current rule as written could increase the costs of disability plans and impair employees' access to disability insurance. It is seeking comments about the disability claims and appeals process, including denial rates, the extent plans rely on new or additional evidence and rationales to deny requests, and the costs and expenses of disability plans.

Although the effective date has been delayed, it is not clear if the new procedures will be significantly modified or eliminated. Accordingly, plan sponsors should continue efforts to identify all of the plans and documents that may need to be updated to reflect the new claims procedures. Most often, these may include qualified and nonqualified retirement plans, severance programs subject to ERISA, long-term and short-term disability plans, group life insurance, and any other ERISA plans and programs that may include disability-related provisions or payment triggers. Next, plan sponsors must ensure that the key changes implemented by the new rule are integrated into the applicable plan documents for these benefits. Finally, plan sponsors must modify their administrative practices to comply with the new disability claims and appeals procedures to the extent not provided under fully-insured programs. The key changes required by the current DOL rules are as follows.

1. **Increase Basic Disclosure Requirements**. Benefit claims denial notices must provide a more exhaustive discussion of the grounds for denying a claim, including specific reasons for the denial; specific plan provisions on which the denial is based; the internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied on in denying the claim (or a statement that none were used); the basis for disagreeing with individuals consulted during

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the claims process, including medical or vocational experts, and disability determinations made by the Social Security Administration; and any additional information necessary to perfect the claim.

If the denial is based on a lack of medical necessity or an exclusion for experimental treatment, the notice must also include an explanation of the scientific or clinical judgment applied (or a statement that such explanation will be provided free of charge upon request). Further, all denial notices must include an explanation of the claims appeals process and a statement that claimants can review and receive copies of all documents free of charge.

2. **Ensure Culturally and Linguistically Appropriate Notices.** All notices must be written in a culturally and linguistically appropriate manner. If a claimant lives in a county where 10 percent or more of the residents are not literate in English, benefit denial notices must include a prominent statement in the relevant non-English language regarding the availability of language services. The plan must also provide verbal assistance and notices in the non-English language.

3. **Add Safeguards to Avoid Conflicts of Interest.** There must be independence and impartiality of all persons involved in the decision-making process, and employment and compensation decisions cannot be based on the likelihood that the individual will deny a benefit claim.

4. **Increase Claimants' Rights.** During the review process, claimants must be guaranteed the right to present evidence supporting their claim and respond to any new information prior to the final decision. They must also be given notice and a fair opportunity to respond if benefits are to be denied on appeal based on new evidence or rationales not used to deny the benefit at the claims stage.

5. **Expand Definition of "Adverse Benefit Determination" to Include Certain Coverage Rescissions.** Certain rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact, are now "Adverse Benefit Determinations" that trigger a plan's appeals procedures and protections (but rescissions for non-payment of premiums are not Adverse Benefit Determinations).

6. **Inform Claimants That They Will Be Deemed to Have Exhausted the Claims and Appeal Process If the Plan Fails to Follow Procedural Requirements.** If the plan does not follow all claims procedures (except those based on minor error), the claimant's available administrative remedies will be deemed to have been exhausted, and the claimant may immediately file suit against the plan in court, so long as it's filed within the plan's statute of limitations.

Even though the state of this rule is uncertain, employers may want to contact their brokers or ERISA counsel for assistance in identifying impacted plans. Unless the rule is completely rescinded, which is unlikely, changes will need to be made by April 1, 2018. Stay tuned for further updates.

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HHS Expands Exemption from Contraceptive Mandate

Universities and publicly-traded, for-profit corporations can now opt out of offering free contraception coverage under their group health plans if they do so for religious reasons. The change comes after a new ruling was issued by the Department of Health and Human Services (HHS).

The Affordable Care Act (ACA) requires employer-sponsored health plans to cover FDA-approved contraceptive methods, sterilization procedures, and fertility education and counseling for women free of charge. This "contraceptive mandate" has been controversial from the beginning, and the subject of numerous lawsuits.

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Religious organizations claimed that requiring them to provide birth control to their employees violated their religious beliefs. In 2011, religious employers were granted an exemption from having to provide birth control to their employees. A similar exemption was later granted to nonprofit religious organizations that do not qualify for the religious exemption but have religious objections to contraceptives. In 2014, the Supreme Court held in *Burwell v. Hobby Lobby Stores, Inc.* that closely held for-profit business owners who had religious objections should not have to provide birth control because requiring them to do so violated the Religious Freedom Restoration Act (RFRA). Following this decision, exemptions existed for religious organizations, religious nonprofits, and certain closely held, for-profit entities.

Beginning October 6, 2017, universities and publicly-traded, for-profit corporations have joined the list of entities that may be eligible for an exemption. After multiple failed attempts to "repeal and replace" the ACA, the Trump Administration exempted a broad range of employers from covering birth control for religious reasons. Entities can also decide which contraceptive items or services they have a religious objection to and limit their plan carve-outs to those specific types of contraception.

There is no filing requirement or certification with HHS required to utilize the new exemption. However, any employer utilizing the exemption will be required to comply with ERISA's notification requirements regarding benefit changes. As with the status of many ACA provisions, the future of the contraceptive exemption remains uncertain. Immediately after the HHS contraceptive rule was published, a number of advocacy groups and some states indicated they would be filing suit. Democrats in Congress have also responded and drafted a bill to reverse this new exemption. Stay tuned for future developments and contact your UBA Partner Firm for additional guidance on whether you may qualify for the exemption.

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The Affordable Care Act – Still the Law of the Land

Despite numerous efforts to repeal and replace the Affordable Care Act (ACA), one thing is certain – for now, the ACA is still the law of the land. For that reason, we have summarized the top five ACA-related items to keep in mind as 2017 comes to an end.

1. Enforcement of the Employer Mandate is Here

In late 2017, large employers began receiving penalty assessments for employer shared responsibility payments for the 2015 calendar year. The IRS is assessing payments based on the number of employees who attained a subsidy on the Health Insurance Marketplace and whether the employer reported they met an affordability safe harbor on the employee's 1095-C.

The IRS outlined the penalty and appeals process in its revised FAQ on employer shared responsibility. Letter 226J will be issued to a large employer if the IRS determines that, for at least one month in the year, one or more of the employer's full-time employees were enrolled in a qualified health plan for which a Health Insurance Marketplace subsidy was issued, and the employer did not qualify for an affordability safe harbor or other relief.

Letter 226J includes: (1) a penalty explanation; (2) a summary table itemizing the proposed payment per month; (3) a response form (Form 14764); (4) an Employee Premium Tax Credit (PTC) Listing (Form 14765), which lists by month the employer's full-time employees who received a Marketplace subsidy and were not offered employer coverage that met an affordability safe harbor; (5) a description of the actions the employer should take depending on whether it agrees or disagrees with the proposed payment; and (6) a description of the actions the IRS will take if the employer does not respond in a timely manner.

A response deadline appears on the Letter 226J, generally 30 days from the date of the letter. After an

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employer responds, the IRS will send its response (Letter 227). If, after such response, the employer still disagrees with the proposed penalty payment, it may request a pre-assessment conference with the IRS Office of Appeals. If an employer fails to respond to either Letter 226J or Letter 227, the IRS will assess the amount of the proposed penalty, then issue a notice and demand for payment (Notice CP 220J).

Employers should be on the look-out for any notice indicating that the IRS believes they owe a shared-responsibility payment.

2. ACA Reporting Obligations Continue

ACA reporting obligations continue for 2017. On July 28, 2017, the IRS issued draft ACA reporting forms for reporting under Code Sections 6055 and 6056. The following draft forms can be accessed on the IRS's website: Forms 1094-B and 1095-B, for entities reporting under Section 6055, including self-funded plan sponsors that are not Applicable Large Employers (ALEs); and Forms 1094-C and 1095-C, for ALEs to report under Section 6056 and for combined reporting under Sections 6055 and 6056 by ALEs who sponsor self-insured plans. The draft forms are substantially the same as the 2016 forms, however, the IRS may still make changes before the final forms are issued.

3. Individuals are Still on the Hook

Advisory letters issued by the Office of Chief Counsel also confirm that individual penalties for failing to have minimum essential coverage continue to apply for 2017. The current penalty is $695 per adult and $347.50 per child (with a family maximum of $2,085), or 2.5% of household income, whichever is higher. The IRS has also stated it will not accept individual tax returns for the 2017 tax year that do not indicate whether the individual had coverage.

4. The ACA's Affordability Percentage Has Been Adjusted Again

In addition, the shared responsibility affordability percentage will decrease to 9.56% in 2018. Under the ACA, coverage is considered affordable if the employee's required contribution for self-only coverage is no greater than a certain percentage of the employee's household income. Adjustments for inflation have caused that percentage to steadily increase over the last few years (9.56% of household income for 2015, 9.66% for 2016, and 9.69% for 2017). However, for the first time, the percentage will decrease to 9.56% for 2018. This drop in the affordability threshold compared to 2017 may place some employers at risk for ACA penalties if the price of coverage is not reduced.

5. Marketplace Subsidies Could Be in Jeopardy

Finally, under the ACA, subsidies are provided to low-income individuals to reduce the cost of purchasing health coverage from the Healthcare Marketplace. After the Trump Administration announced that it would cease making these payments, a number of states filed lawsuits, and in October, Senators Patty Murray and Lamar Alexander made a bipartisan agreement to continue making these subsidy payments for at least two more years. However, the agreement must still be passed by the Senate and the House of Representatives, and President Trump has voiced opposition to it.

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EEOC Wellness Update on Incentive Limitations

Despite efforts by the U.S. Equal Employment Opportunity Commission (EEOC), designing a wellness plan that complies with Title I of the Americans with Disabilities Act (ADA) and Title II of the Genetic Information Nondiscrimination Act (GINA) remains unclear as the EEOC final regulations are now under review.

On May 16, 2016, the EEOC issued final regulations outlining how wellness programs must comply with the ADA and GINA. The rules generally apply to wellness programs that request genetic information, such as family medical history, or involve disability-related inquires and medical examinations, such as a health risk assessment or health screening. While such programs can be useful for promoting employee

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health, the EEOC remained concerned that the programs were not truly voluntary, as required by the ADA and GINA, if they provided a reward for participation. Because rewards for participation are specifically allowed under the wellness rules in the Health Insurance Portability and Accountability Act (HIPAA), there was much confusion regarding the extent to which a plan with incentives satisfying HIPAA may be in violation of the ADA or GINA. In an effort to provide clarity, the EEOC final rules generally state that as long as an incentive does not exceed 30 percent of the total price of an employee-only premium, the wellness program will be considered voluntary. The ADA and GINA incentive limits are less generous than the limits allowed by HIPAA, which can be up to 30 percent of the family premium cost and as high as 50 percent if the incentive relates to tobacco use reduction.

Despite the lower limits than those available under HIPAA, many employee advocates remained concerned that the use of incentives impermissibly coerces employees and family members into providing genetic or disability-related information to an employer. One such group, the American Association of Retired Persons, (AARP) challenged the new rules in October 2016, claiming that the incentives allowed impermissibly discriminate against employees who opt out of sharing their disability and genetic information with employers. The U.S. District Court for the District of Columbia recently ruled in favor of the AARP and found the EEOC rules were "arbitrary and capricious." The court found the EEOC did not provide an explanation, in the rules or in its administrative record, for how the 30 percent limit was created. Because agencies must be able to provide a reasonable basis for their rules, the court found that without any methodology to show that an incentive of up to 30 percent was still voluntary, the agency's action was arbitrary and capricious. However, to avoid causing widespread disruption and confusion for employers who have been relying on and implementing the rules since the beginning of 2017, the court did not throw out the rules. The Court instead opted to remand the rules to the EEOC for reconsideration.

Thus, employers should still comply with the final rules as drafted until the EEOC proposes revised regulations. Although compliance with the regulations will relieve an employer from an EEOC challenge, employers may receive challenges from individual employees who opt out of the wellness program because of concerns with providing sensitive genetic or disability-related information to the employer. Hopefully, the new guidance will be provided soon so that employers can be confident that their wellness programs are not subject to challenge. The EEOC recently filed a status report with the court that its "present intention" is to propose new rules by the middle of next year, estimating that this would result in a new rule taking effect in 2021. However, the EEOC was careful to note that the timeline could change. Thus, employers should continue to look for the revised regulations and additional updates from the EEOC.

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