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ACA Penalties: What we've learned, and where this may be going

The IRS quietly began sending penalty assessments under the Affordable Care Act's employer mandate in late 2017 for the 2015 calendar year. Unofficial guidance from the IRS suggests that more penalty assessments are coming, including assessments for 2016 filings. Here's an overview of what's been happening and where this could be headed.

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HIPAA Penalties: What exactly are the fines for noncompliance?

There has been a lot of talk and a lot of angst about HIPAA penalties in recent years – and with good reason. Following the HITECH Act, not only did penalty amounts rise but random audits were instituted. On top of that, data breaches are at an all-time high. So, what does this mean for companies subject to HIPAA?

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Changes to Form 5500 Reporting Are Coming – Are You Prepared?

In July 2016, the U.S. Department of Labor, Internal Revenue Service, and the Pension Benefit Guarantee Corporation released proposed revisions to Form 5500, required for certain ERISA-covered employee benefit plans. The regulations target plan year 2019 and could include sweeping compliance changes – so it's time to start planning.

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Reminder: Medicare Part D Notices Are Due by October 15

Medicare Part D requires group health plan sponsors providing prescription drug benefits to disclose to Part D eligible individuals and to the Centers for Medicare and Medicaid Services (CMS) whether the coverage it provides is "creditable," meaning that the coverage is expected to pay on average as much or more than the standard Medicare Part D prescription drug coverage.

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What Do the New AHP Rules Mean for You?

The new association health plan (AHP) regulations make it easier for a group of unrelated small employers, including sole proprietors, who satisfy the AHP requirements to sponsor a multiple employer welfare arrangement (MEWA) that is treated as a single employer under Section 3(5) of ERISA.

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ACA Penalties: What we've learned and where this may be going

The IRS quietly began sending penalty assessments under the Affordable Care Act's (ACA's) employer mandate in late 2017 for the 2015 calendar year. Unofficial guidance from the IRS suggests that more penalty assessments are coming, including assessments for 2016 filings. Here's an overview of what's been happening and where this could be headed.

Background

Under the ACA, large employers are required to provide their full-time employees with healthcare insurance that is affordable and meets minimum value. However, penalties for failure to offer such coverage were not assessed until late in 2017. Some speculated that, given the political uncertainty surrounding healthcare reform, the government would either continue to delay enforcement or skip enforcement for 2015 altogether. With its recent actions, the IRS has confirmed that enforcement efforts will continue.

What is the IRS doing now?

The agency started by sending Letters 226J to large employers that for at least one month of 2015 failed to offer coverage to at least 70 percent of their full-time employees and at least one employee received a Marketplace subsidy. In other words, the IRS began by assessing the large "a" penalties for 2015. Many of the assessments resulted from reporting errors on Forms 1094-C. If a company checked "No" to the question of whether they offered minimum essential coverage to at least 70 percent of their full-time employees, and they had at least one employee that received a subsidy, it's likely they received a penalty. Although it seems unlikely, many employers in our experience that actually offered minimum value coverage reported to the IRS that they did not offer coverage at all.

Responding to Penalty Assessments

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
6. A description of the actions the IRS will take if the employer does not respond in a timely manner

The first thing to do when you receive a penalty assessment is to reach out to the agency using the contact number provided on the ESRP Response Form and request a 30-day extension to respond. Otherwise, your response deadline will generally be 30 days from the date of the letter, which may not be sufficient time to gather information needed.

After that, it's important to pull your Form 1094-C and any relevant 1095-Cs from 2015 in order to understand why a penalty was assessed. Many companies find it helpful to seek legal representation at that point.

Responses from the IRS

In general, the IRS has been responsive to arguments that Form 1094-C reporting errors caused an erroneous penalty calculation and the agency has re-calculated penalties accordingly. However, the agency does come back and assess "b" penalties for any employee who received a subsidy on the Marketplace if the company cannot prove that it offered the employee affordable coverage that met minimum value. According to anecdotal evidence, the IRS is not accepting

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arguments that no penalty should be assessed if the company did not receive a notice from the Marketplace that their employee had a received a subsidy. According to the ACA, the U.S. Department of Health and Human Services (HHS) is required to send such a notice before a penalty is assessed.

The most disturbing development appears to be that the IRS is basing "b" penalties on whether employers met an affordability safe harbor and not whether the coverage offered was actually affordable to the individual employee's household income, as is required by the law. Several "b" penalties are on appeal based on this issue and a resolution remains to be seen. This could be an issue for many employers because the affordability safe harbors are complicated and the conditions for using and relying on them are often misunderstood. Fortunately, the penalty for not proving the affordability safe harbor is the lesser "b" penalty ($250 per month for each full-time employee receiving a premium subsidy in 2015).

Could Reporting Penalties Be Next?

In addition to employer mandate penalty assessments, employers are also receiving notices if they failed to file Forms 1094-C and 1095-C for 2015 and 2016. This could be a first indication that reporting penalties could be coming. This is particularly concerning because many companies must reduce their Letter 226J penalty amounts by explaining that their Form 1094-C was incorrect, which can trigger a penalty. How this will play out is yet to be seen.

The ACA is Here to Stay

For now, the ACA is still the law and it is actively being enforced. The best course is to ensure you are compliant by ensuring correct reporting and compliance efforts, including preparing written ACA eligibility provisions that ensure all full-time employees are offered coverage.

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HIPAA Penalties: What exactly are the fines for noncompliance?

There has been a lot of talk and a lot of angst about Health Insurance Portability and Accountability Act (HIPAA) penalties in recent years – and with good reason. Following the Health Information Technology for Economic and Clinical Health Act (HITECH Act), not only did penalty amounts rise, but the U.S. Department of Health and Human Services (HHS) instituted random audits. On top of that, data breaches are at an all-time high. So, what does this mean for companies subject to HIPAA? And what exactly are the penalties for a HIPAA violation?

This question is harder to answer than you might think.

Following the enactment of the HITECH Act in 2009, a new tiered civil penalty structure for HIPAA violations became effective. The structure provides certain guidelines that many have graphed out, such as a minimum $10,000 and maximum $250,000 penalty per violation up to $1.5 million for identical provisions during a calendar year if the covered entity made a conscious, intentional error or exhibited reckless indifference to its HIPAA obligations. Makes sense, right? Not exactly. $10,000 to $1.5 million is quite a spread. The list goes on, but it's very difficult to say what it would mean in actual dollar amounts. The situation is further complicated by the fact that HHS has discretion in determining the amount of the penalty based on factors such as the severity of the violation and the nature and extent of the harm it caused.

All of this may be moot, however, because in practice, it seems to come down to 1) getting caught and 2) the settlement agreement negotiated with HHS.

HIPAA violations are caught when there is a complaint, a breach that must be reported to HHS, or a random audit. In all three of these situations, the agency will look for additional violations when reviewing the case. Then, the company works privately with HHS to resolve the issue. This results

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in disparity between settlement amounts and a significant lack of transparency.

The best way to estimate your liability is to look at resolution agreements provided by HHS on its website that touch on your HIPAA weak points. Take, for example, two covered entities that entered into resolution agreements with HHS in 2016 for failing to put a business associate agreement in place with a vendor. One hospital was fined $1.55 million for failing to have a business associate agreement in place and failing to run an annual risk assessment. The other, a clinic, was fined $750,000 for failing to have a business associate agreement in place with a significant vendor.

How much are HIPAA penalties? The best answer is: High. Your best line of defense is diligent compliance efforts. In particular, sponsors of self-insured health plans, including health reimbursement arrangements and medical flexible spending accounts, should be sure to have written HIPAA policies and procedures in place (and follow them), conduct annual HIPAA training, and perform annual risk assessments regarding the vulnerability of HIPAA-protected health information maintained by the employer. Of course, full compliance with HIPAA requires much more.

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Changes to Form 5500 Reporting Are Coming – Are You Prepared?

In July 2016, the U.S. Department of Labor, Internal Revenue Services and Pension Benefit Guaranty Corporation (the “Agencies”) released proposed revisions to the Form 5500 Annual Return required for certain ERISA-covered employee benefit plans. While the proposed regulations garnered significant attention when they were released, there has been little discussion about the upcoming changes since. The regulations, however, target plan year 2019 and could include sweeping compliance changes for health plans in particular – so it’s time to start planning.

Why the Change?

As you probably know, Form 5500 is the primary source of information about the operations, funding, and investments of private-sector, employment-based pension and welfare benefit plans in the U.S. However, you may not know that Form 5500 also serves as an essential compliance and research tool for the Agencies. The proposed revisions to the Form are aimed at updating and expanding the body of publicly-available plan information to assist with the Agencies’ research and policymaking objectives, and to enable various stakeholders to perform data-based research to understand their plans and plan investments.

Specifically, the proposed revisions will affect both retirement plans and health plans, and are intended to

1. Modernize the financial statements and investment information filed about employee benefit plans.
2. Update the reporting requirements for service provider fee and expense information.
3. Enhance accessibility and usability of data filed on the forms.
4. Require reporting by all group health plans covered by Title I of ERISA.
5. Improve compliance under ERISA and the Internal Revenue Code through new questions regarding plan operations, service provider relationships, and financial management of the plan.

Health Plans Will Be Required to Provide Substantially More Compliance-related Data

The proposed revisions include a new Schedule J (Group Health Plan Information), which would ask health plan sponsors to certify under penalty of perjury that their health plan is compliant with a wide range of federal laws, including the:

- ERISA Summary Plan Description (SPD) requirement

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- ERISA Summaries of Material Modification (SMM) requirement
- Affordable Care Act (ACA)
- ACA Summary of Benefits and Coverage (SBC) requirement
- Health Insurance Portability and Accountability Act (HIPAA) portability and nondiscrimination requirements
- Genetic Information Nondiscrimination Act (GINA)
- Mental Health Parity Act
- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Michelle's Law

The revised form would also ask detailed questions about the plan, including the approximate number of participants and beneficiaries covered under the plan; the number of persons offered and receiving COBRA; grandfathered status; whether the plan offers coverage for employees, spouses, children, or retirees; what type of group health benefits are offered under the plan; funding information; whether there were participant or employer contributions; and very detailed claims information including claim denials.

Historically, the Agencies have focused limited resources on auditing health plans. However, they hope that the inclusion of compliance questions will spark self-policing among plan sponsors and administrators, and encourage them to proactively evaluate whether they meet the group health plan requirements of ERISA.

Small Plans Could Be Required to File 5500s

Certainly, one of the more jarring revisions for small employers is the elimination of the current exemption from filing Form 5500 for small, fully-insured group health plans. Instead, these plans would need to file a limited Form 5500/Schedule J beginning with the 2019 plan year. Specifically, these small plans would be required to complete Lines 1-5 (basic identifying information) on Form 5500 and Lines 1-8 on Schedule J (basic participation, coverage, insurance company, and benefit information).

It appears that at least part of the reason for the new filing requirement is to help the Agencies identify small plans to target for audit. The Agencies report in the proposed revisions that because fully-insured plans often use carrier documents, this change would permit the Department of Labor (DOL) to better identify those plans that may be affected by noncompliant provisions and better coordinate its enforcement efforts with affected service providers and other federal and state agencies.

What Do You Need to Do?

Companies with retirement and welfare plans need to review the proposed revisions and assess which changes might affect their plans. Companies that sponsor health plans, in particular, should begin auditing health plan compliance now to prepare for the upcoming changes. In addition, employers should evaluate their compliance with the reporting and disclosure requirements of ERISA, as well as the other self-certifying compliance items. It is not clear whether we will see all of the proposed changes come to light in 2019, but your plans should be ready in case the revised Form 5500 is released for 2019 plan years. Industry commenters have asked the DOL to postpone the proposals until industry concerns are sufficiently reviewed (particularly, the additional compliance burdens that will be imposed on small employers), but as of now, there are no signs that the DOL will postpone the changes.

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Reminder: Medicare Part D Notices Are Due by October 15

The annual deadline for delivering Medicare Part D disclosure notices to participants is quickly approaching. Medicare Part D requires group health plan sponsors providing prescription drug benefits to disclose to Part D eligible individuals and to the Centers for Medicare and Medicaid Services (CMS) whether the coverage it provides is "creditable,"

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meaning that the coverage is expected to pay on average as much or more than the standard Medicare Part D prescription drug coverage. For calendar year plans, the disclosure to CMS was due March 1. For all plans, notice to Medicare eligible individuals is due by October 15.

Medicare Part D disclosure notices provide important information for Medicare Part D enrollment. Eligible individuals that delay enrolling in Part D coverage may be required to provide proof that they have maintained creditable prescription drug coverage since the end of their initial enrollment period for Part D. Otherwise, the individual may be subject to a late enrollment penalty consisting of higher premiums on a permanent basis. Part D disclosures not only provide notice to individuals of whether their prescription drug coverage is creditable, but may also serve as proof of creditable coverage for late enrollees trying to avoid the late enrollment penalty.

Who Must Receive a Medicare Part D Disclosure Notice?

Notice must be provided to all Part D eligible individuals who are enrolled in or seeking to enroll in the employer's group health plan. Part D eligible individuals may include active employees, disabled employees, COBRA participants, retirees, and covered spouses and dependents of any of these individuals. An employer is generally permitted to provide a single notice to both the Part D eligible individual and all of his or her Part D eligible dependents covered under the same plan. However, a separate disclosure notice must be provided if the employer knows that any spouse or dependent who is Part D eligible resides at a different address from the participant.

When to Provide Medicare Part D Disclosure Notices

Employers must provide creditable coverage disclosures to Medicare Part D eligible individuals at the following times:

1. Prior to commencement of the annual coordinated election period (ACEP) for Medicare Part D
2. Prior to an individual's initial enrollment period (IEP) for Part D
3. Prior to the effective date of coverage for any Part D eligible individual that enrolls in the employer's prescription drug coverage
4. Whenever the employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable
5. Upon request by the Part D eligible individual

CMS will presumably consider the ACEP and IEP disclosure requirements met if notices are provided to all plan participants annually prior to October 15 of each year, assuming that all other conditions associated with the notices have been satisfied.

How to Provide Medicare Part D Disclosure Notices

Notices may be provided separately or with other information provided to participants such as enrollment materials or summary plan descriptions (SPDs). If provided with other information, the notice must be "prominent and conspicuous," which is generally satisfied if the disclosure notice portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) is prominently referenced in at least 14-point font in a separate box, bolded, or offset on the first page of the information being provided.

Notices may be provided by mail or by electronic means, though additional restrictions are placed on electronic delivery. Employers may rely on the Department of Labor's electronic disclosure requirements, which allow the notice to be provided electronically to participants "who have the ability to access electronic documents at their regular place of work if they have access to the plan sponsor's electronic information system on a daily basis as part of their work duties." If this method of delivery is chosen, the employer must inform participants that they are responsible for providing a copy of the

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disclosure to their Medicare eligible dependents covered under the group health plan.

Electronic notice may also be provided to retirees if the Part D eligible individual has indicated to the employer that they have adequate access to electronic information and that they agree to receive information electronically. The employer must be provided with a valid email address and the individual must submit their consent electronically to the employer. However, before individuals can agree to receive information electronically, they must be informed of their right to obtain a paper notice, how to withdraw their consent, and how to update their address information. They must also be advised of any hardware or software requirements to access and retain the notice. Finally, in addition to sending the notice by email, the employer must post the notice (except for personalized notices) on its website with a link on the company's home page to the disclosure notice.

CMS has published model disclosure notices for use by employers on and after April 1, 2011. These notices are accessible online at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html.

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What Do the New AHP Rules Mean for You?

The Department of Labor (DOL) issued final regulations in June designed to expand the availability of multiple employer welfare arrangements (MEWAs) in a new type of MEWA referred to as an association health plan (AHP). The new AHP regulations make it easier for a group of unrelated small employers, including sole proprietors, who satisfy the AHP requirements to sponsor a MEWA that is treated as a single employer under Section 3(5) of the Employee Retirement Income Security Act (ERISA). This is big news for small employers, as AHPs may be able to avoid some of the more expensive Affordable Care Act (ACA) reforms applicable to the individual and small group insurance markets, including the requirement to cover the essential health benefits. Because an AHP does not "look through" the MEWA and base application of the ACA reforms on the size of each sponsoring employer, many employers are concerned that joining an AHP will subject them to other federal laws as a large employer. Employers are also concerned about how other state and federal laws apply to AHPs. While there are still some gray areas, the preamble to the final AHP rule provides guidance, and the DOL and Internal Revenue Service (IRS) have recently issued announcements to further assist employers in understanding the impact of joining an AHP.

In response to the over 900 comment letters received, the preamble to the final rule specifically addressed some employer concerns. For example, the preamble clarifies that nothing in the final rule is intended to indicate that mere participation in an AHP will give rise to joint employer status among participating employers, or that a business's participation in an AHP with independent contractors will cause the business to become the independent contractors' employer. However, the preamble does state that mental health parity laws will apply based on the aggregate size of all employers participating in the AHP. This is consistent with the position historically taken by the DOL that a MEWA sponsored by a bona fide group or association of employers treated as a single employer under ERISA is determined by the size of the aggregate group.

One of the biggest concerns for small employers is whether joining an AHP would cause an employer with fewer than 50 full-time equivalents (FTEs) to become an applicable large employer (ALE) subject to the ACA mandate to offer affordable minimum value health insurance to employees. The preamble to the final rule left this as an open question. However, the IRS for the first time recently clarified that the employer shared responsibility provisions do not apply if an employer that is not otherwise an ALE offers coverage through an AHP. Determining size of an ALE is based on the total employees of each

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employer that is required to be joined as a controlled or affiliated service group under Sections 414(b), (c), (m) and (o) of the Internal Revenue Code (IRC), and are not based on the definition of employer in Section 3(5) of ERISA, which treats an AHP as a single employer. This is an important concept because it should mean that any requirements of the IRC that apply to an "employer" will be based on the size of each plan sponsor and not the AHP.

However, there are numerous other compliance considerations that employers joining an AHP need to consider, particularly under ERISA. On August 20, 2018, the DOL released a publication discussing its position on the application of certain ERISA provisions to AHPs under the new rules. It also reiterated that the final regulations do not affect previously existing MEWAs that complied with earlier DOL guidance. The publication examines the following topics.

- **Disclosure Rules.** As welfare benefit plans, AHPs are still required to furnish certain plan information to participants and beneficiaries (for example, summary plan descriptions (SPDs), summaries of material modifications (SMMs), and summaries of benefits and coverage (SBCs)). The responsibility for compliance with these rules is with the association sponsoring the AHP and not the participating employers.
- **Reporting Rules.** Fully-insured and self-insured AHPs are required to file both a Form 5500 (annual report) and a Form M-1 (to register and report compliance information before operating an AHP in a new state, and annually thereafter) with the DOL. These forms are available on the DOL's Reporting and Filing Web page. The association sponsoring the AHP is responsible for satisfying the plan's reporting requirements. Any employer considering joining an AHP can visit the Department's Web page and use the electronic Form M-1 database to determine whether the AHP has appropriately registered with the DOL.
- **Claims Administration.** AHPs are subject to ERISA's claims procedure requirements. The responsibility for complying with these rules falls on the association sponsoring the AHP.
- **COBRA.** COBRA does not apply to employers with fewer than 20 employees. The DOL intends to issue future guidance on applicability of COBRA to AHPs that provide coverage to member employers with fewer than 20 employees. Historically, MEWAs sponsored by a bona fide group or association employers include federal COBRA as part of the plan requirements. Because COBRA is included in ERISA and the Internal Revenue Code, which have different employer definitions and exclusions, it is possible that COBRA may apply differently depending on the nature of the employers in the AHP.
- **Consumer Health Protections.** AHPs continue to be subject to consumer protections found in ERISA Part 7, including HIPAA, the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act, among others. It is the responsibility of the AHP to comply with ERISA's consumer health protections, not the employer members.
- **Fiduciary Rules.** AHPs are subject to ERISA's fiduciary duty rules, including the requirements to hold plan assets in trust and maintain a written plan document. Employers that are members of an AHP also have a fiduciary duty to monitor the AHP and get periodic reports on the fiduciaries' management and administration of the AHP.
- **Prohibited Transactions.** AHPs are subject to ERISA's prohibited transaction rules. However, to avoid a potential prohibited transaction, ERISA includes a number of statutory and administrative exemptions that permit AHPs to conduct necessary transactions that would otherwise be prohibited. For example, the multiple service exemption under ERISA § 408(b) allows AHPs to pay individuals or

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companies who provide services to the AHP without it constituting a prohibited transaction, but only if the services are necessary to operate the plan, the contract or arrangement under which the services are provided is reasonable, and the compensation for those services is reasonable. This exemption does not cover a fiduciary hiring an affiliate or related person or company to provide services to the AHP (called self-dealing or a "conflict of interest" prohibited transaction). There is a separate statutory exemption for this "conflict of interest" transaction but, in addition to the conditions required by the "service provider" exemption, the affiliate (or related person/company) can be paid only for its direct expenses (not normal fees) incurred when providing services.

- **Voluntary Correction.** AHP fiduciaries may utilize corrective programs such as the DOL's Voluntary Fiduciary Correction Program (VFCP) and Delinquent Filer Voluntary Compliance Program (DFVCP) to correct certain compliance failures. The VFCP may be used to correct fiduciary violations, while the DFVCP may be used to correct failures to file a Form 5500 on time. Particularly important for AHPs is the ability to correct failures by member employers to promptly send participant contributions to the AHP.
- **Enforcement.** The DOL's enforcement authority for MEWAs applies to AHPs. Enforcement may consist of cease-and-desist orders, orders to seize assets of MEWAs in a financially hazardous condition, and criminal penalties for false statements in the sale or marketing of MEWAs.
- **State Authority.** The new rules do not diminish state oversight of AHPs. State insurance regulators maintain their authority to regulate health insurance issuers and the health insurance policies they may sell to AHPs. States also retain their authority to regulate self-insured AHPs to the extent regulation is not inconsistent with ERISA.

Employers and advisors looking to form AHPs under the new regulations will need to consider how the guidance released by the IRS and DOL impacts their compliance efforts. Small employers, in particular, need to stay vigilant because additional guidance is likely forthcoming. The preamble to the final rule specifically declined to consider implications of the new AHP regulations under premium tax credit eligibility rules, network adequacy standards, the Pregnancy Discrimination Act of 1978, other federal nondiscrimination laws, Medicare secondary payer rules, COBRA rules, and VEBA rules. At this point the DOL has only expressed its intention to issue additional guidance regarding the application of the AHP rules to COBRA, but we anticipate that the IRS will continue to chime in on those laws falling under its interpretive jurisdiction.

AHPs under the new rules can be established as soon as September 1, 2018, for fully-insured health plans, while existing AHPs that sponsored self-insured AHPs on or before the date the final regulations were published may expand within the context of the new AHP rules starting on January 1, 2019. All other associations may establish a self-funded AHP starting on April 1, 2019.

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