WELLS FARGO INSURANCE

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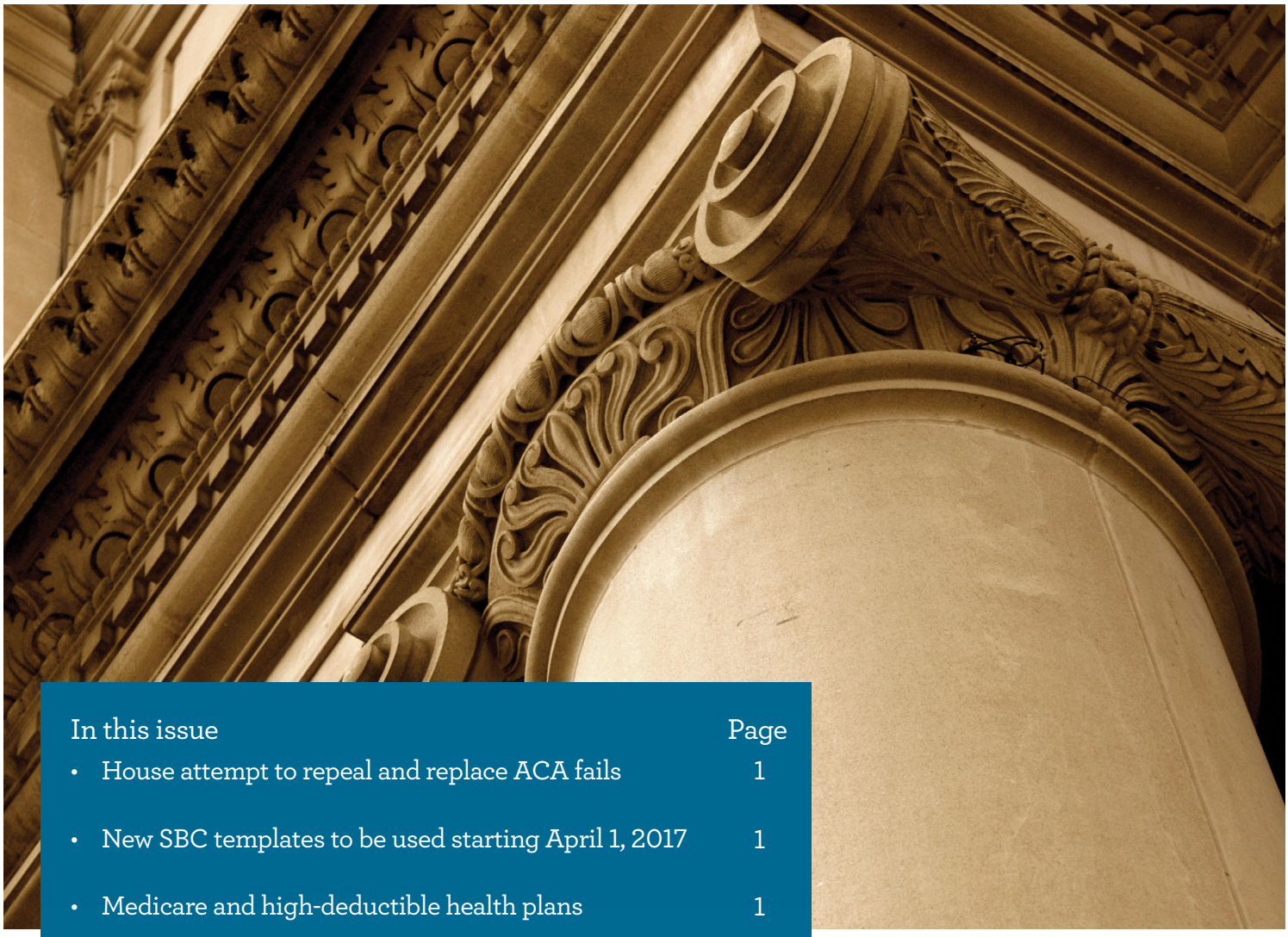
Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice



In this issue

Together we'll go far

House attempt to repeal and replace ACA fails

House leadership withdrew the American Health Care Act on Friday, March 24, 2017, with the consent of the White House. The bill ultimately failed for several reasons:

- It lost support from most conservative public policy groups for not going far enough to repeal the Affordable Care Act (ACA);
- It failed to gain support from physician, patient, and hospital groups, who felt it did not go far enough to sufficiently replace the ACA with something better; and
- Public support for the bill was weak.

House Speaker Paul Ryan and President Trump have indicated a desire to move on to comprehensive income tax reform, although Republicans continue to work to revive a plan to repeal and replace the ACA. Please see our recently released Benefits Compliance Alert on this issue for more details.

New SBC templates to be used starting April 1, 2017

Health plan sponsors required to provide a Summary of Benefits and Coverage (SBC) and related materials to employees are reminded that the final revised SBC template and related materials, issued one year ago, should be used starting with the first day of the first open enrollment period that begins on or after April 1, 2017, with respect to coverage for plan years beginning on or after that date. See our March 2016 Benefits Compliance Update for details on the changes. Templates, instructions and related materials can be found on the Department of Labor website (at the bottom of the Web page).

Medicare and high-deductible health plans

In brief:

- Full-time employees and their spouses who reach age 65 continue to be eligible for coverage under an employer's group medical plan (including a high-deductible health plan (HDHP)), even if they are covered by Medicare.
- An individual who is eligible for – but not covered by – Medicare can still have contributions made to his/her health savings account (or HSA), if the individual is covered by an HDHP (and certain other requirements are met).
- If an individual delays receiving Social Security income benefits past his/her full retirement age, both Social Security and Medicare may be retroactive for up to six months once they start, unless the individual elects otherwise. This special 6-month rule may affect contributions that have been made to the individual's HSA in the meantime.

Employees and spouses who reach age 65 may have access to medical coverage from multiple sources – the employer's group medical plan, the federal Medicare program, and perhaps other federal and state government plans. This confusing situation can get even more complicated if the employer's plan is a high-deductible health plan (HDHP). This article discusses the rules that apply if the employee or spouse is eligible for both Medicare and an HDHP.

Medicare coverage

All U.S. citizens (and certain permanent residents) are eligible for Medicare when they reach age 65. They are not, however, enrolled in (or covered by or "entitled to") Medicare unless they actually apply for Medicare coverage as an eligible individual. There is one important exception

from the application requirement – everyone who begins receiving Social Security income benefits at age 62 or later is automatically enrolled in Medicare Part A (which is free for those credited with at least 40 quarters of Medicare tax payments), without having to file an application, once they are age 65 or over. For example, if an individual begins receiving Social Security income benefits at age 62, he/she will be automatically enrolled in Medicare Part A upon reaching age 65.

HDHP coverage

All employees who satisfy the requirements for eligibility under the employer's group medical plan may enroll for coverage under the plan (along with their spouse, if the plan permits spousal coverage), regardless of the age of the employee or spouse. The Age Discrimination in Employment Act prohibits employers from taking into account an employee's or spouse's age in determining whether they are eligible for plan coverage, so long as the employee is otherwise eligible for coverage. Different rules apply to retiree medical coverage.

For example, an employee who works on a full-time basis after reaching age 65 would be eligible for coverage under the employer's HDHP (assuming that the employee is otherwise eligible, without considering his/her age). The employee can enroll in the HDHP even though he/she is eligible for Medicare, and even if the employee actually enrolls in (or becomes covered by) Medicare.

HSA contributions

One of the advantages of enrolling in an HDHP is that pre-tax (or tax deductible) contributions can be made to the individual's health savings account (HSA). These HSA contributions can be made only if all of the following requirements are met:

1. The individual has HDHP coverage that qualifies under the federal tax rules.
2. The individual cannot be claimed as another person's tax dependent (for example, by a parent). Note that a spouse is not considered the employee's tax dependent.
3. The individual is not covered by Medicare or entitled to Medicare benefits of any kind, including Medicare Part A. Note that eligibility for Medicare is not the same as Medicare coverage or entitlement.
4. If the individual has other healthcare coverage, that other coverage is HDHP coverage that qualifies under the federal tax rules, or is permitted non-HDHP coverage (refer to the box for details). Examples of impermissible coverage that would make the individual's HSA ineligible for contributions include coverage under a spouse's or domestic partner's non-high deductible health plan, a general-purpose health flexible spending arrangement, or a general-purpose health reimbursement arrangement.

> Permitted non-HDHP coverage includes insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (for example, homeowner or auto insurance), or similar liabilities as specified by the Internal Revenue Service; insurance for a specified disease or illness (for example, cancer insurance); insurance that pays a fixed amount per day (or other period) of hospitalization (for example, hospital indemnity insurance); and coverage for accidents, disability, dental care, vision care, or long-term care.

To understand how these rules operate, let's consider an employee who is age 67. She enrolls in an HDHP at work, and wants to make contributions to an HSA. Looking at the four requirements, she has qualifying HDHP coverage, is not someone else's tax dependent, is not covered by Medicare (although she is eligible to enroll), and does not have other healthcare coverage that is impermissible. Therefore, she may make contributions to her HSA. If she later becomes covered by Medicare, then contributions may no longer be made to her HSA at that time, even though she continues to be covered under the HDHP.

Special 6-month rule

Some employees wait until their retirement date before starting their Social Security income benefits and Medicare coverage. If an employee in this situation meets all four of the above requirements (including coverage under an HDHP), then contributions may be made to his/her HSA before the employee retires, even if the employee is age 65 or over. The fact that the employee is eligible for Medicare

does not prevent HSA contributions from being made, as long as the employee is not covered by Medicare. By waiting until after retirement to enroll in Medicare, the employee can maximize the contributions made to his/her HSA.

There is an important "trap," however, that needs to be avoided to take full advantage of this strategy – the special 6-month rule. To understand this rule, it is helpful to know that full retirement age for Social Security income benefits depends on the individual's year of birth, as shown in the following chart:

Individual's Year of Birth	Individual's Full Retirement Age
1954 or Earlier	66 Years
1955	66 Years, 2 Months
1956	66 Years, 4 Months
1957	66 Years, 6 Months
1958	66 Years, 8 Months
1959	66 Years, 10 Months
1960 or Later	67 Years

When an individual delays applying for Social Security income benefits until sometime after he/she has reached full retirement age, the Social Security Administration (SSA) assumes that the individual made a mistake and forgot to apply for benefits on time. To help alleviate the financial burden of this "mistake," SSA will automatically provide Social Security income benefits retroactive to the date when the individual reached full retirement age-- but not for more than six months – unless the individual affirmatively declines to receive benefits on a retroactive basis.

For example, if an individual born in 1948 applies for Social Security income benefits upon reaching age 70, SSA will assume that the individual made a mistake and forgot to apply for benefits upon reaching age 66 (which is the full retirement age for individuals born in 1948). SSA will automatically provide six months' worth of retroactive Social Security income benefits to the individual, unless the individual informs SSA during the application process that his/her Social Security income benefits should begin at age 70, and should not be retroactive for six months.

The "trap" here is that everyone who begins receiving Social Security income benefits is automatically enrolled in Medicare Part A, if they are age 65 or over. Under the special 6-month rule, if Social Security income benefits are provided retroactive for six months, then Medicare Part A coverage will be provided retroactive for six months as well. In the case of an employee who is retiring at age 70, his/her Medicare coverage will begin six months prior to retirement. During those last six months of employment, the employee (in our example) would be covered by both Medicare and the HDHP.

The special 6-month rule creates a problem for employees and spouses, if contributions were made to their HSA during this retroactive period. The HSA was not eligible for contributions during those six months, because one of the four rules set forth above was not met – the individual was covered by Medicare. As a result, six months' worth of excess contributions were made to the HSA, which now must be returned to the individual by the due date for his/her tax return (along with income attributable to the contributions) or the Internal Revenue Service may assess tax penalties against the individual.

Recommendation

If an employer maintains an HDHP, then the HDHP's summary plan description and/or benefits booklet should include the four requirements set forth above for making contributions to an HSA. Some employers go further, and require employees enrolling in an HDHP to make an affirmative declaration during annual open enrollment regarding whether or not the employee and spouse comply with all four requirements for making HSA contributions. Only those employees who submit the declaration would be eligible to make HSA contributions through the employer's Section 125 cafeteria plan.

Medicare Secondary Payer

In brief:

- The Medicare Secondary Payer (MSP) rules apply whenever an individual is covered by both Medicare and an employer's group health plan. The MSP rules determine when the employer's plan must pay on a primary basis and when it would pay on a secondary basis for the individual's medical claims.
- The MSP rules require employer plans to provide employees and spouses who are age 65 or over with the same benefits, under the same conditions, as are provided to employees and spouses who are under age 65.
- The MSP rules prohibit employers from offering financial or other incentives to individuals covered by Medicare if they opt out of the employer's group health plan.

The Medicare Secondary Payer (MSP) rules determine when a group health plan must pay on a primary basis and when it would pay on a secondary basis for a medical care claim for an individual covered under both the group health plan and Medicare. The process for determining whether the employer's plan will pay on a primary or a secondary basis is sometimes referred to as "coordination of benefits" or COB.

The MSP rules apply to every group health plan maintained by an employer or contributed to by an employer (such as a multi-employer plan) that provides health care to employees, former employees or their families. The MSP rules apply to private-sector employers (including religious, charitable, and educational institutions), to the federal government, and to the states (including their agencies, instrumentalities, and political subdivisions).

The MSP rules broadly distinguish between (1) individuals in "current employment status" (including their spouses and family members), and (2) former employees (and their spouses and family members). In addition, the MSP rules distinguish between individuals covered by Medicare because of (a) their age, (b) disability status, or (c) end-stage renal disease (ESRD), which generally involves kidney dialysis and/or kidney transplant.

Circumstances of Multiple Coverage	Additional Conditions	Primary Payer	Secondary Payer
Medicare coverage based on age, and coverage under a group health plan due to current employment status	Employer has 20 or more employees	Group health plan	Medicare
	Employer has fewer than 20 employees	Medicare	Group health plan
Medicare coverage based on age, and retiree health plan coverage or COBRA	Not applicable	Medicare	Group health plan
Medicare coverage based on disability, and coverage under a group health plan due to current employment status	Employer has 100 or more employees	Group health plan	Medicare
	Employer has fewer than 100 employees	Medicare	Group health plan
Medicare coverage based on disability, and retiree health plan coverage or COBRA	Not applicable	Medicare	Group health plan
Medicare coverage based on end-stage renal disease (ESRD), and group health plan coverage (including coverage due to current employment status, retiree health plan coverage, or COBRA)	30 months' coordination period which starts when the individual is first eligible to enroll in Medicare due to ESRD	Group health plan	Medicare
	After 30 months	Medicare	Group health plan

The MSP rules require group health plans to provide employees and spouses who are age 65 or over with the same benefits, under the same conditions, as are provided to employees and spouses who are under age 65. The MSP rules also prohibit group health plans from "taking into account" the fact that an employee, spouse or family member is covered by Medicare, in determining their eligibility for benefits.

In addition, employers may not offer financial or other incentives to individuals covered by Medicare, if they opt out of employer-provided group health coverage. Examples of prohibited actions include:

- Offering a Medicare supplemental policy or other complementary coverage.
- Automatically terminating coverage when an individual becomes covered by (or "entitled to") Medicare.
- Denying Medicare-covered individuals the opportunity to enroll in or renew enrollment in a group health plan.
- Imposing higher premiums, deductibles or copays when an individual becomes covered by Medicare.
- Limiting benefits for Medicare-covered individuals, when benefits are not limited for other plan participants.
- Requiring Medicare-covered individuals to wait longer for coverage to begin.
- Limiting health care provider payments to the amount that Medicare would have paid (unless this is a plan design mechanism which is in place for all plan participants with two or more coverages).

An employee may, however, voluntarily drop employer coverage and rely on Medicare as the sole and primary payer of medical expenses. If an employee chooses not to take employer-provided group medical plan coverage, the employer can still offer coverage under its dental plan and vision-care plan to the employee and family members. However, an employer "can't offer…a plan that pays supplemental benefits for Medicare-covered services or pays for these benefits in any other way," according to the Centers for Medicare and Medicaid Services (CMS).

According to CMS, the MSP rules are violated "every time a prohibited offer is made regardless of whether it is oral or in writing." A violation of the prohibition on financial incentives can lead to civil penalties of up to $5,000 per violation.

If Medicare makes a payment on a primary basis that should have been made by the employer's plan, then it is considered to be a conditional payment. The group health plan that should have paid on a primary basis must reimburse Medicare for its conditional payment if CMS demonstrates that the plan was responsible to pay for the item or service. If CMS must bring legal action to recover a conditional payment, then it is entitled to collect twice the amount of its payment (also known as double damages).

CMS has adopted two administrative procedures to identify potential MSP situations. First, all group health plans are subject to mandatory MSP reporting requirements. These reports help CMS monitor whether group plans are properly paying on a primary basis for Medicare beneficiaries. MSP reporting is generally performed by insurance carriers for insured plans, and by third party administrators (TPAs) for self-insured plans. However, employers that self-administer their health reimbursement arrangements (HRAs) need to comply with the reporting requirements as well, unless the employer's HRA satisfies one of the following exemptions:

- An employer's HRA is exempt from reporting if the annual benefit amount is less than $5,000.
- Employers with fewer than 20 employees (full- or part-time) are exempt from reporting, unless a covered individual has end-stage renal disease and is receiving dialysis or has had a kidney transplant.

The second administrative procedure used by CMS is the Data Match program, which identifies Medicare beneficiaries who are employed (or whose spouses are employed) and who might be covered by a group health plan that would have to pay on a primary basis under the MSP rules. Contacted employers must complete a questionnaire that requests information about the employer's group health plan and the individuals identified by CMS. This information is used by CMS to determine whether Medicare may have mistakenly paid claims on a primary basis for these individuals. Please see our April 2016 Benefits Compliance Update for more information on this topic.

New York enacts paid family leave law

In brief:

- Beginning on January 1, 2018, the New York Paid Family Leave Benefits Law (NYPFLBL) provides a phased-in system of wage replacement to employees who take time off work to bond with a new child, care for a family member who has a serious health condition, or help when a family member is called to active military service.
- The NYPFLBL applies to eligible employees of private employers covered by the New York State Workers' Compensation Law, regardless of the size of the employer.
- Eligible employees will be paid through a state fund that is financed by deductions taken from employee wages.

On April 4, 2016, New York Governor Andrew Cuomo signed the New York Paid Family Leave Benefits Law (NYPFLBL). Starting on January 1, 2018, the NYPFLBL will provide a phased-in system of partial wage replacement for New York employees who take paid family leave, beginning at 8 weeks per year and increasing incrementally up to 12 weeks per year by 2021. NYPFLBL benefits are funded by employees through payroll deductions beginning on July 1, 2017. For more detailed information and frequently asked questions, visit the NYPFLBL Web page.

Covered employers

Private employers in New York State with at least one employee must comply with the NYPFLBL. Public employers (the State, public authorities or any governmental agency or instrumentality) may opt into the program. Note that employers who are not covered under the federal Family Medical Leave Act (FMLA) because they do not employ 50 or more employees within a 75-mile radius are still subject to the NYPFLBL.

Covered employees

A covered employee is a person who works full-time for 26 weeks or part-time for 175 days for a covered employer prior to the start of the requested leave. Individuals who are receiving total disability benefits under workers' compensation, who are not employed, or who are on administrative leave from employment are not eligible to receive paid family leave benefits. Note that the NYPFLBL may cover employees who are not covered by FMLA. FMLA only covers employees who have been employed for 12 months and worked at least 1,250 hours in the prior 12-month period.

Benefits

Eligible employees may take a paid leave of absence from work to:

- Provide physical or psychological care to a family member with a serious health condition,
- Bond with the employee's child during the first twelve months after the child's birth, adoption, or placement for foster care, or,
- Attend a qualifying exigency as interpreted by the Family Medical Leave Act (FMLA) arising when a spouse, domestic partner, child, or parent of the employee is on active duty, or has been notified of an impending call or order to active duty in the armed forces of the United States.

Family member includes a child, parent, grandparent, grandchild, spouse or domestic partner. Child is defined as a biological, adopted, foster son or daughter, stepson or stepdaughter, a legal ward, a son or daughter or a domestic partner, or the person to whom the employee stands in loco parentis. Parent is defined as a biological, foster, or adoptive parent, a parent-in-law, stepparent, legal guardian or other person standing in loco parentis.

An employee that takes leave under NYPFLBL shall not lose any employment benefits that accrued before taking the leave. Employers must maintain employees' existing health benefits during the leave. Additionally, an employer may permit, but not require, an employee to use vacation and sick leave during leave.

Compensation

By 2021, the NYPFLBL will provide employees with the right to take up to 12 weeks of family leave during any 52-week period while receiving the lesser of 67% of their salary or 67% of the New York State Average Weekly Wage. The benefits will be phased in according to the following schedule:

Year	Weeks Available	Max % of Employee Salary	Cap % of State Average Weekly Wage
1/1/2018	8	50%	50%
1/1/2019	10	55%	55%
1/1/2020	10	60%	60%
1/1/2021	12	67%	67%

Notice/posting and recordkeeping requirements

An employee must provide notice within 30 days if the leave is foreseeable. If the leave is not foreseeable, the employee must provide notice as soon as practicable. Covered employers must post a notice about the NYPFBL.

Penalties

Penalties for noncompliance can include a misdemeanor punishable by a fine of not less than one hundred or more than five hundred dollars or imprisonment for not more than one year, or both. Fines increase for subsequent violations.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.