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FEDERAL UPDATES
TOP COMMON GROUP HEALTH PLAN ISSUES

1. FMLA

Final regulations released Feb. 6, 2013, expanded the federal Family and Medical Leave Act (FMLA) to include leave for family members who are on or have been called to active duty or notified of an impending call to active duty in the armed forces. Extended leave is available for an employee to care for a family member with a serious illness or injury. The final regulations also included a revision to the existing poster requirement, requiring employers to replace their existing FMLA posters with the new version. Another recent change, due to the *US v. Windsor* decision from the U.S. Supreme Court and subsequent U.S. Department of Labor guidance in Revised Fact Sheet #28F, is that for purposes of FMLA, eligibility for leave to care for an immediate family member is extended to same-sex spouses under the same terms and conditions as an opposite-sex spouse, if the employee resides in a state that recognizes same-sex marriage.

Compliance Quick Check: Top Common Group Health Plan Issues.

2. MIXING UP HIPAA AND COBRA NOTICES

The HIPAA Special Enrollment Rights Notice and the COBRA Initial Notice are commonly confused, but the application and audience of these two notices are vastly different. Employers should ensure that the HIPAA Special Enrollment Rights Notice is provided to all employees (not just those covered under the plan) who are offered the opportunity to enroll. This means distributing the notice within enrollment materials, as providing within a summary plan description (SPD) would be insufficient. Conversely, the COBRA Initial Notice is only provided to employees and their spouses who are actually covered under the plan. This notice must be provided within 90 days of the coverage beginning date. It is acceptable to include within the SPD or in the same mailing, but if the employee is covering the spouse, it is vital to include a memorandum notifying the spouse of the enclosed COBRA Initial Notice, since the SPD is not normally addressed to the spouse.

3. NONDISCRIMINATION: WHEN IS TESTING REQUIRED?

Corrections to any failed nondiscrimination test are not permitted after year-end. This means that the status of the plan should be monitored during the year so that any adjustments can be made prior to year-end. As a best practice, testing should be performed prior to the beginning of the plan year, several months before the end of the plan year and after the close of the plan year. Results from each test can help a plan sponsor facilitate corrections and show, upon audit, that the plan passes the appropriate tests.

4. MEDICARE/TRICARE PROHIBITION

An employer with 20 or more employees may not offer to pay, subsidize or otherwise reimburse the cost of TRICARE or Medicare coverage for employees or their spouses, as this could be seen as taking such coverage into account and incentivizing the individual to drop group health coverage. Other prohibited actions include excluding eligibility for coverage due to entitlements under TRICARE or Medicare or otherwise "taking into account" such coverage.

5. PAYMENT OF INDIVIDUAL POLICY PREMIUMS

Some employers have begun to explore the possibility of providing contributions toward health coverage purchased in the individual market, including coverage and employee purchases through either a private or public exchange. In response, on Sept. 13, 2013, the Internal Revenue Service (IRS) published Notice 2013-54, essentially prohibiting the payment, subsidy or reimbursement of the cost of individual policy premiums by an employer. The IRS requires that a participant in any employer-sponsored arrangement that is designed to pay for health coverage on a tax-free basis also be enrolled in a group health plan. Employers currently reimbursing individual policy premiums should consult with outside counsel to ensure compliance with the IRS requirements beginning in 2014.

6. ADVANCE NOTICE OF MIDYEAR PLAN CHANGES REQUIRED

Health care reform introduced the summary of benefits and coverage (SBC) requirement. Under the SBC distribution rules, if the plan changes information or plan design midyear for information required to be reflected in the SBC, an updated SBC must be provided 60 days in advance of the effective date of the change. Importantly, though (and as it relates to ERISA), guidance states that if an SBC is provided 60 days in advance, then the requirements to provide a summary of material modifications (SMM) under ERISA is also satisfied. An SMM describing a reduction in covered services or benefits may also be required on an expedited basis when a plan change is made. Plan sponsors must understand the intricacies of each notice when considering making a midyear change in the plan design.

7. FAILURE TO OFFER COBRA

If an employer offers benefits that satisfy the definition of a group health plan, the employer should also offer COBRA in connection with the plan. Commonly overlooked group health plans include health flexible spending arrangements (FSA), health reimbursement arrangements (HRA), Employee Assistance Programs (EAP) and wellness programs. If certain criteria are met, including the fact that the employer is sponsoring the plan and medical care is being provided, COBRA is required. Failure to offer COBRA may subject the employer to penalties under ERISA, an excise tax under the tax code, and penalties and remedies by the courts.

8. AFFORDABILITY UNDER HEALTH CARE REFORM

Wellness credits and surcharges cannot be taken into consideration when determining affordability under the employer mandate, unless the wellness credit or surcharge is tobacco-related. Additionally, small employers must determine affordability for purposes of the Marketplace Notice. Finally, individuals should be informed as to the affordability of coverage for purposes of the premium tax credit subsidies available in the federal marketplace.

9. CHARGING EMPLOYEES DIFFERENT PREMIUMS

In general, an employer is free to design their plan to charge employees different premiums as long as it is based on bona fide employment classifications or participation in a wellness activity or program. However, such plans must ensure they will pass nondiscrimination rules under both Internal Revenue Code (IRC) Section 125 and Section 105(h). The Section 125 rules apply to plans paid for on a pretax basis through a cafeteria plan. Although the rules under Section 105(h) are on hold for fully insured nongrandfathered plans, the nondiscrimination testing under Section 105(h) currently applies to self-insured plans, whether grandfathered or non-grandfathered. Additionally, assessing premium differentials based on the satisfaction of a health standard (such as not smoking or attaining a certain cholesterol level) is only permitted when it is part of a wellness program that satisfies the five criteria of the federal regulations. The premium differential is allowed to be as high as 30 percent (50 percent if the standard is tobacco-related).

10. CONFUSION SURROUNDING IMPUTED INCOME

Employees may only pay for certain qualified benefits, like health and dental insurance, for themselves, spouses, children who are under age 27 as of the end of the taxable year, and IRC Section 105(b) dependents. Due to the U.S. Supreme Court's decision in *US v. Windsor* and the IRS' subsequent ruling on the matter in Revenue Ruling 2013-17, effective Sept. 16, 2013, the definition of "spouse" is expanded to include any spouse where the marriage was performed in a valid jurisdiction, regardless of where the employee and spouse reside. In other words, employees may now pay for coverage for a same-sex spouse on a tax-preferred basis. In the past, the fair market value of coverage provided to a same-sex spouse would have to be added to the employee's income, a practice known as imputing income. No change was made to the imputed income calculation required for coverage provided to civil union partners, domestic partnerships and non-IRC Section 105(b) dependents.

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