Common Compliance Questions

Question 1 – HIPAA- Smoker Surcharge

My client wants to encourage its employees to quit smoking. For 2012, he wants to charge smokers a greater premium for health coverage. Is it possible to charge smokers a greater premium without violating the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")?

Yes. HIPAA generally prohibits a plan from discriminating among similarly situated individuals based on their health status. This means, among other things, that plans usually cannot charge individuals different premiums or impose different costs (i.e., through deductibles or co-pays) based on the presence or absence of a health factor. However, HIPAA also affirmatively recognizes that the nondiscrimination provisions were not meant to prevent a group health plan or an insurer from establishing premium discounts, surcharges or reduced co-payments or deductibles in return for "adherence to programs of health promotion and disease prevention," as provided under Code §9802(b)(2); ERISA §702(b)(2); PHSA §2705(b)(2). Thus, certain programs of health promotion or disease prevention (referred to as "wellness programs") are an exception to HIPAA's general nondiscrimination requirement.

In order to penalize smokers, any surcharge must be provided under a standard-based wellness program. Standard-based wellness programs that condition eligibility for a reward upon a participant's ability to meet a standard related to a health factor are permissible only if they meet the specific requirements set forth in 71 Fed. Reg. 75014 (Dec. 13, 2006).

Standard-based wellness programs must satisfy each of the following five requirements:

- The reward or penalty must be no more than 20% of the cost of coverage (30% starting in 2014);
- the program must be designed to promote health or prevent disease;
- The program must give individuals an opportunity to qualify for the reward at least once a year;
- The reward must be available to all similarly situated individuals; and
- The plan must disclose that alternative standards (or waivers) are available.

For a full explanation of each of the requirements, please review Field Assistance Bulletin No. 2008-02. A link to this bulletin is provided below:

http://www.dol.gov/ebsa/regs/fab2008-2.html

Question 2 – Cafeteria Plans -Health Flexible spending Account

When can a participant of a Health Flexible Spending Account receive reimbursements for medical expenses for a civil union spouse, a domestic partner or a child of either?

For participant of a Health Flexible Spending Account to receive reimbursements for the medical expenses for a civil union spouse, a domestic partner or a child of either, they must qualify as a qualifying relative under Code Section 105(b).

In order to be a qualifying relative under Code Section 105(b) of a participant, the individual must meet following requirements:

- an individual (other than someone who at any time during the taxable year was the spouse, determined without regard to Code Section 7703, of the participant) who for the taxable year of the participant (a) has the same principal place of abode as the participant; and (b) is a member of the participant's household (if this does not violate local law-some local laws prohibit cohabitation by unmarried partners);

- receives over half of his or her support from the participant;

- is not anyone's qualifying child; and

- is not an ineligible individual under Code Section 152. An individual generally will not be a dependent under Code Section 152 if he or she is someone who is not a citizen or national of the U.S., or a resident of the U.S. or a country contiguous to the U.S.

Question 3 – MSP Mandatory Reporting

If a participant in a Health Reimbursement Arrangement ("HRA") is reimbursed his or her entire allocated benefit amount for the plan year before the end of the plan year, does the "responsible reporting entity" ("RRE") have to report such termination of coverage to the Coordination of Benefits Contractor ("COBC") under the Medicare Secondary Payer Mandatory Reporting?

Yes. In an Alert released on September 27, 2011, the CMS Office of Financial Management/Financial Service Group indicated that a notice of termination has to be submitted to the COBC when an HRA insured's HRA benefit coverage is exhausted and no additional funds will be added to the HRA for the remainder of the current plan year for the HRA. A notice of the termination is to be provided to the COBC by including it in the RRE's next regularly scheduled MSP Input File Submission. The RRE may also call the COBC Call Center, at 1-800-999-1118 (TTY/TDD 1-800-318-8782), with the notice of the termination.

This new notice of termination requirement replaces language in Section 7.2.7 on page 67 of Version 3.2 of the GHP User Guide which had stated that a RRE was not required to submit a Termination Notice when the annual benefit value was exhausted, or only when coverage was not continued or not renewed in the subsequent plan year.

In the next plan year when the participant is provided with an additional annual benefit amount, the RRE must submit a new record on the MSP Input File for each Medicare beneficiary that is an active covered individual and whose HRA annual benefit is $5,000 or greater. The Effective Date (Field 10) should reflect the start date of the new coverage period.

Please remember that effective October 3, 2011, only HRA coverage that reflects an annual benefit level of $5,000 or more is to be reported under the Medicare Secondary Payer Reporting Provisions.

Question 4 – Controlled Groups

One of my clients has interests in several other businesses. Each sponsors its own qualified retirement and health and welfare plans. When would these businesses have to be tested together for nondiscrimination testing?

Various businesses would have to be treated as one employer for testing purposes if the requirements for a "Controlled Group" or an Affiliated Service Group" are met.

Members of a Controlled Group

As provided in Code §§414 (b) and (c), all employees of corporations which are members of a controlled group of corporations, or all employees of trades or businesses (whether or not incorporated) which are under common control, are treated as employed by a single employer. This aggregation is required, whether the common control is intentional (through an affirmative corporate transaction) or unintentional (through an inheritance or gift of the stock of a business). There are two ways to form a controlled group:

- Parent-subsidiary group: whenever a group of corporations, trades or businesses are controlled through at least 80% ownership by a common parent, as provided in IRS Regs. §1.414(c)-2(b)(2).

- Brother-sister group: the same five or fewer persons own at least 80% of each trade or business; and taking into account the ownership of each such person only to the extent his ownership is identical with respect to each of the trades or businesses, these persons own more than 50% of the trades or businesses, as provided in IRS Regs. §1.414(c)-2(b)(2).

The attribution rules are important, as constructive ownership is just as important as actual ownership, but attention to potential problems is often overlooked. The following general rules of attribution of ownership apply:

- Attribution from partnerships: An interest owned, directly or indirectly, by or for a partnership is considered to be owned by any partner having an interest of 5% or more in either the profits or capital of the partnership in proportion to that partner's interest in the profits or capital, as provided in IRS Regs. §1.414(c)-4(b)(2)(i).

- Attribution from estates or trusts: An interest in an organization owned, directly or indirectly, by or for an estate or trust is considered to be owned by any beneficiary of the estate or trust who has an actuarial interest of 5% or more in the organization interest. There are special rules for estates, as provided in IRS Regs. §1.414(c)-4(b)(3).

- Attribution from corporations: An interest owned, directly or indirectly, by or for a corporation is considered to be owned by any person who directly owns 5% or more in value of the stock in the proportion to which the value of the person's stock bears to the total value of the corporation's stock as provided in IRS Regs. §1.414(c)-4(b)(4.

- Spouse: By default, an individual is considered to own an interest owned, directly or indirectly, by or for his or her spouse, unless it can be shown that:

  (1) the individual does not, at any time during the taxable year, own directly any stock in the spouse's trade or business; (2) the individual is not a director or employee and does not participate in the management of the spouse's trade or business at any time during the taxable year; (3) the spouse's trade or business does not have more than 50% "passive" income for the taxable year; and (4) the spouse's ownership interest is not, at any time during the taxable year, subject to transfer restrictions running in favor of the other spouse or his minor children. This exception may not apply in a community property state unless the ownership interest held by the spouse is separate property.

  There is no attribution to a spouse who is legally separated from the individual under a decree of divorce, whether interlocutory or final, or a decree of separate maintenance, as provided in IRS Regs. §1.414(c)-4(b)(5).

- Children, grandchildren, parents, and grandparents: By default, an individual is considered to own an interest owned, directly or indirectly, by or for the individual's children who have not attained the age of 21 years, and if the individual has not attained the age of 21 years, an interest owned, directly or indirectly, by or for the individual's parents, as provided in IRS Regs. §1.414(c)-4(b)(6).

Members of an Affiliated Service Group

Unlike the controlled group rules which aggregate businesses based strictly on common ownership, the affiliated service group rule uses functional tests requiring analysis of the interrelationship among entities. Under these rules, aggregation is contingent upon one or more of the business entities constituting a "service organization," which is defined in the Code as an organization "the principal business of which is the performance of services

An organization is a service organization if capital is not a material income-producing factor for the organization or if it is engaged in a specified service field. Prop. IRS. Reg. §1.414(m)-2(f) lists the following as service fields: health, law, engineering, architecture, accounting, actuarial science, performing arts, consulting, and insurance. A service organization may be a sole proprietorship, partnership, corporation, or any other type of entity regardless of its ownership format as provided in Prop. IRS Reg. §1.414(m)-2(e). An affiliated service group is found in three types of business combinations.

The affiliated service group consists of a first organization (FO) and any other service organization which is a shareholder or partner of the FO or which regularly performs services for or with the FO, and any other organization that performs a significant portion of services for the FO and that is owned more than 10% by a Highly Compensated Employee of the FO, as provided in Code §414(m)(2).

Additionally, if one organization exists primarily to provide management services for another organization, then they form an affiliated service group, as provided in Code §414(m)(5). Like the controlled group rules, all employees of the members of an affiliated service group are treated as employed by a single employer, as provided in Code §414(m)(1).

Question 5 – Creditable Coverage under Medicare Part D

Who is required to receive a creditable coverage notice under Part D of Medicare?

Group health plans offering prescription drug coverage must disclose to all Part D eligible individuals enrolled in or seeking to enroll in the coverage and to CMS whether the prescription drug coverage is creditable as provided under SSA §1860D-13(b)(6 ; 42 U.S.C. §1395w-113(b)(6) , as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR §423.56.

A Part D eligible individual is an individual who (1) is entitled to benefits under Medicare Part A or is enrolled in Medicare Part B; and (2) lives in the service area of a Part D plan, as provided in SSA §§1860D-1(a)(3) and 1860D-41(a)(4); 42 U.S.C. §§1395w-101(a)(3) and 1395w-141(a)(4 , as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR §§423.4 and 423.30(a). The following will discuss these requirements.

Individuals who may be eligible for Part D include those who are active employees, disabled, and on COBRA; retirees; and their covered spouses and dependents (including spouses or dependents who are disabled or on COBRA).

Requirement #1: Individual Is Entitled to Benefits Under Medicare Part A or Enrolled in Medicare Part B

The first requirement for being a "Part D eligible individual" is being entitled to benefits under Medicare Part A or being enrolled in Medicare Part B as of the effective date of coverage under the Part D plan, as provided in SSA §§1860D-1(a)(3) and 1860D-41(a)(4); 42 U.S.C. §§1395w-101(a)(3) and 1395w-141(a)(4), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§423.4 and 423.30(a). To satisfy this requirement, an individual must meet one of two alternative tests, described below.

Entitled to Medicare Part A (Individual Must Actually Have Part A Coverage)

CMS interprets "entitled" to mean that an individual must be eligible for the Part A benefit and must have actually applied for and been granted coverage, as provided in Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193,4202. An individual will be "entitled" to Part A only if he or she is eligible for benefits under Part A and has actually applied for and been granted coverage-an individual doesn't become "entitled" to Part A simply because the individual is eligible.

Enrolled in Medicare Part B (Individual Must Actually Have Part B Coverage)

The same interpretation used for entitlement to Part A is used for the alternative test under Part D with respect to Part B, despite the fact that the alternative test uses the term "enrolled" rather than "entitled." Under Part B, an individual is considered to be enrolled when he or she has

applied for Part B coverage (or is deemed to have applied). Nevertheless, CMS doesn't believe that the interpretation of "enrolled" for Part B is the correct interpretation of "enrolled" for Part D. Instead, it interprets "enrolled under Part B" to mean that the individual is entitled to receive benefits under Part B, as provided in Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193,4202 (Jan. 28, 2005). For purposes of Part D, an individual is only "enrolled" in Part B if the individual has coverage under Part B.

Retroactive Effective Dates

Individuals who become entitled to Part A or enrolled in Part B for a retroactive effective date are Part D eligible as of the month in which the applicable notice of entitlement or enrollment is provided, as provided in 42 CFR §423.30(a).

Requirement #2: Individual Lives in the Service Area of a Part D Plan

The second requirement for being a "Part D eligible individual" is that the individual live in the "service area" of a Part D plan; what constitutes a service area varies according to the type of Part D plan, as provided in SSA §§1860D-1(a)(3) and 1860D-41(a)(4); 42 U.S.C. §§1395w-101(a)(3) and 1395w-141(a)(4), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§423.4 and 423.30(a).

Requirement #3: Part D Eligible Individual (Employee, Retiree, Spouse, or Dependent) Must Be "Enrolled in or Seeking to Enroll in" Employer's Prescription Drug Coverage

The disclosure requirement applies to all Part D eligible individuals "enrolled in or seeking to enroll in" the prescription drug coverage, as provided in 42 CFR §423.56(c). 42 U.S.C. §1395w-101(c) does not explain how to determine which individuals might be "seeking to enroll in" the prescription drug coverage. Until further guidance is released, it would reasonable to assume that it is sufficient to identify the individuals who would be eligible to enroll under the terms of the plan documents.

Question 6 – Family and Medical Leave Act

If the employee fails to pay his or her portion of the health insurance premium during FMLA leave and then fails to return from leave, does a qualifying event occur? If it does, does it occur on the last day of FMLA leave?

Under Treasury Regulations Section 54.4980B-10, Q/A-1(a)(1), the relevant consideration for an employee on FMLA leave (or spouse or dependent child of the employee) is whether the employee (or spouse or dependent child) is covered under the group health plan "on the day before the first day of FMLA leave (or becomes covered during the FMLA leave)."

A lapse of coverage during FMLA leave is irrelevant, as provided in Treasury Regulations Section 54.4980B-10, Q/A-3. Although COBRA contemplates a seamless transition from regular plan coverage to continuation coverage, under this special rule a plan may be required to "continue" coverage that already has been lost. Consequently, if the employee declines coverage (or fails to pay the employee portion of the premium for coverage) under the group

health plan during FMLA leave and then fails to return from leave, a qualifying event occurs on the last day of FMLA leave.

Question 7 – Health Savings Accounts

Can an employee participate in either a Health FSA or an HRA the same month and still be eligible to make or receive a contribution to an HSA?

No. The IRS provided in Revenue Ruling 2004-45 that an employee cannot participate in a Health FSA, an HRA and an HSA in the same month, unless the employee's situation is one of the following:

- The employee's expenses reimbursed under a Health FSA and/or an HRA are limited to dental, vision and/or preventive care benefits ("Limited Purpose Health FSA or HRA");
- If an employee suspends participation in an HRA for the year ("Suspended HRA");
- The Health FSA or the HRA pays medical expenses above the deductible of the HDHP ("Post-Deductible Health FSA or HRA"); or
- The HRA pays or reimburses the employee's medical expenses incurred after the employee retires ("Retirement HRA").

Question 8 – ERISA

Are voluntary benefit plans offered to employees subject to ERISA?

No. If the voluntary benefit plan meets the requirements for the safe harbor exemption under DOL Regulations Section 2510.3-1(j) for certain "voluntary employee-pay-all" arrangements.

Under the safe harbor exemption, the employer allows an insurer to sell voluntary policies to interested employees who pay the full cost of the coverage. This exemption permits employees to pay their premiums through payroll deductions and permits the employer to forward the deductions to the insurer. The employer may not, however, make any contribution toward coverage and the insurer may not pay the employer for being allowed into the workplace.

In addition, the employer may not "endorse" the program. For an endorsement not to be found, the insurer, not the employer, must be the entity offering the plan.

Any involvement by the employer (beyond permitted activities in connection with premium/payroll deductions) may take the arrangement outside the exemption and make it subject to ERISA.

Among the activities identified as relevant by the many court cases interpreting this exemption are-

- assisting employees with preparation of claims forms;
- negotiating with insurers;

- recommending the plan to employees;
- recordkeeping (other than maintaining a list of enrolled employees); and
- allowing payroll deductions to be made on a pre-tax basis under the employer's cafeteria plan.

Question 9 – Cafeteria plans

When can an employer allow a participant under a cafeteria plan to change his or her election during the coverage period?

A participant's elections under a cafeteria plan must be irrevocable and cannot be changed during the period of coverage. This is generally the 12-month requirement. Employers are not required to allow any exceptions to this rule. It is very common for most employers allow participants to change their elections during the plan year if the participant experiences an event that falls under one of several exceptions allowed by the IRS under the regulations. It is up to the employer to specify less than all of the exceptions or make the exceptions more restrictive than the tax laws require.

The IRS regulations generally provide 12 different permitted election change events that can warrant a mid-year election changes. These events must be provided in the plan document and the employee summaries.

Please remember that some events provided below do not apply to all of the benefits offered under a cafeteria plan. The right to change elections in the case of a significant cost increase or coverage changes does not apply to health FSAs.

In addition, under proposed cafeteria regulations, a participant must be allowed to change his or her HSA contribution election at least once a month for any reason.

The following events permit a participant to change his or her election under the federal tax laws if the plan so provides (and if permitted for that particular benefit by the tax laws):

1. Change in Status

If certain "changes in status" occur for the participant, or for his or her spouse or dependents, then the participant may change the appropriate election, if the plan so provides. The following events are considered changes in status by the IRS under the regulations:

- a change in the participant's marital status;
- a change in number of dependents;

- a change in employment status;
- a dependent's satisfying or ceasing to satisfy dependent eligibility requirements;
- a change in residence; and
- commencement or termination of adoption proceedings.

The election change generally must be on account of and correspond with a change in status that affects eligibility for coverage under an employer's plan (including a change in status that results in an increase or decrease in the number of a participant's family members or dependents who may benefit from coverage under the plan).

2. Cost Changes, With Automatic Election Increases/Decreases

If benefit premiums for a employer's plan go up by an insignificant amount (e.g., 1%) in the middle of the plan year, then an employer can automatically adjust payroll so that the excess will be paid with pre-tax dollars, assuming that the cafeteria plan so provides in documentation. This is permitted because automatic increases and decreases to participants' elected contributions for a qualified benefits plan may be made to reflect changes in the cost of the plan.

3. Significant Cost Changes

If an employer's benefit premiums increase by a significant amount (e.g., 30%) in the middle of a plan year, participants may make corresponding election changes, if the plan so provides. These include:

- commencing participation in the plan for the option that decreased in cost; or
- in the case of a cost increase, revoking an election for that coverage and either receiving coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available.

As a result, participants may elect to increase their salary reductions for coverage. Alternatively, if a employer offers more than one coverage option, participants may revoke their elections for the option that has increased in cost and switch to another option. And if no other option providing similar coverage is available, then employees can drop their coverage entirely.

4. Significant Curtailment of Coverage

If a participant (or his or her spouse or dependent) has a significant curtailment of coverage during a coverage period that is not a "loss of coverage," a participant may revoke his or her election for that coverage and elect instead to receive coverage under another benefit package

option providing similar coverage. If the curtailment constitutes a loss of coverage, the participant may revoke the election for that coverage and either receive coverage under another benefit package option providing similar coverage or drop coverage if no similar benefit package option is available. In both cases, a participant's election may be changed only if the plan so provides.

5. Addition or Improvement of Benefit Package Option

If a plan adds or significantly improves a coverage option, and if the plan so provides, participants may revoke their elections and elect coverage under the new or improved benefit package option. If a new health coverage option is added, participants can elect to drop coverage under the old option and switch to the new one. This change of election is allowed even for employees who had not previously participated in the cafeteria plan or elected the coverage option, assuming that the plan so provides.

6. Change in Coverage of Spouse or Dependent Under Another Employer Plan

A participant may make an election change that is on account of and corresponds with a change in coverage under another employer plan (including a plan of the same employer or a plan of a spouse's or dependent's employer) if one of two conditions are met (and if the employee's cafeteria plan provides for such an election change):

- Either the other cafeteria plan or qualified benefits plan must permit participants to make an election change that would be permitted under the IRS election change rules, or

- the period of coverage under the employee's cafeteria plan must be different from the period of coverage under the other employer plan.

7. Loss of Certain Other Health Coverage

A participant may make a prospective election to add coverage under a cafeteria plan for him or herself, his or her spouse, or other dependents if any of them lose group health coverage sponsored by a governmental or educational institution. Such coverage includes a state's children's health insurance program (SCHIP); a medical care program of an Indian tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan. The plan document must also permit the change.

8. HIPAA Special Enrollment Rights

HIPAA requires group health plans to provide special enrollment opportunities for certain persons after the initial enrollment period. A special enrollment right can arise as a result of a loss of eligibility for coverage under a group health plan or through health insurance. A special enrollment right can also arise if a new spouse or dependent is acquired by marriage, birth, adoption, or placement for adoption. The cafeteria plan may allow a participant to make an

election change under the cafeteria plan to correspond with these HIPAA special enrollment rights.

9. COBRA Qualifying Event

The cafeteria plan may permit a participant to increase pre-tax contributions for coverage if a qualifying event under COBRA occurs with respect to him or her or his or her spouse or other dependent-such as loss of eligibility for regular coverage due to loss of dependent status under the health plan or a reduction of hours.

10. Judgments, Decrees, or Orders

If a judgment, decree, or order (including a qualified medical child support order) resulting from a divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for a participant's child, then he or she may change his or her election to:

- add coverage if the order requires coverage for the child under the participant's plan; or
- drop coverage if the order requires another individual to provide coverage for the child and the coverage is actually provided.

11. Entitlement to Medicare or Medicaid

If a participant (or the participant's spouse or dependent) becomes entitled to Medicare or Medicaid coverage (i.e., becomes enrolled), then the participant may make a prospective election change to cancel or reduce health coverage under the employer's plan and to make a corresponding change in salary reductions. Loss of Medicare or Medicaid entitlement also allows a participant to make a new election or increase health coverage under the employer's plan. In each case, the plan must provide for the election change.

12. FMLA Leave

A participant may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as provided under the FMLA and IRS rules. For a participant continuing group health plan coverage during an unpaid leave, three payment options can apply, depending on how the plan is drafted. Participant can:

- prepay their contributions on a pre-tax basis (provided that the leave does not straddle two plan years);
- make payments on a pay-as-you-go basis; or

- catch up on the contributions after returning from leave.

Question 10 – COBRA

When any qualified beneficiary (including the covered employee) first becomes entitled to Medicare after electing COBRA coverage, his or her COBRA coverage can be terminated early (i.e., before the end of the maximum coverage period). This rule does not, however, affect the COBRA rights of other qualified beneficiaries in a family unit who are not entitled to Medicare (for example, the spouse and dependent children of a Medicare-entitled former employee).

For COBRA purposes, what does "entitlement to Medicare" mean?

Under COBRA, the term "entitlement" means that an individual who is eligible for Medicare has actually become enrolled in Medicare, as provided under Treas. Reg. § 54.4980B-7, Q/A-3(b)

In other words, an individual is entitled to Medicare only if he or she may currently receive benefits. If the individual must take additional steps to enroll in Medicare before receiving benefits, then that individual is not "entitled" to Medicare for purposes of the COBRA rules until the steps have been taken and the enrollment has become effective.

A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier.