November 2, 2018

In This Edition:

CBIZ Benefits & Insurance Services

Our business is growing yours

www.cbiz.com

Wellness Programs: Litigation Matters and EEOC Regulation Pushback

Violation of HIPAA Wellness Program Rules

The Department of Labor (DOL) brought forth litigation against an Ohio-based corporation over its wellness program design, citing violation of the HIPAA rules relating the discrimination based on health status, as well as breach of fiduciary duty by the plan sponsor.

In the matter of *United States Department of Labor v. Chemstation International, Inc. et al* [Docket No. 3:18-cv-00338 (S.D. Ohio Oct 15, 2018]), the company sponsors a self-insured group health plan, together with a rewards-based wellness program. Employees participating in the wellness program would receive premium discounts toward health coverage as long as they attained and maintained a specified number of healthy outcomes such as body mass index, blood pressure, LDL cholesterol and glucose levels, as well as for nonuse of tobacco products. Those who failed to maintain healthy outcomes or declined to participate in the wellness program were charged higher premiums for health coverage. The company did not offer a reasonable alternative way for individual to achieve the reward as required by the HIPAA law.

The parties settled the matter on October 17, 2018. In accordance with the terms of the court order, Chemstation is required to pay $59,189 reflecting excess withheld premium and lost opportunity costs directly to the affected current and former participants.

The lesson to be learned here is that it is essential to comply with all legal requirements of a wellness program. Failure to do so is a matter that the governing agencies will pursue.

.

Continued from Page 1

Violation of GINA's Employment Discrimination Rules

The Equal Employment Opportunity Commission (EEOC) recently settled a charge against an Indiana company for violation of the Genetic Information Non-Discrimination Act (GINA) employment discrimination rules. In this matter, job applicants and employees were asked to complete post-offer occupational health questionnaires that required disclosure of family medical history, including parents and siblings' history with cancer, diabetes, heart disease and stroke.

The EEOC determined that this conduct violates GINA which provides protection for individuals against employment discrimination, based on his/her genetic information including family medical history. Further, GINA prohibits employers from requesting, requiring or purchasing genetic information from applicants or employees.

To resolve the matter, the company agreed to pay $62,000 in monetary relief to the affected individuals, as well as amend its workplace policies, and provide internal GINA training to avoid further violation. This case is an important reminder for employers to comply with all requirements of the law.

Delay of EEOC Wellness Regulations

It appears that the release of the long-awaited revisions to the Equal Employment Opportunity Commission's (EEOC) wellness program rules relating to the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, particularly those relating to wellness incentives, has been pushed back until next summer.

As background, last August, the U.S. District Court for the District of Columbia vacated a portion of the EEOC's wellness program rules in the *AARP v. EEOC* case; specifically, any wellness incentive based on the collection of medical information derived from a disability-related inquiry or medical examination will not be permitted beginning January 1, 2019 (see our prior *Benefit Beat* articles from April, February and January, 2018 and September, 2017 editions).

The Court further directed the EEOC to re-evaluate other aspects of its rules released in 2016, specifically, the 30% ceiling on the use of incentives, rewards or penalties for participation in a wellness program. These revised rules were initially designated for release sometime in January, 2019.

However, according to the EEOC's Fall Regulatory Agenda, these regulations are not expected to be released until summer, 2019.

A Nationwide End to Gag Clauses

As part of the current Administration's efforts to control prescription drug costs, President Trump signed two new laws on October 10, 2018. These laws, known as the "*Patient Right to Know Drug Prices Act*" (**S. 2554**, P.L. 115-263) applicable to individual and group health plans in the private market, and the "*Know the Lowest Price Act of 2018*" (**S. 2553**, P.L. 115-262), applicable to Medicare Prescription Drug Plan sponsors and Medicare Advantage organizations, are intended to end the so-called "gag clauses" in insurance contracts.

The intent of these laws is to prevent pharmacists from advising individuals about differences between the price, copayment, or coinsurance of a drug under a health plan, and a lower price of the drug without health insurance coverage. Historically, some state insurance laws have governed gag clauses in insurance contracts; these new laws will provide federal protection for consumers.

The law impacting individual and group health insurers took effect on the date of signage; the law impacting Medicare prescription drug plans becomes effective for plan years beginning on or after January 1, 2020.

Massachusetts: Required HIRD Form Due November 30th

As part of the Massachusetts health care reform law, employers employing six or more employees in the Commonwealth are required to make an Employer Medical Assistance Contribution (EMAC) to help fund health coverage for the uninsured. Further, these employers are required to annually file the Health Insurance Responsibility Disclosure (HIRD) form (see *Massachusetts: Employer Medical Assistance Contribution Updates and New Annual Reporting Obligation, Benefit Beat*, February 7, 2018).

The Massachusetts Department of Revenue just released a **set of FAQs** relating to the HIRD reporting form. The purpose of this form is to assist MassHealth in identifying those individuals with access to employer sponsored coverage who may be eligible for premium assistance.

The form is required to be filed by any employer employing 6 or more employees in any month during the

past 12 months preceding November 30th of the reporting year, without regard to whether the employer offers health coverage. Individuals included in quarterly wage reports to the Department of Unemployment Assistance are deemed to be employees.

This form can only be filed online through the MassTaxConnect portal. Reporting entities must log into the portal in order to obtain the HIRD form. The type of information requested for completing this form relates to employer-provided health coverage; specifically, insurance-related information, such as premium cost, types of benefits offered, cost sharing details and eligibility. The form does not collect individually identifiable information.

This report is due annually by November 30th of the reporting year, beginning in 2018. While third party payroll vendors can assist in completing the form, it is ultimately the employer's responsibility. The form is not used to assess penalties against the employer for failure to offer health coverage. A penalty for failure to complete the HIRD form, though, could be imposed.

HHS Increases Penalties for Compliance Failures

Employee benefit plans are subject to oversight by several government regulatory agencies including Health and Human Services (HHS), and the Departments of Labor and Treasury. These governing agencies may adjust certain monetary civil penalties for compliance failures.

To this end, on October 11, 2018, HHS published its annual inflationary adjustments for civil penalties relating to violations of the HIPAA privacy, security and breach rules, failure to provide the summary of benefits and coverage to plan participants, as well as violations relating to the Medicare secondary payor rules.

Following are highlights of the changes. These penalties take effect on October 11, 2018.

HIPAA Privacy, Security and Breach Rules

HHS regulates entities subject to the HIPAA Administrative Simplification laws; specifically, covered entities, which include health care providers, health care clearinghouses, and health plans, as well as business associates. In the event of a breach of unsecured health information of individuals, one of the obligations of the covered entity is to provide notification of the breach to affected individuals, as well as notify the media and HHS in certain circumstances. Failure to adhere to these rules by a covered entity could result in civil penalties.

There are four tiers of civil penalties that could be imposed; following are the inflation-adjusted amounts of potential penalties:

Violation category	*Each violation*	*All such violations of an identical provision in a calendar year*
Did not know a violation occurred	$114 to $57,051	$1,711,533
Violation due to reasonable cause and not willful neglect	$1,141 to $57,051	$1,711,533
Violation due to willful neglect but corrected	$11,410 to $57,051	$1,711,533
Violation due to willful neglect and not corrected	$57,051, no maximum	$1,711,533

Summary of Benefits and Coverage

The Affordable Care Act requires all group health plans, including grandfathered plans, whether insured or self-funded to provide a written summary of benefits and coverage (SBC) to plan participants. There are five instances in which the SBC must be provided: upon application, by the first day of coverage, within 90 days of special enrollment period, upon contract renewal and upon request. Failure to provide the SBC could result in HHS penalties, as well as penalties imposed by the Departments of Labor and Treasury. For HHS purposes, the potential civil penalty for willful failure to provide the SBC is increased to $1,128 per failure (up from $1,105 in 2017).

Medicare Secondary Payor Rule Violations

In certain instances in which employer-provided health coverage is available, Medicare only pays after the employer plan pays. The rules governing these situations are known as the Medicare Secondary Payer Rules (MSP rules). These rules are generally applicable to the working aged, individuals with end stage renal disease and certain disabled individuals.

Working-aged Rule Violations

As background, the working aged MSP rule applies to employers with at least 20 full and/or part-time employees on each working day in each of 20 or more calendar weeks in the current or preceding calendar year. In this category, employer-provided health coverage is the primary payer and Medicare is the secondary payer for the working aged.

The MSP working aged rules require benefits for individuals aged 65 and over in current employment

status, as well as his/her spouse, aged 65 or older must be the same as those available to individuals under age 65. Further, these individuals must be given the same right to participate in the employer-sponsored plan as those individuals under age 65.

An individual who becomes entitled to Medicare due to age can, of his/her own volition, choose to decline or drop employer-sponsored coverage; thus, an employer cannot encourage nor induce the individual to choose Medicare over its plan. The penalty for Instances in which an employer or other entity offers any financial or other incentive to Medicare-eligible individuals to not enroll in a plan that would otherwise be primary will increase to $9,239 per violation (up from $9,054). Further, willful or repeated failures to provide timely and accurate information requested relating to an employee's group health insurance coverage could result in a $1,504 per violation penalty, (up from $1,474 in 2017),

Medicare Mandatory Reporting Violations

For the past decade, insurers, third party administrators (TPAs) and plan administrators of self-funded, self-administered health plans (known as, responsible reporting entities, "RRE") have been subject to a Medicare secondary payor reporting rule. The purpose of this reporting obligation is to ensure that the Medicare secondary payor rules are properly administered. These entities are required to register with the Centers for Medicare and Medicaid Services and accomplish the required reporting through the CMS' dedicated website. The penalty for failure to provide information that identifies situations where the group health plan is or was a primary plan to Medicare to the HHS Secretary pursuant to this reporting obligation will increase to $1,181 per failure (up from $1,157 in 2017).

2019 Pension and Retirement Plan Limits

The IRS released the 2019 cost of living adjustments (IRS Notice 2018-83) applicable to defined benefit and defined contribution plans (highlights below).

	2019	2018
◆ Defined benefit plan annual limit	$225,000	$220,000
◆ Defined contribution plan annual limit	$56,000	$55,000
◆ Elective deferral limit for purposes of cash or deferred arrangements (401(k) plans) and tax-sheltered annuities (403(b) plans)	$19,000	$18,500
◆ Maximum deferral limit for 457 plans	$19,000	$18,500
◆ >Age 50 catch-up contribution limit to 401(k), 403(b) or 457(b) plans	$6,000	$6,000
◆ Maximum deferral limit for SIMPLE plans	$13,000	$12,500

Pension-Retirement Plan COLAs, cont'd

	2019	2018
◆ >Age 50 catch-up contribution limit to SIMPLE plans	$3,000	$3,000
◆ Minimum compensation considered in determining eligibility for a SEP (simplified employee pension)	$600	$600
◆ Threshold for highly compensated employee (HCE)	$125,000	$120,000
◆ Key employee compensation limit for top heavy plan purposes	$180,000	$175,000
◆ Annual compensation limit	$280,000	$275,000

Also see related IRS News Release, 401(k) contribution limit increases to $19,000 for 2019; IRA limit increases to $6,000.

2019 Social Security Cost-of-Living Adjustment

On October 11, 2018, the Social Security Administration announced a 2.8 percent cost of living adjustment for 2019.

The Social Security wage base in 2019 will increase to $132,900, from the 2018 wage level of $128,700. The combined Social Security and Medicare tax rate remains at 7.65% - the Social Security portion is 6.2% on wages up to the applicable maximum taxable amount; the Medicare portion is 1.45% on all wages.

As a reminder, the Affordable Care Act imposes an additional 0.9% Medicare tax on high wage earners, applicable on earnings in excess of $200,000 in a calendar year. The Internal Revenue Service provides a set of FAQs explaining the additional tax.

Additional adjustments are included in the SSA's Fact Sheet: ***2019 Social Security Cost-of-Living Adjustments.***

2019 Medicare Premiums and Deductibles

The Centers for Medicare & Medicaid Services (CMS) announced the 2019 premiums and deductibles for the Medicare Part A and Part B programs. Following are highlights of the changes.

Medicare Part A - Premium and Deductible

- Generally, there is no monthly Part A premium for those with 40+ quarters of Medicare-covered employment. Individuals who have at least 30 quarters of coverage can buy Part A for $240 in 2019; those with less than 30 quarters can buy Part A for $447 per month.
- Part A deductibles in 2019 will increase to $1,364 for first 60 days of inpatient care; an additional $341 coinsurance per day for 61st through 90th day, and

an additional $682 per day coinsurance beyond the 90th day.

Medicare Part B - Premium and Deductible

The annual deductible in 2019 will increase to $185, up from $183 in 2018. The monthly premium will increase to $135.50 for 2019, up from $134 in 2018. However, the amount of monthly premium is adjusted based on revised income levels, as reflected in the chart below:

Beneficiaries filing individual tax returns with income:	*Beneficiaries filing joint tax returns with income:*	*Income-related monthly adjustment amount*	*Total monthly premium amount*
≤ $85,000	≤ $170,000	$0.00	$135.50
> $85,000 and ≤ $107,000	> $170,000 and ≤ $214,000	$54.10	$189.60
> $107,000 and ≤ $133,500	>$214,000 and ≤ $267,000	$135.40	$270.90
> $133,500 and ≤ $160,000	>$267,000 and ≤ $320,000	$216.70	$352.20
>$160,000 and <500,000	>$320,000 and <$750,000	$297.90	$433.40
≥ $500,000	≥ $750,000	$325.00	$460.50

For high-income beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, the Medicare Part B premiums in 2019 are:

Amount of Income	*Income-related monthly adjustment amount*	*Total monthly premium amount*
≤ $85,000	$0.00	$135.50
> $85,000 and <$415,000	$297.90	$433.40
≥ $415,000	$325.00	$460.50

The monthly premium for Medicare Advantage (Part C) and Part D coverage vary by the selected plan.

For 2019, the estimated Medicare Advantage average monthly premium will decline by $1.81 to $28.00 from 2018. The basic Part D premium is also expected to fall from $33.59 in 2018 to $32.50 in 2019.

Additional information about these limits was **released** earlier this year.

Further details about Medicare's premium and deductibles is available from **Medicare's *2018 and 2019 Costs at a Glance*** and a **CMS Fact Sheet**.

ABOUT THE AUTHOR:

Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law. Ms. McLeese is based in the CBIZ Kansas City office.