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WELLNESS RULES UNDER SCRUTINY

Two recent developments in the wellness program arena bear monitoring.

Challenging EEOC's Voluntary Standards. In response to the wellness program final regulations issued by the Equal Employment Opportunity Commission on May 17, 2016, the American Association of Retired Persons (AARP) brought a lawsuit against the EEOC, challenging the voluntary standards of the 30 percent requirement.

As background, the EEOC's regulations relating to the Americans with Disabilities Act (ADA) wellness standards prohibit the collection of medical information except to the extent that the request is voluntary (see *Wellness and the ADA – More Guidance Issued, Benefit Beat,* 7/7/16 and our Special Edition of *At Issue*, dated May 25, 2016, for a summary of the EEOC rules). Accordingly, the use of incentives (financial or in-kind such as time-off awards, prizes, or other items of value) in a wellness program, whether in the form of a reward or penalty, is permissible. If the wellness program is a participatory program or a health-contingent program, or some combination of the two, the maximum allowable incentive available under the program is 30 percent. The AARP challenged the 30 percent standard alleging that the 30 percent threshold is too high to constitute a voluntary standard.

In its review, the Court determined that the EEOC did not provide adequate substantiation for the 30 percent standard; therefore, the matter is returned to the EEOC for further consideration and validation of the 30 percent standard. The Court did say, though, that the May 2016 regulations will remain in effect until further analysis is provided by the EEOC. The Court's position is that plans have been implemented based on these regulations and to suspend them at this time would be too disruptive.

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Employers sponsoring wellness programs should stay tuned for future developments. It is unclear when the EEOC will have an opportunity to review these regulations since many of the EEOC's administrative and enforcement team positions remain unfilled.

Failure to provide reasonable alternatives to achieve wellness goals. The Department of Labor (DOL) is challenging Macy's benefit package, specifically relating to its smoking cessation component of its wellness program in a civil action complaint filed on August 16, 2017 in the U. S. District Court for the Southern District of Ohio (*Acosta v. Macy's Inc.* , S.D. Ohio, No. 1:17-cv-00541). The challenge alleges that Macy's failed to provide a reasonable alternative to participants which would have enabled them to avoid a tobacco surcharge, ranging from $35 to $45, for those who failed to meet the standards of Macy's tobacco cessation program.

As background, a contingent wellness program, whether activity or outcome-based, must provide a reasonable alternative to individuals under certain circumstances. Generally, a smoking cessation program can qualify as a reasonable alternative. The DOL alleges that Macy's continued to charge the smokers the higher rate without giving them an opportunity to achieve the reward.

Employers should review their wellness program to ensure that reasonable alternatives are provided and full rewards are granted to individuals who accomplish the reasonable alternative.

Procedures Important, Even in Denial

ERISA sets forth specific claims and appeal rules to be followed by health and welfare benefit plans, as well as retirement plans. Accordingly, plans are required to provide written notice of claim denials to participants and beneficiaries, in clear, easily understood language, setting forth the specific reasons for the denial, together with information about how the individual could seek a full and fair review of the denied claim. The plan's specific procedures, together with the relevant timeframes for processing claims and appeals, must be set forth in the plan document, as well as the summary plan description (SPD).

A recent case highlights the importance of providing adequate information to enable beneficiaries to exercise their rights under claims and appeals procedures. In *Turner v. Volkswagen Grp. of Am., Inc.*, 2017 WL 3037803 (S.D. W. Va. 2017), an employee was covered under a group plan that included health, life and disability benefits. Following the covered employee/participant's death, his surviving spouse sought the proceeds from the life insurance and long term disability benefits under the plan. While the employee/participant had received confirmation of coverage prior to his death, the insurer denied both the life and LTD benefits. Upon the spouse's inquiry relating to denial of the group life benefit, she subsequently received a letter from the employer/plan sponsor stating that an appeal of the denial must be accomplished within 60 days of the denial, together with the plan's SPD. The Court determined that the denial letter failed to reference the specific plan's internal review procedures in the body of the denial letter and merely enclosing the SPD was insufficient notification to enable the spouse to timely file an appeal.

Harvey Aftermath: Benefit Plan Assistance

Several government agencies including the Internal Revenue Service (IRS) and Department of Labor (DOL) are providing assistance and guidance to assist individuals and businesses affected by Hurricane Harvey. Following are highlights of guidance issued thus far.

- **Retirement plans**. Certain restrictions on plan loans and hardship distributions from retirement plans are eased for participants impacted by the hurricane, according to IRS Announcement 2017-11.
- Plan sponsors of **group health plans** are encouraged to provide reasonable accommodations to prevent loss of benefits by plan participants and beneficiaries who may be unable to meet certain deadlines for filing benefit claims or COBRA elections. See the DOL Compliance Guidance and FAQs for Participants and Beneficiaries for additional information.
- **Leave-based donation programs.** In Notice 2017-48, the IRS provides for certain tax relief for leave-based donation programs set up by employers to aid Hurricane Harvey victims. Under these programs, employees can elect to forgo vacation, sick, or personal leave in exchange for cash payments that the employer makes to charitable organizations. For income and employment tax purposes, leave donations would not be considered wages and thus, are tax free, as long as the employer provides these amounts to charitable organizations (as defined in Code Section 170(c)) before January 1, 2019.
- **Tax Filings**. Relief is available for certain tax filings and payments (see IRS' Tax Relief for Victims of Hurricane Harvey in Texas). Specifically, an extension is available for filing the Form 5500 series. This relief is not extended, however, for the Form W-2 nor the Forms 1094 and 1095.

Additional information relating to tax relief can be found on the IRS's dedicated webpage, Hurricane Harvey Information Center.

Looking ahead as other hurricanes are currently brewing, employers and plan sponsors are encouraged to monitor the IRS and DOL websites should the need for disaster assistance and guidance arise.

Another Delay in Fiduciary Rule Implementation

As has been anticipated for some time, the Department of Labor (DOL) is proposing delaying the January 1, 2018 effective date for certain aspects of fiduciary rules. On August 31, 2017, the DOL's Employee Benefits Security Administration (EBSA) published proposed regulations which would delay, until July 1, 2019, full implementation of the fiduciary rule's Best Interest Contract (BIC) exemption, the Principal Transactions Exemption, and certain amendments to a Prohibited Transaction Exemption. In addition, EBSA issued a Field Assistance Bulletin which sets forth an enforcement policy relating to an arbitration provision in the BIC Exemption and Principal Transaction Exemption.

For background information relating to the investment advice rules, see the May and December 2016 editions of our *At Issue* newsletters, and our *Benefit Beat* implementation coverage this year from the June 13th, April 10th , March 3rd, and February 15th editions.

As is currently the standard, investment advisers must comply with the impartiality standards contained in the fiduciary advice rules that require:

1. Any advisement rendered by a fiduciary must be in the best interest of the investor,
2. The fiduciary must take no more than reasonable compensation for such advice, and
3. The fiduciary must avoid making materially misleading statements.

Comments on these regulations are due by September 15, 2017. In the meantime, compliance with the impartiality standards as described above must continue to be maintained.

Possible Delay or Amendments to Enhanced Disability Claim Rules

The Department of Labor's Employee Benefits Security Administration (EBSA) released final rules on December 19, 2016 providing for enhanced standards for plans that make disability determinations (see *Disability Determinations: New Enhanced Rules Are Coming* (*Benefit Beat*, 1/5/17). These enhanced rules become applicable to all claims for disability benefits filed on or after January 1, 2018, and apply to any ERISA plan that makes a disability determination, including short and long term disability plans and retirement plans if such plan makes a disability determination.

On July 20, 2017, the DOL and EBSA submitted notice to the Office of Management and Budget indicating its intent to delay or amend these final rules due to questions of law and policy. The rationale for the delay or amendment is not publicly available at this time. In this interim, unless and until any amendment or delay is formally announced or put in place, plan sponsors are encouraged to review their current claims and appeal procedures to ensure compliance with the expanded rules.

Overtime Rules Thrown Out for Now

Many will recall that modification to the Department of Labor's (DOL) Wage and Hour Division overtime rules were to take effect on December 1, 2016. In large part, these rules would have changed the salary basis on which overtime is determined, raising it from an equivalent of $23,660 per year to a new level equivalent of $47,476 per year, and tying it to a regular inflationary increase.

On the eve of its effective date, the U.S. District Court of Eastern District of Texas granted a preliminary injunction preventing the DOL from implementing and enforcing the rules. Then, on December 1, 2016, the Department of Justice (DOJ), on behalf of the DOL, filed for an appeal of the District Court's preliminary injunction ruling, and subsequently filed a request for expedited briefing and oral arguments in the Fifth Circuit Court of Appeals on the following day. This was followed by a reply brief filed by the DOJ with the Court on June 30, 2017. Then, just a few days ago, on August 31, 2017, that same District Court has thrown out the overtime rules altogether. It is possible that an appeal could be filed, but for the moment, the overtime rules will not take effect.

Revised Medicaid/CHIP Premium Assistance Notice

Employers sponsoring health plans are obligated to annually provide a premium assistance notice to their workforce. This notification can be accomplished by using a model notice provided by the DOL's Employee Benefit Security Administration (EBSA). The model Medicaid/CHIP notice has been revised and is current as of August 10, 2017. Following are the changes to the revised notice, as compared to the January 31, 2017 version:

- In Massachusetts and Rhode Island, the phone numbers for the relevant agencies have changed;

- Both the website address and phone number for the Medicaid agency in Nebraska have changed; and
- The Medicaid website address has changed in West Virginia.

And finally, EBSA's website address that appears at the end of the model notice has been updated.

The notice explaining the right to premium assistance must be provided to employees residing in the below-listed states at least once annually, without regard to where the employer is located, or where the health plan is situsued:

States with Premium Assistance		
Alabama	Minnesota	Pennsylvania
Alaska	Missouri	Rhode Island
Arkansas	Montana	South Carolina
Colorado	Nebraska	South Dakota
Florida	Nevada	Texas
Georgia	New Hampshire	Utah
Indiana	New Jersey	Vermont
Iowa	New York	Virginia
Kansas	North Carolina	Washington
Kentucky	North Dakota	West Virginia
Louisiana	Oklahoma	Wisconsin
Maine	Oregon	Wyoming
Massachusetts		

The revised Medicaid/CHIP notice is available for viewing and/or downloading from the DOL's website, in both English (pdf or word) and Spanish (pdf or word).

Reminder: Distribute Medicare Part D Notices by October 15th

Plan sponsors have an annual obligation to provide the Medicare Part D creditable notices to Medicare-eligible individuals. The annual Medicare Part D open enrollment period for the 2018 year begins October 15, 2017 and runs through December 7, 2017.

The Medicare Part D Notice of Creditable or Non-creditable Coverage must be provided to Medicare-eligible individuals at least annually, prior to the Medicare Part D open enrollment period. This means that all Medicare Part D notices of creditable or non-creditable coverage must be provided within the 12-month period ending on October 15, 2017.

The Centers for Medicare and Medicaid Services (CMS) provide model language that can be tailored by plan sponsors to satisfy their notice obligation:

- Model Individual Creditable Coverage Disclosure Notice Language (English or Spanish)
- Model Individual Non-Creditable Coverage Disclosure Notice Language (English or Spanish)

New York Paid Family Leave Law Updates

As follow-up to last month's *Benefit Beat* article discussion of the New York Paid Family leave (PFL) law, this article discusses some recently released guidance relating to reporting of employee contributions, as well as some additional compliance tips for employers.

Reporting Contributions on Form W-2. The New York Department of Taxation and Finance released guidance relating to the tax consequences of this law. Under the PFL law, an employee can be required to pay the full cost of the benefit. The tax guidance indicates that the premium is to be paid on an after-tax basis and reported on the employee's Form W-2, using Box 14 (state disability insurance taxes withheld). PFL benefits are taxable non-wage income that must be included in federal gross income. Generally, withholding is not automatic, though, the individual beneficiary can request withholding. The benefits paid are reported by the payer (generally, the insurer) on a Form 1099-MISC.

Next Steps for Employers. In light of the final regulations adopted by New York Workers' Compensation Board and Department of Financial Services, following are some steps for employers to consider in an effort to ensure compliance with the law when it takes effect on January 1, 2018.

1. Contact your state temporary disability insurer to begin the process of obtaining a PFL policy.
2. Determine, in conjunction with your insurer, what, if any, payroll deduction will be collected from your employees.
3. Develop an internal PFL policy. Points to include:
   - *Eligibility*. Generally, employees who regularly work a minimum of 20 hours per week are eligible for PFL benefits after 26 consecutive weeks of employment; those working fewer than 20 hours a week are eligible after 175 work days.
   - *Funding sources* addressing whether contributions will be derived solely by the employee contributions through a payroll deduction process, or, whether the employer fully funds the benefit, or perhaps a combination of both employee/employer contributions;
   - *A description of how leave can be used*. Under the PFL law, instances giving rise for the need for leave include baby bonding, to provide physical or psychological care to a family member with a serious health condition; or to relieve family pressures when the employee's spouse, domestic partner, child, or parent is on active military duty.

Leave taken to attend to the employee's own serious health condition would be handled through the state temporary disability program.

- *Definition of family member*. Keep in mind that the law defines family member as a biological, adopted or foster child, a parent, grandparent, grandchild, spouse, or domestic partner.
- *Amount of leave available*. The law requires that PFL benefits must be available to an eligible employee for the first full day when family leave is required and thereafter during the continuance of the need for family leave, subject to limitations below:

Effective Date	Weekly amount of PFL per any 52-week period	Amount of Benefit	Benefit Cap
January 1, 2018	8 weeks	50% of employee's average weekly wage	50% of the state average weekly wage
January 1, 2019	10 weeks	55% of employee's average weekly wage	55% of the state average weekly wage
January 1, 2020	10 weeks	60% of employee's average weekly wage	60% of the state average weekly wage
January 1, 2021	12 weeks	67% of employee's average weekly wage	67% of the state average weekly wage

- *Coordination with other types of leave*, including but not limited to the New York City Earned Sick leave law, the federal Family and Medical Leave law (FMLA), and any existing internal leave policies and applicable federal, state and local leave laws;
- *A description of the employee notification obligations* addressing both foreseen and unforeseen instances that would give rise for the need for leave and the process for requesting leave. Include the insurer contact information, where applicable. Under the PFL law, employees making a claim for PFL leave are required to complete a designated PFL request form provided by the insurer, or by an employer who is self-funding the benefit. Generally, the employer would be required to complete its portion of the form and return it to the employee within three business days. In addition, consider including an explanation of the process of how employees can provide proper substantiation for the need for leave, for example, medical certification from a healthcare provider, active duty orders or other military documentation, a birth certificate or other documentation of the need for family leave.
- *A description of continuation of benefits during the leave* including how and when health premium or other benefit premiums must be paid, as well as address the manner and methodology of benefit accruals during the leave; and
- *A description of reinstatement rights*. Under the PFL law, an individual is entitled to be returned to his/her same or equivalent position once the individual returns from leave.

And finally, be aware of the workplace posting requirement. Check with the insurer to determine whether a model workplace posting is available.

Additional information and any available updates about the New York PFL program can accessed on the state's dedicated website.

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.