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September 2014 Employee Benefits Update

EEOC Sues Employer, Alleges Wellness Program Violates the Americans with Disabilities Act

The Equal Employment Opportunity Commission (EEOC) has filed a complaint in the Eastern District of Wisconsin, Green Bay division, alleging that Orion Energy Systems, Inc. (Orion) has violated the Americans with Disabilities Act (ADA) by implementing a non-voluntary wellness program and for terminating an employee in retaliation for refusing to participate in the wellness program. This is the first time the EEOC has directly challenged an employer's wellness program as violating the ADA.

Background

Orion implemented its wellness program in 2009. The wellness program had two components: a health risk assessment, which included questions regarding medical history and blood work, and a fitness component, whereby employees were required to use a range of motion machine in Orion's physical fitness room. Employees who failed to participate in the wellness program were required to pay the entire cost of medical coverage and employees who failed to complete the fitness component were assessed a $50 monthly penalty.

Only a single employee refused to participate in the wellness program and, according to the EEOC's complaint, she was terminated for refusing to participate in, and for objecting to, the wellness program. The employee then filed a complaint with the EEOC. The EEOC attempted to resolve the issue through informal methods of conciliation, conference and persuasion, and when those attempts ultimately failed, the EEOC filed suit.

Wellness Programs

Wellness programs must comply with two sets of federal laws: the Affordable Care Act (ACA) and the ADA. The ACA codified the Health Insurance Portability and Accountability Act (HIPAA) requirements for nondiscriminatory wellness programs and sets forth three kinds of wellness programs: participation-based (such as completing a health risk assessment), activity-based (such as participating in a walking program), and outcome-based (such as requiring an employee to quit smoking). The latter two programs, referred to as "health contingent" programs, cannot provide incentives in excess of 30% of the cost of employee-only coverage

POSTED:

Sep 16, 2014

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(50% for tobacco cessation programs). In contrast, the ACA does not limit the incentive that may be provided under a participation-based program.

The ADA generally prohibits medical inquires (such as those included in a health risk assessment) unrelated to employment unless they are voluntary. The ADA does not define what constitutes "voluntary" but the EEOC's position is that, to be voluntary, the employer cannot require participation or penalize employees for failing to participate. The EEOC has not issued guidance on whether the use of incentives to encourage participation impacts the determination of whether the program is "voluntary."

The ADA includes an exemption to the voluntary medial inquiry rule for wellness programs administered as a term of a bona fide employee benefit plan that are based on underwriting, classifying or administering risks. In 2012, the Eleventh Circuit Court of Appeals upheld an employer-sponsored wellness program as not violating the ADA in Seff v. Broward County because, in part, the wellness program was wrapped into a bona fide employee benefit plan (for more detail, please see the September 2012 EB Update. If a wellness program fits within the bona fide employee benefit plan exemption, whether the program uses incentives to encourage participation may be irrelevant.

Take Away

The Orion wellness program may comply with the ACA, but it seems that the EEOC does not equate ACA compliance with ADA compliance. Further complicating matters in the Orion case may be the fact that Orion fired the employee, rather than simply assessing her the full cost of coverage for failing to participate. In the press release announcing the suit, the regional attorney for the EEOC Chicago district reiterated that the EEOC does not dispute that employers may have voluntary wellness programs but emphasized that the program must be voluntary. Imposing "enormous penalties such as shifting 100 percent of the premium for health benefits" to the employee or terminating the employee for refusing to participate compels participation, in the EEOC's view, and makes the wellness program non-voluntary. Plan sponsors of wellness programs that impose financial incentives on participation will want to monitor this case, as well as any further EEOC guidance on wellness programs, to see if the EEOC provides any additional insight on what level of financial incentive shifts a voluntary program into compelled participation.

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SELECT COMPLIANCE DEADLINES AND REMINDERS

Upcoming Health Plan Compliance Deadlines and Reminders

1. *Business Associate Agreements*. Group health plans must have updated business associate agreements (BAA) in place with all business associates by September 22, 2014.

2. *Medicare Part D Notice of Creditable Coverage*. All group health plans that offer prescription drug coverage to Medicare eligible employees (under either an active plan or retiree plan) must provide an annual creditable coverage disclosure notice to Medicare eligible participants and dependents no later than October 15, 2014. Group health plans must also provide notices to each new participant who may be Medicare eligible. Centers for Medicare and Medicaid Services (CMS) provides a model notice that can be accessed through the CMS website. Plan sponsors should review the model notice to ensure that it accurately reflects the nature of the coverage and the rights that individuals have if they lose coverage.

3. *Health Plan Identification Number*. All large group health plans, including plans that do not process their own claims, must have a Health Plan Identification Number (HPID) by November 5, 2014. Plan sponsors that have not already done so should apply for an HPID as soon as possible to ensure the plan has an HPID by the deadline. Small health plans must have an HPID in place by November 5, 2015. A small health plan, for this purpose, is a plan with annual benefits, for a self-funded plan, or premiums, for an insured plan, of $5 million or less. All group health plans subject to the HIPAA administrative simplification rules must have an HPID, including those plans that are excepted from the HIPAA portability rules (e.g., dental plans, vision plans, flexible spending arrangements). Thus, unless plan sponsors have bundled their plans into a single group health plan, it is possible that a plan sponsor would need multiple HPIDs.

4. *Reinsurance Fee*. Plan sponsors must report to the Department of Health and Human Services (HHS) the average number of covered lives under the group health plans by November 15, 2014. HHS will then determine the amount of the plan's reinsurance fee and provide a notice to the plan sponsor no later than December 15, 2014. Plan sponsors must pay the entire fee or the first installment payment within 30 days of receipt of the notice. The 2014 fee is $63/covered life (or $52.50/covered life for the first installment and $10.50/covered life for the second installment).

5. *Open Enrollment Materials*:

    1. Plan sponsors must issue a new summary of benefits and coverage (SBC) to participants and beneficiaries covered under the plan with each open enrollment. Group health plans without open enrollment must issue the SBC 30 days in advance of the plan year (December 2, 2014 for calendar year plans). The Department of Labor (DOL) has confirmed that there are no changes to the SBC template for the 2015 plan year.

    2. Plan sponsors of health reimbursement arrangements (HRA) must offer participants an annual opportunity to opt-out and waive all future reimbursements from their HRA. This notice of opt-out opportunity could be provided with the open enrollment materials.

6. *Employer Shared Responsibility*. Employers must offer coverage to all full-time employees and their dependent children beginning January 1, 2015 (or the first day of the plan year beginning in 2015 for employers that qualify for the fiscal year transition relief). The measurement periods for employers that want to use calendar year stability periods should begin in fall 2014.

Upcoming Retirement Plan Compliance Deadlines and Reminders

Defined Contribution Plans

1. *QDIA Notice*. Plan sponsors of plans that invest participant contributions in a qualified default investment alternative (QDIA) because the participant failed to make an investment election must provide an annual notice to all participants at least 30 days, but not more than 90 days, before the beginning of the plan year. Plan sponsors of calendar year plans must send the notice between October 2 and December 1, 2014.

2. *Automatic Enrollment Notice*. Plan sponsors of plans with an eligible automatic contribution arrangement or a qualified automatic contribution arrangement must provide an annual notice to all participants on whose behalf contributions may be automatically contributed to the plan at least 30 days, but not more than 90 days, before the beginning of the plan year. Plan sponsors of calendar year plans must send the notice between October 2 and December 1, 2014. Plan sponsors may want to combine the automatic enrollment notice with the QDIA notice.

3. *Safe Harbor Notice*. Plan sponsors of safe harbor plans must provide participants an annual safe harbor notice that describes the safe harbor contribution and other material plan features at least 30 days, but not more than 90 days, before the beginning of the plan year. Plan sponsors of calendar year plans must send the notice between October 2 and December 1, 2014. If applicable, plan sponsors may want to combine the safe harbor notice with other notices such as the QDIA notice.

4. *Participant Fee Disclosure*. Plan sponsors of plans permitting participants to direct the investment of their plan accounts must provide participants with an annual participant fee disclosure. Plan sponsors that have not already sent the participant fee disclosure for 2014 must send all participants an updated disclosure.

All Retirement Plans

1. *Windsor Amendment*. Plan sponsors may need to adopt an amendment to comply with the U.S. v. Windsor decision and subsequent Internal Revenue Service (IRS) guidance. For calendar year plans, the amendment must be adopted no later than December 31, 2014.

2. *Discretionary Amendments*. All discretionary amendments to qualified plans must be adopted no later than the end of the plan year in which they are effective. A discretionary amendment generally includes any change to the terms of a plan that is not required for plan qualification. Plan sponsors of calendar year plans must ensure discretionary amendments effective in 2014 are adopted no later than December 31, 2014.

3. *Determination Letter Filing*. Remedial Amendment Period Cycle D individually designed plans must be submitted for a favorable Internal Revenue Service (IRS) determination letter no later than January 31, 2015. Cycle D plans include those sponsored by employers with tax identification numbers ending in a four or a nine, as well as multiemployer plans.

Compliance Updates

Same Sex Marriage

The Seventh Circuit Court of Appeals has unanimously upheld the district courts' opinions striking down the same sex marriage bans in Wisconsin and Indiana.

Both states have stated they intend to appeal the decision to the United States Supreme Court. As with the district court opinions, the Seventh Circuit stayed its decision pending the appeal. Accordingly, plan sponsors in Wisconsin and Indiana do not yet need to take any action in response to the Seventh Circuit's decision.

HIPAA Notice of Creditable Coverage

Effective December 31, 2014, plan sponsors are no longer required to provide participants with HIPAA certificates of creditable coverage.

RETIREMENT PLAN DEVELOPMENTS

DOL Issues Updated Guidance on Locating Missing Participants

The DOL has updated the steps plan fiduciaries must take in locating missing plan participants when terminating a defined contribution plan. Field Assistance Bulletin (FAB) 2014-01. Recognizing that the Internet provides multiple search tools and that the Social Security Administration and IRS have discontinued their letter forwarding services, the DOL has now advised that plan fiduciaries must take the following steps when attempting to locate missing participants:

1. Send notices via certified mail;
2. Check related plan and employer records;
3. Consult the beneficiary of the missing participant; and
4. Use free electronic search tools, such as Internet search engines, public record databases, obituaries and social media.

Additionally, the DOL cautions that even if plan fiduciaries have failed to locate the participant using the above steps, the duties of prudence and loyalty require that fiduciaries consider whether additional search methods should be used. Considerations would include the size of the participant's account and the cost of additional search efforts. The DOL notes that plan fiduciaries could consider commercial locator services, credit reporting agencies, information brokers and investigation databases as possible additional search options.

Plan fiduciaries that are unable to locate participants using the above steps must determine the appropriate distribution of the missing participants' accounts. While the DOL notes that plan fiduciaries may continue to establish a federally insured bank account in the participant's name or transfer the account balance to

a state unclaimed property fund as secondary options, the DOL reiterates that it prefers plan fiduciaries to rollover the account balance to an individual retirement plan. In the event plan fiduciaries cannot rollover the account balance, or if the plan fiduciaries have another compelling reason not to rollover the account balance, the DOL encourages plan fiduciaries to consider bank fees and interest payments as well as whether the state unclaimed property fund maintains a searchable database when deciding between the two alternatives. Finally, the DOL, in consultation with the IRS, has determined that using 100% income tax withholding as an option would be a breach of the fiduciaries' duties.

Though the guidance specifically applies to terminating defined contribution plans, plan fiduciaries of active plans could consider following the same steps for locating missing participants to make plan distributions. To that end, plan fiduciaries should review their missing participant policies and update as necessary to incorporate the steps provided in FAB 2014-01.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Expands Contraceptive Coverage Relief for Religious Employers

HHS has issued two sets of guidance concerning the ACA's contraceptive coverage mandate and the exemption for certain religious employers. First, HHS issued an interim final rule providing an alternative notification option for non-profit religious organizations in response to the United States Supreme Court's interim order in the Wheaton College case. In addition to self-certifying to the plan sponsor's insurer or third-party administrator (TPA), non-profit religious organizations can now send written notice to HHS for insured plans or the DOL for self-funded plans. The respective department will then notify the insurer or TPA of the employer's exemption.

The HHS has also issued proposed regulations extending the contraceptive mandate exemption to closely held, for-profit corporations in response to the Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.* The proposed regulations provide for two alternative approaches for defining a closely held, for-profit corporation: the corporation cannot be publically traded and ownership is either (1) limited to a certain number of owners or (2) a minimum percentage of ownership would be concentrated among a certain number of owners. The proposed regulations solicit comment on an appropriate number of owners and/or concentration of ownership. To qualify for the exemption, the corporation can take valid corporation action in accordance with the corporation's governing

structure and state law stating the owners' religious objection.

Exclusion of Applied Behavior Analysis Therapy May Violate Mental Health Parity and Addiction Equity Act

An Oregon district court has ruled that a group health plan's exclusion of services for "developmental disabilities" violates the Mental Health Parity and Addiction Equity Act (MHPAEA). A.F. v. Providence Health Plan. The Providence Health Plan included coverage for autism but excluded services for developmental disabilities. The plan had accordingly denied coverage for applied behavior analysis (ABA) for treatment of autism spectrum disorder. The court found that the exclusion applied "specifically and exclusively to mental health conditions" and therefore violates the MHPAEA prohibition on separate treatment limits applicable only to mental health or substance abuse disorder benefits.

Michigan Medical Claims Tax Applicable to Self-Insured Plans

The Sixth Circuit Court of Appeals has ruled that ERISA does not preempt a Michigan state law imposing a 1% tax (recently reduced to 0.75%), as well as corresponding recordkeeping and reporting obligations, on medical claims paid by carriers and TPAs for services provided in Michigan to Michigan residents. Self-Insurance Institute of America v. Snyder. Carriers, for purposes of the Michigan law, includes sponsors of group health plans. The district court had likewise concluded that law was applicable to self-funded plans (see the September EB 2012 Update for additional information on the district court decision.

Consequently, TPAs continue to be subject to the tax on any medical claims paid for Michigan residents' in-state claims and the corresponding recordkeeping and quarterly reporting obligations. TPAs will likely pass these fees through to self-funded plans.