EEOC WELLNESS LAWSUIT AGAINST WISCONSIN EMPLOYER ENDS IN $100,000 SETTLEMENT

A Wisconsin employer's settlement last month with the EEOC ended the final round of litigation initiated against it by the EEOC over its workplace wellness plan.

In 2009, Manitowoc-based Orion Energy Systems (Orion) implemented a wellness program that included a health assessment. The health assessment consisted of a personal health questionnaire, a biometric screening, and a blood draw. An Orion employee refused to participate and, as a result, was required to pay her full health premium costs of more than $400 per month. (Meanwhile, for employees who participated in the health assessment, the employer paid 100% of the premium cost). The employee openly questioned the purpose of the health assessment, the confidentiality of its results, and the CEO's response to her questions. Approximately three weeks after declining to participate in the health assessment, her employment was terminated. She then filed a complaint with the EEOC, which in turn sued Orion in August 2014, alleging that the company's wellness program violated the ADA as "involuntary" and that the company had retaliated against her in violation of the ADA.

The ADA generally prohibits employers with 15 or more employees from requiring medical examinations or making disability-related inquiries of an employee, unless the examination or inquiry is job-related and consistent with business necessity. The law includes an exception for "voluntary" wellness programs, but the EEOC had not finalized its definition of a "voluntary" wellness program until May 2016, nearly seven years after the events at issue in this case.

In a mixed September 2016 decision, the court for the Eastern District of Wisconsin ruled against the EEOC by finding that the wellness plan was voluntary. The court determined that the health assessment incentive (the premium cost) was permitted within the framework of a "voluntary" plan, and therefore was *not* prohibited under the general ADA medical examination and inquiry rules. While shifting even 100% of the premium cost to the employee was a strong incentive, it was still not an involuntary "compulsion," the court reasoned, because employees could still choose between completing the health assessment or paying the full premium.

While the court's ruling essentially approved the design of the wellness plan, it declined to dismiss the employee's ADA retaliation and interference claims. In other words, it was only the termination (allegedly in response to the employee's refusal to participate in the wellness plan) that the court found troubling.

To resolve these remaining issues, Orion agreed to pay the former employee $100,000. Orion also agreed:

- Not to maintain any wellness program in the future with disability-related inquiries or medical examinations that do not meet the criteria for "voluntary" wellness plans as defined under the May 2016 final EEOC regulations;
- Not to engage in any form of retaliation, including interference or threats, against any employee for raising objections or concerns as to whether the wellness program complies with the ADA;
- To tell its employees that any concerns about its wellness program should be sent to its human resources department;
- To train its management and employees on the law against retaliation and interference under the ADA; and
- To conduct an additional training meeting with its chief executive officer, its chief operating officer, its chief financial officer, its HR director, and all employees responsible for negotiating or obtaining health coverage or selecting a wellness program. This training is to include an explanation of the settlement terms and the ADA's requirements regarding wellness programs.

While Orion, in the consent decree, "continues to deny the EEOC allegations," the settlement serves as a reminder to employers not to base any employment decisions on participation or non-participation in a workplace benefit program. Wellness programs must comply not only with multiple provisions of the ADA, but also with HIPAA, the Genetic Information Nondiscrimination Act (GINA), the Affordable Care Act, and other laws. As these rules, and relevant case law, continue to evolve, it is important that employers maintaining, implementing, or considering updating a wellness plan proceed with an awareness of the potential costs of noncompliance.

DON'T OVERLOOK LIFE-INSURANCE CONVERSION NOTICE OBLIGATIONS

Employer, Not Insurer, Found Liable for Payment of Life Insurance Benefit

A court ruling earlier this month highlights the importance for employers of reviewing internal policies and procedures regarding the communication of post-employment life insurance rights. In *Erwood v. WellStar Health Systems*, a federal judge in Pennsylvania ruled that an employer owes more than $750,000 to the widow of a deceased former employee.

In this case, an employee terminated employment at the end of his FMLA period and died of a terminal illness just over nine months later. Although the former employee and his spouse believed he would continue to be covered under a life insurance policy following the end of his employment, the group policy coverage lapsed and was not continued because the company's benefits representative did not properly explain the post-employment individual

policy conversion right.

Although the availability of a conversion right was mentioned in a summary plan description, the court found that the employer did not satisfy its disclosure obligations to the employee because no specific form, deadline, or other essential information about the conversion right was ever mentioned or provided, even when the employee and his spouse had reached out with questions and attended an in-person meeting. Instead, the representative simply provided multiple assurances during the employee's FMLA leave period that all benefit coverages would "remain the same."

The court held that the failure to provide the employee with specific conversion right election information amounted to a breach of the fiduciary obligation imposed by ERISA to convey complete and accurate information material to the beneficiary's circumstances. The court also found that an ERISA fiduciary may not, in the performance of its duties, materially mislead those to whom the duties of loyalty and prudence are owed. That duty not only includes the affirmative duty to inform, but also the duty to inform when the fiduciary knows that silence might be harmful to the beneficiary. The court found that the employer had breached these fiduciary obligations in its failure to provide the required conversion notice, and, as a result, found that such breaches amounted to a material misrepresentation by the employer resulting in harm to the spouse as beneficiary.

Unfortunately, the company's benefit representative was unaware of the company's communication and fiduciary obligations to provide notice to the employee of the conversion right and wrongly assumed that such notice would be provided by the life insurance carrier itself. Because the deceased employee and his spouse had relied on the company's communications to their detriment, the judge used the equitable remedy provisions of ERISA to award the widow the full amount of the life insurance benefit, $750,000 (plus interest), she would have received under the policy, had the life insurance benefit continued from the date on which employment ended.

Compare and Contrast with COBRA

Most employers are quite familiar with the obligation to provide a notice of COBRA or state continuation coverage to group health plan participants who cease to be eligible for the workplace group health insurance plan. The process of providing continuation coverage notices has become routine, and indeed, is often handled by the plan's group health insurance carrier.

However, the opposite is true of group life insurance policies. Not only are some employers less aware that group life insurance coverage applies only to active employees, the contractual language of group policies typically requires the employer (rather than the insurer) to provide the conversion right notices when employment ends.

The court's decision in *Erwood* highlights the importance of periodically reviewing internal post-employment benefits right notice obligations and of understanding who exactly has those obligations. This is particularly important in light of the fact that employers may change carriers over time, and that the details of conversion notice requirements may vary from carrier to carrier.

When the same insurer provides both long-term disability and life insurance, it may be that the insurer will be aware of an employee terminating employment on account of disability. In such case, it is possible that an insurer will be willing to assist in making sure that an employee receives a life-insurance conversion notice. It is more common, however, that the onus for providing notice of conversion rights rests solely on the employer, and not the carrier. The *Erwood* decision makes that reality clear for employers.

Because beneficiaries often become aware that eligibility or conversion information was inaccurate or incomplete (or that premiums have lapsed) only after the plan participant has passed away, life insurance errors of this kind are prime candidates for the application of an (often expensive) equitable remedy under ERISA that makes the beneficiary whole.

QSEHRAS ALLOW SMALL EMPLOYERS TO REIMBURSE EMPLOYEES' PERSONAL HEALTH COSTS

Although the Affordable Care Act's (ACA's) market reforms eliminated the ability of employers to permissibly reimburse employees for individually-incurred health insurance or medical costs, recent legislation now affords certain small employers with an alternate reimbursement option. The 21st Century Cures Act amended the Internal Revenue Code to authorize the creation of a new stand-alone HRA vehicle known as a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

An employer may elect to implement a QSEHRA if the business offers *no* group health plan *and* is exempt from the ACA's Employer Shared Responsibility provisions by virtue of having had fewer than 50 full-time (including full-time equivalent) employees in the prior year. The 50-employee limit applies to the aggregate number of employees across all commonly-controlled or affiliated businesses.

A QSEHRA is not a "health plan" within the meaning of the ACA, but may be used to pay for or reimburse the costs of medical care and health insurance premiums incurred on behalf of

an eligible employee or the employee's family members. The employee must provide proof of the expenses or coverage costs and the IRS may later request written substantiation. Reimbursements in a calendar year may range up to $4,950 (for payments relating to only the employee) or up to $10,000 (for family coverage costs). These amounts will be adjusted for inflation, and must be prorated for partial years.

Only an employer may fund a QSEHRA. Funds paid into the QSEHRA must be in addition to salary and not paid as a salary substitute. Accordingly, salary reduction contributions by employees are not permitted. With some exceptions, the reimbursement must be made available "on the same terms to all eligible employees" of the employer. Employees who have been employed by the QSEHRA sponsor for less than 90 days, or who work part time, are part of a collective bargaining unit, or are under age 25 may be excluded from participation.

The rules require an employer to furnish a written notice to its QSEHRA-eligible employees at least 90 days before the beginning of a year for which the QSEHRA is provided. In the case of an employee who is hired mid-year, the notice must be provided no later than the date on which the employee begins participation in the QSEHRA.

The notice must include the amount of the eligible employee's permitted benefit under the QSEHRA and advise the employee to inform any health care Exchange of such benefit amount if the employee is applying for advance payment of the premium assistance tax credit.

Under an initial transition rule, the first-applicable QSEHRA notice deadline was March 13, 2017. In Notice 2017-20, however, the Treasury Department and IRS suspended the notice deadline and waived any penalties that could have been imposed on employers for failure to provide the first written notice. Future guidance will specify a revised notice deadline, and will provide at least 90-days' additional time for employers to prepare and provide the notice.

While QSEHRA benefits must be reported (but not treated as taxable) on the employee's W-2 and Form 1095-B, its benefits are exempt from COBRA, or similar, continuation coverage requirements.

Ultimately, whether or not implementation of a QSEHRA makes sense for a small employer will depend on the business's specific personnel-related objectives and goals. For some employers, the cost and administrative requirements may outweigh the potential advantages, while for others a QSEHRA will present the best possible avenue to provide employees with assistance toward paying for health care.

EMPLOYMENT LAWSCENE ALERT: EXECUTIVE ORDER HALTS IMPLEMENTATION OF DOL FIDUCIARY RULE

Early this afternoon (Friday, February 03, 2017), President Trump signed an Executive Order directing the Department of Labor (DOL) to halt implementation of final regulations relating to "investment advice fiduciaries," as defined under ERISA and the Internal Revenue Code.

The Order directs the DOL to reevaluate the regulations and to report back to the President. The regulations, collectively known as the "Fiduciary Rule," had been set to take initial effect on April 10, 2017. The Fiduciary Rule's effective date is now expected to be at least delayed, if not also altered or withdrawn.

The purpose of the Fiduciary Rule, which has been over six years in the making, is to impose a fiduciary standard on individuals and companies receiving compensation for retirement investment advice, including brokers and insurance agents who are currently held to a lesser standard dating to 1975.

The rule would also have required brokers to clearly and prominently disclose any conflicts of interest, like hidden fees or other undisclosed commission payments often buried in the fine print.

A 2015 government study concluded that retirement plan savers lose $17 billion, in the aggregate, each year due to receiving conflicted investment advice that reduces the value of their retirement accounts.

The Trump Administration, on the other hand, takes the view that the DOL rule is unnecessary. The White House Press Secretary called the DOL Fiduciary Rule "a solution in search of a problem," and as protecting consumers "from something they don't need protection from." This view reflects the perspective of those who regard the Fiduciary Rule as an unneeded limit upon investor options and its implementation as a burden upon asset management firms.

Industry spokespersons, as well as politicians with competing views are certain to continue to engage in lively debate regarding the future of the Fiduciary Rule.

While such a discussion has been ongoing over recent years, financial advisors and brokers have steadily worked to update their compensation methods to provide greater transparency to retirement plan savers. For this reason, it is not clear that even the elimination of the Fiduciary Rule would reverse the market trend of providing greater clarity regarding the fees and costs of investing.

We will continue to monitor relevant developments.

EXECUTIVE ORDER AFFIRMS COMMITMENT TO REPEAL THE ACA; MAKES NO IMMEDIATE CHANGES FOR EMPLOYERS

Within hours of being sworn in on Friday, January 20, 2017, President Trump signed an executive order (the Order), that affirmed the administration's policy of seeking "the prompt repeal" of the Affordable Care Act (ACA). The Order, however, neither specifically mentions employers nor has any immediate impact on employers' obligations under the ACA.

It is important to note that the one-page Order does not repeal any specific provision of the ACA, much of which is governed by existing law and regulations that cannot be eliminated with the stroke of even the Presidential pen.

Instead, the Order directs the Secretary of the Department of Health and Human Services the heads of other federal agencies "with authorities and responsibilities under" the ACA to "exercise all authority and discretion available to them", "to the maximum extent permitted by law," to:

- "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement" of the ACA that "would impose a fiscal burden on any State or a cost, fee, tax , penalty, or regulation burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchaser of health insurance, or makers of medical devices, products, or medications"; and to

- "provide greater flexibility to States and cooperate with them in implementing healthcare programs."

Each "department or agency with responsibilities relating to healthcare or health insurance" is directed, "to the maximum extent permitted by law," to:

- "encourage the development of a free and open market in interstate commerce for the offering o healthcare services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers."

While some pundits have quipped that the Order is a license for employers to cease complying with the ACA or to cease offering health insurance, no such authority is contained

in the Order. What the Order may permit is greater discretion in granting “hardship exemptions” from the individual mandate. Federal officials in the new administration might also be more receptive to state requests for waivers under Medicaid.

We advise employers to continue to observe the ACA status quo, which includes continuing to focus on complying with ACA Employer Reporting obligations (using IRS Form 1095-C) for the 2016 calendar year.

This is because, as the Order specifically states, any revision of existing regulations can only be changed under the rules of the Administrative Procedures Act, which requires the public issuance of proposed rules, followed by a period of public input. Despite the new administration’s Order (and the House of Representative’s January 13 vote to begin repealing the ACA), there is no specific change currently available for employers in 2017.

Instead, employers should continue to heed ACA requirements. Only agency rulemaking or congressional action could relieve employers of ACA reporting and other obligations, but either type of action would likely take significant time.

We will continue to monitor developments regarding the possible repeal of the ACA and how any subsequent actions may affect employers’ obligations.

IMPORTANT HIPAA AND ACA BENEFIT UPDATES FROM THE HHS AND IRS

Be Aware: Current Phishing Email is Disguised as Official OCR Audit Communication

As many HIPAA covered entities and their business associates are aware, the Office for Civil Rights (“OCR”) division of the United States Department Health and Human Services (“HHS”) has begun a second-round of audits to examine compliance with the HIPAA Privacy, Security and Breach Notification Rules. Specifically, the audits are intended to review the policies and procedures adopted and employed by covered entities and business associates to meet selected standards and implementation specifications of the Privacy, Security, and Breach Notification Rules.

In an alert issued today, the HHS announced that it has come to their attention that a phishing email is being circulated on mock HHS Departmental letterhead under the signature of the OCR’s Director, Jocelyn Samuels. The email appears to be an official government communication and targets employees of HIPAA covered entities and their business

associates. The email prompts recipients to click a link regarding possible inclusion in the HIPAA audit program. The link then directs individuals to a website marketing cybersecurity services. The HHS is taking the unauthorized use of its material very seriously and stresses that the site is in no way associated with the HHS or OCR. Anyone wondering if they have, in fact, received an official HHS or OCR communication may send an email to OSOCRAudit@hhs.gov to seek verification.

IRS Deadline for Providing 2016 ACA Statements to Employees Extended to March 2, 2017

Under the Affordable Care Act's information reporting rules, an "applicable large employer" (meaning an employer with at least 50 full-time, including full-time equivalent employees) must file a Form 1095-C with the IRS for each employee who was a full-time employee for any month of the calendar year. The employer also must provide each full-time employee a completed Form 1095-C (or a satisfactory substitute for such form).

Larger employers must also provide a Form 1095-C (or substitute form) to each of its full-time employees, regardless of whether the employer offered health coverage to all, some, or none of its full-time employees.

In Notice 2016-70, the IRS recently offered a 30-day extension of the (otherwise applicable) January 31, 2017 deadline to furnish the Form 1095-C statements to employees. The new due date for providing the ACA statements to employees is March 2, 2017. This is a hard deadline; no 30-day extension may be obtained.

Note that there is no extension of the deadline to provide the Forms 1095-C to the IRS under cover of transmittal Form 1094-C. The deadline for paper filing is February 28, 2017 and the electronic filing deadline is March 31, 2017. (Electronic filing is required for applicable large employers filing 250 or more employee statements.)

EMPLOYMENT LAWSCENE ALERT: IRS ANNOUNCES 2017 EMPLOYEE BENEFIT PLAN LIMITS

The Internal Revenue Service recently published the cost-of-living adjustments to the dollar limits under various employer-sponsored retirement and health plans for 2017. The majority of the dollar limits are either unchanged or will increase only slightly.

Employer-sponsors of benefit plans should update payroll and plan administration systems

for the 2017 limits and ensure that any new limits are incorporated into relevant participant communications, enrollment materials and summary plan descriptions, as applicable.

Health FSA Employee Contribution Limit Increasing to $2,600

For 2017, the maximum dollar limitation on employee salary reductions for contribution to health flexible spending arrangements (health FSAs) will increase to $2,600 from the prior limit of $2,550.

2017 Qualified Retirement Plan Limits

For retirement plans beginning on and after January 1, 2017, the following dollar limitations apply for tax-qualified retirement plans:

- The elective deferral limit under Section 402(g) or the Internal Revenue Code (Code) will remain unchanged at $18,000 for employees who participate in:
    - Code Section 401(k) plans;
    - Code Section 403(b) plans; and
    - Most Code Section 457 plans.
- The catch-up contribution limit for those age 50 and over under will remain unchanged at $6,000 for all plans other than SIMPLE 401(k) and SIMPLE IRAs. (For these SIMPLE plans, the catch-up contribution limit for those age 50 and over under will remain unchanged at $3,000).
- The limitation on the annual benefit for a defined benefit plan will increase from $210,000 to $215,000.
- The limitation on annual additions (meaning total employee plus employer contributions) to a participant's defined contribution plan will increase from $53,000 to $54,000.
- The limit on the amount of annual compensation taken into account under a tax-qualified retirement plan will increase from $265,000 to $270,000.
- The limitation used in the definition of a highly compensated employee (HCE) under Code Section 414(q) will remain unchanged at $120,000.
- The limitation used in the definition of a key employee in a top-heavy plan under Code Section 416 will increase from $170,000 to $175,000.
- The dollar amount under Code Section 409(o) for determining the maximum account balance in an employee stock ownership plan (ESOP) subject to a five-year distribution period will increase from $1,070,000 to $1,080,000. The dollar amount used to determine the lengthening of the five-year distribution period will increase from $210,000 to $215,000.

Prior Guidance on Additional 2017 Limits

Social Security Taxable Wage Base

On October 18, the Social Security Administration announced that the Social Security wage

base for 2017 will increase significantly (from $118,500) to $127,200. This is the maximum wage base subject to the FICA tax and is also the maximum "integration level" for plans using "permitted disparity."

2017 Health Savings Account Limits

The combined annual contributions to an HSA must not exceed the maximum annual deductible HSA contribution, which for 2017, is $3,400 for single coverage and $6,750 for family coverage. The catch-up contribution for eligible individuals age 55 or older by year end remains at $1,000.

EMPLOYMENT LAWSCENE ALERT: NEW FLSA OVERTIME RULES MAY HAVE EMPLOYEE BENEFIT PLAN IMPLICATIONS

The Department of Labor's (DOL's) final overtime rule (the Final Rule) takes effect December 1, 2016. As described in our prior post, the cumulative effect of the Final Rule will be to significantly expand the categories of employees eligible for overtime protection. As part of preparing to comply with the new wage and hour law, employers must also consider whether and how any changes to compensation practices will affect employee benefit plans. This post describes the tax-qualified retirement plan issues that employers should take into account as the December 1 Final Rule deadline approaches.

Classification Changes

To the extent that benefit plan documents condition eligibility on an employee's classification (such as salaried, hourly, exempt, or non-exempt), compensation structures revised to comply with the Final Rule could cause large cohorts of employees to either lose or gain benefits. As an example, if a specific employee is reclassified from hourly to salaried status (or vice versa) in response to the Final Rule, that individual might gain (or lose) the right to participate in an employee benefit plan. Corresponding modifications to the terms of those plans may be necessary to continue to provide current benefit levels and, or, to ensure that retirement plans will continue to satisfy underlying participation requirements in light of resulting eligibility changes.

Compensation Changes

By the same token, FLSA-related compensation adjustments may result in unanticipated

changes to overall benefit contribution obligations. This is particularly true for 401(k)s, and similar tax-qualified retirement plans, under which employer contributions are calculated in accordance with a specific plan definition of "compensation." The impact of pay changes on employer retirement plan contributions will vary case by case, but in general, may fluctuate not only to the extent that employee base pay is increased or decreased, but also by whether a given plan's "compensation" definition includes or excludes overtime pay.

Tax-Qualification Compliance Issues

In some cases, plan compensation definitions should be amended as required to attain a result in line with overall benefits and compensation objectives. Although a tax-qualified retirement plan may exclude (or be amended to exclude) overtime pay from its compensation definition, such exclusion is permissible only if the compensation taken into account after the exclusion satisfies annual nondiscrimination testing requirements. Employers that expect a significant increase in overtime wages as a result of compliance with the Final Rule, as well as employers with plans already excluding overtime pay, should determine now whether projected increases in overtime wages could affect their plans' ability to continue to satisfy tax nondiscrimination requirements in light of existing or revised plan terms.

Employers choosing to amend a retirement plan's compensation definition to exclude overtime pay will need to consider other legal and operational issues in addition to nondiscrimination testing. For example, in the case of a "safe harbor" 401(k) plan, the modification may need to be coordinated with the start of a plan year. In addition, time may be needed to update payroll systems and plan administrative processes to properly capture the new pay exclusion.

Proceed with Caution before Reducing Benefits to Offset New Overtime Costs

Some employers may be facing higher compensation costs as part of a strategy for maximizing the available exemption from the overtime rules. While it may be tempting to offset some of these costs by reducing employee benefits spending, it is crucial to consider underlying benefit-related legal requirements as they proceed. In some cases, benefit reductions are limited by law, while in others, unintended consequences may result.

For example, the Affordable Care Act requires large employers (generally 50 employees and above) to either offer "affordable" and "minimum value" health care coverage to certain employees or risk exposure to significant tax penalties. A large employer may incur penalties, without regard to whether an employee is exempt or non-exempt under the Final Rule, if he or she works more than 30 hours per week but is not offered ACA-compliant coverage. A reduction or elimination of an employer premium contribution (or an increase in employee cost sharing) must therefore be carefully analyzed to assess the extent to which it could

affect a group health plan's "minimum value" and "affordability" metrics, thereby increasing employer exposure to ACA penalties.

Conclusion

It is no surprise that the Final Rule requires many employers to make extensive changes to their compensation and employee classification practices. What may be more surprising is the extent to which FLSA-related changes promise to impact employee benefit plans, as well. To avoid any benefits cost or compliance surprises, employers should carefully review whether and how sponsored employee benefit plans will be affected by other changes made to comply with the Final Rule.