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Benefits & Employment Briefing

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## IRS Releases New Guidance on Applicability of Employer Mandate and Nondiscrimination Testing to ICHRAs

Earlier this year, the Departments of Treasury, Labor, and Health and Human Services issued final regulations creating a new individual coverage HRA (ICHRA). However, the final regulations did not explain how employers can establish and administer ICHRAs in compliance with affordability requirements under the ACA and nondiscrimination requirements under the Internal Revenue Code.

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## HIPAA Compliance: Responding to Orders and Subpoenas Requesting an Employee's Health Information

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## DOL Releases New MHPAEA Guidance

The new FAQs primarily address nonquantitative treatment limitations and include a new model form that individuals can use to request information regarding their benefits governed by the Mental Health Parity and Addiction Equity Act of 2008.

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## New Overtime Rule under the Fair Labor Standards Act

The Department of Labor recently announced a new overtime rule that expands employers' obligations to pay overtime to an estimated 1.3 million workers. The new rule increases the minimum salary threshold for FLSA white collar exemptions to approximately $35,568 per year, which is a moderate increase from the current threshold of around $23,660 per year.

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## Is Your VEBA a MEWA? If So, You May Be Subject to the Annual Fee on Health Insurance Providers

The Court of Federal Claims recently determined that Voluntary Employees' Beneficiary Associations (VEBAs) constituting Multiple Employer Welfare Arrangements (MEWAs) are subject to the annual fee on health insurance providers imposed under Section 9010 the Patient Protection and Affordable Care Act (ACA). Employers taking advantage of VEBAs and MEWAs should assess the applicability of this ruling to their arrangement.

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## IRS Releases New Guidance on Applicability of Employer Mandate and Nondiscrimination Testing to ICHRAs

Earlier this year, the Departments of Treasury, Labor, and Health and Human Services (the Departments) issued final regulations creating new opportunities for establishing health reimbursement arrangements (HRAs). In particular, the Departments created a new individual coverage HRA (ICHRA) that can satisfy an employer's requirement to offer minimum essential coverage under the Patient Protection and Affordable Care Act (ACA) by integrating the HRA with individual market coverage or Medicare. However, the final regulations did not explain how employers can establish and administer ICHRAs in compliance with affordability requirements under the ACA and nondiscrimination requirements under the Internal Revenue Code (the Code).

On September 30, 2019, the Internal Revenue Service (IRS) issued proposed regulations that attempt to clarify how the Code's employer shared responsibility and self-insured health plan nondiscrimination rules apply to ICHRAs. The proposed regulations expand on concepts discussed in the final ICHRA regulations and in IRS Notice 2018-88 and provide employers with a framework for how this new type of HRA can be administered in compliance with the ACA and the Code.

The proposed regulations generally cover two main topics: 1) how applicable large employers (ALEs) can maintain compliance with the ACA's affordability requirements, and 2) how Code Section 105(h)'s nondiscrimination requirements apply to ICHRAs.

### ICHRAs and Affordability

The proposed regulations provide multiple safe harbors that would simplify affordability determinations for ALEs. An ICHRA is considered affordable if an employee's required contribution does not exceed a specified percentage of the employee's household income (for example, 9.78% for 2020). For these purposes, an employee's required contribution is equal to the monthly premium for single coverage under the lowest-cost silver plan offered on the Exchange in the rating area where the employee lives minus the monthly allowance that the employer makes available for self-only coverage under the ICHRA.

Recognizing that it is difficult for an ALE to determine affordability because it may not necessarily know an employee's household income or where the employee currently resides, the proposed regulations lay out new safe harbors addressing this hurdle by providing assumptions needed for application of the currently affordability safe harbors applicable to group health plans to ICHRAs.

#### *Look-Back Month Safe Harbor*

To help ALEs determine how much they will need to contribute to employees' ICHRAs before the beginning of the plan year, the IRS has developed the look-back month safe harbor. This is helpful because the Exchange generally does not determine premium costs until shortly before open enrollment begins on November 1 of each year, which often will not leave employers with sufficient time to calculate and make sufficient contributions to employees' ICHRAs.

The look-back month safe harbor allows ALEs to rely on prior months to determine an employee's required ICHRA contributions. A calendar year ICHRA may use the monthly premium for the lowest-cost silver plan offered on the Exchange in the employee's rating area during January of the prior year (that is, the look-back month). For example, the look-back month for an ICHRA with a calendar year plan year starting January 1, 2020, would be January 2019. ALEs with non-calendar year ICHRAs may also use this safe harbor by relying on the monthly premium during January of the current year.

#### *Location Safe Harbor*

To assist employers with keeping track of an employee's rating area, the proposed regulations allow employers to use the primary site of employment where the employee will be reasonably expected to perform services on the first day of the plan year rather than the employee's residence. The proposed regulations also address related issues such as employees who change worksites midyear and employees who work remotely.

To help ALEs find the lowest-cost silver plan for applicable locations in states using the federal Exchange platform, the Centers for Medicare & Medicaid Services (CMS) released a downloadable tool that gives employers access to health insurance premium data by geographic location and provides specific rate information for the lowest cost silver plan based on an eligible employee's age and geography.

***Affordability Safe Harbors***

The proposed regulations clarify that the general affordability safe harbors for group health plans apply to ICHRAs. Also, an affordable ICHRA is treated as providing minimum value under Code Section 4980H(b).

The affordability safe harbors allow ALEs to rely on more readily available sources of information to approximate an employee's household income and determine whether the employee's required ICHRA contribution is affordable. For example, ALEs can look to an employees' reported income in Box 1 of the employee's Form W-2 or an employee's rate of pay in determining whether coverage is affordable. Alternatively, coverage will also be deemed affordable if the employee's required ICHRA contribution for the calendar month does not exceed 9.78% (for 2020) of 1/12th of the federal poverty line for a single individual for the applicable calendar year.

It is important to remember that ICHRAs are funded solely by employer contributions. Accordingly, when applying the general affordability safe harbors, "employee contributions" refer to the additional amounts that employees must pay for their insurance premiums on top of the employer's ICHRA contributions.

**ICHRAs and Nondiscrimination**

Because an HRA is a self-funded health plan, ICHRAs will generally be subject to the nondiscrimination requirements imposed under Code Section 105(h). Section 105(h) prohibits discrimination in favor of highly compensated individuals (HCIs) in both plan design and plan operation. To be nondiscriminatory in design, employers must provide uniform contributions to all participants, and amounts cannot vary based on age, length of service, or compensation. If the plan fails this nondiscrimination test, the excess reimbursements will become taxable to the HCIs. However, the proposed regulations provide that contributions may increase based on (1) the number of dependents covered and (2) the participant's age, so long as the oldest participants do not receive an amount greater than three times what the youngest participants receive. An ICHRA must satisfy these exceptions within specified classes of employees (as defined in the ICHRA final regulations). However, even if these exceptions are met, an ICHRA must still be nondiscriminatory in operation (for example, a plan may be discriminatory in operation if a disproportionate number of HCIs qualify for and utilize the maximum benefit amount). The proposed regulations also confirm that an ICHRA that only reimburses insurance premiums is treated as an insured plan and will not be subject to the Code Section 105(h) rules.

**What this Means for Employers**

Employers may begin offering ICHRAs in 2020, and the rules surrounding these new plans are complex. However, the proposed regulations simplify some of the administrative concerns associated with determining an ICHRA's affordability under the ACA and may result in more ALEs becoming comfortable with the idea of offering the new arrangement. The simplified procedures are also consistent with the current administration's goal of expanding HRAs to give employers and employees more health coverage options.

Although the ICHRA was established primarily to address the needs of smaller employers, the IRS is clearly expecting employers of all sizes (including ALEs) to use the new ICHRA. Employers interested in adopting an ICHRA should consult with their advisors and ERISA counsel to assess the new requirements and associated risks. Employers should also stay alert for any changes that develop as the proposed regulations are finalized and look out for additional guidance regarding ACA reporting for ICHRAs, which the IRS has indicated it will provide prior to early 2021.

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## HIPAA Compliance: Responding to Orders and Subpoenas Requesting an Employee's Health Information

Employers commonly receive requests from an attorney, a court, or administrative agency for information regarding one of its employees. However, what if the information being requested is health-related information? Will the employer violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by complying with the request? The rules surrounding disclosure of an employee's health information can be complex. However, if you receive such a request, there are three basic questions you should consider before responding:

1. Does HIPAA apply to the request?
2. If so, is the disclosure allowed under HIPAA?
3. What information should be disclosed?

We will walk through these questions and highlight important considerations when determining how employers should respond to a request for an employee's health information. However, these situations are very fact-intensive, and employers should consult with their broker or ERISA counsel to determine its specific obligations when responding to such a request.

**Step 1: Determine whether HIPAA applies.**

To determine whether HIPAA applies, you must consider (1) whether the information being requested will come from a Covered Entity or Business Associate, and (2) whether the request is seeking protected health information (PHI). If the request is for PHI from a Covered Entity or Business Associate, HIPAA will generally apply.

There's a common misconception that HIPAA applies directly to employers. However, HIPAA only applies to three types of entities (commonly referred to as "Covered Entities") and Business Associates of those Covered Entities. Covered entities include healthcare providers, healthcare clearinghouses, and group health plans. Most employers find themselves subject to HIPAA's requirements because they sponsor and maintain a group health plan; but importantly, it is the plan itself that is subject to HIPAA, not the employer. Thus, HIPAA will generally come into play when the information being requested is from the employer's group health plan. Business Associates of Covered Entities create, receive, maintain or transmit PHI on behalf of the Covered Entity. Common examples of Business Associates include brokers, consultants, third-party administrators, and attorneys.

Even if the information is being requested from a Covered Entity or Business Associate, HIPAA only applies if the information constitutes PHI. PHI is individually identifiable health information created or received by a Covered Entity or Business Associate which relates to past, present, or future health care or payment for health care. The key factors here are that (1) the information must be individually identifiable, and (2) it must be health information. Information from a Covered Entity is generally presumed to be individually identifiable unless certain identifiers have been removed (for example, names, dates, ZIP codes). Also, health information is broadly defined as any information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. This includes demographic information that is not inherently health-related. Common examples of PHI include medical records, claims information, and flexible spending account information.

However, importantly, PHI does not include information from an individual's employment records because, again, employers are not directly subject to HIPAA. Accordingly, if an employer receives a request for health-related information maintained in an employee's personnel file (for example, disability accommodations, FMLA certifications, and accident reports), this information is not protected by HIPAA, although other state and federal laws may apply. HIPAA also contains a separate exception that allows an employer to disclose information as authorized by and to the extent necessary to comply with laws relating to workers' compensation.

**Step 2: Assess whether disclosure is allowed under HIPAA based on the kind of document received and who is making the request.**

If HIPAA applies, next you will need to consider whether disclosure of the PHI is allowed. A Covered Entity or Business Associate is generally prohibited from using or disclosing PHI without an individual's authorization unless for purposes of treatment,

payment, or healthcare operations. However, there are limited exceptions to this general rule, including disclosures in administrative or judicial proceedings.

Whether disclosure is permitted is based in part on what kind of document or person is making the request. First and foremost, the requesting party must have proper authority to request the information. Covered Entities and Business Associates should confirm with their legal counsel that such authority is present (for example, subpoenas issued from outside the state are generally unenforceable).

If the order, warrant, subpoena, or summons is issued by a court (that is, signed by a judge or magistrate) or an administrative tribunal, the employer should strictly comply and disclose the information expressly authorized by the order, warrant, subpoena, or demand. The employer should also strictly comply with subpoenas issued in a grand jury proceeding.

If the subpoena or other lawful process is signed by a person other than a judge, magistrate, or administrative tribunal (for example, it is signed by a lawyer, prosecutor, or court clerk), the employer may not disclose information unless and until it has done one of the following: (1) notified the individual that it has received a subpoena requiring disclosure of their information and explained that it is required to respond unless the individual quashes the subpoena and notifies the Covered Entity before the deadline for responding to the subpoena; or (2) obtained satisfactory written assurances from the entity issuing the subpoena that either: (a) the entity made a good faith attempt to give the individual written notice of the subpoena, the notice included sufficient information to permit the individual to object to the subpoena, and the time for raising objections has passed or the court ruled against the individual's objections; or (b) the parties have agreed on a protective order or the entity seeking the information has filed for a protective order. The employer may also consider obtaining a HIPAA-compliant authorization from the individual allowing their information to be released. If the employer receives an administrative subpoena, summons, or investigative demand (such as a subpoena from the Department of Health and Human Services requesting census or claims data from the group health plan in connection with a plan audit), the employer may comply with the request if the issuing entity confirms: (1) the information sought is relevant and material to a legitimate law enforcement inquiry, (2) the request is specific and limited to the extent reasonably necessary for the purpose of the request, and (3) de-identified information could not reasonably be used.

Also, don't forget that HIPAA does not preempt more limited state laws. Covered Entities and Business Associates should be aware of any state laws that impose obligations in addition to those required by HIPAA, and work with legal counsel to ensure that it complies with all applicable legal requirements.

**Step 3: Decide what information should be disclosed.**

Even if HIPAA allows disclosure of the individual's PHI, the Covered Entity or Business associate should only disclose the minimum information necessary to satisfy the request. In other words, disclosures should be limited to the PHI expressly authorized by the order or warrant. If HIPAA does not allow disclosure of the information, then the Covered Entity or Business Associate may not disclose the PHI. However, this does not mean that the request can be ignored. Ignoring a subpoena or court order can subject the Covered Entity or Business Associate to fines and other penalties. If the entity receives a subpoena, but believes that disclosure is prohibited by HIPAA, the entity should respond with an objection based on HIPAA and wait for the court to order disclosure.

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## DOL Releases New MHPAEA Guidance

The Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments) recently issued new Frequently Asked Questions (FAQs) addressing compliance under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The DOL and Department of Treasury are charged with enforcing the MHPAEA's requirements over private group health plans, while HHS governs public sector group health plans. The new FAQs primarily address nonquantitative treatment limitations and include a new model form that individuals can use to request information regarding their benefits governed by the MHPAEA.

**What is the MHPAEA?**

The MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. However, the MHPAEA does not require group health plans and health insurance issuers to cover MH/SUD benefits. Although the law's requirements apply only to large group health plans and health insurance issuers that choose to include MH/SUD benefits in their benefit packages, the Patient Protection and Affordable Care Act (ACA) builds on the MHPAEA and requires coverage of mental health and substance use disorder services as one of ten essential health benefit categories in non-grandfathered individual and small group plans.

Specifically, the MHPAEA requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to annual and lifetime dollar limits, financial requirements, and treatment limitations. If health coverage includes both medical/surgical benefits and MH/SUD benefits, the MHPEA imposes the following limitations:

- Health coverage cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.
- The financial requirements (for example, deductibles and copayments) and treatment limitations (for example, number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. This substantially all/predominant test must be applied separately to six classifications of benefits: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drug.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to MH/SUD benefits.
- If the health coverage provides for out-of-network medical/surgical benefits, it must also provide for out-of-network MH/SUD benefits.
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

Treatment limitations may be quantitative treatment limitations (QTLs), which are numerical in nature (such as visit limits), or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment (such as preauthorization requirements). The rules for financial requirements and QTLs are different from the rules for NQTLs, and group health plans and health insurance issuers have historically struggled more to comply with the NQTL rules.

**Mental Health Parity Implementation Final FAQs**

The new FAQs address various NQTLs, and whether specific plan designs and practices are consistent with the MHPAEA. The new FAQs also reiterate disclosure requirements under the MHPAEA (such as criteria for medical necessity determinations with respect to MH/SUD benefits, and the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits). These specific disclosure requirements are in addition to the general obligations under Section 104(b) of the Employee Retirement Income Security Act (ERISA), which require disclosure of instruments under which the plan is established or operated (and other documents) to plan participants within 30 days of request. The FAQs note that "instruments under which the plan is established or operated" include documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

To simplify the process for requesting this information, the FAQs include a new claims form that participants and beneficiaries may use to request information from a health plan concerning treatment limitations. The claims form replaces earlier versions issued in June 2017 and April 2018, and allows individuals to request various types of MH/SUD benefits-related information from the plan by checking boxes on the form.

Information and documents that may be requested on the new form include:

- Specific plan language concerning a treatment limitation
- All of the medical/surgical and MH/SUD benefits to which the limit applies for a given benefit classification
- Factors used in developing plan limits (for example, excessive utilization), and sources used to evaluate the factors (including any processes, strategies, or evidentiary standards)
- Methods and analyses used in developing plan limits
- Evidence demonstrating that a plan limit was applied no more stringently (as written and in operation) to MH/SUD benefits than to medical/surgical benefits

Any information or documentation requested in the form must be provided to the participant within 30 calendar days from the date that the group health plan or health insurance issuer receives the request.

**FY2018 MHPAEA Enforcement Fact Sheet**

In conjunction with the FAQs, the DOL also issued an "Enforcement Fact Sheet" reporting on the DOL's MHPAEA investigations during the 2018 fiscal year. The DOL conducts MHPAEA compliance reviews, including for compliance with the requirements for QTLs and NQTLs. Many of these reviews stem from participant complaints where the facts suggest the problems are systemic and adversely impact other participants. The 2018 Fact Sheet reported that the DOL investigated and closed 115 health plan investigations in 2018 that involved plans subject to MHPAEA and cited 21 MHPAEA violations as a result of these investigations. Of these violations, 55 percent involved NQTLs.

The DOL also released information regarding its 2018 enforcement strategy, which explains that the DOL's enforcement approach has shifted toward the following two goals: (1) maximizing the DOL's limited resources by focusing on investigations targeted to achieve high impact (for example, working with third-party administrators to obtain voluntary global corrections in cases where a violation relates to an insurance product, prototype document, or systemic operation affecting multiple group health plans); and (2) using specialized, interdisciplinary teams to target and evaluate complex MHPAEA compliance issues like NQTLs.

**What this Means for Employers**

The new FAQs, along with the enforcement strategy factsheet, should remind employers that MHPAEA enforcement is still a priority for the DOL. Although compliance with NQTLs has been a high-priority item for the DOL over the last several years, the focus on plan disclosures involving MH/SUD benefits in the FAQs may signal an upcoming emphasis on ensuring that plans are timely providing parity-related documents in response to participants' requests. Employers may also see additional activity from employees seeking parity-related information, and recourse from employees when such information is not timely or sufficiently provided (like lawsuits or complaints to the DOL). Group health plans should expect to receive participant requests for plan information regarding plan limits affecting MH/SUD benefits and related information. Accordingly, employers should work with their brokers or ERISA counsel to evaluate their current administrative processes and confirm that procedures are in place to timely respond to those requests.

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## New Overtime Rule under the Fair Labor Standards Act

The Department of Labor (DOL) recently announced a new overtime rule that expands employers' obligations to pay overtime to an estimated 1.3 million workers. Discussions about changing the rule have been ongoing since early 2016, when President Obama directed the DOL to revise the regulations governing the white-collar exemptions under the Fair Labor Standards Act (FLSA). The new rule increases the minimum salary threshold for FLSA white collar exemptions to approximately $35,568 per year, which is a moderate increase from the current threshold of around $23,660 per year. The acting labor secretary, Patrick Pizzella, described this rule as "a common-sense approach that offers consistency and certainty for employers as well as clarity and prosperity for American workers." The rule will take effect on January 1, 2020, and employers should be wary of the new implications.

**Background**

Under the FLSA, covered employers are generally required to pay employees one and one-half times their regular rate of pay for any time worked in a week that is over forty hours (that is, overtime pay). However, as with many rules, there are exceptions. The white-collar exemptions under the FLSA spare employers from paying overtime to administrative, executive, and professional employees, among others. Determining whether an employee is exempt depends on the employee's primary job duties, level of discretionary authority, and whether a minimum salary requirement is met. The current minimum salary threshold was set in 2004 under the Bush administration and dictates that any employee earning less than $455 per week is nonexempt and entitled to overtime pay.

Rumblings regarding raising the minimum salary threshold began in the early days of the Obama administration. On May 23, 2016, the DOL published a rule raising the minimum salary for exempt employees to $913 per week (annualized to $47,476 per year). The 2016 rule more than doubled the salary threshold for exempt employees and included a provision that would automatically increase the threshold amount every three years. An estimated 4.2 million workers would have been affected by the 2016 rule.

The rule was scheduled to take effect on December 1, 2016. However, 21 states and a myriad of employer-friendly organizations filed lawsuits across the country. These suits were consolidated before the United States District Court for the Eastern District of Texas, and an emergency motion for a preliminary injunction was filed to prevent the 2016 rule's implementation. On November 22, 2016, just ten days before implementation, Judge Amos Mazzant granted the motion and temporarily blocked the new overtime rule. Judge Mazzant later granted summary judgment on the issue, finding that the DOL exceeded its rulemaking authority and permanently striking down the 2016 rule.

Employers have been anxiously waiting for a new overtime rule to take root. The DOL has spent months holding public forums, issuing a request for information, sending a proposal to the Office of Management and Budget, and seeking comments on the proposed rule. Finally, on September 24, 2019, the DOL issued a final rule raising the threshold salary for white-collar exemptions under the FLSA.

**Highlights from the New Overtime Rule**

Starting January 1, 2020, the new overtime rule will:

- Raise the salary threshold to $684 per week or $35,569 per year. The DOL only contemplates one salary threshold, regardless of exemption, location, or industry. Employers may use non-discretionary bonuses and incentive payments (like commissions), paid at least annually, to offset up to 10 percent of the salary threshold; provided that the employee is paid at least 90 percent of the threshold amount (at least $615.60 per week). If the salary paid plus the additional bonuses and payments do not equal the threshold salary after fifty-two weeks, the employer will have one additional pay period to make up the difference.
- Raise the total annual compensation requirement for highly compensated employees from $100,000 to $107,432. Further, to be exempt as a highly compensated employee, an employee must receive at least $684 per week on a salary or fee basis.
- Modify the special salary levels for workers in U.S. territories, such as Puerto Rico, Guam, the U.S. Virgin Islands, America Samoa, and the Commonwealth of the Northern Mariana Islands.
- Modify the special salary level for the motion picture industry.

The new rule has not affected the job duties test, which is the crux of the white-collar exemption analysis. Under the test, an employee's job duties must primarily involve executive, administrative, or professional duties as defined by DOL regulations. Further, unlike the 2016 rule, the new overtime rule does not include a provision that automatically adjusts the threshold salary. However, the DOL voiced its intent to assess and update the salary thresholds more frequently through the notice and comment rulemaking process.

**What This Means for Employers**

Though there is always a chance that a court could grant a last-minute injunction to stop implementation

of the new rule, it seems unlikely given the more reasonable salary threshold and the revisions that the DOL made to the 2016 rule. Employers should work with their attorneys and advisors to develop a compliance strategy that fits their business priorities and be prepared to implement the new rule in 2020.

For example, some currently exempt workers may need to be reclassified to nonexempt status if they do not meet the new salary threshold. Alternatively, employers may consider raising workers' pay to meet the new threshold salary. This latter option may be particularly attractive for those job positions that commonly work more than forty hours a week. However, simply raising an employee's salary does not necessarily mean that he or she will be exempt. The employee must still meet the requirements of the job duties test to be exempt from overtime pay, and simply raising the salary of an employee who does not meet these requirements may increase the potential damages available to them in the event of lawsuit for unpaid overtime under the FLSA. The new rule will take effect January 1, 2020, and employers should begin analyzing their options and developing a thoughtful pay strategy as soon as possible to ensure compliance.

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## Is Your VEBA a MEWA? If So, You May Be Subject to the Annual Fee on Health Insurance Providers

The Court of Federal Claims recently determined that Voluntary Employees' Beneficiary Associations (VEBAs) constituting Multiple Employer Welfare Arrangements (MEWAs) are subject to the annual fee on health insurance providers imposed under Section 9010 the Patient Protection and Affordable Care Act (ACA) (*Iowa Bankers Benefit Plan v. United States*). Employers taking advantage of VEBAs and MEWAs should assess the applicability of this ruling to their arrangement, and if applicable, make sure that they are reporting premium data and paying required fees to the Internal Revenue Service (IRS).

### Background

Section 9010 of the ACA imposes an annual fee on each covered entity engaged in the business of providing health insurance in the United States. A "covered entity" is defined as any entity that provides health insurance for any United States health risk. Certain types of entities are specifically excluded from the definition of covered entity, and therefore, the annual fee requirement. Two relevant exceptions include: (1) any entity which is described in Section 501(c)(9) of the Internal Revenue Code (the Code) and which is established by an entity other than by an employer or employers for purposes of providing healthcare benefits (Section 9010(c)(2)(D)), and (2) any employer to the extent that such employer self-insures its employees' health risks (Section 9010(c)(2)(A)). Regulations adopted by the Department of Treasury clarify that the exclusion under Section 9010(c)(2)(D) does not apply to MEWAs.

The covered entity's annual fee is dictated by a statutorily defined formula that generally requires the covered entity to pay a portion of the aggregate fee amount each year for all covered entities under Section 9010, as determined by the IRS. To determine its fee amount, each covered entity (including each controlled group that is treated as a single covered entity) must report its net premiums during the previous year to the IRS by April 15 of the year in which the fee is due. This reporting is done on a Form 8963. The IRS will then make a preliminary calculation of the fee, which is communicated to the covered entity using Letter 5066C. Each covered entity must then pay its fee to the IRS by September 30 of the applicable fee year.

### Court Rules that VEBA is Subject to the Annual Fee on Health Insurance Providers

Iowa Bankers Insurance and Services, Inc. (IBIS) established a benefit plan to provide a variety of health and welfare benefits to financial employers located in Iowa (the Plan). From 2014 to 2016, the Plan paid around $3.7 million in fees under Section 9010. However, believing that the Plan was exempt from those fees, IBIS sought refunds from the IRS. The IRS did not return the Plan's fee payments, so the Plan filed suit in June 2017.

The Plan qualifies as both a VEBA and a MEWA. A VEBA is a trust that provides for the payment of life insurance, sickness, accident, or other benefits to its members. Internal Revenue Code section 501(c)(9) exempts VEBA benefit payments to its members from federal income tax. Any group of employees that share a qualifying employment-related bond may establish a VEBA, and an employer (or multiple

employers) may establish a VEBA on behalf of their employees. By contrast, a MEWA is an arrangement that is established or maintained for the purpose of offering or providing welfare benefits to the employees of two or more employers (but does not include plans or arrangements established or maintained pursuant to collective bargaining agreements).

During the proceedings, the Plan argued that it is not an entity subject to the annual fee for two alternative reasons: (1) because it is a VEBA established by an entity (other than by an employer or employers) under Section 9010(c)(2)(D), or (2) because the entity constitutes a single employer that self-insures its own employees' health risks under Section 9010(c)(2)(A).

The Court concluded that Section 9010(c)(2)(D) is ambiguous as to whether an entity like the Plan is "established . . . by an employer or employers," such that it does not qualify for the exclusion from the annual fee. Thus, the Court relied on the Department of Treasury's regulations in concluding that VEBAs created and maintained solely by multiple employers, which by definition qualify as MEWAs, are "established . . . by an employer or employers" and do not qualify for Section 9010(c)(2)(D)'s exclusion. The exclusion does not apply to an entity that is both a non-fully insured MEWA and a VEBA because it is established by the employers whose employees participate in the MEWA.

Further, in response to the Plan's alternative argument that it qualifies for the Section 9010(c)(2)(A) exclusion as an arrangement of a "single employer" that self-insures its own employees, the Court held that this defense had been waived because it was not raised in the Plan's complaint. But, the Court went on to explain that, on the merits, the claim still failed because the ERISA Section 3(5)'s broad definition of employer did not apply to ACA Section 9010 and the Plan's participating employers could not constitute a single entity under ERISA or the Code.

**What this Means for Employers**

The Court's decision ultimately provides that, while VEBAs may fall under a "covered entity" exclusion, MEWAs do not qualify for this exception. Thus, employers sponsoring VEBAs should assess whether their arrangement constitutes a MEWA, and if so, seek legal counsel to determine their obligation to pay annual provider fees under Section 9010 of the ACA.

Because the current administration has historically sought to encourage association health plans, and the imposition of this type of fee may deter such arrangements, it is unclear whether this ruling will spark further action by regulators to broaden the covered entity exceptions. Employers maintaining or considering such an arrangement should stay tuned. However, for now, arrangements like the one established by IBIS should continue complying with the reporting and fee payment obligations imposed on covered entities by the IRS.

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