COMPLIANCE UPDATE

AssuredPartners

3RD QUARTER 2018

Medicare Part D Notices

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires group health plan sponsors that provide prescription drug coverage, to annually disclose to individuals eligible for Medicare Part D whether the plan's coverage is creditable or non-creditable.

This notice is important because Medicare beneficiaries who are not covered by creditable prescription drug coverage and do not enroll in Medicare Part D when first eligible will likely pay higher premiums if they enroll at a later date. Although there are no specific penalties associated with this notice requirement, failing to provide the notice may be detrimental to employees and may cause consequences for employers if an employee does have to pay a higher premium.

***Plan sponsors must provide the annual disclosure notice to Medicare-eligible individuals before Oct. 15, 2018* —the start date of the annual enrollment period for Medicare Part D.**

CMS has provided two model notices for employers to use:

- A **Model Creditable Coverage Disclosure Notice** for when the health plan's prescription drug coverage is creditable; and
- A **Model Non-creditable Coverage Disclosure Notice** for when the health plan's prescription drug coverage is not creditable.

These model notices are also available in Spanish on CMS' **website**. Plan Sponsors should carefully review and customize these notices to ensure they accurately reflect their plan provisions.

Disclosure notices must be provided to all Part D eligible individuals who are covered by, or who apply for, the plan's prescription drug coverage, regardless of whether the prescription drug coverage is primary or secondary to Medicare Part D.

The disclosure notice requirement applies to Medicare beneficiaries who are active or retired employees, disabled or on COBRA, as well as Medicare beneficiaries who are covered as a spouse or dependent. To simplify plan administration, we recommend plan sponsors provide the disclosure notice to ALL plan participants.

Summary Annual Reports Due

ERISA Plans that do not meet an exemption for filing Form 5500 must provide a Summary Annual Report (SAR), a narrative summary of a plan's Form 5500, to plan participants by the last day of the ninth month following the end of the plan year. For calendar year plans, the deadline is **September 30th**. Plans that have filed for an extension to filing the Form 5500 must provide the SAR within two months after the extension.

ACA Reporting

The IRS has released the DRAFT forms and related instructions (see links below) for the 2018 Section 6055 and 6056 reporting, required by the Affordable Care Act (ACA). The forms are essentially unchanged from the 2017 forms but should not be filed with the IRS until they have been released as FINAL.

Forms must generally be filed with the IRS no later than February 28 (March 31, if filed electronically) of the year following the calendar year to which the return relates. Individual statements must be furnished to individuals on or before Jan. 31 of the year immediately following the calendar year to which the statements relate. The IRS extended the deadline for furnishing the individual statements for 2017 but there has been no indication yet of an extension for 2018. Employers should prepare to adhere to the previously required deadlines.

If you are looking for a reporting vendor, please contact your AssuredPartners' Benefits Team for information about our reporting services, AssuredAnswers.

Links and Resources:

- 2018 Draft forms **1094-C** and **1095-C** - for use by all applicable large employers (ALEs) (fully insured and self-insured)
- 2018 Draft forms **1094-B** and **1095-B** - for use by insurers and self-insured plan sponsors that are not ALEs
- 2018 Draft **Instructions for forms 1094-C and 1095-C**
- 2018 Draft **Instructions for forms 1094-B and 1095-B**
- **Q&As on Section 6055** and **Q&As on Section 6056**
- **Q&As on Employer Reporting using Form 1094-C and Form 1095-C**.

Affordable Health Plans in 2019

For plan years beginning in 2019, employer-sponsored coverage will be considered affordable if the employee's required contribution for self-only coverage does not exceed 9.86 percent of the employee's household income for the year, for purposes of both the pay or play rules and premium tax credit eligibility.

Exchange Model Notice

The Department of Labor (DOL) recently extended the expiration date on its **model Exchange notices** through May 31, 2020. These model notices (or a modified version), which the DOL calls "Model Notices to Employees of Coverage Options," may be used to comply with the Exchange notice requirement under the Affordable Care Act (ACA).

Background

As of 2013, the ACA requires all employers that are subject to the Fair Labor Standards Act (FLSA) to provide a written notice to their new employees about the ACA's Health Insurance Exchanges (known as Exchanges or Marketplaces). The notice must be provided to all new hires within 14 days of the employee's start date. However, there is no requirement to provide the Exchange notice to current or existing employees on an annual basis.

The Exchange notice must:

- Include information regarding the existence of an Exchange, as well as contact information and a description of the services provided by an Exchange;
- Inform the employee that he or she may be eligible for a premium tax credit if the employee purchases a qualified health plan through the Exchange; and
- Contain a statement informing the employee that, if he or she purchases a qualified health plan through the Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of that contribution may be excludable from income for federal income tax purposes.

More compliance assistance information is available in a **DOL Technical Release**.

Extended Expiration Date

Although the DOL recently extended the expiration date on its model Exchange notices, through May 31, 2020, the content of the DOL's model notices has not substantively changed, and the expiration date does not mean that the model notice is out-of-date or that employers should stop using it. The expiration date is included on the model notices largely as an administrative function for the DOL and does not impact the notices' applicability or an employer's ability to use them. Employers can continue to use and rely on DOL model notices after the expiration date has passed.

No Penalties for Failure to Comply

Although employers should provide an Exchange notice to their new hires, the DOL asserted in an **FAQ** that there is no fine or penalty under the ACA for failing to provide the notice. This means that employers cannot be fined for failing to provide employees with notice about the ACA's Exchanges.

However, there are several reasons employers may still want to provide the notice. For example, the Exchange notice can help employers answer employee questions about what the Exchange is, how Exchange plans are different from the employer's plan and whether the employer's plan is intended to be affordable and provide minimum value. If the employer's plan is affordable and provides minimum value, employees will not be eligible for federal subsidies through the Exchange.

— Source: Zywave

New Model FMLA Forms

The DOL's model FMLA forms expired earlier this year, on May 31, 2018. The DOL extended the forms' expiration date on a month-to-month basis while it waited for the OMB approval to release updated forms. After receiving the OMB's approval, the DOL released the updated model forms, which contain the new expiration date of Aug. 31, 2021.

Employers that use the model FMLA forms should start using the DOL's updated models as soon as possible. Although no substantive changes were made to the updated FMLA forms, they contain a new expiration date. The updated model forms as well as other very helpful information is available on the DOL's FMLA **webpage**.

Health FSA Carryovers

In a **response** to an individual's request for a change in the health FSA rules, one that would allow savings to be accumulated over several years, the IRS reminds us of the basic rules on health FSA carryovers.

Under the current rules, employers do have the option of including a provision in their health FSA that will allow amounts unused at the end of the plan year, up to $500, be carried over to the next year.

However, offering a carryover is an alternative to offering a health FSA grace period. Health FSA plans are not allowed to include both.

Allowing a carryover can help reduce health FSA forfeitures, may encourage more employees to participate in the health FSA and may also ease the year-end spending rush that often occurs with many health FSAs. Keep in mind, there are administrative and compliance issues that must be considered when determining whether health FSA carryovers should be implemented.

The IRS response also includes a reminder that there are two other account-based plans that an employer may establish-HSAs and HRAs-that do allow funds to be accumulated and used for medical expenses incurred in later years.

—Source: EBIA Weekly – September 6, 2018 (Thomson Reuters EBIA Checkpoint)

Employers Not Required to Provide Specific Requested Reasonable Accommodations

The Americans with Disabilities Act (ADA), as well as state and local laws, requires that employers provide reasonable accommodations to employees with disabilities. Employees are able to request specific reasonable accommodations, but employers are not required to provide all requests as they may choose among these reasonable accommodations or provide alternatives (as long as the reasonable accommodation is effective).

In a recent court case, **Sessoms v. Trustees of the Univ. of Pennsylvania** (June 20, 2018), the Third Circuit Court of Appeals (covering DE, NJ & PA) ruled in favor of the University of Pennsylvania saying they demonstrated good faith in its negotiations on reasonable accommodations for their employee. The employee, who suffered from mental and physical disabilities as well as having difficulties with her supervisor, requested that the University of Pennsylvania allow her to work on a part-time basis, before returning to full-time, after her medical leave and to transfer her to a new, "lower-stress" department under a new supervisor.

The University of Pennsylvania chose to accommodate her request for a part-time schedule but kept her in the same position under the same supervisor. The employee declined this reasonable accommodation and was ultimately terminated. She filed the lawsuit claiming they did not engage in a good-faith effort to reasonably accommodate her requests/disabilities. As already stated, the court ruled in the University of Pennsylvania's favor and concluded that the employee did not provide evidence of other available positions and that her unwillingness to accept the part-time schedule which included working under the same supervisor was unreasonable.

The **Equal Employment Opportunity Commission (EEOC)** already stated long before this that an employer is not required to provide the requested reasonable accommodations and can instead consider alternatives, stating that:

— Source: AP Benefit Advisors Blog, August 24, 2018.

MLR Rebates

The Affordable Care Act (ACA) established medical loss ratio (MLR) rules to help control health care coverage costs and ensure that enrollees receive value for their premium dollars. The MLR rules require health insurance issuers to spend 80-85 percent of premium dollars on medical care and health care quality improvement, rather than administrative costs.

Issuers that do not meet these requirements must provide rebates to consumers. Rebates must be provided by September 30 following the end of the MLR reporting year. **For the 2017 reporting year, issuers are required to pay rebates by September 30, 2018.**

Employers that receive a rebate must quickly determine what their MLR requirements are (requirements vary depending on the type of plan and whether the funds are plan assets) and what options they have for distributing these funds.

Employers have only 90 days from the date they receive a rebate to complete their handling and any distribution of the rebate.

Federal Court Approves $115 Million Settlement

In re Anthem, Inc. Data Breach Litigation, 2018 WL 3872788 (N.D. Cal. 2018)

Available at **https://www.gpo.gov/fdsys/pkg/USCOURTS-cand-5_15-md-02617/pdf/USCOURTS-cand- 5_15-md-02617-53.pdf**

A federal court has approved a proposed **$115 million** class action settlement arising from a breach of protected health information (PHI) that was discovered in 2015 and affected more than 78 million individuals. The settlement provides class members who took corrective or protective actions in response to the data breach **up to $10,000 each** ***(up to $15 million in the aggregate)*** for reimbursement of out-of-pocket expenses. Class members also received fraud resolution services, and those submitting claims are entitled to no-cost credit monitoring services for six years, including identify theft insurance, or an alternative cash payment.

The results of this case illustrate the importance of closely monitoring compliance with HIPAA's privacy and security rules. Group health plans, employer-plan sponsors, and business associates must have incident response and breach notification plans ready to go. Constant vigilance is the best policy.

For more information on HIPAA compliance, **click here** to view the recording of our recent client webinar, ***"HIPAA Privacy Rule & Security Rule Risk Analysis"***

— Source: EBIA Weekly – September 6, 2018
(Thomson Reuters EBIA Checkpoint)

ONE TO WATCH

The House Rules Committee met on September 12, 2018 to prepare the Save American Workers Act of 2018 and the expectation is it will be brought before the full House of Representatives very soon.

This bill generally applies to applicable large employers, subject to the Affordable Care Act's employer

mandate. The bill would:

- Repeal the 30-hour threshold for classification as a full-time employee for purposes of the employer mandate and replace it with a 40-hour per week threshold.
- Suspend the employer mandate from December 31, 2014 to January 1, 2019.
- Delay implementation of the "Cadillac Tax" – the 40% excise tax on high cost employer- sponsored health coverage – to December 31, 2022.
- Repeal the excise tax on indoor tanning services.
- Require individual health insurance coverage statements, i.e. Forms 1095-B and 1095-C, be furnished only upon request by the individual with respect to whom the information is reported. This change would apply to statements with respect to returns for calendar years after 2018.

According to one of the bill's supporters, William F. Sweetnam, Jr., ECFC Legislative and Technical Director, "[g]iven that the House Rules Committee usually does not take up legislation that will not pass in the House, we should anticipate that H.R. 3798 will be passed by the House when it is considered." The bill will then move to the Senate for consideration, the timing of which is uncertain, stated Sweetnam, since the Senate has yet to consider any health care bills passed by the House since July of this year. "Nevertheless, the provisions of all of these bills could be in the mix in any larger legislative package that the Senate will consider this year," he noted.

We will continue to monitor the status of these bills and provide our clients with any updates as they are received.

Should you have any questions or concerns about any of the topics addressed in this Newsletter, please contact a member of your AssuredPartners compliance team.