2019: Third Quarter

# Compliance Digest

## Compliance Bulletins Released July-September

Laurie Bracelin | Millenium Insurance Group

(717) 354-4774 | lbracelin@millig.com

# 2019 Compliance Bulletins

## July



## August



## September



# Excepted Benefit HRAs

## Highlights from the Final Rule

Published: July 1, 2019

The Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") finalized rules creating two new Health Reimbursement Arrangement (HRA) options available to employers beginning January 2020. These final rules generally follow the proposed guidance (issued in October 2018) with some notable changes.

This article addresses the new Excepted Benefit HRA ("EB HRAs"). Individual Coverage HRAs are discussed in a separate update.

Briefly, beginning with the first plan year on or after January 1, 2020, employers are permitted to offer EB HRAs. An EB HRA is generally available when an employer offers a traditional group health plan, subject to certain conditions, including a $1,800 maximum annual benefit.

### Excepted Benefit HRA

The regulations create an EB HRA. This type of HRA is different from an HRA integrated with a group health plan or an individual coverage HRA and is subject to more restrictive conditions.
To be considered an EB HRA (or other account-based plan), the arrangement must meet the following conditions:

- The annual EB HRA contribution cannot exceed $1,800. The $1,800 will have a cost-of- living adjustment annually beginning with the 2021 plan year.

- The EB HRA must be offered with a traditional group health plan, although the employee is not required to enroll in the traditional group health plan to access the HRA. This is a significant difference from previous rules that only permitted employers to offer integrated HRAs, which require coverage in the group health plan coverage.

- The EB HRA cannot reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA premiums), or Medicare premiums.

- The EB HRA must be made available under the same terms to similarly situated individuals regardless of any health factor.

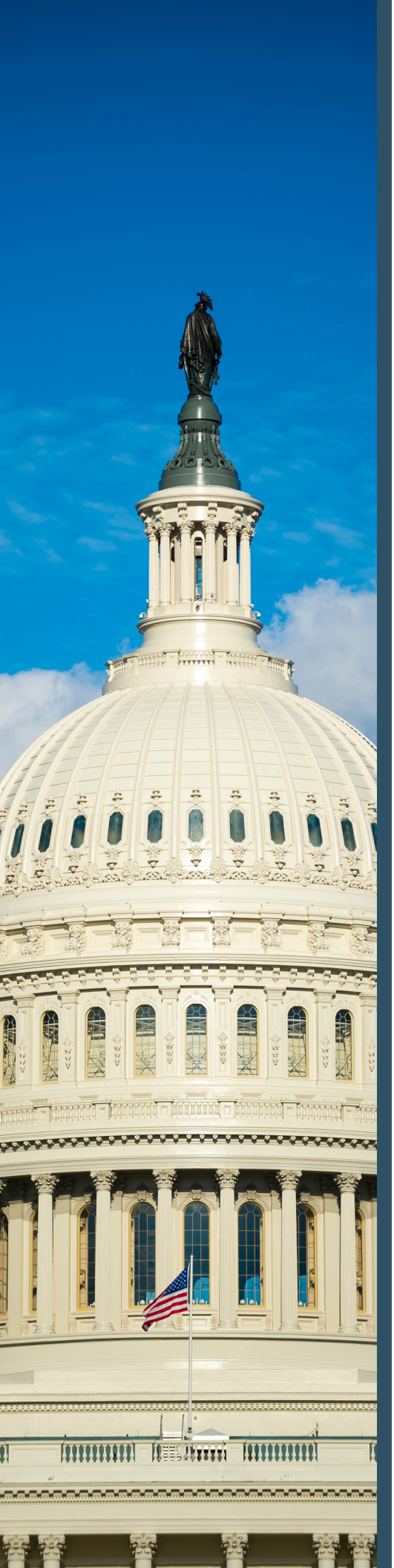
It is important to note the following:

- If an employer offers an EB HRA, the employer may not offer a QSEHRA or an Individual Coverage HRA to the same person.

- An EB HRA may be disqualifying coverage for purposes of HSA eligibility if it reimburses medical expenses otherwise covered by a qualified high deductible health plan (QHDHP) prior to satisfaction of the required deductible. Thus, this is not likely a good option if offering a QHDHP and health savings account (HSA).

## Employer Action

Employers may want to look at whether offering an EB HRA is an option for their employee benefit plan strategy in 2020 or beyond. Employers interested in adding an EB HRA to their benefit offerings should review the final rule and supporting guidance and work with their benefits consultant and third-party administrators to understand the various requirements.



# New Executive Order Addresses Healthcare Issues

Published: July 5, 2019

On June 24, 2019, President Trump issued an Executive Order ("EO") directing the relevant federal agencies to issue regulations or other guidance to make available more meaningful information related to the price and quality of healthcare.

This summary highlights aspects of the EO that may be relevant to employer-sponsored group health plans and their covered participants.

- By October 22, 2019, the Treasury shall issue guidance to expand the ability of patients to select a qualified high-deductible health plan ("QHDHP") that can be used alongside a health savings account ("HSA"), and that cover low-cost preventive care, before the deductible, for medical care that helps maintain health status for individuals with chronic conditions. This may provide first dollar coverage of more items and services for individuals with a QHDHP, particularly as it relates to individuals with chronic conditions (e.g., diabetes).

- By December 21, 2019, the Treasury shall propose:
  - Regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under section 213(d). This has the potential to make the monthly fees associated with certain programs reimbursable through a health FSA, HRA, or HSA.
  - Guidance to increase the Health FSA carry over without penalty. This could increase the dollar amount available for a health FSA carryover (currently capped at $500).

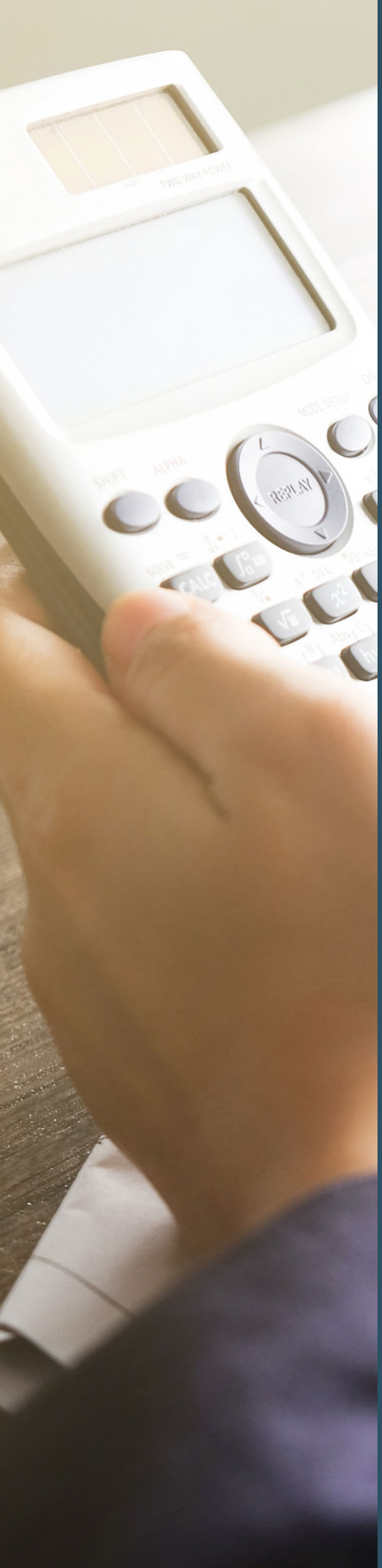
- By August 23, 2019, the Department of Health and Human Services ("HHS") shall issue regulations requiring hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format. Currently we have varying state laws and federal rules that took effect in January under the ACA that required hospitals to post online their "list prices," but hospitals set them themselves and they have little relation to actual costs or what insurers actually pay.

- By December 21, 2019, HHS shall submit a report to the President on additional steps the Administration may take to address issues on surprise medical billing.

- By September 22, 2019, direct the relevant agencies to solicit comments on a proposal to require healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care.

## Next Steps

The EO provides the relevant agencies with their marching orders to develop new regulations and other guidance on these issues. In the next 3-6 months, it is likely we will see new proposed rules that may directly impact employer health plans. We will continue to keep you apprised.



# IRS Expands Preventive Care for QDHDPs

Published: August 6, 2019

On June 24, 2019, the President issued an Executive Order directing the Department of the Treasury and the IRS to issue guidance that expands the ability of HSA-qualifying high-deductible health plans (QHDHPs) to cover low-cost preventive care that helps maintain health status for individuals with chronic conditions before the statutory minimum deductible for QHDHPs has been met. In response, on July 17, 2019, the Treasury Department and IRS issued Notice 2019-45 expanding the list of preventive care benefits.

Briefly, the following services and items are treated as preventive care when:

- prescribed to treat an individual diagnosed with the associated chronic condition (as specified in the IRS guidance), and
- prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition.

| Preventive Care for Specified Conditions | For Individuals Diagnosed with |
|---|---|
| Angiotensin Converting Enzyme (ACE) inhibitors | Congestive heart failure, diabetes, and/or coronary artery disease |
| Anti-resorptive therapy | Osteoporosis and/or osteopenia |
| Beta-blockers | Congestive heart failure and/or coronary artery disease |
| Blood pressure monitor | Hypertension |
| Inhaled corticosteroids | Asthma |
| Insulin and other glucose lowering agents | Diabetes |
| Retinopathy screening | Diabetes |
| Peak flow meter | Asthma |
| Glucometer | Diabetes |

| Preventive Care for Specified Conditions | For Individuals Diagnosed with |
|---|---|
| Hemoglobin A1c testing | Diabetes |
| International Normalized Ratio (INR) testing | Liver disease and/or bleeding disorders |
| Low-density Lipoprotein (LDL) testing | Heart disease |
| Selective Serotonin Reuptake Inhibitors (SSRIs) | Depression |
| Statins | Heart disease and/or diabetes |

Services and items not listed here that are for secondary conditions or complications that occur notwithstanding the preventive care are not treated as preventive care for this purpose.

Any items or services that constitute preventive care under earlier guidance, continue to be treated as preventive care. Further, nothing in Notice 2019-45 affects the definition of preventive care under the ACA and the services and items included on this list are not treated as ACA mandated preventive care.

The IRS will review the list of preventive care services and items every 5-10 years to determine whether additional items or services should be added or removed.

This guidance is effective July 17, 2019.

## Why is this Helpful?

In order to preserve HSA eligibility, individuals must satisfy the statutory minimum deductible before the QHDHP can pay for non-preventive medical services or items. While the QHDHP is permitted to cover preventive care items and services before satisfaction of the required deductible, the list of permitted preventive care is narrow and only includes preventive services and items:

- as required to be covered by non-grandfathered plans under the ACA; and

- as described in IRS Notice 2004-23, which includes:
  - periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations);
  - routine prenatal and well-child care;
  - immunizations for adults and children;
  - tobacco cessation and obesity weight-loss programs; and
  - screening devices.

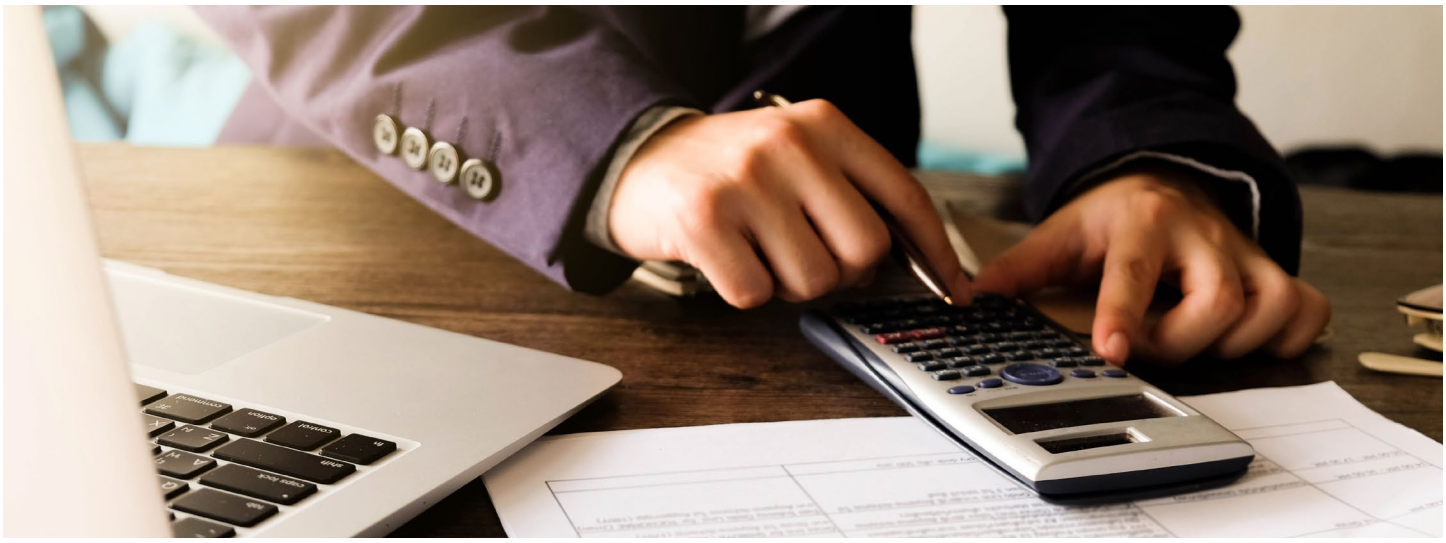
Importantly, under this definition, preventive care does not include any service or benefit intended to treat an existing illness, injury, or condition. Thus, many individuals with certain chronic conditions must satisfy the minimum deductible before the plan would pay for services and items associated with their condition.

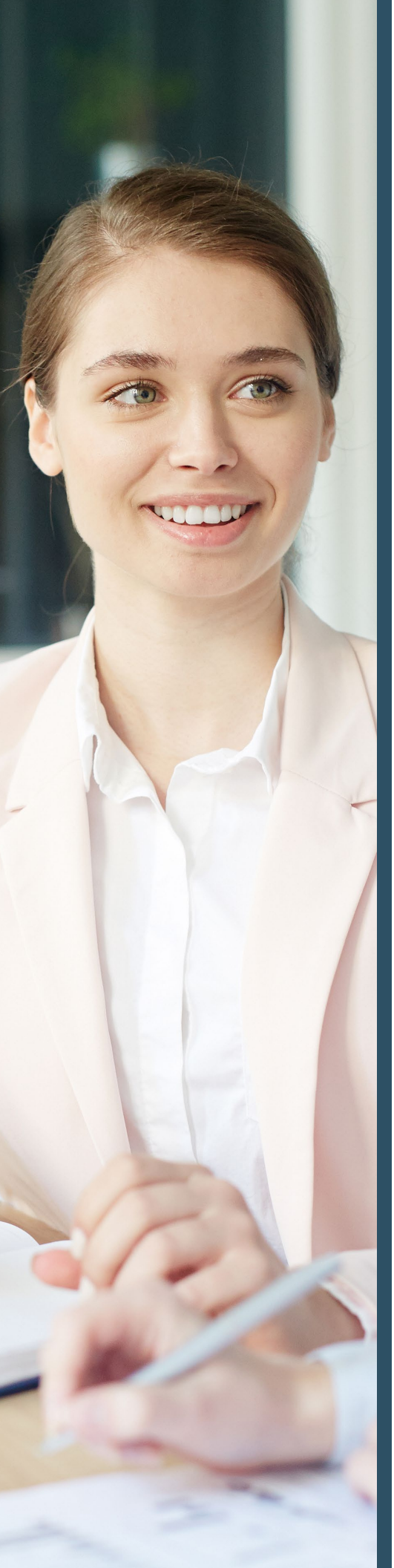
This new guidance allows individuals diagnosed with certain chronic conditions (as described in the IRS list) to have certain services and items treated as preventive care by the QHDHP when prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition.

## Employer Action

- **Fully insured QHDHPs.** The insurance carrier will determine when to expand the definition of preventive care as permitted under this guidance. Carriers may wait until the next policy year to make this change or may make the change mid-year.

- **Self-funded QHDHPs.** Plans may be amended to adopt this expanded definition of preventive care for individuals with chronic conditions mid-year or wait until the next plan year. Any change is subject to approval by the TPA and stop loss carrier.





# IRS Announces 2020 ACA Affordability Indexed Amount

Published: August 6, 2019

The IRS recently announced in Revenue Procedure 2019-29 that the Affordable Care Act (ACA) affordability indexed amount under the Employer Shared Responsibility Payment (ESRP) requirements will be 9.78% for plan years that begin in 2020. This is a decrease from the 2019 percentage amount (9.86%).

## Background

Rev. Proc. 2019-29 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

## Determining Affordability in 2020

An employer will not be subject to a penalty with respect to an ACA full-time employee (FTE) if that employee's required contribution for 2020 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

1. The W-2 safe harbor.

   The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.78% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

2. Rate of pay safe harbor.

   The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.78% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

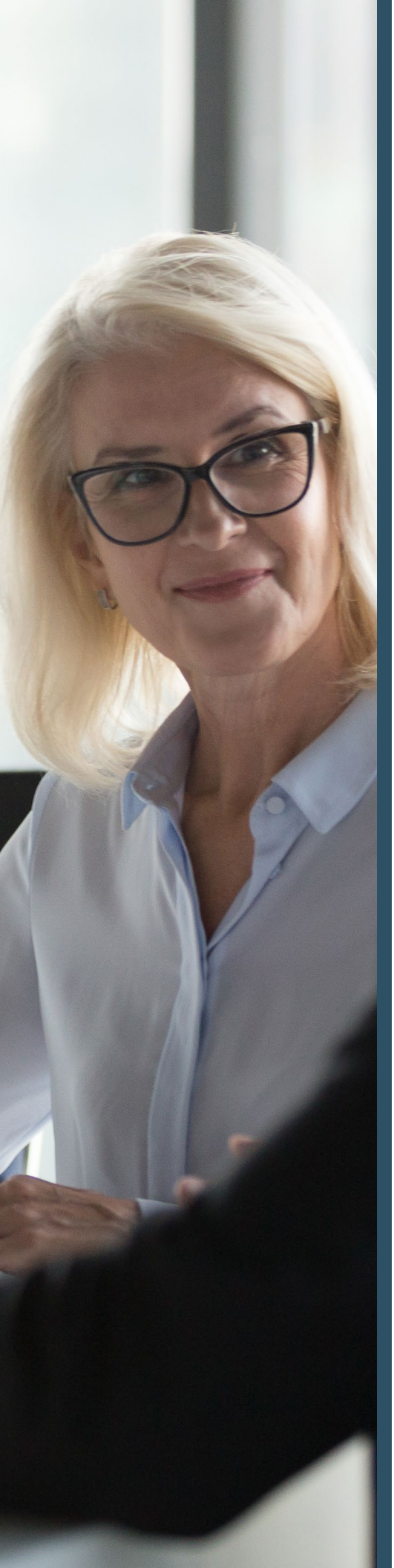
3. Federal Poverty Level (FPL) safe harbor.

   Coverage is affordable if it does not exceed 9.78% of the FPL.

   For a 2020 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $101.79 (48 contiguous states), $127.14 (Alaska), or $117.19 (Hawaii).

## Employer Action

Employers budgeting and preparing for the 2020 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.



# Anti-Assignment Clause Upheld Against Out-Of-Network Provider

Published: September 6, 2019

Another recent court case highlights how self-insured group health plans should ensure their plan documents contain strong language that prohibits third parties, particularly out-of-network health providers, from being assigned rights to pursue claims against such plans on behalf of a member. Such anti-assignment clauses can reduce some litigation risks.

## Background

Self-insured group health plans frequently provide members with coverage when using out-of-network medical providers. Generally, claims for such providers' services are susceptible to denial and "offset." When a plan denies a claim, out-of-network providers may be left trying to collect the balance of billed charges from members, who often do not have the resources to pay. Thus, out-of-network providers routinely require patients to sign assignment-of-benefit forms, and/or other related forms, such as authorized-representative-designation forms, and forms granting power of attorney. With such forms, providers take the position that they stand in the shoes of the member, can demand payment, and can directly sue the plans when they refuse to pay alleged amounts due.

Group health plan sponsors and fiduciaries generally desire to limit the risk of such actions by out-of-network providers, and well-drafted health plan documents typically include strong anti-assignment language. Historically, numerous courts, including the First, Second, Third, Fifth, Ninth, Tenth, and Eleventh Circuits have consistently upheld anti-assignment clauses whereby providers are generally denied standing to bring legal action against plans. However, on occasion, courts have held that plans have waived such clauses through actions involving providers in the claims process.

## Anti-Assignment Clause Case

In The Medical Society of the State of New York et al v. UnitedHealth Group Inc. et al, various out-of-network surgeons, surgical practices, and associations of which they were members sued United Health Group ("United") in the U.S. District Court for the Southern District of New York for refusing to pay for certain services, primarily facility fees for office-based surgeries. Nineteen United plans were involved, and each plan had an anti-assignment clause, but did give the

plans discretion to pay out-of-network providers directly for services. While various plans had slight variations on anti-assignment language, six of them included the following language:

> You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

While United often did pay these providers directly, it also would: (a) provide providers with denial-of-claim explanations, (b) remain silent when providers asked about anti-assignment provisions, (c) allow providers to proceed in the internal claims appeal process when an authorized representative, and (d) seek repayment from providers for overpayments, or effect offsets. The plaintiffs argued that these actions resulted in a waiver of the anti-assignment clause. However, the court rejected those arguments and concluded that "no reasonable jury could find ... that United clearly manifested an intention to relinquish its right to enforce the anti-assignment clauses." Thus, the court upheld the clauses, and United was granted partial summary judgment.

The plaintiffs further argued that they nonetheless had standing to sue as the members' authorized representative or attorney-in fact, and United's appeal notification letters that were sent to providers indicated that a patient's authorized representative could file an appeal on the patient's behalf. However, the court observed that the plaintiffs did not bring the suit in their roles as authorized representatives, and were seeking damages on its own behalf, which could only be done through a valid assignment.

## Employer Action

While this case is related to United and fully-insured plans, the same concepts apply to self-insured group health plans. Plan Sponsors and/or fiduciaries of such plans should consider the following:

- Review both the formal health plan document and the Summary Plan Description (SPD) with respect to an anti-assignment clause. Consider confirming, where possible, that the clause seems consistent with clauses that have been upheld in the plan's jurisdiction, and if there is no clause, or it appears the clause is inadequate, consider enhancing the provisions in these documents.

- Use caution when engaging in a plan's appeals process with a provider to avoid giving the provider an argument that the plan has waived its right to enforce an anti-assignment clause.

- Watch for further developments on providers using authorized-representative-designation forms, and/or forms granting power of attorney in order to assert standing in seeking recovery of amounts they are allegedly owed.

# California Relaxes Registration Requirements for Opposite-Sex Domestic Partners

Published: September 10, 2019

Effective January 1, 2020, California eliminates the requirement that at least one member of an opposite-sex couple be at least age 62 and eligible for Social Security benefits in order for the couple to register as domestic partners with the state of California. For employers who sponsor fully-insured benefit plans, this may result in more employees enrolling a registered domestic partner in an employer-sponsored health plan.

## Background

Under California law, domestic partners who are registered with the state's domestic partner registry are generally afforded the same rights, protections, and benefits as are granted to legal spouses.

If an insured group health plan offers coverage to legal spouses of employees residing in California, the plan is required to also offer coverage to the registered domestic partners of employees in California. Self-insured plans are not required to treat registered domestic partners the same as legal spouses in California for plan eligibility purposes. However, an employer with a self-insured plan may voluntarily choose to extend coverage to domestic partners; either requiring a couple be registered to be eligible, or crafting its own domestic partner eligibility criteria.

Under current law, in order to be registered domestic partners, a couple must file a Declaration of Domestic Partnership with the California Secretary of State, which attests that the couple meets certain criteria at the time of filing. One requirement is that one or both members of an opposite-sex couple must be (1) eligible for Social Security benefits, and (2) at least age 62.

## California SB 30

California Senate Bill 30 was signed into law by Governor Newsom on July 30, 2019. This new law eliminates the additional requirement for opposite-sex couples that one or both members be eligible for Social Security benefits and age 62 or older in order to register as domestic partners. This change is effective January 1, 2020. Beginning January 1, 2020, the domestic partner definition outlined in Section 297 of the California Family Code will read:

a. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.

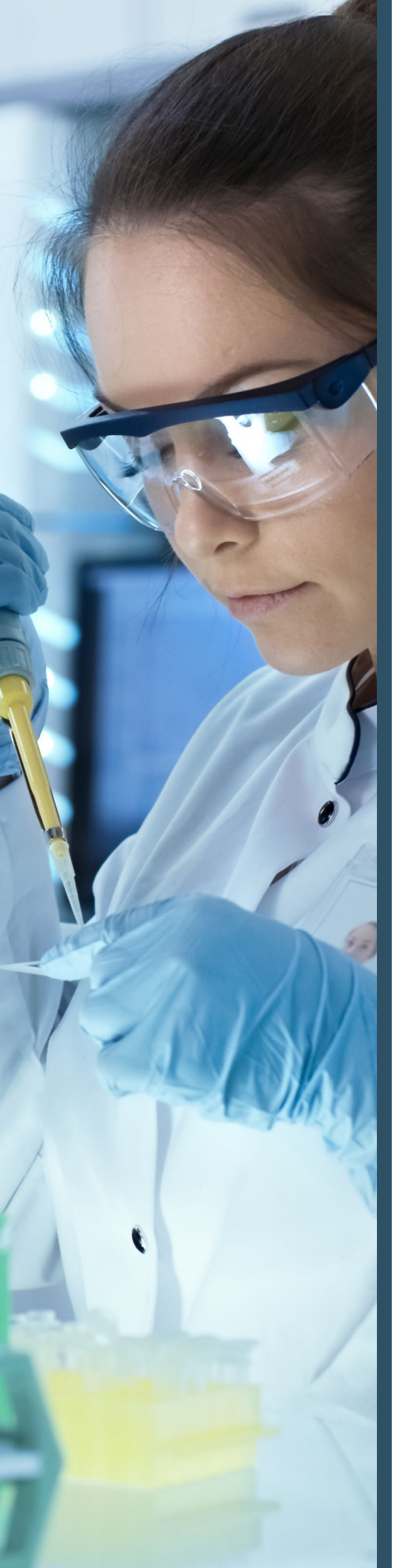
b. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
   1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
   2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
   3. Both persons are at least 18 years of age, except as provided in Section 297.1.
   4. Both persons are capable of consenting to the domestic partnership.

After January 1, 2020, same-sex and opposite-sex partners will be subject to uniform rules for registering as domestic partners. This could result in an increase in the number of employees who have registered domestic partners, and therefore an increase in the number of employees looking to enroll registered domestic partners in any insured group health plan sponsored by their employer.

## Employer Action

Employers with California employees should review the language in their plan documents, summary plan descriptions, employee handbooks, open enrollment materials, and other communications to see if there is a definition of domestic partner that will need to be updated. No change to the term "registered domestic partner" is necessary, but a list of the specific criteria required to register as a domestic partner in California will need to be updated, effective January 1, 2020.

In addition, an employer with a self-insured plan that has voluntarily extended coverage to domestic partners, and whose crafted definition of eligible domestic partner includes a requirement that one or both members of an opposite-sex couple be at least age 62 and/or eligible for Social Security benefits (to mirror the current California requirements), may want to consider amending that criteria to reflect the upcoming change in the California definition of domestic partner.



# IRS Ruling on Genetic Testing Services as Medical Care

Published: September 12, 2019

In a private letter ruling ("PLR") released August 16, 2019, the IRS ruled that a taxpayer can allocate the cost of a DNA collection kit and related health services between non-medical ancestry services and health services that are medical care for tax purposes. Thus, a portion of the cost could be reimbursed by a health flexible spending account (FSA) or other account-based health plan.

## Background

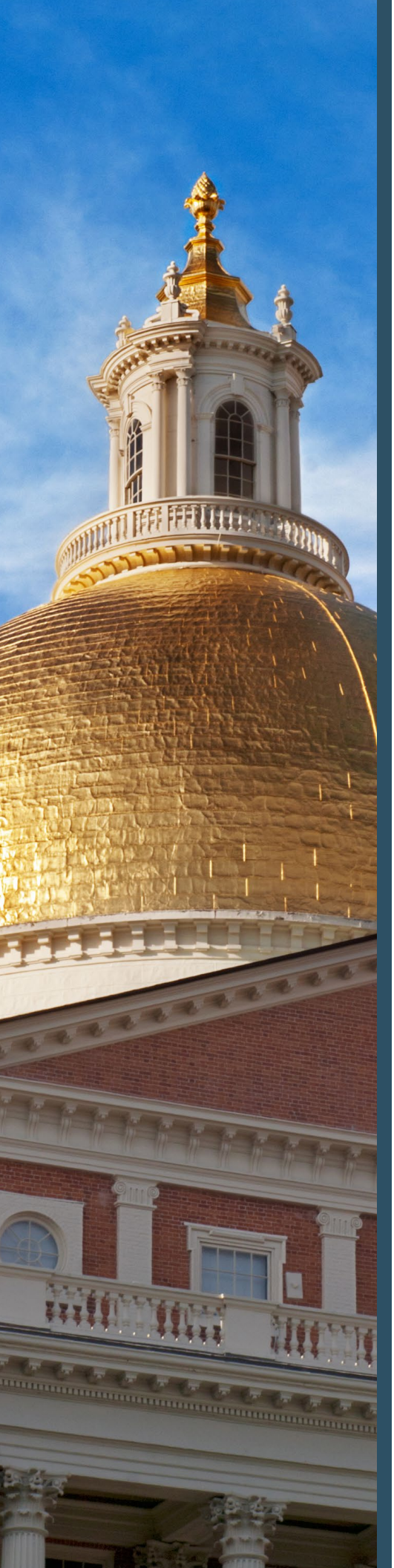
The Internal Revenue Code (IRC) generally provides tax advantages for health related expenses that provide for "medical care," which is defined in IRC § 213(d)(1)(A). This includes allowing for pre-tax reimbursement for the "diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body," and includes diagnostic services (as set forth in IRS regulations), for employees who participate in an employer-sponsored health flexible spending account (FSA), health reimbursement arrangement (HRA), and health savings account (HSA). However, no such tax advantages apply to expenditures that are merely beneficial to the general health of an individual.

In PLR 201933005, the taxpayer sought to use a health FSA to purchase genetic testing services that include reports on an individual's ancestry and health. The taxpayer conceded that the ancestry portion was not for medical care. However, as part of the services, a DNA sample was tested through a process called genotyping and further analysis of the genetic information was done resulting in reports providing lab results and general information. In the PLR, the IRS cited the IRC, IRS regulations and prior guidance relating to allocation of certain expenses as between medical care and non-medical items and services and determined that the genotyping, but not the reports providing general information, was medical care. The IRS concluded the taxpayer must allocate the price of the DNA collection kit between the ancestry services and the health services using a percentage. With respect to the health services portion, the IRS provided that the taxpayer may use a reasonable method to value and allocate the cost between services that are medical care, such as the lab testing, and non-medical, such as the general information reports.

It is important to note that a PLR issued by the IRS may not be cited or used as precedent, as it is directed specifically to the taxpayer who has requested it. Nonetheless, such a ruling does provide some insight as to the IRS's thinking on certain tax issues.

## Next steps

Employers with account-based plans, such as health FSAs, HRAs and HSAs, may want to review their plans regarding their past practices in allowing reimbursement for DNA collection kits that include genetic testing services. To the extent such plans expressly exclude covering such kits or services, no further action is required. However, to the extent such plans generally allow reimbursement for any expenses that provide "medical care," sponsors may want to evaluate whether to provide an express exclusion, or determine how to go about evaluating whether just a portion of the cost of such kits or services should be reimbursed.



# Upcoming Deadline for Massachusetts PFML

Published: September 16, 2019

The Massachusetts Department of Family and Medical Leave ("DFML") has finalized regulations regarding Massachusetts Paid Family and Medical Leave ("PFML"). The final regulations were effective July 1, 2019 and did not substantially differ from the proposed regulations previously issued by the DFML. Much of the below information has already been provided in our earlier article (Click Here) and this article shall briefly serve as a reminder of the upcoming October 1 withholding date.

## Background

In 2018, Massachusetts enacted legislation to create a statewide PFML program providing benefits beginning in January 1, 2021 and July 1, 2021. With limited exception, all employers with employees in Massachusetts will be required to provide paid family and medical leave benefits to their employees through the state program or an approved private plan.

If providing benefits through the state program, employers will begin withholding contributions on October 1, 2019 (they were previously scheduled to begin on July 1, 2019).

Employers may opt out to provide an approved private plan to employees. These arrangements must be approved by the DFML. If the employer secures approval on or before December 20, 2019 (previously July 1, 2019), the employer will not be required to remit contributions for the full period that begins with the October 1 start date.

## Important Items to Remember/Note

- Generally, the DFML follows the same eligibility criteria as the unemployment insurance program in Massachusetts. Therefore, if an employer submits its Massachusetts W-2 employees for unemployment in Massachusetts, the employer would be subject to the PFML program.

- Employers that participate in the state program must begin withholding PFML contributions for the October 1 to December 31 quarter through MassTaxConnect by January 31, 2020 (for MassTaxConnect: https://mtc.dor.state.ma.us/mtc/).

- The total contributions for an employee has been adjusted from 0.63% to 0.75% of qualifying earnings, capped at the Social Security maximum, currently $132,900.

- If an employer has at least 25 covered individuals (which includes employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. If an employer has fewer than 25 covered individuals in Massachusetts, the employer is not required toward the medical leave or family portions of the benefit. The final regulations include a new contributions provision allowing an employer to deduct differing percentages from the wages or qualifying payments of different groups of covered individuals, but the employer may not deduct more than the maximum percentages allowed by the PFML law. The DFML will also refund contributions to an employer that overpays its contributions.

- If an employer chooses to provide benefits through an approved private plan option, it may do so through an insurance policy or self-insurance. If the employer's plan provides for insurance, the forms of the policy must be issued by a Massachusetts licensed insurance company (at this time, the carriers have not yet responded with new products in the marketplace). If an employer's plan is in the form of self-insurance, the employer must secure a surety bond running to the state in an amount based on the number of covered individuals and the surety company issuing the bond must be authorized to transact business in Massachusetts.

- An employer already providing a paid leave benefit to its workforce may be eligible to receive an exemption from the medical leave contribution, family leave contribution, or both through its MassTaxConnect account. The deadline to file for a private plan exemption for first quarter contributions is December 20, 2019. A self-insured employer must complete the state approved bond form and submit it to the DFML in order to complete the exemption application. The DFML may assess a penalty, including retroactive contributions to the Public Trust Fund, if an employer offers a private plan that has not received DFML approval or fails to renew an approved private plan prior to January 1, 2021.

- Employers should already have posted the mandatory PFML workplace poster (which can be found at https://www.mass.gov/files/documents/2019/06/14/20190614_DFML%20Notice_English.pdf.

- Employers must notify each of their Massachusetts W-2 employees in writing about available PFML benefits on or before September 30, 2019 (and issue this notice to each employee within 30 days of their first day of employment). If more than 50% of an employer's workforce is made up of Massachusetts 1099-MISC contractors, the employer is required to inform them of PFML benefits and protections the same as Massachusetts W-2 employees.

- Employers must file quarterly reports through MassTaxConnect beginning in January 2020. Reporting and documentation guidelines will be announced prior to October 1, 2019.

## Additional Guidance

- The definition of "employment" for PFML includes the statutory exclusions contained in Massachusetts unemployment law (i.e., service performed by a student in the employ of a school, college or university, if such service is performed while regularly attending classes at such institution, is not covered by PFML).

- An employer may require intermittent leave to be taken in increments not smaller than a designated minimum time period; provided, however, that an employer's designated minimum time period may not be greater than four consecutive hours.

- Where the approved claim involves leave on an intermittent or reduced leave schedule, the wait period is seven consecutive calendar days, not the aggregate accumulation of seven days of leave.

- The DFML may contact an employee's health care provider to verify or supplement information necessary to support a leave certification.

- An employer is not required to restore an employee who was hired for a specific term or only to perform work on a discrete project, if the employment term or project is over and the employer would not otherwise have continued to employ the employee.

## Employer Action

Employers with employees in Massachusetts should work with labor counsel and payroll processors to finalize their leave policies and procedures to make sure they are compliant with the Act by October 1, 2019. In addition, employers should monitor the state's PFML website for additional guidance and regulations

# Medicare Part D Notification Requirements

Published: September 19, 2019

Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is “creditable” or “non-creditable.” This notification must be provided **prior to October 15th each year**. Also, following the plan’s annual renewal, the employer must notify the Centers for Medicare & Medicaid Services (“CMS”) of the creditable status of the drug plan.

This information serves to summarize these requirements in more detail.

## What are the Notification Requirements About?

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Also, the employer must annually notify CMS as to whether or not the employer plan is creditable.

## Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html
(notices last updated by CMS for use on or after April 1, 2011).

These model notices, when appropriately modified, will serve as a proper notice for purposes of this requirement. Spanish notices are also provided at the above link.

## To Whom Should the Participant Notice Be Sent?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

## When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to October 15th each year (or next working day);[2]
- Prior to an individual's Initial Enrollment Period for Part D;
- Prior to the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, prior to the ACEP each year (October 15th or next working day for 2011 and subsequent years), CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should provide the participant notice to new hires and newly eligible individuals under the group health plan.

## How Should the Participant Notice Be Sent?

Entities have flexibility in the form and manner they provide notices to participants.

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

**Mail**

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

**Electronic Delivery**

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements 29 CFR § 2520.104b-4(c)(1)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

**Open Enrollment Materials**

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

## Personalized Notices

A personalized notice is only provided upon request of the beneficiary. If an individual requests a copy of a disclosure notice, CMS recommends that entities provide a personalized notice reflecting the individual's information.

For more information on the participant disclosure requirement, visit: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

## CMS Notification

### When and How Should Notification Be Given to CMS?

Employers will also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (February 29, 2020 for a 2020 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and

- Within 30 days after any change in the creditable coverage status.

Notice must be submitted electronically by completion of a form found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

Additional guidance on completing the form including screen shots is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/2009-06-29_CCDisclosure2CMSUpdatedGuidance.pdf

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CredCovDisclosureCMSInstructionsScreenShots110410.pdf

## How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

### Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected amount of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

### Simplified Determination

Most entities will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
  - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
  - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
  - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- a combined plan year deductible for all benefits under the plan,
- a combined annual benefit maximum for all benefits under the plan, and/or
- a combined lifetime benefit maximum for all benefits under the plan.