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ACA Information Returns May Continue to Be Filed After June 30, 2016

Published: July 1, 2016

The IRS just announced that although the deadline to electronically file ACA information returns (Form 1094-C with related Forms 1095-C) with the IRS is midnight ET on June 30, 2016, the ACA Information Returns (AIR) system will remain up and running after the deadline. If an employer is not able to submit all required ACA information returns by June 30, 2016, the IRS has indicated that the employer should complete the filing after the deadline.

It is important to note the following:

- The AIR system will continue to accept information returns filed after June 30, 2016. In addition, an employer can still complete required system testing after June 30, 2016.
- If any of an employer's transmissions or submissions were rejected by the AIR system, an employer has 60 days from the date of rejection to submit a replacement and have the rejected submission treated as timely filed.
- If an employer submitted and received "Accepted with Errors" messages, the employer may continue to submit corrections after June 30, 2016.

Penalties For Late Filing

The IRS acknowledges that some filers are still in the process of completing their 2015 tax year filings. The IRS has reiterated that filers of Forms 1094-B, 1095-B, 1094-C and 1095-C that miss the June 30, 2016 due date will not generally be assessed late filing penalties under section 6721, if the reporting entity has made legitimate efforts to register with the AIR system and to file its information returns, and it continues to make such efforts and completes the process as soon as possible. In addition, consistent with existing information reporting rules, filers that are assessed penalties may still meet the criteria for a reasonable cause waiver from the penalties.

If an employer is not an electronic filer and missed the May 31, 2016, paper filing deadline for ACA information returns, that employer should also complete the filing of its paper returns as soon as possible.

EEOC Issues Model Notice for Wellness Programs

Published: July 6, 2016

New rules published on May 17, 2016 under the Americans with Disabilities Act ("ADA") provide a helpful roadmap to designing an incentive-based wellness program that will not run afoul of the ADA's general rule that employers are prohibited from requiring medical exams or asking disability-related inquiries unless job-related and consistent with business necessity.

In order for such program to be "voluntary" under the ADA, the employer, in part, must provide a notice that clearly explains what medical information is obtained, who will receive it, how it will be used and the restrictions on disclosure (including whether the restrictions on disclosure comply with HIPAA Privacy Rule).

The EEOC recently published a model notice and FAQs regarding the notice that can be used by employers for purposes of complying with the ADA. The following summarize the highlights.

- **Effective date.** The requirement to provide the notice takes effect as of the first day of the plan year that begins on or after January 1, 2017 for the health plan an employer uses to calculate any incentives it offers as part of the wellness program.

- **Timing.** This notice must be provided to employees before providing any health information and with enough time to decide whether to participate in the program. Waiting until after an employee has completed a health risk assessment ("HRA") or medical examination to provide the notice is illegal.

- **Format.** The notice can be given in any format that will be effective in reaching employees being offered an opportunity to participate in the wellness program. For example, it may be provided in hard copy or as part of an email sent to all employees with a subject line that clearly identifies what information is being communicated (e.g., "Notice Concerning Employee Wellness Program"). Avoid providing the notice along with a lot of information unrelated to the wellness program as this may cause employees to ignore or misunderstand the contents of the notice.

- **Responsibility to provide.** The employer is responsible for providing the notice, but may have its wellness program provider give the notice to employees. However the employer is ultimately responsible for ensuring employees receive it.

- **HIPAA and ADA notice interaction.** Generally, the current HIPAA notice applicable to health-contingent programs does not disclose the information required under the ADA. To the extent the employer's wellness program is health-contingent (meaning outcomes-based or activity-based and tied to a group health plan) and requires medical exams or disability-related inquiries, employers are required to comply with both the ADA and HIPAA notice obligations. It is not clear whether the ADA model notice (specifically, the third paragraph) is sufficient to meet the HIPAA disclosure rules for purposes of a health-contingent program. Additional guidance would be welcome. In the case of a program that is participatory or not part of a health plan, but requires medical exams or disability-related inquiries, only the ADA notice is required.

- **Model notice language can be adapted.** As long as the notice tells employees, in language they can understand, what information will be collected, how it will be used, who will receive it, and how it will be kept confidential, the notice is sufficient. Employers do not have to use the precise wording in the EEOC sample notice. The EEOC notice is written in a way that enables employers to tailor their notices to the specific features of their wellness programs.

- **No signed authorization requirement.** The ADA rule only requires a notice, not signed authorization, though other laws may require authorization. Title II of the Genetic Information Nondiscrimination Act ("GINA") requires prior, written, knowing, and voluntary authorization when a wellness program collects genetic information, including family medical history.

- **Spousal HRAs.** The ADA does not apply to HRAs for spouses. However, GINA is applicable. Under GINA, an employer that requests current or past health status information of an employee's spouse must obtain prior, knowing, written, and voluntary authorization from the spouse before the spouse completes a health risk assessment. The GINA authorization has to be written so that it is reasonably likely to be understood by the person providing the information. It also has to describe the genetic information being obtained, how it will be used, and any restrictions on its disclosure.

Employer Action

An employer that uses an HRA and/or medical exams (e.g., physicals, biometric screenings, etc.) as part of a wellness program will need to provide notice to employees effective for plan years that begin on or after January 1, 2017. Remember, this notice must be provided before an employee is asked to provide any health information or undergo a medical exam.

For the EEOC's sample notice, visit https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm

For the FAQs, visit https://www.eeoc.gov/laws/regulations/qanda-ada-wellness-notice.cfm

FAQ Suggests Employers Include Marketplace Options with COBRA Notices

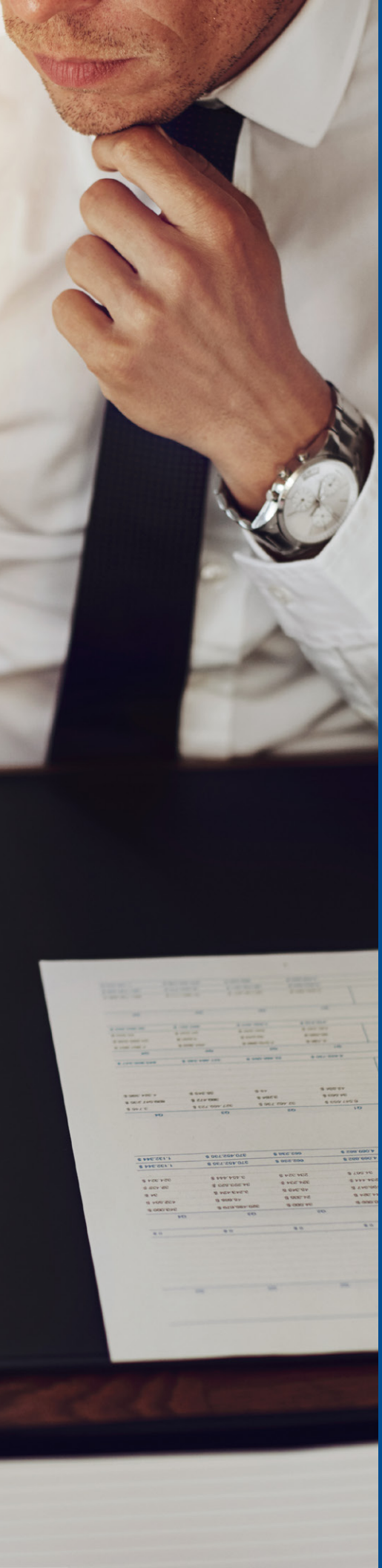
Published: July 12, 2016

On June 21, 2016, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") issued the 32nd Affordable Care Act ("ACA") FAQ describing information that may be appropriate to include with COBRA notices. Many wondered if it were appropriate to provide information and if so, what kind of information could be provided about the Health Insurance Marketplaces/Exchanges ("Marketplaces") so that COBRA-eligible individuals could consider health coverage alternatives available through the Marketplaces and possibly investigate whether they may be eligible for premium tax credits and cost-sharing reductions. The current model COBRA notice includes some information to help make qualified beneficiaries aware of other coverage options available in the Marketplaces, but that information is limited. Note that employers also should send a Notice of Coverage Options to all employees at time of hire. That document describes Marketplace options as well.

Under this new FAQ, the DOL indicated that it would be appropriate for an employer to provide additional information about the availability of Marketplace coverage provided that any communication can be "easily understood by the average participant." In that vein, any additional information should not be too lengthy or difficult to understand. Specifically, plan administrators are encouraged to include with the COBRA election notices additional information about the Marketplaces such as: how to obtain assistance with enrollment (including special enrollment), the availability of financial assistance, information about Marketplace websites and contact information, general information regarding particular products offered in the Marketplaces, and other information that may help qualified beneficiaries choose between COBRA and other coverage options. In addition, communications may include information that is specifically tailored to particular groups such as young adults aging out of dependent coverage on their parents' health plan.

Employers should consider adding more detailed information about the availability of Marketplace coverage to assist COBRA qualified beneficiaries in making informed elections and understanding available options. For those using COBRA administration vendors, employers can request that additional Marketplace information be included with notices being sent to COBRA qualified beneficiaries.

For the FAQ, visit:
https://www.dol.gov/ebsa/pdf/faq-aca-32.pdf



DOL Penalties Increase

Published: July 25, 2016

In 2015, Congress passed the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the "Inflation Adjustment Act") to direct federal agencies to adjust the civil monetary penalties for inflation every year. Civil penalties ensure compliance with federal regulation by incentivizing employers not to violate federal regulation and providing federal agencies the power to ensure compliance. However, when penalties are too low, or have failed to be increased for inflation, compliance with federal regulation remains stagnant.

Following the directive of the Inflation Adjustment Act, the Department of Labor's Employee Benefits Security Administration ("EBSA") published an Interim Final Regulation that increases certain penalties applicable to employee benefit plans to match other penalties that remain unchanged.

The updated penalties go into effect on August 1, 2016 and apply to assessments after August 1, 2016 whose associated violations occurred after November 2, 2015.

Updated Penalties

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	Current Penalty	Updated Penalty
Failure to file **Form 5500**	Up to $1,100 per day	Up to $2,063 per day
Failure of a **MEWA** to file reports	Up to $1,100 per day	Up to $1,502 per day
Failure to provide **CHIP Notice**	Up to $100 per day per employee	Up to $110 per day per employee
Failure to disclose CHIP/Medicare Coordination to the State	$100 per day, per violation (per participant/beneficiary)	$110 per day per violation (per participant/beneficiary)
Failure to provide **SBCs**	Up to $1,000 per failure	Up to $1,087 per failure
Failure to furnish **plan documents** (including SPDs/SMMs)	$110 per day $1,100 cap per request	$147 per day $1,472 cap per request
Genetic information failures	$100 per day	$110 per day
De minimis failures to meet genetic information requirements (Minimum)	$2,500 minimum	$2,745 minimum
Failure to meet genetic information requirements – not de minimis failures (Minimum)	$15,000 minimum	$16,473 minimum
Cap on unintentional failures to meet genetic information requirements (Maximum)	$500,000 maximum	$549,095 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

Form 5500 Proposed Changes

Published: July 27, 2016

The US Department of Labor's Employee Benefits Security Administration (EBSA) issued a "Proposed Revision of Annual Information Returns/Reports" that would make changes to the Form 5500. If adopted, the proposed changes will be effective for plan years beginning on or after January 1, 2019 (filings due in 2020).

EBSA is requesting comments on the proposed changes due by October 4, 2016. Any comments received will be available for public review.

Background

An employee benefit plan established by a private employer must comply with the Employee Retirement Income Security Act (ERISA). ERISA requires pension, health and welfare plans to file an annual return, the Form 5500. The Form 5500 contains information related to an employee benefit plan's operation, funding, asset, and investment information. EBSA, federal and state agencies, private entities, and participants use the Form 5500 to obtain information related to the plan.

The proposed changes would serve five purposes:

1. to modernize financial reporting;
2. to provide greater information related to group health plans;
3. enhance data mineability;
4. improve service provider fee information; and
5. enhance compliance with ERISA and the Internal Revenue Code.

Proposed Changes

The following outlines the changes applicable to health and welfare plans only. However, a number of proposed changes apply to retirement plans, including defined contribution, defined benefit, profit sharing and ESOPs. These changes are not discussed in this summary.

All Health Plans Require a Form 5500 Filing

A small health and welfare plan is a plan with fewer than 100 participants on the first day of the plan year. Currently, small health and welfare plans are exempt from filing the Form 5500 if the plan is unfunded or fully insured.

Large health and welfare plans (those with at least 100 participants on the first day of the plan year) are subject to a Form 5500 filing. However, as noted in the preamble to the proposed rule, information reported in the Form 5500 is generally very limited (particularly for self-funded health plans).

The proposed rule requires all health plans (regardless of size) to file the Form 5500 and required schedules. Small, insured health plans will have a limited reporting obligation as compared to large plans and self-funded plans.

All Health Plans Must Provide a Schedule J – Group Health Plan Information

According to EBSA, existing Form 5500 requirements related to group health plans fail to consider laws enacted after the initial reporting regulations, including:

- Health Insurance Portability and Accountability Act (HIPAA);
- Title I of the Genetic Information and Non-discrimination Act of 2008 (GINA);
- Mental Health Parity Act and Mental Health Party and Addiction Equity Act (MHPAEA);
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- The Women's Cancer Rights Act of 1998 (WHCRA);
- Michelle's Law; and
- The Affordable Care Act (ACA).

Due to the number of laws enacted that affect group health plans governed by ERISA, EBSA determined changes to the Form 5500 are necessary to ensure proper documentation of compliance with these various laws. As such, the EBSA is proposing a new Schedule J.

The Schedule J would require the following information:

- **COBRA**
  information related to the COBRA coverage, including number of persons covered, eligibility (employees, spouses, children, retirees, etc.), and type of benefits (medical/surgical, pharmacy, prescription drug, mental health/substance use disorder, wellness program, preventive care, vision, dental, etc.).

- **Funding & Benefit Arrangements**
  information related to plan funding and benefit arrangements (insured, self-insured, trust, or general assets of employer), policy number, and employer and/or participant contributions.

- **Group Health Benefit Design**
  information related to the grandfathered status and type of benefit offered (high deductible health plan, health flexible spending account (Health FSA), health reimbursement arrangement (HRA)).

- **Rebates**
  information related to the plan's receipt of rebates, refunds, reimbursements, or offsets (e.g. Medical Loss Ratio Rebates), including the amount received and distribution method to participants (check, premium holiday, payment of benefits, or other).

- **Service Providers**
  information related to service providers not already listed on Schedule A or C, including the name, address, contact information, employer identification number, and National Insurance Producer Registry (if applicable).

- **Stop Loss**
  information related to the premium paid and individual and aggregate claim limits.

- **Claims Payment Data**
  information related to pre and post service benefit claims submitted, claims approved, claims denied, claims appealed, claims upheld at denials, claims payable after appeals, and claims not adjudicated within the required time frames.

- **Inability to Pay Claims**
  information related to a plan's inability to pay claims at any time during the year; if fully insured, delinquent payments to an insurance carrier; and if a lapse of coverage occurred.

- **Plan Assets**
  information related to plan funding including trust, insurance company, or employer assets.

- **Plan Documents**
  information related to content requirements of plan documents, summary plan descriptions (SPD), summaries of material modifications (SMM), and summary of benefits and coverage (SBC).

- **Specific Legal Compliance**
  specific questions requesting certification of compliance with applicable federal laws (HIPAA, GINA, MHPAEA, NMHPA, WCRA, Michelle's Law, and ACA).

Claims Adjudication Data

In addition to the information to be collected on Schedule J, EBSA is specifically requesting comments on the collection of additional claims data that would provide information related to adjudication practices and policies.

Data to be collected would include:

- Dollar amount of claims denied;
- Denial codes;
- Benefits denied (e.g. mental health/substance abuse or medical/surgical benefits);
- Uniform classification of denial codes (for example, provider's point of service fee; schedule of negotiated fee; Medicare reimbursement rates; state prevailing fees; or other reasonable method.)

DFE Reporting – GIAs

A Group Insurance Arrangement (GIA) filing as a Direct Filing Entity (DFE) would have no changes to its Form 5500 requirements. The GIA must file the same forms, schedules and attachments required of a large group health with a trust. A fully insured group health plan participating in a GIA would continue to be exempt from the reporting requirements of the Form 5500 if the GIA files a Form 5500. In addition, the GIA would be required to file a Schedule J for each separate employer's participating plan.

Employer Action

These proposed changes are significant and, if adopted in the current form, will create a substantial burden on all employers, carriers and third-party administrators supporting group health plans.

For now, employers should review health and welfare plans to ensure compliance with all applicable federal regulations.

ACA Section 1557 Nondiscrimination Provisions Affect Group Health Plans

Published: August 1, 2016

On May 18, 2016, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) published a final rule implementing Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability. Notably, this rule expands on prior civil rights law to prohibit sex discrimination in health care.

This article highlights the effect of the final rule on employer-sponsored group health plans. As the guidance also applies to certain business practices of covered entities, affected employers should carefully review it.

Applicability

The rule applies to covered entities. A covered entity is any health program or activity that receives funding from HHS (e.g., hospitals that accept Medicare or doctors who receive Medicaid payments, insurance carriers that participate in the Marketplaces and health programs administered by HHS).

The final rule clarifies that the rule shall apply to all of the operations of the covered entity, including third party administrator (TPA) services.

Section 1557 does not provide an exemption for religious entities. However, application of the final rule is not required if doing so would violate applicable federal statutory protections for religious freedom and conscience.

What's Prohibited?

The final rule prohibits covered entities from discriminating on the basis of race, color, national origin, sex, age or disability when providing or administering health-related insurance or other health-related coverage.

Discriminatory Actions

The final rule clarifies that discriminatory actions specifically include:

- Denying or limiting health coverage;
- Denying a claim;
- Employing discriminatory marketing or benefit designs; and
- Imposing additional cost sharing.

Sex Discrimination

The final rule also provides detail on the prohibition of discrimination based on sex; specifically, discrimination on the basis of sex stereotyping and gender identity.

- Individuals cannot be denied health care or health coverage based on their sex, including their gender identity and sex stereotyping.
- Women must be treated equally with men in the health care they receive and the insurance they obtain.
- Categorical coverage exclusions or limitations for all health care services related to gender transition are discriminatory.
- Individuals must be treated consistent with their gender identity, including in access to facilities. However, providers may not deny or limit treatment for any health services that are ordinarily or exclusively available to individuals of one gender based on the fact that a person seeking such services identifies as belonging to another gender.
- Sex-specific health programs or activities are permissible only if the entity can demonstrate an exceedingly persuasive justification, that is, that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

TPAs

An insurer's TPA services will be subject to Section 1557 when the insurer (1) receives federal financial assistance and (2) is principally engaged in providing health insurance and TPA services.

A TPA of a self-insured plan is not automatically subject to Section 1557. The final rule provides that the OCR will review to determine whether the discriminatory decision or conduct was the result of the TPA or the employer's actions. If the conduct is related to the administration of the plan, then OCR will process a complaint against the TPA if the TPA is a covered entity. If the conduct is related to the decision or action by the employer, the OCR will proceed with a complaint against the employer if the employer is a covered entity subject to Section 1557. If the employer is not a covered entity under Section 1557, OCR will refer the matter to the EEOC for additional consideration.

Enforcement

Enforcement mechanisms available for other federal civil rights laws will be available for Section 1557 violations. This means that noncompliance can result in termination of federal financial assistance or referral to the Department of Justice to bring proceedings. Additionally, the rule provides a private right of action for damages for violations of Section 1557.

Effective Date

The final rule is effective July 18, 2016.

However, if changes to health insurance or a group health plan design (e.g., cost sharing, covered benefits, or benefit limitations and restrictions) are required in order to comply with the provisions set forth in Section 1557, the rule will be effective on the first day of the first plan year beginning on or after January 1, 2017.

Implications for Employer-Sponsored Group Health Plans

- Employers should determine whether they are considered covered entities under Section 1557. Employers in the health care services industry should pay special attention to Section 1557, as many receive Federal funding which will make them subject to these rules.
- Effective for plan years that begin on or after January 1, 2017, most group health plans will need to remove any exclusion, restriction or limitation on coverage for specific health services related to gender transition (e.g., an exclusion for reassignment surgery). Employers intending to exclude transgender services from their group health plan should consult with counsel to understand potential ramifications.

Opt-Out Bonuses May Affect Affordability

Published: September 14, 2016

On July 8, 2016, the Internal Revenue Service (IRS) issued proposed regulations that, among other things, address affordability determinations for individuals who are eligible for employer-sponsored health coverage. This proposed rule builds on earlier guidance, Notice 2015-87, describing the effect an opt-out payment has on affordability. This latest guidance likely signals the direction the IRS will take in their final rule with respect to the affordability of employer-sponsored health plans.

According to this guidance, the IRS anticipates issuing final regulations on opt-out arrangements and affordability prior to the end of 2016.

For employers that qualified for limited relief (defined below), this guidance is not effective until the issuance of final regulations. For employers that did not qualify for relief (as described later in the article), these requirements currently apply.

Background

Applicable large employers ("ALEs") may be subject to the Employer Penalty if any full-time employee ("FTE") receives a Premium Tax Credit ("PTC") to purchase Exchange coverage. There are two penalties, "A" and "B." The "B" Penalty can apply when the ALE offers at least 95% of FTEs and their dependent children minimum essential coverage ("MEC") but the coverage is not affordable, does not provide minimum value, or excludes 5% or fewer FTEs and an FTE receives a PTC.

The concept of affordability is significant as it affects:

- whether an employer is subject to a "B" Penalty assessment;
- how an employer reports the affordability of any group health plan coverage offered to FTEs on Form 1095-C (Line 15); and
- how the affordability safe harbor is used for those who waive coverage (Line 16).

Under a cafeteria plan, an employer may offer an employee a "cash option," a taxable amount that is available if the employee declines coverage under the employer's health plan (also referred to as an "opt-out bonus" or "opt-out arrangement").

On December 16, 2015, the IRS issued Notice 2015-87 where it specified situations that would affect the determination of affordability by either increasing or decreasing the employees cost of self-only coverage. The Notice discussed opt-out arrangements, but requested public comments to issue proposed regulations.

Opt-Out Arrangements

The proposed regulations specify when an opt-out arrangement affects the cost of coverage and therefore, affordability.

- **Rule:** A conditional opt-out payment does NOT affect affordability. To qualify as a conditional opt-out payment, the employee must:
  - decline the employer sponsored coverage, and
  - provide reasonable evidence that the employee and the expected tax family have MEC, other than individual coverage (whether or not obtained in the Marketplace).

For this purpose, the "expected tax family" is composed of the individuals for whom the employee can claim a personal exemption on his/her tax return.

Reasonable evidence includes an attestation that the employee and the expected tax family have MEC or other reasonable proof of coverage. Such documentation must be furnished by the employee at least annually and within a reasonable amount of time prior to the start of the plan year. Providing documentation during the annual open enrollment period would be reasonable.

If an opt-out arrangement meets the requirements above, the payment will not affect the cost of coverage.

- **Rule:** An unconditional opt-out payment affects affordability. For example, if an employee declines coverage and receives a taxable payment with no other conditions, this is not a conditional opt-out payment and the amount of that payment is added to the employee's cost of coverage when determining affordability.

Effective Date

Employers that qualified for relief contained in Notice 2015-87 (generally those employers with opt-out arrangements in effect or communicated prior to December 16, 2015) are not required to include unconditional opt-out payments into the cost of coverage for purposes of affordability until final regulations are issued; this delay includes reporting the employee contribution amount on line 15 of the 1095-C.

Employers that implemented opt-out payments on or after December 16, 2015 are currently subject to these requirements and will report the amount including the unconditional opt-out bonus on line 15 of the 1095-C.

Collectively Bargained Plans

The proposed rule clarifies and expands the relief provided under Notice 2015-87 for opt-out arrangements provided under collective bargaining agreements in effect before December 16, 2015. Until the later of (1) the beginning of the first plan year following the expiration of the collective bargaining agreement in effect before December 16, 2015, or (2) the applicability date of these regulations with respect to the employer mandate and applicable reporting, employers participating in the collective bargaining agreement are not required to increase the amount of an employee's required contribution by amounts made available under an opt-out arrangement.

Employer Action

Employers should review any opt-out arrangements in place and determine if the arrangement meets the conditional opt-out arrangement requirements. If so, the employer should ensure proper disclosure to employees of the arrangement and annual collection of proof of other coverage.

If an employer determines its opt-out arrangement does not meet these requirements, the employer should consider amending the opt-out arrangement requirements to meet eligibility. Otherwise, employers will have to consider the opt-out in their affordability calculation.

Medicare Part D

Reminder to Distribute Creditable Coverage Notice

Published: September 15, 2016

Employers who sponsor 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.**

Below you will find detailed information regarding these requirements.

Background

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.

Notice to Participants

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 were last updated by CMS for use on or after April 1, 2011).

Spanish notices are also provided at the above link.

Who must receive the Participant Notice?

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;
- 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 October 15th, 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?

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 Web site, 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.**
>
> **Please see page xx for more details.**

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.

HHS Penalties Increase

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On September 6, 2016, the Department of Health and Human Services ("HHS") issued an interim final regulation that adjusts civil penalties for inflation. The interim final regulation does not follow the usual procedures that offer a notice and comment period. As such, a Notice of Proposed Rulemaking has not been issued and a comment period is not provided due to potential delay in the applicability of the regulation.

The adjusted penalties are applicable to penalties assessed after August 1, 2016, whose associated violations occurred after November 2, 2015.

The following chart contains updated penalties applicable to group health plans only:

Description	Current Penalty	Updated Penalty
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$100 per violation $37,561 annual cap	$150 per violation $37,561 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision w/ out knowledge	$100 min. $50,000 max. $1,500,000 annual cap	$110 min. $55,010 max. $1,650,300 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision w/ reasonable cause and not to willful neglect	$1,000 min. $50,000 max. $1,500,000 annual cap	$1,100 min. $55,010 max. $1,650,300 annual cap

Description	Current Penalty	Updated Penalty
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND corrected during 30-day period	$10,000 min. $50,000 max. $1,500,000 annual cap	$11,002 min. $55,010 max. $1,650,300 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND NOT corrected during 30-day period	$50,000 min. $1,500,000 max. $1,500,000 annual cap	$50,000 min. $1,500,000 max. $1,500,000 annual cap
Failure to Provide the Summary of Benefits Coverage	$1,000 per day	$1,087 per day
Penalty for an employer or other entity to offer financial or other incentive to individual entitled to Medicare/Medicaid benefits not to enroll under a group health plan that would be primary	$5,000	$8,908
Penalty for entity serving as insurer, TPA, or fiduciary for a group health plan that fails to provide information to HHS Secretary identifying when the GHP was primary payer to Medicare	$1,000	$1,138

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