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Compliance Bulletins Released July-September

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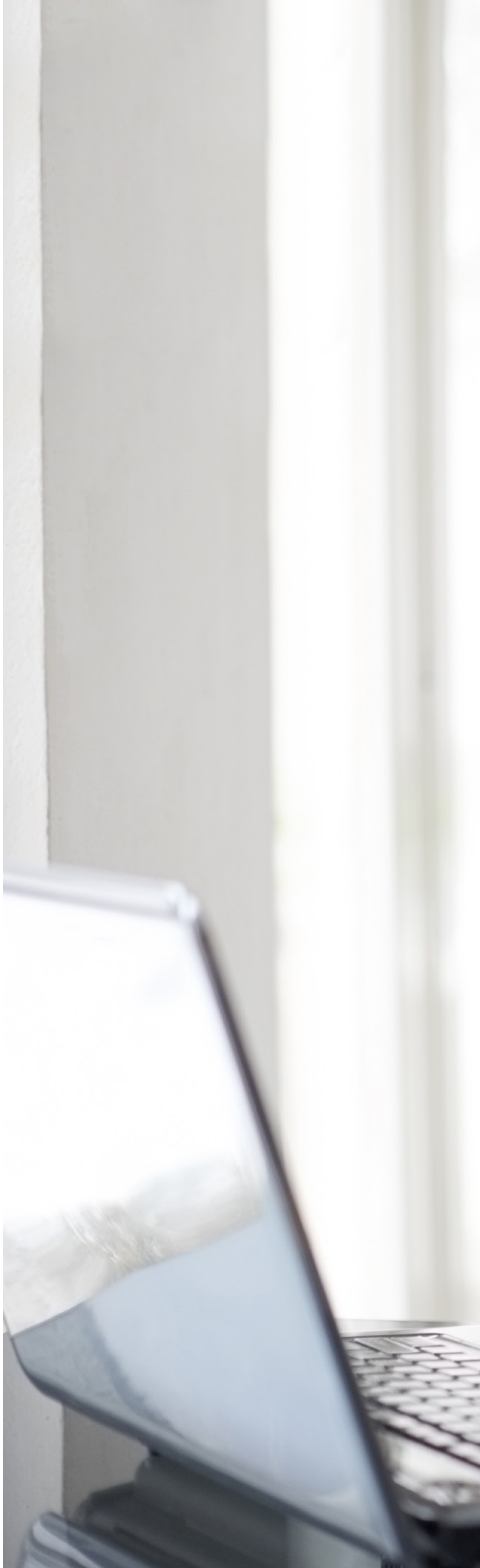

Mental Health Parity

FAQ 38

Published: July 7, 2017

The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to employers with at least 51 employees offering a group health plan that includes any mental health and substance use disorder (MH/SUD) benefits. MHPAEA also applies to non-grandfathered insured plans in the small group market.

Briefly, MHPAEA generally requires parity between MH/SUD benefits and medical surgical benefits. This means that coverage limits that apply to MH/SUD benefits cannot be more restrictive than the coverage limits that apply to medical and surgical benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance or out-of-pocket limits.
- Treatment limits, such as limits on the number of days or visits covered, or other limits on the scope or duration of treatments (for example, pre-authorization requirements).

The Departments of Health and Human Services, Treasury and Labor (collectively, the Departments) issued FAQ 38 to:

- Clarify that eating disorder treatment is a mental health benefit as defined by MHPAEA, and
- Seek public comment on disclosure requirements.

MHPAEA and Eating Disorders

FAQ 38 clarifies that MHPAEA applies to any benefits a plan or health insurance carrier offers for treatment of an eating disorder. Eating disorders are mental health conditions and therefore treatment of an eating disorder is a "mental health benefit" within the meaning of that term as defined by MHPAEA.

The Departments request comments on whether any additional clarification in needed regarding how the requirements of MHPAEA apply to treatment of eating disorders. Comments can be submitted via email to e-ohpsca-mhpaea-eatingdisorders@dol.gov by September 13, 2017.

Disclosure Requirements

MHPAEA also imposes several disclosure requirements on group health plans and health insurance carriers. A plan or carrier must:

- Disclose the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request, and

- Make available the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to the participant or beneficiary.

The Departments are requesting comments on a series of previously asked questions related to MHPAEA disclosures included in FAQ 34.

Additionally, the Departments are soliciting comments on a draft model form that participants, enrollees, or their authorized representatives could use to request information from their health plan or carrier regarding nonquantitative treatment limitation (NQTLs) that may affect their MH/SUD benefits, or to obtain documentation after an adverse benefit determination involving MH/SUD benefits to support an appeal.

New York Paid Family Leave

Final Regulations

Published: July 21, 2017

On July 19, 2017, the Notice of Adoption for Paid Family Leave was published in the New York State Register, finalizing the New York Paid Family Leave ("NYPFL") regulation.

The following summarizes public comments received and effect on the final regulation:

Comment	Effect
Requesting that employers not provide NYPFL to employees not living or working in New York	Employees who work in New York with incidental work outside NY are covered If an employee works in another state and only incidentally works in NY, the employee is not covered If the employee does not perform the work in any other single state, he/she is a covered employee if: • The employee is based in New York; • Controlled from New York • Employee lives in New York ** No changes to the regulation were made; additional examples will be added to FAQs posted on the state's website*
General comment about an employee having a child in 2017 and eligible for the employer's leave and effective 2018, eligible to take leave under the Family Medical Leave Act.	The NYPFL benefits become effective 1/1/2018 Employees are permitted to take NYPFL to bond with a child within the first 12 months after the child's birth Beginning in 2018, leave to bond with a child under NYPFL will run concurrently with FMLA ** No changes to the regulation were made.*

Comment	Effect
General question about the requirement of an employer to deduct NYPFL contributions beginning 7/2017.	An employer may, but is not required to, take employee contributions beginning July 2017. ** No changes to the regulation were made.*
Clarification on whether an employee working less than 20 hours is eligible for NYPFL benefits on the 175th day of work OR the 175th day of employment.	An employee working less than 20 hours is eligible for NYPFL on the 175th day worked. ** No changes to the regulation were made.*
Request to clarify if paid time off counts towards eligibility hours if the employee contributed to NYPFL.	Paid time off in which deductions are made count towards the number of work days necessary to meet the 20 hour per week eligibility. ** Change was made.*
Concern over the NYPFL definition of average weekly pay when an employee takes intermittent leave and the week the employee takes the leave, the employee works less than the full week.	Employer may exclude the final partial week when calculating the average weekly wage. ** Change was made.*
Question relating to calculation of average weekly rate. Can the employer use fractional number of days to calculate the average daily rate?	Yes, the employer may use fractions to accurately calculate an average daily wage. ** Change was made.*
Question relating to an employee that becomes eligible for NYPFL, is laid-off, and is then rehired. Must the employee requalify for NYPFL?	No, an employee may take an unpaid leave of absence, with employer approval, and immediately become eligible for benefits upon return. ** No changes to the regulation were made.*
Relating to state employers – Must state employers provide an option of waiver to employees or is it permissive?	State employers are required to provide a waiver option. ** Change was made.*
Request to allow employers to choose measurement methods similar to FMLA to calculate the 12-month period.	Employers may choose any method used under FMLA. ** No changes to the regulation were made.*
Request to require Collective Bargaining Agreements (“CBAs”) to provide benefits at least as beneficial as NYPFL.	NYPFL requires approval of a collectively bargained plan ** Change was made.*
Comment from carriers expressing concern over pre-filed claim confirmation of receipt required to be completed in one day.	The NYPFL requires a carrier to send a list of required documents within five business days of receiving a NYPFL leave request. After documents are received, the carrier must review the information and ensure its accuracy. Change made to allow the carrier three days to acknowledge receipt of information/documents. The carrier still has 18 days to pay the claim or deny the claim, which begins the date the information is received. ** Change was made.*

Comment	Effect
Question as to how employee contributions for NYPFL may be used.	NYPFL employee contributions can only be used to provide NYPFL benefits - 1) pay for policy or 2) provide self-insurance. If an employer has withheld surplus contributions, these must be returned to employees. **No changes to the regulation were made.*
Comment requesting an amendment to the NYPFL to become responsible for medical costs if the employer fails to provide health benefits while the employee is on leave.	The NYPFL provides that the employer's cancellation of insurance is punishable. Furthermore, an employer's cancellation of insurance may be grounds for discrimination. ** No changes to the regulation were made.*
Comments requesting general language that NYPFL does not reduce or infringe on any other rights of the employee.	Worker's Compensation Board does not have jurisdiction to do this and the statement is overly broad. ** No changes to the regulation were made.*

For additional information:

https://docs.dos.ny.gov/info/register/2017/july19/Rule%20Makings.pdf

(beginning on page 22)

California Limits Surprise Medical Bills

Published: August 1, 2017

On September 23, 2016, Governor Brown signed Assembly Bill 72, California's law prohibiting surprise medical bills from out-of-network providers operating at in-network facilities. The new law takes effect for plans renewed on or after July 1, 2017 and prohibits balance billing of individuals for non-emergency services. The law establishes a reimbursement formula for out-of-network providers and requires any balance billing issues to be resolved between the carrier and service provider.
The law does not apply to Medical plans, self-funded plans, fully insured plans written outside of California, or individuals that are not insured. Balance billing related to Emergency services is already prohibited in California.

Surprise medical bills result when an individual inadvertently receives services from an out-of-network provider operating inside a facility that is in-network but the individual was not able to consent to the services and did not know the provider was not actually an in-network provider. This situation frequently occurs with anesthesiologists or radiologists that work in a hospital or medical office that is contracted with an insurance network but those individual providers are not part of the same network. The ACA limitations on out-of-network cost sharing allow individuals to be held fully responsible for any balance billing.

When processing an out-of-network claim, insurance carriers will often apply a payment formula for a portion of the claim, such as 60% of the usual and customary charge. The provider, at their discretion, can then bill the individual that received the services. This could be a significant charge because an out-of-network provider is not limited as to what can be charged for services in the same way that an in-network provider agreed when they joined the network.

For example, anesthesiology provided in-network may be billed at $2,500 but discounted to $700, of which the individual may pay $140. However, the same anesthesiology services provided out-of-network may be billed at $2,500 with no discount applied. The individual would be balance billed for the amount in excess of the insurance payment. This is illustrated in the chart below:

Anesthesiology	Billed Cost	Insurance Discount	Insurance Payment	Individual Payment	Balance Bill
In-Network Provider	$2,500	-$1,800	$560	$140	$0
Out-of-Network Provider	$2,500	$0	$480	$140	$1,880

The law requires the reimbursement rate for an out-of-network provider at an in-network facility to be either the average of the health insurer's contracted rate or 125% of Medicare reimbursement for the same or similar service in the same geographic area, whichever is greater. Additionally, the out-of-network provider must accept this amount as full payment. The law further requires that any disputes as to the reimbursement would be resolved by an insurer's internal review process or, if that fails to reach a resolution, an independent dispute resolution process (IDRP). The California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) would establish the IDRP.

Health Insurers are required to provide the DMHC and CDI with data listing their average contracted rates for their most frequently provided services by out-of-network providers, their methodology for determining their average contracted rate, and their policies used to determine their average contracted rate. The DMHC and CDI will use this information to establish an average contracted rate methodology for the IDRP by January 1, 2019.

Individuals can agree to balance billing in writing that meets the following criteria:

- Provided 24 hours in advance of the care
- In a document that is separate from any other consent required for the treatment
- Is not obtained by the facility
- Is not obtained while the individual is being prepared for the procedure
- Provides an estimate of the individual's total out of pocket cost and prohibits collecting more than the estimated amount
- Informs the individual that they may seek care form an in-network provider by contacting the insurer
- Is provided in the language spoken by the individual providing consent
- Advises that the out-of-network costs are in addition to in-network costs and may not count towards the annual deductible or out of pocket maximum.

The law also limits the collection and debt information that can be provided to a credit reporting agency.

Employers should ensure that their fully insured plans renewing on or after July 1, 2017 comply with the new law.

Update

Employer Penalty and 1094-C/1095-C Reporting

Published: August 22, 2017

Applicable large employers ("ALEs") may be resting easy, having had no notification from the IRS of 2015 or 2016 assessments under the Employer Shared Responsibility Provisions (the Employer Penalty) and having reasonably expected that the Republican-led administration would limit or choose not to enforce this mandate.

However, the recent failure in the Senate to pass legislation to repeal and replace the Affordable Care Act ("ACA") has left many employers wondering whether:

- Penalties associated with the Employer Penalty will be enforced; and
- Forms 1094-C and 1095-C will be required going forward.

Recently, the IRS published draft versions of the 2017 Forms 1094-C (https://www.irs.gov/pub/irs-dft/f1094c--dft.pdf) and 1095-C (https://www.irs.gov/pub/irs-dft/f1095c--dft.pdf). These versions are substantially similar to past Forms. Notably though, the Form 1094-C has reserved areas once used to reflect available transition relief (Line 22 Certifications of Eligibility, Boxes "B" and "C"). Final versions of the Forms are expected in the fall. Draft instructions for the 2017 Forms have not yet been released.

To date there has been no guidance issued by the IRS that eliminates penalties for Employer Penalty violations or fines associated with failures to accurately complete, provide and/or file Forms 1094-C and 1095-C. While some employers may think a Trump-led IRS will ignore these requirements, absent non-enforcement guidance from the agency, employers should continue to comply.

Why Comply? The Alternative may be Expensive.

The potential penalties are not limited to the "A" and "B" Employer Penalty assessments (which are substantial).

There are also significant penalties associated with failures to accurately complete, provide and/or file Forms 1094-C and 1095-C:

- The penalty for failure to file a correct information return is $260 for each return for which the failure occurs, with the total penalty for a calendar year not to exceed $3,193,000.
- The penalty for failure to provide a correct payee statement is $260 for each statement for which the failure occurs, with the total penalty for a calendar year not to exceed $3,193,000.
- Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

An employer intentionally ignoring the 1094-C and 1095-C requirement could be assessed penalties of more than $520 per form, up to $6,386,000 per year.

Next Steps

At this point, ALEs should:

- Prepare for CY 2017 Form 1094-C and 1095-C reporting. The Form 1095-C for CY 2017 will be due January 31, 2018 to ACA FTEs and, for self-insured group health plans, any covered non-ACA FTEs. Filings to the IRS are expected electronically by April 2, 2018 (and, for those eligible, on paper by February 28, 2018). We will update you if any extension of time is announced.
- Prepare to address notifications of a potential penalty assessment from the IRS. Likely, any notices associated with the 2015 calendar year would be issued first, with 2016 notices to follow.
- Continue to identify ACA FTEs using the appropriate measurement method (monthly or look-back) and manage offers and affordability of coverage. Understand any potential penalty liability that exists in your organization.
- Await updates from the IRS, including issuance of the final CY 2017 Forms and Instructions, likely in September or October.

DOL Sues Health Plan Alleging SPD and Wellness Program Failures

Published: August 23, 2017

On August 16, 2017, the Department of Labor ("DOL") filed a lawsuit against Macy's Inc. Health and Welfare plan (and its third party administrators) under ERISA Title I.

Specifically, the complaint alleges:

- The health plan and its fiduciaries failed to follow the written terms of the health plan's Summary Plan Description (SPD) when reimbursing out-of-network claims; and
- The wellness program that includes a tobacco surcharge violated the HIPAA wellness program rules.

The complaint alleges breach of fiduciary duty and asks, in part, for readjudication of all out-of-network claims administered outside plan terms and for restitution of all the tobacco surcharges imposed.

Failure to Amend SPDs

According to the DOL's complaint, Macy's changed the reimbursement threshold for out-of-pocket claims from
"the lesser of the provider's normal charge for a similar service or supply or between 75%-80% of usual and customary charges" to the Medicare Allowable Rate when it is less than the provider's normal charge for a similar service or supply. Allegedly, the SPD was not amended to include language describing that the reimbursement for out-of-network claims would be the Medicare Allowable Rate when less than provider's normal charge. Additionally, the health plan participants were not provided a copy of any summary of material modification reflecting the change in reimbursement.

Wellness Program Failures

The DOL alleges the tobacco cessation wellness program sponsored by Macy's did not meet the requirements of the wellness regulations to provide a nondiscriminatory wellness program for the years 2011 to present day. Briefly, the employer imposed a surcharge on an employee's premium for individuals who were smokers. While such surcharges are permissible, there are specific guidelines that must be followed to comply with HIPAA wellness regulations.

Specifically, the DOL alleges the wellness rules were violated because the program:

- Required covered members participating in a tobacco cessation program to be tobacco free for six consecutive months in order to avoid a premium surcharge;
- Did not allow individuals who completed the tobacco cessation program to avoid the entire surcharge (i.e., retroactively correct the application of a surcharge); and
- From 2011-2013, the materials describing the wellness program failed to include a notice of a reasonable alternative standard to avoid the surcharge.

Why is this Important?

The recent filing by the DOL of this complaint signals the agency has not backed away from pursuing ERISA violations against employer-sponsored health plans. It also highlights the importance for plans to keep documents up-to-date to ensure administration is consistent with the written terms of the plan. Finally, it highlights the importance of following the rules when it comes to wellness programs, specifically offering a reasonable alternative to achieve the reward without conditioning it on satisfying the original standard (e.g., non smoker status) and making the full reward available upon completion of the alternative.

It will be interesting to see Macy's response and to follow developments in this litigation and any actionable items for plan sponsors. We will continue to keep you apprised.

New York Paid Family Leave

Tax Guidance Issued

Published: September 12, 2017

On August 25, 2017, the State of New York's Department of Taxation and Finance ("NYDTF") issued much needed guidance related to the taxability of benefits received under the New York Paid Family Leave ("NYPFL") program, which becomes effective on January 1, 2018.

The guidance answers certain fundamental tax treatment questions and states:

- Benefits paid to employees will be taxable non-wage income that must be included in federal gross income;
- Taxes will not automatically be withheld from benefits; employees can request voluntary tax withholding;
- Premiums will be deducted from employees' after-tax wages;
- Employers should report employee contributions on Form W-2 using Box 14 - State disability insurance taxes withheld; and
- Benefits should be reported by the State Insurance Fund on Form 1099-G and by all other payers on Form 1099-MISC.

We will continue to keep you apprised.

For additional information, visit: https://www.tax.ny.gov/pdf/notices/n17_12.pdf

Medicare Part D Notification Requirements

Creditable Coverage Reminder

Published: September 26, 2017

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. For 2017, the 15th falls on a Sunday, so employers have until Monday, October 16th to provide this notification. 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.

Below you will find a summary of these requirements.

Employer Action

If you have not already done so, make sure to send these notices no later than October 16, 2017.

What are the Notification Requirements?

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);
- 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 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.

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 Notice

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 (March 1, 2017 for a 2017 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.

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