2018: Third Quarter

Compliance Digest

Compliance Bulletins Released July-September

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This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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New Jersey Out-of-Network Bill

Published: July 26, 2018

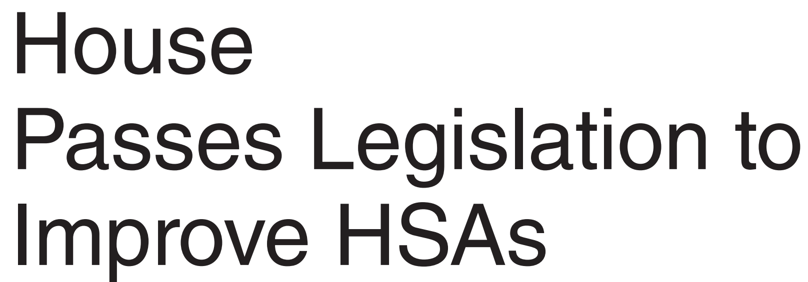
On June 1, 2018, New Jersey Gov. Murphy passed the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the "OON Act"). In general, the OON Act applies to emergency services and other care provided by out-of-network physicians in in-network settings (i.e. hospital-based physicians). It takes effect on **September 1, 2018**.

The Act provides reforms to several aspects of the state's health care system involving disclosures of out-of-network (OON) charges, arbitration for billing disputes, and provider network adequacy audits. The bill applies to fully-insured plans and does not apply to self-insured plans unless they choose to opt-in.

The Act requires that a covered patient be responsible only for "in-network" amounts when receiving care at an in-network facility, but may be receiving care from an OON provider. The Act prohibits out-of-network health care providers from directly or indirectly waiving or paying all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider.

Health care professionals and health care facilities are required to provide disclosures of out of network status and obtain specific, knowing and voluntary consent from patients who wish to receive out of network services at the out of network cost. The health care providers and insurance carriers will look to negotiate or go to arbitration for a disputed fee amount. However, the providers cannot seek payment from the patient for payment of out of network balances unless the patient has given a specific consent to do so.

Employers should connect with their carriers for specific direction and questions on this new law.



House Passes Legislation to Improve HSAs

Published: August 7, 2018

The House of Representatives passed two pieces of legislation that, among other things, purport to improve and “modernize” health savings accounts (“HSAs”).

The two bills are:

- H.R. 6199, Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018 (for a copy, visit https://www.congress.gov/115/bills/hr6199/BILLS-115hr6199eh.pdf)
- H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018 (for a copy, visit https://www.congress.gov/115/bills/hr6311/BILLS-115hr6311eh.pdf)

While the bills call for significant changes to the current rules affecting HSAs, the specific details are very different.

Summary of Proposed Changes

H.R. 6199 would:

- Exclude a direct primary care service arrangement from being treated as a disqualifying coverage for purposes of HSA eligibility. This would apply so long as the aggregate fees for all services do not exceed $150/month (or $250/month for coverage for more than one individual).
    - This would not include: procedures that require anesthesia, prescription drugs (other than vaccines), and laboratory services not typically administered in a primary care setting.
    - This would permit reimbursement from the HSA on a tax-free basis for direct primary care service arrangements subject to the monthly dollar limits described above. However, such fees are reportable for information purposes on the Form W-2.

- Permit individuals to maintain HSA eligibility when, in connection with employment, the individual (or the individual's spouse) receives (or is eligible to receive) "qualified items and services" at:
  - A health care facility located at a facility of the employer operated primarily for the benefit of the employer's employees (e.g., an onsite clinic)
  - Health care facilities located within supermarkets, pharmacies, or similar retail locations
  - For purposes of the above, "qualified items and services" are limited to the following:
    - Physical examinations,
    - Immunizations,
    - Drugs other than prescribed drugs,
    - Treatment for injuries occurring during employment,
    - Drug testing as a requirement of employment.
    - Hearing and visions screenings, and
    - Other similar items and services that do not provide significant medical benefits.
  - Treat a spouse's traditional health FSA coverage as non-disqualifying coverage for purposes of an employee's HSA eligibility in certain instances.
  - Create additional flexibility for health FSA and HRA conversions to fund HSAs including a conversion to HSA compatible arrangements for the remainder for the year.
  - Expand the definition of a qualified expense for purposes of health FSA, HRA, and HSA reimbursement to include certain menstrual care products and qualified sports and fitness expenses up to $500 (or $1,000 family) (e.g., gym memberships).

H.R. 6311 would:

- With respect to HSAs:
  - Expand HSA eligibility to age-based Medicare Part A eligible individuals (i.e., individuals age 65 and older).
  - Increase the maximum annual HSA contribution to match the out-of-pocket limit (as opposed to an IRS defined limit usually well below the maximum out of pocket).
  - Permit both spouses to make catch-up contributions to a single HSA (as opposed to requiring each spouse to have his/her own HSA to make a catch-up contribution).
  - Permit Bronze and Catastrophic plans to qualify as a high deductible health plan ("HDHP") for purposes of HSA eligibility.
  - Permit reimbursement of qualified medical expenses incurred within a 60-day period prior to the establishment of the HSA.
- Create a "Premium Copper Plan" in the individual Marketplace.
- Increase the health FSA carryforward from a maximum of $500 to the remaining account balance at the end of the year.
- Delay reinstatement of the Annual Fee on Health Insurance Carriers until January 1, 2022.

Both pieces of legislation have been sent to the Senate for consideration. Whether the Senate will take up these bills, let alone approve them "as is," remains uncertain. There appears to be some bi-partisan appetite to loosen the current HSA rules, which means it is possible that we may see changes to these arrangements, which could be effective as early as January 1, 2019. We will continue to keep you apprised.

NYC Mandates Employers Allow Temporary Schedule Changes

Published: August 14, 2018

As of July 18, 2018, employers in New York City must allow their employees to request two temporary schedule changes per calendar year for “personal events.” The law requires alteration in the hours, times, or location of work, including, but not limited to using short-term unpaid leave, paid time off, working remotely, or swapping or shifting working hours with a coworker.

“Personal events” include:

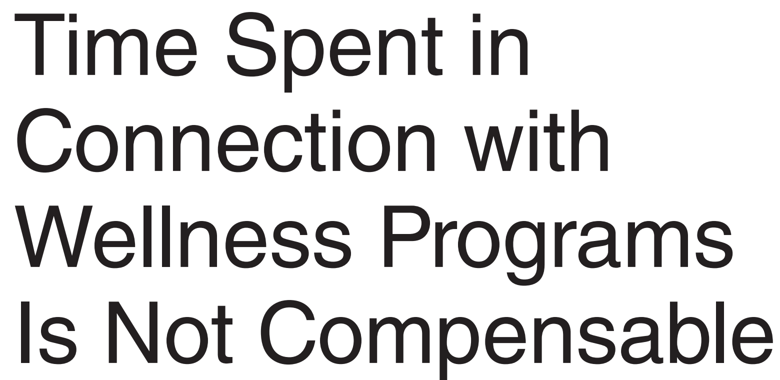
- The need to provide care to a minor child or care recipient;
- The need to attend a legal proceeding or hearing for subsistence benefits; or
- Any circumstance that would constitute a basis for safe time or sick time pursuant to New York City’s Earned Sick and Safe Time Act.

Please note, that the new law does exempt certain employees including:

- Employees employed for fewer than 120 days;
- Employees who do not work at least 80 hours in a calendar year in NYC;
- Certain employees covered by a collective bargaining agreement that waives the provisions of this law and addresses temporary changes to work schedules;
- Certain employees in motion picture, television, and live entertainment industries;
- Employees of federal, state, or local government.

Employers must post the Notice “You have a Right to Temporary Changes to Your Work Schedule” which can be found on the NYC Consumer Affairs website, linked below.

For more information on the NYC Temporary Schedule law, please visit the NYC Consumer Affairs website or view the NYC Frequently Asked Questions.



Time Spent in Connection with Wellness Programs Is Not Compensable

Published: September 13, 2018

Often, employers question whether they should be paying employees for time spent related to completing certain wellness activities such as:

- attending an in-person health education class and lecture (e.g., nutrition or diabetes management);
- taking an employer-facilitated gym class or using the employer-provided gym;
- participating in telephonic health coaching and online health education classes through an outside vendor facilitated by the employer;
- participating in Weight Watchers;
- voluntarily engaging in a fitness activity (e.g., going to personal gym, exercising outdoors, participating in a Fitbit challenge);
- getting a biometric screening; and
- attending a benefit fair.

The answer is not specifically addressed by the Fair Labor Standards Act ("FLSA") and seems particularly unclear when the employer uses incentives such premium discounts to encourage participation in the wellness program.

Under the FLSA, time is compensable when employees perform duties predominantly for the benefit of the employer. Time is not compensable for "off-duty" periods when the employee:

- is completely relieved from duty; and
- has a long enough amount of time that enables him or her to use the time effectively for his or her own purposes.

On August 28, 2018, the Department of Labor ("DOL") concluded in an information letter that when the employer does not require attendance, even when attendance results in reduced medical plan contributions, participation in the wellness activities is "voluntary." Assuming there is no direct financial benefit to the employer, attendance predominantly benefits the employee. Therefore, under these circumstances, the DOL stated that the time spent by the employees related to wellness activities does not have to be paid.

Medicare Part D Notification Requirements

Published: September 20, 2018

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.

Employer Action

If you have not already done so, make sure to send these notices no later than October 15, 2018.

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 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.
>
> 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, 2019 for a 2019 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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