



AssuredPartners COMPLIANCE OBSERVER

2nd Quarter 2017

CURRENT STATUS OF THE EMPLOYER MANDATE

At this time, the Affordable Care Act (ACA), including its employer mandate rules, remains federal law. Proposed legislation to repeal and replace the ACA is currently making its way through the federal legislative process. Both the American Health Care Act (AHCA), released in May, and the recent Better Care Reconciliation Act (BCRA), released on Thursday June 22, propose to reduce the penalties for failing to comply with the ACA's employer mandate to zero beginning in 2016, effectively repealing the ACA's employer mandate.

The ACA's future is still uncertain. Since neither the AHCA or BCRA have been signed into law, the ACA's employer mandate, and its penalty provisions, remain intact. However, because the employer mandate has been criticized as burdensome for employers and an impediment to business growth, it seems likely that its repeal will be part of any Republican plan to repeal and replace the ACA.

If the ACA's employer mandate is repealed, Applicable Large Employers (ALEs) will no longer be required to provide affordable, minimum value coverage to their full-time employees in order to avoid possible penalties. Many ALEs will likely want to modify their plan designs to go back to pre-ACA eligibility rules. Possible modifications that ALEs may consider include:

- Changing health plan eligibility rules so that only employees who have a full-time work schedule (for example, 40 hours per week) are eligible for coverage;
- Eliminating health plan coverage for employees who are part time, seasonal or temporary;
- No longer using the monthly or look-back measurement method to track employee hours and make eligibility determinations; and
- Increasing the amount that employees who elect group health plan coverage are required to contribute.

It is difficult to predict whether federal agencies, such as the IRS and DOL, will issue guidance in the event the ACA's employer mandate is repealed in order to help ALEs work through the changes. Even if federal agencies plan on issuing implementation guidance, it may take some time before it is available. In the meantime, ALEs that are considering changes to their health plan's design and administration should continue to consider their compliance obligations under ERISA and the ACA mandates that may remain intact.

Source: Zywave

REMEMBER - PCORI Fees are due July 31st!

Employers that sponsor self-insured health plans, including certain FSAs and HRAs, must report and pay the required PCORI fees via IRS Form 720, Quarterly Federal Excise Tax Return. For plan years ending between January 1, 2016 and September 30, 2016, the fee for an employer sponsoring an applicable self-insured plan is \$2.17 multiplied by the average number of lives covered under the plan. For plan years ending between October 1, 2016 and December 31, 2016, the fee is \$2.26 multiplied by the average number of lives covered under the plan.



NEW EXPIRATION DATE FOR EXCHANGE NOTICE

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) has extended the effective date of its model Health Insurance Exchange Notices through May 31, 2020. Previously, these model notices were set to expire on May 31, 2017. No other changes have been made to these notices.

[Click here](#) to access the model notices with the new expiration date. Please note that there are two separate notices - one for employers that offer a health plan to some or all employees, and another for employers that do not offer a health plan.

These model notices are the most current versions provided by the EBSA. For further guidance regarding these notices, please contact the EBSA directly at 1-866-444-3272.

ASSESSMENT OF 2015 'PAY OR PLAY' PENALTIES EXPECTED IN 2017

The Internal Revenue Service (IRS) has announced that it expects the letters informing applicable large employers (ALEs) of their potential liability for a "pay or play" penalty for the 2015 calendar year (reporting occurred in 2016) to be issued in 2017.

Background

The Affordable Care Act's (ACA) Employer Shared Responsibility Provision required ALEs (employers with an average of 50 or more full-time employees including full-time equivalent employees) to offer health insurance coverage to their full-time employees and their dependents beginning in January 2015. Employers who did not offer health insurance coverage, or offered health insurance coverage that did not meet minimum requirements or was not affordable, are subject to an Employer Shared Responsibility Payment.

The ACA requires ALEs to annually file information returns (Forms 1094-C and 1095-C) with the IRS and provide statements to their full-time employees about the health care coverage they offered (or did not offer). The information on Forms 1094-C and 1095-C is intended to help the IRS verify the accuracy of reported offers of coverage and calculate any applicable employer shared responsibility penalty.

TIGTA Audit

In April, the Treasury Inspector General for Tax Administration (TIGTA) released the results of an audit it conducted to assess the IRS's efforts in implementing the employer shared responsibility rules and related reporting requirements.

The TIGTA audit revealed a number of major system and operational problems that have hindered or delayed the IRS' enforcement of the provisions. As a result, the IRS has been unable to identify the employers potentially subject to an employer shared responsibility penalty or to assess any penalties.

2015 Penalty Letters

Although no letters have been sent yet, the IRS has indicated it plans to mail letters to ALEs informing them of their potential liability for a 2015 penalty in 2017. These letters will:

- Include the names of the employees who received a subsidy for the applicable tax year; and
- Provide ALEs with an opportunity to respond before any penalty liability is assessed or notice and demand for payment is made.

These IRS notices are separate from the Section 1411 Certification [letters](#) sent by the Department of Health and Human Services (HHS) that employers began receiving in 2016. The Section 1411 Certifications are sent to all employers with employees who receive a subsidy to purchase coverage through an Exchange (including both ALEs and non-ALEs). Section 1411 Certifications do not trigger or assess any penalties for any employers.

According to the IRS, it expects to publish guidance in the form of an Internal Revenue Bulletin prior to sending any letters to ALEs regarding the 2015 calendar year. The IRS also expects to supplement the guidance and widely distribute information to ensure ALEs are properly informed of when and how the IRS will be contacting them.

For future years, the IRS expects to begin issuing letters in the latter part of each calendar year in which reporting was due (for example, in late 2018 for reporting in 2018 for coverage in 2017).

For additional guidance, please see [IRS Q&As on Employer Shared Responsibility Provisions](#).

Source: Zywave, HR360

NEW DRAFT MODEL FORM FOR MENTAL HEALTH PARITY REQUESTS

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires group health plans and issuers to disclose certain information to plan participants regarding the plan's coverage of mental health and substance use disorder (MH/SUD) benefits. [Final regulations](#) under MHPAEA require the following disclosures:

- Upon request, health plan sponsors and issuers must disclose information on **medical necessity criteria** for both medical and surgical and MH/SUD benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply non-quantitative treatment limitations (**NQTLs**) with respect to medical and surgical and MH/SUD benefits. To avoid possible penalties under ERISA, plan sponsors should respond to these requests within **30 calendar days**. If a plan sponsor does not respond within 30 calendar days, penalties of up to \$110 per day may apply.
- Group health plans that are subject to ERISA must provide the **reasons for a denial of MH/SUD benefits** in the plan's claim denial notice in accordance with the Department of Labor's claims procedure regulations. Participants in non-ERISA plans may request this information, and the plan must respond within in a reasonable time and in a reasonable manner.

To help improve these disclosures, the Departments released a [draft model form](#) that participants, enrollees or their authorized representatives may use to obtain information on their plan's coverage of MH/SUD benefits.

By issuing the draft model form, the federal government has indicated that mental health parity compliance, including the application of NQTLs, will continue to be a high priority. A bipartisan law from 2016—[The 21st Century Cures Act](#)—calls for more education on mental health parity and increased enforcement of MHPAEA's requirements

ACTION STEPS

Employers with group health plans should review the draft model form in anticipation of participants' requests for information on their MH/SUD benefits. It is possible that the availability of the model form will generate requests for detailed information on plan benefits.

Plan sponsors should respond to these information requests **within 30 calendar days** in order to avoid possible penalties under the Employee Retirement Income Security Act (ERISA).

5500 Deadline – July 31, 2017 for Calendar Year Plans

Plan administrators of ERISA employee benefit plans must file Form 5500 by the last day of the seventh month following the end of the plan year, unless an extension has been granted. Form 5500 reports information on a plan's financial condition, investments and operations. Form 5558 is used to apply for an extension of two and one-half months to file Form 5500.

Small health plans (fewer than 100 participants) that are fully insured, unfunded or a combination of insured/unfunded, are generally exempt from the Form 5500 filing requirement.

Click here for the [DOL website](#) and the latest Form 5500 instructions for more detailed information on the filing requirements.

MEDICARE SECONDARY PAYER RULES

As a general rule, the Medicare Secondary Payer (MSP) statute prohibits group health plans from "taking into account" the Medicare entitlement of a current employee or a current employee's spouse or family member. Among other things, the MSP rules govern when a group health plan must pay first (primary) and when it may pay secondary on a claim for medical care if an individual is covered under both a group health plan and Medicare.

Group health plans that are primary to Medicare:

- Must provide Medicare-entitled employees (and spouses) with the **same benefits** as employees (and spouses) under age 65;
- **Cannot take into account** an individual's Medicare entitlement; and
- **Cannot offer any financial or other incentive** to encourage Medicare-entitled individuals to terminate enrollment in or opt out of group health plan coverage.

Who must comply with the MSP Rules?

The MSP rules apply to private-sector employers, as well as to religious, charitable, and educational institutions; the federal government; and states (including their agencies, instrumentalities, and political subdivisions). Certain small employers, however, have been given an exception from some, but not all, of the requirements.

In general, the prohibition against taking into account Medicare entitlement based on age and the requirement that certain individuals receive the same benefits under the same conditions, do not apply when the employer's **group health plan is a secondary payer** to Medicare because the employer has fewer than 20 employees in at least 20 weeks in either the current or preceding calendar year.

Additionally, employers generally cannot pay for or reimburse employees or retirees for Medicare premiums as this arrangement will generally be considered an "employer payment plan" and violate certain Affordable Care Act (ACA) insurance reform provisions. To avoid being considered an employer payment plan and potentially be able to pay for or reimburse Medicare premiums, an employer must ensure that such reimbursement arrangement be integrated with another group health plan it sponsors and follow other specific guidelines. Employers that reimburse Medicare premiums and do not follow this guidance may be liable for an excise tax of \$100 per participant per day or other penalties under the ACA. Further, it is very risky for any employer who must comply with the MSP rules (i.e. where Medicare is the secondary payer) as this type of arrangement takes into account Medicare entitlement of the beneficiary. Accordingly, unless the employer meets the MSP small employer exception, this type of Medicare reimbursement arrangement is not advisable.

Violations of the MSP Rules

A violation of the prohibition on offering incentives can trigger financial penalties of up to **\$8,908** per violation.

CMS has advised that an employer cannot offer, subsidize or be involved in the arrangement of a Medicare supplement policy where the law makes Medicare the secondary payer. Because this type of arrangement takes into account the Medicare entitlement of the employee, CMS has warned that it would subject the employer to possible excise taxes under the Internal Revenue Code.

Employers that are considering reimbursing employees' Medicare premiums may wish to consult with legal counsel to confirm that the arrangement will comply with applicable laws.

More information on the MSP rules is available on CMS's MSP [Web page](#), including the [Medicare Secondary Payer Manual](#).

FAILURE TO PROVIDE LIFE INSURANCE CONVERSION INFORMATION COSTS EMPLOYER \$750,000

A federal court recently ordered WellStar Health System Inc. to pay \$750,000.00 to a former employee's widow for breaching its fiduciary duty in administering its group life insurance plan. ([Erwood v. Life Ins. Co. of N. Am., 2017 U.S. Dist. LEXIS 56348 \(W.D. Pa.2017\)](#))

Background

Dr. Erwood, a neurosurgeon covered under his employer's life insurance plan became terminally ill with a brain tumor, took extended Family and Medical Leave Act (FMLA) leave from which he was unable to return, and eventually died. During his illness, he and his wife regularly communicated with his employer's benefits department and were repeatedly assured that their benefits remained the same. When he died, however, the insurer denied the life insurance claim because he was not an active employee at the time of death and had not elected to convert to individual coverage. Dr. Erwood's wife, Patricia, filed a claim under ERISA § 502(a)(3) against WellStar, as plan administrator, for breaching its fiduciary duty by failing to adequately inform the couple of the need to convert the group coverage to an individual policy during Dr. Erwood's FMLA leave.

The Case

A district court in the Third Circuit held that WellStar had breached its fiduciary duty by failing to adequately inform the couple of the requirements and procedures for converting the group life insurance policies following Dr. Erwood's leave under the FMLA.

The court explained that to prevail against the employer, Patricia must demonstrate that (1) the employer was acting as a fiduciary, (2) the fiduciary made misrepresentations or failed to provide adequate information, (3) the faulty disclosure was material, and (4) the disclosure was detrimentally relied on.

The court first concluded that the employer was a fiduciary, not only because it was the plan administrator, but also because it expressly assumed responsibility under its agreement with the insurer to inform employees about their conversion rights. The court next concluded that the employer failed to provide adequate information to its employee, even though the insurer had provided an administrative services manual explaining the employer's obligation to provide conversion paperwork when appropriate. The employer pointed out that its summary plan description (SPD) and FMLA packet referenced conversion rights, but the court found these materials inadequate in this situation. According to the court, once a participant or beneficiary has requested information from a fiduciary who is aware of the individual's circumstances, the fiduciary has an affirmative obligation to convey complete and accurate information-including information not specifically requested if the fiduciary knows (or should know) that silence may be harmful.

The court concluded that the employer was aware of the couple's circumstances and breached its disclosure duty by failing to provide adequate conversion information. The court "easily" determined that the employer's

misrepresentation was material, given the amount involved, and the couple's failure to convert the coverage showed detrimental reliance. Explaining that surcharge is an appropriate form of relief for fiduciary breach, the court awarded the wife an amount equal to the lost life insurance proceeds: **\$750,000**.

This case serves as a good reminder that employers must understand and properly administer conversion procedures under their group life insurance policies.

Source: EBIA/Thomson Reuters

Should you have any questions or concerns about these issues please contact a local member of your AssuredPartners Benefits Team.

AssuredPartners, Inc. and its partner agencies strive to provide you with insurance and benefit related information as part of our service to you that is both accurate and informative. Laws, regulations and circumstances change frequently, and similar situations or slight changes to laws and regulations can lead to entirely different results. The information contained in this document is for educational and informational purposes only, and, as such, you should always seek the advice of competent legal counsel for answers to your specific questions.

