AssuredPartners INC. COMPLIANCE OBSERVER Newsletter

3rd Quarter 2016

Medicare Part D Notices are due by October 14th

Each year, Medicare Part D requires group health plan sponsors to disclose to individuals who are eligible for Medicare Part D whether the health plan's prescription drug coverage is creditable. Specifically, this means employers must notify Medicare eligible individuals if their prescription drug plan is expected to cover, on average, as much as the standard Medicare Part D prescription drug plan.

Plan sponsors must provide the annual disclosure notice to Medicare-eligible individuals ***before* Oct. 15, 2016**—the start date of the annual enrollment period for Medicare Part D. CMS has provided model disclosure notices for employers to use.

This notice is important because Medicare beneficiaries who are not covered by creditable prescription drug coverage and who choose not to enroll in Medicare Part D when first eligible will likely pay higher premiums if they enroll at a later date. Thus, although there are no specific penalties associated with this notice requirement, failing to provide the notice may trigger adverse employee relations issues.

Disclosure notices must be provided to all Part D eligible individuals who are covered under, or who apply for, the plan's prescription drug coverage, regardless of whether the prescription drug coverage is primary or secondary to Medicare Part D. The disclosure notice requirement applies to Medicare beneficiaries who are active or retired employees, disabled or on COBRA, as well as Medicare beneficiaries who are covered as a spouse or dependent. To simplify plan administration, we recommend plan sponsors provide the disclosure notice to all plan participants.

The CMS Website provides complete text of the guidance and Model Disclosure Notices for both Creditable and Non-Creditable coverage, including Spanish versions. Plan Sponsors should carefully review and customize these notices to ensure they accurately reflect their plan provisions.

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Final Nondiscrimination Standards under ACA Section 1557

On May 13, 2016, the Department of Health and Human Services (HHS) issued a final rule implementing Section 1557 of the Affordable Care Act (ACA) regarding nondiscrimination in federally funded health programs. The final rule:

- Prohibits discrimination in health care on the basis of race, color, national origin, age, disability and sex (including discrimination based on pregnancy, gender identity and sex stereotyping);
- Enhances language assistance for people with limited English proficiency; and
- Helps to ensure effective communication for individuals with disabilities.

These nondiscrimination protections apply to ***covered entities*** that (1) operate a "health program or activity" and (2) receive federal financial assistance administered by HHS, including both federally facilitated and state-based Exchanges. Entities that operate a "health program or activity" encompass most health care and insurance entities, examples include: ***Hospitals, Health clinics, Group Health Plans, Health Insurance Issuers, Third Party Administrators, Physician practices, Community Health Centers, Nursing Facilities, etc. .***

Federal financial assistance means any HHS administered grants, loans, subsidies, contracts, or other arrangements by which the federal government provides assistance in the form of funds, services of federal personnel, or property. ***Medicare (other than Medicare Part B payments), Medicaid, and the Children's Health Insurance Program are forms of "federal financial assistance."***

HHS establishes numerous requirements for Covered Entities under the Final Rule. For example, a Covered Entity:

- must not discriminate on the basis of race, color, national origin, age, disability or sex (including discrimination based on pregnancy, gender identity and sex stereotyping) when providing or administering health-related insurance or other health-related coverage;
- must not exclude from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in, its health programs or activities on the basis of the race, color, national origin, age, disability or sex (including discrimination based on pregnancy, gender identity and sex stereotyping) of an individual with whom the individual or entity is known or believed to have a relationship or association;

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- must take reasonable steps to provide access to each individual with limited English proficiency who is eligible to be served or likely to be encountered within the entities' health programs and activities;
- must provide notice to beneficiaries, enrollees, applicants, or members of the public of individuals' rights under Section 1557 and of the entity's nondiscrimination obligations
- must post taglines in the top 15 languages spoken by individuals with limited English proficiency in that state that indicate the availability of language assistance;
- must take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with others;
- must ensure that its health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities.

Further, a Covered Entity that employs 15 or more persons must adopt a grievance procedure that incorporates appropriate due process standards and allows for the prompt and equitable resolution of complaints concerning actions prohibited by Section 1557 and must designate at least one employee to coordinate compliance with the requirements of the Final Rule.

The Final Rule became effective on July 18, 2016; however, for those insurance issuers or group health plans that must alter their plan benefit designs based on the Final Rule, the effective date is the first day of the first plan or policy year on or after **January 1, 2017**.

Notices and taglines must be posted by October 16, 2016. Covered entities may either use the model notice and model nondiscrimination statement prepared by OCR or create their own notices and statements. For more information about translated notices and taglines, visit HHS' website.

Self-Insured Group Health Plans:
In general, most self-insured group health plans are not subject to Section 1557; however, the plan's third-party administrator (TPA) may be. If so, the regulation impacts the TPA's administration of the plan (handling of claims, for example), but not the plan design itself, if it's created by your organization. OCR will review discrimination complaints on a case-by-case basis to determine if discrimination exists with the administration of the plan or with the plan design. If discrimination is found in the plan design, OCR will process the complaint against the employer/plan sponsor and will typically refer the matter to the Equal Employment Opportunity Commission (EEOC), if OCR does not have jurisdiction over the claim.

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Employers with self-insured plans should review their plan design and determine what areas of potential liability may exist. Serious consideration should be given to any identified issues and any decisions made in the capacity of the employer and plan sponsor should be documented. Plans can continue to use reasonable medical management techniques and neutral standards for the benefits provided, but blanket exclusions (for example, a plan that excludes coverage for all health services related to gender transition of coverage) may be a target for litigation.

IRS Finalizes Regulations Implementing Same-Sex Marriage Decisions and Guidance

The IRS has issued final regulations reflecting the U.S. Supreme Court decisions on same-sex marriage and prior IRS guidance in Revenue Ruling 2013-17. The final regulations, which took effect September 2, 2016 and largely track proposed regulations issued in 2015, amend existing IRS regulations to provide that, for federal tax purposes, the terms "spouse," "husband," and "wife" mean an individual lawfully married to another individual, and the term "husband and wife" means two individuals lawfully married to each other.

In a change from the proposed regulations, the final regulations provide that the domestic marriage of two individuals is recognized for federal tax purposes if the marriage is recognized by the state, possession, or territory of the United States in which the couple entered into the marriage. Foreign marriages, on the other hand, are recognized if the relationship would be recognized as a marriage by any state, possession, or territory of the United States. The final regulations also provide that domestic partnerships, civil unions, or similar relationships not denominated as marriage under the laws of the state, possession, or territory of the United States where the couple entered into the relationship are not considered marriage for federal tax purposes.

The final regulations do not break new ground; rather, they confirm and formalize changes that were previously announced in sub-regulatory guidance. With the publication of these regulations, Revenue Ruling 2013-17, which was issued immediately following the Windsor decision, is obsolete. However, taxpayers may continue to rely on guidance that applied Revenue Ruling 2013-17 to employee benefit plans, such as IRS Notices 2014-1 (addressing cafeteria plans, health FSAs, DCAPs, and HSAs) and 2014-19 (addressing qualified retirement plans).

Source: EBIA

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Proposed Notice of Benefit & Payment Parameters for 2018

The Departments of Health and Human Services (HHS) recently released a Proposed Notice of Benefit and Payment Parameters for 2018. This proposed rule describes benefit and payment parameters under the Affordable Care Act (ACA), applicable for the 2018 benefit year, including updated standards relating to:

- Annual limitations on cost-sharing;
- The individual mandate's affordability exemption; and
- Special enrollment periods in the Exchange.

Annual Limitations on Cost-sharing
Under the proposed rule, the out-of-pocket maximum would increase for 2018 to $7,350 for self-only coverage and $14,700 for family coverage.

Individual Mandate's Affordability Exemption
Under the proposed rule, the required contribution percentage would decrease in 2018. The proposed rule would provide that, for 2018, an individual is exempt from the individual mandate penalty if he or she must pay more than 8.05 percent of his or her household income for MEC.

Exchange Special Enrollment Periods
The proposed rule would amend the provisions relating to special enrollment periods in the individual market in an effort to clarify the requirements and limit abuse. In addition, the proposed rule would also codify the certain existing special enrollment periods, in an effort to provide clarity and certainty.

Source: Zywave

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Health Savings Account (HSA) Eligibility Rules

Many employers offer high-deductible health plans (HDHPs) to control premium costs, and then pair this coverage with a health savings account (HSA) to help employees with their health care expenses. An HSA is a tax-favored trust or account that can be contributed to by, or on behalf of, an ***eligible*** individual for the purpose of paying qualified medical expenses.

HSAs provide a triple tax advantage—contributions, investment earnings and amounts distributed for qualified medical expenses are all exempt from federal income tax, FICA tax and most state income taxes. Due to an HSA's potential tax savings, federal tax law imposes strict eligibility requirements for HSA contributions.

Only an eligible individual can establish an HSA and make HSA contributions (or have them made on his or her behalf). An individual's HSA eligibility is determined monthly, and, as a general rule, contributions can only be made for the months in which the individual satisfies all of the HSA eligibility criteria.

WHO is an ELIGIBLE INDIVIDUAL?

To be HSA-eligible for a month, an individual must:

- ✓ Be covered by an HDHP on the first day of the month;
- ✓ Not be covered by other impermissible health coverage (with certain exceptions);
- ✓ Not be enrolled in Medicare; and
- ✓ Not be eligible to be claimed as a dependent on another person's tax return.

The full-contribution rule that applies to individuals who are HSA-eligible on Dec. 1 is an exception to this general rule. Under this exception, an individual is treated as HSA-eligible for the entire calendar year for purposes of HSA contributions if he or she becomes covered under an HDHP in a month other than January and is HSA-eligible on Dec. 1 of that year. An individual who relies on this special rule must generally remain HSA-eligible during a 13-month testing period, with exceptions for death and disability.

HDHP COVERAGE

To be eligible for HSA contributions for a month, an individual must be covered under an HDHP as of the first day of the month and have no other impermissible coverage.

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NO DISQUALIFYING COVERAGE

To be eligible for HSA contributions, an individual generally cannot have health coverage other than HDHP coverage. This means that an HSA-eligible individual cannot be covered under a health plan that provides coverage below the HDHP minimum annual deductible.

An individual who has non-HDHP coverage with a deductible below the minimum HDHP deductible that is not preventive care, permitted coverage or permitted insurance will not be an eligible individual for HSA purposes.

Individuals who are covered by general-purpose health FSAs or HRAs are not eligible for HSA contributions. A general-purpose health FSA or HRA is one that pays or reimburses all qualifying medical expenses of an employee and his/her dependents. This includes an individual whose spouse is enrolled in a general-purpose health FSA or HRA through his/her employer. In addition, an individual's HSA eligibility may be affected when a health FSA incorporates a grace period or a carry-over feature.

Although general-purpose health FSA or HRA coverage will prevent an individual from being eligible for HSA contributions, certain health FSA or HRA designs preserve HSA eligibility. These include:

- ✓ **Limited-purpose health FSA or HRA**—This type of health FSA or HRA pays or reimburses qualifying medical expenses that are permitted coverage, permitted insurance or preventive care (for example, dental or vision coverage).
- ✓ **Post-deductible health FSA or HRA**—This type of health FSA or HRA pays or reimburses medical expenses incurred after the individual has met the minimum annual deductible within the HDHP.
- ✓ **Suspended HRA**—A suspended HRA, pursuant to an election made before the beginning of the HRA coverage period, does not pay or reimburse at any time, any medical expenses incurred during the suspension period, except preventive care, permitted insurance or permitted coverage.
- ✓ **Retirement HRA -** A retirement HRA pays or reimburses medical expenses incurred after the individual retires.

MEDICARE ENTITLEMENT

An individual who is entitled to Medicare benefits is not eligible for HSA contributions. **To be entitled** to Medicare benefits, ***an individual generally must be both eligible and enrolled***. Eligibility for Medicare benefits alone does not make an individual ineligible for HSA contributions.

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IRS Notices 2004-50and 2008-59 confirm that a Medicare-eligible individual who is not actually enrolled in Medicare Part A, Part B, Part D or any other Medicare benefit may contribute to an HSA until the month that he or she is enrolled in Medicare.

TAX DEPENDENT

An individual who can be claimed as a tax dependent of another individual is not eligible for HSA contributions. In general, a taxpayer may claim an individual as his or her tax dependent if the individual is:

- The taxpayer's child and under age 19 at the end of the tax year;
- The taxpayer's child, a student and under age 24 at the end of the tax year; or
- A member of the taxpayer's household for whom the taxpayer provided over half of the support for the year and whose gross income does not exceed the personal exemption amount.

Source: Zywav

Health Savings Account (HSA) Contribution Limits for Spouses

There is a special contribution limit for married individuals, which provides that if either spouse has family HDHP coverage, then both spouses are treated as having only that family coverage. This means that if both spouses are HSA-eligible and either has family HDHP coverage, the spouses' combined contribution limit is the annual maximum limit for individuals with family HDHP coverage.

Annual Limits for 2017

- **$3,400 for single coverage**
- **$6,750 for family coverage**

Individuals who are age 55 or older by the end of the tax year are permitted to make an additional $1,000 HSA contribution to his/her separate HSA, called a "catch-up contribution."

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ACA Reporting – Section 6055/6056

2015 Reporting

According to the IRS, you may continue to electronically file your 2015 ACA information returns after the required deadline of June 30, 2016.

It is important to note the following:
The ACA Information Returns (AIR) system will continue to accept information returns filed after June 30, 2016. In addition, you can still complete required system testing after June 30, 2016.

If any of your transmissions or submissions were rejected by the AIR system, you have 60 days from the date of rejection to submit a replacement and have the rejected submission treated as timely filed.

If you submitted and received "Accepted with Errors" messages, you may continue to submit corrections after June 30, 2016.

The IRS is aware that some filers are still in the process of completing their 2015 tax year filings. As is the case for other information returns, penalties may be associated with the submission of the ACA information returns for failure to timely file required returns. As the IRS has publicly stated in various forums in recent months, 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 you are not an electronic filer and you missed the May 31, 2016, paper filing deadline for ACA information returns, you should also complete the filing of your paper returns as soon as possible.

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Solicitation of Tax Payer Identification Numbers (TIN)/ Social Security Numbers (SSN) for ACA Reporting

Applicable Large Employers (ALEs) who did not provide the TIN/SSNs of individuals on their 2015 ACA ALE reporting must conduct the annual solicitation of TIN/SSNs ***on or before October 12th***.

If the TIN/SSN is not received after this solicitation, an ALE must solicit the TIN/SSN again by December 31, 2017 to show reasonable cause.

2016 Reporting

Employers should start planning now for 2016 reporting. The IRS has just recently released ***final*** forms (1094-B and 1095-B) and ***final*** instructions for Section 6055 reporting. Draft forms for Section 6056 (1094-C and 1095-C) were released earlier this year. Draft instructions for these forms are also available.

The IRS has given no indication that another extension of the filing deadlines will be offered this year. Employers should begin reviewing the forms and instructions and collecting relevant data to ensure they are prepared to meet the following deadlines for their 2016 ACA Reporting:

- **January 31, 2017 - Statements for 2016 must be furnished to individuals**
- **February 28, 2017 - Returns for 2016 must be filed with the IRS (March 31, 2017, if filed electronically).**

Please contact your local member of the AssuredPartners team if you have questions or need assistance with these or other compliance matters.

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