Compliance Recap

August 2019

August was a relatively quiet month in the employee benefits world.

The Department of Labor (DOL) issued its updated Medicaid / CHIP Model Notice. The Centers for Medicare and Medicaid Services (CMS) revised its Medicare Secondary Payer User Guide and changed reporting requirements regarding prescription drug coverage beginning January 1, 2020.

The Treasury, DOL, and Department of Health and Human Services (HHS) issued FAQs regarding enforcement of the Final 2020 Benefit and Parameters Rule. The Internal Revenue Service (IRS) released a private letter ruling addressing whether certain expenses qualify as Section 213(d) medical care expenses.

The DOL issued an advisory opinion addressing whether intermittent Family and Medical Leave Act (FMLA) leave can be taken to attend special education meetings for an employee's children.

UBA Updates

UBA updated or revised existing guidance:

- Sample Open Enrollment Notices Packet
- Final 2020 Benefit Payment and Parameters Rule

DOL Issues Updated Medicaid / CHIP Model Notice

The Department of Labor (DOL) issued an updated Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Model Notice. Employers should distribute the updated model notice before the start of the plan year if they have any employees in a state listed in the notice.

See the UBA Sample Open Enrollment Notices Packet for the updated model notice.

CMS Requires Prescription Drug Coverage Reporting under Section 111 MSP Reporting

The Centers for Medicare and Medicaid Services (CMS) revised its Section 111 Medicare Secondary Payer (MSP) User Guide and issued FAQs that require responsible reporting entities (RREs) to submit primary prescription drug coverage information as part of their Section 111 MSP Mandatory reporting requirements effective January 1, 2020.

The RRE for reporting primary prescription drug coverage is the entity that has direct responsibility for processing and paying prescription drug claims. In most cases, the RRE will be the insurer or TPA. For example, if the plan sponsor contracts with a third party such as a pharmacy benefits manager (PBM) to administer prescription drug coverage, then the third party or PBM is considered the RRE for prescription drug reporting purposes. However, for self-funded plans that are self-administered, the RRE will usually be the plan administrator.

Treasury, DOL, and HHS Issue FAQs on Enforcement of Final 2020 Benefit and Parameters Rule

On August 26, 2019, the Treasury, Department of Labor (DOL), and the Department of Health and Human Services (HHS) (collectively, the Departments) issued FAQs About Affordable Care Act Implementation Part 40 (FAQs) regarding enforcement of the final rule.

Under the FAQs released after the final rule was published, the Departments will not initiate an enforcement action if an issuer or group health plan excludes the value of drug manufacturers' coupons from the annual limitation on cost sharing, until the final 2021 benefit payment and parameters rule is issued and effective.

Read more about the FAQs.

IRS Releases Private Letter Ruling Regarding Section 213(d) Medical Care Expenses

The Internal Revenue Service (IRS) released a private letter ruling (Letter) regarding whether the price of a DNA collection kit – specifically services and reports related to a person's health that are generated from analyzing the collected DNA – qualify as Section 213(d) medical care expenses.

Health services such as genotyping are medical care under Section 213(d) while reports that provide general information are not medical care. The IRS concluded that the DNA collection kit's price must be allocated between health services that are medical care, such as genotyping, and the non-medical services, such as reports that provide general or ancestry information.

DOL Issues Advisory Opinion on FMLA

The Department of Labor (DOL) issued an advisory opinion regarding whether an employee may take intermittent leave under the Family and Medical Leave Act (FMLA) to attend special education meetings with a speech pathologist, school psychologist, and occupational therapist to discuss the employee's children's individualized education programs.

The DOL concluded that the employee's attendance at the meetings is "care for a family member . . . with a serious health condition" under FMLA and is a qualifying reason for taking intermittent FMLA leave.

Question of the Month

Q. Under the ACA, if an employer's size grows, when does the employer need to offer coverage and report on coverage offered?

A. If the employer employs an average of at least 50 full-time or full-time equivalent employees during calendar year 2019, then it would make offers of coverage in 2020, and report in 2021 on its offers of coverage made in 2020.

The applicable large employer determination is a three-year cycle. For example, an employer's size, calculated at the conclusion of 2019, determines its obligations for 2020, which it reports on in 2021.

If 2019 is the first time that a company is an applicable large employer, then the company will have until April 1, 2020, to offer coverage. If the company has individuals who are currently full-time employees and the company offers a group health plan, then the company must offer coverage to those full-time employees on January 1, 2020.

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