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DOL Clarifies FMLA Qualifying Event

Under the federal Family and Medical Leave Act (FMLA), an eligible employee is entitled to leave to care for a family member including parent, child or spouse with a serious health condition. Further, FMLA leave can be taken on an intermittent or reduced leave schedule for medically necessary treatment and procedures.

The Wage and Hour Division of the Department of Labor recently reviewed a scenario wherein an eligible employee took FMLA leave to attend a Committee on Special Education (CSE) meeting to discuss an Individualized Education Program (IEP) of the employee's child. The DOL opined in **Opinion Letter FMLA2019-2-A** that the need to attend these specialized meetings to address the educational and special medical needs of the employee's children, who have serious health conditions as certified by a health care provider, would be a qualifying reason for taking intermittent FMLA leave.

While every IEP meeting may not rise to a level of a qualifying FMLA event, employers should be aware that, in certain circumstances, these types of meetings could qualify as care for a family member. Keep in mind that medical certification can be used to validate the need to care for a family member.

Do Tax, says the IRS

The IRS issued a Revenue Ruling (**RR 2019-19**) affirming that a taxpayer cannot delay inclusion of a retirement plan distribution by not cashing the distribution check.

In summary, a qualified retirement plan distribution is includible in income in the year of the distribution, without regard to whether the check is cashed in that year. The plan administrator must accomplish the requisite tax withholding of the plan distribution and provide the beneficiaries their requisite IRS Form 1099-R.

A Fiduciary Reality Check

A recent Fourth Circuit Court of Appeals decision warrants the attention of ERISA plan administrators and fiduciaries.

In the matter of ***Dawson-Murdock v. National Counseling*** (Appeal No. 18-1989, July 24, 2019. 4th Cir.), a widow sought to receive a life insurance benefit as the named primary beneficiary of her husband's life insurance policy. As background, her husband had been employed by National Counseling and covered under a Unum group life insurance plan. He moved from a full time to part time status and continued to pay premium for the life insurance coverage. However, the change in employment status made him ineligible to continue participation in the group plan in accordance with the terms of the plan. His employer/plan administrator failed to notify him of the ineligibility to the benefit due to his change in employment status, which would have allowed him to convert to an individual policy. Upon his death, the widow sought the life insurance benefit from Unum. She was contacted by HR representative from National Counseling who initially stated that Unum denied the claim. The HR representative assured her that the company would ensue resolution with Unum to ensure she received the benefit so that she need not appeal Unum's decision. A few months later, the HR representative advised that the company would not pay it, and by that time, she missed the opportunity to appeal Unum's decision. The spouse sought legal proceedings against the company in its failure, as a fiduciary, to notify the employee of his ineligibility and right to convert the policy, as well as advising her not to appeal Unum's decision. The Fourth Circuit Court returned the case to a lower court for further evaluation.

The take away for an employer/plan administrator is to be diligent in benefit plan administration, and be fully cognizant that each act taken could constitute a fiduciary act, whether as a named fiduciary or a functional fiduciary.

MSP Reporting Rule Expanded to Include Prescription Drug Coverage

In certain instances in which employer-provided health coverage is available, Medicare only pays after the employer plan pays. The rules governing these situations are known as the Medicare Secondary Payer Rules (MSP rules). The MSP rules are generally applicable to the working aged, individuals with end stage renal disease and certain disabled individuals.

In 2007, an MSP reporting requirement was imposed, primarily on insurers, third party administrators (TPAs) and plan administrators of self-funded, self-administered health plans (known as, responsible reporting entities, "RRE"). The purpose of this reporting obligation is to ensure that the MSP rules are properly administered. Insurers, TPAs and plan administrators are required to register with the Centers for Medicare and Medicaid Services (CMS) to accomplish the required reporting through a dedicated CMS website.

In October, 2018, a law was enacted that expands the reporting obligation to include prescription drug coverage. The *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT)* requires reporting for Medicare beneficiaries who have prescription drug coverage other than, or in addition to Medicare Part D, which is primary to Medicare. This includes prescription drug coverage for an individual who is Medicare-eligible and currently employed, or is the spouse or family member of a worker who is covered by a prescription drug plan. Initially, RREs had the option to include prescription drug coverage in its annual report; however, reporting prescription drug coverage becomes mandatory beginning January 1, 2020. As a result, CMS released a revised **user guide** together with a **set of FAQs** to assist RREs with their prescription drug coverage reporting obligation.

Generally, employers are not involved in this reporting requirement, except to the extent that the insurer or TPA may ask the employer to assist in collection of the required information.

Reminder: Distribute Medicare Part D Notices by October 15th

Plan sponsors have an annual obligation to provide the Medicare Part D creditable coverage notices to Medicare-eligible individuals. The annual Medicare Part D open enrollment period for the 2020 year begins October 15, 2019 and runs through December 7, 2019.

Who gets the Medicare Part D notice? The notice must be provided to all Medicare-eligible individuals including employees, former employees and Medicare-eligible dependents covered by the plan or who become eligible to enroll in the plan.

Contents of notice. The Centers for Medicare and Medicaid Services (CMS) provide model language that can be tailored by plan sponsors to satisfy their notice obligation:

- Model Individual Creditable Coverage Disclosure Notice Language (English or Spanish)
- Model Individual Non-Creditable Coverage Disclosure Notice Language (English or Spanish)

Timeframe for providing notice. The Medicare Part D Notice of Creditable or Non-creditable Coverage must be provided at least annually, prior to the Medicare Part D open enrollment period. This means that all Medicare Part D notices of creditable or non-creditable coverage must be provided within the 12-month period ending on October 15, 2019. In addition, the notice must be provided prior to an individual's initial enrollment in Part D, prior to the effective date of coverage for any Medicare-eligible individual that joins the plan, at the point when prescription drug coverage ends, or changes from creditable to non-creditable coverage, or vice versa; and upon an individual's request.

Form and manner of providing notice. The notice must be written and can be delivered in paper, either by hand or by US mail. It can be included in plan materials as long as the creditable coverage is prominently displayed in at least 14-point font in a separate box, bolded or offset on the first page of plan participant information.

The disclosure notice may be provided electronically only if the Medicare beneficiary has adequate access to electronic information. Prior to agreeing to receive information electronically, the individual must be informed of right to obtain a paper version, and the procedures for withdrawing consent and updating address information, and identify any hardware or software requirements to access and retain the creditable coverage disclosure. If an individual consents to electronic distribution, a valid e-mail address must be provided to the entity, and the beneficiary's consent must be submitted electronically to the entity. In addition to e-mailing the disclosure notice to the beneficiary, the entity must also post the notice on its website, if applicable, with a link to the creditable coverage notice on the entity's homepage.

San Francisco HCSO Expenditure Rates for 2020

Covered employers subject to San Francisco's Health Care Security Ordinance (HCSO) are required to make health care expenditures to, or on behalf of, their covered employees. These expenditure amounts are adjusted annually, in accordance with the Ordinance. These expenditure rates do not apply to businesses with 19 or fewer employees or nonprofits with 49 or fewer employees.

The required minimum health care expenditure is calculated by multiplying the total number of "hours paid" to that employee by the applicable expenditure rates, which for 2020 and 2019 are as follows:

HCSO Health Care Expenditure Rates		
Employer Size *(company-wide)*	2020	2019
◆ 100+ Employees	$3.08/hour	$2.93 hour
◆ 20-99 Employees	$2.05/hour	$1.95/hour
◆ Nonprofits 50-99 Employees		

District of Columbia's Employer Reporting Obligation

In 2018, the District of Columbia passed an ordinance requiring District residents to maintain minimum essential coverage beginning January 1, 2019, or be subject to a penalty. For this purpose, *minimum essential coverage* (MEC) is defined as health coverage that meets one of the following three definitions:

- Minimum essential coverage, as defined by the Affordable Care Act as of December 15, 2017. Generally, this means any comprehensive health coverage whether insured or self-funded and whether group or individual;
- The Immigrant Children's Program; or
- Health coverage provided under a multiple employer welfare arrangement (MEWA), as long as such MEWA coverage existed on December 15, 2017.

If the individual and/or dependent fails to maintain MEC, then a District shared responsibility payment is due. The maximum amount of the District shared responsibility payment is determined using the District's average premium for bronze-level plans.

While an employer is not responsible for offering MEC to its DC residents, it may have a reporting and disclosure obligation. Generally, according to recent guidance from the District of Columbia Office of Tax and Revenue (OTR), an *applicable reporting entity* can use the IRS Forms 1094/1095 B and C series, as applicable. An employer is deemed to be an 'applicable reporting entity' if it employs 50 or more full-time employees.

As a reminder, the IRS Form 1094/1095-B series is used to report MEC; it is generally used by insurers. Applicable large employers use the IRS Form 1094/1095-C series to report offers of coverage. Part three of the C series is used by self-funded plans to report MEC.

Additionally, the IRS Forms 1094/1095 B and C series are to be filed electronically with the OTR by uploading the files through **MyTax.DC.gov**. The filing due date is June 30, 2020 for the 2019 filing year. For tax years after December 31, 2019, the deadline is 30 days after the IRS deadline for submitting forms.

According to the guidance, the reporting entity is not obligated to send duplicate notices. In other words, satisfaction of the federal notice to participants on the Form 1095-B or 1095-C will suffice.

Employers who may be subject to this filing requirement will want to stay tuned for future developments. There are some outstanding questions such as, would an employer have a reporting obligation if the insurer is accomplishing the MEC reporting on its behalf?

Website address changes for Model DOL-EBSA Forms

To assist employers and plan administrators in compliance with various employee benefit laws, the Department of Labor's Employee Benefits Security Administration (EBSA) provides model notices and forms. EBSA recently re-designed its website, which resulted in a change to the website addresses of several model DOL-EBSA forms. Many of the Model Notices & Disclosures can be found by topic via EBSA's **Plan Administration and (Health Plan) Compliance** webpage. These include:

- Affordable Care Act model forms including the notice of grandfathered health plan status, the patient protection notice, notice of marketplace options, summary of benefits and coverage template and glossary, and the three types of claims and appeal notices;
- COBRA continuation of coverage model notices including the initial/general notice and election notice;
- View only Forms 5500 and M-1, and the model summary annual report;
- *Model Notice for Employers Regarding Premium Assistance Opportunities*, also known as the Medicaid/CHIP notice. The DOL recently re-issued this notice, made current as of July 31, 2019 (see our article in the August *Benefit Beat)*.

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