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HR News Alert

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October 2014 Issue

In this Issue

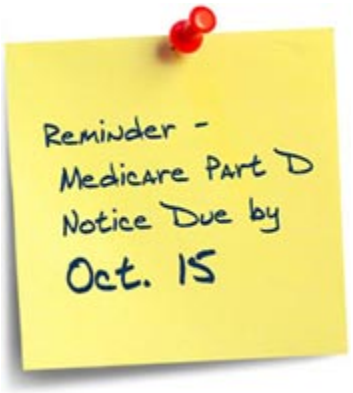
Employers Must Provide Medicare Part D Notices by October 15th

In preparation for the Medicare fall open enrollment period, employers sponsoring **group health plans that include prescription drug coverage** are required to notify all Medicare-eligible individuals whether such coverage is creditable. Creditable coverage means that the coverage is expected to pay, on average, as much as the standard Medicare prescription drug coverage.

Written Disclosure Provided to Certain Individuals
This written disclosure notice must be provided annually **prior to October 15th**, and at various other times as required under the law, to the following individuals:

- Medicare-eligible active working individuals and their dependents (including a Medicare-eligible individual when he or she joins the plan);
- Medicare-eligible COBRA individuals and their dependents;
- Medicare-eligible disabled individuals covered under an employer's prescription drug plan; and
- Any retirees and their dependents.

Model notices are available from the Centers for Medicare & Medicaid Services (CMS).



Online Disclosure Also Required
Additionally, employers are required to complete an online disclosure to CMS to report the creditable coverage status of their prescription drug plans. This disclosure is also required annually, **no later than 60 days from the beginning of a plan year**, and at certain other times.

Our Medicare section features additional information for employer-sponsored group health plans.

IRS Updates Q&As on ACA Information Reporting

Two sets of recently updated Q&As from the Internal Revenue Service (IRS) provide guidance on the information reporting requirements under the Affordable Care Act (ACA). One set of Q&As relates to information reporting by health coverage providers under Internal Revenue Code (IRC) section 6055, and the other set of Q&As relates to reporting on offers of health insurance coverage by employers under IRC section 6056.

ACA Information Reporting Basics
The ACA requires insurers, self-insuring employers, and other parties that provide minimum essential health coverage (MEC) to report information on this coverage to the IRS and to covered individuals ("section 6055 reporting"). Large employers (generally those with **50 or more full-time employees**, including full-time equivalents) are also required to report information to the IRS and to their employees about their compliance with the employer shared responsibility provisions ("pay or play") and the health care coverage they have offered ("section 6056 reporting").

Updated Q&As
Both sets of Q&As make clear that information reporting under sections 6055 and 6056 is voluntary for calendar year 2014. Therefore, the first section 6055 and 6056 returns required to be filed are for the 2015 calendar year and **must be filed no later than February 29, 2016** (or March 31, 2016, if filed electronically). The Q&As also provide information regarding what information is required to be reported, and how to report the required information, among other things.

Draft Forms & Instructions
The Q&As also reference draft forms that were recently released to help reporting entities prepare for compliance. The following draft forms, including draft instructions, are now available:

MEC Reporting (Section 6055)

- Draft Form 1094-B
- Draft Form 1095-B
- Draft Instructions

Large Employer Reporting (Section 6056)

- Draft Form 1094-C
- Draft Form 1095-C
- Draft Instructions

Employers that are subject to both reporting provisions (generally large employers that sponsor self-insured group health plans) are permitted to satisfy their reporting obligations on Form 1095-C, which will have separate sections for reporting under sections 6055 and 6056. Click here for more information on the reporting requirements.

Our ACA by Year & Company Size section features additional requirements under Health Care Reform.

Additional Permitted Election Changes for Health Coverage Under Cafeteria Plans

New agency guidance expands the application of the permitted election change rules for employer-sponsored health coverage under a cafeteria plan in two situations -- an employee's **enrollment in Marketplace coverage** and **reduction in hours of service** -- provided specific conditions are met. The guidance became effective on **September 18, 2014**.

Current Permitted Election Changes
Generally, elections under a cafeteria plan (also known as a section 125 plan) must be made before the start of a plan year and are irrevocable during the year, with limited exceptions such as certain "changes in status" (including changes in employment status) and with respect to special enrollment rights.

Highlights of New Guidance
In general, a cafeteria plan may allow an employee to prospectively revoke an election of coverage under a group health plan -- that is not a health flexible spending arrangement (FSA) and that provides minimum essential coverage (MEC) -- provided the following conditions are met:

Revocation Due to Enrollment in Marketplace Coverage

1. The employee is eligible for a special enrollment period to enroll in Marketplace coverage, or the employee seeks to enroll in such coverage during the Marketplace's annual open enrollment period; and
2. The employee (and any related individuals who cease coverage due to the revocation) enrolls in Marketplace coverage, effective immediately following the last day of the original coverage that is revoked. For this purpose, a cafeteria plan may rely on an employee's reasonable representations.

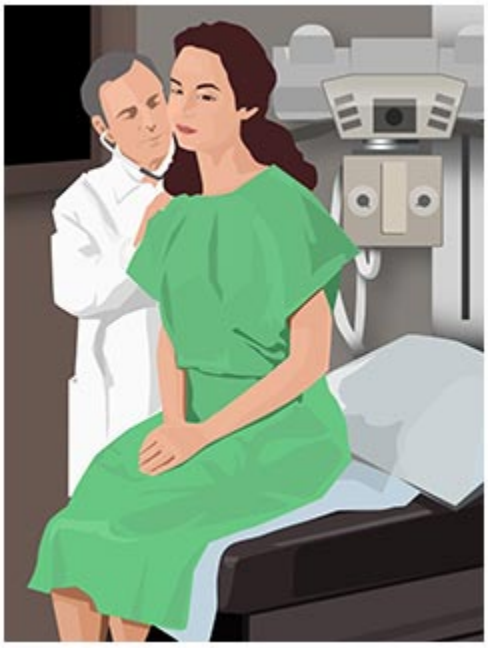
Revocation Due to Reduction in Hours of Service

1. The employee changes from full-time status to part-time status (i.e., he or she will reasonably be expected to average **less than 30 hours of service** per week after the change), even if the reduction in hours does not result in the employee ceasing to be eligible under the group health plan; and
2. The employee (and any related individuals who cease coverage due to the revocation) enrolls in another plan that provides MEC, effective no later than the first day of the second month following the month the original coverage is revoked. For this purpose, a cafeteria plan may rely on an employee's reasonable representations.

Cafeteria plans **must be amended** to provide for the new permitted election changes in accordance with the guidance under Notice 2014-55, which generally provides that such amendments can be made for plan years beginning in 2014 at any time on or before the last day of the plan year beginning in 2015.

Be sure to visit our section on Permitted Election Changes for more information.

IRS Adjusts Applicable Dollar Amount Used to Determine PCORI Fee



The Internal Revenue Service (IRS) has issued guidance which increases the applicable dollar amount used to determine the Patient-Centered Outcomes Research Institute (PCORI) fee. For plan years ending on or after October 1, 2014 and before October 1, 2015, **the fee is $2.08** (multiplied by the average number of lives covered under the plan).

PCORI Basics
PCORI fees are imposed on plan sponsors of applicable self-insured health plans for each plan year ending on or after October 1, 2012 and before October 1, 2019. The fees support research to evaluate and compare health outcomes and the clinical effectiveness of certain medical treatments, services, procedures, and drugs. Details on how to determine the average number of lives covered under a plan, as well as various examples, are included in final regulations.

For plan years ending on or after October 1, 2013 and before October 1, 2014, the fee for an employer sponsoring an applicable self-insured plan is $2.00 ($1.00 for plan years ending before October 1, 2013) multiplied by the average number of lives covered under the plan.

Fee Rises
Pursuant to recent guidance, **for plan years ending on or after October 1, 2014 and before October 1, 2015, the fee is $2.08** (multiplied by the average number of lives covered under the plan).

For plan years ending on or after October 1, 2015 and before October 1, 2019, the fee is further adjusted to reflect inflation in National Health Expenditures (which will be published in future IRS guidance).

Our PCORI Fees for Self-Insured Plans section features more information on calculating and paying the fee.

OSHA Final Rule Updates Reporting & Recordkeeping Requirements

The Occupational Safety and Health Administration (OSHA) has released a final rule, **effective January 1, 2015**, that changes the criteria for reporting severe injuries and revises the list of employers partially exempt from OSHA's recordkeeping provisions.

More Incidents Must Be Reported
Under the final rule, employers must notify OSHA of all work-related fatalities **within 8 hours**, and of all work-related in-patient hospitalizations, amputations, or losses of an eye **within 24 hours**. To assist employers, OSHA is developing a web

portal for employers to report incidents electronically, in addition to phone reporting options.

It is important to note that **all employers covered by the Occupational Safety and Health Act** -- even those who are exempt from maintaining injury and illness records -- **are required to comply** with OSHA's new severe injury and illness reporting requirements. **OSHA covers most private sector employers** and their workers in all 50 states, the District of Columbia, and other U.S. jurisdictions either directly through federal OSHA or through an OSHA-approved state program.

New List of Industries Partially Exempt from Recordkeeping
OSHA has also updated the list of industries that, due to relatively low occupational injury and illness rates, are exempt from the requirement to routinely keep injury and illness records. The new list is based on updated injury and illness data from the Bureau of Labor Statistics. **The new rule maintains the exemption for any employer with 10 or fewer employees -- regardless of its industry classification -- from the requirement to routinely keep records of worker injuries and illnesses**.

"State Plan" States: Check Your State Plan for Implementation Date
Establishments located in states under federal OSHA jurisdiction must begin to comply with the new requirements on January 1, 2015. **Establishments located in states that operate their own safety and health programs ("state plan" states) should check with their state plan for the implementation date of the new requirements**. OSHA encourages the states to implement the new coverage provisions on January 1, 2015, but some may not be able to meet this deadline.

Click here for more information, including Fact Sheets and FAQs.

To learn more about worker safety and health, please visit our section on Safety & Wellness.

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