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2022 Most Frequently Asked Questions

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Presented by the Regulatory and Legislative Strategy Group

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Presentation Agenda

1. COVID-19 Deadlines Extension
2. Benefits and Unpaid/Unprotected Leave
3. Medicare Entitlement
4. Controlled Groups and MEWAs
5. ACA – Full-Time and Part-Time Employees and the Look-Back Measurement Method
6. ERISA and IRS Disclosure Requirements

COVID-19 Extended Deadlines:

Still in play? What timelines and employers are affected?

Are Plans Still Required to Extend Certain Deadlines Under COBRA, HIPAA and ERISA for up to One Year?

Short Answer: Yes.

- Described in EBSA Disaster Relief Notice 2021-01.
- Private employers who offer benefits to their workers must allow employees more time to make changes to their health care coverage (due to HIPAA special enrollment events), file claims and appeal adverse determinations (see details below).
- Former employees and other qualified beneficiaries also have an extended time period to elect COBRA continuation coverage or pay their COBRA premiums.
- The deadlines for the above are extended until the earlier of:
  - One year from the original deadline/start date; or
  - The end of the Outbreak Period
    - 60 days following the end of the National Emergency (which has not yet been announced)

Are Plans Still Required to Extend Certain Deadlines Under COBRA, HIPAA and ERISA for up to One Year?

Employers subject to IRC/ERISA must comply with the Outbreak Period rules.

Extension of deadlines apply if the employer's plan is subject to the IRC and/or ERISA.

- This includes church plans (apart from the COBRA extensions, which do not apply to church plans unless the church plan elects to be subject to ERISA).
- Does not include non-federal governmental plans (but is optional for these plans).

Are Plans Still Required to Extend Certain Deadlines Under COBRA, HIPAA and ERISA for up to One Year?

COBRA, HIPAA and claims/appeals/review timelines affected.

HIPAA Special Enrollment

- Employee enrollment requests for HIPAA special enrollment events, which include:
- Adding a new dependent on account of marriage, birth or adoption
- Enrolling in health coverage on account of a loss of eligibility under another group health plan, Medicaid or CHIP
- Gaining new eligibility for a premium subsidy toward employee contributions from Medicaid or a CHIP plan
- Losing other group health coverage or health insurance coverage
- Losing entitlement under Medicare, Medicaid or Children's Health Insurance Program Reauthorization Act (CHIPRA)

COBRA

- COBRA election and premium payment deadlines for qualified beneficiaries and COBRA election notice deadline(s) for plan administrators

Claims, Appeals and Review

- Claims-related deadlines, including claims filing deadlines (e.g., Health FSA claims), appeal of adverse benefit determination deadlines and various external review deadlines

Are Plans Still Required to Extend Certain Deadlines Under COBRA, HIPAA and ERISA for up to One Year?

Cafeteria plan-related timelines are not affected.

- The timelines prescribed in the employer's cafeteria plan continue to apply as normal for status change events and other mid-year election change events under the Section 125 Cafeteria Plan Rules.
  - » Note: Although a mid-year election change could occur well after the occurrence of a corresponding HIPAA special enrollment event, an employee may still elect coverage on a pre-tax basis under the Section 125 rules.
  - » Other HIPAA special enrollment concerns:
    - Even if the request is made nine months later, the effective date of coverage for birth/adoption will be the date of the birth/adoption. Premiums for that retroactive coverage can likely be paid on a pre-tax basis.
    - However, for special enrollments due to marriage or loss of other coverage, the terms of the medical plan will determine the effective date of coverage. However, pre-tax premiums will be allowed only for coverage on a going-forward basis.

Maintenance of Employee Benefits:

Requirements for Non-FMLA Leave and Leave After FMLA Exhaustion

What Happens to an Employee's Benefits After They Exhaust FMLA Leave or Take Non-FMLA Leave?

Check the benefit plan documents regarding their continued eligibility.

- Under the Family Medical Leave Act (FMLA) an employer's obligation to continue coverage for an employee out on FMLA leave ends after the protected leave has been exhausted. **29 U.S.C. §2614(c)**
  - » State laws may affect this
- Whether an employee is still eligible for benefits during non-protected leave, including leave taken after FMLA leave has been exhausted, **is a plan design issue.**
- Employers should look to their plan's eligibility provisions to see if employees on non-protected leave can continue as active under the given benefit plan (and check with the carrier/stop loss).
- If an employer uses the look-back measurement for determining eligibility, the employee will likely remain eligible under the terms of the plan during his/her/their stability period if the employee averaged 30 or more hours a week during their measurement period.

What Happens to an Employee's Benefits After They Exhaust FMLA Leave or Take Non-FMLA Leave?

Plan design considerations:

- Offering COBRA at the time unpaid, unprotected leave begins
- May consider offering an employer subsidy for coverage to a valid business class of employees if an employer wants to be more generous than what the law requires (if a self-funded plan, subject to Section 105(h) non-discrimination testing)

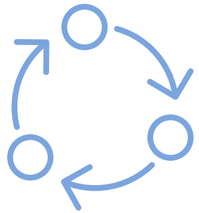
Medicare Entitlement & Employee Benefits:

How Medicare Entitlement Affects Active Employee Eligibility for Benefits

How Does an Active Employee's Medicare Entitlement Affect Their Various Benefits?

Two main concerns:

HSA eligibility



Continued eligibility for group health plan coverage

- Largely depends on whether the employer is subject to the Medicare Secondary Payer (MSP) Rules

How Does an Active Employee's Medicare Entitlement Affect Their Various Benefits?

HSA Eligibility

Medicare entitlement means HSA ineligible.

- Individuals enrolled in Medicare (Parts A, B, C or D) are not eligible to contribute to an HSA. **Internal Revenue Code §223(b)(7)**
  - » Ineligible to contribute on a pre-tax or post-tax basis
  - » This rule applies to age, disability and ESRD-based Medicare enrollment
  - » Prior to an individual's Medicare entitlement event, individuals should speak with their Medicare advisor in seeking certain Medicare advice, including a delay in their Medicare enrollment.
- Can continue to use HSA distributions to pay qualified medical expenses (or withdraw funds on a taxable basis for nonmedical expenses).

How Does an Active Employee's Medicare Entitlement Affect Their Various Benefits?

HSA Eligibility

Being age 65 or older does not necessarily mean HSA ineligible.

- If the individual is actively working at age 65 and is not collecting Social Security payments (which trigger mandatory Medicare Part A coverage), the individual may delay Medicare.
- If Medicare enrollment is delayed, then Medicare coverage will be backdated when the individual enrolls to the latter of:
  - (a) the individual's 65th birthday month, or
  - (b) six months prior to the date the beneficiary enrolls in Medicare. **42 CFR §406.6(d)(4)**
- **The retroactive effective date is important to note since it will affect the beneficiary's maximum HSA contribution amount for the year.**
- When an individual has other disqualifying health coverage (e.g., Medicare), the annual contribution limit is prorated based on the number of months in the tax year they are HSA-eligible.
- Medicare-entitled individuals should be aware of this rule, as it could cause them to have excess HSA contributions for the year in which Medicare becomes effective.

How Does an Active Employee's Medicare Entitlement Affect Their Various Benefits?

The Medicare Secondary Payer (MSP) Rules

Medicare Secondary Payer rules – Employers with 20 or more Employees.

- For age-based Medicare, these requirements **apply only to group health plans of employers with 20 or more employees for each working day in at least 20 weeks in either the current or the preceding calendar year.**
  42 U.S.C. §1395y(b)(1)(A)(ii).
  - » It includes all employees (full-time (FT), part-time (PT), leased) and includes all employees under two or more employers under common control. (26 U.S. Code Section 52).
  - » The 20-employee threshold matters at the time the individual in question receives Medicare benefits. When the employer becomes subject to the MSP rule, the MSP requirements will apply to that group health plan.
- Application of MSP rules is different for disability and ESRD-based Medicare

How Does an Active Employee's Medicare Entitlement Affect Their Various Benefits?

The Medicare Secondary Payer (MSP) Rules

Being subject to the Medicare Secondary Payer rules will determine whether Medicare entitlement can affect benefits and eligibility under an employer's group health plan (GHP).

- MSP rules prohibit a GHP from "taking into account" the Medicare entitlement of a current employee (or a current employee's spouse or family member) for age-based Medicare. **42 U.S.C. §1395y(b)(1).**
- Employer must provide the current employee or the current employee's spouse who is age 65 or older with the same benefits, under the same conditions, as are provided to employees and spouses who are under age 65. **42 U.S.C. §1395y(b)(1)(A)(i)(II).**
  - **This "same benefits same conditions" rule includes taking Medicare entitlement/eligibility (based on age) into account when determining plan eligibility.**
- No incentivizing Medicare entitled/eligible employees to drop employer GHP. **42 CFR §411.101.**

How Does an Active Employee's Medicare Entitlement Affect Their Various Benefits?

The Medicare Secondary Payer (MSP) Rules

Employers exempt from MSP rules can limit Medicare-entitled employee's eligibility

- Exempt employers are not barred by the MSP rules from taking Medicare entitlement into account regarding GHP eligibility.
- Even if the MSP rules do not apply, carving out Medicare-eligible employees from eligibility into a group health plan would be subject to carrier approval and would need to be reflected in the written plan document and Summary Plan Description (SPD).
  - » Note: Employers exempt from the MSP rules are not exempt from the Medicare Part D notice requirements.

Controlled Groups and MEWAs

Group Health Plans
with Multiple Employers

Can an Employer Offer Its Health Plan to Another Organization's Employees?

The same group health plan can be offered to two (or more) separate employers if they are in the same controlled group of entities:

- IRC Section 414 – Types of controlled groups **(PS, BS, Combined)**
  - **Parent-Subsidiary (PS) –** One or more commonly owned corporations are connected through stock ownership with a common parent corporation
    - 80% or more stock of each corporation is owned by one or more corporations in the group (does not include common parent); and
    - Parent owns 80% or more of at least one corporation.
  - **Brother-Sister (BS) –** A group of two or more corporations, in which five or fewer common owners (individual, trust or estate) own directly or indirectly a "controlling interest (CI)" of each group and have "effective control (EC)"
    - CI - Generally means 80% or more of stock ownership in each corporation; and
    - EC – Generally more than 50% of identical stock in each corporation.

Can an Employer Offer Its Health Plan to Another Organization's Employees?

An employer can offer the same group health plan (GHP) to multiple employers within the same controlled group of entities.

- Most important question to ask is "Are the entities in the same controlled group of entities?"
- Other things to consider:
  - **Unified GHP is Optional –** Need not all be in the same group health plan (subject IRC NDT).
  - **ACA Reporting –** Each Applicable Large Employer (ALE) has a separate Form 1094/1095-C filing/furnishing requirement and must report each Aggregated ALE member on Form 1094-C, Part III.
  - **State Law/Group Category, Carrier Requirements –** Some state laws require employers in the same controlled group to have large group coverage based on number of employees in the controlled group (CG) of entities (not per employer), also subject to certain insurance carrier requirements for % of eligible employees in CG reflected in the carrier proposal.

Can an Employer Offer Its Health Plan to Another Organization's Employees?

If an employer combines plans that are not in the same controlled group, there could be significant penalties.

- An employer that combines multiple employers/individuals/entities into one group health plan could unintentionally create a Multiple Employer Welfare Arrangement (MEWA)
- Things to consider:
  - **Penalties –** For failure to file an M-1 (not required for a health plan with 25% or more common ownership) and other important disclosures/filings, the DOL penalty alone could be up to **$1,746 per day.**
  - **Not Only Organizations –** This issue does not only occur with organizations. This could occur with individuals too (independent contractors, board members, etc.).
  - **MEWAs and State Law –** If an employer decides to create a MEWA, there are multiple federal and state laws involved. Some state laws prohibit self-funded MEWAs.

Affordable Care Act: Employer Mandate

Full-Time Transition to Part-Time Status

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

Failure of ALE to Offer Coverage to FT Employee = Potential Penalties

Applicable Large Employer (ALE)

- Averaged 50 or more FT/FTE employees in the previous year

Full-Time Employee

- An employee expected to have 30 or more hours of service a week/130 or more hours of service in a month.
- An employee that averages 30 or more hours of service a week/130 or more hours of service a month during a measurement period.

Measurement

- Under the Employer Mandate, there are two ways to measure employee hours, the Monthly Measurement Method (MMM) and the Look-Back Measurement Method (LBMM).

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

The Monthly Measurement Method (MMM) may be utilized with full-time employees, in addition to variable hour/seasonal employees.

- **Monthly Measurement Method –** The Monthly Measurement Method provides that any employee expected to have 130 or more hours of service in a month should be offered coverage on the first day of that month.
  - » This is different from the Look-Back Measurement Method because it does not look at the previous work history/past hours of service of the employee.
  - » Essentially, an employer must know what the employee's hours of service will be in the coming month.
  - » So long as an employer offers coverage on the first day of the month in which the employee would have 130 or more hours of service in that month, an employer avoids potential penalties for that FT employee under the Employer Mandate.

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

Look-Back Measurement Method (LBMM)

- **Use of LBMM may only be for Variable Hour/Seasonal Employees**
- **Reminder:** Measurement Period, Admin Period (if applicable) and Stability Period.
- Keep coverage in place during the entire Stability Period if EE averaged hours of service of 30 or more a week/130 or more a month during the MP. EE considered FT for the entire Stability Period.

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

ALEs could be subject to penalties for failure to offer coverage to a part-time employee that transitioned from full-time status during Stability Period.

Look-Back Measurement Method

- **If a variable hour/seasonal (VH/S) employee averages 30 or more hours of service a week/130 or more hours of service a month during the measurement period, the employer should offer coverage to this employee for the entire consecutive Stability Period**
  - **Keep Coverage in Place During Stability Period -** If VH/S employee averaged 30 or more hours per week/130 or more hours per month during their Initial/Standard Measurement Period, they are treated as a full-time employee during their entire consecutive Stability Period, regardless of reduced hours during that period (however, does reduce average # of hours for the following Stability Period).

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

Look-Back Measurement Method (LBMM) and Employees hired as FT Employees

- **Some FT employees may also be subject to the LBMM if they are in the same employment category of employees as variable hour/seasonal.**
  - » An employer is required to apply the same Measurement Method to all employees in the same employment category: 1) salaried vs. hourly 2) employment in different States 3) Collective Bargaining Agreement (CBA) vs. non-CBA; and 4) Group of CBA vs. another group of CBA.

- **However, use of the Measurement Period that would delay coverage to a Variable Hour/Seasonal Employees under the LBMM does not apply to FT employees subject to the LBMM**
  - » Typically, coverage should be offered to FT employees within 90 days of hire, despite being potentially subject to the LBMM

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

ALEs could be subject to penalties for failure to offer coverage to a non-variable hour full-time employee subject to the LBMM

Look-Back Measurement Method

- **FT Employee Subject to LBMM Category of Employees –** Although employees expected to have 30 or more hours of service a week cannot be subject to a measurement period prior to benefits eligibility under the ACA, FT employees may still be subject to some of the rules surrounding the LBMM due to employment category (e.g., hourly)
- **Example:** Martin works for ABC, Inc. as an hourly FT benefits-eligible employee, and therefore must be offered coverage within the first 90 days of hire pursuant to the ACA. ABC, Inc. uses the Look-Back Measurement Method for its variable-hour employees, who work on an hourly basis as well. Martin is also therefore subject to the LBMM, despite the requirement to offer Martin medical coverage within 90 days of hire.

Could an ALE Be Subject to Penalties for Failing to Offer MEC to Employees Who Transition to Part-Time Status?

ALEs could be subject to penalties for failure to offer coverage to full-time employees that later transition to part-time status under the LBMM.

Look-Back Measurement Method

- **If an FT employee is offered coverage within the first full three months of employment and in a class of employees subject to the LBMM (e.g., hourly), and that employee later becomes a part-time employee:**
-
  - **Transition Occurs During/Prior to the Standard Measurement Period (SMP):** MMM until completion of SMP – Employer provides coverage pursuant to the MMM (i.e., coverage offered in a month of 130 or more hours of service). Then see below for Stability Period rules if employee averaged 130 or more hours of service during the SMP.
  - **Transition Occurs During Stability Period:** During the Stability Period, if an employee otherwise is entitled to an offer of coverage for the entire Stability Period and was offered coverage within the full three (3) months of hire, an employer may revoke such offer if the employee averages less than 30 hours of service a week for a three-month period. The transitioning FT employee would then be subject to the MMM until the end of his/her/their Stability Period.

Disclosure Requirements: ERISA and the IRS

Disclosure of Important Plan Information to Plan Participants

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

There are multiple federal governmental rules surrounding group health plans and the disclosure of required documents to plan participants.

- **Department of Labor (DOL) related to ERISA plan documents**
  - Summary Plan Description (SPD)/Summary Material Modification (SMM)
  - Summary of Benefits and Coverage (SBC)
  - Summary Annual Report (SAR)
  - COBRA General/Election Notices
  - Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice
  - Wellness Program Disclosure
  - Other Disclosure Notices (e.g., Newborns Act, Michelle's Law (if applicable), WHCRA, MHPAEA Denial/Increased Cost Exception, Grandfathered Plan, Marketplace/Exchange, Patient Protection Act Notice, HIPAA Portability Notice, Notice of Privacy Practice, Medicare Part D Notice)

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Under the rules, these documents should be delivered in a manner that is "reasonably calculated to ensure actual receipt" under a method "likely to result in full distribution":

- **General Rule: First-class mail, records kept in the regular course of business.**
  - » Plan Sponsor must ensure the mailing list is comprehensive (includes all participants/others who have a right to receive documents) and updated.
- **Hand delivery to participants/others who have a right to receive documents.**
  - » Plan Sponsor is responsible for proof of hand delivery to individuals.
  - » Plan Sponsor cannot only place disclosures/notices in locations frequently visited by participants.
  - » Plan sponsors may want to consider signed acknowledgment of receipt of documents as proof.

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Electronic delivery of the documents is acceptable under the rules:

- **Electronic delivery of the documents under the rules is possible, but only under the following circumstances:**
  - Acceptable methods for electronic delivery include:
    - Email or email with attachments
    - Magnetic disk/CD-ROM
    - Use of posting on a company website

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Electronic delivery of the documents is acceptable under the rules:

- **Electronic delivery of the documents under the rules is possible, but only under the following circumstances:**
  - Elements of proper electronic delivery to individuals:
    - Website should include easy instructions/prominent link(s) as to where to find documents
    - Must ensure actual receipt by individuals of documents posted (website/email delivered to individual)
    - Timing, format and content requirements are met for documents (notice provided each time the law requires distribution of relevant notice/document)
    - Provide written or electronic notice to employees of where to find the document (and if posted delivered around the posting date), along with the document's significance and ability to request a paper copy
    - Allow individuals to request a paper copy of the disclosure

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Electronic delivery of the documents is acceptable under the rules:

- **Electronic delivery of the documents under the rules is possible, but only under the following circumstances:**
  - Employee has a computer as part of their daily job duties
    - Has the ability to access the documents at any location where the individual could be expected to perform employment duties; and
    - Has access to an electronic information system that is an integral part of his/her/their employment duties.
      Note: A computer kiosk (many times used for clocking in) is not considered access to a computer as normal job duties

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Electronic delivery of the documents is acceptable under the rules:

- **Electronic delivery of the documents under the rules is possible, but only under the following circumstances:**
  - Individual consents to electronic delivery
    - The individual must receive a notice containing the following, prior to consenting:
      - This notice must be provided each time an electronic disclosure is made, unless a plan sponsor furnishes this notice with other plan disclosures (then notice delivered in a conspicuous manner)
      - Types of documents that will be received electronically
      - Notification that electronic consent can be revoked or modified at any time (including procedures on how to revoke and modify information)
      - Right to request a paper version of the document (and whether there is a charge associated)
      - The electronic delivery system, and what hardware/software is necessary to use it

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Additional things to consider:

- **Summary of Benefits and Coverage**
  - Delivery can be accomplished prior to enrollment (open enrollment/special enrollment) through the benefits administration system, regardless of whether the employee has access to a computer as part of their daily job duties
- **Centers for Medicare and Medicaid (CMS) Medicare Part D Notice**
  - If delivered by first-class mail to the participant's house, Notice is considered delivered to plan members that reside in the same household as a plan participant
- **COBRA General/Election Notices**
  - If delivered by first-class mail to the participant's house, Notice is considered delivered to plan members that reside in the same household as a plan participant

What Are the Rules Surrounding the Delivery of Plan Disclosure Documents to Employees/Plan Participants?

Additional things to consider:

- **HIPAA Privacy Notice**
  - » Delivery must be completed by first-class mail/hand delivery unless there is consent for electronic delivery
- **Form 1095-C**
  - » Delivery must be completed by first-class mail/hand delivery unless there is consent for electronic delivery

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