Employee Health & Benefits

COMPLIANCE CENTER OF EXCELLENCE

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2019 COMPLIANCE NEWSLETTER

IN THIS EDITION:

Medicare Part D Notice Reminder

The Annual Notice Deadline is October 14, 2019

Employer group health plans that include prescription drug coverage must provide a Medicare Part D creditable and/or non-creditable coverage notice ("Notice"), as applicable, each year to all Medicare-eligible employees and dependents before the annual October 15th Medicare Part D enrollment period. The purpose of this annual Notice is to notify Medicare beneficiaries whether or not their employer's prescription drug coverage is at least as good as Medicare's prescription drug coverage, in order to help them decide whether to enroll in Medicare Part D.

Take Action

Employers should review their prescription drug coverage to determine creditable coverage status and distribute the appropriate Notice on or before October 14th. If a plan has multiple benefit options providing prescription drug coverage, the test must be applied separately for each benefit option.

Take Note and Give Notice

In order to assist employers with Notice requirements, the remainder of this alert provides additional background details including:

- Which employers are subject to Medicare Part D Notice requirements;
- Who is considered a "Medicare Part D eligible individual";
- Model Notices;
- Notice deadlines;
- Methods of delivery;

We will also address how to determine creditability when there is an account-based plan and creditable coverage reporting to CMS.

Employers Subject to Medicare Part D Notice Requirements

An employer is subject to the Notice requirements if it offers prescription drug coverage to its active employees and/or retirees, which includes Medicare Part D eligible individuals (including dependents). As a best practice, we recommend all employers sponsoring a prescription drug benefit to assume it is responsible for providing the Notice and notifying CMS, as discussed below.

Medicare Part D Eligible Individuals

All Medicare Part D eligible individuals who are applying for, or are covered by, the employer's prescription drug benefits plan must receive the Notice. A "Medicare Part D eligible individual" is a person who:

- Is entitled to benefits under Medicare Part A and/or is enrolled in Medicare Part B, as of the effective date of coverage under a Medicare Part D plan (active employees may have Medicare coverage); and
- Resides in a "service area" of a Medicare Part D plan. A "service area" is defined as a location that meets certain pharmacy access standards. Most individuals live in a service area.

"Medicare Part D eligible individuals" may include active employees, employees who are disabled or on COBRA, retired employees, and their covered spouses and dependents. An employer may not know the Medicare eligibility status for all of these individuals, and we recommend employers provide the Notice to all covered individuals. Please see *Method of Delivery* below for delivery to covered families living at the same address.

Model Disclosure Notices

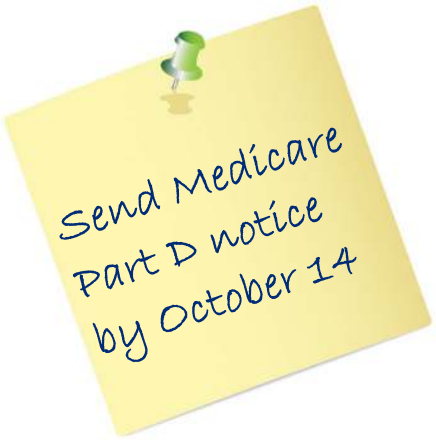
The Centers for Medicaid and Medicare Services (CMS) provides guidance and model creditable and non-creditable coverage disclosure Notices on its website. While the templates are dated April 2011, no changes have been made to the standard language since that time.

An employer may include multiple plan options in the same Notice, so long as the plans have the same creditable (or non-creditable) status.

Notice Deadlines

Although October 14th is the due date most associated with the Medicare Part D Notice, there are other times when Notice must be given to Medicare Part D eligible individuals.

- Prior to an individual's initial enrollment period for Medicare Part D;
- Prior to the effective date of coverage for any Medicare-eligible individual that joins the employer's plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and,
- Within a reasonable amount of time after an individual requests a copy.



Method of Delivery

Plans may provide the Notice with other member information materials (including new hire and open enrollment materials) or in a separate mailing. If the Notice is included in a separate packet of legal notices or in a benefits enrollment guide, the Notice must either appear on the first page (we interpret this to mean it is sufficient if it appears after the table of contents) or a call-out box must appear on the first page indicating this Notice is included in the materials, and a cross-reference to the page where it may be found. When the Notice is provided with other materials, the delivery guidance also indicates the initial disclosure portion of the Notice or the call-out box must appear in 14-point font. The delivery guidance provides the following sample call-out box:

> If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page [XX] for more details.

The Notice may be hand-delivered, mailed (first-class) or sent electronically. For paper delivery, a single Notice can be provided to a family living at the same address. Employers providing the Notice electronically may rely upon this method as long as certain conditions from the Department of Labor (DOL) are satisfied. For electronic delivery without getting consent from the participants, the DOL requires that:

- The employee has work-related computer access and use the computer as an integral part of their job;
- The employee can access the documents in electronic format at their work site;
- Appropriate measures are taken to ensure actual receipt by participants; and,
- Participants must be notified in writing or electronically of their right to receive a paper copy of the Notice free of charge.

If an employee does not use a computer as an integral part of their job, or the employer cannot satisfy all of the above, an employer may rely on electronic delivery if the employee provides advance consent.

In addition, if an employer provides the Notice electronically, it must also notify participants that they are responsible for providing a copy of the disclosure to their Medicare-eligible dependents covered by the group health plan.

Determining Creditability When There is an Account-Based Plan

Health Reimbursement Accounts (HRAs)

Plan sponsors who offer HRAs in conjunction with a major medical plan or on a stand-alone basis must take the HRA into account for Medicare Part D creditable coverage purposes if the HRA can be used to reimburse for the cost of prescription drugs.

- **Participation in Medical Plan + HRA:** If an individual participates in both the HRA and the major medical plan, creditable coverage is determined by increasing the expected prescription drug claims payable from the major medical plan by the amounts credited to the HRA.

  For HRAs that pay for both prescription drug costs and other medical claims, a reasonable portion of the year's HRA contribution may be allocated to prescription drug coverage.

  > **Example 1:** A medical plan has an annual deductible of $1,000. The employer makes an annual HRA contribution of $500. If the HRA can reimburse for both prescription drugs and other medical expenses, only a reasonable portion of the $500 should be allocated to prescription drug coverage for creditability determination purposes. This amount could be based on average reimbursement data and/or other facts and circumstances.

  If an HRA is limited to reimbursement for prescription drugs, the entire HRA contribution should be allocated to prescription drug coverage.

  > **Example 2:** A medical plan has an annual deductible of $1,000. The employer makes an annual HRA contribution of $500. If the HRA can only reimburse prescription drug expenses, then the sponsor is considered to provide drug coverage with a $500 annual deductible.

- **Stand-alone HRA:** If the HRA is offered on a stand-alone basis without requiring participation in a medical plan,[1] creditable coverage is determined as if the HRA were a medical plan with no deductible and an annual limit equal to the amount of the credit for that year.[2]

Health Flexible Spending Accounts (FSAs)

Health FSAs are not included when determining the creditable coverage status of an underlying medical plan and are not independently subject to the Notice requirement.

Health Savings Accounts (HSAs)

HSAs are not included when determining the creditable coverage status of an underlying HDHP and are not independently subject to the Notice requirement.

Creditable Coverage Reporting to CMS

An often overlooked requirement for the employer is the obligation to report the creditable coverage status of its prescription drug plan(s) to CMS. The Online Disclosure to CMS Form should be completed (i) annually no later than 60 days from the beginning of a plan year (contract year, renewal year), (ii) within 30 days after termination of a prescription drug plan, and (iii) within 30 days after any change in creditable coverage status. Interestingly, there are no penalties for failing to provide this disclosure to CMS.

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[1] This can present certain compliance issues if the HRA is offered to current employees.
[2] CMS, Treatment of Account-Based Health Arrangements under the Medicare Modernization Act," last updated December 28, 2005: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/Downloads/AccountBasedPlansGuidanceRev1.pdf.

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The Affordable Care Act's Employer Mandate: Part 2

Determining Full-Time Employees

This article is Part 2 in a series intended to provide an overview of the Employer Shared Responsibility provisions (also known as the "employer mandate") under the Affordable Care Act (ACA). The employer mandate generally requires employers known as applicable large employers (ALEs) to offer medical coverage to full-time employees and certain dependents in order to avoid potential penalties.

We covered how to determine whether an employer is an ALE in Part 1. This Part 2 will address how to determine who is an ACA-defined full-time employee (FTE). This article assumes an employer has already determined it is an ALE, and we will be using the terms ALE and employer interchangeably throughout.

Full-Time Employee Status Matters

Although ALE status is determined using both full-time employees and full-time equivalent employees (described in Part 1), the employer mandate penalties only take full-time employees into account. This is why it is so important to be able to identify the full-time employees. This article **does not** attempt to address all of the nuances that apply under the ACA's measurement rules.

What's in a Name?

Continuing from Part 1, the employer mandate is filled with many defined terms, including:

- **Full-time employee (FTE)** – An employee who is reasonably expected to work at least 30 hours per week on average and/or who does average at least 30 hours of service per week over the course of a measurement period.

- **Part-time employee (PTE)** – An employee who is not reasonably expected to work at least 30 hours of service per week on average and/or who averages less than 30 hours of service over the course of a measurement period.

- **Variable-hour employee** – A new employee with a flexible or uncertain work schedule preventing the employer from determining whether the employee will reasonably average more or less than 30 hours of service per week. Factors the employer should consider when classifying an employee as a variable-hour employee include:

  a) Whether the individual is replacing an employee who averaged 30 or more hours of service per week;

  b) Whether employees in the same or comparable position typically average 30 or more hours of service per week; and

  c) How the position was advertised (i.e., as a full-time or part-time position).

  Please do not confuse a short-term or high turnover position with the definition of variable hour employee. If we know the employee will average 30 or more hours per week, the employee is not a "variable-hour employee" (but he or she might be a "seasonal employee").

Note: The term "variable-hour employee" only applies to the look-back measurement method (describe later in this article). Technically, an employee is only a variable-hour employee when initially hired. The variable-hour employee will subsequently measure and be classified as an FTE or PTE thereafter.

- **Seasonal Employee** – An employee hired into a position customarily needed for six months or less and related to staffing needs that recur around the same time each year. These are not the same as temporary employees who are hired as needs arise throughout a year. A seasonal employee can be subject to measurement even if reasonably expected to average at least 30 hours of service per week, and the idea is the seasonal employee will be gone before having to be treated as an FTE for ACA purposes.

Note: The term "seasonal employee" only applies to the look-back measurement method.

- **Hour of service** – Each hour for which an employee is paid for duties performed or entitled to payment for periods during which no duties are performed (i.e., vacation, holiday, illness, incapacity, disability,[3] layoff, jury duty, military duty, or leave of absence).

- **Break in service** – A period of consecutive weeks in which the employee is not credited with an hour of service.

[3] *Paid disability leave generally counts toward hours of service unless solely paid for after-tax by the employee or provided through a workers' compensation program.*

- **Limited Non-Assessment Period (LNAP)** – A period during which an ALE will not owe an employer mandate penalty without regard to whether an FTE was offered coverage. LNAPs include:
  a) January through March of the first calendar year in which an employer is considered an ALE, but only for employees not offered coverage during the prior year.
  b) A waiting period before coverage is effective.[4]
  c) An employee's first calendar month of employment if hired after the 1st of the month.
  d) An employee's initial measurement period and initial administrative period under the look-back measurement method (described later in this article).
  e) If an employee in an initial measurement period transitions to a known FTE position, the three full calendar months following the transition qualify as an LNAP. In the real world, many employers will transition the employee to FTE status faster than the rules require.

Different Strokes for Different Folks Possible

Employers may use different measurement methods for the following categories – or combination of categories – of employees:

1. Salaried employees and hourly employees;
2. Employees located in different states (but not within the same state);
3. Collectively bargained employees and non-collectively bargained employees; and
4. Employees subject to different collectively bargained agreements.

In other words, an employer can use a different measurement method for salaried, non-collectively bargained employees than it uses for hourly, collectively bargained employees. This rule also permits an employer to use measurement periods that differ in length and/or their beginning and end dates for different categories of employees when using the look-back measurement method.

[4] *The waiting period rules vary between the monthly measurement and look-back measurement methods.*

Monthly Measurement Method (MMM)

Under the MMM, an employer measures an employee's actual hours of service at the end of each calendar month. If an employee averages 30 or more hours of service per week (130/month) for a calendar month, the employee was an FTE for that month. Since coverage cannot be offered retroactively, an employer may be exposed for failing to offer coverage to an employee determined to be an FTE after-the-fact unless an LNAP applies. If an employer does not select a measurement method, the ACA rules default the employer to the MMM.

Weekly Rule: The MMM rules also permit employers to measure hours of service using a "weekly rule" method. Under this method, the employer can use the number of work weeks used for payroll purposes during a calendar month. This can result in some months having 4 weeks and others having 5 for measurement purposes.

- 4-week months → FTE = 120+ hours
- 5-week months → FTE = 150+ hours

Look-Back Measurement Method (LBMM)

Under the LBMM, an employer can make certain employees[5] wait until the end of a measurement period to determine if they were FTEs after-the-fact. The employee's FTE or PTE status is then locked in for a corresponding stability period. Unlike the MMM, an employer can avoid potential penalties by prospectively offering coverage during an FTE's corresponding stability period.

An employee who is locked in as an FTE during a corresponding stability period cannot lose that status during the stability period while employed by the employer, even if the employee's hours are reduced.[6]

Remember: An employee's FTE status is protected prospectively during a stability period because the employee retroactively measured as an FTE. Also, an employee who is reasonably expected to average 30 or more hours of service per week is a known FTE and should not be made to wait for measurement to determine FTE status.

Under the LBMM, there are separate measurement rules for new employees and ongoing employees.

New Employee

An employee who has been employed for less than one complete standard measurement period (defined below).

Ongoing Employee

An employee who has been employed for at least one complete standard measurement period or who was present when the first standard measurement period was implemented.

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[5] *These are variable hour, seasonal, and part-time employees.*
[6] *Similarly, PTE status cannot generally be affected either. In the real world, many employers will transition the employee to FTE status faster than the rules require.*

New Employees

Initial Measurement Period (IMP)

- The employer may determine the months in which the IMP begins and ends
- The IMP can be 3 – 12 months in length (but the minimum ISP is 6 months)
- IMP used to determine whether new employees measure as FTEs or PTEs

The IMP may begin on the date of hire or the first of the following month

The IMP may also begin on the first payroll date that occurs between the date of hire and first of the following month

Initial Stability Period (ISP)

- The ISP can be 6 – 12 months, but it cannot be shorter than the employer's IMP
- During the ISP, the employee is treated as either:
  (1) An FTE for employer mandate purposes, or
  (2) A PTE and no coverage must be offered to avoid penalties

For new variable hour and seasonal employees, the ISP must begin immediately after the IAP

For those who are determined to be FTEs, The ISP must be the same length as the SP for ongoing employees

Initial Administrative Period (IAP)

The period of time during which the employer finishes measurement, determines whether coverage should be offered, and conducts enrollment.

- The employer is permitted to select an IAP of up to 90 days.
- The IAP may include a period beginning before and after the IMP. This allows an employer to begin the IMP on the first of the following month or next payroll period instead of the date of hire. The remaining IAP may be used after the IMP and before the ISP begins.
- The IMP and the IAP *combined* may not exceed 13 months and a fractional month from the date of hire. In other words, the ISP cannot begin later than the 1st day of the 14th month after the date of hire.

Ongoing Employees

Standard Measurement Period (SMP)

- The employer may determine the months in which the SMP begins and ends
- The SMP can be 3 – 12 months in length (but the minimum SP is 6 months)
- An employer can administer the SMP to coincide with a calendar year, a non-calendar plan year, or a different 12-month period (i.e. an annual enrollment event)

Standard Stability Period (SP)

- The SP can be 6 – 12 months, but it cannot be shorter than the employer's SMP
- During the SP, the employee is treated as either:
  (1) An FTE for employer mandate purposes, or
  (2) A PTE and no coverage must be offered to avoid penalties

The SP must begin immediately after the AP.

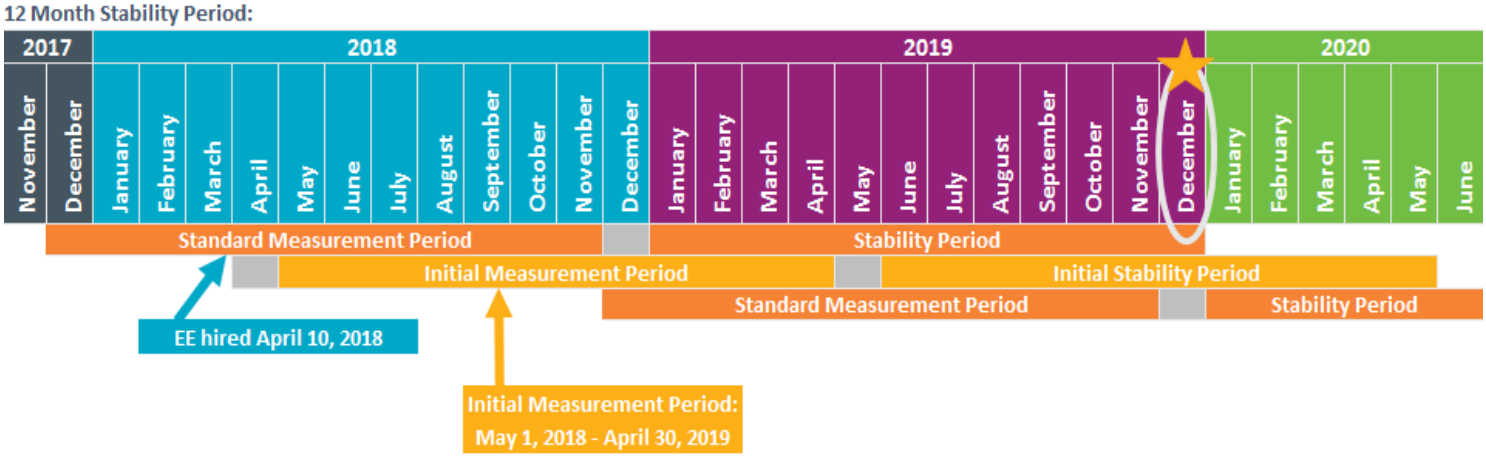
Standard Administrative Period (AP)

The period of time during which the employer finishes measurement, determines whether coverage should be offered, and conducts enrollment.

- The employer is permitted to select an AP of up to 90 days.
- The AP begins immediately after the SMP ends.

NOTE: The AP cannot exceed 90 days, and nearly all 3-month time frames will exceed the maximum period allowed for an AP in any given year (e.g. using all of October, November, and December results in an AP of 92 days).

Putting it Together – The LBMM and When a New Employee Becomes an Ongoing Employee



New Employee

- Employee hired April 10, 2018
- IAP 1: April 10-30, 2018
- IMP: May 1, 2018 - April 30, 2019
- IAP 2: May 1-30, 2019
- ISP: June 1, 2019 - May 31, 2020

Ongoing Employee

- SMP: Dec 1 - Nov 30
- ★ Employee becomes an ongoing employee as of Dec 1, 2019, the first date the employee was employed through an entire SMP
- Employee remains subject to the June 1, 2019 - May 31, 2020 ISP
- SMP will determine if the employee is full-time or part-time for 2020 SP (if measures as an FTE, must be treated as FTE for entire SP)

A Quick Side-by-Side of Some Remaining Items

Monthly Measurement Method	Look-Back Measurement Method
Easy for an employer whose workforce is made up entirely or almost entirely of known FTEs and PTEs	Better suited for employers with a more flexible workforce and/or a workforce with a less certain FTE/PTE status
Less record keeping	Generally best to hire a vendor and/or use specific software for measurement
Employer can adjust quickly for changes from FTE to PTE status	Employee is "locked in" as an FTE (or PTE)[7] for the corresponding stability period
Handling a break in service is straightforward. • If an FTE has a break in service less than 13 weeks (26 for educational institutions), the employee is considered a continuing FTE and cannot be subject to a new waiting period upon returning to work. Coverage must be reinstated by the first of the month following the return. • If the break in service is 13 weeks or more (or 26 for educational institutions), the returning employee can be treated as a new employee and subjected to another waiting period.	Breaks in service are modified by special rules • If an FTE has a break in service less than 13 weeks (26 for educational institutions), the employee resumes their prior stability period. Coverage must be reinstated by the first of the month following the return. The employee generally earns 0 hours of service during the break in service for measurement purposes. • If the break in service is due to FMLA, USERRA, or jury duty, the employee does not have a break in service, and the employer must account for this leave period in the measurement period by either: 1. revising the measurement period to exclude this leave; or 2. using the employee's weekly average hours of service during the rest of the measurement period for this leave period Note: If the FMLA, USERRA, or jury duty is concurrent with other paid leave, the employee is already accruing hours of service.
Full-time determination is at the end of the month, leaving exposure without a remedy	Rules vary depending on whether the employee is hired as full-time or non-full-time. The MMM is running in the background during the first measurement period

[7] *Again, in the real world, many employers will transition the employee to FTE status faster than the rules require.*

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2020 Employer Affordability Safe Harbor

Employer Mandate: Part 3 Sneak Peak

We will do a deep dive into *what kind* of medical coverage must be offered to avoid potential employer mandate penalties in Part 3 of our Affordable Care Act (ACA) Employer Mandate series. On July 23, 2019, the IRS released Revenue Procedure 2019-29, updating the ALEM's required contribution percentage for affordability for plan years beginning on January 1, 2020 through plan years beginning on December 1, 2020.

Plan year beginning on or after	Section 4980H(a) Annual Penalty	Section 4980H(b) Annual Penalty	Employer Affordability Safe Harbor
January 1, 2019	$2,500	$3,750	9.86 %
January 1, 2020	$2,580 (projected)	$3,870 (projected)	9.78 %

Impact of Updates

For applicable large employers (as defined by the ACA) planning their 2020 contribution strategy, the affordability percentage is declining to 9.78% from 2019's indexed value of 9.86%. This means employers will be responsible for more of the employee-only premium for the 2020 plan year if pursuing a strategy to minimize potential employer mandate penalties.

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