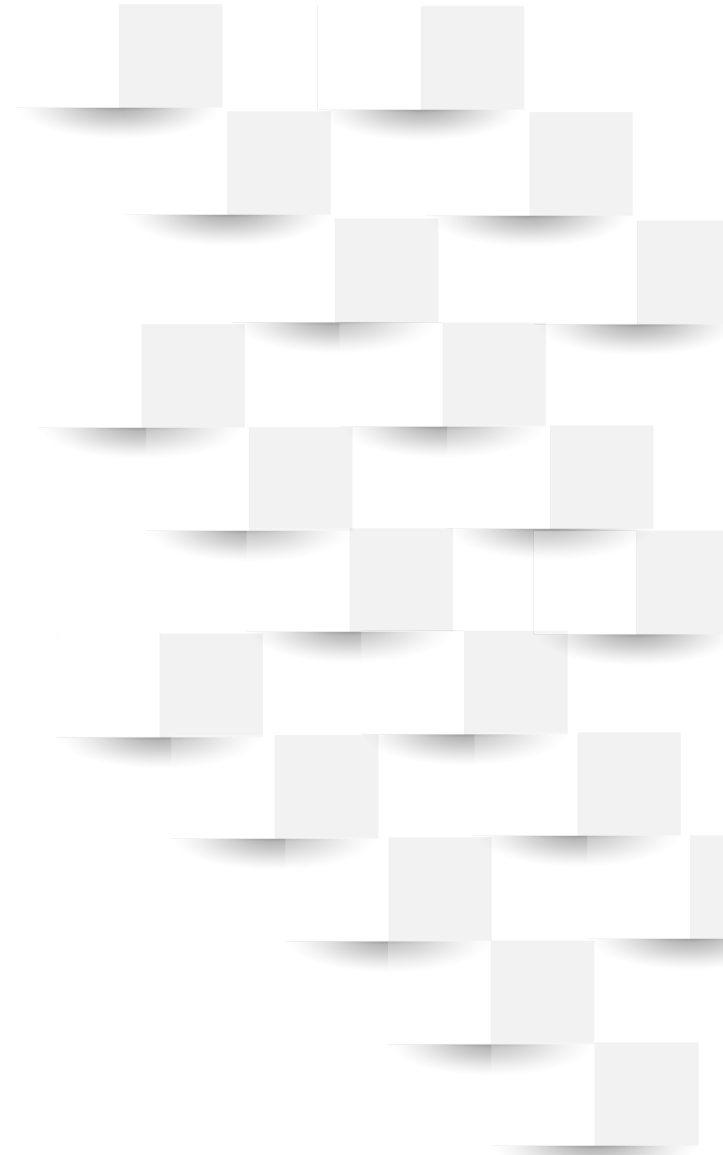




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# Common Employee Benefits Compliance Questions

July 2024



## Medicare Part D – Creditable Coverage

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**Who is responsible for determining whether an employer-sponsored prescription drug plan is creditable and notifying plan participants?**

- A. Insurance carrier
- B. TPA
- C. Plan sponsor
- D. CMS

### **Medicare Part D Coverage Changes in 2025**

Coverage that is currently creditable may no longer be creditable under the new Part D benefit parameters beginning in 2025 (e.g., HDHPs)

## HSA Contributions

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**An individual enrolled in a general-purpose health FSA January – April 2024. In May 2024, the individual does not elect the health FSA and enrolls in single HDHP coverage. How much can the individual contribute to an HSA for 2024?**

- A. \$0. Participation in a general-purpose health FSA at any time during the year makes the individual ineligible to contribute to an HSA
- B. \$2,766.66 (8/12 of \$4,150)
- C. \$4,150, the annual contribution limit for single coverage, if the individual will be enrolled in qualifying HDHP coverage through the end of 2025
- D. B or C

# HSA Contributions

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## General Rule – Eligibility Determined Monthly

- Each month that an individual is HSA eligible, the individual is eligible to contribute up to 1/12 of the applicable annual maximum
- HSA-eligible May – December 2024 allows an individual to contribute 8/12 of the annual contribution maximum

## Full Contribution Rule

- Individuals may make a full year's contribution based on the HDHP coverage in effect on December 1st so long as the individual remains eligible to contribute to an HSA for a thirteen-month "testing period" that starts on December 1st and runs until the following December 31<sup>st</sup>
- HSA-eligible May – December 2024 allows an individual to contribute the full annual contribution maximum if individual remains HSA-eligible through December 2025

## HSA Contributions – Participant Poll

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### Which of the following best describes your offering?

- No HDHP option
- Offer an HDHP option and allow employees to make pre-tax HSA contributions, but no employer HSA contribution
- Offer an HDHP option, allow employees to make pre-tax HSA contributions, and employer HSA contributions to those who enroll in the employer's HDHP
- Offer an HDHP option, allow employees to make pre-tax HSA contributions, and employer HSA contributions to those who enroll in the employer's HDHP, in another employer's HDHP, or in an individual HDHP
- Other

## COBRA & Health FSAs

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**Which of the following statements is true about an employer's obligation to offer federal COBRA continuation for a health FSA?**

- A. An offer of COBRA is required for the health FSA for 18, 29, or 36 months just like for any other group health plan coverage
- B. An offer of COBRA is not required for health FSAs
- C. An offer of COBRA is required only through the end of the current plan year, and only if the health FSA is underspent
- D. An offer of COBRA is required for general-purpose health FSAs, but not limited-purpose health FSAs

**UNDERSPENT = Health FSA benefit still available is greater than the COBRA premium due for the remainder of the year**

## Nondiscrimination

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**When benefits are made available on a tax-favored basis, which of the following will not be a problem under §125 nondiscrimination rules?**

- A. Shorter waiting period for managers than for the rest of the eligible employees
- B. 80% employer contribution for salaried employees and 50% employer contribution for hourly employees
- C. Employer contribution decreases (employee contribution increases ) as compensation increases
- D. Base plan available for all eligible employees; buy-up plan available solely for executives

**Benefit nondiscrimination rules restrict a plan's ability to favor highly compensated or key employees on a tax-favored basis**

## **Nondiscrimination – Participant Poll**

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### **Check all that apply:**

- We offer the same benefits to all full-time employees
- We differ plan/benefit options between classes of employees
- We apply a shorter waiting period for certain classes of employees
- We offer a larger employer / smaller employee contribution for higher paid employees
- We offer a larger employer / smaller employee contribution for lower paid employees



## State Continuation

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Employer offers a fully-insured plan that was issued in California, but the plan provides coverage for employees in multiple states. Employee works for an office location in Arizona and resides in Colorado. Upon the employee's termination of employment, which state's continuation rules apply?

- A. Arizona
- B. California
- C. Colorado
- D. None of the above

State continuation requirements, along with many other state-level coverage mandates, generally apply only to fully-insured policies and are based on where the policy is issued, not where the employer is or where employees work or reside

## Affordability

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Assume a Sept - Aug plan year. Employee earns \$18/hr in Sept 2023, and pay increases to \$20/hr in Jan 2024. Which calculation is correct for the rate of pay safe harbor in Apr 2024 if the employee has 145 hours of service?

- A.  $\$18 \times 130 \times 9.12\%$
- B.  $\$18 \times 145 \times 8.39\%$
- C.  $\$20 \times 130 \times 9.12\%$
- D.  $\$18 \times 130 \times 8.39\%$

### Hourly Rate

- As of the beginning of the coverage period or when first eligible

### Hours of Service

- Always use 130, regardless of actual hours of service

### Affordability Percentage

- Applies based on plan year, not calendar year

## Affordability – Participant Poll

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### Check all that apply:

- Some full-time employees are offered only a MEC that does not provide minimum value
- Most full-time employees are offered minimum value coverage, but it is unaffordable for most employees
- Most full-time employees are offered minimum value coverage, but it is unaffordable for some of our lowest paid employees
- Most full-time employees are offered minimum value coverage that is affordable
- We are not an ALE (<50 FTEs) subject to Employer Shared Responsibility Penalties

## Medicare Secondary Payer (MSP) Rules

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**Medicare is the primary payer (the employer's group health plan is the secondary payer) in which of the following scenarios?**

- A. Retiree on retiree plan of employer with 500 employees
- B. Disabled dependent of employer with 75 employees
- C. Employee with ESRD in 3<sup>rd</sup> year of receiving dialysis
- D. All of the above**

	Employer's Plan Payer Status Based on Type of Medicare		
	Age-Based	Disability-Based	ESRD
<b>Active Employees</b>			
<20 Employees	Secondary	Secondary	Primary First 30 Months
20-99 Employees	Primary	Secondary	Primary First 30 Months
100+ Employees	Primary	Primary	Primary First 30 Months
<b>Retired Employees</b>	Secondary	Secondary	Primary First 30 Months
<b>COBRA Participants</b>	Secondary	Secondary	Primary First 30 Months

## §6056 Offer of Coverage Reporting

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**Employer went over 50 full-time equivalents (FTEs) for the first time in April 2023 and averaged >50 FTEs for 2023. When will the employer be required to file Form 1094-C and Form 1095-Cs for the first time?**

- A. Early in 2024 for the 2023 calendar year
- B. Early in 2025 for the 2024 calendar year, but only if the employer offered self-funded coverage or the carrier didn't handle the filing
- C. Early in 2025 for the 2024 calendar year**
- D. Early in 2024, but only for offers of coverage Apr – Dec 2023

**Applicable large employer (ALE) = averaged 50 or more FTEs in previous calendar year**

- Average 50 or more FTEs in 2023
- Offer minimum value, affordable coverage to full-time employees in 2024
- Report on offers of coverage early in 2025 for the 2024 calendar year

## §6056 Reporting – Participant Poll

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**If you are an applicable large employer in 2024, how will you submit your reporting early in 2025?**

- Payroll vendor employer reporting tool/module
- Benefits administration platform employer reporting tool/module
- Stand-alone third-party vendor employer reporting tool
- Self-service online software tool or spreadsheet
- In-house process + electronic submission solution
- We are not an ALE (< 50 FTEs)

## HIPAA Special Enrollments

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**A group health plan is required to allow mid-year enrollment or a switch in plan options for which of the following events?**

- A. Employer lowers the cost of coverage mid-year
- B. Employee's spouse's employer is going through open enrollment
- C. Employee gets married
- D. Employee loses other coverage due to nonpayment
- E. All of the above

### **HIPAA Special Enrollment Events =**

- a loss of coverage (loss of eligibility, not for a voluntary loss of coverage or nonpayment);
- acquisition of a dependent through marriage, birth or adoption; or
- becoming eligible for a Medicaid or CHIP subsidy



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July 2024

