From the HR Hotline

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Zywave's HR consultants continue to provide expertise and serve as a valuable resource for navigating the pressing challenges facing employers today. This team, the HR Hotline, fields dozens of questions each day from employers seeking answers to their HR questions.

In recent months, employers have been requesting clarification or seeking guidance on midyear benefits election changes, the U.S. Department of Labor's (DOL) new overtime rule, Affordable Care Act (ACA) eligibility and specific leave of absence situations, including those under the Family and Medical Leave Act (FMLA). While questions surrounding these topics can vary based on locality, employer and individual circumstances, federal agencies offer guidance that can aid employers in addressing day-to-day challenges in the workplace.

This article explores questions and answers to common HR situations.

Are We Required to Provide Employees With Voting Leave?

Although there is no federal law that entitles employees to take time off in order to vote, over half of the states in the United States have enacted laws requiring private employers to provide voting leave in certain circumstances. The terms of the leave requirements vary by state; however, some states have voting leave laws that:

- Require the voting leave to be paid.
- Impose a notice requirement on employees.
- Mandate employers to post a notice of employee rights under such voting leave laws.
- Allow employers to designate the hours employees may be absent to vote.

Some states specify that voting leave is only required when employees do not have sufficient nonworking time to cast their ballots. Most states have not addressed whether employers may consider an employee's ability to vote by mail in determining whether the employee has enough time outside of work to vote. However, a small number of states have specifically included provisions in their voting leave laws that require employers to provide time off to cast and request absentee ballots.

In addition to voting leave, some states require employers to provide leave for election workers to perform their election duties. Most states require employees to provide advance notice of such election worker leave; generally, such leave is not required to be paid. Other states require employers to provide leave so employees may fulfill their duties as elected officials.

Given the variance in state laws, employers should carefully review the laws of the states where they have employees to ensure they provide voting and other election-related leave.

For more information, employers can check the following resources:

- Voting and Elections in the United States provides answers to common questions about voting in the United States
- U.S. Election Assistance Commission offers resources for election officials to administer elections and encourage voter participation.

How Much Will the ACA Pay-or-Play Affordability Percentage Increase by in 2025?

The IRS recently released Revenue Procedure 2024-35 to index the contribution percentage in 2025 for determining the affordability of an employer's plan under the ACA. For plan years beginning in 2025, employer-sponsored coverage will be considered affordable under the ACA's "pay-or-play" rules if the employee's required contribution for self-only coverage does not exceed 9.02% of their household income for the year.

Affordability Test

The ACA's pay-or-play rules require applicable large employers (ALEs) to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or risk paying a penalty. The affordability of health coverage is a key point in determining whether an ALE may be subject to a penalty. An ALE's health coverage is considered affordable if the employee's required contribution to the plan does not exceed 9.5% (as adjusted annually) of the employee's household income for the taxable year. This percentage is adjusted annually based on health plan premium growth rates in relation to income growth rates.

In recent years, the affordability percentage has been adjusted to:

- 9.12% for plan years beginning in 2023
- 8.39% for plan years beginning in 2024
- 9.02% for plan years beginning in 2025

The affordability test applies only to the portion of the annual premiums for self-only coverage and does not include any additional cost for family coverage. Also, if an employer offers multiple health coverage options, the affordability test applies to the lowest-cost option that provides minimum value.

Because an employer generally will not know an employee's household income, the IRS has provided three optional affordability safe harbors that ALEs may use to determine affordability based on information that is available to them: the Form W-2 safe harbor, the rate of pay safe harbor and the federal poverty level safe harbor.

Affordability Percentage for 2025

For 2025, the affordability percentage increases to 9.02%. This means that an ALE's health coverage for the 2025 plan year will be considered affordable if a full-time employee's required contribution for self-only coverage under the lowest-cost option does not exceed 9.02% of their income.

This is an increase from the affordability contribution percentage for 2024. As a result, some employers may have additional flexibility in setting their employee contributions for 2025 to meet the adjusted percentage.

How Do I Tell if Our Business Is Covered Under the ACA?

The ACA requires ALEs to offer affordable, minimum-value health coverage to their full-time employees or pay a penalty. This employer mandate is known as the "employer shared responsibility" or "pay-or-play" rules.

To qualify as an ALE, an employer must employ, on average, at least 50 full-time employees, including full-time equivalent employees (FTEs), on business days during the preceding calendar year. All employers who employ at least 50 full-time employees, including FTEs, are subject to the ACA's employer shared responsibility rules. This applies to for-profit, nonprofit and government employers.

A full-time employee is an individual who works, on average, 30 or more hours of service each week. For this purpose, 130 hours in a calendar month is treated as the monthly equivalent of 30 hours of service per week. Hours worked by employees with fewer than 30 hours per week must be counted and then divided by 120 per month to determine the number of FTEs. The number of FTEs is then added to the actual full-time employee count.

Employers determine each year, based on their current number of employees, whether they are considered an ALE for the next year.

For More Information

The following resources from the IRS further detail ACA shared responsibility requirements:

- The IRS published final regulations on the ACA's employer shared responsibility rules.
- The IRS has also provided questions and answers for employers regarding employer shared responsibility rules.

How Do We Determine Whether Our Prescription Drug Coverage Is Creditable?

Employers who provide prescription drug coverage to individuals who are eligible for Medicare Part D must inform these individuals and the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is "creditable."

A group health plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. Prescription drug coverage that does not meet this standard is called "noncreditable."

Currently, there are two permissible ways for employers to determine whether their prescription drug coverage is creditable. Employers with insured plans should ask their health insurance carriers if they have made this determination for the insured product. If an employer must make the determination itself, it may be able to use a simplified method, depending on the plan's design. When a plan's design is not eligible for the simplified method, an actuarial determination must be made.

Employers should keep in mind that, beginning in 2025, the creditable coverage status of their prescription drug coverage may be impacted as a result of cost-reduction provisions affecting Medicare Part D plans as part of the Inflation Reduction Act of 2022.

Creditable Coverage

Employers with group health plans that provide prescription drug coverage to individuals eligible for Medicare Part D must comply with certain disclosure requirements. Employers must inform these individuals and CMS whether their prescription drug coverage is creditable, meaning at least as good as Medicare Part D coverage. These disclosures must be made on an annual basis and at certain other designated times.

There is no penalty or fee for the employer for offering noncreditable prescription drug coverage. Noncreditable prescription drug coverage can still be a valuable benefit for employees. However, individuals need to know whether their prescription drug coverage is creditable or noncreditable. If the coverage is noncreditable and Medicare-eligible individuals fail to enroll in Part D during their initial enrollment period, they can be subject to a higher Part D premium if they enroll in Part D at a later date.

Creditable Coverage Determination

A group health plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS guidelines. In general, this actuarial determination measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the Medicare Part D prescription drug benefit.

For plans with multiple benefit options (e.g., high deductible health plans and health maintenance organizations), the creditable coverage test must be applied separately for each benefit option.

Under existing CMS guidance, there are two ways for an employer to determine whether its prescription drug coverage is creditable:

As a first step, employers with insured prescription drug plans should ask their carriers whether they have determined whether the plan's coverage is creditable.

For self-insured plans, or where the carrier for an insured plan has not made a determination about whether the plan is creditable, employers may use a simplified determination—as long as the coverage meets certain design requirements. If it doesn't, the employer must use an actuarial determination method. However, CMS' Final Part D Redesign Program Instructions state that, given the significant changes made to Medicare Part D by the Inflation Reduction Act of 2022, the agency is going to reevaluate the continued use of the existing simplified determination methodology (discussed below) or establish a revised one for calendar year 2026. This will be addressed in future guidance. CMS will continue to permit the use of the simplified determination methodology, without modification, for calendar year 2025 for group health plan sponsors who are not applying for the retiree drug subsidy.

Simplified Determination

Employers whose prescription drug coverage meets certain design requirements may be eligible to use a simplified determination that the coverage is creditable. The standards for the simplified determination, described below, vary based on whether the employer's prescription drug coverage is "integrated" or "nonintegrated" with other types of benefits, such as medical benefits.

Employers who apply for the retiree drug subsidy cannot use the simplified determination method.

Integrated Plans

An integrated plan combines the prescription drug benefit with other coverage (e.g., medical, dental or vision) and has all of the following plan provisions:

- A combined plan year deductible for all benefits under the plan
- A combined annual benefit maximum for all benefits under the plan
- A combined lifetime benefit maximum for all benefits under the plan

The ACA prohibits health plans from imposing lifetime and annual limits on the dollar value of essential health benefits.

An integrated plan's prescription drug coverage will be deemed creditable if it satisfies all of the following four criteria:

- It provides coverage for brand and generic prescriptions.
- It provides reasonable access to retail providers.
- It is designed to pay, on average, at least 60% of participants' prescription drug expenses.
- It has no more than a $250 deductible per year, has no annual benefit maximum (or a maximum annual benefit of at least $25,000) and has no less than a $1 million lifetime combined benefit maximum.

Nonintegrated Plans

A nonintegrated prescription drug plan is deemed to be creditable if it satisfies the above criteria 1, 2 and 3 and it satisfies at least one of the following:

- The prescription drug coverage has no maximum annual benefit or a maximum annual benefit of at least $25,000.
- The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare-eligible individual.

Actuarial Determination

If a plan sponsor cannot use the simplified determination method to evaluate the creditable coverage status of the prescription drug coverage it offers, then it must make an annual actuarial determination.

This determination must assess whether the expected amount of paid claims under the prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

The actuarial determination does not require an attestation by a qualified actuary unless the plan sponsor is an employer or union electing the retiree drug subsidy. Nonetheless, an employer may need to hire an actuary to make the determination.

More Resources

- CMS' Creditable Coverage webpage includes information and resources about the Medicare Part D disclosure requirements, including:
- Model creditable coverage notices for individuals
- The online disclosure form for CMS

We Have an Employee Who Is Requesting FMLA Leave on an Intermittent or Reduced-schedule Basis. How Does Intermittent FMLA Work?

The FMLA is a federal law that provides eligible employees of covered employers with unpaid, job-protected leave for specified family and medical reasons. Under the FMLA, eligible employees may take leave for their own serious health conditions, for the serious health conditions of family members, to bond with newborns or newly adopted children, and for certain military family reasons.

Eligible employees may take up to 12 weeks of leave during any 12-month period. Covered employers must grant eligible employees up to a total of 26 weeks of unpaid leave during a single 12-month period to care for a covered service member with a serious injury or illness who is their spouse, son, daughter, parent or next of kin.

In some cases, employees may take FMLA leave intermittently. When leave is taken after a child's birth or after the placement of a child for adoption or foster care, an employee may take intermittent leave only if the employer agrees. However, an employee is entitled to take leave because of a serious health condition or to care for a covered service member on an intermittent or reduced-schedule leave when medically necessary. An employee is also entitled to use intermittent or reduced-schedule leave for qualifying exigencies.

If an employee needs leave intermittently or on a reduced schedule for planned medical treatment for their own serious health condition or that of a qualifying family member, the employee must make a reasonable effort to schedule the treatment so as to not unduly disrupt the employer's operations.

Also, if intermittent leave is taken, the employee may be transferred to an alternative position (with equal pay and benefits) that better accommodates the intermittent periods of leave. When the employee no longer needs to continue on intermittent or reduced-schedule leave, the employee must be restored to the same or equivalent job that the employee left when the leave started.

Links and Resources

- The DOL's FMLA webpage, which includes links to the DOL's model FMLA forms and poster
- The Employer's Guide to the FMLA, a publication of the DOL's Wage and Hour Division

Employers should note that compliance requirements vary by locality, and they should contact local legal counsel for legal advice. We'll continue to keep you apprised of noteworthy updates on these topics. For resources on any of these topics discussed, contact us today.

HR Hotline can provide general guidance but cannot provide tax advice or review plan documents for compliance.