Healthcare Reform

Frequently Asked Questions

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

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General

1. Is a self-insured plan required to comply with ACA?

Yes, both self-insured and fully insured plans must comply with the ACA.

2. Is a governmental entity required to comply with ACA?

Yes. There are no exceptions for nonfederal governmental plans.

3. As a self-insured non-Federal governmental plan, can we still opt out of the requirements of HIPAA including Mental Health Parity?

Self-insured governmental plans can opt out of some requirements, but the opt-out election will no longer be available for other requirements. ACA made several significant changes to the Public Health Service Act (PHSA) which resulted in changes to HIPAA's opt-out provision. Prior to enactment of ACA, sponsors of self-insured nonfederal governmental plans could elect to "opt out" of all seven of the following requirements:

- Limitations on preexisting condition exclusion periods.
- Requirements for special enrollment periods.
- Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the Genetic Information Nondiscrimination Act of 2008).
- Standards relating to benefits for newborns and mothers.
- Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act of 2008).
- Required coverage for reconstructive surgery following mastectomies.
- Coverage of dependent students on a medically necessary leave of absence.

Under the revised PHSA, non-federal governmental plans can no longer choose to exempt your plan from categories 1 through 3 listed above but may continue to exempt the plan from requirement categories 4 through 7. This change is effective for plan years starting on or after September 23, 2010.

Further, beginning December 29, 2022, non-federal governmental plans who have not applied for an exemption of #5 above can no longer seek the exemption. Those with a current exemption in place cannot renew that exemption once that exemption expires (i.e., for exemption elections expiring 180 days from December 29, 2022). Plans subject to collective bargaining agreements with

varying lengths may seek renewals on the exemption until the date on which the last collective bargaining agreement terminates.

A Non-Federal Governmental Plans Module User Manual that describes the process for filing the opt-out electronically can be found here: http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOSNon-FedModuleUserManual.pdf.

4. Does a church plan that is not subject to ERISA have to comply with ACA?

Yes. The Act does not include a blanket exception for church plans. However, there are special rules or exceptions that may apply for certain provisions including contraceptive coverage, external claim reviews, medical loss ratio (MLR) rebates, and W-2 reporting. Those special rules or exceptions are discussed in later sections of these FAQs.

5. Does the ACA apply to expatriate plans?

Due to the special challenges in complying with certain provisions of ACA, Congress enacted legislation in 2014 that exempts expatriate plans from most of the ACA market reforms if the plan meets certain requirements. The changes are effective for plan years starting on or after July 1, 2015. In addition, several other changes were made including:

- Expatriate health plans are considered "minimum essential coverage" (MEC) for purposes of the individual mandate.
- Expatriate health plans are considered minimum essential coverage under an employer-sponsored plan for purposes of the Employer Mandate for certain foreign employees working in the U.S. and certain U.S. expatriates working overseas.
- Expatriate plans are not subject to the health insurance fee (after 2015), the transitional reinsurance fee, and the PCORI fee.

For a summary of the provisions on expatriate plans and the ACA, see Gallagher's Expatriates under the ACA Spotlight.

Employer Mandate

6. Does the Employer Mandate require me to offer coverage and pay for it?

You are not required to offer coverage nor pay any part of the coverage if you offer it.

However, you are subject to the Employer Mandate if you are an applicable large employer or ALE. An ALE is an employer that employed at least 50 full-time employees (including full-time equivalent employees) on business days in the preceding calendar year.

7. How do I determine how many full time employees I have?

For purposes of determining if you employ at least 50 full-time employees (including full-time equivalent employees), they are defined as those common law employees who work on average 120 hours per month.

For information on which workforce members are common law employees, see Gallagher's Spotlight: Which Workforce Members are Employees. Generally, a common law employee/employer relationship exists when the employer for whom services is performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished.

Accordingly, a leased employee (as defined in Code Section 414(n)(2)), a sole proprietor, a partner in a partnership, a worker described in Code Section 3508 (that is, real estate agents and direct sellers), or a 2-percent S corporation shareholder are not common-law employees.

Also, you do not have to count veterans as employees for any month in which a veteran has medical coverage provided by TRICARE or under certain other limited Veterans Affairs (VA) medical programs. This exemption is effective for months starting on or after January 1, 2014.

8. We employ about 40 full-time employees working 120 or more hours per month and about 25 part-time employees and seasonal workers. So we are not subject to the Employer Mandate penalties, right?

You may be. The Employer Mandate does not require you to provide coverage for employees working on average less than 30 hours per week ("part-time"). However, the hours worked by part time employees are counted to determine whether you have at least 50 full-time employee equivalents and therefore are subject to the Employer Mandate. This is done by taking the total number of monthly hours worked by part time employees (but not to exceed 120 hours for any one part-time employee) and dividing by 120 to get the number of "full time equivalent" employees. You would then add those "full-time equivalent" employees to your 40 full-time employees.

The hours worked by seasonal workers are also counted to determine whether you have at least 50 full-time employee equivalents and therefore are subject to the Employer Mandate. For purposes of determining whether you are a large

employer, seasonal workers are workers who perform labor or services on a seasonal basis (i.e. exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year). There is an exemption from the Employer Mandate that says you would not be considered to employ more than 50 full-time employees if:

- Your workforce only exceeds 50 full-time employees for 120 days, or fewer, during the calendar year; and
- The employees in excess of 50 who were employed during that 120-day (or fewer) period were seasonal workers.

9. Our workforce numbers go up and down during the year. How do we determine if we had at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year?

For purposes of determining if you are a large employer, the formula requires the following steps:

- Determine the total number of full-time employees working at least 120 hours per month (including any full-time seasonal workers) for each calendar month in the preceding calendar year;
- Determine the total number of full-time equivalents (including non-full-time seasonal employees) for each calendar month in the preceding calendar year;
- Add the number of full-time employees and full-time equivalents described in Steps 1 and 2 above for each month of the calendar year;
- Add up the 12 monthly numbers;
- Divide by 12.

If the average per month is 50 or more, you are a large employer.

10. We are a subsidiary of a parent corporation with only 30 full-time employees. Are we exempt from the Employer Mandate?

In order to determine if the members of your controlled group constitute an ALE, you will have to count all the employees of the controlled group or affiliated service group together. Gallagher's Spotlight on Controlled Group Status summarizes the IRS rules for determining controlled group status. If an employer is unsure of their controlled group status, they should confirm with legal counsel or their tax advisor.

If the total for all the related employers within the controlled group is at least 50 full time employees, then each separate company, including those companies that individually do not employ enough employees to meet the threshold, is considered a large employer subject to the Employer Mandate. For example, if an applicable large employer is comprised of a parent corporation and 10 wholly owned subsidiary corporations, each of the 11 corporations, regardless of the number of employees, is considered a large employer.

Updated: 7/22/25

11. If we are a large employer and don't offer coverage to any full-time employee, how is the penalty calculated?

If you don't offer coverage to your full-time employees (and their dependents), you are subject to an employer shared responsibility penalty if at least one of your full-time employees purchases coverage at a Marketplace with premium tax credits. Employees eligible for a premium tax credit are those whose household income is between 100% (133% in states that expanded Medicaid) and 400% of the federal poverty level and who are not eligible for employer-sponsored coverage that is affordable and meets minimum value. The monthly penalty you would have to pay would be 1/12 of $2,000 (this amount will be adjusted annually for inflation) multiplied by the number of full-time employees you have for that month (minus the first 30). The annual penalty of $2,000 is indexed each year as follows:

2015: $2,080	2020: $2,570	2025: $2,900
2016: $2,160	2021: $2,700	2026: $3,340
2017: $2,260	2022: $2,750	
2018: $2,320	2023: $2,880	
2019: $2,500	2024: $2,970	

12. We are a large employer that offers coverage to our full-time employees except for a certain class of full time employees. In that case, how is the penalty calculated?

If you offer coverage to less than 95% of your full-time employees and their dependents, you are subject to an employer shared responsibility penalty if at least one of your full-time employees purchases coverage at a Marketplace with premium tax credits. The monthly penalty you would have to pay would be 1/12 of $2,000 (indexed annually) multiplied by the number of full-time employees you have for that month (minus the first 30).

Updated: 7/22/25

13. If we offer coverage to our full-time employees, will we be exempt from the Employer Mandate penalties?

Not necessarily. If you have at least 50 full-time employees and you offer coverage to at least 95% (70% for the 2015 plan year if certain criteria are met) of your full-time employees, you are still subject to a penalty if:

- A full-time employee's contribution for employee-only coverage exceeds 9.5% of the employee's household income (note: see below regarding three affordability "safe harbors") or the plan's value is less than 60%; and
- The employee's household income is less than 400% of the federal poverty level; and
- The employee waives your coverage and purchases coverage at a Marketplace with premium tax credits.

The penalty will be calculated separately for each month in which the above applies. The amount of the penalty for a given month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. This amount will be adjusted annually for inflation. The annual penalty of $3,000 is indexed each year as follows:

2015: $3,120	2020: $3,860	2025: $4,350
2016: $3,240	2021: $4,060	2026: $5,010
2017: $3,390	2022: $4,120	
2018: $3,480	2023: $4,320	
2019: $3,750	2024: $4,460	

14. If we owe a penalty, how will the IRS advise us of the amount we have to pay?

The IRS will send you Letter 226J informing you of your potential liability for an employer shared responsibility payment. The IRS determination of whether you may be liable for an employer shared responsibility payment (ESRP) and the amount of the potential payment are based on information that was reported to the IRS on Forms 1094-C and 1095-C for the calendar year and information about your full-time employees that were provided with a premium tax credit. The Letter 226J will contain the name and contact information of a specific IRS employee that you can contact if you have questions about the letter.

You will also have an opportunity to respond to a Letter 226J before any liability is assessed and notice and demand for payment is made. Letter 226J will

provide instructions for how to respond in writing, either agreeing with the proposed ESRP or disagreeing with part or all or the proposed amount. The response to Letter 226J will be due by the response date shown on Letter 226J, which generally will be 30 days from the date of Letter 226J. If, after correspondence between yourself and the IRS or a conference with the IRS Office of Appeals, the IRS or IRS Office of Appeals determines that you are liable for an ESRP, the IRS will assess the ESRP and issue a notice and demand for payment on Notice CP 220J. Notice CP 220J will include a summary of your ESRP and will reflect payments made, credits applied, and the balance due, if any. That notice will instruct you on how to make the payment.

15. If our employee qualifies for premium tax credits with respect to one of his dependent children, will we be liable for a penalty?

No. An employee's receipt of a premium tax credit or cost sharing reduction with respect to coverage for a dependent (including a spouse) will not result in liability for an ALE.

16. How do we know which of our employees is considered "full-time" requiring us to pay a penalty if they qualify for premium tax credits at the Marketplace (if the employee has a variable work schedule or is seasonal)?

For purposes of the Employer Mandate penalties, the guidance permits you to use two methods to determine if an employee is a full time employee. The first is a "look-back measurement period/stability period" method where you may use a standard measurement/stability period for ongoing variable hour employees, while using a different initial measurement/stability period for new variable hour and seasonal employees. The second method is the "monthly" method where full-time employee status is determined on a month-to-month basis.

Please see Gallagher's Compliance Consulting page with our Counting Hours Toolkit for more information on determining full-time status under the ACA Employer Mandate.

17. If we use the look-back measurement and stability period method, how long can the measurement and stability periods be?

For ongoing employees, the standard measurement period must be at least 3 but not more than 12 consecutive months. The stability period for employees that are determined to be full-time must be the greater of six consecutive calendar months or the length of the standard measurement period. If an employee does not work full time, the stability period cannot be longer than the standard measurement period.

18. If we use a measurement/stability period safe harbor, which hours count when calculating the number of hours worked in the measurement period?

For hourly employees, you must calculate actual hours of service and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. See Gallagher's What Counts as an Hour of Service.

For non-hourly employees, you are permitted to calculate the number of hours of service using one of three methods. You may apply different methods for different classifications of non-hourly employees, so long as the classifications are reasonable and consistently applied. The three methods are:

- Counting actual hours of service (as in the case of hourly employees) and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoffs, jury duty, military duty or leave of absence; or
- Using a days-worked equivalency method whereby the employee is credited with eight hours of service for each day the employee is credited with at least one hour of service (including hours of service for which no services were performed); or
- Using a weeks-worked equivalency of 40 hours of service per week for each week, the employee is credited with at least one hour of service (including hours of service for which no services were performed).

However, you cannot use the days-worked or weeks-worked equivalency method if the result would be to substantially understate an employee's hours of service (e.g. employees working three 10-hour days).

19. Do we have to calculate hours of service for payments made to an employee under a short or long-term disability plan?

Periods during which an employee receives payments due to short-term disability or long-term disability do result in hours of service for any part of the period during which the recipient remains an employee of the employer, unless the payments are made from an arrangement to which the employee paid the full cost of the coverage, and the employer did not contribute directly or indirectly. For this purpose, a disability arrangement for which the employee paid the full cost of the coverage with after-tax contributions (so that the benefits received under the arrangement are excluded from income) would be treated as an arrangement to which the employer did not contribute, and payments from the arrangement would not result in hours of service.

20. **Do we have to calculate hours of service for payments made to an employee as a result of worker's compensation, or unemployment or state temporary disability insurance laws?**

No. An hour of service does not include an hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a payment made or due under a plan maintained solely for the purpose of complying with applicable workers' compensation, or unemployment or state temporary disability insurance laws.

21. **We have full-time employees that work outside the U.S. Do their hours have to be counted when determining if they are full-time employees?**

No. Hours worked outside the United States not paid in US-source income do not have to be counted.

22. **Do we have to use the same method of counting hours for all of our non-hourly employees?**

No. You may apply different methods of calculating non-hourly employees' hours of service for different categories of non-hourly employees, provided the categories are reasonable and consistently applied.

You may also change the method of calculating a non-hourly employee's hours of service for one or more categories of non-hourly employees for each calendar year.

23. **Can a school district employer use a 12-month measurement period by counting only the hours of service that were incurred during the school year (and no hours for the summer break)?**

No. For employees of educational institutions, a 12-month measurement period is permitted but a special averaging rule applies that says for employment break periods (e.g. summer break) of four or more consecutive weeks, you must either:

- Determine the average hours of service per week for the employee during the measurement period excluding the employment break period and use that average as the average for the entire measurement period; or
- Credit the employee with hours of service for the employment break period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of an employment break period (but no more than 501 hours of service are required to be credited).

Also, you cannot treat your employees who work during the active portions of the academic year as seasonal employees. See Gallagher's Spotlight on Counting Hours for Primary and Secondary Education Employers for more information.

24. We generally do not track the full hours of service of our adjunct faculty but instead compensate them on the basis of credit hours taught. How should we count hours of service for our adjunct faculty?

You must use a reasonable method for crediting hours of service that is consistent with the purposes of the Employer Mandate. For example, a method of crediting hours would be reasonable if it considered all of your adjunct professor's hours of service including classroom or other instruction time and other hours that are necessary to perform the employee's duties, such as class preparation time, faculty meetings, or office hours.

Until further guidance is issued, one method that is reasonable for this purpose would credit an adjunct faculty member of an institution of higher education with (a) 2 1/4 hours of service (representing a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers) per week for each hour of teaching or classroom time and, separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform (such as required office hours or required attendance at faculty meetings).

For example, assume an adjunct professor teaches a course load of twelve credit hours and is required to hold office hours for 2 hours per week and attend a one-hour faculty meeting each week. Under the method above, the university would credit the adjunct professor with 27 hours of service per week (12 x 2.25) for teaching time, an additional 2 hours per week for the office hours, and 1 hour for the faculty meeting. This would result in a total credit of 30 hours of service per week, and the adjunct would be a full-time employee for purposes of ACA.

25. As an educational organization, we frequently employ students. Do their hours have to be counted?

It will depend on the situation. The hours of students in positions subsidized through the federal work study program or a substantially similar program of a State or political subdivision do not have to be counted. However, all hours of service for which a student employee is paid or entitled to payment in a capacity other than through the federal work study program (or a State or local government's equivalent) are required to be counted as hours of service.

26. Do we have to count the hours of our unpaid interns?

No. Services performed by an intern do not count as hours of service to the extent that the intern does not receive, and is not entitled to, payment in connection with those hours.

However, hours of service for which interns receive, or are entitled to receive, compensation are counted and are subject to the general rules, including the option to use the look-back measurement or monthly method for determining full-time employee status.

27. How do we count hours when an employee works for more than one employer member of our controlled group?

In determining hours of service and status as a full-time employee, you must combine all the hours of service for all of the employer members of the controlled group.

In cases where a full-time employee works for more than one member of your controlled group, the full-time employee is treated as the employee of the employer member for whom the employee had the greatest number of hours of service for the calendar month. If the full-time employee works an equal number of hours for two or more members of your controlled group, the employer members have discretion to designate whom the employee worked for during the calendar month.

28. Do we have to count hours for the volunteer fire department or other voluntary positions that are nominally paid for their expenses or may receive cash awards?

No. Hours of service do not include hours worked as a “bona fide volunteer.” Bona fide volunteers include any volunteer (including a volunteer firefighter) who is an employee of a government entity or an organization described in section 501(c) that is exempt from taxation under section 501(a) whose only compensation from that entity or organization is in the form of (i) reimbursement for (or reasonable allowance for) reasonable expenses incurred in the performance of services by volunteers, or (ii) reasonable benefits (including length of service awards), and nominal fees, customarily paid by similar entities in connection with the performance of services by volunteers.

29. Do our members of a religious order have to be treated as full-time employees of their orders?

There are no special rules for members of a religious order but until further guidance is issued, you do not have to count as an hour of service any work performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

30. Do we have to count hours that an employee is on-call when determining if they are full-time employees?

It will depend on the situation. Generally, you will be required to use one of the reasonable methods for crediting hours of service for any on-call hour for which payment is made or due, for which the employee is required to remain on-call on your premises, or for which the employee's activities while remaining on-call are subject to substantial restrictions that prevent the employee from using the time effectively for the employee's own purposes.

31. If an employee takes unpaid FMLA leave or goes on unpaid military leave during their measurement period, how do we account for that time upon their return to work?

For periods of special unpaid leave including under FMLA, USERRA or on account of jury duty, you must determine the average hours of service per week for the employee during the measurement period – excluding the special unpaid leave period – and use that average as the average for the entire measurement period. Alternatively, you can choose to credit employees with hours of service during the leave at a rate equal to the employee's average weekly rate during the weeks in the measurement period that were not special unpaid leave.

The rule for special unpaid leave does not apply if you are using the monthly method to determine full-time employee status.

32. If an employee meets the 30 hours per week requirement over the measurement period, do we need to enroll them the day after the measurement period ends?

For ongoing employees, you can build in an "administrative period" after the measurement period ends and before the associated stability period begins. This administrative period can't reduce or lengthen the measurement period or the stability period; it can't be longer than 90 days; and it must overlap with the prior stability period; so that, during the administrative period, you continue to offer coverage to ongoing employees until the new stability period begins.

For new variable or seasonal employees, you can build an administrative period before the start of the stability period. This administrative period must not exceed 90 days in total. For this purpose, the administrative period is counted from the date of hire to the date the employee is first offered coverage under your group health plan, other than the initial measurement period. Thus, for example, if you begin the initial measurement period on the first day of the first month following the employee's start date, the period between the employee's start date and the first day of the next month must be considered in applying the 90-day limit on the administrative period. Similarly, if there is a period between the end of the initial measurement period and the date the employee is first offered coverage under your plan, that period must be considered in applying the 90-day limit on the administrative period.

In addition, you are limited in how long the initial measurement period and the administrative period combined can be for a new variable or seasonal employee. Specifically, your initial measurement period and administrative period together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee's start date. For example, if you use a 12-month initial measurement period for a new variable hour employee, and begin that initial measurement period on the first day of the first calendar month following the employee's start date, then the administrative period before coverage starts cannot be longer than one month, assuming, of course, the employee met the full-time hours requirement during the initial measurement period.

33. How does the full-time employee safe harbor work for ongoing employees?

For ongoing employees with variable hours, you have the option to determine each ongoing employee's full-time status by looking back at a standard measurement period between 3 and 12 consecutive calendar months (as chosen by you). You can choose the months in which the standard measurement period starts and ends, provided that you are uniform and consistent in applying it for all employees in the same category. (See below in this section for permissible categories.) For example, if you chose a standard measurement period of 12 months, it could be the calendar year, a non-calendar plan year, or a different 12-month period, such as one that ends shortly before the start of the plan's annual open enrollment season. If you determine that an employee averaged at least 30 hours per week during the standard measurement period, then you must treat the employee as a full-time employee during a subsequent "stability period", regardless of the employee's number of hours of service during the stability period, so long as he or she remained an employee. The stability period would have to be at least six consecutive calendar months and no shorter than the standard measurement period. If you determine that the employee did not work full-time during the standard measurement period, you will not have to treat the

employee as a full-time employee during the stability period that follows and you would not incur an Employer Mandated penalty.

Example – Facts: You choose a 12-month stability period that begins January 1 and a 12-month standard measurement period that begins October 15. Consistent with the terms of your group health plan, only an ongoing employee who works full-time (an average of at least 30 hours per week) during the standard measurement period is offered coverage during the stability period associated with that measurement period. You also choose to use an administrative period between the end of the standard measurement period (October 14) and the beginning of the stability period (January 1) to determine which employees worked full-time during the measurement period, notify them of their eligibility and of the coverage available under the plan for the calendar year beginning on January 1, answer questions and collect materials from employees, and enroll those employees who elect coverage in the plan. Previously determined full-time employees already enrolled in coverage continue to be offered coverage through the administrative period until January 1.

Situation: Phil and Cara have been employees for several years, continuously from their start date. Phil worked full-time during the standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2 and for all prior standard measurement periods. Cara also worked fulltime for all prior standard measurement periods but is not a full-time employee during the standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2.

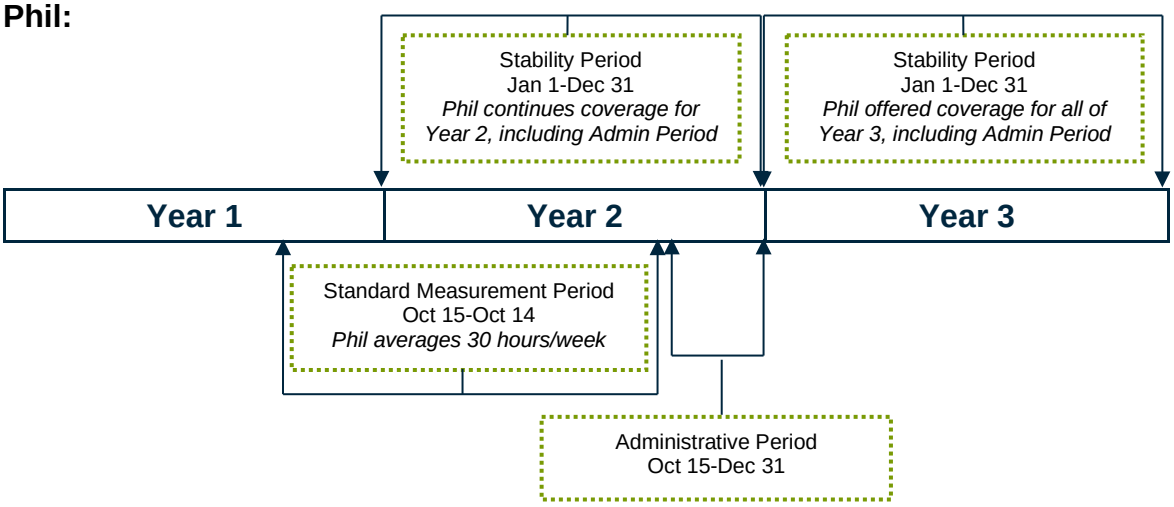
Conclusions: Because Phil was employed for the entire standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2, he is an ongoing employee with respect to the stability period running from January 1 through December 31 of Year 3. Because Phil worked full-time during that standard measurement period, he must be offered coverage for the entire Year 3 stability period (including the administrative period from October 15 through December 31 of Year 3). Because Phil worked full-time during the prior standard measurement period, he would have been offered coverage for the entire Year 2 stability period, and if enrolled he would continue such coverage during the administrative period from October 15 through December 31 of Year 2.

Because Cara was employed for the entire standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2, Cara is also an ongoing employee with respect to the stability period in Year 3. Because Cara did not work full-time during this standard measurement period, she is not required to be offered coverage for the stability period in Year 3 (including the administrative period from October 15 through December 31 of Year 3). However, because Cara worked full-time during the prior standard measurement

period, she would be offered coverage through the end of the Year 2 stability period, and if enrolled would continue such coverage during the administrative period from October 15 through December 31 of Year 2.

In this example, you would comply with the standards because your measurement and stability periods are no longer than 12 months; the stability period for ongoing employees who work full-time during the standard measurement period is not shorter than the standard measurement period; the stability period for ongoing employees who do not work full-time during the standard measurement period is no longer than the standard measurement period; and the administrative period is no longer than 90 days.

Phil:



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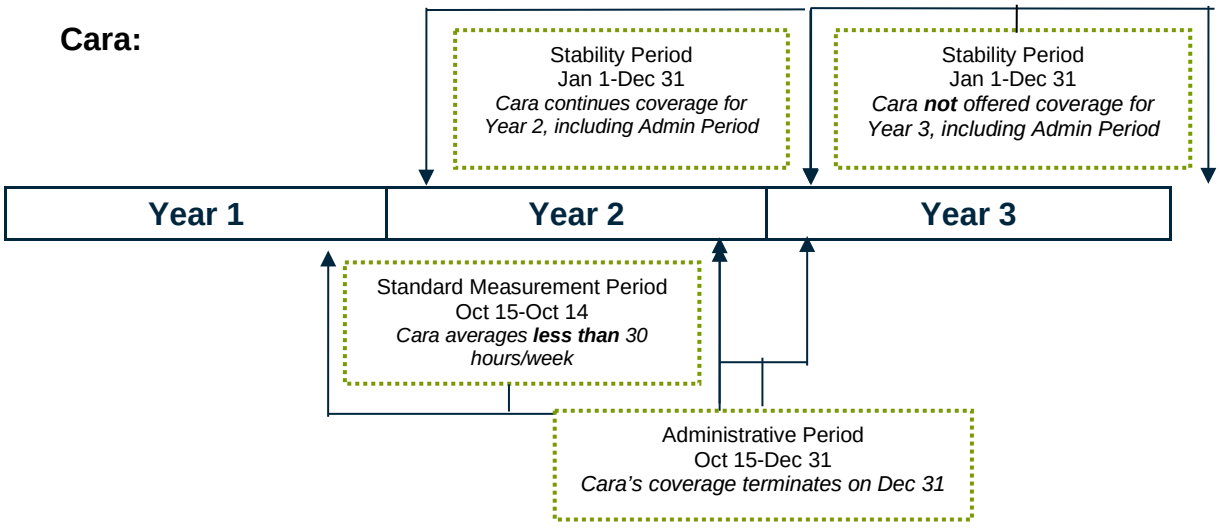


34. How are new employees classified?

New hires are generally classified based on the employees' hours worked, or the number of hours the employee is reasonably expected to work as of their hire date.

- **New employee reasonably expected to work full-time (i.e. 30 or more hours per week)** – If you reasonably expect an employee to work full-time when you hire them, and coverage is offered to the employee before the end of the employee's initial 90 days of employment, you will not be subject to the Employer Mandate payment for that employee, if the coverage is affordable and meets the minimum required value.
- **New employee reasonably expected to work part-time (i.e. less than 30 hours per week)** – If you reasonably expect an employee to work part-time and the employee's number of hours do not vary, you will not be subject to the Employer Mandate penalty for that employee if you don't offer them coverage.
- **New variable hour and seasonal employees** – If based on the facts and circumstances at the date the employee begins working (the start date), you cannot determine that the employee is reasonably expected to work on average at least 30 hours per week, then that employee is a variable hour employee. A "seasonal employee" is defined for purposes of the Employer Mandate as an employee who is hired into a position for which the "customary" annual employment is six months or less. Customary means that by the nature of the position an employee typically works for a period of six months or less, and that period should begin each calendar year in approximately the same part of the year, such as summer or winter.

Factors to consider in determining if a new hire is or is not a full-time employee as of their start date include, but are not limited to, whether the employee is replacing an employee who was or was not a full-time employee, the extent to which employees in the same or comparable positions are or are not full-time employees, and whether the job was advertised, or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description), as requiring hours of service that would average 30 (or more) hours of service per week or less than 30 hours of service per week.

35. If we use the look-back measurement period/stability period method for new variable hour, part-time, or seasonal employees, how long can the initial measurement and stability periods be?

Once hired, you have the option to determine whether a new variable hour, part-time, or seasonal employee is a full-time employee using an "initial measurement period" of between three and 12 months (as selected by you). You would measure the hours of service completed by the new employee during the initial measurement period to determine whether the employee worked an average of 30 hours per week or more during this period. If the employee did work at least 30 hours per week during the measurement period, then the employee would be treated as a full-time employee during a subsequent "stability period," regardless of the employee's number of hours of service during the stability period, so long as he or she remains an employee. The stability period must be a period that is the same length as the stability period for ongoing employees, must be for at least six consecutive calendar months, and cannot be shorter than the initial measurement period. If the employee didn't work on average at least 30 hours per week during the measurement period, you would not have to treat the employee as a full-time employee during the stability period that followed the measurement period. That stability period could not be more than one month longer than the initial measurement period and must not exceed the remainder of the first entire standard measurement period (plus any associated administrative period) for which a variable hour employee, seasonal employee, or part-time employee has been employed.

Example – Facts: For new variable hour employees under a calendar year plan, you use a 12-month initial measurement period that begins on the start date and apply an administrative period from the end of the initial measurement period through the end of the first calendar month beginning on or after the end of the initial measurement period.

Situation: Dianna is hired on May 10, 2022. Dianna's initial measurement period runs from May 10, 2022, through May 9, 2023. Dianna works an average of 30 hours per week during this initial measurement period. You offer affordable coverage to Dianna for a stability period that runs from July 1, 2023, through June 30, 2024.

Conclusion: Dianna worked an average of 30 hours per week during her initial measurement period and you had: (1) an initial measurement period that does not exceed 12 months; (2) an administrative period totaling not more than 90 days; and (3) a combined initial measurement period and administrative period that does not last beyond the final day of the first calendar month beginning on or after the one-year anniversary of Dianna's start date. Accordingly, from Dianna's start date through June 30, 2024, you are not subject to an Employer Mandate

penalty with respect to Dianna because you complied with the standards for the initial measurement period and stability periods for a new variable hour employee. However, you must test Dianna again based on the period from October 15, 2022 through October 14, 2023 (your first standard measurement period that begins after Dianna's start date) to see if she qualifies to continue coverage beyond the initial stability period.

36. Do we have to make the measurement period and stability period the same for all employees?

No. You may use measurement periods and stability periods that differ either in length or in their starting and ending dates for the following categories of employees:

- Each group of collectively bargained employees covered by a separate collective bargaining agreement;
- Collectively bargained and non-collectively bargained employees;
- Salaried employees and hourly employees;
- Employees whose primary places of employment are in different States.

37. At what point would we stop using the initial measurement/stability period and transition an employee to ongoing status?

Once a new employee, who has been employed for an initial measurement period, has been employed for an entire standard measurement period, the employee must be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees.

Example: If you have a calendar year standard measurement period that also uses a one-year initial measurement period beginning on the employee's start date, you would test a new variable hour employee whose start date is February 12 for full-time status first based on the initial measurement period (February 12 through February 11 of the following year) and again based on the calendar year standard measurement period (if the employee continues in employment for that entire standard measurement period) beginning on January 1 of the year after the start date.

If you determine the employee is a full-time employee during the initial measurement period or standard measurement period, then he or she must be treated as a full-time employee for the entire associated stability period. This is the case even if the employee is determined to be a full-time employee during the initial measurement period but determined not to be a full-time employee during the overlapping or immediately following standard measurement period. In

that case, you may treat the employee as a part-time employee only after the end of the stability period associated with the initial measurement period. Thereafter, the employee's full-time status would be determined in the same manner as that of other ongoing employees.

In contrast, if you determine the employee is not a full-time employee during the initial measurement period, but IS determined to be a full-time employee during the overlapping or immediately following standard measurement period, you must treat the employee as a full-time employee for the entire stability period that corresponds to that standard measurement period (even if that stability period begins before the end of the stability period associated with the initial measurement period). Thereafter, the employee's full-time status would be determined in the same manner as that of other ongoing employees.

38. How is a new full-time employee's status determined for the months before the employee has worked one full standard measurement period?

The employee's status as a full-time employee for that period is based on the employee's hours of service for each calendar month. If the employee's hours of service for the calendar month equal or exceed an average of 30 hours of service per week, the employee is a full-time employee for that calendar month. Once the new employee has worked one full standard measurement period and becomes an ongoing employee, their status as a full-time employee will be determined based on their average hours of service under that standard measurement period.

39. Can we change the timing or duration of our standard measurement and stability periods?

You may change your standard measurement period and stability period for subsequent years, but you may not change them once the standard measurement period has begun.

40. If one of our new variable hour, part-time, or seasonal employees is promoted to a permanent full-time position during their initial measurement period, how should their eligibility for coverage be treated?

For a new variable hour, part-time, or seasonal employee who changed employment status to full-time during their initial measurement period, you should treat her as a full-time employee on the earlier of:

- The first day of the fourth month following the change in employment status; or

- If the employee averages 30 or more hours of service per week during the initial measurement period, the first day of the initial stability period that would have applied had the employee not had a change in employment status.

41. What happens if the change in employment status occurs during a stability period?

An ongoing employee's change in employment status during his or her stability period would not affect the employee's status as a full-time employee or non-full-time employee for the remainder of that stability period.

42. What happens if an employee fails to make a timely contribution (e.g., tipped employees, reduced work schedules, and leaves of absence) during the stability period?

If your employee's payment is late, you must provide the employee with a 30-day grace period in order to make the payment. If your employee does not make the payment within the grace period, you are not required to provide coverage for the period for which the premium is not timely paid and may terminate coverage. In addition, you are treated as having offered that employee coverage for the remainder of the coverage period (typically the remainder of the plan year) and cannot be penalized for terminating coverage if the premium is not paid. Similarly, if the employee makes a partial payment that is "not significantly less" than the total amount due (the lesser of 10% of what is due or $50), you must either accept the deficient payment as payment in full or notify the employee in writing of the underpayment and give the employee a reasonable amount of time to pay the remaining balance.

43. If an employee reduces their hours during their stability period and wants to terminate their coverage, can we let them do so?

At your discretion, you may choose to amend your Section 125 cafeteria plan to allow an employee to prospectively revoke coverage under your plan provided the following conditions are met:

- The employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee's status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee losing eligibility under the group health plan (this may occur, for example, if a full-time employee is in a stability period); and
- The employee's election to revoke your group health plan corresponds to the employee's intended enrollment (and any covered dependents), in another

plan that provides minimum essential coverage (MEC). The new coverage must be effective no later than the first day of the second month following the month that includes the date your coverage is revoked. For example, if the employee revokes coverage effective on May 31st, they must intend to enroll in any other minimum essential coverage that is effective no later than July 1st. You may rely on a certification from the employee that the employee and related individuals have enrolled in or intend to enroll in new MEC coverage by the required deadline.

To allow this new permitted election change, you must amend your Section 125 cafeteria plan. You must adopt the amendment on or before the last day of the plan year in which you allow the new election change, and you must inform participants of the plan amendment. For your plan year that starts in 2014, you may amend your plan to adopt the new permitted election change at any time on or before the last day of the plan year that begins in 2015.

In 2022, the IRS issued guidance meant to close the “family glitch.” The Marketplace process for determining whether family members had affordable coverage created the family glitch. In essence, as long as the employee was offered affordable coverage; no family member in the household could access Marketplace premium assistance. Beginning with the Marketplace annual enrollment period in 2022 for 2023 coverage, the Marketplace determines family members’ eligibility for Marketplace premium assistance based on whether the cost of employer-sponsored family coverage is affordable. This change has no effect on the Employer Mandate or ALE liability. To address this change, beginning January 1, 2023, the IRS allowed two new election events that permit an employee to drop coverage for a family member if that family member becomes eligible for a Marketplace special enrollment event or during the Marketplace annual enrollment event. The employee’s election to drop coverage for the family member(s) cannot be effective until the day immediately before the day the Marketplace coverage begins. Employers that choose to adopt the changes in their cafeteria plan must do so on or before the last day of the plan year in which the elections are allowed.

Please note: These new events do not apply to an employee’s health FSA elections. The employee cannot be allowed to revoke or change their health FSA election.

Also, you should verify that your insurer or stop loss insurer will allow employees to make a mid-year election change to drop the coverage under these circumstances.

44. We frequently have variable hour employees whose contracts are terminated and then they are rehired at a later date. Can we treat them as new employees and start the measurement period over again for purposes of determining if they are a full-time employee?

It will depend on the length of the non-employment period. If the period of non-employment is at least 13 weeks (26 weeks for employees of educational organization), you may treat the rehired employee as a new employee.

You can also use the "rule of parity" that says an employee may be treated as a new employee if the period of non-employment of less than 13 weeks (for an employee of an educational organization employer, a period that is shorter than 26 weeks) is at least four weeks long and is longer than the employee's period of employment immediately preceding the period of non-employment. For example, if an employee works for six weeks, terminates employment, and is rehired ten weeks later, that rehired employee is treated as a new employee because the ten-week period of non-employment is longer than the immediately preceding six-week period of employment.

45. What happens if the break in service is less than 13 weeks (26 weeks for an educational organization) and the "rule of parity" does not apply?

For employees that are treated as continuing employees (as opposed to an employee who is treated as terminated and rehired), the measurement and stability period that would have applied to the employee had the employee not experienced the period of non-employment would continue to apply upon the employee's resumption of service. For example, if the continuing employee returns during a stability period in which the employee is treated as a full-time employee, the employee is treated as a full-time employee upon return and through the end of that stability period and must be offered coverage again as of the first day that employee is credited with an hour of service, or, if later, as soon as administratively practicable. For this purpose, offering coverage by no later than the first day of the calendar month following resumption of services is deemed to be as soon as administratively practicable.

46. If we transfer an employee out of the U.S., is that considered a termination of employment?

You may treat an employee as having terminated employment if the employee transfers to a position outside the U.S. if the position is anticipated to continue indefinitely or for at least 12 months and if substantially all of the employee's compensation will constitute income from sources outside the United States.

47. What if we bring an employee into the US from one of our foreign locations?

You may treat an employee transferring to the U.S. from a position outside the U.S. (with compensation from sources outside the U.S.) as a new hire. However, if the employee previously had hours of service at your U.S. location, then the rules related to rehired employees would apply (i.e. breaks in service of more or less than 13 weeks).

48. When we have large projects to complete, we occasionally hire temporary employees who may be hired to work a 40-hour per week schedule when initially employed but may not work at least 30 hours per week thereafter. How should we classify them in order to determine if we should be offering them coverage?

A new non-seasonal employee that is expected to be employed initially at least 30 hours per week can be classified as a variable hour employee if, based on the facts and circumstances at the start date, the period of employment at more than 30 hours per week is reasonably expected to be of limited duration and it cannot be determined that the employee is reasonably expected to be employed on average at least 30 hours per week over your entire initial measurement period. You must assume that the temporary employee will work for the entire duration of the initial measurement period—you may not consider their limited duration to automatically classify them as variable hour.

For example, say you hire an employee to fill in for employees who are absent and to provide additional staffing at peak times. You expect that this employee will average 30 hours of service per week or more for the first few months of employment, while assigned to a specific project, but you also reasonably expect that the assignments will be of unpredictable duration, that there will be periods of unpredictable duration between assignments, that the hours per week required by subsequent assignments will vary, and that the employee will not necessarily be available for all assignments.

In this example, you must assume that the temporary employee will work for the entire duration of the initial measurement period. But because you cannot determine whether this employee is reasonably expected to average at least 30 hours of service per week over the duration of the initial measurement period, you may treat this employee as a variable hour employee.

If the temporary employee is hired as a full-time employee for an indefinite period that is longer than three months, then they should be offered coverage consistent with waiting period rules. A temporary employee who would otherwise be eligible for coverage but has a tenure of under three months generally should not raise

issues under the Employer Mandate, since penalties do not apply until the first day of the fourth month after the individual is hired. If temporary employees are excluded under the terms of the plan, then a temporary employee who is hired to work a full-time schedule and is not offered coverage could result in penalties if that employee were to purchase coverage at a Marketplace with premium tax credits.

49. If we hire temporary workers from a temporary staffing agency for short assignments, will we be required to offer them coverage if they average 30 or more hours per week?

No. Employees of temporary staffing agencies are generally considered common-law employees of the temporary staffing agency. So the staffing agency has the obligation to determine if they are full-time employees of the agency.

50. We occasionally use employees from a PEO or other staffing firm. Are we required to offer them coverage if the PEO or staffing firm is already offering them coverage?

No, if certain conditions are met. If the PEO or staffing firm offers coverage to your employee that is performing services for you as your common-law employee, the PEO or staffing firm's offer is treated as an offer of coverage made by you if the fee you pay to the PEO or staffing firm for an employee enrolled in the staffing firm's plan is higher than the fee you would pay to the staffing firm for the same employee if the employee did not enroll in the staffing firm's plan.

51. If we contract with a school district to provide them with workers for school cafeterias or as bus drivers, do the special averaging rules for educational organizations apply to them?

Yes, in certain circumstances. The special averaging rules would apply to any employee providing services primarily to any educational organizations if a meaningful opportunity to obtain a work assignment during the entire year (to an educational organization or any other type of service recipient) is not made available.

For example, the special averaging rule would apply with respect to your employee who is placed as a bus driver or cafeteria worker if they are not provided with a meaningful opportunity to obtain a work assignment during one or more months of the calendar year (for example, during the summer recess period). In contrast, the special averaging rules would not apply to your employee if the employee were offered a meaningful opportunity to obtain a work assignment during all months of the year (for example, in the case of a school

cafeteria worker, by working at a hospital cafeteria during the school's summer recess period).

52. **As a home care agency, we do not generally direct and control our workers. Do we have to count them as full-time employees for either determining if we are a large employer or for offering coverage?**

Each case will have to be evaluated to determine whether you or the service recipient is the common law employer of the provider. If the service recipient has the right to direct and control the home care provider as to how they perform the services, including the ability to choose the home care provider, select the services to be performed, and set the hours of the home care provider, these facts would indicate that the service recipient may be the employer under the common law standard rather than your agency. In that case, you would not be subject to penalties with respect to that particular provider.

53. **We are an agricultural operation that frequently employees workers with H-2A and H-2B visas. Are these workers counted as employees for purposes of the Employer Mandate?**

Yes. There are no special rules for H-2A or H-2B workers though in many cases they can be classified as seasonal employees and thus would be subject to your measurement method.

54. **If we elect not to use the look-back measurement method to determine our employee's status, is there any other method we can use?**

There is another method that is referred to as the "monthly method." Under the monthly method, the determination of the employee's status is based on hours of service in each month and is not based on averaging over a prior period. However, IRS representatives have informally indicated that this method was intended to be used simply as a method used at the end of the year to determine whether penalties would apply for any months of the year.

55. **As a member employer of a controlled group, do we have to use the same method for determining our employee's status as the other employer members of the controlled group?**

No. You may use different measurement methods (the look-back measurement method or the monthly measurement method) and/or different starting and ending dates and lengths of measurement and stability periods.

Updated: 7/22/25

56. We pay 100% of the employee-only cost but only pay 50% of the family cost. Is our plan considered "affordable"?

Yes. Your plan would be affordable because the determination of affordability is based on the employee's required contribution for employee-only coverage. Because your employees pay less than 9.5% of their household income (indexed annually) towards the cost of employee-only coverage, the plan is considered affordable. This is the case even if the employee contribution for family coverage exceeds 9.5% of the employee's household income.

For years after 2014, the affordability threshold is indexed as follows:

2015: 9.56%	2020: 9.78%	2025: 9.02%
2016: 9.66%	2021: 9.83%	2026: 9.96%
2017: 9.69%	2022: 9.61%	
2018: 9.56%	2023: 9.12%	
2019: 9.86%	2024: 8.39%	

57. How will we know if the contribution exceeds 9.5% (indexed annually) of the employee's household income?

If you offer minimum value coverage to your full-time employees and their dependents, there are three affordability "safe harbors" that will allow you to easily determine if the cost of your group health plan is affordable. The three safe harbors are:

- **Form W-2 safe harbor**– If you offer full-time employees and their dependent children the opportunity to enroll in your plan, you can compare the employee contribution of self-only coverage for your lowest cost plan that meets the minimum value against the employee's current W-2 wages as reported in box 1 of Form W-2. If the cost of the coverage for self-only coverage does not exceed 9.5% (indexed, see FAQ 56) of the employee's wages as described above, the coverage is affordable. Application of this safe harbor is determined after the end of the calendar year on an employee-by-employee basis, considering the Form W-2 wages and the required employee contribution for that year. In addition, to qualify for this safe harbor, the employee's required contribution must remain a consistent amount or percentage of all Form W-2 wages during the calendar year (or during the plan year for plans with non-calendar year plan years) so that you are not

permitted to make discretionary adjustments to the required employee contribution for a pay period.

- **Rate of pay safe harbor** – For hourly employees, you would on a monthly basis (1) take the lower of the employee's hourly rate of pay as of the first day of the coverage period (generally the first day of the plan year) or the employee's lowest hourly rate of pay during the calendar month, (2) multiply that rate by 130 hours per month, and (3) determine affordability based on the resulting monthly wage amount. Specifically, the employee's monthly contribution amount (for the self-only premium of the employer's lowest cost coverage that provides minimum value) is affordable if it is equal to or lower than 9.5% (as indexed) of the computed monthly wages (that is, the employee's applicable hourly rate of pay x 130 hours). For non-hourly employees (e.g. salaried employees), you would compare the employee contribution to the employee's monthly salary as of the first day of the coverage period. This safe harbor cannot be used for non-hourly employees if the monthly compensation is reduced, including due to a reduction in work hours.
- **Federal poverty line safe harbor** – Your coverage will be affordable if the employee's cost for self-only coverage under your plan does not exceed 9.5% (as indexed) of a monthly amount determined as the federal poverty line for a single individual in the state in which the individual is employed, divided by 12. You are permitted to use the federal poverty line guidelines in effect six months prior to the beginning of the plan year.

You may choose to use one or more of these safe harbors for all of your employees or for any reasonable category of employees, provided you do so on a uniform and consistent basis for all employees in a category. Reasonable categories generally include specified job categories, nature of compensation (for example, salaried or hourly), geographic location, and similar bona fide business criteria.

58. Some of our employees are paid on a commission-only basis. How should we determine if coverage is affordable for those employees?

Recognizing that the rate of pay safe harbor cannot be used for employees who are compensated solely on the basis of commissions, the final regulations indicate that you should use the two other affordability safe harbor methods, Form W-2 wages and federal poverty line, for determining affordability for your employees whose compensation is not based on a rate of pay.

59. We have several employees whose main source of income is tips. How should we determine if coverage is affordable for these employees?

Similar to commission-only employees, you would have to use either the Form W-2 wages or the federal poverty line affordability safe harbors for determining affordability for employees whose compensation is not based on a rate of pay.

60. If we use the W-2 affordability safe harbor, how do we determine affordability for employees that work only part of the year?

For an employee not offered coverage for an entire calendar year, the Form W-2 safe harbor is applied by adjusting the Form W-2 wages to reflect the period for which coverage was offered, then determining whether the employee's required contribution for the employer's lowest cost self-only coverage that provides minimum value, totaled for the periods during which coverage was offered, does not exceed 9.5% (as indexed) of the adjusted amount of Form W-2 wages.

To adjust Form W-2 wages for this purpose, the Form W-2 wages are multiplied by a fraction equal to the number of calendar months for which coverage was offered over the number of calendar months in the employee's period of employment during the calendar year.

Example: Cathy is employed from May 15, 2025, through December 31, 2026. In addition, Cathy and her dependents are offered coverage during the period from August 1, 2025, through December 31, 2025. Cathy's contribution for self-only coverage is $100 per calendar month, or $500 for her period of employment. For 2025, Cathy's Form W-2 wages are $15,000. For purposes of applying the affordability safe harbor, the Form W-2 wages are multiplied by 5/8 (5 months of coverage offered over 8 months of employment during the calendar year) which equals $9,375. Accordingly, affordability is determined by comparing the adjusted Form W-2 wages ($9,375 ($15,000 x 5/8)) to the employee contribution for the period for which coverage was offered ($500).

Conclusion: Because the employee contribution of $500 is less than 9.02% of $9,375 (Cathy's adjusted Form W-2 wages for 2025), the coverage offered is treated as affordable for 2025.

61. How are our wellness incentives considered when determining if our employee's contribution for employee– only coverage exceeds 9.5% (as indexed) of the employee's household income?

If your plan charges a higher contribution for tobacco users, the affordability of the coverage will be determined by using the lower contribution that is charged to non-tobacco users, or tobacco users who complete the related wellness

program. In other words, the plan may assume that each employee has earned the tobacco-related incentive and would be paying the lower contribution. However, wellness program incentives that do not relate to tobacco use are treated as not earned in calculating affordability. In other words, the affordability of a plan that charges a higher contribution for participants who do not complete the related wellness program will be determined based on the higher contribution.

62. Are contributions to an integrated HRA taken into account for purposes of determining whether our coverage is affordable?

Yes, if the amounts you make available for the current plan year under an integrated HRA may be used by an employee to pay premiums for your plan or used to pay both premiums for your plan and also for cost-sharing and/or for other health benefits not covered by the plan. The HRA contributions are counted toward the employee's required contribution (and thus reduce the dollar amount of the employee's required contribution). Your contribution to an HRA (and any resulting reduction in the employee contribution) is treated as pro-rata for each month of the plan year.

Example: The employee contribution for health coverage under the major medical plan is generally $200 per month. For the current plan year, you make $1,200 newly available under an integrated HRA that the employee may use to pay their share of contributions for the major medical coverage, pay cost-sharing, or pay towards the cost of vision or dental coverage.

Conclusion: Your $1,200 employer contribution to the HRA reduces the employee's required contribution for the coverage. The employee's required contribution for the major medical plan is $100 ($200 - $100) per month because 1/12 of the $1,200 HRA amount per month is considered as an employer contribution whether or not the employee uses the HRA to pay their share of contributions for the major medical coverage.

63. If we provide employees with a flex contribution that they can spend on benefits, would our flex contributions be treated as reducing the employee's contribution for affordability purposes?

The amount of the flex contribution is treated as reducing the amount the employee has to contribute only if:

- the employee may not opt to receive the amount as a taxable benefit (e.g. cash),
- the employee may use the amount to pay for minimum essential coverage, and

- the employee may use the amount exclusively to pay for medical care, within the meaning of Code Section 213.

If your flex contribution can also be used to pay for any non-health care benefits under the Section 125 cafeteria plan (such as disability, dependent care, or group term life insurance), that contribution will not be treated as reducing the required employee contribution. Similarly, a flex contribution that is available to pay for health care but also could be received as cash does not reduce the employee's required contribution.

Example (Health Flex Contribution Reduces Dollar Amount of Employee's Required Contribution): An employee electing self-only coverage is required to contribute $200 per month toward the cost of coverage. You offer flex contributions of $600 for the plan year that may only be applied toward the employee's share of contributions or contributed to a health FSA.

Conclusion: Your $600 contribution reduces the employee's required contribution. The $600 is considered as an employer contribution (and therefore reduces the employee's required contribution) regardless of whether the employee elects to apply the health flex contribution toward the employee contribution for the group health coverage or elects to contribute it to the health FSA. The employee's required contribution for purposes of affordability becomes $150 ($200 - $50) per month.

Example (Employer Flex Contribution Does Not Reduce Dollar Amount of Employee's Required Contribution): An employee electing self-only coverage under the health plan contributes $200 per month toward the cost of coverage. You offer a flex contribution of $600 for the plan year that can be used for any benefit under the Section 125 cafeteria plan (including benefits not related to health) or it can be taken as cash.

Conclusion: Because the $600 flex contribution is not usable exclusively for medical care, it is not treated as reducing the employee's required contribution. Thus, the employee's required contribution is still $200 per month.

64. We offer an opt-out bonus under our Section 125 plan to employees that waive our coverage. Do those amounts have to be included when determining if our coverage is affordable?

Yes. An opt-out bonus adopted after December 16, 2015 will be treated as increasing an employee's contribution for health coverage beyond the amount of any salary reduction contribution, including for those employees who elect coverage and don't receive the bonus. For example, if you offer coverage through a Section 125 cafeteria plan, requiring employees who elect self-only

coverage to contribute $200 per month toward the cost of that coverage, and offer an additional $100 per month in taxable wages to each employee who declines the coverage, the offer of $100 in additional compensation to waive coverage is treated as increasing the employee's contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.

65. If we make payment of the opt-out bonus also contingent on the employee proving that they have other employer-sponsored coverage (or Medicare, Tricare, etc.), then would the opt-out bonus still have to be treated as increasing the employee's contribution?

It would be unless certain requirements are met. For conditional opt-out bonuses adopted after December 16, 2015, the opt-out bonus will not affect the affordability calculation only if the payment of the opt-out bonus is conditioned on all of the following requirements:

- The employee must decline to enroll in the employer-sponsored coverage;
- The employee must provide reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer's plan year to which the opt-out arrangement applies ("employee's expected tax family") have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies. Reasonable evidence of alternative coverage can include the employee's attestation that the employee and all other members of the employee's expected tax family, if any, have or will have minimum essential coverage, or any other reasonable evidence;
- The arrangement must also provide that any opt-out payment cannot be made if the employer knows or has reason to know that the employee or any other member of the employee's expected tax family does not have (or will not have) the required alternative coverage; and
- The opt-out arrangement must also require that the evidence of other coverage be provided no less frequently than every plan year to which the eligible opt-out arrangement applies, and that the evidence be provided no earlier than a reasonable period before the commencement of the period of coverage to which the eligible opt-out arrangement applies.

Assuming all the above requirements are met, a conditional opt-out payment may be excluded from the employee's required contribution for the remainder of the plan year, even if the alternative coverage subsequently terminates for the employee or any other member of the employee's expected tax family.

66. We make payments for fringe benefits pursuant to the Service Contract Act (SCA) or Davis-Bacon Act (DBA). How are those payments taken into account for purposes of determining whether our coverage is affordable?

Until further guidance is issued, your fringe benefit payments (including flex credits or flex contributions) under the SCA or DBA that are available to employees to pay for coverage under your plan (even if alternatively available to the employee in other benefits or cash) will be treated as reducing the employee's required contribution for participation in the plan, but only to the extent the amount of your payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBA.

Example: XYZ, Co offers employees subject to the SCA or DBA coverage through a Section 125 cafeteria plan, which the employees may choose to accept or reject. Under the terms of the offer, an employee may elect to receive self-only coverage under the plan at $200 per month or may alternatively decline coverage under the health plan and receive a taxable payment of $700 per month. For the employee, $700 per month does not exceed the amount required to satisfy the fringe benefit requirements under the SCA or DBRA.

Conclusion: Until further guidance is issued, the required employee contribution for an employee who is subject to the SCA or DBA is deemed to be $0.

67. How do we calculate whether our plan's share of the total allowed cost of benefits is at least 60%?

The IRS released three possible methods for determining whether your coverage meets the 60% minimum value threshold. The three methods are:

- **Minimum Value (MV) Calculator** – HHS and Treasury have developed an MV calculator for insured large group or self-insured plans to use to determine whether a plan provides the minimum 60% value. You can access the calculator and methodology at: https://www.cms.gov/marketplace/resources/regulations-guidance
- **Design Based Safe Harbors** - The IRS would develop an array of design-based safe harbors in the form of checklists that would provide a simple, straightforward way for plan sponsors to determine minimum value – without

the need of actuarial expertise or performing calculations. If your self-insured plan's terms are consistent with or more generous than any one of the safe harbor checklists, your plan would be treated as providing minimum value.

- **Actuarial Certification** - Plans with nonstandard features that are not able to use the MV calculator or the safe harbor checklists would have to obtain appropriate certification of the plan's value by an actuary. An actuary performing an actuarial certification for a plan with nonstandard features must use the MV Calculator to determine the plan's MV for plan coverage the MV calculator measures. The actuary would then add to that MV percentage the result of the actuary's analysis of the nonstandard features.

In addition, all the amounts you contribute for the current plan year to an employee's HSA are considered in determining your plan's share of costs for purposes of MV and are treated as amounts available for first dollar coverage. Amounts you newly made available under an HRA that is integrated with your major medical plan for the current plan year count for purposes of MV in the same manner if the amounts may be used only for cost-sharing and may not be used to pay insurance premiums. With respect to wellness plan incentives not related to tobacco use, your plan's share of costs for MV purposes is determined without regard to reduced cost-sharing (e.g. lower or waived deductibles, coinsurance, copays) available under a wellness program (i.e. the higher, non-discounted cost-sharing is used). However, for wellness programs designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the terms of the program relating to prevention or reduction of tobacco use (i.e. the lower, cost-sharing is used).

68. Can we satisfy the Minimum Value (MV) requirement if we offer a plan that does NOT include hospitalization and/or physician services benefits?

No. Your plan will not provide minimum value if it excludes substantial coverage for in-patient hospitalization services or physician services (or both), even if it shows a value of 60% when using the online Minimum Value Calculator.

69. Do I have to "offer" and pay for dependent coverage also? What if the dependent (spouse or children) are covered by another employer's plan?

The Act does not require you to offer or pay for health coverage that includes spouses and dependent children (but see the section entitled "Dependents to Age 26" for the requirements that apply to plans that provide coverage for children). However, to avoid penalties under the Employer Mandate and to qualify for the Form W-2 affordability "safe harbor" described above, you will have to offer qualified coverage to all full-time employees and their dependent children until the end of the month in which the child turns 26. The regulations

define an employee's dependent children as the employee's biological and adopted children. Thus, an offer of coverage to an employee's spouse, stepchild or foster child is not required in order to comply with the Employer Mandate.

Also, the term dependent does not include a child who is not a citizen or national of the United States unless the child is a resident of the United States or a country contiguous to the United States (certain adopted children are excepted from this rule).

70. We don't know our employee's household income. How will we know if an employee is eligible for a premium subsidy?

It will be up to the Marketplace in your state to determine if an individual is eligible for a premium subsidy. You may be notified by the Marketplace if/when an employee is qualified and may have the ability to appeal that determination.

71. Will we be able to file an appeal if we disagree with the Marketplace's determination that our employee qualifies for premium tax credits or cost-sharing reductions because our plan does not offer qualifying coverage?

Yes. HHS has provided an appeal process that allows you to appeal a determination that your employee is eligible for premium tax credits or cost-sharing reductions in part because your plan is either unaffordable or the plan's share of the total allowed cost of benefits is less than 60%.

You will have 90 days from the date you are notified that one of your employees qualified for premium tax credits to file your appeal. You will be permitted to submit evidence to support your appeal including information pertaining to whether coverage was offered to the employee, whether the employee has elected such coverage, the employee's portion of the lowest cost minimum value plan you offer, and whether or not the employee is in fact employed by you.

72. We offer coverage to most of our full-time employees but have one class of full-time employees that are not eligible for coverage. Which penalty will apply to our plan?

If you offer coverage to at least 95% of your full-time employees (and their dependent children), you will be subject to 1/12 of the 4980H(b) penalty (indexed annually) for each full-time employee that receives a premium tax credit or cost-sharing reduction for coverage purchased through a Marketplace for that month because your coverage is unaffordable or does not meet a minimum value.

If coverage is not offered to at least 95% of your full-time employees (and their dependents), then you will be subject to the monthly 4980H(a) penalty (indexed

annually) multiplied by the number of full-time employees you have for that month (minus the first 30) if at least one employee receives a premium tax credit or cost-sharing reduction through the Marketplace.

See FAQs 11 and 13 for the current penalty amounts under 4980H(a) and (b).

73. **As the parent corporation of several subsidiary corporations, are we responsible for a single penalty payment for all of the subsidiary corporations in the controlled group?**

No. For any year that you are considered a large employer, the Employer Mandate standards generally are applied separately to each member company of the controlled group in determining liability for, and the amount of, any penalty payment. Further, each of the member companies cannot be held liable for the penalties of any other entity in the controlled group.

74. **If we offer no coverage to our full-time employees and the penalty assessment is done separately for each subsidiary, does each subsidiary get the 30-employee reduction?**

No. For a controlled group that is a large employer under the aggregation rules, only one 30-employee reduction is allowed. The 30-employee reduction must be allocated ratably among the member companies of the large employer based on each company's number of full-time employees compared to the total number of employees within the controlled group.

75. **If we offer coverage that is not affordable but require our full-time employees to enroll, thereby making them ineligible for a premium subsidy, will we avoid being penalized?**

No. You cannot make your employees ineligible for a premium tax credit by providing them with mandatory coverage (i.e. where they are not offered an opportunity to decline) that is not affordable or does not meet minimum value. You must allow employee to decline your coverage unless the coverage meets both of the following requirements:

- It provides minimum value; and
- It is offered either at no cost to the employee or at a cost, for any calendar month, of no more than 9.5% (indexed) of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12.

76. If we contribute to a multiemployer union plan for our unionized employees, how will we know if we are subject to a penalty for the union members that work for us for 30 or more hours per week?

You will not be subject to a penalty with respect to a full-time union employee if:

- You are required to make a contribution to a multiemployer plan pursuant to a collective bargaining agreement or an appropriate related participation agreement; and
- Coverage under the multiemployer plan is offered to the full-time employee (and the employee's dependents); and
- The coverage offered to the full-time employee is affordable and provides minimum value.

For purposes of determining whether coverage under the multiemployer plan is affordable, you may use any of the affordability safe harbors. Coverage under a multiemployer plan will also be considered affordable if the employee's required contribution, if any, toward self-only health coverage under the plan does not exceed 9.5% (as indexed) of the wages reported to the qualified multiemployer plan, which may be determined based on actual wages or an hourly wage rate under the applicable collective bargaining agreement.

Marketplace

77. What is the Exchange or Marketplace?

A Marketplace (formerly known as an "Exchange") is an arrangement through which private and non-profit insurers offer small employers (up to 100 employees) and individuals the ability to purchase health insurance. The Act requires each state to set up a Marketplace exchange for the purchase of health insurance coverage. Coverage can be purchased through the Marketplace starting in 2014. States have the option to allow large employers (more than 100 employees) to begin purchasing coverage through a State Marketplace starting in 2017.

Regional or national Marketplaces could also be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the Marketplace.

It is expected that each Marketplace will offer four categories of plans plus a catastrophic plan including:

- **Bronze**: Essential health benefits covering 60% of the benefit plan costs;
- **Silver**: Essential health benefits covering 70% of the plan benefit costs;

- **Gold**: Essential health benefits covering 80% of the plan benefit costs
- **Platinum**: Essential health benefits covering 90% of the plan benefit costs;
- **Catastrophic**: Available to individuals under age 30, or people 30 or older with a hardship exemption or affordability exemption (based on Marketplace or job-based insurance being unaffordable). Provides catastrophic coverage only, with the coverage level set at the current High Deductible Health Plan levels except that preventive benefits and coverage for three primary care visits would be exempt from the deductible.

78. Am I considered a small employer for purposes of buying insurance through the Marketplace exchange?

A small employer for purposes of buying coverage through a State or federally facilitated SHOP Marketplace is defined as an employer with 50 or less full time equivalent employees. Starting in 2016, all SHOPs will be open to employers with up to 100 FTEs.

Federally facilitated SHOPs will use the same counting method that is used for determining if an employer is a “large employer” under the Employer Mandate. Both full-time employees and full-time equivalent employees will be counted. State-operated SHOPs are permitted to use the state’s own employee counting methods for determining the employer’s size and employee’s status as a full-time employee until 2016.

Starting in 2017, states can allow businesses with more than 100 employees to purchase coverage through a Marketplace.

79. We are a small employer. If we buy coverage through our state Marketplace, what information will we have to provide to our employees so that they can elect and enroll in a plan?

You will be required to provide information to your employees about the timeframes for enrollment, instructions on how to access the Marketplace website and any tools available to compare plan options, and the Marketplace’s toll-free customer service hotline.

80. If we have employees that are not offered or waive our coverage, when can they buy insurance at a Marketplace?

Coverage can be purchased during the annual open enrollment period. For special enrollment events, they will be able to purchase individual policies for up to 60 days following the event. The Marketplace special enrollment events can be found at https://www.healthcare.gov/coverage-outside-open-

enrollment/special-enrollment-period.Under rules issued by HHS, individuals would have to provide proof documenting that any of the above events actually occurred before being allowed to enroll under a special enrollment opportunity.

81. **Our plan is a non-calendar year plan renewing each July 1st. Will employees who waive our coverage at open enrollment be able to purchase coverage at a Marketplace at that time?**

Yes. A Marketplace must allow an employee and his or her dependents to enroll in a qualified health plan under a special enrollment if the employee or his or her dependents fail to enroll in a non-calendar year group health plan, even if the employee or his or her dependents have the option to renew the coverage for the next plan year.

82. **We have an employee who is leaving and benefits don't begin with the new employer for 90 days. Is the employee able to opt out of COBRA coverage and go to the Marketplace to buy coverage?**

Yes. The employee can either elect COBRA or go to the Marketplace to purchase coverage instead. The decision to not elect COBRA will not affect the determination of whether the employee is eligible for premium tax credits at a Marketplace.

83. **If an employee elects COBRA, can the employee drop it at a later date to buy coverage at the Marketplace?**

No. In order to buy coverage at the Marketplace, the employee would either have to wait until the next annual open enrollment period, or the employee would have to exhaust the full duration of COBRA to qualify for a special enrollment event at the Marketplace.

84. **We pay the cost of the first 3 months of COBRA coverage for our employees who are laid off. Will that prevent them from buying coverage at a Marketplace after the subsidized period has ended?**

Yes. Employees who accept the subsidized COBRA coverage would either have to wait until the next annual open enrollment period to enroll at a Marketplace, or they would have to exhaust the full duration of their COBRA coverage to qualify for a special enrollment event at the Marketplace.

Marketplace Notice

85. What is the Marketplace Notice?

You must provide a written notice to each employee and to each newly hired employee, informing them of the following:

- The existence of the State's Marketplace including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance.
- If your plan pays less than 60% of the total allowed costs of benefits provided under the plan, a statement that the employee may be eligible for a premium tax credit and a cost sharing reduction if the employee purchases a qualified health plan through the Marketplace.
- If the employee purchases a qualified health plan through the Marketplace, a statement that the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of any employer contribution may be excludable from income for Federal income tax purposes.

86. Who should receive the Marketplace notice? Can we include it in our health plan enrollment materials?

The Marketplace notice must be sent to all employees (including those working fewer than 30 hours per week and temporary and seasonal employees), regardless of their eligibility or enrollment in your medical plan. Distribution via health plan materials would therefore not satisfy the notice requirement.

The notice should also be distributed to employees who are not present at the workplace, such as those on FMLA or other leaves of absence.

87. Does the notice have to be provided to former employees who are COBRA qualified beneficiaries or retirees?

No. Only your new employees must receive the notice within 14 days of hire.

88. Do we have to provide the notice to new hires?

Yes. You must provide the notice within 14 days of their start date.

89. We have union employees that are covered by a collectively bargained multiemployer plan, not our company's group plan. Am I responsible for providing the notice to these employees?

Yes. You must furnish the notice to all of your employees – regardless of an employee's benefit eligibility or enrollment status, full or part-time status, or union affiliation.

The requirement to provide the Marketplace notice can be satisfied if another entity (such as an issuer, multiemployer plan, or third-party administrator) sent the notice on your behalf. Although, you are not relieved of your obligation to provide the notice to all employees if the other entity only provides the notice to those employees enrolled in the plan, while not providing the notice to those employees not enrolled in the plan. You must therefore ensure the notice is provided to all employees.

90. Can we provide the notice electronically?

It may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor are met.

91. Can we hand deliver the Marketplace notice?

The guidance only expressly permits first-class mail and electronic disclosure. However, it also refers to ERISA's disclosure regulations, which allow hand delivery. As such, hand delivery appears to be acceptable as long as you take steps reasonably calculated to ensure actual receipt of the notice.

You will need, however, to distribute the notice by mail or electronically to employees that are not present at the workplace, such as those on FMLA or other leaves of absence.

92. Are there model Marketplace notices we can use to satisfy our notice obligation?

Two model notices were provided with the guidance. One model notice is for employers that offer health plan coverage and the other is a model notice for employers not offering plan coverage. The model notices can be accessed at the DOL website at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice. The notices are available in both English and Spanish and in Word and PDF format.

93. Are any parts of the model notice optional?

According to the guidance, if you are using the model notice for employers that provide coverage to their employees, all the content on pages 2 and 3 of the model notice is optional. However, on the model notice itself, only the content on page three is expressly labeled as optional. At the minimum, we do recommend that you complete fields #3-12 of Part B on page two, as this is generic employer information that should not require customization for any specific employee.

94. My organization is a controlled group of corporations comprised of a number of affiliated member employers. Which employer name and EIN should be reflected on page two of the notice – the parent company or the member employer?

The guidance does not specify which employer name and EIN may or must be used on the Marketplace notice. It would likely be most reasonable to use the name and EIN of whichever employer could most easily answer questions related to the employees' coverage eligibility, enrollment, and costs. For example, if your parent company sponsors a single health plan for all employees of all member employers and enrollment is handled by a centralized Human Resource Department for all the member employers, use the parent company name and EIN. Alternatively, if the member employers in your controlled group each independently sponsor their own plans and handle enrollment for their own employees, use the member employer's name and EIN.

95. Is there a fine or penalty for not providing the Marketplace notice?

You will not be fined or penalized if you fail to provide the notice, but the DOL also reiterated that employers should still provide the written Marketplace notice to its employees.

Grandfathered Plans

96. What does "grandfathered plan" mean?

Existing plans, including plans maintained pursuant to a collective bargaining agreement, in operation as of March 23, 2010 are grandfathered if no significant changes have been made to the plan. However, certain benefit mandates included in the Act will apply.

97. It sounds like our plan is grandfathered. What benefit changes will we have to make? And by when?

The legislation includes the following mandates which all grandfathered group health plans, including collectively bargained plans, will have to comply with beginning with the first plan year starting on or after September 23, 2010:

- Provide coverage to dependent children until they turn age 26 unless they are eligible for any other employer provided coverage that is not a group health plan of a parent
- Eliminate lifetime aggregate dollar limits on “essential health benefits”
- Eliminate annual dollar limits on “essential health benefits” (unless permitted by the Secretary)
- Eliminate preexisting condition exclusion for enrollees up to age 19
- Prohibit the rescinding of coverage except in the case of fraud, intentional misrepresentation, or nonpayment of premiums

Starting in 2014, grandfathered plans that become non-grandfathered must:

- Eliminate annual aggregate benefit limits
- Provide coverage of dependents to age 26 regardless of eligibility for other coverage
- Eliminate preexisting condition limitations for adults
- Eliminate waiting periods of greater than 90 days

98. Our plan is collectively bargained, and we heard that we don’t have to make any changes until the last collective bargaining agreement expires. Has that changed?

Insured and self-insured plans maintained pursuant to a collective bargaining agreement ratified before March 23, 2010 are deemed to be grandfathered plans. Because they are grandfathered plans, they are subject to the same reforms and effective dates as any other grandfathered plan.

For insured collectively bargained plans only, the plan will remain grandfathered until the last agreement expires, even if plan changes, including changing insurers, are made during the collective bargaining agreement that would normally result in a loss of grandfathered status.

After the last collective bargaining agreement expires, the determination of whether the plan is still grandfathered is made by comparing the coverage on the expiration date with the coverage that was in effect on March 23, 2010.

99. We also provide dental and vision coverage to our employees. Are we required to make these changes for those plans as well?

Maybe. The mandated changes for grandfathered plans only apply to your group health plans that are not “excepted benefits” as defined under HIPAA. If your dental and/or vision are excepted benefits, then you are not required to make any of the required changes for those coverages.

HIPAA excepted benefits include most health FSAs and limited scope dental and vision plans. Excepted benefits will be those dental and vision benefits that are either provided under a separate policy or contract of insurance or are not an integral part of the group health plan (i.e. employees can waive the dental or vision).

100. We provide retiree health coverage for our retired employees. Will these benefit mandates apply to our retiree plan?

It depends. There is an exception for retiree-only plans subject to ERISA that cover fewer than two active employees. For health insurers and nonfederal governmental plans subject to the Public Health Service Act, HHS has indicated they will apply a “non-enforcement” policy for insured retiree-only plans and retiree plans sponsored by non-federal governmental entities. In addition, HHS is encouraging states, which have enforcement authority over insurers, not to enforce the new health care reform provisions on these plans.

If your retiree plan covers both retirees and active employees under the same plan, then the exception will not apply and the health care reform provisions that apply to the plan will apply to both active and retired employees covered under the plan.

If your retiree plan also covers individuals on long-term disability benefits, the answer is not clear. Until guidance is issued, HHS will treat these plans as satisfying the exception and will not apply either HIPAA or the health care reform mandates to this type of plan. However, HHS will be reviewing these types of plans and may release further guidance at a later date. If the guidance is more restrictive, it will be prospective, applying only to plan years that begin sometime after issuance. Pending such further guidance, if you choose to adopt any or all of the HIPAA or health care reform mandates, it will not prejudice your exemption.

101. We made some plan design changes that are effective 7/1/10. Will they result in a loss of grandfathered status?

It depends. Certain plan changes made after March 23, 2010 will result in a loss of your plan's grandfathered status unless the changes were adopted or incorporated into a legally binding contract that was executed before June 14, 2010 (See the Q&A on "transition rules' later in this section). The changes that can cause a loss of grandfathered status are more specifically described below and include any decrease in the plan's coinsurance amount, reductions in annual limits or employer contributions, reductions in benefits for the treatment or diagnosis of a particular condition, and in some cases, a change of insurers. Also, increases in coinsurance, copays, deductibles and out-of-pocket maximums can cause your plan to lose grandfathered status. If your plan changes are any of the increases described above, it will require an analysis of the amount of the increase compared to increases in medical inflation.

102. Specifically, what are the changes that cause a plan to lose grandfathered status?

Any of the following six plan design changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a plan to lose grandfather status:

- Elimination of all or substantially all benefits for a particular medical condition.
- Any increase in the employee's coinsurance percentage.
- A deductible or out-of-pocket maximum increase that exceeds medical inflation plus 15%.
- A copay increase that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation).
- A decrease in the employer contribution towards the cost of coverage by more than 5%.
- Imposition of annual limits on the dollar value of all benefits below specified amounts.

These six changes are the **only** plan design changes that will cause a cessation of grandfather status.

103. How do we know what medical inflation is?

Medical inflation means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor. To calculate medical inflation, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U

(unadjusted) published by the Department of Labor for March 2010) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

The CPI – U values can be found on the Bureau of Labor Statistics website at: https://www.bls.gov/news.release/cpi.t03.htm

Beginning June 15, 2021, group health plans may use an alternative method to determine medical inflation based on the ACA premium adjustment percentage. Under the alternative approach, permitted increases may be determined by reference to the greater of the method described above or the most recently published "premium adjustment percentage" since 2013. HHS publishes the premium adjustment percentage annually when they issue the "benefit and payment parameter" rules. The rate reflects the cumulative growth in premiums for private health insurance.

In addition, increases in cost sharing necessary to maintain high deductible health plan qualified status (to enable HSA contributions) are permitted.

104. Will changing insurers cause a loss of grandfather status?

It depends. If the change in insurers was effective after March 23, 2010 but prior to November 15, 2010, your plan has lost grandfathered status.

If you changed insurers and your new insurance policy was effective on or after November 15, 2010, your plan does not lose grandfathered status unless your new policy includes plan design changes that, when compared to the previous insurance policy, would exceed the allowable changes that generally cause a plan to lose grandfather status (e.g., increase in cost sharing, significant increases in copays, deductibles, etc.).

105. Is there anything we have to provide to the new insurer regarding the benefits and contributions we had under the prior insurer?

Yes. You must provide your new health insurer documentation of the benefits, cost sharing, employer contributions, and annual limits under the prior insurer sufficient to determine whether any plan changes that would cause a loss of grandfathered status have been made.

106. Will changing a self-insured TPA cause our self-insured plan to lose its grandfathered status?

No. Changing third party administrators (TPAs) will not result in the loss of grandfathered status for your self-insured plan.

107. **Our plan is currently insured but we are considering a change to self funding and changing our PPO network. Would these changes cause our plan to lose grandfathered status?**

The guidance we have does not address the effect of changing your plan's funding mechanism from insured to self-insuring or changing networks. Further guidance is necessary on this question, and it may depend on the date you make the changes. What we do know is that changing from self-insuring to insured coverage will not cause a loss of grandfathered status if the new insurance policy is effective on or after November 15, 2010 and no changes are made to the contributions or benefits that would normally cause a loss of grandfathered status. If the change was effective prior to November 15th, the new insurance policy would not be grandfathered.

The agencies responsible for enforcing the rules have invited comments from the public regarding the effect of these types of changes (or any other changes) so we anticipate that further guidance will be forthcoming. However, it appears that any new standards subsequently published in the final regulations that are more restrictive than what was included in the interim final regulations would only apply prospectively to changes to plans made after the publication of final rules.

108. **We are thinking of amending our plan to delete coverage for depression. If we make this change, will it cause our plan to lose its grandfathered status?**

Yes. The elimination of all benefits or substantially all benefits to diagnose or treat a particular condition will cause a loss of grandfathered status.

109. **Our plan currently pays 90% of covered services and the employee pays 10%. We want to reduce our share to 80%. Would that cause the loss of grandfathered status?**

Yes. Any increase in the participant's coinsurance amount will cause the plan to lose grandfathered status.

110. **Our plan currently pays 90% of covered services but we want to reduce that to 50% for durable medical equipment only. Would that cause a loss of grandfathered status?**

Yes. Because it is an increase in the participant's coinsurance amount, it would cause the plan to lose grandfathered status.

111. **Our plan is facing a significant premium increase this year so we want to raise the deductible. What effect will this have on our grandfathered plan status?**

It depends. Employers are permitted to raise plan deductibles (or other fixed cost sharing amounts such as out-of-pocket limits) but your plan would cease to be a grandfathered plan if the increase since 3/23/10 is greater than a percentage equal to medical inflation plus 15%.

112. **Our plan has a $10 office visit copay. We want to raise it to $20. Will this cause our plan to lose grandfathered status?**

Maybe. The increase to your copay will result in a loss of grandfathered status if the increase is more than the greater of:

- $5 (adjusted for medical inflation); or
- A percentage equal to medical inflation plus 15%.

113. **Our grandfathered plan had a $30 office visit copay on March 23, 2010 and we want to raise it to $45 effective June 15, 2021. Will the increase cause our plan to lose grandfathered status?**

The increase to your copay will result in a loss of grandfathered status if the increase is more than the greater of:

- $5 (adjusted for medical inflation); or
- A percentage equal to medical inflation plus 15%; or
- The most recent premium adjustment percentage, plus 15 percentage points.

114. **We want to raise the copay for office visits. Will that one change cause our plan to lose grandfather status?**

Yes. Any copay increase that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation) from March 23, 2010, will cause a plan to lose grandfather status, even if all other copay amounts remain the same.

115. **We want to reduce our employer contribution toward the grandfathered coverage family tier by 20%, will this change cause us to lose grandfathered status?**

Yes. To retain grandfathered plan status, you cannot decrease the percentage of premiums you pay by more than 5 percentage points below your contribution rate on March 23, 2010. This rule applies to any tier of coverage (e.g. self-only, 2 person, family, etc.) for any class of employee. Because the decrease in your

contribution for family coverage would be 30%, your plan would lose grandfathered status.

116. **Does our plan lose grandfathered status for all plan options if only one plan option makes changes to cause the loss of grandfathered status?**

If the changes to the one plan option result in a loss of grandfathered status of that option, only that option will be affected. The remaining options will remain grandfathered for as long as no changes are made to the other options that would result in a loss of grandfathered status of those options

117. **If we implement a new wellness program that includes a smoker surcharge, could that cause our plan to lose its grandfathered status?**

Yes. According to the DOL, adding a surcharge (such as contribution or cost-sharing surcharges) may implicate the grandfather plan rules and should be examined carefully before implementing. For example, if a contribution surcharge decreases the employer's contribution for a plan option by more than 5% for any tier of coverage (single, two-person, family, etc.), then it could cause the loss of grandfather status for that option.

118. **We are going to change the tiers of coverage under our plan from self-only and family to a multi-tiered structure. Will our plan lose grandfathered status?**

The determination of whether the change in employer contribution will cause a loss of grandfathered status is made on a tier-by-tier basis. So, if you change the tier structure from what was in place on March 23, 2010, your contribution for any new tier is tested by comparing it to the contribution rate for the corresponding tier on March 23, 2010. For example, if your contribution rate for family coverage was 50% on March 23, 2010, then your contribution rate for any new tier, other than employee-only, must be within 5% of 50% (or at least 45%). If it is lower than 45%, you would lose grandfathered status.

If, however, your new tier structure only adds a new coverage tier, without eliminating or modifying any other coverage tier, and those individuals eligible under the new tier were not previously covered under the plan, then the new tier would not be compared to those in place on March 23, 2010, and would not cause the plan to lose grandfathered status.

119. **Our grandfathered plan operates on a calendar plan year but we are considering a plan amendment that will cause it to relinquish grandfather**

status. If we decide to make this amendment effective on July 1, 2022, does our plan relinquish grandfather status in the middle of the plan year?

Yes. Your plan will cease to be a grandfathered health plan when the plan amendment becomes effective on July 1, 2022. You would then have to make all the other plan changes that apply to non-grandfathered plans effective concurrent with the change that causes the loss of grandfathered status. If you want to avoid relinquishing grandfathered status in the middle of a plan year, any changes you make that would cause your plan to relinquish grandfather status should be made effective the first day of the next plan year.

120. **We have to make changes due to Mental Health Parity for our next plan year starting on August 1, 2022. Will these changes cause our plan to lose grandfathered status?**

No. Plan changes made to comply with Federal or State legal requirements will not cause a loss of grandfathered status unless the mandated changes exceed the allowable changes established in the grandfathered plan regulations.

121. **If we lose our grandfathered status, what are the other ACA requirements that will apply?**

In addition to the changes required for grandfathered plans, any new plan or any plan that loses its grandfathered status will have to comply with the additional requirements listed below effective for plan years starting on or after September 23, 2010:

- Provide coverage to children to age 26 regardless of whether they are eligible for other employer-sponsored coverage;
- Provide coverage for recommended preventive services, without cost sharing
- For emergency room care:
- No pre-authorization permitted – in or out of network
- Identical coverage in and out of network
- For Primary Care Physician Designations:
  - Participants may designate any available participating primary care provider
  - Parents may select pediatrician for child(ren)
  - May not require authorization or referral for OBGYN care from participating obstetrician or gynecologist
- New claims appeal rules including both internal and external review

- Nondiscrimination rules for fully insured health plans under Code Section 105(h) - On December 22, 2010, it was announced that enforcement of this rule will be delayed until further guidance is issued.

For plan years starting on or after January 1, 2014, new plans or plans that have lost grandfathered status will have to comply with additional requirements including:

- No discrimination against individuals participating in clinical trials;
- No discrimination based on health status;
- Provide essential benefits (small group insured plans only);
- No discrimination against health care providers acting within the scope of their professional license and applicable State law;
- Prohibit out-of-pocket limits in excess of the applicable out-of-pocket limits for qualified high deductible health plans; and
- Prohibit out-of-pocket limits in excess of applicable out-of-pocket limits as determined by HHS for plan years starting on or after January 1, 2015.

Starting in 2022, grandfathered plans that become non-grandfathered must comply with the ACA requirement to post machine-readable files on a public website of the plan. The files include in-network negotiated rates, out-of-network allowed amounts, and prescription drug costs and must be updated monthly. There are specific format requirements as well. Group health plans may contract with the insurer or TPA to perform this task; however, self-insured plans remain liable upon the TPA's failure to comply. Later guidance permits the files to be posted on the insurer or TPA's website if the plan itself does not have a public website.

Beginning in 2023 and into 2024, grandfathered plans that lose grandfathered status must make a self-service, internet based tool where participants may make price comparisons on 1) the first defined 500 services by the beginning of the plan year in 2023, and 2) all covered items and services by the beginning of the plan year in 2024. Group health plans may contract with the insurer or TPA to comply with this task, but self-insured plans remain liable if the TPA fails to comply.

122. We intend to keep our plan grandfathered as long as possible. Is there anything we have to do to verify we have not made any changes that would result in the loss of grandfathered status?

Yes. You will be required to maintain records of your plan's grandfathered status for as long as the plan takes the position that it is grandfathered. This means you

must maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify your plan's status as a grandfathered health plan. This should include intervening and current plan documents, health insurance policies, certificates, or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates.

In addition, you must make these records available for inspection to participants or State or Federal agencies upon request.

123. Will we have to tell our employees about our plan's grandfathered status?

Yes. To maintain status as a grandfathered plan, you must disclose, in any plan materials provided to participants, that your plan believes it is a grandfathered plan under ACA. This includes SPDs, open enrollment materials, or materials provided upon opportunities to enroll in, renew or change coverage. The disclosure must also provide contact information for questions and complaints. The following model language can be used to satisfy the grandfathered plan disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply, and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.]

Dependents to Age 26

124. Do we have to offer coverage to adult children even if the "child" already has coverage through their own employer's plan?

If your plan is non-grandfathered, you are not able to deny coverage to adult children even if they have coverage through their own or any other employer's plan.

Before 2014, you must provide coverage to dependent children until they turn 26, unless they are eligible to enroll for any other employer provided coverage that is not a group health plan of a parent. This could include coverage through their own employer's plan or through a spouse's employer's plan.

While it is not entirely clear from the guidance we have, it appears that the child is not treated as eligible for other coverage until the first date the individual can actually enroll and be covered under the plan. For example, if the child is eligible for other coverage but cannot be enrolled due to plan restrictions, they probably remain eligible under the parent's plan until such time they can actually enroll in the other plan. Also, coverage cannot be denied under the parent's plan if the child is only eligible to enroll for COBRA coverage under their former employer or spouse's former employer's plan.

Starting in 2014 and later, coverage under all plans must be available regardless of whether the child has any other coverage (but COB rules may still apply).

125. Our plan covers stepchildren and in some cases grandchildren if they meet specific criteria. Will we now have to cover them to age 26 as well?

The DOL issued "safe harbor" guidance that says plans that cover the following categories of children to age 26 will be in compliance with this requirement:

- Biological children (sons, daughters);
- Stepchildren;
- Adopted children (including children placed for adoption); and
- Foster children who are placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Coverage can be discontinued for children in any of the above categories prior to age 26 if the applicable relationship no longer exists. For an individual who is not in one of the four categories, such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

126. Can I charge more for these adult children?

In most cases, no. The employee cannot be required to pay more for a child's coverage based on their age (e.g. adding a surcharge for children over age 18 or over age 23). However, an additional surcharge for adult children could be applied if that surcharge is applied for every new child added to the plan regardless of age.

127. Can I offer a more limited benefit to these adult children?

No. The benefits or coverage cannot vary based on the child's age. It must be identical to the coverage that is provided to similarly situated children who are not adult children.

128. If the adult child is married, are they still allowed to have the coverage?

Yes. Eligibility for coverage of children up to age 26 cannot be based on factors such as financial dependence, student status, residence, or marital status.

129. Do I have to cover the spouse or child (the grandchild of the employee) of the adult child too?

No. Plans that provide dependent coverage are only required to provide coverage to the employee's children (e.g. biological or adopted children) until the age of 26. The plan is not required to provide coverage to the employee's son-in-law or daughter-in-law or grandchildren.

130. We have an employee whose child is 25 but is not a full time student, does this mean we will have to calculate imputed income for that employee?

Not for federal tax purposes. The definition of a tax dependent in the Internal Revenue Code for group health plan purposes was amended as part of the health care reform package to include children until the end of the year they turn age 26. This change will also apply to children to age 26 who are covered under a plan that currently extends coverage to children to age 26 (or older).

The IRS issued Notice 2010-38 that offers guidance on the tax exclusion for these adult children. It clarifies several items including:

- Child is defined as son/daughter, stepson/daughter, adopted child or eligible foster child, without regard to whether the child is financially supported by the employee or resides with the employee or is a full time student
- Coverage for these adult children can be paid for on a pretax basis under a Section 125 cafeteria plan

- The change in status regulations will be amended so that employees can add coverage under a Section 125 plan for a newly eligible adult child where the plan has been amended mid-year to add the adult child coverage.

131. Does the same change apply for state tax purposes?

In many cases, states have adopted the federal definition of gross income so that whatever is included (or not included) in income for federal purposes also applies at the state level. However, there were some states (e.g. California) where this was not the case and coverage for adult children was still taxable. Fortunately, all the states that were nonconforming with the federal rules have now either passed resolutions or legislation conforming to the state tax treatment of adult dependent coverage with the federal tax treatment of adult dependent coverage.

Preexisting Condition Exclusions

132. May a plan exclude coverage for services that are the result of an injury that occurred before the effective date of the employee's coverage?

No. As described, this provision is a preexisting condition exclusion. For plan years beginning on or after September 23, 2010, the provision cannot be applied to enrollees under age 19, and for plan years beginning in 2014, all preexisting condition exclusions must be eliminated.

Lifetime and Annual Maximums

133. We have two plan options. One has a $1 million lifetime maximum and the other has a $2 million lifetime maximum. How will these maximums be affected?

Effective with your first plan year starting on or after September 23, 2010, lifetime maximums that apply to essential health benefits (EHBs) will have to be eliminated regardless of whether or not your plan is grandfathered.

134. Our plan is self-insured. How do we know what benefits are "essential health benefits"?

The Act defines essential health benefits (EHBs) to include the following categories of coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization

- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (services for individuals under 19 years of age)

Final regulations state that a self-insured plan would be in compliance if it used one of the following choices as a benchmark plan, reflecting the scope of essential health benefits offered by a typical employer plan and supplemented as needed to ensure coverage of all ten statutory categories:

- Any EHB benchmark plan that has been selected, whether by active State selection or by default, to be the EHB benchmark plan for a State, including coverage of any additional required state-mandated benefits; or
- Any of the three plan options that are the current base-benchmark plan options under the Federal Employees Health Benefit Program (FEHBP), supplemented, as necessary, to include coverage of any additional required state-mandated benefits.

135. Can we still keep our lifetime limit for benefits that are not considered EHBs?

Yes. Lifetime limits on benefits that are deemed not to be essential health benefits are permitted.

136. Does the prohibition on annual and lifetime dollar limits apply to expenses incurred out-of-network?

Yes. There is no exception for out-of-network benefits.

137. Our plan has an annual maximum of $10,000 for chiropractic care. Do we have to remove the limit?

Until HHS has provided more guidance on the specifics of what is an EHB and whether chiropractic care would fall under one of the categories of EHBs, it's not possible to answer this question. Until these regulations are issued, the agencies enforcing ACA have said they will take into account good faith efforts to comply with a reasonable interpretation of the term EHBs.

An alternative to having annual dollar maximums might be to replace them with day or visit limits, which are not limited or restricted for chiropractic care at this time.

138. **We offer our employees a high deductible health plan combined with a Health Reimbursement Arrangement (HRA). We contribute $1,000 annually to each employee's HRA. Does the elimination of annual limits mean we have to change our HRA?**

No. When HRAs are integrated with other coverage under a group health plan (e.g. with a high deductible major medical plan) and the employee is enrolled in both, the fact that the benefits are limited under the HRA does not cause it to violate ACA if the major medical coverage is in compliance with all the applicable health insurance reform provisions.

An HRA is integrated with a group health plan coverage that provides minimum value only if ALL the following conditions are met:

- The HRA is available only to employees who are actually enrolled in the non-HRA group health plan coverage (e.g., a major medical plan);
- Any employee receiving the HRA is actually enrolled in a group health plan that provides minimum value;
- Under the terms of the HRA, an employee (or former employee) may permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt-out of and waive future reimbursements from the HRA.

If an HRA is integrated with coverage that does not meet minimum value, then the same requirements described above apply but the HRA must be limited to reimbursement of only one or more of the following: copays; co-insurance; deductibles; and premiums under the non-HRA coverage, as well as medical care (as defined under Code Section 213(d)) that does not constitute essential health benefits.

139. **If we offer our employees an HRA that allows them to purchase coverage on the individual market, will the HRA be integrated with that individual market coverage and therefore satisfy the annual limit and/or preventive care requirements?**

Beginning in 2014 through December 31, 2019, an employer-sponsored HRA plan cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore it would

violate the prohibition on annual dollar limits and the requirement to provide certain preventive services at 100%.

Starting January 1, 2020, individual coverage HRAs (ICHRAs) may be offered that reimburse employees for the cost of individual market coverage if certain requirements are met.

140. If we offer to reimburse our employees for individual or Marketplace coverage premiums, will that arrangement satisfy the annual limit requirements?

Not entirely. Your reimbursements cannot be integrated with individual market coverage, unless you provide an ICHRA. Otherwise, reimbursing premiums would violate the prohibition on annual dollar limits because it would impose an annual dollar limit up to the cost of the individual market coverage. See FAQ 140.

Rescissions

141. ACA prohibits “rescissions”. What does this mean and how will it affect our plan?

Rescissions are defined as a cancellation of coverage that has a retroactive effect. Rescissions are prohibited unless the termination is due to fraud, or an intentional misrepresentation of a material fact, and are permitted by the written terms of the plan. Therefore, effective for plan years starting on or after September 23, 2010, your group health plan will not be permitted to terminate coverage retroactively under any circumstances unless the employee performs an act of fraud, or the employee intentionally misrepresents a material fact and the plan has been drafted or amended to provide that such misrepresentations will result in a termination of coverage.

Retroactive cancellation of coverage due to a failure to pay timely premiums is not considered a rescission.

142. We have several locations and sometimes we are not immediately notified by supervisors or managers when an employee loses eligibility for plan coverage when they are reassigned to a part time position. We can still terminate coverage retroactively in those cases, right?

Yes, as long as you did not continue withholding contributions from the employee’s paycheck and paying claims. If you continued to withhold contributions and provide coverage, then the coverage can only be terminated prospectively.

Example. Joe has coverage under the plan as a full-time employee. The employer reassigns Joe to a part-time position and Joe is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from Joe's paycheck and paying claims submitted by Joe. After a routine audit, the plan discovers that Joe is no longer eligible. The plan rescinds Joe's coverage effective as of the date he changed from a full-time employee to a part-time employee.

Conclusion. The plan cannot rescind Joe's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may only cancel coverage for Joe prospectively.

143. We only reconcile our bill or data feed for eligible employees and dependents once a month. Can we still retroactively terminate employees and dependents off our coverage on that reconciliation back to the end of the previous month?

If you cover only active employees and families (and COBRA participants) and the individual who is no longer eligible for coverage pays no premiums for coverage after the termination (subject to COBRA), then it will not be considered a rescission, but rather a retroactive elimination of coverage back to the date of termination, due to delay in administrative recordkeeping.

144. What if we have an employee who notifies us of his final divorce from his spouse. Are we allowed to terminate the coverage of the spouse retroactively to the date of the divorce?

If your plan does not cover ex-spouses (other than under COBRA) and the COBRA premium is not paid by the employee or ex-spouse, then you are allowed to retroactively terminate coverage back to the date of divorce without it being an improper rescission. Of course, COBRA may require coverage to be offered for up to 36 months, if the COBRA premium is paid.

Patient Protections

145. What are the special rules that will apply to our HMO option regarding the choice of primary care physicians (PCP)?

The new rules on PCPs are effective for plan years starting on or after September 23, 2010 but only apply to non-grandfathered plans. If your HMO option is not grandfathered, you must allow participants or beneficiaries to elect a PCP including:

- Designating any participating primary care physician who is available to accept the individual; and
- Designating any participating physician who specializes in pediatrics who is available as a child's PCP.

Beginning January 1, 2022, under the Consolidated Appropriations Act, 2021 (CAA, 2021) all group health plans, including grandfathered plans, must permit each participant, beneficiary, or enrollee to designate any available participating primary care provider.

146. We read that HMOs cannot require females to get authorization for OB/GYN services. How does that work?

This new rule applies only to non-grandfathered plans. If your HMO option is not grandfathered, it cannot require an authorization or a referral from the HMO or a PCP for a female seeking OB/GYN services from a participating health care professional (i.e. physician, physician assistant, midwife, etc.) who specializes in OB/GYN care.

Beginning January 1, 2022, under the CAA, 2021, all group health plans, including grandfathered plans can no longer require preauthorization for a female participant or beneficiary who seeks OB/GYN care.

147. Do we have to notify the employees enrolled in or enrolling in the HMO of these new rules?

Yes. If your non-grandfathered HMO plan requires the designation of a PCP, you must provide a notice informing each employee of the following:

- The plan requirements for electing a PCP;
- That any participating primary care physician who is available to accept the participant can be designated as a PCP;
- That any participating physician who specializes in pediatrics can be designated as a PCP for a child;
- The plan may not require authorization or referral for OB/GYN services provided by a participating professional who specializes in OB/GYN care.

This notice must be included in the plan's SPD or any other similar description of the benefits under the plan. The DOL has issued a model notice for this purpose, which can be downloaded in Word format from their website at: http://www.dol.gov/ebsa/healthreform/

Beginning January 1, 2022, all group health plans (grandfathered and non-grandfathered) that require designation of a primary care provider must provide a

notice to each plan participant describing the plan's requirements regarding designation of a primary care provider and certain other rights of the participant or beneficiary.

148. There are new rules for emergency room services. How will they affect our plan?

For all plans, regardless of grandfathered status, starting with plan years beginning on or after January 1, 2022, similar but expanded emergency room protections will apply through the No Surprises Act's surprise billing provisions.

In general, the NSA prohibits "surprise" balance billing for emergency medical treatment provided by an out-of-network provider, care provided by an out-of-network provider while the patient is in an in-network facility, and air ambulance services from an out-of-network provider. Balance billing is the practice of billing a patient for the difference between (1) an out-of-network provider's billed charges and (2) the amount paid by the plan or insurer plus the individual's cost-sharing obligation (e.g., deductible, copay, or coinsurance).

If a group health plan provides benefits for "emergency services," the plan must cover the services subject to a number of conditions, as described below Emergency services include both of the following—

- Initial services. A medical screening examination within the capability of a hospital emergency department or freestanding independent emergency department, including ancillary services routinely available in the emergency department, to determine whether an "emergency medical condition" exists.
- Post-stabilization services. Additional services covered under the plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after a participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the initial services were provided.

An emergency medical condition is a medical condition, including a mental health condition or substance use disorder, manifesting itself through acute symptoms of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the individual's health in serious jeopardy, impair bodily functions, or result in serious dysfunction of bodily organ or part.

- The plan cannot impose prior authorization, even if provided out-of-network.
- The services must be covered without regard to whether the provider of services is a "participating provider" (i.e., without regard to whether the

provider is in-network or otherwise has a contractual relationship with the plan or a participating emergency facility).

- If the services are provided by a "nonparticipating provider" (i.e., the services are provided out-of-network, meaning by a provider that does not have a contractual relationship with the plan) or a nonparticipating emergency facility, then the following apply:
  - The plan may not impose any administrative requirement or coverage limitation that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities.
  - The plan must count any cost-sharing payments toward any in-network deductible or out-of-pocket maximums under the plan, and the in-network deductible or out-of-pocket maximums must be applied in the same manner as if the participant's cost-sharing payments were made for services by a participating provider or facility.
  - The participant's cost-sharing may not be greater than the cost-sharing that would apply if the services were provided by a participating provider or participating emergency facility;
  - The participant's cost-sharing must be calculated as if the total amount charged for such services is equal to the "recognized amount."

See our Surprise Billing Toolkit for more information. The legislation has been the subject of numerous lawsuits that have impacted the negotiation and independent resolution (IDR) process that takes place between the provider and the plan sponsor (typically, through the plan's insurer and TPA) and outlines the process through which the IDR entity selects the appropriate amount of the provider's payment from the plan.

149. Do the out-of-network emergency room minimum payment guidelines for non-grandfathered plans apply if our state has a law prohibiting balance billing?

No. The minimum payment standards do not apply to plan years beginning before January 1, 2022 in cases where State law prohibits a participant or beneficiary from being required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer provides in benefits.

In such cases, the group health plan must provide participants with adequate and prominent notice of their lack of financial responsibility with respect to the balance-billed amounts to prevent inadvertent payment by the participant.

For plan years beginning on or after 1/1/22, the No Surprises Act provides balance billing protections for certain emergency and non-emergency services, and air ambulance services provided by non-network providers.

Preventive Care

150. Our plan currently provides coverage for preventive services but we apply copays and deductibles to those services. I've heard we will have to eliminate these cost-sharing provisions. Is that true?

The Act does require new plans to provide first dollar coverage to certain specified preventive services and immunizations for plan years beginning on or after September 23, 2010, but this requirement does not apply to grandfathered plans.

Updated: 7/1/25

151. We may have one plan option that is not grandfathered. What are the preventive services that the plan will have to cover without cost-sharing?

- Evidence-based items or services that have a rating of A or B in the current recommendations of the USPSTF;
- Immunizations for routine use in children, adolescents, and adults as recommended by the ACIP of the Centers for Disease Control;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA; and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

A list of the required services can be found on the HHS website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1

The Supreme Court ruled that the USPSTF was properly appointed, thus upholding the task force's preventive care recommendations since passage of the ACA. Non-grandfathered plans must continue to follow their recommendations in accordance with the ACA preventive care mandate.

152. Does the list of women's evidence-informed preventive care and screenings include coverage for contraception?

Yes. Beginning with plan years starting on or after August 1, 2012, non-grandfathered plans will have to provide coverage with no cost-sharing for all FDA approved contraceptive methods, sterilization procedures, and contraceptive education and counseling for all women with reproductive capacity.

The full list of covered women's preventive services can be found on the HHS website here: http://www.hrsa.gov/womensguidelines\.

153. We are a church that believes contraception is contrary to our religious tenets, so we do not currently cover them. Will we have to change our plan to add coverage for contraceptives?

No. Group health plans sponsored by religious employers, and group health insurance coverage provided in connection with such plans, are exempt from the requirement to cover contraceptive services.

A religious employer is defined as an employer that organized and operated as a non-profit entity and is referred to in Section 6033(a)(3)(A)(i) or Section 6033(a)(3)(A)(iii) of the Internal Revenue Code of 1986, as amended. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order.

154. Are there any exemptions for employers with religious objections to providing some or all contraceptives in their plans?

Yes. Final regulations issued on November 15, 2018 provide that the following entities are not required to provide contraceptive coverage if they object to providing or arranging coverage for some or all contraceptive services, based on its sincerely held religious beliefs:

- A church, an integrated auxiliary of a church, a convention or association of churches, or a religious order;
- A nonprofit organization;
- A closely-held, for-profit entity;
- A for-profit entity that is not closely held;
- Any other non-governmental employer; or
- An institution of higher education in its arrangement of student health insurance coverage.

Previously, certain employers were required to engage in a process for arranging contraceptive coverage for covered individuals outside the employer's plan. The November 2018 regulations made this process optional for any of the above employers that object to providing or arranging coverage for some or all contraceptive services, based on its sincerely held religious beliefs.

155. We have a moral (but not religious-based) objection to providing contraceptive coverage. Is there an exemption for us?

Regulations issued on November 15, 2018 provide that the following entities are not required to provide contraceptive coverage if they object to providing or arranging coverage for some or all contraceptive services, based on its sincerely held moral convictions:

- A nonprofit organization;
- A for-profit entity that has no publicly traded ownership interests (for this purpose, a publicly traded ownership interest is any class of common equity securities required to be registered under the Securities Marketplace Act of 1934); or
- An institution of higher education in its arrangement of student health insurance coverage.

Previously, certain employers were required to engage in a process for arranging contraceptive coverage for covered individuals outside the employer's plan. The November 2018 regulations made this process optional for such employers that object to providing or arranging coverage for some or all contraceptive services, based on its sincerely held moral convictions.

In January 2023, newly proposed regulations were issued which would eliminate the moral exemption, but those regulations were pulled back and left unfinalized.

156. We are a religiously affiliated, non-profit organization that believes providing a self-certification to our carrier or TPA makes us complicit in providing contraception. Prior to the November 2018 regulations, were we required to provide the self-certification to our carrier or TPA?

No. In a decision issued on July 3, 2014, the U.S. Supreme Court ruled that a religiously affiliated non-profit college was not required to provide the self-certification to their TPA or carrier. Instead, they only needed to provide a letter to HHS declaring their religious objection to the contraceptive mandate in order to avoid being penalized for not providing contraception coverage. In response to the Supreme Court decision, regulations have been issued allowing you to notify HHS of your objection to providing coverage for some or all contraceptive instead of providing it to the TPA or carrier.

The notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on sincerely held religious beliefs to covering some or all contraceptive services, as applicable (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (that is, whether it is a student health insurance plan or a church plan); and the name and contact information for any of the plan's TPAs and health insurance carriers.

A model notice for informing HHS of your objection to providing contraceptive coverage is available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Model-Notice-8-22-14.pdf

After you have notified HHS of your objection, the Department of Labor or the Department of Health and Human Services will send a separate notification to your plan's carrier or TPA informing them that HHS has received your notice and describing the obligations of the carrier or TPA to provide or arrange separate contraceptive coverage for plan participants and beneficiaries without imposing cost-sharing requirements.

In November of 2018, new regulations were implemented that makes the notice to HHS described above optional for plan sponsors that have a religious objection to contraceptive coverage, including religiously affiliated organizations such as schools, hospitals, and charities.

157. If we decide to send a notice to HHS describing our objection to providing contraceptive coverage, where do we send the notice?

The notice to HHS, and any subsequent updates, should be sent electronically to: marketreform@cms.hhs.gov, or by regular mail to:

Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW, Room 739H
Washington, D.C, 20201

158. If we decide to send the self-certification to our TPA, are they required to provide or arrange for contraception coverage for our participants or beneficiaries?

No. The TPA is under no obligation to provide or arrange the contraceptive coverage, but if they refuse to provide contraceptive coverage, they are prohibited from entering into or remaining contracted with you or your plan to provide administrative services.

159. How is a closely held corporation defined for purposes of this exemption?

A closely held for-profit entity entitled to the accommodation is an entity that --

- The organization's highest governing body (such as its board of directors, board of trustees, or owners, if managed directly by its owners) has adopted a resolution or similar action, under the organization's applicable rules of governance and consistent with state law, establishing that it objects to covering some or all of the contraceptive services on account of the owner's sincerely held religious beliefs;
- Is not a nonprofit entity;
- Has no publicly traded ownership interests, (for this purpose, a publicly traded ownership interest is any class of common equity securities required to be registered under Section 12 of the Securities Marketplace Act of 1934); and
- Has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals or has an ownership structure that is substantially similar thereto, as of the date of the entity's self-certification to their TPA or carrier or notice to HHS.

The organization must make its self-certification or notice available for examination upon request by the first day of the first plan year to which the accommodation applies. The self-certification or notice must be executed by a person authorized to make the certification or notice on behalf of the organization and must be maintained in a manner consistent with the record retention requirements under Section 107 of ERISA.

160. What if we are unsure of our status as a closely held corporation meeting that definition?

If you need further information regarding whether you qualify for the accommodation, you may send a letter describing your ownership structure to the Department of Health and Human Services. If you do not receive a response from the Department of Health and Human Services to a properly submitted letter describing your current ownership structure within 60 calendar days, for as long as you maintain that structure, you will be considered to meet the requirements for the accommodation.

161. If we have to cover contraceptives, can we cover only oral contraceptives?

No. The guidelines require you to cover without cost sharing at least one form of contraception in each of the methods that the FDA has identified for women including, but not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health

care provider. However, your plan is permitted to use reasonable medical management techniques to control costs and promote efficient delivery of preventive services.

162. Can we cover only the generic versions of prescribed contraceptive drugs or impose cost-sharing on brand name drugs?

You may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. To use this approach, your plan must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version.

Also, if a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then your plan or must provide coverage for the brand name drug without cost-sharing (but also subject to reasonable medical management).

163. Do we have to cover over-the-counter contraceptives?

Contraceptive methods that are generally available OTC must be covered only if they are an FDA-approved method and they are prescribed by a health care provider.

164. Is our non-grandfathered plan required to cover without cost sharing recommended women's preventive services for dependent children, including recommended preventive services related to pregnancy, such as contraceptives, preconception and prenatal care?

Yes. Non-grandfathered health plans must cover specified recommended preventive care services without cost sharing for all participants and beneficiaries under a group health plan. Thus, if a non-grandfathered health plan provides coverage for dependent children, it must also provide contraceptives, preconception and prenatal care for dependent children.

165. Do we have to cover contraceptives for men?

The general preventive care rules defined by the USPSTF include certain services for men, but this does not include male contraception or sterilization. However, the 2021 HRSA guidelines have expanded to include contraceptives that are not female-controlled, such as male condoms, but it does not include male sterilization.

166. Can our non-grandfathered health plan limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity, or recorded gender?

No. The individual's attending provider will determine whether a sex-specific recommended preventive service is medically appropriate for that individual. If an attending provider determines that a recommended preventive service is medically appropriate for an individual (e.g., a mammogram for a transgender male that has residual breast tissue) and the individual otherwise meets the criteria in the applicable recommendation or guideline, then your non-grandfathered health plan must provide coverage without cost sharing for that service.

167. Does our non-grandfathered option have to provide 100% coverage for both in-network and out-of-network services on the list?

No. You are only required to eliminate cost-sharing provisions on in-network providers. You are permitted to impose cost-sharing on covered preventive services that are delivered by out-of-network providers.

If your plan does not have in its network a provider who can provide a particular preventive service, then your plan must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.

168. Our non-grandfathered option has a limit on well-baby visits per year. Can we keep that or other limits on the applicable preventive services?

Yes. Nothing in the regulations prevents you from using reasonable methods to determine the frequency, method, treatment, or setting for an item or service on the list as long as it doesn't conflict with specific recommendations in the guidelines. Reasonable medical management techniques may generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review or similar practices.

169. Is our plan permitted to impose cost-sharing for treatments arising from preventive services?

Yes. Your plan may apply cost sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service (subject to any applicable state laws).

170. If a colonoscopy is scheduled and performed as a screening procedure, may we impose cost-sharing for the cost of a polyp removal during the colonoscopy?

No. Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is considered an integral part of a colonoscopy. Accordingly, your plan may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. In addition, the plan may not impose cost sharing with respect to anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that the anesthesia would be medically appropriate for the individual.

In addition, a plan cannot impose cost sharing for the bowel preparation medications prescribed for a colonoscopy performed as a screening procedure.

New guidance issued in 2022 requires non-grandfathered plans to cover without cost-sharing follow-up colonoscopies conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for adults aged 45 to 49. This coverage must be available for plan years beginning on or after May 31, 2022.

171. What if an employee goes to their doctor for an office visit but also gets one of the recommended preventive services at the same time. Can we still apply a copay to the office visit charge?

It will depend on the situation:

- If a preventive service is billed separately from the office visit and the primary purpose of the visit is not for preventive purposes, then you may impose cost-sharing requirements with respect to the office visit.
- If a preventive service is not billed separately from the office visit and the primary purpose of the office visit is for preventive services, then you may not impose cost-sharing requirements with respect to the office visit.
- If a preventive service is not billed separate from the office visit and the primary purpose of the office visit is not for preventive purposes, then you may impose cost-sharing requirements with respect to the office visit.

172. Some of the recommended preventive services include things like aspirin or other over-the-counter medications. Is our plan required to cover those items?

Aspirin and other over-the-counter recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.

173. The list of required preventive services requires us to cover tobacco-use counseling and provide tobacco cessation interventions. For employees who use tobacco products, what services are we expected to provide as preventive coverage?

You may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service (to the extent not specified in the recommendation or guideline). So, you would be in compliance if, for example, your plan covers without cost-sharing and without requiring individuals to get prior authorization:

- Screening for tobacco use; and,
- For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
  - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and
  - All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider.

174. What happens when there are changes to the recommendations or guidelines for covered preventive services?

If something new is added to the recommendations or guidelines, your plan will not have to cover it until the plan year that begins on or after one year after the date the recommendation or guideline is issued.

If a recommendation or guideline is eliminated after the start of your plan year, your plan is only required to provide that coverage through the last day of the plan year. However, if a preventive care recommendation or guideline is downgraded to a “D” rating, or any item or service associated with any recommendation or guideline is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency, there is no

requirement to cover these items and services through the last day of the plan year.

175. Our non-grandfathered group health plan excludes weight management services for adult obesity. Is this still permissible?

No. Non-grandfathered plans must cover, without cost sharing, screening for obesity in adults. In addition, for adult patients with a body mass index (BMI) of 30 or higher, the preventive care recommendations include intensive, multicomponent behavioral interventions for weight management. The recommendation specifies that intensive, multicomponent behavioral interventions include, for example, the following:

- Group and individual sessions of high intensity (12 to 26 sessions in a year),
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes.

Internal Claim and Appeal Process and External Review

176. What are the ACA claims and appeals processes and how do they apply?

Starting with the first plan year beginning on or after September 23, 2010, non-grandfathered fully insured and self-insured plans must implement expanded claims and appeal procedures and an external review process. Beginning in 2022, the external review process also applies to grandfathered plans but only for adverse benefit determinations subject to the No Surprises Act surprise billing protections (generally, out-of-network emergency claims, non-emergency claims at a network facility provided by an out-of-network provider, and air ambulance services).

177. Does a governmental plan that is not subject to ERISA and does not follow the current ERISA guidelines have to comply with the expanded internal claim and appeal process?

Yes, if the group health plan is non-grandfathered. Because ACA applies to all group health plans, you would have to incorporate the current ERISA claims and appeals processes as updated by ACA for your plan.

This same rule will apply for church plans that are not currently subject to the ERISA claims and appeals process.

Beginning in 2022, the external review process also applies to grandfathered plans but only for adverse benefit determinations subject to the No Surprises Act surprise billing protections (generally, out-of-network emergency claims, non-emergency claims at a network facility provided by an out-of-network provider, and air ambulance services).

178. What changes did ACA make to ERISA's current claims and appeals rules?

The changes that have been made are:

- An adverse benefit determination now includes any rescission of coverage;
- The plan must provide, free of charge, any new or additional evidence or rationale used by the plan in connection with the claim determination. This evidence must be provided in advance to give the participant a reasonable opportunity to respond prior to the review date;
- The plan must ensure that all claims and appeals are reviewed in a manner designed to ensure the independence and impartiality of the persons involved in making the decision;
- The plan must provide notices of adverse benefit determinations to enrollees in a culturally and linguistically appropriate manner;
- Additional content requirements apply for notices to claimants identifying the claim involved, including, for example, the denial code, a description of the plan's available internal appeals and external review processes, and contact information for any office of health insurance consumer assistance;
- The regulations emphasize completely following a full and fair process of review. Accordingly, failure to strictly adhere to the review requirements (except for errors that are minor and are non-prejudicial and attributable to good cause outside the plan's control) will allow the participant to initiate an external review and pursue any available remedies under applicable law, such as judicial review.

On September 20th, 2010 the DOL announced a delay in enforcement of #4, #5 and #6 above until July 1, 2011, for group health plans that are working in good faith to implement the new standards.

On March 18, 2011, the DOL announced a further delay in enforcement of #4 and #6 until the first day of the first plan year starting on or after January 1, 2012. For the requirements of #5 (e.g. denial codes, description of the plan's internal appeals and external review process, disclosure of the availability of an office of consumer assistance) the effective date has been changed from July 1, 2011 to the first day of the first plan year starting on or after July 1, 2011.

Note: Requirements in the interim final regulations including making urgent care claim determinations within 24 hours, providing diagnosis and treatments codes in all adverse determination notices, providing adverse benefit determinations in a culturally and linguistically appropriate manner, and requiring strict adherence to the internal appeals and external review process were dropped or significantly modified on June 24, 2011.

179. Are we required to include diagnosis and treatment codes in our adverse benefit determination notices?

No. However, plans are required to provide notification to claimants of their right to request the inclusion of diagnosis and treatment codes (and their meaning) in all adverse benefit determination notices.

180. What must our plan do to ensure our adverse benefit determination notices are provided in a culturally and linguistically appropriate manner?

If you have employees living in a county where 10% or more of the population residing in that county are literate only in the same non-English language, your plan must:

- Provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language;
- Include in any adverse benefit determination notice a one-sentence statement in the non-English language describing the plan's language assistance services; and
- Provide a translation of adverse determination notices upon request.

Information on all counties meeting the 10% threshold will be made available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html.

181. How does the external review process apply to my plan?

Your plan must comply with either a State external review process or a new Federal external review process.

If your plan is insured, a State external review process will apply if the State has a process that complies with minimum standards established under ACA. If no process exists or the State process does not meet the minimum standards, then the Federal external review process will apply.

For self-insured plans, the Federal process will apply in most cases. However, the State process will apply to self-insured plans in states where the state's own external review process is binding on plans such as MEWAs or plans that are not subject to ERISA such as church and governmental plans.

Beginning in 2022, the external review process also applies to grandfathered plans but only for adverse benefit determinations subject to the No Surprises Act surprise billing protections (generally, out-of-network emergency claims, non-emergency claims at a network facility provided by an out-of-network provider, and air ambulance services).

182. How do the Federal external review process work?

Self-insured ERISA plans may choose to participate in the Federal external review process administered by HHS through an agreement with Maximus (a federal contractor) or engage in the private accredited IRO process for plans subject to ERISA and/or the Code (see below). Alternatively, self-insured ERISA plans can voluntarily comply with a state external review process if it's made available.

All insured plans and all self-insured nonfederal governmental health plans in States whose external review processes are found not to meet NAIC guidelines must also participate in a Federally administered external review process. Plans and issuers may choose to participate in the Federal external review process administered by HHS through an agreement with Maximus (a federal contractor) or engage in the private accredited IRO process for plans subject to ERISA and/or the Code.

183. Do we have to hire an independent review organization (IRO) to handle our external review process until the federal process is available?

Yes, in most cases; however, insurers and TPAs typically provide access to the necessary IROs to handle the external review process.

Under the safe harbor, a plan would have to contract with at least two IROs by January 1, 2012 and three IROs by July 1, 2012 that are accredited by URAC for assignments under the plan and then you must randomly rotate claims assignments among the IROs. In addition, each IRO contract will have specific provisions to ensure their compliance with the external review process. A list of the required contract provisions can be found in DOL Technical Release 2010-01 at the DOL website here: http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

184. Is there any alternative to hiring three IROs for our self-insured plan?

Maybe. Because the safe harbor is just a guideline, plans that do not strictly comply with all the standards set forth in the technical release will be subject to a facts and circumstances analysis. Thus, a plan that does not satisfy all of the standards of the technical release's safe harbor may in some circumstances nonetheless be considered to be in compliance with the guidance.

For example, one of the standards set forth in the technical release requires self-insured plans to contract with independent review organizations (IROs) and to rotate claims assignments among them (or to incorporate other independent, unbiased methods for selection of IROs, such as random selection). However, a self-insured group health plan's failure to contract with at least two (or three) IROs does not mean that the plan has automatically violated the safe harbor. Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.

Another alternative is that you may choose to voluntarily comply with the provisions of that State external review process if the State chooses to expand access to their State external review process to self-insured plans.

185. Our plan is a self-insured nonfederal governmental plan. What's the process for participating in the Federally administered external review process administered by HHS?

For elections made prior to June 15, 2015, you must submit the following information regarding your election of a Federal external review process to HHS via email at ExternalAppeals@cms.hhs.gov by the earlier of January 1, 2012 or the date by which your plans intended to use the Federal external review process:

- Contact information for the plan administrator, including name, mailing address, telephone number, facsimile number, and electronic mail address.
- A statement as to whether you will be complying with the HHS-administered process or the private accredited IRO process.

You must also notify HHS as soon as possible if any of the above information changes at any time after it is first submitted.

For elections made on or after June 15, 2015, you must submit information regarding your election of a Federal external review process to HHS via their Health Information Oversight System (HIOS) by the date on which you intend to begin using the Federal external review process.

186. How do we use the HIOS system to elect Federal external review?

HHS has posted instructions on using HIOS to make an election to use a Federal external review process at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/HHS-SRG-on-HIOS-elections_-FINAL.pdf.

187. Does the external review process apply to all adverse benefit determinations?

For plans subject to a state external review process (e.g. an insured plan), the state will determine the scope of claims subject to that state's external review process.

For self-insured plans subject to the federal external review process, the external review process only applies to claims that involve:

- Medical judgment (e.g. experimental, medical necessity) as determined by the external reviewer; or
- Rescission of coverage.

The enforcing agencies have reserved the right to expand the scope of claims eligible for external review starting in 2014, but they indicated they will give sufficient advance notice to enable plans to comply if any new rules are issued at that time.

For plan years that begin on or after January 1, 2022, the external review process is also available to any adverse benefit determination that relates to a surprise medical bill or surprise air ambulance bill that is subject to the No Surprises Act protections (i.e., surprise bills arising out of out-of-network emergency care, non-emergency care provided at a network facility by an out-of-network provider, and out-of-network air ambulance services).

188. Are there any model notices we can use to develop our self-insured plan's adverse benefit determination notices?

Yes. The following model notices are available at the DOL website:

- Model Notice of Adverse Benefit Determination
- Model Notice of Final Internal Adverse Benefit Determination
- Model Notice of Final External Review Decision

Updated model notices can be downloaded from the DOL website at: Internal Claims and Appeals and External Review | U.S. Department of Labor (dol.gov).

189. Will the requirements for internal and external claims and appeals processes apply to my life or disability coverage?

No. The new changes under ACA only apply to health insurers and group health plans.

Cost-Sharing Limits

Updated: 7/1/25

190. What cost-sharing limits should we be aware of?

Yes. For plan years starting on or after January 1, 2014, the out-of-pocket maximums for non-grandfathered plans (including both insured and self-insured plans of large and small employers) cannot exceed the self-only and family out-of-pocket maximums applicable to HSA-qualified high deductible health plans (HDHP). The annual out-of-pocket maximums for qualified HDHPs for 2014 were $6,350 for self-only coverage and $12,700 for family coverage. For plan years starting after 2014, these amounts will be indexed by HHS using a specific methodology as described in ACA that is different than the indexing applicable to HSA-qualified HDHPs. The indexed amounts for plans that are not HDHPs are:

2015: $6,600/$13,200	2020: $8,150/$16,300	2025: $9,200/$18,400
2016: $6,850/$13,200	2021: $8,550/$17,100	2026: $10,600/$21,200
2017: $7,150/$14,300	2022: $8,700/$17,400	
2018: $7,350/$14,700	2023: $9,100/$18,200	
2019: $7,900/$15,800	2024: $9,450/$18,900	

The out-of-pocket maximum is a total cost-sharing limit for essential health benefits. The out-of-pocket maximum includes deductibles, coinsurance, copays, or similar charges and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the plan. The out-of-pocket maximum does not include premiums, costs for non-essential health benefits, balance billing amounts for non-network providers, or expenditures for non-covered services.

Qualified HDHPs must meet the lower annual out-of-pocket limits.

191. If our deductible or out-of-pocket maximum for family coverage exceeds the annual out-of-pocket limit for self-only coverage, what do we need to do to ensure our plan is in compliance?

For non-grandfathered plan years starting in 2016 or later, the self-only maximum annual limit on out-of-pocket costs applies to any individual who is enrolled in family coverage or other coverage that is not self-only coverage. Accordingly, if your plan has an annual family out-of-pocket or deductible limit that exceeds the self-only out-of-pocket limit, then your plan must include an “embedded” out-of-pocket limit for each covered individual. For example, if your plan has a family deductible or out-of-pocket limit of $10,000 in 2023 and one family member

incurs an expense of $9,500, that family member would be responsible for expenses only up to the $9,100 self-only out-of-pocket limit for 2023, and the remaining $400 must be paid in full by your plan.

192. Do the out-of-pocket cost-sharing limits also have to apply to our out-of-network benefits?

No. Cost-sharing amounts paid by the participant for services obtained from out-of-network providers do not have to count towards the out-of-pocket maximum limits.

193. We have a separate pharmacy benefit manager for our self-insured medical plan with a separate prescription drug out-of-pocket maximum. Will we have to coordinate the two benefits so that the overall out-of-pocket maximum limits are not exceeded?

If your plan is non-grandfathered, the two processes will need to be coordinated, which may require regular communications between your service providers.

However, under a transition rule for plans that utilize more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the out-of-pocket rule will be satisfied for the first plan year starting on or after January 1, 2014 if both of the following conditions are satisfied:

- The plan complies with the out-of-pocket requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage); and
- To the extent the plan includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies to prescription drug coverage), the separate out-of-pocket maximums cannot exceed the same out-of-pocket dollar amounts that apply to the major medical coverage.

194. Can we divide the annual limit on out-of-pocket costs across multiple categories of benefits (e.g. medical and Rx), rather than reconcile those claims under a single out-of-pocket maximum across multiple service providers?

Yes. You are permitted to use separate out-of-pocket limits for different categories of benefits, provided that the combined amount of any separate out-of-pocket limits does not exceed the annual limitation on out-of-pocket maximums for that year.

195. We have a separate pharmacy benefit manager for our self-insured medical plan but our prescription drug benefit does not have an out-of-pocket maximum. Will we have to add one for 2014 that complies with the maximum out-of-pocket limit?

No. If your prescription drug benefit is administered by a separate service provider, and it currently has no out-of-pocket limit, you will not be required to add one for 2014, as long as your major medical coverage complies with the out-of-pocket requirement. For plan years starting in 2015 and after, the two processes will need to be coordinated so that the combined major medical and prescription drug out-of-pocket maximum does not exceed the statutory limits.

Updated: 6/1/25

196. Can we exclude the value of drug manufacturer's coupons in the out-of-pocket maximum?

Yes, for plan years starting on or after January 1, 2020 if certain conditions are met. Group health plans will be allowed to exclude from the plan's maximum cost-sharing limits any amounts paid using drug manufacturer coupons for brand name drugs so long as you have amended your plan document to exclude the value of manufacturer's drug coupons from the out-of-pocket maximum. For example, if the employee's standard cost-share for a brand name drug is $100, but a manufacturer coupon reduces it to $30 at the point of purchase, only $30 has to be applied to the out-of-pocket maximum.

In 2023, a Texas court struck down the 2020 rule and required that drug manufacturer coupons count toward the plan's out-of-pocket maximum. However, HHS announced that it would not enforce the court's decision and that they intended to issue future guidance on how plans, including HDHPs, can comply with the requirements. HDHPs are also subject to IRS rules pertaining to the HDHP minimum deductible, and in those rules, the discount or coupon value cannot be counted toward the HDHP deductible, rather only the amount actually spent by the participant can count toward the HDHP deductible. As of June 2025, this issue has not been clarified by HHS, the DOL, or the IRS.

197. How are out-of-pocket costs determined if we are using a reference-based pricing model for certain procedures?

If your non-grandfathered plan utilizes reference-based pricing (or similar network design), it may treat providers that accept the reference based-price as the only in-network providers for purposes of determining what counts towards an individual's OOP limit as long as the non-grandfathered plan uses a reasonable method to ensure that it provides adequate access to quality providers at the reference-based price.

If your plan does not ensure that participants have adequate access to quality providers that will accept the reference price as payment in full, the plan is required to count an individual's out-of-pocket expenses for providers who do not accept the reference price toward the individual's OOP limit.

198. How do we know if we are providing adequate access to quality providers at the reference-based price?

Plans are encouraged to consider network adequacy approaches developed by the States, as well as reasonable geographic distance measures, and whether patient wait times are reasonable.

In addition, your plan should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:

- Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable waiting time or travel distance).
- The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

Summary of Benefits and Coverage (SBC)

199. What is the Summary of Benefits and Coverage (SBC)?

Group health plans and insurers will have to provide a new four-page “Summary of Benefits and Coverage” (SBC) describing the benefits and limitations of the coverage available under your plan as well as simulated coverage example calculations for two common benefit scenarios - having a baby and managing diabetes. In addition, the summary must include:

- Contact information – such as a telephone number for customer service and an internet address – for obtaining a copy of the insurance policy or certificate;
- An internet address (or similar contact information) for obtaining a list of network providers;
- An internet address linking individuals to information about their prescription drug coverage if a formulary is used;
- An internet address linking individuals to a uniform glossary defining commonly used medical insurance terms; and

- A statement about whether the plan provides minimum essential coverage and minimum value requirements.

You may provide the SBC as a stand-alone document or in combination with other summary materials (for example, an SPD), if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in an SPD) and in accordance with the timing requirements for providing an SBC. The SBC must: 1) use terminology understandable by the average plan enrollee; 2) not exceed four double-sided pages in length; and 3) not include print smaller than 12-point font.

The SBC must be provided in addition to the current SPD that is already required under ERISA.

200. We have three plan options, will we have to provide a separate SBC for each option?

Yes. A separate SBC must be created and distributed for each benefit option offered under your plan. An SBC for each option must be provided to any individual who is eligible for those options. If a newly eligible employee is eligible for all three options, then you must provide the employee with an SBC for each option.

201. Is there a deadline for providing SBCs to our newly eligible employees?

Yes. For participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees), an SBC must be provided by the first day of the first open enrollment period.

For participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), you must provide the SBC.

The SBC must be distributed to newly eligible employees as part of any written enrollment materials that are distributed by the plan. If the plan does not distribute written enrollment materials, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage.

202. We have a self-insured PPO option, but we also have an insured HMO option. Will our insurer help us with creating the SBC?

Yes. Your health insurer must provide the SBC to you for your insured HMO option though you may be responsible for distributing the SBC to your employees and their beneficiaries.

For your self-insured option, as the plan administrator you will be responsible for creating and distributing the SBC to your employees and beneficiaries. You are also allowed to hire a third party to create and/or distribute the SBC as long as it's provided in a timely fashion and in accordance with the SBC form and content rules.

203. When will our insurer provide us with the SBCs so we can distribute them to our employees?

You should contact your insurer for information on when they will be available for distribution.

If you request information from any insurer, the insurer is required to provide you with an SBC no later than seven business days following your request. If you subsequently apply for coverage with that insurer, they must provide a second SBC as soon as practicable after receiving your application but in no event later than seven business days following receipt of the application. If there is a change in the SBC before the coverage is offered or becomes effective, an updated SBC must be provided no later than the first day of coverage.

When you renew with your insurer (for example, in a succeeding policy year), the insurer must provide you with a new SBC when the policy is renewed.

204. After our employee's initial enrollment, at what other times does the SBC have to be distributed to participants and beneficiaries?

You will have to provide the SBC in several circumstances including:

- Within 90 days of enrollment pursuant to a HIPAA special enrollment opportunity.
- At open enrollment, if you require participants and beneficiaries to actively elect to maintain coverage or provide them with the opportunity to change coverage options, you must provide the SBC at the same time you distribute open enrollment materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic, and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.
- Upon request, as soon as practicable, but in no event should it be sent later than seven business days following the request.

205. **If our employee is eligible for a special enrollment opportunity, do we have to provide him with SBCs for all of our plan options?**

No, but if an individual eligible for special enrollment is contemplating their coverage options and would like to receive SBCs before applying for coverage, they may request an SBC with respect to any particular benefit package and you must provide it as soon as practicable, but in no event later than seven business days following receipt of the request.

206. **What happens if negotiations with our insurer are not completed until we are already within 30 days of the renewal date?**

If the policy, certificate, or contract of insurance has not been issued or renewed before such a 30-day period, the SBC must be provided as soon as practicable but in no event later than 7 business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of your intent to renew, whichever is earlier.

207. **If we have more than one plan option, does that mean we have to provide every eligible employee with a new SBC for each option every year at open enrollment?**

Not necessarily. You are required to provide a new SBC automatically at open enrollment, but only for the benefit option in which a participant or beneficiary is enrolled. You do not have to automatically provide SBCs for benefit options in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit option (or more than one other benefit option) for which the participant or beneficiary is eligible, the SBC (or SBCs) must be provided as soon as practicable but in no event later than seven business days following the employee's request.

208. **Are we required to provide a separate SBC for each coverage tier (e.g., self-only coverage, employee-plus-one coverage, family coverage, etc.) within a benefit option?**

No. You may combine information for different coverage tiers in one SBC provided the appearance is understandable, the coverage examples are completed assuming the cost sharing (e.g., deductible and out-of-pocket limits) for the self-only coverage tier, and this assumption is noted on the coverage examples.

209. Do we have to send each employee and dependent an SBC or can we just send it to the employee?

If an employee/participant and any beneficiaries are known to reside at the same address, you can send a single notice to that address. However, if you know that a spouse or dependent's address is different from the employee/participant's address, you must send a separate SBC to the spouse or dependent at their last known address.

210. Our coverage is structured in a way that is different than contemplated by the SBC templates (e.g. different network or drug tiers, or in denoting the effects of a health flexible spending account, health reimbursement arrangement, or wellness program). How do we describe those benefits in the SBC?

To the extent your plan has terms that are required to be described in the SBC template that cannot reasonably be described in a manner consistent with the template and instructions, you must accurately describe the relevant plan terms while using your best efforts to do so in a manner that is still consistent with the instructions and template format as reasonably possible.

211. What if we have carved out a certain benefit, such as carving out the pharmacy benefit to a pharmacy benefit manager (PBM)?

If you use two or more insurance products provided by separate insurers or use a combination of insured and self-insured coverage (e.g. insured medical and self-insured Rx), you are responsible for providing complete SBCs that integrate both coverage types. However, you may contract with one of your issuers (or other service providers) to perform that function or you must synthesize the information into a single SBC or provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements.

The DOL says that you can contract with another party (e.g., the PBM) to assume responsibility to:

- Complete the SBC,
- Provide the required information to you so you can complete a portion of the SBC, or
- Deliver an SBC in accordance with the final regulations.

If you contract this responsibility to the vendor, the following conditions must also be satisfied:

- You monitor the vendor's performance under the contract;

- If you learn of a violation of the final regulations and have the information to correct it, you correct the violation as soon as practicable; and
- If you have knowledge of a violation of the final regulations and you don't have the information to correct it, you must communicate with participants and beneficiaries regarding the lapse and begin taking significant steps as soon as practicable to avoid future violations.

212. Do we have to provide an SBC for our dental or vision coverage?

You will not have to provide an SBC for your dental or vision coverage if they are limited scope HIPAA excepted benefits. Excepted benefits are those dental and vision benefits that are either provided under a separate policy or contract of insurance or are not an integral part of the group health plan (i.e. employees can waive the dental or vision).

213. Are we required to provide SBCs to individuals who are COBRA qualified beneficiaries?

Yes. While a qualifying event will not usually trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a current employee. There are also limited situations in which a COBRA qualified beneficiary may need to be offered coverage that is different than the coverage he or she was receiving before the qualifying event, and this may also trigger the right to an SBC.

214. Where possible, we provide our plan communications to employees using electronic media (e.g. internet posting, email). Can the SBC be distributed electronically?

Yes. The SBC can be provided in paper format, or it can be provided electronically. To provide it electronically to participants already covered under the plan, the disclosure must comply with the DOL's ERISA regulations for electronic disclosures.

With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

- The format is readily accessible;
- The SBC is provided in paper form free of charge upon request; and
- In a case in which the electronic form is an Internet posting, you timely notify the individual in paper form (such as a postcard) or email that the SBC

documents are available on the Internet, you provide the Internet address, and you notify the individual that the documents are available in paper form upon request.

215. Can the SBC be provided electronically through our online enrollment system?

Yes. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online.

In either case, the individual must have the option to receive a paper copy upon request.

216. Our plan is a governmental plan that is not subject to ERISA. Do we still have to comply with the ERISA electronic disclosure regulations?

Governmental plans can provide the SBC electronically if either the substance of the provisions of the DOL electronic disclosure rules are met, or if the provisions governing electronic disclosure in the individual health insurance market in your state are met.

217. If we make mid-year changes to our plan that require us to change the information in the SBC, do we have to send out a new SBC?

No. However, if you make a mid-year material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC, you must provide notice of the modification to enrollees not later than 60 days prior to the date on which such modification will become effective. Of course, providing an updated SBC reflecting the modification no later than 60 days prior to the effective date of the change will also satisfy your obligation.

You are required to comply with this 60-day advance notice requirement for any mid-year changes you make after the SBC requirement is effective for your group health plan.

Like the SBC, the 60-day advance notice can be provided in paper format or electronically if the disclosure complies with the DOL's regulations for electronic disclosures.

218. Will we also have to send a Summary of Material Modification (SMM) to the plan participants if we have sent out the SBC advance notice?

No. If you provide the advance notice of a material modification in a timely manner, the notice will also satisfy your obligation to provide a Summary of Material Modification (SMM) as required under ERISA.

219. Are there model notice/templates we can use to fulfill the SBC obligation?

Yes. There are sample templates and documents that can be used to comply with the requirement. Updated materials are issued periodically.

You can view or download the following templates and documents that are currently applicable for plan years that started on or after 4/1/17 and the new templates and document that are applicable for open enrollments for plan years starting on or after January 1, 2021 on the DOL website here: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

- Summary of Benefits and Coverage Template (in both pdf and Word format)
- Sample Completed Summary of Benefits and Coverage
- Instructions for Completing the SBC - Group Health Plan Coverage
- Why This Matters language for "Yes" Answers
- Why This Matters language for "No" Answers
- HHS Information for Simulating Coverage Examples
- HHS Coverage Example Calculator
- Uniform Glossary of Coverage and Medical Terms

220. We have several employees who are fluent only in a non-English language. Do we have to provide a translated version of the SBC to them?

Under some circumstances, you (or the insurer) will be required to provide a “culturally and linguistically appropriate” notice to individuals who are only fluent in a non-English language. To satisfy this requirement, certain support services such as a telephone customer service hotline that can answer questions in the non-English language must be made available if notices are being sent to a participant or beneficiary in a county where the U.S. Census Bureau has determined that 10% or more of the population in that county is literate only in a non-English language.

In addition, SBCs sent to those counties must include a statement, prominently displayed, in the applicable non-English language clearly indicating how to access the language services provide by the plan or insurer. Sample language

for this statement is available on the model notice of adverse benefit determination at: http://www.dol.gov/ebsa/IABDModelNotice2.doc.

A translated SBC in the applicable non-English language must be provided upon request. To help plan sponsors meet the language requirements for open enrollments and plan years starting before April 1, 2017, HHS has provided written translations of the SBC template, sample language, and uniform glossary in Spanish, Tagalog, Chinese, and Navajo at: http://cciio.cms.gov/resources/other/index.html#sbcug.

Current county-by-county data can be accessed at: https://www.cms.gov/files/document/clas-county-data-2023.pdf

90-Day Waiting Period Limit

221. Can we change our waiting period to three months instead of 90 days?

No. Because three consecutive months in some cases may result in a waiting period that is more than 90 days, using three months instead of 90 days is not permitted. All calendar days are counted toward the 90-day limit beginning on the employee's start date, including weekends and holidays.

222. Our plan currently has a 90 day waiting period and then coverage is effective on the first day of the month following 90 days. Will that satisfy the requirement?

No. Except for a limited exception for certain "variable hour" employees (see below), you are not permitted to delay the effective date of coverage to the first day of the month following 90 days.

223. We currently require new employees to complete an orientation period before becoming permanent employees and eligible for coverage. Are we required to include the orientation period as part of the waiting period?

You are permitted to condition eligibility on among other things, satisfying a reasonable and bona fide employment-based orientation period of no more than one month during which you and the employee would evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. If you condition eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period of one month or less, the maximum 90-day waiting period could then begin on the first day after the orientation period.

For purposes of the length of the orientation period, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee's start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31. If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly, if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

224. If we require new full-time employees to complete a one-month orientation period plus satisfy our 90-day waiting period, are we automatically exempt from having to pay an Employer Mandate penalty for that 120-day period?

No. The final regulations clarify that compliance with the 90-day waiting period/orientation period final regulations do not ensure compliance with the Employer Mandate rules. Those rules state that you will not be subject to a penalty for the first three full months of employment if you provide affordable, minimum value coverage to newly hired full-time employees by the first day of the fourth full calendar month of employment. Therefore, if you have a one-month orientation period, you may comply with both the 90-day waiting period/orientation period rules and the Employer Mandate by offering coverage no later than the first day of the fourth full calendar month of employment. However, you may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to an assessable payment under the Employer Mandate. For example, if an employee is hired as a full-time employee on January 6, and you offer coverage May 1st (the first day of the fourth month after the start date), you comply with both provisions and would not be subject to an assessable payment under the Employer Mandate. However, if you start coverage May 6th, which is 121 days after the date of hire, you may be subject to an assessable payment under the Employer Mandate.

225. Part-time employees are not eligible for our plan but there are situations where a part-time employee is promoted to full-time status. Assuming an employee worked as a part-time employee for more than 90 days, would we have to allow him to enroll immediately?

No. A waiting period is defined as the period that must pass before coverage becomes effective for an employee who is otherwise eligible to enroll. Because

the employee was not eligible to enroll as a part-time employee, a 90-day waiting period can be applied commencing on the date the individual becomes a full-time employee.

226. **If we implement a 90-day waiting period but an employee fails to complete the enrollment forms in a timely fashion and coverage is delayed a month, will that violate the law?**

No. As long as your employee had the opportunity to elect coverage that would begin on a date that does not exceed the 90-day limit, you will not be in violation of the law merely because the employee took additional time to elect coverage.

227. **Only full-time employees working 30 or more hours per week are eligible for our plan. Sometimes we have new hires with variable work schedules where it cannot be immediately determined if they will regularly work 30 hours per week. How can we handle those situations without violating the waiting period rules?**

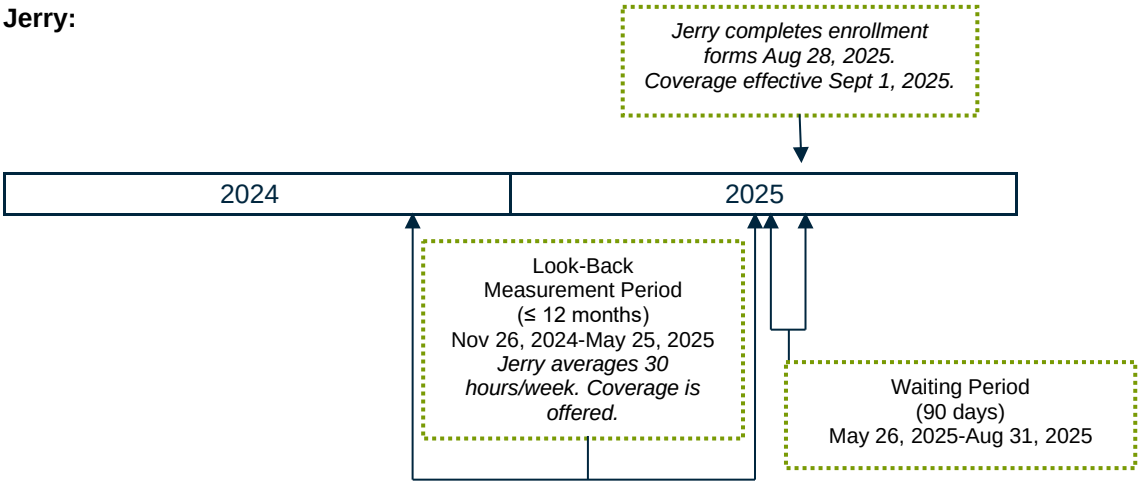
You may take a reasonable period of time to determine whether the employee works enough hours to meet the plan's eligibility criteria, which may include a look-back measurement period that is no more than 12 months long. If in reviewing the measurement period, you determine the employee has worked the requisite hours to be eligible for coverage, then up to a 90-day waiting period can be applied but in no case can the coverage start later than 13 months plus a fraction of a month from the employee's start date.

Example: Under your group health plan, only employees who work full time (defined under the plan as regularly working 30 hours per week) are eligible for coverage. Jerry begins working on November 26, 2024. Jerry's hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability. Therefore, you cannot determine at Jerry's start date that he is reasonably expected to work full time. Under the terms of the plan, variable hour employees such as Jerry are eligible to enroll in the plan if you determine they are full time after a look-back measurement period of 6 months. You then make coverage effective no later than the first day of the first calendar month after a 90-day waiting period, if the applicable enrollment forms are received. Jerry's 6-month measurement period ends May 25, 2025. Jerry is determined to be full time, and you notify him of his plan eligibility. If Jerry then elects coverage by completing his enrollment form on August 28, 2025, his first day of coverage will be September 1, 2025.

Conclusion: In this Example, because Jerry's coverage becomes effective no later than 13 months from his start date, plus the time remaining until the first day of the next calendar month, the plan is in compliance with the requirement. The

measurement period is 12 months or less (and is, therefore, permissible) because you may use a reasonable period of time to determine whether Jerry is full time and the waiting period you apply after the end of the measurement period is 90 days or less (and is, therefore, permissible).

Jerry:



228. **In addition to covering full-time employees working 30 or more hours per week, part-time employees also become eligible for coverage when they have completed a cumulative 1,200 hours of service. Will this have to be changed to comply with the 90-day rule?**

No. A cumulative hours of service condition with respect to part-time employees is permitted as long as the amount of cumulative hours worked required for eligibility is less than or equal to 1,200 hours. Accordingly, coverage for part-timers under your plan must begin no later than the 91st day after a part-time employee has worked 1,200 hours. In addition, the cumulative hour requirement can only be applied one time. Re-application of the requirement to the same individual each year is prohibited.

229. **We have employees covered by a multiemployer plan operating under a collective bargaining agreement that allows employees to earn eligibility for coverage by working hours for multiple contributing employers over a quarter. Is that allowed?**

If the employee earns eligibility by aggregating hours worked in a quarter across multiple contributing employers, and then retains coverage through the next full quarter, regardless of whether the employee has terminated employment, it would be considered to be a design that accommodates a unique operating structure and not designed to avoid compliance with the 90-day waiting period limit.

Clinical Trials

230. Our plan is not grandfathered so what will we have to do to comply with the clinical trial mandate?

Under the clinical trial mandate, if your plan is providing coverage to "qualified individuals", then starting with any plan year that begins on or after January 1, 2014, the plan:

- May not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and
- May not discriminate against the individual on the basis of the individual's participation in the trial.

231. How is a "qualified individual" defined?

A "qualified individual" is defined as a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either:

- The referring health care professional is a provider participating in the trial and has concluded that the individual's participation in such trial would be appropriate; or
- The participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

232. Will we have to provide coverage for the investigational item, device or service?

No. Your plan is only required to cover the patient's routine costs. Routine patient costs would include any items and services consistent with the coverage provided under your plan that is typically covered for individuals who are not enrolled in a clinical trial. Your plan would NOT have to cover:

- The investigational item, device, or service itself;
- Any items or services that are not used in the direct clinical management of the patient but rather, are provided in connection with data collection and analysis needs; or

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

233. How will we know if a trial is an approved trial?

An approved clinical trial is defined as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is any of the following:

- The study or investigation is federally approved or funded by certain governmental entities or departments;
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The health care provider participating in the trial should be able to verify that it's an approved trial.

234. Can we require employees or dependents that are qualified individuals to use our HMO's in-network providers?

You can require the employee to use an in-network provider only if the in-network provider is participating in the trial and will accept the individual as a participant in the trial.

If the employee or dependent is participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides (and therefore is outside the network), then the plan will have to cover the routine medical costs associated with the trial if the plan otherwise covers routine out-of-network services.

235. Are there examples of the types of services we would have to provide?

Yes. If your plan generally covers chemotherapy to treat cancer, the plan cannot limit the coverage of chemotherapy for an individual due to the fact that it is provided in connection with the individual's participation in an approved clinical trial for a new anti-nausea medication. In addition, if your plan typically covers items and services to diagnose or treat certain complications or adverse events, the plan cannot deny coverage of those items and services when provided to diagnose or treat complications or adverse events (e.g., side effects) in connection with an individual's participation in an approved clinical trial.

Medical Loss Ratio Rebates

236. Insurers are required to follow new minimum medical loss ratio (MLR) guidelines. Will this affect our plan?

Insurers are required to track and report to HHS their MLR, which is the proportion of premium revenues spent on medical claims and quality improvement. Insurers in the large group market must have a medical loss ratio of at least 85%. The medical loss ratio for insurers in the small group market must be at least 80%. If the insurer fails to meet these standards, the insurance companies will be required to provide a rebate to their policyholders.

Insurers must provide the rebates to the group policyholder (usually the employer) through lower premiums or in other ways that benefit the participants.

237. If our insurer has to pay a rebate, when will we receive it?

The MLR percentage is calculated on a calendar year basis. If a rebate is payable, it must be paid by August of the following year. The first insurer rebates were paid by August 1, 2012 for the 2011 calendar year.

For rebates payable for the 2014 calendar year and later, the rebate must be paid no later than September 30 of the following year.

238. If we receive a rebate, are there guidelines or limits on how we can spend the money?

If you receive a rebate, how you can use it will vary by your plan type:

- **ERISA Plans** - To the extent that distributions, such as premium rebates, are considered to be plan assets, they become subject to the requirements of Title I of ERISA. Therefore, plan sponsors will have to determine if the rebate is a plan asset and to what extent the rebate is attributable to participant contributions. The DOL has issued Technical Release 2011-04 that gives specific instructions to plan sponsors of ERISA plans regarding their responsibilities under ERISA concerning rebates.
- **Nonfederal Governmental Plans -** The employer must use the amount of the rebate that is proportionate to the total amount of premium paid by all participants under the policy (1) to reduce subscribers' portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan; (2) to reduce subscribers' portion of the annual premium for the subsequent policy year for only those subscribers covered by the group health policy on which the rebate was based; or (3) to

provide a cash refund only to subscribers that were covered by the group health policy on which the rebate is based. The reduction in premium or cash rebate may, at the option of the policyholder, be: 1) divided evenly among the participants; 2) divided based on each participant's actual contribution to premiums; or 3) apportioned in a manner that reasonably reflects each participant's contributions.

- **Church Plans** - Rebates may only be paid to the employer if the insurer receives written assurance from the employer that the amount of the rebate that is proportionate to the total amount of premium paid by all participants under the policy will be used for the benefit of current participants using one of the options described above for nonfederal governmental plans. Otherwise, the issuer must distribute the rebate directly to the participants of the group health plan.

There are special rules for rebates paid in the case of a terminated plan.

239. The rebate we received for our ERISA plan is less than the amount we paid out of our general assets towards the cost of coverage. Are we allowed to keep the whole amount?

You could keep the whole amount of the rebate only if it is less than the total amount you paid for the year AND your plan document was drafted to provide that insurer refunds or rebates should be used first to offset your contributions.

240. What if our ERISA plan document is silent as to premium rebates or refunds?

If there are no provisions in your plan document or other written instruments governing your plan, then you must determine what portion of the refund are plan assets under ERISA's general standards of fiduciary conduct. Once the amount of the rebate that is plan assets is determined, you have a fair amount of leverage in determining both how that money will be used and exactly which individuals will receive the rebate*, provided that the money is used for the exclusive benefit of participants and beneficiaries*. This includes returning the rebate to participants in cash, using it to offset future employee contributions, or to make enhancements to future benefits.

241. **We use a VEBA trust to fund our plan where both the employer and employee contributions are deposited into the trust. Can we get our portion of the rebate back?**

No. For insured plans that are funded solely by trust assets, the whole amount of the rebate is plan assets and must be returned to the trust or to plan participants.

242. **Are former employees who were covered under our ERISA plan last year entitled to a share of an MLR rebate?**

Maybe. If you decide that part of the rebate is plan assets that must be returned to participants, then that should also include former participants. However, under DOL guidelines, you don't have to share the rebate with former participants if you find that the cost of tracking down and distributing the rebate to them approximately equals or exceeds the proceeds that would be paid to them.

If you choose to issue a rebate directly to participants, you should weigh the costs of whether to include former participants in the distribution to determine if those costs approximate or exceed the cost of the proceeds.

243. **Are our COBRA participants entitled to a share of an MLR rebate?**

The statutory and regulatory language on MLR rebates refers to "enrollees," "participants" and "subscribers," which generally includes COBRA qualified beneficiaries. Therefore, it is likely that COBRA qualified beneficiaries should receive the same share of any MLR distribution that is provided to similarly situated active employees. Also, because a plan should include only the net cost of the active rate (insurance rate less experience rebates) in determining the applicable COBRA premium, an MLR rebate should reduce the COBRA applicable premium for your insured group health plan.

244. **If we receive a rebate for our PPO option but not our HMO option, would we have to apply the portion of the rebate that is plan assets to the PPO plan only (since that's where the rebate came from) or could the enhancement be applied to the HMO plan?**

The rebate should only be used for the plan option that created the rebate.

245. **As a governmental plan, are we required to track down former participants and return their portion of the rebate to them?**

No. For governmental and church plans, the rebate amount attributable to employee contributions must be returned to the participants that are in the plan at the time the rebate is received.

246. Is there a timeframe under which our ERISA plan must use MLR refunds?

Yes. ERISA fiduciary duty rules, including the trust requirements for plan assets, govern the treatment of MLR rebates from insurers. However, the DOL will not enforce ERISA's trust requirement under certain circumstances, including if the portion of the rebate that is plan assets is used within three months of its receipt.

In addition, directing the insurer to hold and apply the rebate to future benefit enhancements you have adopted would also avoid the need for a trust.

Conversely, if you receive the rebate and the portion that is plan assets is not used up within three months, the money will be subject to ERISA trust requirements.

247. Must our ERISA plan issue refunds or provide premium reductions to participants in proportion to whatever each individual employee actually paid (for example, based on employee-only versus family coverage or salary-dependent employee contributions)?

Not necessarily. Absent plan document terms that specifically describe the disposition of the rebate, the DOL has indicated that acceptable methods may include:

- Dividing the rebate evenly among participants,
- Dividing the rebate based on each participant's actual contribution to premium, or
- Apportioning the rebate in a manner that reasonably reflects each participant's contribution to premium (e.g. single vs. family coverage).

It is up to you to decide which of these options is the most "reasonable, fair and objective" in consideration of the plan's contribution structure and other circumstances.

248. If we have to return a portion of the refund to participants, will it be taxable to them?

For cash refunds, if your employees pay their contribution on a pretax basis, then the rebate payment will be taxable for the employee. If the employee contributions were initially paid with after-tax dollars, the refund will not be subject to federal taxes unless the participant deducted the premium payments on their individual Form 1040.

If you use the refund for a contribution holiday or contribution reduction for your plan participants, to the extent that a premium refund will result in less

contributions for an employee to pay for benefits and more money paid as taxable take-home pay, that increased income is taxable. For example, if an employee makes $500 per week and the pre-tax contribution is $50, the employee is only taxed on $450. However, if the employer receives a rebate and determines that it must return $50 to an employee as a premium holiday for that week, then the employee's taxable income for that week is $500, not $450. In other words, the $50 the employer paid gets taxed only because it was not salary-reduced on a pretax basis from the employee's pay.

The IRS has issued a comprehensive set of FAQs addressing the federal tax consequences to employees when a MLR rebate stems from a group health insurance policy. The FAQs can be accessed at the IRS website here: Medical Loss Ratio (MLR) FAQs | Internal Revenue Service (irs.gov).

249. If the plan asset portion of the MLR rebate can be classified as de minimis, does that mean the employer can use the money for purposes other than specified under the plan document, MLR rules or ERISA's fiduciary rules?

No. If you determine that the administrative cost of reducing the employee contributions or paying cash to participants would be equal to or greater than the cost of the rebate amount itself, then you would still have to use the money for another allowable purpose such as enhancing the benefits for the plan participants.

250. What types of things would be considered benefit enhancements?

Examples of benefit enhancements include lowering the plan deductible, increasing the plan cost-sharing payment, reducing office visit copays, increasing a benefit limit, etc. Generally, this would entail using the portion of the rebate that is plan assets to pay the increased premium associated with the benefit enhancement. For example, if the amount to be returned to participants is $10,000, and the insurer indicates that for $10,000 they would reduce the deductible for all participants in the plan option that generated the rebate from $500 to $250, then that may be an appropriate use of the rebate.

251. Instead of returning money back to participants, can we instead use the rebate to fund a wellness program for our employees?

Providing wellness incentives is not explicitly allowed or prohibited as a "benefit enhancement" under the MLR rules. If you determine that distributing payments to participants is not cost-effective (e.g. the payments are of de minimis value or give rise to tax consequences to the participants) then there is a possibility that paying for biometric screenings or other wellness screenings for plan participants may be prudent and appropriate.

W-2 Reporting

252. Is it true we have to make changes to what we report on our employee's W-2?

Yes. You are required to report the aggregate cost of employer sponsored health coverage on your employees' W-2. The amount to be reported on the W-2 is NOT included in the employee's gross income.

On March 29, 2011 and January 2, 2012, the IRS issued guidance that includes a delay in the W-2 reporting requirement until further guidance is issued for the following employers:

- Employers filing fewer than 250 W-2s for the previous calendar year (for example, employers filing fewer than 250 W-2s for taxable year 2022 will not be required to report the cost of coverage on the 2023 W-2);
- Employers sponsoring self-insured plans that are not subject to federal COBRA continuation coverage such as self-insured church plans; and
- Federally recognized Indian tribal governments and tribally chartered corporations that are wholly owned by a Federally recognized Indian tribal government.

The Form W-2 includes code DD that should be used to report the aggregate cost of employer sponsored health coverage in Box 12 on your employees' Form W-2.

253. What coverage is included in the amount that we must report on the W-2?

The aggregate cost of your health coverage is the total cost of coverage provided to the employee under all your employer-sponsored coverage including:

- Medical coverage
- Dental and vision, unless HIPAA excepted stand-alone plans (i.e., coverage offered under a separate policy, certificate, or contract of insurance or coverage, and employees may waive separately)
- Prescription drug coverage
- Executive physical benefits
- On-site clinics*
- EAPs that provide medical care*
- Wellness programs that provide medical care*
- Medicare supplemental policies
- Health FSA – employer contributions only (e.g., "seed" or match)

- Hospital or other fixed indemnity insurance or specified illness insurance if the employer makes any contribution towards the cost of the fixed indemnity or specified illness insurance or allows employees to purchase the coverage on a pre-tax basis under a Section 125 plan

*See below for more details and exceptions

254. **Our EAP and wellness programs are considered group health plans but the cost is so little we don't charge a premium to COBRA qualified beneficiaries to access them. Do we still have to include their cost in the aggregate reportable cost?**

No. The cost of coverage provided under an EAP, wellness program, or on-site medical clinic that qualifies as a group health plan subject to COBRA does not have to be included in the aggregate reportable cost if you do not charge COBRA qualified beneficiaries to access those benefits. However, if you charge a COBRA premium for such coverage, then it must be included in the aggregate reportable cost on the W-2.

255. **We offer an EAP to our employees that our long-term disability insurer provides for no additional cost as an add-on to the LTD benefits. Do we still have to include it in the aggregate reportable cost?**

No. Group health plan coverage provided as an add-on or value-added program does not have to be reported if the EAP portion of the program providing the health benefits is only incidental in comparison to the portion of the program providing the disability benefits.

256. **We are a church plan, and our medical plan is self-insured, and our dental and vision are excepted benefits, so we are not required to report them. Do we still have to report the cost of our EAP or wellness program?**

No. Because your plan is not subject to COBRA or any other federal continuation coverage requirement you do not have to report the cost of coverage provided under an EAP, wellness program, or on-site medical clinic, even if they qualify as group health plans.

257. **We are a controlled group of corporations comprised of a number of member employers. Do we have to aggregate all the W-2s we filed for all of**

our member employers to determine if we filed less than 250 W-2s in the preceding year?

No. The exemption for employers that filed fewer than 250 W-2s applies separately to each member employer of your controlled group.

258. **Is there coverage we don't have to include in the reporting?**

Yes. Your reporting should not include:

- Long term care, accident, or disability income benefits
- Health reimbursement arrangements (delayed until further notice)
- Specific disease, indemnity, etc. coverage if not excludable from employee's gross income
- Specified illness or disease policies such as cancer policies where the full premium is paid by the employee on an after-tax basis
- Hospital (or other) Indemnity insurance policies where the full premium is paid by the employee on an after-tax basis
- Archer MSA or HSA contributions of the employee or the employee's spouse
- Employee salary reduction contributions to a Health FSA
- Referral-only EAP

259. **What value should we use for the costs that must be reported?**

If your plan is insured, you can use the premium charged by the insurer as the reportable amount. If your plan is self-insured, you may calculate the reportable cost using the COBRA applicable premium (minus the 2% admin fee).

260. **Our insurer charges us a composite rate for all covered employees. Do we report the same amount for every employee?**

Yes. Where the insurer is charging a single composite rate for all employees, you can use that composite rate to calculate the reportable cost.

261. **We are an S corporation and our 2% or greater shareholder-employees are required to include the value of group health plan premium payments we make on their behalf in their income. Would we still have to also report this cost in Box 12 of their W-2?**

No. Payments or reimbursements of health insurance premiums for a 2% or greater shareholder-employee of an S corporation do not have to be reported in Box 12 on the W-2 if the individual is required to include the premium payments in gross income.

262. What do we do when an employee terminates employment in the middle of the year?

You may apply any reasonable method of reporting the cost of coverage for an employee who terminated employment during the calendar year, provided that the method is used consistently for all employees receiving coverage who terminate employment during the year. For example, calculating the total cost per month and then multiplying it by the number of covered months (including COBRA months) is a reasonable method. Or, as an alternative, it would be a reasonable method to do the calculation without including the COBRA months.

Under the transition rules that apply until future guidance, if the terminated employee requests a W-2 before the end of the calendar year, the employer is not required to report any amount of health benefits on that W-2.

263. What amount do we report if there is a cost or coverage change in the middle of the year?

The reportable cost must reflect the increase or decrease in cost for the periods to which the increase or decrease applies.

If an employee changes coverage during the year (e.g. terminates coverage, changes plan options, adds or drops dependents) the reportable cost must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods the employee had coverage.

If the change in coverage in the middle of a month where costs are determined on a monthly basis, an employer may use any reasonable method to determine the reportable cost for such period, such as using the reportable cost at the beginning of the period or at the end of the period, or averaging or prorating the reportable costs, provided that the same method is used for all employees with coverage under that plan.

264. What happens if the employee notifies us of a coverage change that may have an effect on the aggregate reportable cost for the previous year? For example, if one of our employees notifies us of a divorce in January that occurred in the preceding year and would reduce the cost of the employee's coverage for that year?

The aggregate reportable cost for a calendar year reported on Form W-2 may be based on the information available to you as of December 31 of the calendar year. Therefore, if an employee notifies you of a coverage change in the subsequent calendar year that has a retroactive effect on his or her coverage for

the prior year, you are not required to include it in the calculation of the aggregate reportable cost for that prior year. In addition, you are not required to furnish a Form W-2c if a Form W-2 has already been provided for a calendar year, before this type of notification (for example, if a Form W-2 is provided to employees on January 15, and an employee notifies you of a retroactive change on January 20).

265. **We contribute to a multiemployer plan for our union employees. Do we have to report that contribution or the value of the multiemployer plan coverage on the union employee's W-2?**

No. Neither the amount you contribute, nor the cost of the coverage provided to an employee under a multiemployer plan must be included when determining the aggregate reportable cost that must be reported on the W-2.

266. **Do we have to provide a W-2 that includes the aggregate cost of our health plan coverage to retirees covered by our plan that don't receive any other compensation from us?**

No. You are not required to issue a Form W-2 to an individual to whom you are not otherwise required to issue a Form W-2.

Section 6055 – Minimum Essential Coverage Reporting

267. **What forms should we use to file the Section 6055 return?**

If you are a large employer, you can use Form 1095-C, along with transmittal Form 1094-C. Employers that are not applicable large employers (e.g., small, self-insured employers) can use Form 1095-B, along with transmittal Form 1094-B. If you are both a large employer and have a self-insured plan, Form 1095-C can be used to satisfy both Sections 6055 and 6056 reporting requirements (see the section below on the Section 6056 reporting requirements).

The IRS releases final versions of the combined 1094-C and 1095-C forms and instructions, which are available HERE and HERE.

268. **If our plan is fully insured, do we still have to file the Section 6055 forms?**

No. Your insurer is responsible for filing the Section 6055 forms.

269. What is the deadline for filing the Section 6055 return?

The return must be filed on or before February 28th of the year following the calendar year in which you provided minimum essential coverage, regardless of your plan year. The returns can be filed electronically.

For filings prior to January 1, 2024, employers that file 250 or more Section 6055 returns during the calendar year must file electronically. If you file electronically, you have an additional month until March 31st to file the report.

Beginning with filings after December 31, 2023, the electronic filing threshold will reduce to 10 returns (in the aggregate, considering each IRS information return, including W-2s, 1095-Bs and -Cs, 1099s, and more), requiring employers that file 10 or more informational returns with the IRS must file electronically.

Information on the filing the returns electronically can be found at the ACA Information Returns (AIR) website here: https://www.irs.gov/e-file-providers/affordable-care-act-information-returns-air

270. If we provide minimum essential coverage to our employees under a self-insured plan, who is responsible for the Section 6055 reporting?

The plan sponsor that establishes and maintains the plan must file the Section 6055 forms. So, if minimum essential coverage is provided under your self-insured plan, you must file a Section 6055 annual return using forms 1094-C and 1095-C with the IRS for every employee covered under the plan for at least one month of the year.

271. What information will we have to include on the Code Section 6055 return for our self-insured plan?

Your Section 6055 return using Form 1095-C must include the following information for each employee covered under the plan for at least one month of the year:

- The name, address, and EIN of the employer sponsoring the plan;
- The name, address, and taxpayer ID number (generally the social security number (SSN)) of the employee or former employee;
- The name and SSN of each other covered individual;
- The months during which each individual was enrolled in coverage during the calendar year for at least one day.

Updated: 6/1/25

272. What if we are not able to get the spouse's or children's social security number (SSN)?

You can provide the dates of birth in lieu of SSNs but only if you are informed that an individual does not have an SSN or you are unable to obtain an SSN after making reasonable efforts to obtain it.

To demonstrate reasonable efforts, you are required to request the SSNs from covered individuals at the time their relationship with the individual begins – for employers, this means on the date the employer receives a substantially complete application for new coverage or to add an individual to existing coverage or, if already enrolled on September 17, 2015, the next open enrollment period. If the covered individual does not provide the SSN, you must make the first annual solicitation at any reasonable time after the individual's substantially complete initial application for coverage (e.g., within 75 days). If the covered individual fails to provide the SSN at that time, then you must make a second annual request by December 31 of the following year. If the covered individual fails or refuses, you can then use the individual's date of birth without making any additional efforts to obtain the SSN. You should document your efforts to obtain missing SSNs.

For example, if you make an unsuccessful initial solicitation for an SSN on June 1, 2016 when the employee first enrolls in coverage, you must make the first annual solicitation no later than 75 days (or at any reasonable time) after June 1, 2016. The second annual solicitation must be made by December 31, 2017, to have acted in a responsible manner. Assuming that request is also unsuccessful, you would not be penalized if your Section 6055 reporting submitted in early 2018 reported a date of birth in place of the SSN for the individual in question.

For employer reports to the IRS that are due after December 31, 2024, the IRS expressly allows for an individual's date of birth to be substituted for the SSN, if the SSN is unavailable. This reduces the impact on employers by eliminating the ongoing solicitation requirement before being able to use the date of birth in lieu of the SSN.

273. We are a parent of a controlled group of corporations comprised of a number of member employers and our plan covers employees of all the member employers. Do we have to file the Section 6055 return on behalf of the other employer members?

No. Your plan is treated as being sponsored by more than one employer and each member-employer is responsible for filing the return for its own employees.

However, one member of your controlled group may assist you and/or the other members by filing returns and furnishing the employee statements on behalf of all the employer members of the controlled group.

274. Can our TPA file the Section 6055 report on our behalf?

Generally, yes, but the regulations do not allow you to transfer the liability for reporting failures to your TPA or any other third party.

However, governmental employers that maintain self-insured health plans may enter into a written agreement with another governmental unit, or an agency or instrumentality of a governmental unit, designating the other governmental unit, agency, or instrumentality as the person responsible for the Section 6055 return with the IRS and for providing the statement to the employees.

The designated agency must be part of the same governmental unit as the government employer. For example, a state health department may designate the state personnel agency to file the required return and statements. The designated agency must accept the designation, and the agreement must be in writing. In the absence of such a designation, the government employer that maintains the self-insured group health plan will remain the responsible party under Section 6055.

275. Do we have to provide reporting on HSAs, HRAs or FSAs?

HSAs are not minimum essential coverage, so reporting is not required. Reporting is not required for FSAs that supplement group health plans that are providing minimum essential coverage. HRAs are considered self-insured minimum essential coverage though reporting is generally not required for HRAs that supplement group health plans that are providing minimum essential coverage. If however, the HRA covers individuals that are not covered under the major medical plan (e.g. employee has self-only coverage and family HRA or an individual coverage HRA), then reporting is required showing the months the family members that are not covered under the major medical plan had coverage under the HRA.

In addition, you do not have to file a Section 6055 report for the following:

- On-site medical clinic;
- Wellness programs that offer reduced premiums or cost-sharing under a group health plan;
- Coverage that supplements your primary health plan; or
- Coverage that supplements government provided coverage such as Medicare.

276. Do we file a Section 6055 return for employees that are offered our coverage but waive it?

No.

277. If my Section 6055 filing is incorrect due to retroactive enrollment of a baby or some other circumstance that occurs at the end of the year, will I be required to file a corrected return with the IRS?

Yes, when information on the form filed with the IRS becomes incomplete or incorrect, you are required to file a corrected return.

278. Do we have to provide a copy of the Section 6055 return to our employees?

Yes. You will have to provide a copy of the Form 1095-C filed with the IRS or a substitute statement that includes the information that was included on the 1095-C and a phone number of the person that has been designated as your contact person to each employee named in your Section 6055 filings. You do not need to provide a copy to those employees who were not eligible for the coverage or waived the coverage.

279. Is the deadline for sending Form 1095 to employees reporting the same as the IRS filing deadline?

No. The statement to your employees must be furnished to them on or before January 31 of the year following the calendar year in which you provide them with minimum essential coverage, regardless of your plan year. The IRS return is due on or before February 28th (March 31st if filing electronically) of the year following the calendar year in which minimum essential coverage was provided.

For 2021 and later, the deadline is permanently extended from January 31 to March 2 (March 1 in leap years).

Updated: 6/1/25

280. Do we have to mail the form to the employee, or can we provide it electronically?

Either method is allowed. You can satisfy your obligation by sending the statement by first class mail to the primary insured employee's last known permanent address, or, if no permanent address is known, to the individual's temporary address.

You can send the statement electronically if the employee has specifically consented to receiving the statement electronically in a manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished. Prior to, or at the time of consenting, you must

provide a conspicuous disclosure to the employee that includes all of the following:

- The statement will be furnished on paper if the employee does not consent to receive it electronically;
- The consent applies to each statement required to be furnished after the consent is given until it is withdrawn or only to the first statement required to be furnished following the date of the consent;
- The employee can request a paper copy of the statement and the procedure for obtaining a paper copy of their statement after giving the consent and whether a request for a paper statement will be treated as a withdrawal of consent;
- The employee may withdraw a consent by writing (electronically or on paper) to the person or department whose name, mailing address, telephone number, and email address is provided in the disclosure statement;
- There may be conditions under which you will cease furnishing statements electronically to the employee and what those conditions are (e.g. if the employee terminates employment);
- The employee must update their contact information and the procedures for updating that information; and
- A description of the hardware and software required to access, print, and retain the statement, and if applicable, the date when the statement will no longer be available on your web site. You must also advise the employee that the statement may be required to be printed and attached to a Federal, State, or local income tax return.

If you change the hardware or software required to access the statement that creates a material risk that the employee will not be able to access a statement, you must, prior to changing the hardware or software, notify the employee. The notice must describe the revised hardware and software required to access the statement and inform the employee that a new consent to receive the statement in the revised electronic format must be provided. After implementing the revised hardware or software, you must then obtain the new consent from the employee to receive the statement electronically.

For calendar years after 2023, ALEs are no longer required to send Forms 1095-C to individuals unless a form is requested. ALEs must give individuals timely notice that they may request their Form, and if requested, the Form must be provided by the later of January 31 of the year following year to which the form relates (e.g., January 31, 2025 for 2024 forms) or 30 days after the request. To take advantage of the alternative form of disclosure, an ALE must post a notice by the due date for furnishing the statement (including the automatic 30-day

extension). See *New ACA Employer Mandate Disclosure Method Offers Employers Flexibility* for more information.

281. If one of our employees dies during the year, do we still have to provide the statement for that employee?

Yes. Statements must be provided to deceased individuals if they had any months of coverage during the prior year because the individual's estate may be liable for penalties if the estate is not able to establish coverage under the individual mandate.

Updated: 6/1/25

282. Are we subject to penalties if we fail to file the required information in a timely manner?

If you fail to timely file complete and accurate 2024 Forms 1094 and 1095 with the IRS or fail to timely furnish a correct Form 1095 statement to responsible individuals, then you could be subject to a penalty of $330 per return with a maximum of $3,987,000 for a calendar year. However, penalties may be reduced if corrective action is taken within 30 days and may even be waived if the failure to file timely or accurately is due to reasonable cause and not due to willful neglect.

Relief from these penalties is available for returns filed and statements furnished for coverage in 2015 – 2020 if you can show that you have made good faith efforts to comply. No relief will be provided if you cannot show a good faith effort to comply with the requirements or you fail to timely file the return or furnish a statement by the appropriate deadline.

Special rules apply that increase the per-statement penalties and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

Section 6056 – Applicable Large Employer Reporting

283. What forms should we use to file the Section 6056 return?

The filing may be made on IRS Form 1095-C for every employee who was full-time for at least one month of the year. The 1095-Cs will be filed with a single transmittal form, Form 1094-C. Form 1095-C can be used to satisfy both the Sections 6055 and 6056 reporting requirements. If you are a large employer that provides insured coverage, you are required to complete only the section of Form 1095-C that reports the information required under Section 6056.

The IRS releases final versions of the combined 1094-C and 1095-C forms and instructions, which are available HERE and HERE.

284. What is the deadline for filing the Section 6056 return with the IRS?

The return must be filed with the IRS on or before February 28th of the year following the calendar year to which the reporting relates regardless of your plan year. The return can be filed electronically and employers that file 250 or more Section 6056 returns must file electronically. If filing electronically, you have an additional month until March 31st to file the Section 6056 report.

Beginning with filings after December 31, 2023, the electronic filing threshold will reduce to 10 returns (in the aggregate, considering each IRS information return, including W-2s, 1095-Bs and -Cs, 1099s, and more. Therefore, employers that file at least 10 IRS informational returns must file electronically.

Information on filing the returns electronically can be found at the ACA Information Returns (AIR) website here: https://www.irs.gov/e-file-providers/affordable-care-act-information-returns-air

285. We are a large employer so we will also have to file the Code Section 6056 return. What information will we have to include on the Code Section 6056 return?

If you employ an average of at least 50 full time employees (including full-time equivalents), you are considered a large employer and must file a Section 6056 annual return with the IRS for every employee who was full-time for at least one month of the year. Your return must show:

- Your employer's name, the date, and the employer's EIN and the calendar year for which the information is reported;
- The name and telephone number of your contact person;
- A certification as to whether you offered your full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under your plan by calendar month;
- The number of full-time employees for each calendar month during the calendar year, by calendar month;
- For each full-time employee, the months during the calendar year for which minimum essential coverage under the plan was available;
- For each full-time employee, the employee's share of the lowest cost monthly premium for self-only coverage providing minimum value offered to that full-time employee under your plan, by calendar month; and

- The name, address, and taxpayer identification number (SSN) of each full-time employee during the calendar year and the months, if any, during which the employee was covered under your plan.

The return will also include indicator codes (rather than having you provide specific or detailed information) for you to report the following information:

- Whether the coverage offered to your full-time employees and their dependents provides minimum value and whether the employee had the opportunity to enroll his or her spouse in the coverage;
- The total number of employees by calendar month;
- Whether an employee's effective date of coverage was affected by a permissible waiting period;
- Whether you had no employees during a particular month;
- Whether you are part of a controlled group, and, if applicable, the name and EIN of each employer member of the controlled group;
- If an appropriately designated person is reporting on your behalf that is a governmental unit for purposes of Section 6056, the name, address, and identification number of the appropriately designated person;
- If you are a contributing employer to a multiemployer plan, whether you are subject to an Employer Mandate penalty due to your contributions to the multiemployer plan; and
- If a third party is reporting on behalf of your aggregated employer group, the name, address, and identification number of the third party.

286. If we are subject to both the Sections 6055 and 6055 reporting because we are a large employer with a self-insured plan, can we combine the filings to streamline the process?

Yes. The IRS will be providing a single combined Form 1095-C for reporting the information required under both Sections 6055 and 6056.

287. We offer coverage to all of our full-time employees. Is there an easier way to satisfy the Section 6056 reporting requirement?

Yes. The final rule provides several alternatives to the general method that you can use under certain circumstances. First, you can report simplified Section 6056 information and use a simplified statement for your employees as long as you made a "qualifying offer" of health insurance to a full-time employee for all months during the year in which the employee was a full-time employee. A qualifying offer of insurance is one that provides minimum value at a cost of 9.5% or less of the federal poverty level for employee-only coverage and also offered

minimum essential coverage to the employee's spouse and dependents. Once the IRS issues the return forms, it is expected that you will be able to use a code indicating that you have made a qualifying offer to some or all of your full-time employees.

If you offer coverage to at least 98% of your employees – including full-time and part-time employees - you will not be required to determine for Section 6056 reporting purposes whether your employees are full-time or part-time employees and will not be required to provide a total count of your full-time employees. To qualify for this alternative method, you must certify that you have offered coverage to at least 98% of your employees included in the report and that the coverage offered is both affordable and provides minimum value.

288. We are a parent of a controlled group of corporations comprised of a number of member employers and our plan covers employees of all the member employers. Do we have to file the Section 6056 return on behalf of the other employer members?

No. Each employer member with full-time employees that is the common-law employer of the employee is responsible for the filing with respect to its full-time employees even though the determination of whether you are a large employer is made at the aggregated group level.

However, employer-members of your controlled group without any full-time employees are not required to file the Section 6056 report.

289. We contribute to a multiemployer plan on behalf of our union employees. Are we required to file returns under Section 6056?

Yes, however, the multiemployer plan may file the return with respect to the employees that it covers and assist you in providing the statements to those employees. For any employees you provide coverage under your own plan, you will be responsible for the reporting and for providing a statement to the covered employees.

290. Does Section 6056 apply to nonprofit and/or governmental employers?

Yes, Section 6056 applies to all applicable large employer regard to whether the employer is tax-exempt or a governmental employer (including the United States, states and their subdivisions, and Indian tribal governments).

291. Can our TPA file the Section 6056 report on our behalf?

Generally, yes, but the regulations do not allow you to transfer the liability for reporting failures to your TPA or any other third party.

However, a large employer that is a governmental unit or any agency or instrumentality may appropriately designate another person that is part of, or related to, the same governmental unit as the large employer to report on its behalf.

The designation must be in writing, must be signed by both the large employer member and the designated person, and must include the name, address, and employer identification number of the designated person. The designation must contain information identifying the category of full-time employees (which may be full-time employees eligible for a specified health plan, or in a particular job category, as long as the specific employees covered by the designation can be identified) for which the designated person is responsible for reporting under Section 6056 on behalf of the large employer. If the designated person is responsible for reporting under Section 6056 for all full-time employees of a large employer, the designation must indicate that is the case. The designation must contain language that the designated person agrees and certifies that it is the appropriately designated person under Section 6056(e), and an acknowledgement that the designated person is responsible for reporting under Section 6056 on behalf of the large employer and subject to the requirements of Section 6056. The designation must also include the name and employer identification number of the large employer.

For example, a political subdivision of a state may designate the state, another political subdivision of the state, or an agency or instrumentality of the state as the designated person for purposes of Section 6056 reporting. The person designated might be the governmental unit that operates the relevant health plan or the governmental unit that does other information reporting on behalf of the designating governmental unit. If the written designation is accepted by the designee and is made before the filing deadline, the designated governmental unit is the designated entity responsible for Section 6056 reporting.

292. Do we file a Section 6056 return for full-time employees that are offered our coverage but waive it?

Yes.

293. Do we file a Section 6056 return for full-time employees that are not offered our coverage?

Yes.

294. If I am a large employer but all my employees are part-time employees, will I be required to report pursuant to Section 6056?

No. Applicable large employers without any full-time employees are not subject to the Section 6056 reporting requirements.

295. How do we report on a full-time employee that works for more than one employer member of our controlled group?

In cases where a full-time employee works for more than one member of your controlled group, the full-time employee is treated as the employee of the employer member for whom the employee had the greatest number of hours of service for the calendar month. If the full-time employee works an equal number of hours for two or more members of your controlled group, the employer members have discretion to designate who the employee worked for during the calendar month.

Updated: 6/1/25

296. Do we have to provide a copy of the Section 6056 return to our full-time employees?

Before reporting began on 2024 calendar years (in 2025), an employer had to provide a Form 1095-C statement to each full-time employee named in your Section 6056 return that includes the name, address and contact information of the entity that filed the return and the information in the return pertaining to that individual. You can either provide a copy of the Form 1095-C return filed with the IRS or a substitute statement that includes the information that was included on the return.

For calendar years after 2023, ALEs are no longer required to send Forms 1095-C to individuals unless a form is requested. ALEs must give individuals timely notice that they may request their Form, and if requested, the Form must be provided by the later of January 31 of the year following year to which the form relates (e.g., January 31, 2025 for 2024 forms) or 30 days after the request. To take advantage of the alternative form of disclosure, an ALE must post a notice by the due date for furnishing the statement (including the automatic 30-day extension). See *New ACA Employer Mandate Disclosure Method Offers Employers Flexibility* for more information.

297. What is the deadline to provide the reporting to my employees?

The 1095-C statement must be furnished to your full-time employees on or before January 31 of the year following the calendar year in which you provide them with minimum essential coverage.

For 2021 and later, the deadline is permanently extended from January 31 to March 2 (March 1 in leap years).

298. Do we have to mail the form to the employee, or can we provide it electronically?

Either method is allowed. You are permitted to mail it separately to the employee to the employee's last known permanent address or, if no permanent address is known, to the employee's temporary address. Alternately, it can be included in the same mailing with one or more of the other required information returns such as the combined Sections 6055 and 6056 employee 1095-C statement and the Form W-2.

You can send the 1095-C statement electronically if the employee has specifically consented to receiving the statement electronically in a manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished. Prior to, or at the time of consenting, you must provide a conspicuous disclosure to the employee that includes all of the following:

- The statement will be furnished on paper if the employee does not consent to receive it electronically;
- The consent applies to each statement required to be furnished after the consent is given until it is withdrawn or only to the first statement required to be furnished following the date of the consent;
- The employee can request a paper copy of the statement and the procedure for obtaining a paper copy of their statement after giving the consent and whether a request for a paper statement will be treated as a withdrawal of consent;
- The employee may withdraw a consent by writing (electronically or on paper) to the person or department whose name, mailing address, telephone number, and email address is provided in the disclosure statement;
- There may be conditions under which you will cease furnishing statements electronically to the employee and what those conditions are (e.g. if the employee terminates employment);
- The employee must update their contact information and the procedures for updating that information; and
- A description of the hardware and software required to access, print, and retain the statement, and if applicable, the date when the statement will no longer be available on your web site. You must also advise the employee that the statement may be required to be printed and attached to a Federal, State, or local income tax return.

If you change the hardware or software required to access the statement that creates a material risk that the employee will not be able to access a statement, you must, prior to changing the hardware or software, notify the employee. The notice must describe the revised hardware and software required to access the statement and inform the employee that a new consent to receive the statement in the revised electronic format must be provided. After implementing the revised hardware or software, you must then obtain the new consent from the employee to receive the statement electronically.

Updated: 6/1/25

299. Are we subject to penalties if we fail to file the required Section 6056 information in a timely manner?

If you fail to timely file complete and accurate 2024 Forms 1094-C and 1095-C with the IRS or fail to timely furnish a correct statement to responsible individuals, then you could be subject to a penalty of $330 per return with a maximum of $3,987,000 for a calendar year. However, penalties may be reduced if corrective action is taken within 30 days and may even be waived if the failure to file timely or accurately is due to reasonable cause and not due to willful neglect.

Relief from these penalties is available for returns filed and statements furnished for coverage in 2015-2020 if you can show that you have made good faith efforts to comply. No relief will be provided if you cannot show a good faith effort to comply with the requirements or you fail to timely file the return or furnish a statement by the appropriate deadline.

Special rules apply that increase the per-statement penalties and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

Small Business Premium Tax Credit

Updated: 6/1/25

300. As a small employer with only 21 employees, will we be eligible for any assistance to help us provide coverage to our employees?

It depends. Effective January 1, 2010, premium subsidies are available for small employers with fewer than 25 full-time equivalent employees and average annual wages of $50,000 or less that purchase coverage for employees and pay at least 50% of the cost. Additional premium subsidies are available for employers with 10 or less full time equivalent employees and an average annual wage of $25,000 or less. These dollar amounts are indexed annually for inflation. For 2025, the average annual wage thresholds increased to $33,330 and $66,660.

The IRS has more information about the credit, including tax tips, guides and answers to frequently asked questions available on their website at:

https://www.healthcare.gov/small-businesses/provide-shop-coverage/small-business-tax-credits/

301. How much is the tax credit?

For 2010 through 2013, the tax credit is 35% of the employer's contribution towards health premiums. Starting in 2014, the maximum credit will increase to 50% of premiums paid, but the credit will only be available if you purchase coverage through a SHOP Marketplace.

The tax credits are reduced if the number of your full time employees exceeds 10 or if average annual wages exceed $25,000.

302. Does it include dental or vision?

Yes. The credit can also apply to dental or vision; long-term care, nursing home care, home health care, or community-based care; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental health insurance.

303. Can premiums we paid in 2010, but before the new health reform legislation was enacted, be counted in calculating the credit?

Yes. In computing the credit for a tax year beginning in 2010, you may count all premiums paid in 2010.

304. We are a tax-exempt organization. Can we qualify for the tax credit?

Yes. The tax credit is available to you if you're an organization described in Code section 501(c) that is exempt from tax under Code section 501(a). The tax credit is 25% of your contribution towards health premiums. However, the amount of the credit cannot exceed the total amount of income and Medicare (i.e., hospital insurance) tax you are required to withhold from your employees' wages for the year and your share of Medicare tax on your employees' wages.

Starting in 2014, the maximum credit will increase to 35% of premiums paid, but the credit will only be available if you purchase coverage through a SHOP Marketplace.

305. Can we claim the credit if we had no taxable income for the year?

Yes. For a tax-exempt employer, the credit is a refundable credit so even if you have no taxable income, you may receive a refund.

306. How do we claim the tax credit?

The credit is claimed on your company's annual income tax return with an attached Form 8941, Credit for Small Employer Health Insurance Premiums, showing the calculation of the credit.

A tax-exempt small business claims the credit by filing the Form 990-T, Exempt Organization Business Income Tax Return, with an attached Form 8941 showing the calculation of the claimed credit. Filing Form 990-T with an attached Form 8941 is required for a tax-exempt eligible small business to claim the credit, even if it is not otherwise required to file Form 990-T.

307. Is there a limit on the number of years a small business can claim the tax credit?

Yes. Starting in 2014, the credit will be available to eligible small employers for two consecutive taxable years.

308. How do we determine how many full time equivalent employees (FTE) we have for the purposes of the tax credit?

The number of FTEs is determined by dividing the total hours for which you paid wages to your employees during the year (but not more than 2,080 hours for any employee) by 2,080. The result, if not a whole number, is then rounded to the next lowest whole number.

Example: For the 2010 tax year, an employer pays 5 employees wages for 2,080 hours each, 3 employees' wages for 1,040 hours each, and 1 employee wages for 2,300 hours.

The employer's FTEs would be calculated as follows:

Total hours not exceeding 2,080 per employee is the sum of:

a. 10,400 hours for the 5 employees paid for 2,080 hours each (5 x 2,080)
b. 3,120 hours for the 3 employees paid for 1,040 hours each (3 x 1,040)
c. 2,080 hours for the 1 employee paid for 2,300 hours (lesser of 2,300 and 2,080)

This adds up to 15,600 hours.

15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number = 7.

309. How do we determine the amount of our average annual wages?

The amount of your average annual wages is determined by first dividing (1) the total wages paid by the employer to employees during your tax year; by (2) the number of your full time equivalent employees for the year. The result is then rounded down to the nearest $1,000 (if not otherwise a multiple of $1,000). For this purpose, “wages” means wages as defined for FICA purposes (without regard to the wage base limitation).

Example: For the 2010 tax year, an employer pays $224,000 in wages and has 10 FTEs. The employer’s average annual wages would be: $22,000 ($224,000 divided by 10 = $22,400, rounded down to the nearest $1,000).

310. Do we have to count our seasonal employees when determining the number of full time equivalent employees, we have or the amount of our average annual wages?

No. Seasonal employees (i.e. workers who perform labor or services for no more than 120 days during the taxable year and retail workers employed exclusively during holiday seasons) are excluded when determining if you have less than 25 full time equivalent employees for purposes of the small business premium tax credit and from the calculation of the employer's annual wage level for purposes of the credit.

Patient -Centered Outcomes Research Institute Fee (PCORI)

311. What is the Patient-Centered Outcomes Research (PCORI or CER) fee?

ACA established the Patient-Centered Outcomes Research Institute. Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will assist patients, clinicians, purchasers and policymakers in making informed health decisions through the dissemination of comparative clinical effectiveness research findings.

The trust fund will be funded in part by fees paid by health insurers and plan sponsors. The fee was originally imposed for each plan year ending on or after October 1, 2012, and before October 1, 2019. But in 2019, Congress passed a $1.4 trillion package to fund the federal government through September 2020. The legislation included a 10-year extension of the PCORI fee through September 20, 2029.

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312. How much is the fee?

For plan years ending before October 1, 2013, the fee is $1 multiplied by the average number of lives covered under the plan for the plan year. For plan years that end on or after October 1, 2013 but before October 1, 2014, the fee is $2 multiplied by the average number of lives covered under the plan for the plan year. The fee amount will be indexed annually starting in 2014 as described below:

- $2.66 per covered life for policy years and plan years ending on or after October 1, 2020, and before October 1, 2021.
- $2.79 per covered life for policy years and plan years ending on or after October 1, 2021, and before October 1, 2022.
- $3.00 per covered life for policy years and plan years ending on or after October 1, 2022, and before October 1, 2023.
- $3.22 per covered life for policy years and plan years ending on or after October 1, 2023, and before October 1, 2024.
- $3.47 per covered life for policy years and plan years ending on or after October 1, 2024, and before October 1, 2025.

313. If our medical plan is fully insured, is there anything we have to do?

For insured plans, the insurer will be responsible for all the PCORI fee requirements including reporting on and paying the fee.

314. We sponsor a self-insured health plan. How will we pay the fee?

You must pay and report the fee on IRS Form 720, “Quarterly Federal Excise Tax Return.” The Form 720 can be filed and paid electronically or submitted on-line using an approved transmitter software. The fee is due once a year (not quarterly), which will be due by July 31 of each year. Your payment and return will cover the plan year that ended during the preceding calendar year. For example, for applicable plan years that end in 2012, the first due date for filing Form 720 is July 31, 2013.

Information on paying the fee electronically through the Electronic Federal Tax Payment System (EFTPS) can be found here: https://www.eftps.gov/eftps/

315. Our plan is not subject to ERISA. Do we still have to pay the PCORI fee?

Yes. The fee applies to church and governmental plans that are not subject to ERISA on the same basis it applies to ERISA plans.

316. **We sponsor a single self-insured plan that covers employees of three other employer-members of our controlled group. Is each employer member responsible for their own fee?**

No. The fee is imposed on the plan sponsor of the plan, not each participating employer member.

317. **If we have two plan options, one is a self-insured PPO option and the other is an insured HMO option. Will there be two fees for our arrangement?**

Yes. For the insured plan option, the insurer will report and pay the fee. For the self-insured plan option, you will have to report and pay the fee.

318. **Can we hire our TPA to file the return on behalf of our self-insured plan?**

No. There is no way for a third party to file Form 720 on behalf of the plan sponsor. The IRS indicated that the costs of establishing such a third-party payer program would outweigh the benefits given the limited period over which the fee will apply.

319. **Can we use plan assets from our plan trust or employee contributions to pay the PCORI fee?**

No. The fee is imposed on the plan sponsor, not the plan. As such, paying the PCORI fee generally is not a permissible expense of the plan for purposes of ERISA.

320. **Our self-insured plan includes prescription drug benefits managed by a pharmacy benefit manager. We will have to pay two separate fees?**

No. A single self-insured plan that provides two or more separate health benefits will only be assessed as a single fee. Even if the prescription drug benefits are provided under a separate plan, you will still only pay a single fee as long as each plan operates on the same plan year basis.

321. **We also sponsor a health care FSA and provide dental and vision benefits. Will we have to pay a separate fee for them?**

The fee does not apply to HIPAA-excepted health FSAs and according to the final regulations, it does not apply to limited-scope dental or vision benefits that are offered separately from the medical benefits. An example from the regulations illustrates this point:

Example 1: Plan Sponsor D sponsors and maintains three separate plans to provide certain benefits to its employees – Plan 501, Plan 502, and Plan 503. Plan 501 is a calendar year plan that provides accident and health benefits on a self-insured basis to employees of Plan Sponsor D. Plan 502 is a calendar year HRA that can be used to pay for qualified accident and medical expenses for employees of Plan Sponsor D and their eligible dependents. Plan 503 provides dental and vision benefits for employees of Plan Sponsor D and eligible dependents on a self-insured basis.

Conclusion: Because Plan 501 and Plan 502 provide accident and health coverage and are maintained by Plan Sponsor D for the benefit of its employees, Plans 501 and 502 are applicable self-insured health plans that are subject to the fee. Because dental and vision benefits are excepted benefits, Plan 503 is not an applicable self-insured health plan subject to the fee.

322. We offer a health reimbursement arrangement (HRA) that is integrated with a high deductible health plan. Do we have to pay separate fees for each plan?

An HRA is not subject to a separate fee if the HRA is integrated with another self-insured plan that provides major medical coverage as long as you are the plan sponsor for both plans and they both have the same plan year.

However, if the HRA is integrated with an insured major medical plan, then the insurer will pay the fee for the major medical plan, and you will be responsible for reporting and paying the fee for the HRA. You may treat each employee's HRA as covering a single covered life. You are not required to include in your count of covered lives any spouse, dependent, or other beneficiary of the employee.

323. We don't offer a major medical plan, but we offer a stand-alone HRA to help our employees pay for their health care expenses. Will we have to pay the fee for the HRA?

Yes. If you only sponsor a stand-alone HRA or FSA, you will have to pay the fee for that HRA or FSA. However, you may treat each employee's health HRA or FSA as covering a single covered life. You are not required to include in your count of covered lives any spouse, dependent, or other beneficiary of the employee.

324. Will the fee apply to our EAP or wellness program if they provide limited medical benefits?

Even though they may be considered group health plans, the fee will not apply for an EAP, disease management program, or wellness program if the program does not provide significant benefits for medical care or treatment.

325. We have employees working and living overseas that are covered under a separate expatriate plan. Does this fee apply to that coverage?

No. The fee does not apply to any group insurance policy or self-insured plan if the facts and circumstances show that the policy or plan is designed specifically to cover primarily employees who are working and residing outside of the United States.

Individuals (and their dependents) would be deemed to be living outside the United States if the address you have on file for the primary insured person is outside the United States.

326. For our self-insured plan, how do we determine the average number of lives covered under our plan for the plan year?

You can choose one of three alternative methods to determine the average number of lives covered under the plan for the plan year:

- **Actual Count Method** – add the total number of lives covered for each day of the plan year and divide that total by the number of days in the plan year.
- **Snapshot Method** – add the total number of lives covered on one date in each quarter, or more dates if an equal number of dates are used for each quarter and divide that total by the number of dates on which the count was made. For this purpose, the date or dates for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, the first day of each month, etc.) or, each date used for the second, third, and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year. There are two methods you can use under the snapshot method for counting the number of covered lives:
  - *Snapshot Factor Method* – The sum of the number of participants with employee-only coverage on the designated date, plus the product of the number of participants with coverage other than employee-only coverage on the date multiplied by 2.35; or

- *Snapshot Count Method* – The actual number of lives covered on the designated date.

- **5500 Method** – add together the number of participants (i.e. employees or former employees) covered at the beginning of the plan year and the number of participants covered at the end of the plan year, as reported on the Form 5500 filed for the applicable self-insured health plan for that plan year. If your plan only offers employee-only coverage, then you would add the number of participants covered at the beginning of the plan year to the number of participants covered at the end of the plan year and then divide by two.

You must use the same method of calculating the average number of lives covered under the plan consistently for the duration of the plan year. However, you may use a different method from one plan year to the next.

327. Do we include COBRA qualified beneficiaries in our count?

Yes. The fee applies to individuals covered as COBRA qualified beneficiaries.

328. Do we have to count covered retirees and their dependents when calculating the fee?

Yes. The fee applies to retiree coverage whether provided under an active employee plan or a stand-alone, retiree-only plan.