The Affordable Care Act, Eight Years Later: A Reset for Employers

Thursday, October 18, 2018 at 12:00pm EDT;
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Speakers

BUTZEL LONG

In the beginning. . .

- "Patient Protection and Affordable Care Act" -- signed March 23, 2010
- "Health Care and Education Reconciliation Act" -- signed March 30, 2010 (technical corrections)
- ACA "Mandates" – staggered effective dates, transition rules

ACA EMPLOYER MANDATES AND BEYOND*

*Not meant to be all-encompassing, but a snapshot of key provisions impacting employers

INTRODUCTION

ACA MANDATES & "GRANDFATHERED PLANS"

"Grandfathered Plans"

- Some ACA reforms for group health plans ("GHPs") inapplicable to "grandfathered plans"

- Grandfathered plan = plan essentially frozen in place on March 23, 2010 (except for required ACA mandates and required improvements)

"Grandfathered Plans"

- Subsequent regulations - requirements so that GHP may remain grandfathered (including notice of grandfathered status and cost-sharing adjustment caps)

- Supreme Court noted millions of employees still covered in grandfathered plans in *Burwell v. Hobby Lobby*

Part I

ACA MANDATES: APPLICABLE TO BOTH NON-GRANDFATHERED & GRANDFATHERED PLANS

ACA Mandates – All GHPs

- ACA mandates currently applicable to all GHPs, whether "grandfathered" or non-grandfathered:
  - No lifetime or annual dollar limits
  - Dependent coverage to age 26
  - No rescission except in narrow circumstances
  - No preexisting condition exclusions
  - No excessive waiting periods
  - Summary of Benefits and Coverage

No Lifetime Limits – As Enacted

- May not establish lifetime limits on **dollar value** of essential health benefits ("EHBs") for any participant or beneficiary

- May still place **lifetime per beneficiary limits on non-EHBs**, if such limits otherwise legally permissible

No Lifetime Limits - Today

- **STILL APPLIES**, with minor adjustments:
  - May exclude **all** benefits for a condition
  - **BUT NOTE**: if GHP provides any benefits for a condition, then lifetime limit ban applies

No Lifetime Limits - Today

- **STILL APPLIES**, with minor adjustments:
  - If grandfathered, self-funded, or large group market insured GHP, must currently define EHBs (for lifetime limit ban) consistent with either the state benchmark plan or federal employees health program

No Annual Limits – As Enacted

- May not establish annual limits on **dollar value** of EHBs for any participant or beneficiary.

- May still place annual **per beneficiary limits on non-EHBs**, if such limits otherwise legally permissible

No Annual Limits - Today

- **STILL APPLIES**, with similar minor adjustments to ban on lifetime limits:
  - May exclude **all** benefits for a condition
  - **BUT NOTE**: if GHP provides any benefits for a condition, then annual limit ban applies

No Annual Limits - Today

- **STILL APPLIES**, with minor adjustments:
  - If grandfathered, self-funded, or large group market insured, must currently define EHBs (for annual limit ban) consistent with either the state benchmark plan or federal employees health program

No Lifetime/Annual Limits – Today
EHB Benchmark Plans

- For 2019, EHB benchmark plan - a benchmark plan sold in 2014 (changes to come for 2020)
- For state benchmark plans: www.cms.gov/cciio/resources/data-resources/ehb.htm#ehb
- Mental Health Parity EHBs – 2017 standard
- CMS Fact Sheet for Final Rule of April 8, 2018: www.cms.gov/newsroom/fact-sheets/hhs-notice-benefits-and-payment-parameters-2019

No Annual Limits – Today
FSAs

- **EXCEPTION** if proper plan design:
  - **Health FSAs** NOT subject to annual limit ban, IF AND ONLY IF reimbursements available do not exceed more than 5 times the cost

No Annual Limits – Today
HRAs

- **IMPACT ON HRAs**:
  - Absent exemption (e.g. retiree-only HRA, stand-alone dental expense plan), HRA **must** be paired (integrated) with GHP offered by employer
  - Generally, not deemed "integrated" (for purposes of annual limit ban) if HRA used to reimburse purchase of individual insurance coverage

Extension of Dependent Coverage – As Enacted

- IF "dependent coverage" of children provided, must offer such coverage for adult child until age 26
- Turns on status of child only (not financial dependency)
- No requirement to provide coverage for child of adult child receiving dependent coverage

Extension of Dependent Coverage - Today

- **SAME, with clarifications**:
  - Meaning of "dependent" safe harbor: "dependent child" as described in Internal Revenue Code Section 152(f)(1) (*e.g.*, biological or adopted son, daughter, stepson, or stepdaughter, as well as eligible foster children)
  - Uniformity of terms of coverage requirement to all "dependent children" regardless of age

Patient Protection Against Rescission – As Enacted

- No rescission of coverage after enrollment, absent:
  - Fraud **AND/OR**
  - Intentional misrepresentation of material fact as prohibited by plan terms

- **NOTICE REQUIRED BEFORE RESCISSION** for above reason or reasons

Patient Protection Against Rescission - Today

- **NO CHANGE**, just clarification in final regulations:
  - Cannot rescind unless 30 days written notice issued
- NOT RESCISSION IF ANY OF FOLLOWING:
  - Prospective cancellation or discontinuance
  - Retroactive cancellation for failure to timely pay required premiums/contributions
  - Initiated by uncoerced individual

Patient Protections– Today
End-Run by "Low-Cost" Plans

- ADMINISTRATION Actions:
  - Executive approval of "low-cost" plans outside of employer GHPs and Exchanges (so-called "skinny plans")
  - No protection against fraud upon consumer under Association Health Plans ("AHPs") or Short-Term Limited Duration Insurance ("STLD")

Patient Protections – Today
End Run - AHPs

- Final Rule: June 21, 2018 – AHPs for non-employer-sponsored plans across state lines or regions

- "Commonality of interest" test: associations in same trade, industry or profession across the United States OR same principal place of business within state or metro area, even if area crosses state lines

Patient Protections – Today
End Run - AHPs

- Lawsuit filed by 12 states in DC Circuit Court on July 26, 2018:
  - Argues Final Rule = unconstitutional executive action
  - Argues Final Rule changes ERISA definition of "employer" (small employer now defined as "large employer")
- Vermont Act 131

Patient Protections – Today
End Run - AHPs

- Problems associated with AHPS:
  - Insurer reluctance to establish AHPs in low service areas
  - No ACA patient protections against fraud
  - No pre-existing condition mandate or guaranteed issue or renewability

Patient Protections – Today
End Run – STLD INSURANCE

- Non-employer-sponsored insurance policies – Final Rule, August 1, 2018

- Duration of "short-term" extended:
  - Prior Rule - no more than 3 months (transitional between jobs)
  - Current Rule – for issuer contract with expiration of less than 12 months after original effective date, may be extended to 36 months

Patient Protections – Today
End Run – STLD INSURANCE

- Impact on employer-sponsored plans - adverse selection
- No ACA mandates for ESB coverage (e.g., STLD provides no maternity coverage, prescription drug, mental health benefits, preventive services)
- Not subject to ACA prohibition on pre-existing condition exclusion or lifetime and annual dollar limits

Patient Protections – Today
End Run – STLD INSURANCE

- Can charge higher premiums based on health status, gender, age & other factors (or deny coverage)

- Not subject to ACA cost-sharing limitations
  - Kaiser FF April 2018 report: cost-sharing as high as $30,000 per policy period (ACA, $7,350 in 2018)

- Vermont Act 131

No Preexisting Condition Exclusions – As Enacted and Today

- No preexisting condition exclusions permitted in any GHPs
- **NO SIGNIFICANT CHANGE to ACA itself**

No Preexisting Condition Exclusions – End Run – Tax Reform Implications

- Tax Cuts and Jobs Act (2017) – eliminated penalty for 2019 for failure to comply with individual mandate, creating basis for potential end-run around pre-existing condition exclusion:
  - Texas lawsuit by states to invalidate all of ACA based on zero penalty in 2019 for failure to comply with mandate
  - What if mandate is severed from ACA?

No Preexisting Condition Exclusions – Tax Cuts and Jobs Act Implications

- June 3, 2018 AG Sessions letter to Rep. Paul Ryan – federal government refused to defend ACA:
  - Unusual stance - no declaration of unconstitutionality
    Note: Taking Care Clause of Federal Constitution (*US v. Windsor*)
  - DOJ agrees mandate is severable, but "non-severable" from "guaranteed issue" and community rating

No Preexisting Condition Exclusions – Tax Cuts and Jobs Act Implications

- If Texas severs ACA mandate, guaranteed issue, and community rating:
  - States may step in to stabilize rates for pre-existing conditions in public exchanges
  - Kaiser News: Alaska & Minnesota programs

Prohibition on Excessive Waiting Periods – As Enacted

- No waiting period in excess of 90 days

Prohibition on Excessive Waiting Periods – Today

- **STILL APPLIES**, but some leeway:
  - Employee may take more than the 90 day limit to elect coverage, if plan permits (as long as the plan permits the employee to elect coverage that will begin no later than the 90th day)
  - Eligibility conditions based on factors OTHER than time passage permitted (e.g., job classification conditions)

Prohibition on Excessive Waiting Periods – Today

- **STILL APPLIES**, but some leeway:
  - 12 month look-back period permitted for variable hour employees in order to assess whether employee meets an hours of service eligibility requirement
  - One-month orientation period permitted

Summary of Benefits and Coverage – As Enacted

- "Summary of Benefits and Coverage" - must contain key components of coverage and cost-sharing
  - Include uniform glossary required
  - Follow governmental model
  - Deliver at time of application, enrollment, and re-enrollment
  - Must provide 60-day advance notice of plan modification not reflected in the most recent SBC

Summary of Benefits and Coverage - Today

- **STILL APPLIES,** with clarifications:
  - Two rounds of agency templates
    (Most recent template an attempt to streamline information and reduce pages)
  - "Good faith" compliance standard – i.e., if plan administrators make best efforts to comply, will not be penalized for mistakes

PART II

ACA MANDATES: NON-GRANDFATHERED PLANS

ACA Mandates – Not Applicable to "Grandfathered Plans"

- ACA mandates applicable to non-grandfathered plans:
  - Maximum out-of-pocket limits and deductibles
  - Patient protections
  - Clinical trial coverage
  - Prohibition on discrimination in favor of highly compensated individuals
  - Coverage of preventive health services
  - Enhanced appeals processes
  - Reporting on transparency in coverage/quality of care

Maximum Out-of-Pocket Limits and Deductibles – As Enacted

- Out-of-pocket limits and deductibles for EHBs not to exceed statutorily-specified amounts

Maximum Out-of-Pocket Limits and Deductibles – Today

- **SOME CHANGE:** deductible limits repealed

- **SOME CLARIFICATION** in agency guidance:
  - Application of Limits - only to in-network benefits
  - "Embedded" rule – individual may not be required to pay more than the individual out-of-pocket limit, even in family coverage

Patient Protections – As Enacted

- Miscellaneous "patient's bill of rights" requirements:
  - Designations of primary care physicians
  - Coverage of emergency room services regardless of network
  - Access to pediatric care
  - Access to OB/GYN care

Patient Protections - Today

- NO SIGNIFICANT CHANGE under ACA itself:
  - General requirements in effect
  - Regulations elaborate on cost-sharing for emergency room visits and issuance of notices

Coverage in a Clinical Trial – As Enacted & Today

- IF offer of coverage for participation in clinical trial:
  - No denial of such participation or discrimination against participant based on such participation
  - No denial (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with participation in clinical trial

Prohibition on Discrimination in Favor of Highly Compensated Individuals – As Enacted & Today

- Fully-insured GHPs subject to Internal Revenue Code requirements prohibiting discrimination in favor of highly compensated individuals

- Still awaiting guidance & no enforcement yet

Coverage of Preventive Health Services – As Enacted

- Coverage without cost sharing for:
  - Evidence-based items or services currently rated "A" or "B" in the USPSTF
  - Immunizations recommended per Advisory Committee on Immunization Practices
  - Evidence-informed preventive care and screenings for children in Health Resources and Services Administration (HRSA) guidelines
  - Preventive care and screenings for women in HRSA guidelines

Coverage of Preventive Health Services – Today

- Lists of applicable services routinely updated
- Regulations clarify:
  - Billing techniques for dual-purpose office visits
  - Exemption from requirement for out-of-network providers if in-network provider can accommodate

Coverage of Preventive Health Services – Contraceptive Mandate

- May 4 Executive Order – vigorous enforcement of federal law's protection of religious freedom
- AG Memo May 6, 2017 – expanded *Hobby Lobby* application to closely held businesses to all businesses with sincere religious beliefs
- October 6, 2017 Executive Agency Interim Final Rules: Religious and Moral Conviction Exemptions

Coverage of Preventive Health Services – Contraceptive Mandate

- Self-certified Religious Conviction (sincerely held religious belief) by non-governmental or governmental plan sponsors, non-profit or for-profit corporations, institutions of higher learning, health care issuers, third-party administrators, or individuals

Coverage of Preventive Health Services – Contraceptive Mandate

- Self-certified Moral Conviction (conscience protection) by all group health plans, certain institutions of higher learning, non-profits, closely held corporations with no publicly traded ownership, health care issuers, or individuals

Coverage of Preventive Health Services – Contraceptive Mandate

- Women's health not "important governmental objective" or all plans would be subject to ACA preventive services mandate (*Hobby Lobby)*
- Removal of contraceptive mandate from 2012 Guidelines & prohibition against inclusion in future
- National injunction against IFRs entered, then stayed pending appeal in the Third Circuit

Appeals Processes – As Enacted

- Mandates effective appeals process for appeals of coverage determinations and claims in two parts:
  - Internal claims appeal process with notice rights, benefit claim file review by participant, taking of evidence, and receipt of continued coverage through appeal decision
  - External review process

Appeals Processes – Today

- Regulations - elements of satisfactory internal processes, e.g.
  - Ability for claimant to respond to new or additional evidence
  - Safeguards against conflicts of interest
  - Detailing the information that must be included in notices of decisions)

Appeals Processes - Today

- Mode of external review process depends on type of plan:
  - Insured GHP or self-insured non-ERISA GHP in a state that has an external review process that includes the consumer protections in the NAIC Uniform Model Act: use state processes
  - Self-insured ERISA GHP: federal external review process

Reporting on Transparency in Coverage & Quality of Care – As Enacted & Today

- Specified information to HHS (and available to public) including (but not limited to):
  - Data on enrollment
  - Claims payment policies and practices
  - Data on denied claims
  - Cost-sharing information

Reporting on Transparency in Coverage & Quality of Care – As Enacted & Today

- Reports to HHS and enrollees on improving health outcomes, improving patient safety, and wellness and prevention programs

- Still waiting on guidance & no enforcement until issued

Part III

2019 REQUIREMENTS – EMPLOYER REPORTING AND COST CONSIDERATIONS

Inclusion of the Cost of Employer-Sponsored Health Coverage – As Enacted

- Employers must include the aggregate cost of applicable employer-sponsored coverage in an applicable employee's Form W-2.
  - The amount does not include the amount of any salary reduction contributions to a flexible spending arrangement.

FPL Safe Harbors for Reporting

- Employee's W-2 wages (reported in box 1) generally on first day of plan year
- Employee's rate of pay as of the first day of the plan year (for hourly workers, hourly wage multiplied by 130 per month)
- Individual FPL for six months prior to beginning of plan year

2019 Affordability Requirements

- Notice 2018-34:
  - ACA's affordability standard – adjusted for inflation
  - 2019 affordability for calendar year plans: employee contribution for lowest cost, self-only coverage option cannot exceed 9.86% of employee's household income

Notice 2018-34 – 2019 Chart

Household income %	Initial %	Final %
Less than 133%	2.08%	2.08%
133% - 149%	3.11%	4.15%
150% -199%	4.15%	6.54%
200% - 249%	6.54%	8.36%
250% - 299%	8.36%	9.86%
300% - 400% (not over)	9.86%	9.86%

Notice 2018-34 – Premium Payment

- 2019 affordability for calendar year plans using FPL to determine affordability:
  - Employee premium payment cannot exceed $99.75 per month, up from $96.08 per month in 2018

Inclusion of the Cost of Employer-Sponsored Health Coverage – Today

- IRS notices clarify requirements of reporting, including:
  - Not required to file if employer files fewer than 250 forms
  - For EAP, on-site medical clinics, and wellness programs which provide employer-sponsored healthcare coverage and where employer charges COBRA premium - include in report
  - Small employers offering qualified small employer health reimbursement arrangements ("QSEHRA") – required to report the total amount of permitted benefit under the QSEHRA

No Preexisting Condition Exclusions – Tax Cuts and Jobs Act Implications

- Tax Cuts and Jobs Act eliminates penalty *beginning in 2019,* but does NOT eliminate the individual mandate itself (26 U.S.C. §5000A(c)(3)(A))

- Because ACA mandate continues:

  – Premium tax credit for certain silver plan enrollment continues

  – Employer-shared responsibility continues

Employer Shared Responsibility and Reporting – First IRS 226J Penalties

- IRS issuing 226J letters providing "initial" assessment of Employer Shared Responsibility Payments (ESRP) for 2017 based on information from employer reporting forms (Form 1095-C)
  - 30-day response time – ALERT MAILROOM
  - ALEs reported separately – ALERT ALES of short response time and coordinate single response

Employer Shared Responsibility and Reporting – Today

- Call IRS at number listed on Form 14764 and request 30-day extension immediately
- Notify firm (law firm or accounting firm) that employer uses to interface IRS and complete Form 2848 (stating for 4980H penalty and year)
- Notify benefit or payroll firm that provided data for employer reporting forms to collect information to challenge initial assessment

Employer Shared Responsibility and Reporting – Possible IRS 227 Responses

- 227J Letter – acknowledges receipt of signed Form 14764 if employer agrees with initial assessment (no response required)

- 227K Letter – acknowledges receipt of challenge and indicated ESRP reduced to zero (no response required)

Employer Shared Responsibility and Reporting – Possible IRS 227 Responses

- **227L Letter** – acknowledges receipt of challenge & revised ESRP with updated Form 14765 enclosed **(Response required if no agree – request meeting or appeal)**

- **227M Letter** – acknowledges receipt of challenge but states no change in assessment (**Response required if no agree – request meeting or appeal**)

- 227N Letter – Appeals decision: final decision from IRS (no response required)

Part IV

DELAYED OR REPEALED MANDATES

Tax on "Cadillac Plans" – As Enacted

- 40% excise tax imposed on health insurance issuers and self-funded GHP administrators of high-cost employer-sponsored health plans
  - Excise tax imposed on "excess benefits" – i.e., the monthly aggregated excess amount above statutory dollar limit (e.g., 1/12 of $10,200 for self-only coverage and $27,500 for family coverage in 2018) adjusted for several factors (cost, age/gender, and retirement)

Tax on "Cadillac Plans" - Today

Delayed until 2022

Automatic Enrollment – As Enacted

- Employers with more than 200 full-time employees must automatically enroll new full-time employees, subject to adequate notice and opt-out opportunities, in a health plan offered by the employer

Automatic Enrollment – Today

REPEALED!

Free Choice Vouchers – As Enacted

- Employers offering minimum essential coverage to employees through GHPs and also paying for a portion of plan cost – required to provide a "free choice voucher" for employees with contributions between 8% and 9.8% of household income

Free Choice Vouchers – Today

REPEALED!

Part V

NON-DISCRIMINATION & WHISTLEBLOWER PROVISIONS APPLICABLE TO EMPLOYERS

ACA 1557 Nondiscrimination Provision – Enacted

- An individual shall not, on the grounds prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973, excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance or is administered by an entity established under HHS (**NOTE – CMS**)

ACA 1557 Nondiscrimination Provision – Enacted

- Prior Administration - forms for Notice of provision if GHP or health care provider received federal assistance (typically Medicare or Medicaid payments) in connection with health care programs
- Section 1557 grievance procedure required
- Taglines for notice and procedure in 15 common languages

ACA 1557 Nondiscrimination Provision – Enacted

- Prior Administration regulation defined ACA 1557 discrimination as including:
  - Discrimination against gender identity disorder or dysphoria
  - Arguably, failure to provide gender transition services
  - Failure to comply with contraceptive mandate in 2012 Guidelines

- Federal district court in Texas issued national injunction staying this part of regulation

Reasonable Break Time for Nursing Mothers – As Enacted

- Employer to provide reasonable break time for employee to express breast milk for 1 year after birth:
  - Place (must be other than a bathroom) for expressing must shielded from view and free from intrusion
  - Not required to compensate for break time
- Not applicable to employer with less than 50 employees if compliance would create undue hardship

Reasonable Break Time for Nursing Mothers – Today

- **SAME**, with clarifications:
  - Every employee counts towards 50-employee threshold
  - Temporary spaces permissible
  - Non-payment for non-exempt employees (salaried employees paid even for breaks under the FLSA)

ACA Anti-Retaliation Provision – As Enacted

- No discharge or other discrimination against employee in terms and conditions or privileges of employer in retaliation for an employee's:
  - Receiving premium tax credit or cost-sharing reduction subsidy OR
  - Objecting to or refusing to participate in an ACA violation

ACA Whistleblowing Protection – As Enacted

- No discharge or other discrimination against employee in terms and conditions or privileges of employer in retaliation for an employee's:
  - Reporting (or about to report or cause to be reported) ACA violation (whether act or omission) to employer, Federal government, or state AG - OR
  - Testifying (or is about to testify) in a proceeding concerning a violation, assisting or participating (or about to assist or participate) in a proceeding

Complaint Procedure

- Complaint Procedure for employees who seek redress under whistleblower provisions.
  - File with OSHA 180 days or less after the date of the alleged violation
  - OSHA will investigate and determine if a violation likely occurred (burden on complainant, with employer afforded opportunity to rebut)
  - OSHA will issue order for relief if violation found

Part VI

ADDITIONAL MANDATES

Simple Cafeteria Plans – As Enacted & Today

- Eligible employers maintaining a simple cafeteria plan not subject to cafeteria plan nondiscrimination requirements
  - Available to employers with average of 100 or fewer employees on business days during either of two preceding years
  - All employees with at least 1,000 hours of service in preceding year are eligible and may elect any benefits available under the plan (subject to permissible exclusions if under age 21, less than 1 year of service, or union)
  - Employer required to contribute to non-HCE and non-key employees an amount at least equal to: a uniform percentage of not less than 2% of compensation; or an amount equal to the lesser of 6% of compensation or 2x the amount of salary reduction contributions

Limitation on Flexible Spending Arrangements – As Enacted

- Health FSAs cap - $2,500 annually in salary reduction contributions, with optional adjustment for inflation

Limitation on Flexible Spending Arrangements – Today

- **Not much has changed**, but some important IRS guidance clarifies treatment of employer contributions:
  - If standard employer contribution (i.e., a flex credit), then such amount not treated as part of limit
  - However, if employee has option to convert the flex credit to cash, then flex credit deemed a salary reduction contribution and thus counts towards limit

Distributions for Medicine Tax-Qualified only if Prescribed – As Enacted

- Distributions/payments for medicines reimbursable or deductible unless the medicine is prescribed
  - NOTE: applies even if medicine available over-the-counter

- Exception - insulin

Distributions for Medicine Tax-Qualified only if Prescribed or Insulin – Today

- **Not much has changed** – requirements remain as enacted in the statute, aside from some very minimal agency sub-guidance clarifications.

Small Employer Tax Credit – As Enacted

- Small employers (employers with no more than 25 full-time equivalent employees) may receive tax credit for providing health insurance, provided:
  - Average annual wages may not exceed $50,000 adjusted for inflation and
  - Employer maintains contribution arrangement through which it pays at least half of insurance premiums

Small Employer Tax Credit - Today

- Regulations clarify meaning of employee and how to count employees, including calculation of full-time equivalents.
- As of 2014, **only eligible** if coverage purchased through a SHOP (Small Business Health Options Program) Exchange.

MEWA Reporting – As Enacted

- Administrators of multiple employer welfare arrangements (MEWAs) required to register with the Department of Labor prior to operating in a state

MEWA Reporting – Today

- Updated regulations and the Form M-1 to account for mandatory MEWA reporting every time a MEWA begins operating in a state:
  - Must be filed within 30 days prior to operating in any state and
  - In addition to an annual reporting obligation, must also file within 30 days of knowingly expanding operations into an additional state, experiencing a merger, a participant increase of 50 percent or more, or a material change.

Notice of Coverage Options – As Enacted

- An employer subject to FLSA must provide written notice to new employees & current employees, informing of:
  - Existence of an Exchange
  - Potential eligibility for a premium tax credit or cost-sharing reduction and
  - Loss of employer contribution to the employer's GHP if the employee opts for Exchange coverage

Notice of Coverage Options – Today

- Still a "requirement" to provide to new employees:
  - DOL has model templates and model language for COBRA election notices.
  - DOL has indicated in an FAQ that **no penalty** applies for failure to issue the notice.

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QUESTIONS?