COST-SHARE CONTRIBUTION MODELS: A GUIDE FOR EMPLOYERS

Employers that sponsor group health plans, particularly those that are subject to the ACA, should be closely attentive to the compliance implications of the employee cost-share contribution models associated with the plans.

OVERVIEW

Employers that sponsor group health plans typically require enrolled employees to pay a portion of the monthly premium according to a cost-share model (also referred to as a contribution model). While employers have broad discretion to structure cost-share models for dental, vision, life and disability benefits as they see fit (provided they do not charge employees more than the gross premium), there are several compliance considerations regarding cost-share models for medical plans.

This Guide for Employers addresses the key medical cost-share considerations for applicable large employers (ALEs) — that is, employers with a combined total of 50 or more full-time employees (those working 30 or more hours per week) and full-time equivalents. It summarizes the ACA affordability test and safe harbors and discusses a variety of employer cost-sharing arrangements, including models based on premium discounts or surcharges, salary bands and base/buy-up structures. It addresses special considerations regarding opt-out or waiver incentives (cash in lieu of benefits) and provides a general overview of the nondiscrimination rules that apply to cost-sharing arrangements for fully insured and self-insured plans. The guide also includes appendices with details of the **Employer Mandate** affordability threshold and penalties (Appendix A), a chart of **Sample ACA Affordability Safe Harbor Calculations** (Appendix B), a **Sample Notice for Employer Sponsored Wellness Programs** (Appendix C), and a **Sample Notice of Availability of Reasonable Alternative Standard** (Appendix D).

ACA AFFORDABILITY

The ACA employer mandate, also called the employer shared responsibility (ESR) provision, has been in effect since January 1, 2015. It requires ALEs to provide minimum value (MV) coverage at an affordable cost-share level to substantially all full-time employees (FTEs) and their dependent children until age 26. In the context of the ESR requirement, an employer-provided health plan is considered affordable if the employee cost-share of premium for the lowest-cost, self-only coverage does not exceed a specified percentage of an employee's annual household income. (See Appendix A, **Employer Mandate**, for details of the affordability threshold for current and recent past years.)

The statute initially set the affordability threshold (technically the "required contribution percentage") at 9.5% of household income for 2014 and required the IRS to make annual adjustments to that percentge thereafter. The affordability threshold applies to an employer's policy or contract year, not the calendar year, and it is measured against the lowest self-only cost-share amount, regardless of an employee's actual enrollment tier.

Because employers generally will not know their employees' household income, employers may instead rely on one or more of the safe harbors described below to establish a plan's affordability. Employers can use different safe harbors for different categories of employees and can change safe harbors as of each new plan year, but they must apply the safe harbor(s) consistently and uniformly to all employees in each category for the duration of each plan year. Acceptable categories of employees include specified job classifications, hourly vs. salaried employees, geographic location or any other legitimate business criteria.

In general, employer HSA contributions and wellness program premium discounts (with the exception of tobacco-related discounts) are not included in determining affordability, and contributions to integrated HRAs may only be included if HRA funds can be used to pay premiums. Note that safe harbor calculations that rely on an annual value must be divided by 12 to compute monthly amounts. (See Appendix B, **Sample ACA Affordability Safe Harbor Calculations**, for illustrations of each of the safe harbor calculations.)

- **Federal Poverty Line (FPL) Safe Harbor:** Under the FPL safe harbor, coverage is deemed affordable if the lowest cost-share for self-only coverage does not exceed the affordability threshold relative to the FPL for an individual, as published annually by the US Department of Health and Human Services (HHS). (See Resources, below.) The FPL safe harbor is the easiest affordability safe harbor to administer because contribution rates can be standardized across all employee groups regardless of actual wages paid. Also, employers can use the FPL guidelines in effect six months prior to the beginning of the plan year. However, the FPL safe harbor will generally require a lower self-only cost-share (and therefore a higher employer cost-share) than the other two safe harbor options would likely permit.
- **Rate of Pay Safe Harbor:** Under the rate of pay safe harbor, coverage is deemed affordable if the lowest cost-share for self-only coverage does not exceed the affordability threshold relative to an employee's rate of pay. For an hourly employee, the rate of pay calculation assumes 130 hours of work per calendar month (multiplied by the hourly employee's rate of pay), regardless of whether the employee actually works more or less than 130 hours per month. For a salaried employee, the rate of pay calculation uses the employee's monthly salary as of the first day of the monthly coverage period. The rate of pay safe harbor cannot be used for tipped or commission employees. Employers can generally satisfy the rate of pay safe harbor by setting the lowest cost-share for self-only coverage at a level that is affordable either for the lowest hourly rate employee or for the lowest minimum wage that applies to the employer's workforce.
- **Form W-2 Safe Harbor:** Under the Form W-2 safe harbor, coverage is deemed affordable if the lowest cost-share for self-only coverage does not exceed the affordability threshold relative to an employee's Form W-2 wages as reportable in Box 1. Note that Box 1 ("Wages, tips, other compensation") reporting is offset by pre-tax retirement, health and commuter benefits contributions, which may change during the W-2 reporting year. Projected W-2 wages can be prorated by the relevant factor for FTEs who work for less than the full calendar year. The Form W-2 safe harbor can technically be satisfied by charging employees a fixed percentage (not greater than the affordability threshold variable) of their taxable wages, but employers rarely take this approach because it yields highly individualized cost-share amounts. The Form W-2 safe harbor is commonly used by employers whose full-time salaried and hourly employees have reasonably predictable monthly incomes, including the offsets to monthly income for purposes of Box 1 reporting. Employers using the Form W-2 safe harbor often consider prior year W-2 information or projected W-2 information based on the start date of the plan year when establishing a cost-share model designed to satisfy the Form W-2 affordability threshold. However, it is important to recognize that affordability under the Form W-2 safe harbor is assessed on a "real time" month-to-month basis based on current year Form W-2 earnings, even though these earnings have not yet been reported.

Employers that fail to offer minimum essential coverage (MEC) to the required portion of the workforce, or that fail to offer MV coverage that qualifies as affordable, are subject to penalties (respectively, " Penalty A" and "Penalty B") if any FTE receives a premium tax credit (federal premium assistance) through a health insurance exchange. Employers are not liable for both Penalty A and Penalty B simultaneously even if both failures co-exist in the same calendar month. Note that affordability tests and penalty assessments are calculated and imposed separately on each company within a controlled group (referred to as "controlled group members").

Although Penalty A (for failure to offer MEC to the required portion of the workforce) is generally the more severe penalty, employers that want to limit exposure to Penalty B (for failure to offer affordable MV coverage) should ensure that their cost-share model yields affordable coverage for most or all FTEs. Penalty B is expressed as an annual amount but is assessed in monthly increments at one-twelfth (1/12) of the annual amount, multiplied by the actual number of FTEs that received a premium tax credit in any given month of the reporting year. Unlike Penalty A, Penalty B is assessed only relative to individual employees (i.e., those for whom the cost-share amount was deemed unaffordable and who received a premium tax credit) and not on the broader

employee population. It is triggered only if Penalty A does not also apply to the same reporting month.

Employers are not required to use an affordability safe harbor, but doing so protects employers from Penalty B liabilities, even if an employee receives a premium tax credit for marketplace coverage based on actual household income qualifications. Employers should retain documentation regarding the safe harbor(s) they use each plan year to substantiate their reporting on Form 1095-C. For further discussion of the affordability safe harbors as well as the employer mandate penalties, including a glossary of relevant terms (such as minimum essential coverage and minimum value), see the NFP publication **ACA: Employer Mandate Penalties and Affordability**.

In addition, see the NFP publication **ACA: FAQs on IRS Letter 226-J** for information about responding to letters of proposed ESRPs (IRS Letter 226-J). For more detailed information about ACA annual reporting requirements related to affordability, including the requirements to report the exact employee cost-share amount (dollars and cents) for the lowest-cost monthly premium for self-only coverage and to disclose the applicable safe harbor code(s) for the prior calendar year, see the NFP publications **ACA: Employer Mandate Reporting Requirements** and **ACA: FAQs on Form 1095-C**.

Fixing the ACA "Family Glitch"

In late 2022, the IRS finalized its proposed rule to fix the "family glitch" in eligibility rules for the ACA premium tax credit. The new final rule is effective starting in the 2023 tax year. Under the so-called "family glitch" circumstance, family members were previously ineligible for a premium tax credit if the cost of self-only coverage was affordable, as described above. To increase access to premium tax credits for low-income families, the new rule applies a separate affordability standard for family members based on the full cost-share contribution for family coverage.

Under the rule, an eligible employer-sponsored plan will be treated as affordable for family members (i.e., the spouse if filing jointly and tax dependents) if the employee cost-share of premium for family coverage (as distinct from self-only coverage) does not exceed 9.5% of household income (adjusted annually). As a result, an employee's family may qualify for a premium tax credit even if the employee does not.

Importantly, the resolution of the "family glitch" issue does not impact the ACA affordability test and does not increase an employer's exposure to ESR penalties. ALEs will continue to measure affordability based on the cost of self-only coverage, and employer mandate penalties will continue to be triggered only by an employee's receipt of a premium tax credit and not by a premium tax credit granted to the employee's spouse or dependents. However, employers may see an indirect impact of the IRS final rule with more families dropping employer-sponsored coverage for newly subsidized ACA marketplace coverage beginning in 2023.

COST-SHARE MODELS

Background

The concept of "cost-share models" in connection with employer group health plans refers to how employers and employees share gross premium costs (as distinct from costs associated with the delivery of healthcare services). In general, the greater the employee's exposure to cost-sharing at time of service – such as through deductibles, copayments and coinsurance – the lower the employee's cost-share contribution to participate in the healthcare plan. Most employers require some amount of employee cost-sharing for plan participation. (If no employee cost-sharing is required, the plan is considered "non-contributory" and may be subject to rules requiring the enrollment of all benefits-eligible employees.) In addition, most medical insurers require employers to contribute at least half of the premium cost for covered employees.

As employers seek strategic ways to balance the rising costs of healthcare with their own bottom line and the desire to remain competitive for talent in the labor market, it has become increasingly important to understand the impact of cost-sharing structures on the net premium costs to employees and employers alike. Employment factors such as corporate culture, industry-specific turnover rates and overall compensation strategies, which are beyond the scope of this publication, also provide important context for making decisions about the cost of employee benefits.

The cost-share models discussed below provide a number of alternatives for employers to consider as they develop strategic

solutions to their employee benefits needs. All of the models assume that employee cost-share contributions to healthcare premiums are processed through the employer's Section 125 plan, which permits such contributions to be made on a pre-tax basis, and are therefore subject to the applicable nondiscrimination rules. Those rules allow employers to vary cost-share requirements among different sectors of the workforce, provided the variance is based on a business purpose ("a bona fide employment-based classification") and as long as the result doesn't favor highly compensated employees (HCEs) or key employees. The rules are discussed in greater detail in the Nondiscrimination Rules section below.

It is important for self-insured employers to note that cost-share requirements must not be differentiated based on utilization. For example, employers cannot charge a higher cost-share for employees in location A versus location B if the basis for the differential is the higher utilization (claims costs) in location A. This is because HIPAA rules prohibit plans from discriminating against participants based on health status, including claims utilization, with respect to plan eligibility or cost-share requirements.

Health Premium Enrollment Tiers

In the context of cost-share models, health premium enrollment tiers refer to the options for enrolling one or more eligible dependents on a healthcare plan in addition to "employee only" coverage (also called "single", "individual" or "self-only" coverage). The following information pertains equally to medical, dental and vision plans, which can have separate enrollment tier structures, except that any references to ALEs pertain exclusively to major medical healthcare plans that are subject to the ACA.

The simplest enrollment tier option is a two-tier structure ("employee only" and "employee plus one or more dependents"). Three- and four-tier enrollment structures, which are more common, allow gross and net premium costs to be allocated among family contracts (any enrollment other than single coverage) with greater differentiation among numbers and types of dependents. Five-tier enrollment structures allow even greater differentiation among numbers of minor dependents ("employee plus child" versus "employee plus children"). Enrollment tier structures with more than five tiers are permitted but uncommon; they are administratively burdensome and tend to be used only when employers specifically want to allocate employee cost-share on a per-participant basis.

Enrollment tier structures give employers a measure of flexibility to establish employee cost-share models based on the numbers and types of dependents enrolled on the plan. Healthcare data shows that, in general, adult dependents (spouses and domestic partners) tend to generate higher claims costs than children; consequently, enrollment tiers that distinguish between adult and child dependents generally yield higher gross premium costs for the tiers that include spouses and domestic partners. Whereas ALEs are required to allow employees to enroll children up to age 26 on their medical plans, employers can exclude spouses and domestic partners from the plans altogether or can impose financial disincentives for the enrollment of spouses and domestic partners, subject to state law requirements. (See under Spousal Surcharges below.)

There are no compliance concerns regarding the number of enrollment tiers an employer adopts for its healthcare plan offering(s), except that, in order to avoid potential ESR penalties, ALEs must permit the enrollment of an employee's children up to age 26 on at least one tier, and must ensure that the cost-share amount for the lowest-cost self-only coverage meets the ACA affordability threshold. Employers should carefully consider the rationale for adopting or modifying their plans' enrollment tier structures, including the opportunity to achieve greater or lesser cost-sharing among different family tiers and the opportunity to manage costs by discouraging the enrollment of spouses and domestic partners who may have independent enrollment options under another employer's plan.

Spousal Surcharges

Employers are not required by federal law to permit the enrollment of spouses or domestic partners on their healthcare plans, but the vast majority of employers do so to remain competitive in the labor market. Employers that wish to deter (but not entirely prohibit) the enrollment of spouses and domestic partners can create financial disincentives for such enrollments. These can take the form of structuring proportionately higher cost-share requirements for certain enrollment tiers or imposing outright "spousal surcharges" for enrolling spouses and domestic partners. Typically these disincentives are designed to apply only when an eligible adult has access to primary healthcare coverage through another employer.

Working-spouse provisions (also referred to as "spousal carve-out" or "spousal exclusion" policies, wherein spouses and domestic partners who are eligible for other group health plan coverage are not eligible for the the employer's coverage) are permitted under federal law for plans that are subject to ERISA. However, some states have marital discrimination laws that could make such provisions impermissible if the state law is not preempted by ERISA. Governmental plans (including state, city and county, public school and school district plans) and church plans are statutorily exempt from ERISA. For further information about such exemptions, see the NFP publication **ERISA Compliance Considerations for Health and Welfare Benefit Plans**.

Employers that adopt working-spouse provisions must also consider the administrative processes for securing any discretionary documentation of the spouse's or domestic partner's eligibility for or enrollment in alternative coverage. Employers are permitted to rely on an honor system for this purpose, or they can require employees to provide specific evidence of the alternative coverage. Employers that require employees to submit certification documents in connection with working-spouse provisions (or any other employee benefits provisions) should specify the acceptable documents and should note the document submission requirements in the plan document (per the eligibility terms), on the relevant benefits enrollment form or platform, and in the employee handbook, benefits guide, or other employee-facing communications as applicable. Employers should ensure that any certification documents are handled according to the employer's policies governing personal and confidential employee information, and documents should be maintained according to the employer's record retention policies.

Finally, employers with grandfathered plans should evaluate whether implementing a working-spouse provision will cause the plan to lose its grandfathered status under ACA. Simply changing the plan's eligibility rules (such as by excluding or conditioning the enrollment of spouses or domestic partners) will not affect the plan's grandfathered status, but implementing a spousal surcharge that exceeds the maximum allowable premium cost-share increase will cause the plan to lose its grandfathered status. (A group health plan will lose its grandfathered status if, among other things, the employer's cost-share contribution toward the cost of coverage for any enrollment tier decreases by more than 5% below the contribution rate in effect on March 10, 2010.) Over time, many plans have lost their grandfathered status due to other intervening events, but preserving a plan's grandfathered status remains a relevant concern for some employers.

Wellness Incentives and Disincentives

Employers are permitted to implement cost-share models that include premium differentials in the form of discounts to incent, or surcharges to discourage, certain wellness activities or outcomes. Linking a wellness program directly and exclusively to an employer's cost-share model – that is, making the reward or penalty available only to employees who are enrolled in the health plan – ensures that the program does not constitute a stand-alone group health plan. (A stand-alone wellness program that is available to all employees, regardless of their enrollment status in the employer's healthcare plan, may create independent compliance obligations under ERISA, COBRA, HIPAA, GINA and the ACA. These obligations are presumably already satisfied by the major medical healthcare plan to which the employer's cost-share model is attached.)

Employers that implement cost-share differentials in connection with health-contingent wellness programs must ensure that any such wellness programs, whether activity-based or outcome-based, meet the requirements of the HIPAA portability and nondiscrimination rules that pertain to wellness programs. (A wellness program is considered to be health-contingent if it requires an individual to satisfy a standard related to a health factor in order to obtain a reward.) The HIPAA wellness program rules impose five specific requirements:

- Employees must have an opportunity to qualify for the reward at least once per year (such as relative to each year's open enrollment).
- The reward must not exceed "the applicable percentage" of the cost of self-only coverage under the plan. (The aggregate of all wellness rewards is generally capped at 30% of the gross cost of self-only coverage, except the cap is increased to 50% for tobacco cessation programs.)
- The incentive must be reasonably designed to promote health or prevent disease.
- The full reward must be available to all similarly situated individuals.
- There must be a "reasonable alternative standard" (or waiver of the standard). Employers must include a description of

the reasonable alternative standard in all plan materials (e.g., open enrollment materials and SPD) describing the wellness program. (See Appendix D, **Sample Notice of Availability of Reasonable Alternative Standard**.) Note that, in general, employers must pay the cost of providing a reasonable alternative standard in connection with a wellness program; any such cost does not affect the calculation of affordability.

The HIPAA wellness program rules, which apply to plan years starting on and after January 1, 2014, are discussed in greater detail in the NFP publication **Agencies Issue Final HIPAA Wellness Program Rules Under ACA**. The publication includes a step-by-step guide for group health plans, including grandfathered plans, to evaluate their wellness programs under HIPAA rules.

For purposes of affordability, wellness program incentives (other than those related to tobacco use) are not treated as having been earned. In other words, the non-wellness (i.e., "non-participating") rate is the rate that must be affordable for purposes of the ACA employer mandate. In contrast, for wellness programs related to tobacco use, the non-smoker rate is used for purposes of affordability. Importantly, an employee who satisfies the reasonable alternative standard mid-year is entitled to the full plan year reward, which can require employers to make a cost-share adjustment to accommodate for the reward retroactive to the start of the plan year. In addition, note that wellness rewards in the form of cash (e.g., bonuses) or cash equivalents (e.g., gift cards) constitute taxable earnings to the employee, as can many other noncash rewards (e.g., products, services or discounts). Each type of reward should be reviewed individually to determine if it is taxable to the employee.

Special Note Regarding COVID-19 Vaccine Incentives and Disincentives: Employers are permitted to implement cost-share models that include premium differentials explicitly related to an employee's COVID-19 vaccination status (which is considered a health factor), provided the employer adheres to the HIPAA wellness program rules noted above. Employers that choose to modify their cost-share models to incorporate a COVID-19 vaccination status factor, or to offer vaccine-related incentives to employees who are not enrolled in the employer's healthcare plan, should be mindful of the various compliance obligations associated with these practices. It is possible that the IRS and the DOL will choose not to enforce the rules surrounding COVID-19 vaccination wellness programs in the interest of public health; however, the agencies have made no public announcements to that effect. Pending further explicit guidance on this topic, employers are encouraged to consult with legal counsel to ensure that their COVID-19 vaccination program is implemented in a way that complies with all applicable laws, including employment-related laws and state laws.

Salary-Based Cost-Share Models

Employers with fully insured healthcare plans are permitted to implement cost-share models that are based on employee salaries. (By contrast, self-insured plans are prohibited under IRC Section 105(h) nondiscrimination rules from basing cost-share models on an employee's salary, age, or length of service.) Pay-based contribution models can express premium cost-share as a fixed percentage of each employee's pay; however, this can create significant administrative burdens for payroll systems and for reporting cost of coverage information on Form 1095-C, Part II, line 15. Employers that adopt salary-based cost-share models more typically establish a manageable number of premium payment tiers according to defined pay ranges or bands.

In a salary-based cost-share model, the cost-share per salary band can be expressed as a fixed percentage of pay or a fixed dollar amount; either of these variables can vary by salary band. The number of bands and the salary range of each band should reflect organic workforce groupings to minimize the frequency of salary band migration due to across-the-board wage increases. Employers with variable or hourly pay employees generally assign salary bands according to current base pay, regular rate of pay (for hourly employees) or prior year annualized pay.

Employers that implement salary-based cost-share models generally do so in order to benefit lower-income employees who are often heavily burdened by healthcare costs, including plan deductibles and co-insurance exposures, even if the premium cost-share does not exceed the affordability threshold. The adoption of these models varies by industry and according to employers' organizational culture and budgetary needs. Employers can adjust the number and salary ranges of the bands in a salary-based cost-share model to accommodate workforce changes over time; however, as with other cost-share model features, employers should avoid making changes during the plan year. Any mid-year plan changes to cost-share models can create significant challenges for affordability and nondiscrimination rules as well as basic employee communications. All of these topic are discussed in greater detail below.

Base/Buy-Up Cost-Share Models

A base/buy-up cost-share model allows employers to cap their share of premium costs per enrollment tier at the level established for the employer contribution to the least rich plan design that is offered (for purposes of this discussion, the "low plan"). The employee cost-share for any plan other than the low plan is then calculated as the cost-share for the low plan plus 100% of the gross premium difference between the richer plan and the low plan. There are no compliance considerations that are unique to the base/buy-up cost-share model, but the model is subject to all of the normal nondiscrimination rules and affordability considerations that are discussed elsewhere in this publication.

Opt-Out Incentives

Employers are permitted to offer cash incentives for employees to waive or decline the employer's healthcare plan. Opt-out incentives (also referred to as cashable waivers or cash in lieu of benefits), if provided, typically apply exclusively to medical plans, although employers can also apply them to dental and vision plans, provided the plans are contributory (i.e., they require employees to pay a cost-share contribution for participation). In general, employers are not permitted to provide opt-out incentives for any non-contributory healthcare plans, although state insurance laws can differ on this regulatory issue.

Employers should note that any amount paid to an employee as an opt-out incentive constitutes taxable earnings to the employee and must be included in the employee's gross income. (An exception to this rule applies under IRC Sections 105 and 106 if the employer is paying for or reimbursing medical expenses of the employee and/or the employee's tax dependents, in which case the payment or reimbursement is not taxable.) Note that it is critically important for employers to retain documentation of employee waivers under an opt-out incentive program to support that the employer made an offer of coverage, even if the offer was declined.

Employers have discretion to pay opt-out incentives (if any) as a lump sum amount at the start or end of the plan year or ratably according to a less frequent payment schedule of the employer's choosing. Most employers align opt-out payments with the default schedule for processing healthcare deductions, as this reduces the risk of paying opt-out sums for months when the employee is no longer entitled to benefits (such as after employment termination or following a reduction in standard hours) or has enrolled in the employer's healthcare plan (such as may occur due to a mid-year qualifying event). It also simplifies the tracking of monthly cost of coverage data for Form 1095-C reporting.

Section 125 is the exclusive means by which an employer can provide employees with a choice between taxable cash and nontaxable benefits. Thus, the terms of any opt-out incentive must be included as a qualified benefit in the written Section 125 plan document. Employers are encouraged to review their Section 125 plan document carefully and update it as need to include as a qualified benefit any opt-out incentive the employer has determined to offer.

Importantly, an opt-out provision may adversely affect the ACA affordability calculation if it is not structured as an "eligible opt-out arrangement." An employee who is otherwise entitled to the employer's healthcare benefits can waive coverage under Section 125 for any reason, regardless of whether they have other coverage or satisfy any other conditions. This is referred to as an unconditional waiver. However, if an employer pays taxable cash (in lieu of nontaxable benefits) to an employee who does not have other healthcare coverage, or whose other healthcare coverage does not meet the ACA definition of MEC, the full amount of the opt-out incentive constitutes an employee contribution under the affordability test. The revised cost-share contribution that is increased by the addition of this opt-out amount must be applied to the entire cost-share model for purposes of calculating affordability. Note that the issue of eligible versus ineligible opt-out arrangements applies only to employers who implement a cashable waiver design on or after December 16, 2015. If the employer's design was adopted before that date, they are not required to treat the opt-out payment as increasing the employee's required contribution.

For an opt-out incentive to be considered an "eligible opt-out arrangement," it must satisfy the requirements for a conditional waiver. The employee who declines coverage must provide reasonable evidence that they, and all family members included on their tax return, have or are expected to have other healthcare coverage that meets the ACA definition of MEC during the plan year for which the opt-out incentive is offered. The evidence of other MEC coverage must be recertified annually with each new plan year. The MEC cannot be coverage in the individual market, either on or off the exchange; however, it can be government coverage such as Medicare Part A, Medicaid, CHIP or TRICARE programs.

Further, the employer cannot make opt-out payments if the employer knows (or has reason to know) that the employee does not have MEC. (Because it can be difficult to distinguish between individual coverage and group coverage based solely on a health plan ID card, employers should require employees who seek the opt-out incentive to self-certify regarding whether their coverage constitutes MEC.) In addition, opt-out incentives should not be provided to enable employees to purchase coverage on the exchange.

Finally, employers that offer (or wish to offer) an opt-out incentive in connection with their healthcare plan should be mindful of the Medicare Secondary Payer rules, which prohibit employers from offering financial incentives to Medicare-eligible employees to waive or cancel coverage in an employer-sponsored group health plan. While it could be argued that cash in lieu of benefits is a financial incentive not to enroll in a group health plan that is primary to Medicare, HHS representatives have informally indicated that no violation occurs when employees entitled to Medicare have the same cash-out rights as employees who are not entitled to Medicare under a bona fide cafeteria plan meeting the requirements of Section 125. Similar rules apply for TRICARE-eligible employees. Offering the same cash incentive to all benefits-eligible employees allows employers to avoid potential Medicare Secondary Payer issues and also to avoid – or at least severely limit – any nondiscrimination rule failures as described in the Nondiscrimination Rules section below.

MID-YEAR CHANGES TO COST-SHARE MODELS

Employers are permitted to make mid-year changes to their cost-share requirements, provided the resulting model continues to satisfy any carrier requirements regarding the balance between employer and employee contributions. Employers should also consider the impact on ACA affordability, which is measured on a discrete month-by-month basis (not an annual average). Any mid-year changes to enrollment tiers or cost-share models, including the implementation or discontinuation of any premium differentials or opt-out programs, may affect ACA affordability and should be re-examined to avoid potential ESR penalties.

Employers should also consider whether the revised cost-share model produces a significant cost change – either an increase or decrease – to employees. A significant cost change could constitute a qualifying event if the Section 125 plan document permits mid-year election changes due to significant cost changes. If permitted by the plan document, a significant mid-year cost change would allow employees to drop (if no other benefit package providing similar coverage is available) or change coverage (or, in some instances, add coverage if not previously enrolled) as of the mid-year effective date.

There is no specific regulatory measure of "significant" in this context; the assessment instead relies loosely on whether a reasonable employee would perceive the change as significant. Employers should base their "significant vs. insignificant" determination on an array of comparative facts and circumstances, including the dollar amount or percentage of the cost change and the history of year-over-year cost-share changes. (For example, if recent annual cost-share increases have been in the range of 3 - 5%, an increase of 15 - 20% appears significant.) Generally, the cautious approach is to assume that most non-nominal changes in the cost of coverage should be considered significant. Cost changes that are deemed insignificant can be processed automatically, provided the employer's authority to proceed in this manner is included in the plan document.

Note that mid-year cost-share changes, like annual plan year cost-share changes, may affect the grandfathered status of an employer's healthcare plan. Episodic cost-share changes due to processing Medical Loss Ratio rebates or discretionary premium credits from insurers (e.g., rebates or credits that result in premium holidays of several months) should be considered for purposes of assessing whether a mid-year cost change is significant; however, these premium refunds or reductions have no bearing on the grandfathered status of a plan.

As with all cost-share changes, employers that make mid-year changes to their cost-share structure should clearly communicate the changes to employees. As a technical matter, the compliance rules related to mid-year cost-share changes do not specifically require advance notice to employees, but common sense and best practices call for employers to keep employees informed about matters that affect their benefits and their net pay, even if the changes are insignificant.

Employers should be especially attentive to communicating with employees regarding cost-share changes that are significant, regardless of whether such changes trigger mid-year election entitlements. In addition, if mid-year cost-share changes are made in connection with other benefit plan changes that require distribution of a Summary of Material Modifications (SMM),

employers should ensure that SMM communications are issued timely and in a manner that is consistent with the DOL electronic distribution rules. (For information about electronic distribution rules, see the NFP publication **Electronic Distribution Rules: A Guide for Employers**.)

NONDISCRIMINATION RULES

Employers that apply the same cost-share requirements to all employees on a per plan, per enrollment tier basis will largely avoid triggering testing failures under the nondiscrimination rules, which prohibit favoring HCEs. That said, employers are permitted to vary their cost-share contribution models for different segments of the workforce, provided the variance is based on a bona fide employment-based classification and does not discriminate in favor of HCEs. (Employers can discriminate in favor of, but not against, non-HCEs.)

Two sets of nondiscrimination rules may be applicable, depending on if the plan is fully insured or self-insured. Section 125 nondiscrimination rules apply if employees can pay any portion of their premium pre-tax via salary reduction (as most do). Further, Section 105(h) nondiscrimination rules apply to self-insured group health plans (currently under nonenforcement for fully insured plans). Both rules generally prohibit discriminating in favor of HCEs.

An HCE is defined differently under each set of rules. Under Section 125, an HCE is any officer, a more-than-5% shareholder/owner, or any individual with compensation in excess of an IRS-indexed annual amount. In contrast, HCE is defined as the top five highest paid officers, highest paid 25% and a more-than-10% shareholder under Section 105(h). For details of the HCE threshold for current and recent past years, see the NFP publication **Employee Benefits Annual Limits**.

Importantly, under Section 105(h) nondiscrimination rules, cost-share models cannot base employee premium contributions on age, salary or length of service (tenure), although these are permissible classification distinctions for fully insured plans. Both self-insured and fully insured plans can provide different cost-share models based on geographic location, employee type (salaried/hourly), and distinctions based on job duties, responsibilities, tasks and authority level of a job.

At a high level, cost-share models that are salary banded or that include premium differentials based on variables other than enrollment tier, or that include opt-out provisions, should confirm that any such variance is based on a bona fide business classification that does not result in favoring HCEs (i.e., HCEs receive better benefits). In these instances, employers should review the cost-share model with the party responsible for performing their plan's nondiscrimination testing to ensure that it passes all applicable tests. When a plan fails the nondiscrimination test, generally, the HCE participants lose the tax advantages associated with Section 125.

Employers are encouraged to perform nondiscrimination testing early in the plan year so that plan failures can be corrected by reducing the pre-tax payroll deductions of HCEs as necessary prior to the end of the calendar year.

SUMMARY

Employers that sponsor group health plans, particularly those that are subject to the ACA, should be closely attentive to the compliance implications of the employee cost-share contribution models associated with the plans. Employers are encouraged to consider their cost-share models narrowly relative to the service-related cost exposures of the underlying healthcare plan designs and more broadly in the context of their overall workforce compensation strategy.

Once a cost-share model has been implemented, including the enrollment tier structure as well as any premium differentials that are applied on the basis of variables other than enrollment tiers, significant future changes to the model require thoughtful employee communications and a keen awareness of how the changes might positively or negatively affect different segments of the workforce. Employers also need to consider important regulatory factors, such as ACA affordability and nondiscrimination rules, and should take into account additional requirements that may be associated with mid-year changes to the model.

To discuss your cost-share model compliance considerations and other aspects of your employee benefits program, or for copies of NFP publications, contact your NFP benefits consultant. For further information regarding NFP's full range of consulting services, see **NFP.com**.

RESOURCES

Final Rule 2014

Final Rule 2022

HHS Federal Poverty Guidelines

IRS Affordability and Minimum Value FAQs

IRS FAQ

About NFP

NFP is a leading property and casualty broker, benefits consultant, wealth manager, and retirement plan advisor that provides solutions enabling client success globally through employee expertise, investments in innovative technologies, and enduring relationships with highly rated insurers, vendors and financial institutions.

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For more information, visit **NFP.com**.

APPENDIX A

Employer Mandate

	2024	2023	2022
Penalty A, annual (per FT EE*)	$2,970	$2,880	$2,750
Penalty B, annual (per EE receiving premium tax credit)	$4,460	$4,320	$4,120
Affordability threshold	TBD	9.12%	9.61%

*Minus the first 30 FT employees.

The chart above is excerpted from the NFP publication **Employee Benefits Annual Limits**. See that publication for other annual limits that affect group health plans.

APPENDIX B

Sample Affordability Safe Harbor Calculations

Federal Poverty Line (FPL) Safe Harbor

	2023 (July-Dec)	2023 (Jan-June)	2022 (July-Dec)	2022 (Jan-June)	2021
Affordability threshold*	9.12%	9.12%	9.61%	9.61%	9.83%
Federal poverty line**	$14,580	$13,590	$13,590	$12,880	$12,880
Maximum self-only cost-share (per month)***	$110.80	$103.28	$108.83	$103.14	$105.50

*Affordability threshold pertains to plan years beginning in the referenced calendar year.

**FPL safe harbor uses federal poverty line for one person household. Annual FPL figures shown are for the 48 contiguous states and the District of Columbia; figures for Alaska and Hawaii are higher.

***The calculation formula for the FPL safe harbor "Maximum Self-Only Cost-Share (per month)" is as follows: (Affordability Threshold x Federal Poverty Line) / 12. For plan years beginning between January and June of a calendar year, plan sponsors can rely on the prior calendar year federal poverty line for the FPL safe harbor calculation. While there appears to be no formal guidance regarding the rounding rules for ACA affordability calculations, the dollar figures in this chart have, in an abundance of caution, been uniformly rounded down to the nearest penny.

Rate of Pay Safe Harbor

		Maximum Self-Only Cost-Share (per month)		
		2023	2022	2021
Affordability threshold*		9.12%	9.61%	9.83%
	Sample Hourly Rate of Pay**			
	$7.25	$85.95	$90.57	$92.64
	$10.00	$118.56	$124.93	$127.79
	$15.00	$177.84	$187.39	$191.68
	$20.00	$237.12	$249.86	$255.58
	$25.00	$296.40	$312.32	$319.47
	$30.00	$355.68	$374.79	$383.37
	Sample Monthly Salary***			
	$2,083	$189.96	$200.17	$204.75
	$2,500	$228.00	$240.25	$245.75
	$2,917	$266.03	$280.32	$286.74
	$3,333	$303.96	$320.30	$327.63
	$3,750	$342.00	$360.37	$368.62
	$4,167	$380.03	$400.44	$409.61

*Affordability threshold pertains to plan years beginning in the referenced calendar year.

**The calculation formula for the Rate of Pay safe harbor "Maximum Self-Only Cost-Share (per month)" for Hourly employees is as follows: (Affordability Threshold x Hourly Rate of Pay x 130). While there appears to be no formal guidance regarding the rounding rules for ACA affordability calculations, the dollar figures in this chart have, in an abundance of caution, been uniformly rounded down to the nearest penny.

***The calculation formula for the Rate of Pay safe harbor "Maximum Self-Only Cost-Share (per month)" for Salaried employees is as follows: (Affordability Threshold x Monthly Salary). See previous note regarding penny rounding practice.

Form W-2 Safe Harbor

		Maximum Self-Only Cost-Share (per month)		
		2023	2022	2021
Affordability threshold*		9.12%	9.61%	9.83%
	Sample Annual Earnings (Form W-2, Box 1)**			
	$25,000	$190.00	$200.20	$204.79
	$30,000	$228.00	$240.25	$245.75
	$35,000	$266.00	$280.29	$286.70
	$40,000	$304.00	$320.33	$327.66
	$45,000	$342.00	$360.37	$368.62
	$50,000	$380.00	$400.41	$409.58

*Affordability threshold pertains to plan years beginning in the referenced calendar year.

**The calculation formula for the Form W-2 safe harbor "Maximum Self-Only Cost-Share (per month)" is as follows: (Form W-2 Box 1 Earnings x Affordability Threshold) / 12. While there appears to be no formal guidance regarding the rounding rules for ACA affordability calculations, the dollar figures in this chart have, in an abundance of caution, been uniformly rounded down to the nearest penny.

APPENDIX C

Sample Notice for Employer-Sponsored Wellness Programs

New rules published on May 17, 2016, under the Americans with Disabilities Act (ADA) require employers that offer wellness programs that collect employee health information to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. The EEOC has published the sample notice below to help employers comply with the ADA:

Notice Regarding Wellness Program

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested]. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the incentive].

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any]. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [name] at [contact information].

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as [indicate services that may be offered]. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.]

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact [insert name of appropriate contact] at [contact information].

APPENDIX D

Sample Notice of Availability of Reasonable Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right or you in light of your health status.