June 18, 2025

Introduction to COBRA, FMLA, and Other Federal Mandates

Patrick O. Myers

VP, Benefits Compliance Counsel

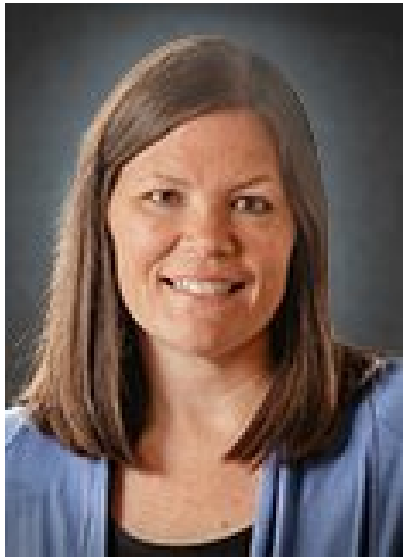
Kelly Eckman

VP, Benefits Compliance

NFP®
An Aon Company

Today's Speakers

Patrick Myers
V.P. and Counsel
NFP Benefits Compliance



Kelly Eckman
V.P.
NFP Benefits Compliance

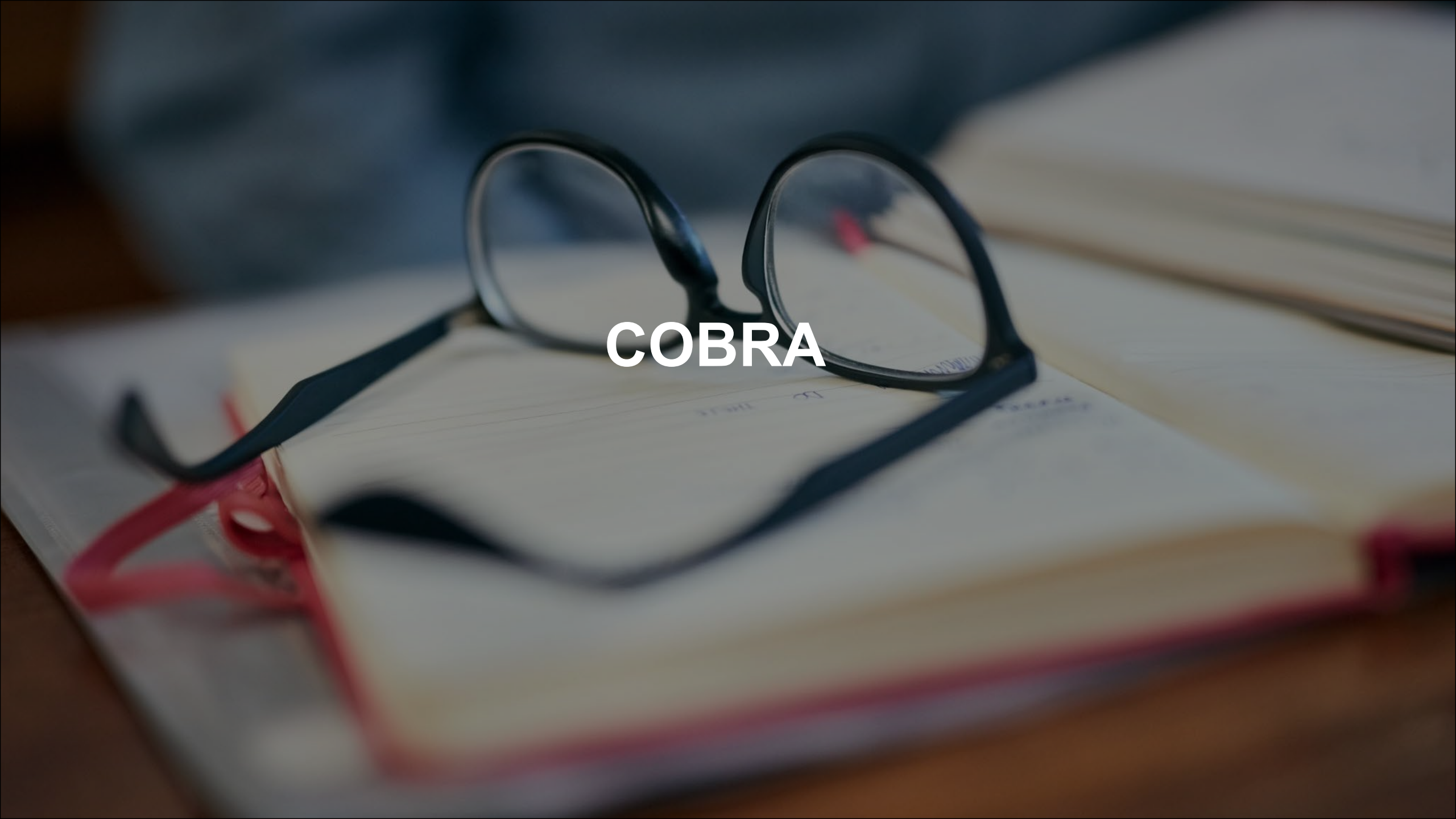
NFP
An Aon Company

Please note that the following is intended to be used for general guidance purposes only — it is not intended to constitute tax or legal advice. Any question of application of the law should be addressed to legal or tax counsel. The information is current as of June 18, 2025.

Agenda

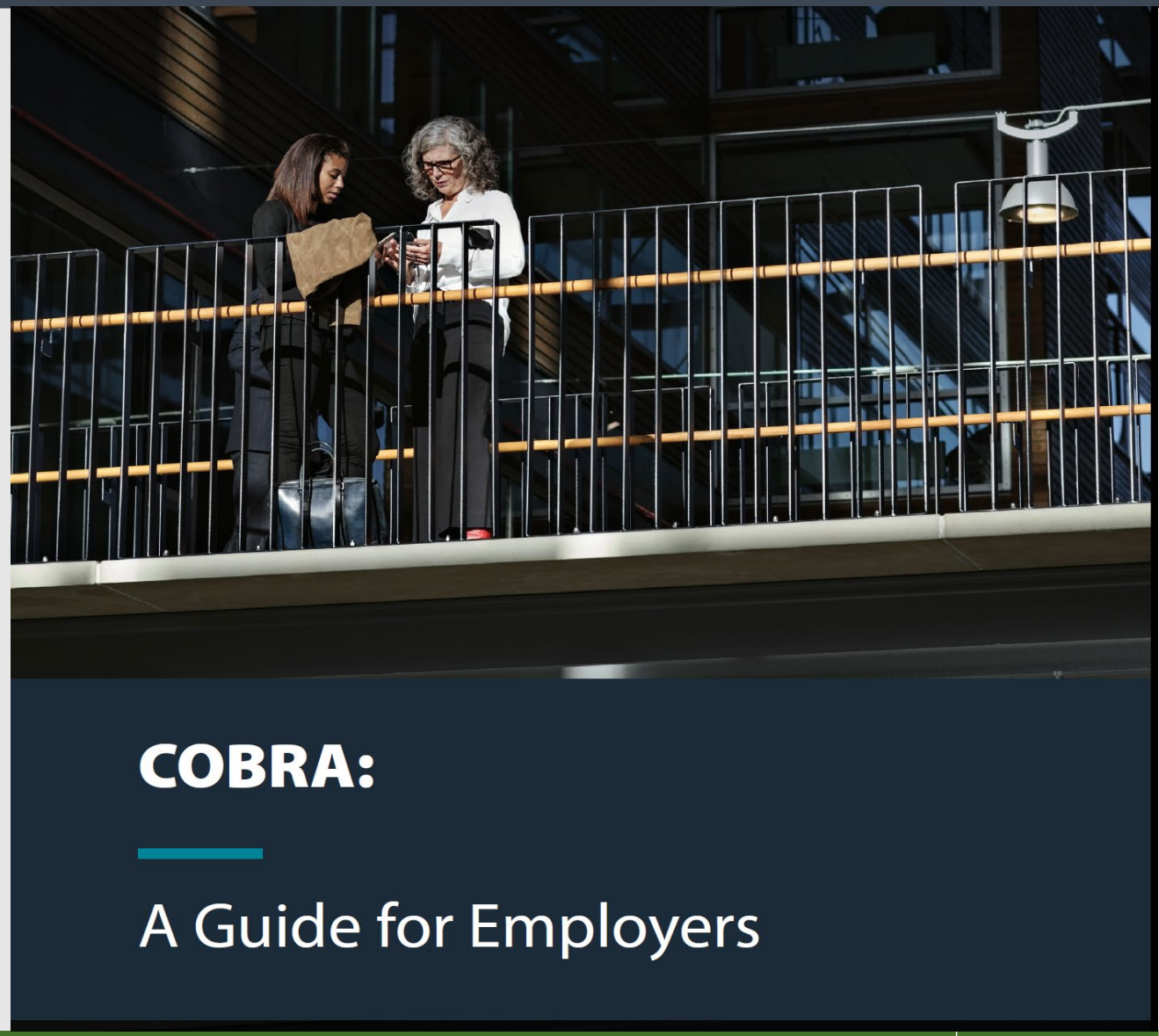
What we will cover today:

- COBRA
- Medicare Basics
- FMLA
- Other Federal Mandates
  - TRICARE
  - USERRA
  - QMCSO
  - Transparency Rules
- Key Takeaways and Resources


COBRA

Plans subject to COBRA

- Applies to public and private employers
- Doesn't apply to governmental plans or church plans
- Small employer exception – employers with less than 20 common-law employees (on 50% of its typical business days in previous calendar year)
  - Count employees – not just plan participants
  - Count employees of related employers (e.g., all employees within a controlled group are counted)
  - Count part-time employees on a pro-rata basis
  - Count employees outside U.S.
  - If meet minimum employee requirement midyear, then employer would be obligated to comply with COBRA the following calendar year even if headcount later drops below 20



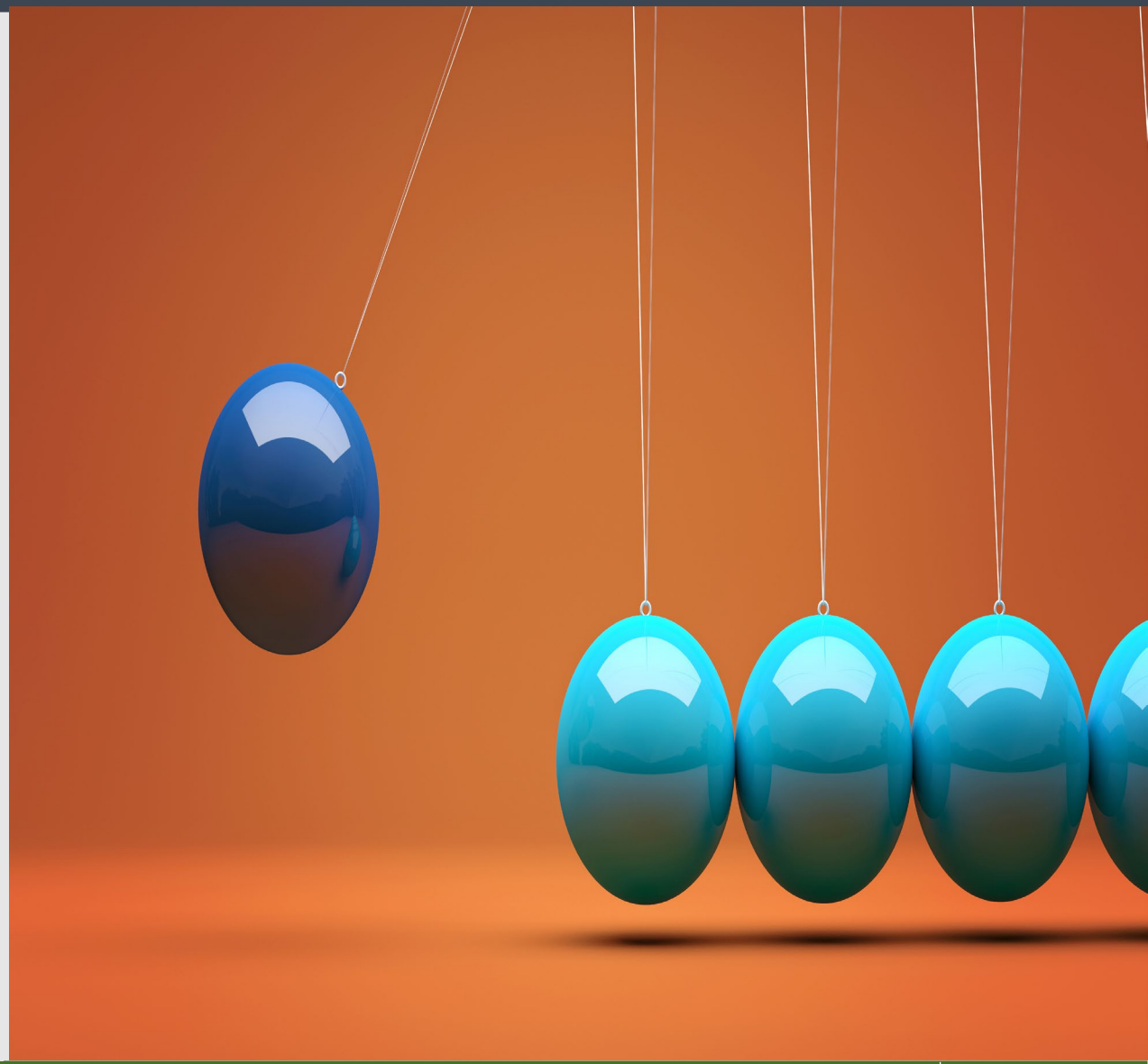
Coverage subject to COBRA

Coverage Type	Subject to COBRA	Coverage Type	Subject to COBRA
Medical	Yes	Disability (STD/LTD)	No
Dental	Yes	Group Term Life	No
Vision	Yes	AD&D	No
Prescription Drug	Yes	Fixed Indemnity	No
HRA (including ICHRA and EBHRA)	Yes	Long-Term Care	No
Health FSA	Yes	HSA	No
Disease-Specific	Maybe**	Dependent Care FSA	No
Wellness Program	Maybe**		
EAP	Maybe**		
Point Solution Program	Maybe**		

*Health FSAs may qualify for a special limited COBRA obligation.
**This coverage must be scrutinized for whether it includes medical care.

Coverage Exceptions

- FSAs
  - COBRA coverage continuation rights only apply to "underspent" health FSAs (i.e., when the participant's remaining balance – their annual election minus reimbursed claims – exceeds the maximum health FSA COBRA premium that can be charged through the end of the plan year).
- Point Solution Programs
  - Point solution programs are subject to COBRA (as well as ERISA, HIPAA, and the ACA) if the program provides medical care.
- Disability, group term life, and AD&D plans
  - Disability, group term life, and AD&D plans generally do not provide "medical care"; therefore, no COBRA obligation extends to these benefits.



Who must be offered COBRA?

A group health plan must offer COBRA continuation to "qualified beneficiaries" (QBs).

A "qualified beneficiary" is anyone that was covered by the plan immediately before a qualifying event.

- Could include employee, spouse, and dependent children of covered employees, and children born to, or adopted by, a covered employee during COBRA enrollment
- Does not extend to domestic partners, tax dependents who are not a dependent child
  - A DP covered on the plan prior to COBRA event can enroll in COBRA along with QB, but the DP could not independently elect COBRA

- If a QB is offered a COBRA election, but chooses not to elect COBRA, then they will not be a QB upon the expiration of the election period
- Each QB has an independent election right to COBRA
- ERs can be more generous but would need approval of carrier/TPA/stop-loss

What must be offered?

- QBs must be given opportunity to elect ***same*** coverage that they had just before the qualifying event under each benefit/coverage option
- COBRA coverage must be identical to coverage provided to similarly situated beneficiaries under the plan
- When coverage can be changed:
  - Active employees are permitted to change coverage during Open Enrollment
  - Can add family members under HIPAA special enrollment right
  - If region-specific plan fails to be of value to QB
  - If there is a modification by employer in the plan

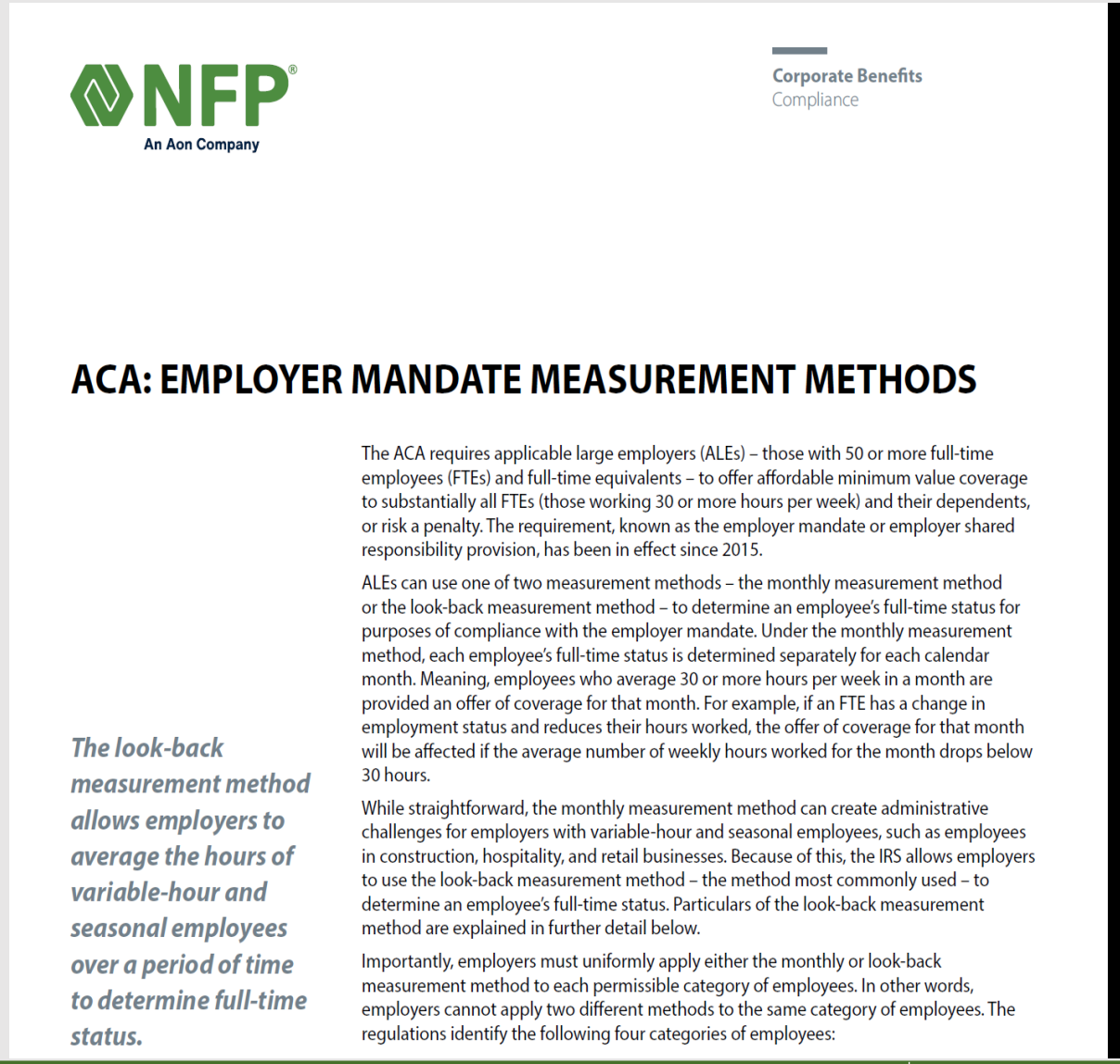
When and how long?

Qualifying events (QEs) must cause (or will cause) a loss of coverage

- Qualifying Events Include:
  - Termination of employment (voluntary or involuntary) – ***18 months***
  - Reduction of hours (e.g., full-time to part-time) – ***18 months***
  - Divorce or legal separation – ***36 months***
  - Death of the covered employee – ***36 months***
  - Dependent child ceases to be a dependent – ***36 months***
  - Employee becomes entitled to Medicare benefits (if loss of eligibility) – ***36 months***
  - Employer's bankruptcy – only for retirees
- No coverage for termination of employment due to gross misconduct
- Possible extensions – Disability extension and multiple qualifying event rule
- Possible shortening of duration, such as missed payments, employer ceases to operate plan, Medicare entitlement *after* electing COBRA

A note about ACA Measurement Periods

- Refresher of look-back measurement period
  - Employer may track variable-hour employees using the look-back measurement period to determine whether they are a full-time equivalent (meaning that they work at least 30 hours per week)
  - Once FT status is determined, it's generally locked in for the entire stability period
- If employee has a reduction of hours (transitioning from full-time to part-time) during stability period, their FT status is generally locked in (and they are still eligible during the stability period). So, no COBRA.
  - And if they fail to pay premiums, and coverage terminates, it's not a COBRA event.
- If employee is terminated from employment during stability period, it is a COBRA event!



NFP
An Aon Company

Corporate Benefits
Compliance

ACA: EMPLOYER MANDATE MEASUREMENT METHODS

The look-back measurement method allows employers to average the hours of variable-hour and seasonal employees over a period of time to determine full-time status.

The ACA requires applicable large employers (ALEs) – those with 50 or more full-time employees (FTEs) and full-time equivalents – to offer affordable minimum value coverage to substantially all FTEs (those working 30 or more hours per week) and their dependents, or risk a penalty. The requirement, known as the employer mandate or employer shared responsibility provision, has been in effect since 2015.

ALEs can use one of two measurement methods – the monthly measurement method or the look-back measurement method – to determine an employee's full-time status for purposes of compliance with the employer mandate. Under the monthly measurement method, each employee's full-time status is determined separately for each calendar month. Meaning, employees who average 30 or more hours per week in a month are provided an offer of coverage for that month. For example, if an FTE has a change in employment status and reduces their hours worked, the offer of coverage for that month will be affected if the average number of weekly hours worked for the month drops below 30 hours.

While straightforward, the monthly measurement method can create administrative challenges for employers with variable-hour and seasonal employees, such as employees in construction, hospitality, and retail businesses. Because of this, the IRS allows employers to use the look-back measurement method – the method most commonly used – to determine an employee's full-time status. Particulars of the look-back measurement method are explained in further detail below.

Importantly, employers must uniformly apply either the monthly or look-back measurement method to each permissible category of employees. In other words, employers cannot apply two different methods to the same category of employees. The regulations identify the following four categories of employees:

How much does it cost?

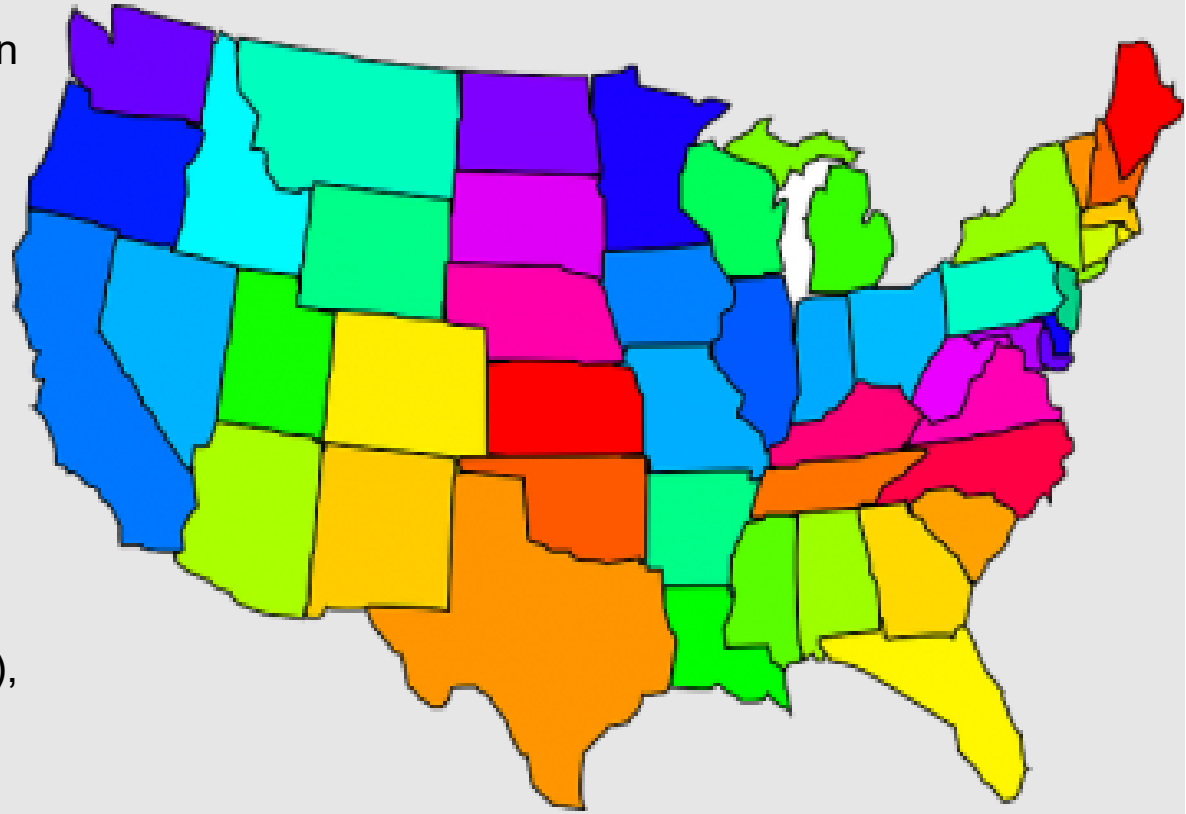
- Federal COBRA allows employers to charge up to 102% of ‘applicable premium’ for COBRA continuation (150% for disability extension)
- ‘Applicable Premium’ – the cost to the plan for the period of coverage for similarly situated beneficiaries
- Cost to plan includes total cost of coverage employee and employer paid portions
- Include cost of providing coverage for both active employees and COBRA
- COBRA premium must remain fixed for 12-month period

Overview of COBRA

- Initial (General) Notice
- Election Notice
- Notice of Unavailability
- Extension Notice
- Open Enrollment Notice
- Notice of Early Termination

State "mini-COBRA" laws

- Varies by state in both employer eligibility and duration of continuation
- Generally, applies to under 20 fully insured plans, but may also apply to larger fully insured plans and provide more generous benefits than required under Federal COBRA
  - CA and NY: Fully insured plans of all sizes; extends up to 36 months medical only
  - Example: TX employees that exhaust federal COBRA are entitled to an additional 6 months of state continuation – even for those events that provide 36 months of coverage
- Generally, does not apply to self-insured or level-funded plans
- Some states further limit administrative fee (some prohibit surcharge), have notice requirements, or require a conversion option
- Work closely with insurance carrier to understand obligations for the states in which you have employees




Medicare

Medicare Basics

- Federal health insurance program for those age 65 or older, or those considered disabled by Social Security
- Just because someone is 65 doesn't mean they have to enroll in Medicare – depends on each person's circumstances

Part A	Part B	Part C	Part D
"Original Medicare"	**"Original Medicare"**	**"Medicare Advantage"**	**"Prescription Drug Plan"**
Provides 'hospital insurance' • Inpatient hospital care • Skilled nursing facility stays • Hospice and home healthcare	Provides 'medical insurance' • Doctor and clinical labs • Outpatient and preventive care • Screenings, surgical fees and supplies • Physical and occupational therapy	• Combination of Parts A and B • Can be combined with Part D through many Medicare Advantage plans including prescription drug coverage • May include additional services like dental or vision	• Stand-alone drug plan, most commonly paired with Original Medicare • Can also be combined with Part C
Most people don't pay a premium	Standard premium is $185.00/month (high income earners may pay an additional surcharge)	Premium varies by plan, may be as low as $0	Premium varies by plan (high income earners may pay an additional surcharge)

Medicare Secondary Payer Rules

Rules that prohibit employers from offering financial incentives to Medicare-eligible individuals or otherwise trying to entice them to enroll in Medicare instead of the group health plan

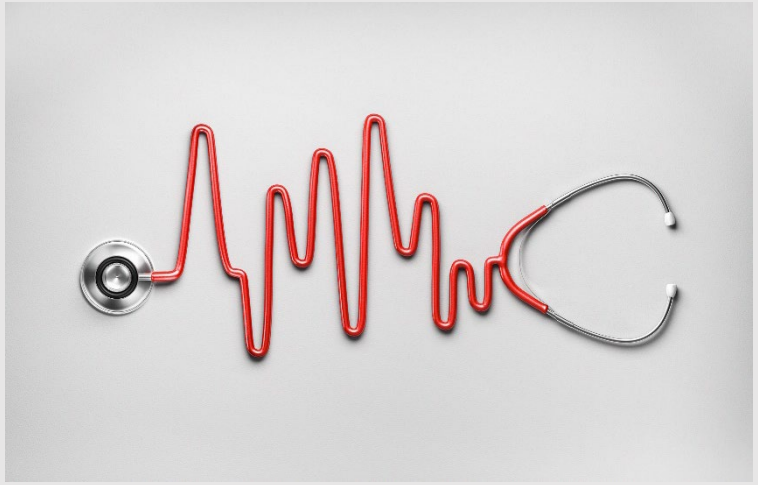
- Applies to employers with 20 or more EEs for each working day in at least 20 weeks in either the current or preceding calendar year
  - If Medicare due to disability, must have 100 or more EEs on at least 50% of its regular business days during the previous calendar year
  - If Medicare due to ESRD, no size restrictions, all plans must comply with COB rules for the 1st 30 months
- Impacts whether the group health plan pays primary or secondary
- Employers with 20 or more EEs cannot reimburse or pay for Medicare for their employees unless you utilize an ICHRA. *Note:* the ICHRA would need to be offered to all EEs in a class, you can't single out Medicare-eligible EEs
- Employers can still offer an opt-out or cash-in-lieu arrangement as long as it is for any eligible EE and not just those on Medicare
- Can offer Medicare plans to retirees
- Penalties for noncompliance may be assessed

Medicare Part D Requirements

Employers have 2 separate compliance notice/disclosure requirements:

Notice to Eligible Employees:

- By October 14 annually (non-calendar year plans often provide at OE and then again close to the Oct 14 deadline)
- Informs whether the plan is creditable or not – important information for individuals enrolled in Medicare to help make Part D enrollment decisions
- Carrier/TPA may provide creditable/non-creditable status; if not, need an actuarial determination



Online Disclosure to CMS

- Due 60 days following the start of plan year
- Reports creditable or non-creditable status of plan to CMS
- If creditability status changes midyear must file an updated disclosure

Medicare Interaction with Other Laws

HSA

Once enrolled in Medicare neither the individual nor the employer can no longer make HSA contributions

- Status is based on the 1st day of the month

Part A is retroactive up to 6 months (but no sooner than the month in which you turn 65) – this can trip people up trying to pro-rate HSA contributions

If EE is not enrolled in Medicare but spouse is, it does not impact the EE's ability to contribute to an HSA

- Contributions based on enrollment tier, regardless of if the other person covered is enrolled in Medicare
- Can use your HSA to pay for your spouse's qualified medical expenses

HSA funds can be used to pay for qualified medical expenses, dental & vision expenses, and also premiums for Part B, Part D, or Part C (Medicare Advantage)

- Cannot use an HSA to pay for a Medicare Supplement

Medicare Interaction with Other Laws

Midyear election change rules

- Enrollment in Medicare creates a midyear election change event only for the person who enrolls
- Must meet Section 125 consistency rules
  - If spouse enrolls in Medicare but not the EE, the EE cannot drop their own coverage, can only drop the spouse's coverage
  - Cannot add new participants when someone drops coverage
- Notification requests must comply with Section 125 plan rules

Medicare Interaction with Other Laws

COBRA

- If EE enrolls in Medicare – and remains an active EE – this **does not** create a COBRA qualifying event for any covered spouse or dependents
  - MSP rules prohibit automatically terminating group health coverage upon Medicare enrollment (the EE can voluntarily drop coverage though)
  - Since the EE can remain on the group health plan while also enrolled in Medicare, if they decide to voluntarily drop the group plan in favor of Medicare it is a voluntary loss of coverage for the spouse/dependents and thus not a COBRA qualifying event
  - EEs enrolling in Medicare while still actively working should be cautious if they cover a spouse/dependent

- NFP's *Compliance Corner* FAQ Do Dependents Get COBRA if Employee Drops Coverage Midyear?

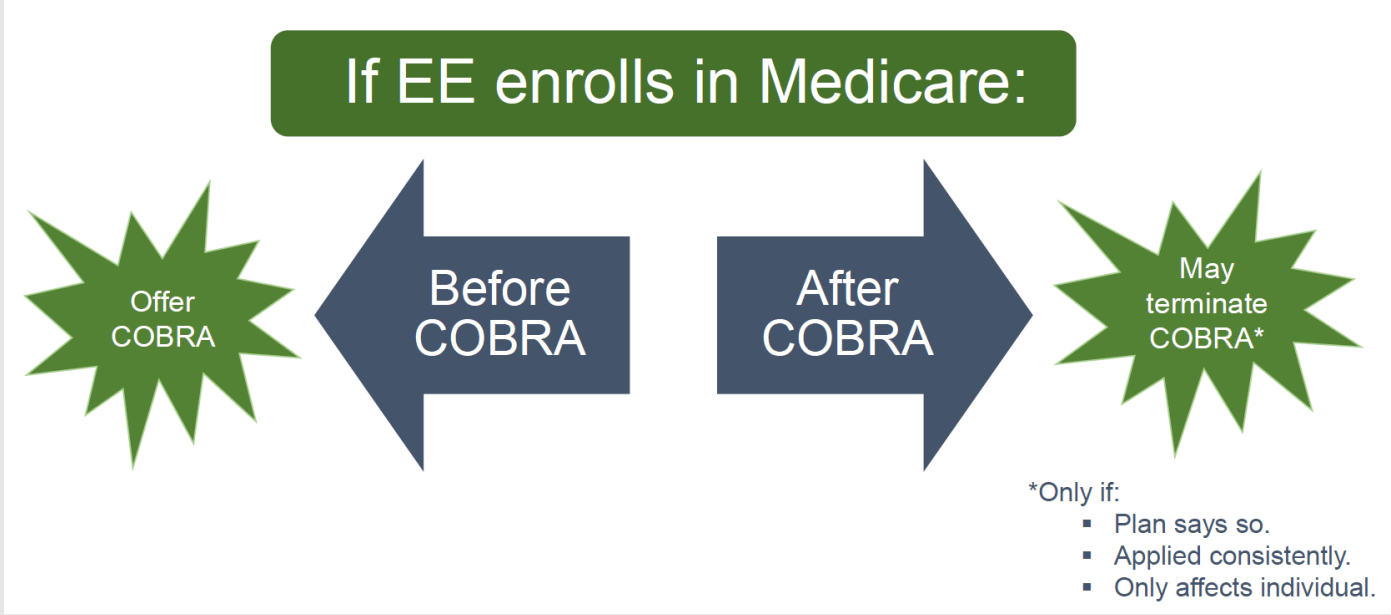
NFP's *COBRA: A Guide for Employers* publication includes a discussion on allowable triggering events and covers why Medicare enrollment rarely creates a COBRA qualifying event

Medicare Interaction with Other Laws

If the Medicare-eligible EE terminates employment, COBRA is offered

When a covered employee's COBRA qualifying event occurs **within the 18-month period after the employee becomes entitled to (enrolled in) Medicare**:

- Maximum coverage period extends to 36 months for spouse and dependent children
- Measured 36 months after the employee becomes enrolled in Medicare, not from qualifying event date
- Qualifying event must be termination of employment or reduction of hours
- Employee remains entitled to 18 months



If the employee's COBRA qualifying event occurs before enrolling in Medicare, any covered dependents would be limited to the original 18 months – not the extension of up to 36 months.


FMLA

The Basics

- Family Medical Leave Act (FMLA)
- Applies to
  - Private employers with 50 or more employees
  - Governmental employers and public and private elementary or secondary schools of all sizes
- Eligible employees
  - Worked for employer for at least 12 months
  - With 1250 hours of service in prior year
  - Works at a location where the employer employs at least 50 employees within 75 miles of that worksite
- Job-protected leave
- Health benefits continued under the same conditions as if working

Reasons for Leave

- An eligible employee may take up to 12 workweeks of leave in a 12-month period for one or more of the following reasons:
  - The birth of a son or daughter or placement with the employee for adoption or foster care;
  - To care for a spouse, son, daughter, or parent who has a serious health condition;
  - For the employee's own serious health condition that makes him or her unable to perform the essential functions of the job; or
  - For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active-duty status.
- An eligible employee may also take up to 26 workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the service member.

Notices

- General Notice
- Eligibility Notice & Rights & Responsibilities Notice
- Designation Notice
- Notice of Nonpayment of Premiums
- Open Enrollment Notice

Coverage during FMLA

- Health benefits continued under the same conditions as if working.
  - Employees are still responsible for their share of the premiums
  - If benefits change while the employee is on FMLA, then they are entitled to those changed benefits

- Coverage can end during FMLA for one of the following reasons:
  - The employee can choose to drop coverage while on FMLA (they must get it back when they return!); or
  - The employee fails to pay their share of premiums.

- If the employee does not return to work after their FMLA leave, then the employer is not obligated to continue benefits. Note that there is likely an obligation to provide COBRA election notices when an employee fails to return from FMLA leave (even if coverage was dropped at the beginning of the leave or during the leave).

Paying for coverage during FMLA

- Employees have three different ways to pay their share of premiums while on FMLA.
  - Pre-pay
  - Pay-as-you-go
  - Pay upon return to work

- The employer should provide advance notice of premium payment requirements and deadlines. The employee cannot be required to pay more than if actively working.
- If the employee agrees to pay their share during the leave, and fails to do so, then:
  - Unless the employer has a longer grace period, their obligation to maintain coverage ends if the employee's premium share payment is more than 30 days late.
  - If the employee misses a payment deadline, nonpayment notice must be mailed 15 days before coverage ends advising of termination on a specific date if payment is not received by that date.

State FML

- Many states have their own version of the federal FMLA.
- State FML are often broader in application.
  - For instance, some states also cover “safe leave,” generally for an employee or their family member who is a victim of domestic violence, stalking, or sexual assault or abuse.
  - The family relationships that are recognized under statutory programs vary from state to state and often include relationships such as domestic partners, siblings, grandparents, and grandchildren, that are not otherwise recognized under the federal FMLA.
  - Employers that are covered by federal FMLA (and/or a state’s version of FMLA) will run such leave concurrently whenever the qualifying reason for leave is the same.
- State FML may also provide partial wage replacement to eligible employees.

The state-by-state details appear in this publication in the order shown on the chart below. To discuss your state leave 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.

Chart of Statutory Disability (DI) and Paid Family Leave (PFL)

State	DI	PFL	Effective Dates	Private Option Available?
California	X	X	In force	Yes
Colorado	X	X	In force	Yes
Connecticut	X	X	In force	Yes
Delaware	X	X	Payroll deduction effective 1/1/2025; Benefits effective 1/1/2026	Yes
District of Columbia (DC)	X	X	In force	No
Hawaii	X		In force	Yes
Maine	X	X	Payroll deduction effective 1/1/2025; Benefits effective 5/1/2026	Yes
Maryland	X	X	Payroll deduction effective 1/1/2027; Benefits effective 1/3/2028	Yes
Massachusetts	X	X	In force	Yes
Minnesota	X	X	Payroll deduction effective 1/1/2026; Benefits effective 1/1/2026	Yes
New Hampshire	X (Limited circumstances)	X	In force (Participation is voluntary for private ERs)	Yes
New Jersey	X	X	In force	Yes

Other Federal Mandates

Other Federal Mandates

- USERRA
- TRICARE
- QMCSO
- CAA 2021 Rules
  - RxDC
  - Gag Clause Attestation

USERRA

Uniformed Services Employment and Reemployment Rights Act

- Applies to all employers regardless of size
  - Model notice available from DOL https://www.dol.gov/sites/dolgov/files/VETS/legacy/files/USERRA_Private.pdf

- EEs absent from work due to uniformed service must be:
  - Offered the option to continue group health coverage (at their own expense) for a period of up to 24 months
  - Guaranteed reemployment upon return
  - Reinstated if health coverage continued

- Applies to periods of leave 31 days or longer
  - Absences 30 days or less coverage should continue like normal at regular active EE rates

TRICARE

- U.S. military health care program providing benefits to active duty and retired service members and their families.

- Similar employee protections to Medicare – applies to employers with 20 or more EEs for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

- Employers are prohibited from:
  - Incentivizing someone eligible for TRICARE to not enroll or to drop the group health plan
  - Imposing stricter eligibility requirements for participation

- SPDs should disclose information about TRICARE and coordination of benefits (COB).

QMCSO

Qualified Medical Child Support Order

- Creates a right to enroll a dependent child if not already enrolled
- Must have written procedures to determine a **qualified** order
  - National Medical Support Notice (NMSN) can be a QMCSO
- Each state will have specific financial requirements that may impact whether enrollment is required
  - When in doubt check with the court
- Expiration of the coverage period in the notice does not create a right to disenroll the dependent midyear

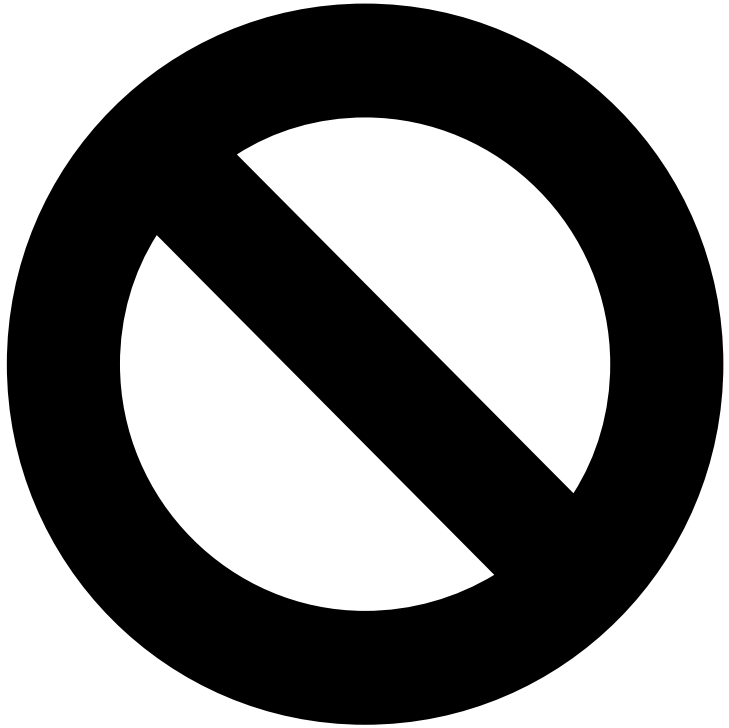
CAA 2021 Rules

RxDC Reporting

- Due June 1 each year
- Reports general plan information and Rx claims/spending information
- Fully insured plans the carrier files – but employers usually need to provide some information to the carrier
- Self-insured plans – TPA may file but need to confirm; employers would still need to provide some information

Gag Clause Attestation

- Plans cannot enter into contracts that would restrict them from accessing provider-specific cost and quality of care information or from providing information to participants or providers
  - Example of a gag clause: TPA contract that prohibits the plan's access to network rates because the TPA considers that information proprietary
- Due annually by December 31 (can file early)
- Fully insured plans the carrier usually files but need to confirm
- Self-insured plans (or level-funded) can enter into a written agreement with the TPA to file on their behalf; do not assume the TPA is handling it



Key Takeaways and Resources

Key Takeaways and Resources

- COBRA requirements are prescriptive – employers need to ensure they are following notice timelines
- Medicare enrollment should not be influenced by the employer
- FMLA and other LOAs make benefits eligibility and administration tricky – be aware
- Employers should not assume the carrier or TPA is handling all transparency requirements – confirm!
- Counting employees varies by federal law; employers with populations on the cusp of 20 or 50 EEs should be careful and stay on top of headcounts to ensure compliance with applicable laws

Key Takeaways and Resources

NFP An Aon Company

Corporate Benefits
Compliance

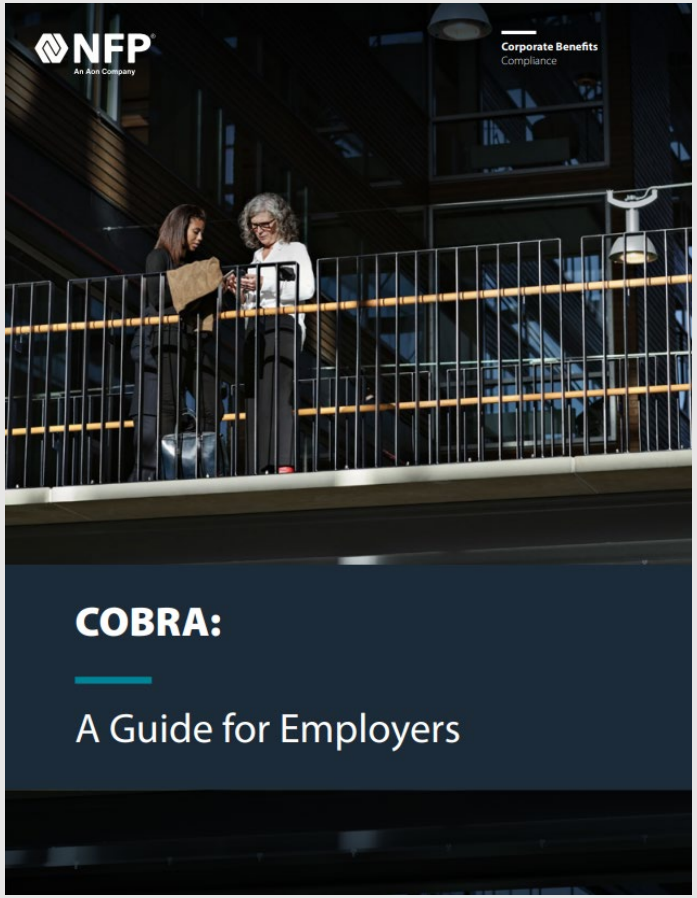
MEDICARE PART D CREDITABILITY DETERMINATIONS AND DISCLOSURES: A GUIDE FOR EMPLOYERS

Plan sponsors that offer prescription drug coverage must disclose the plan's Medicare Part D creditable status to Medicare eligible individuals and their families by each October 14, and to CMS within 60 days after the start of the medical plan year.

Employers of all sizes and plan funding types (fully insured and self-insured) that sponsor group health plans have two separate annual compliance obligations regarding the creditable status of the employer's prescription drug plan(s) relative to Medicare Part D, which is Medicare's standard prescription drug coverage. One obligation is to their employees and the other is to the Centers for Medicare and Medicaid Services (CMS).

Employers must notify employees and their family members regarding the creditable status of their prescription drug plan(s) by each October 14, prior to the October 15 start of the annual Medicare open enrollment period. They must also disclose the creditable status of the plan(s) to CMS within 60 days after the start of the medical plan year (policy year or contract year, regardless of the ERISA plan year). Additional disclosure requirements apply when there is a change to the creditable status of an employer's prescription drug plan.

NFP Observation:	Employers need to be aware of the changes to Medicare Part D owing to the impact of the Inflation Reduction Act of 2022 (IRA) on the value of Medicare Part D effective for plan years beginning in 2025. Specifically, some group health plans that were creditable relative to Medicare Part D in prior years may not be creditable in the future. Although the compliance obligations regarding confirming a plan's creditable status and making Medicare Part D disclosures have not changed, it is increasingly important for employers to understand the concept of Part D creditability and comply with the employee notice and CMS disclosure requirements related to their prescription drug plans.



NFP An Aon Company

CORPORATE BENEFITS
COMPLIANCE

Compliance Checklist

Generated on: 04/24/2025

NFP An Aon Company

Corporate Benefits
Compliance

TRANSPARENCY AND CAA 2021 OBLIGATIONS OF GROUP HEALTH PLANS

This publication provides a high-level overview of important compliance requirements and effective dates under the Transparency in Coverage final rule, the No Surprises Act, and related federal legislation.

Recent federal legislation imposed significant new compliance obligations upon group health plan sponsors. These laws are designed to achieve several important objectives. One goal is to enable plan sponsors and participants to better evaluate healthcare options and make cost-conscious decisions by ensuring access to certain cost and quality of care information. Another purpose is to reduce the potential for participants to receive unexpected bills for healthcare services. Over the long term, the laws are intended to create a more competitive healthcare marketplace that puts downward pressure on prices and thus lowers overall healthcare costs.

To achieve these objectives, the DOL, IRS, and HHS first issued the Transparency in Coverage (TiC) final rule in October 2020.[1] This rule requires non-grandfathered group health plans to disclose certain data, such as in-network (INN) provider negotiated rates and historical out-of-network (OON) allowed amounts, to the public via machine-readable files posted to a website. Additionally, these plans must provide participants with personalized cost-sharing information for covered services via an online self-service tool. The rule has phased-in effective dates from 2022 to 2024, with all items and services required to be available via an online self-service tool for plan years beginning in 2024.

Subsequently, Congress passed the Consolidated Appropriations Act, 2021 (CAA) in December 2020. This stimulus relief measure incorporates patient protections and a variety of additional transparency and disclosure obligations that apply to group health plans (including grandfathered plans). Among other provisions, the CAA No Surprises Act (NSA) includes comprehensive surprise billing prohibitions.

On August 20, 2021, the DOL, IRS, and HHS released FAQs regarding the implementation of various CAA provisions.[2] This guidance provided temporary enforcement relief with respect to specific CAA provisions pending the issuance of regulatory guidance. Subsequently, implementing regulations were proposed or issued regarding some CAA provisions, but the industry is awaiting further guidance. Nonetheless, many CAA requirements, including the No Surprises Act (NSA) surprise billing prohibitions, took effect for plan years beginning on or after January 1, 2022.

Accordingly, group health plan sponsors should ensure that they are consulting with their carriers or ASO providers regarding implementing these requirements by the applicable deadlines. Although plan sponsors are ultimately responsible for compliance, most will rely heavily upon TPAs to timely satisfy their obligations. So, plan sponsors should routinely keep these mandates in mind when negotiating service agreements and vendor contracts for upcoming plan years. They should also budget for potential additional costs of compliance. Employers should engage counsel for legal advice regarding the specific application of these laws to their group health plans and/or for assistance with related vendor contract negotiations.

This publication, presented in chart format, provides a high-level overview of important compliance requirements and effective dates under the recent federal legislation. References are provided for regulatory guidance issued as of the publication date; additional implementing guidance is expected.

1. DOL, HHS, and IRS, "**Transparency In Coverage**," Federal Register, govinfo.gov, 2020.
2. DOL, HHS, and IRS, "**FAQs About Affordable Care Act and Consolidated Appropriations Act**," dol.gov, 2021.


Questions?
Thank you for joining us!