McGOHAN BRABENDER'S
COMPLIANCE IN MOTION

SEPTEMBER 2025

Trial Court Vacates 2017 Rules Which Expanded Exemptions to Contraceptive Mandate

The Affordable Care Act (ACA) mandates that all non-grandfathered medical plans must cover a federally defined list of preventive care services and drugs in-network without cost-sharing. A particularly contentious part of that mandate is the requirement to cover women's sterilization and contraceptives.

After many lawsuits made their way to the Supreme Court of the United States (SCOTUS), rules were issued in 2017 to provide that most employers with a sincerely held religious or moral objection can be exempt from the contraceptives to which they object. Those 2017 rules were originally challenged but upheld by SCOTUS in July 2020.

Five years later, on August 13, 2025, a trial court **ruled** in Pennsylvania v. Trump that the 2017 rules were arbitrary and capricious and did not follow reasoned decision-making. This ruling is expected to be appealed to the Third Circuit. In the meantime, the expanded exemptions from contraceptive mandates under the 2017 religious and moral objection rules can no longer be relied upon. So, objecting employers, without an explicit exemption, should work with counsel to determine how to proceed.

WHO THIS APPLIES TO:

- Employers sponsoring a non-grandfathered medical plan who object to covering one or more of the women's sterilization or contraceptive coverage benefits.

GO DEEPER:

On July 8, 2020, SCOTUS **ruled** 7-2 that the 2017 expanded exemptions from the contraceptive mandate were issued under proper statutory authority, were correct to address the Religious Freedom Restoration Act (RFRA), and had followed the procedural requirements of the Administrative Procedures Act (APA).

The Biden administration had proposed to amend the 2017 rules to create "individual contraceptive arrangements" and to undo the moral exemption. However, after reviewing 44,000 public comments and with the election of President Trump, they withdrew that proposal and left the 2017 rules intact.

Since revisions to the 2017 rules were withdrawn, the trial court has now determined that the 2017 religious and moral exemption rules did not adhere to the APA's requirement to follow "reasoned decision-making." The court contends that the 2017 rules were arbitrary and capricious and must be stricken in their entirety because:

- The religious exemption rule did not reasonably address the problem it purports to resolve and did not provide a satisfactory explanation for why exemption was opened to essentially any employer, including publicly traded companies;
- The moral exemption rule considered improper factors not authorized by Congress; and
- A reasoned explanation was not provided for why it was so necessary to reverse the narrow exemptions in previous rulemaking and to expand exemptions so broadly. The rules must reasonably consider other alternative pathways that still protect contraceptive and sterilization access for women.

With the 2017 religious and moral exemption rules now vacated, objecting employers who only qualify for exemption because of the 2017 rules will either need to comply with an "accommodation" process (which is only available to some employers, not broadly for all employers), or must work with their legal counsel to explore their legal options (i.e., as Little Sisters of the Poor will do now with respect to their own health plan since they object to participating in the accommodation process).

PRACTICAL IMPLICATIONS TO EMPLOYERS:

It is expected that ligation will continue on this issue, potentially again going as far as the SCOTUS. For employers with non-grandfathered medical plans who object to one or more of the women's contraceptive or sterilization coverage mandates, outright exemption is extremely limited, and for the two other narrow categories of employers there is an accommodation process which must be followed. Otherwise, the plan must cover each mandated service and drug.

Outright Exemption: In final regulations issued July 2013, nonprofit entities described in Internal Revenue Code sections §6033(a)(3)(A)(i) or (iii) were allowed to be exempt from contraceptive mandates to which they object. This includes *"churches, their integrated auxiliaries and conventions or associations of churches," and "the exclusively religious activities of any religious order."*

Certain Other Employers with Religious Objection Can Participate in an Accommodation Process: The 2013 rules provided that other nonprofit entities that hold themselves as religious organizations may navigate a special accommodation process to object to one or more contraceptives. In 2015, this was expanded to include certain closely held for-profit entities with a sincerely held religious objection. These religious non-profits, or closely held for-profit employers, must comply with an accommodation process in one of two ways:

1. Self-certify to the insurer or third-party administrator (TPA) that they are an eligible organization and list the contraceptives which they have a sincere religious objection to covering.
    - EBSA Form 700 is available for the self-certification.
    - This makes the insurer or TPA directly liable under the regulations to take sole responsibility for creating a plan that covers these contraceptives at no cost to covered women or the employer, and to provide annual notification to plan participants on the availability of that coverage.
2. Self-certify their qualification and objection to the Department of Labor (DOL) or Department of Health and Human Services (HHS) via an alternative model notice.
    - DOL or HHS will then notify the insurer or TPA to create the additional coverage plan and provide the required annual notification to participants.

However, two courts have granted a permanent injunction barring enforcement of the accommodation requirement from the plaintiffs in these two cases:

- The six employers in **Assn. of Christian Schools International v Azar**
- Members of the **Christian Employers Alliance**

Other Employers: With the 2017 expanded exemptions vacated at this time, objecting employers with a non-grandfathered plan cannot exclude women's contraceptive or sterilization coverage to which they object unless they follow the exemption or accommodation provisions discussed above.

Update on Two Tobacco Incentive Lawsuits

Two recent court decisions offer insight for employers on when a complaint about a tobacco wellness program might lead to litigation. In the Chirinian v Travelers **decision**, the court determined the employer complied with most of HIPAA's wellness rules but was missing language in its ERISA summary plan description (SPD). In the Buescher v North American Lighting **decision**, the court determined the employer complied with most of HIPAA's wellness rules and dismissed all of the plaintiff's claims, with the exception of a complaint that the notice of a reasonable alternative was not adequate.

WHO THIS APPLIES TO:

- Any size employer with a health plan incentive tied to tobacco status.

GO DEEPER:

For employers offering health plan incentives tied to tobacco status, ERISA, ACA and HIPAA all provide a framework employers can follow to avoid liability for discriminating against someone based on a health factor (tobacco use). There are language and notice requirements, incentive limits, a requirement to provide an annual opportunity to qualify, and a requirement to provide a reasonable alternative standard to earn the same full year incentive whether or not an individual quits tobacco.

In the first case, Travelers complied with all these rules except one. While most health plans describe their wellness programs and incentives in a benefit guide and/or in dedicated wellness program materials, Travelers also included information about the wellness program in their ERISA summary plan description (SPD). However, the court held that all plan materials describing the wellness program and incentive must address all aspects of being able to request a reasonable alternative, including the option for the participant to ask the employer to create a reasonable alternative with the help of their personal physician. Travelers' SPD did not mention the ability to work with their personal physician as an option, so that complaint was not dismissed.

In the second case, the North American Lighting incentive program complied with most of HIPAA's requirements, but they did not respond to the part of the complaint alleging their failure to provide a notice of a reasonable alternative, so that complaint was not dismissed.

PRACTICAL IMPLICATIONS TO EMPLOYERS:

It is important when sponsoring wellness programs to not only design them well with reasonable alternatives, but also to provide required notices and to ensure all plan materials describing the program and incentives include all required language. A lawsuit can ensue simply for missing a required statement.

Court Issues a Stay on Several Provisions of the June 25 ACA Final Rules

A June 25, 2025, final rule had made adjustments to several Affordable Care Act (ACA) provisions, primarily focusing on the public health insurance Exchange Marketplace to adjust things like special enrollments, tax credits, and open enrollment periods. On Monday, August 25, 2025, a federal court in Maryland **issued** a stay on portions of that rule, but this should not directly impact employers or their group health plans. The federal government has provided a **list** of the changes that will not take effect as a result of this ruling, and none of them directly impact employers.

WHO THIS APPLIES TO:

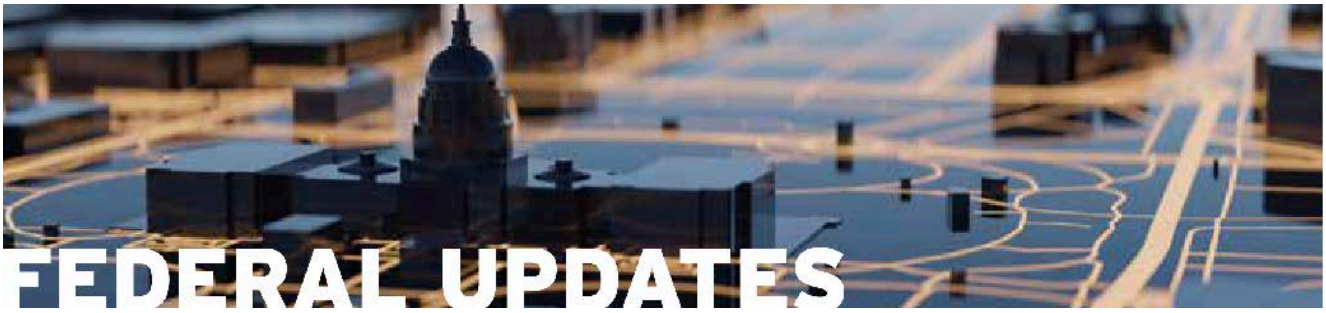
- No impact to employers or their group health plans, and no action needed.

GO DEEPER:

One challenge was to the provision that adjusted the methodology for calculating the premium adjustment percentage which increased the out-of-pocket limit (OOP) for non-grandfathered plans renewing next year to $10,600 per person and $21,200 per family. The court determined that the government had followed proper procedures to reasonably determine the adjustment was necessary and appropriate, so the revised OOP for non-grandfathered plans renewing in 2026 will remain at the revised limits.

Another challenge was to the provision that alters de minimis tolerances for various metal levels within Exchange plans. Typically, plans must have an actuarial value within ±2 percentage points of each metal level to qualify for that metal level (silver is 70% +/-2, gold is 80% +/-2, platinum is 90% +/-2), with bronze at 60% +5% or -2%. Those tolerances were proposed to adjust to +2/-4 (and +5/-4 for bronze). The court determined regulators "provided an insufficient and conclusory rationale for altering the de minimis variation," so the change in tolerances is blocked. In an employer context, this simply means an applicable large employer (ALE) sponsoring an individual coverage health reimbursement arrangement (ICHRA), which must base affordability on the lowest-cost silver plan for the respective ZIP code, will continue to likely be a plan providing close to a 68% actuarial value rather than a plan as low as 66%.

Other provisions challenged, such as changes to special enrollment periods or qualifications for tax credits, are not directly impactful to employers or group health plans outside of affecting which full-time employees may or may not qualify for tax credits that could potentially trigger penalties to ALEs. So, there is no direct impact to employers and no action employers need to take.



FEDERAL UPDATES

ACA FAQs Part 71

On July 30, 2025, federal regulators published **FAQs Part 71** providing instructions for group health plans to calculate qualifying payment amounts (QPAs) under the No Surprises Act. The FAQ also calls attention to the revised formula published in June 2025 for determining the way the out-of-pocket limit is calculated for non-grandfathered plan years beginning in 2026.

WHO THIS APPLIES TO:

- No Surprises Act: All size employers sponsoring a medical plan.
- OOP Limits: All size employers sponsoring a non-grandfathered medical plan.

GO DEEPER:

Questions 1 and 2 on the No Surprises Act: The No Surprises Act requires health plans to run a special payment process for three categories of medical services (brief overview here). Both the member's cost sharing and the initial payment determination must be based on a federally defined qualifying payment amount (QPA), but the carrier and provider have 30 days to negotiate a different amount for the carrier to pay them. This process and the way the QPA is determined have been the subject of multiple lawsuits.

Given the bouncing back and forth about which rules apply and do not apply based on what courts overturn, these FAQs instruct plans to follow the 2023 QPA rules, but grant enforcement relief for following the 2021 rules for services provided before February 1, 2026. They also encourage States to do the same. The second FAQ says if a plan is wanting to use the 2021 QPA rules, they must disclose they are utilizing the 2021 rules if the provider asks how the QPA was determined.

The insurance carrier or third party administrator (TPA) determines the QPA on behalf of group health plans, so they are primarily responsible for following these rules and providing required notices.

Questions 3 and 4 on Revising the 2026 OOP Limit: In June 2025, a final rule revised the methodology to calculate the premium adjustment percentage which is used to index the annual out-of-pocket limit (OOP) for the upcoming calendar year. Non-grandfathered plans must include deductibles, coinsurance and copays toward the OOP.

These FAQs just call attention to the changes published in June which result in the non-grandfathered plan OOP for 2026 being $10,600 for self-only coverage and $21,200 for other-than-self-only coverage (*note $10,600 is a per-person limit within family coverage*).

Non-Enforcement of Short-Term Limited Duration Insurance (STLDI) 2024 Rule

On August 7, 2025, the federal government **announced** they will not take enforcement action with respect to final rules issued in 2024 impacting short-term limited-duration insurance (STLDI). While this only impacts the individual insurance market, there are times when losing access to STLDI triggers a qualifying event to enroll in group health plan coverage. Outside of that edge case, employers are not impacted.

HOT TOPICS

MLR Rebates Reminder for Employers

Health insurance carriers are required to send out Medical Loss Ratio (MLR) payments to employers by September 30th when they did not spend enough of the premiums collected the previous calendar year on claims and allowable plan expenses. Most carriers are becoming better about not collecting more insurance premiums than MLR rules allow, so MLR rebates are not usually expected. But occasionally they still occur, and the employer has 90 days to determine how much of the rebate must be shared back with participants and former participants.

WHO THIS APPLIES TO:

- Any size employer with a fully-insured health plan the previous calendar year who receives an MLR rebate check this August or September.

GO DEEPER:

When an employer receives a MLR rebate check from the insurer, they need to carefully consider how the funds must be spent. They may not be able to keep the rebate unless their plan document specifies such rebates are retained by the employer. An employer with such language can simply retain the full rebate as taxable income to the organization.

Without such plan language, any portion of the rebate that is considered "plan assets" must be used in a very specific manner as described below. In other words, if employees paid any portion of the total premium, then that portion related to the MLR rebate may be considered plan assets which can only be used to benefit those participants, not the employer.

For instance, if employees paid 20% of total premiums last year and the employer contributed 80%, then 20% of the MLR rebate may be considered "plan assets" and should only be used for the benefit of plan participants.

There are three basic methods an employer may use to spend the participants portion of the MLR rebate:

1. Pay out a taxable cash refund
2. Offer a premium holiday for the amount of the rebate
3. Provide some type of benefit enhancement (keeping in mind participants must actually receive this within 90 days)

If the employer determines they need to share some of the rebate with former participants, a premium holiday or benefit enhancement might not work for them and sending a check may be more appropriate.

There is no de minimis exception to get out of distributing any portion that is considered plan assets (with a small exception regarding whether to include former participants).

In other words, even if the rebate is a very small amount and dividing it up between participants results in a few dollars, any portion related to plan assets still must be given back to current participants, and possibly to former employees (such as COBRA qualified beneficiaries and retirees).

Employers have express latitude under federal guidance to just divvy up the amount attributable to employees in an equal distribution. So, unless they choose, the employer does not need to further allocate the rebate for more equitable distribution reflective of how much different people paid. For example, if the employer provides single coverage at no cost to employees, the employer could issue an equal payment to all plan participants or could do further calculations to determine those in single coverage should not receive funds because they did not pay for coverage last year, so the rebate is shared with those who did pay.

DOL Guidance for Handling MLR Rebates

Annual Medicare Part D Notices Due by October 15

Each year prior to October 15th, employers must provide coverage notices to all Medicare Part D eligible individuals who are covered under, or who apply for, the employer's prescription drug coverage indicating whether that coverage is creditable or not creditable (i.e, does the plan on average pay as well as Part D pays). This includes individuals eligible for Medicare due to age, disability, or end stage renal disease (ESRD) whether they are enrolled in the medical plan for active employees, under COBRA or other continuation coverage, or retiree coverage.

WHO THIS APPLIES TO:

- All size employers with medical plans providing prescription drug coverage
- All size employers with an individual coverage health reimbursement arrangement (ICHRA) reimbursing not just insurance premiums but also prescription drug expenses

GO DEEPER:

Determining Whether the Prescription Drug Coverage is Creditable

The notices required by October 15 are to disclose the creditable or non-creditable status of the employer's prescription drug plans. Employer should already know the status of each prescription drug plan's creditability, as notice would have been provided with open enrollment materials and a disclosure to the Centers for Medicare and Medicaid Services (CMS) is required shortly after renewal.

Each prescription drug plan an employer sponsors must be separately evaluated using actuarial principles subject to CMS rules to determine whether it expects to pay, on average, as much for prescription drug claims as Medicare Part D expects to pay. The employer is not required to sponsor creditable plans, but is required to determine the creditable status of each plan it sponsors.

The employer will ideally secure a creditability determination from the carrier or TPA for each specific plan they offer. Often, the carrier provides a chart of off-the-shelf prescription drug plan options to show which plans for the upcoming calendar year are creditable or not creditable. As long as the employer is implementing an off-the-shelf, pre-designed plan without changes, they rely on the creditability determination chart.

If the TPA or carrier will not make a creditability determination, the employer must either use CMS's design-based "simplified determination method" or obtain a determination using actuarial principles.

Simplified Determination Method

The simplified determination method is not always straightforward for an employer to use. Since last updated in 2009, it requires comparing the plan's deductible to the Medicare Part D deductible, ensuring adequate coverage of generics and brand drugs, adequate in-network retail pharmacy access for where participants are located, and determining the plan expects

to pay at least 60% of prescription drug claim costs (so participants are expected on average to pay no more than 40% of prescription drug claim costs).

Revised Simplified Determination Method

A new option for 2026 (which becomes the sole simplified determination method in 2027) removes the need to evaluate the deductible but adds reasonable access to biologicals to the list of requirements and increases the expectation for the plan to pay at least 72% of prescription drug claim costs rather than 60%. This **revised simplified determination** method is discussed starting at the bottom of page 27.

It is not always straightforward for an employer to determine whether a plan has "reasonable access" to generics, brands and biologicals; has "reasonable access" to retail pharmacies where participants are located, and expects to pay at least 72% of prescription drug claims costs. When a simplified determination seems out of reach, the determination of creditable coverage status does not require an attestation by a qualified actuary unless the employer is electing the Medicare RDS (retiree drug subsidy), but the use of generally accepted actuarial principles in accordance with CMS guidelines is still required.

Providing the Creditable or Non-Creditable Notice

The employer must give a notice to Medicare-eligible individuals enrolled or seeking to enroll. Identifying these individuals can be difficult, particularly when eligibility for Medicare is based on a factor other than age, such as disability or end-stage renal disease. As a result, it is recommended employers provide Medicare Part D disclosures to everyone enrolled, or seeking to enroll, in the group plan.

CMS provides a **model notice** with fields the employer must complete. Employers do not have to use the model notices, but do have to ensure required content elements are provided. The model notice has not changed since 2011.

The notice may be sent by mail, handed out at work, or sent electronically if the DOL's electronic disclosure requirements are met (i.e., employees have electronic access as a material part of their daily job or give consent to electronic delivery). If electronic delivery is chosen:

- the employer must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan; and
- the notice must be posted on the employer's website, if applicable, with a link to the creditable coverage disclosure notice on the employer's home page.

If The Employer Knows a Creditable Plan Will No Longer Be Creditable January 1

If an employer knows before the October 15th notice deadline that a creditable plan option is going to lose creditability starting January 1, the employer would ideally include that detail in the notice they provide or in a cover letter. Some individuals already eligible for Part D may have been delaying enrollment due to having creditable coverage through their employer, so knowing in advance that their coverage will not be creditable in January may influence whether they want to elect Part D during the open enrollment period that begins October 15 (electing during the Part D open enrollment allows Part D coverage to start January 1).

Special Rules Allow Providing in Open Enrollment Materials Instead of Sending by October 15

If an employer would prefer, they could call special attention to the required notice in open enrollment materials and avoid the need to send a special mailing (or avoid the need to send an email and link on their website home page). The notice just has to be provided anytime within the past twelve months before October 15th and must be "prominent and conspicuous" enough in open enrollment materials to call attention to the importance of it and direct people where to find it in the materials.*

This means that the disclosure notice portion of the document (or a reference to the section in the document being provided to the individual that contains the required notice) must be prominently referenced in at least 14-point font in a separate box, bolded, or offset on the first page of the provided plan participant information. This is typically accomplished by including a correctly sized text box in the table of contents pointing to the notices section or page of the open enrollment materials, such as this example:

> ***If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page xx for more details.***

**Note that this approach is likely inappropriate when there is a change in the plan's creditable status since the last Medicare Part D Notice was distributed.*

Penalties for Non-Compliance

While there is currently no direct penalty to an employer for failing to provide these notices, someone with non-creditable coverage who delays enrolling in Part D until after they are first eligible will experience a late enrollment penalty payable for life. Therefore, it is important employers are doing their part to regularly educate employees when one or more plan options is not creditable so they can know when they or a dependent should weigh the pros and cons of delaying Part D and being subject to a late enrollment penalty if they stay in the non-creditable plan.

FAQ:

What rules must an employer follow with respect to court orders and other changes in circumstances affecting a participant's covered spouse or dependent?

Spouse Citizenship/Residency Change:

Changes in a spouse's legal status or residence in the country does not necessarily create a qualifying event to enroll or terminate the spouse from the plan mid-year. This is because spouses are often eligible regardless of their citizenship or where they live, so they do not gain or lose eligibility when these events occur.

There may be a couple very narrow exceptions:

1. When someone moves into or out of an HMO service area, the HMO will often not allow a person to enroll unless they reside in the HMO service area; so someone who gains or loses eligibility for the HMO plan due to a change in permanent residence might trigger a qualifying event.
2. When a spouse moves from a country and loses foreign government health coverage as a result, this can also trigger a qualifying event.

Legal Separation:

Employees who cover their spouse often seek to terminate their soon-to-be former spouse from their health coverage. Importantly, this often runs afoul of court or state rules on what can occur during divorce proceedings. Employers should also be aware of the implications under their plan. First, employers should be aware of whether the state the employee resides in actually recognizes legal separation. Not all states do, and simply separating from a spouse would not trigger a mid-year change on the plan.

Legal separation would only require the employee to terminate the spouse prior to divorce if plan terms deem legally separated spouses ineligible for coverage. Note, that this is rarely the case. As such, an employee seeking to terminate a spouse's coverage while the divorce is ongoing would rarely be considered a qualifying event to do so mid-year.

If the employee does remove the spouse from the plan (say at open enrollment), the employer should potentially caution the employee that they could violate the court's order. Under COBRA rules, an employer that is aware of this dynamic must also ensure that COBRA (if applicable) is offered to the spouse (who is dropped at open enrollment) when the divorce is finalized.

Court Ordered Former Spouse Coverage :

Benefit plan eligibility terms almost always state that only current spouses are eligible for enrollment in active coverage. Once the spouse is divorced from the employee, they can no longer remain enrolled and should be offered COBRA (or state continuation). Sometimes a divorce decree from the court orders the employee to provide health insurance to the former spouse for a certain amount of time. However, the plan terms do not allow this via active coverage.

Formerly Enrolled Spouse - A spouse that was formerly enrolled and loses coverage due to divorce can be offered continuation coverage for up to 36 months. So, the employee may have to comply with the court order by paying for the spouse's COBRA (which the employer could allow the employee to pay for post-tax). However, if the employee is not careful to provide the employer the

decree within the 60 days after the divorce is granted, they miss their deadline under COBRA and it would not be offered. In that situation, the employee would have to identify alternative coverage for the spouse.

This is often the unfortunate situation that arises when an employee and spouse fail to notify the employer of their divorce until long after the decree was issued. The spouse is found ineligible, terminated from the plan retroactively, and COBRA cannot be offered because the 60-day divorce notification deadline has long passed.

Some state laws try to stipulate spouses must remain enrolled in active coverage for a certain amount of time following a divorce. If employees are located in such states, employers should visit with counsel to determine whether their plan must comply and how, as ex-spouses are generally excluded from eligibility and unable to receive tax-favored coverage.

Spouse Not Formerly Enrolled - A spouse that was not formerly enrolled and is therefore not losing coverage due to divorce is not offered COBRA. So, the employee ordered to provide coverage for the ex-spouse must identify alternative coverage for them.

Court Ordered Legal Custody:

A court order granting legal custody or possession of a child is not enough, on its own, to create a qualifying event to enroll the child. The order must require the employee to provide insurance coverage for the child. Some situations granting legal custody actually require another parent or individual to provide coverage for the child. So, an employer cannot make the assumption that an order granting custody or possession requires adding the child to coverage.

If the order includes instructions to cover the child or relative, the employee must provide the order timely to the employer to allow for a qualifying event to enroll the child mid-year.

Such an order does not permit enrolling the child (or enrolling the employee and child) retroactively on a pre-tax basis. Only coverage starting the next day (or the first of the next month) may be paid pre-tax. If the employer allows retroactive coverage (such as the start of the month or back to the date of the order), then the retroactive portion should be withheld from pay after tax.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN):

This type of court or state order is usually sent to the employer directly rather than given by the employee to the employer. Employers must have written procedures they follow to address these promptly and in a way that protects the privacy of the other parent. Keep in mind, though, that each state or court issuing these orders may require different ways of responding:

- If the employee is in a new hire waiting period or not in an eligible position, the employer must generally respond to the order advising the child cannot enroll at this time as the employee is not yet eligible (or is in a position that will not allow them to become eligible, such as a part-time position). The court/state will generally respond by requiring enrollment once/if the employee becomes eligible.
- If the cost would not meet the wage affordability requirements outlined in the order, then the employer must respond to the order indicating what coverage would cost so the court can determine how to proceed.
- Such an order does not permit enrolling the child (or enrolling the employee and child) retroactively on a pre-tax basis. Only coverage starting the next day (or the first of the next

month) may be paid pre-tax. If the employer allows retroactive coverage (such as the start of the month or back to the date of the order), then the retroactive portion should be withheld from pay after tax.

Court Ordered Custody/Medical Support Removal:

It is often believed this type of court document allows removing the child from coverage (e.g., when a child ages out of child financial and health support). However, unless the order mandates the child be removed from coverage, it is not a qualifying event to drop the child. The child remains eligible and the court order does not require coverage to stop, so a qualifying event has not occurred. The child must remain enrolled until a valid qualifying event occurs, or at least until open enrollment.

(Note, an order actually directing the employee to drop the child at a certain date or age almost always does so because it directs another individual to take over such coverage; it rarely requires an employee to stop coverage for the child altogether since the ACA allows for coverage up to age 26).

PRACTICAL IMPLICATIONS TO EMPLOYERS:

Employers should be aware of court orders and legal change dynamics, ensuring they understand the implications of the changing situation and how benefits are and are not impacted.

It is recommended employers remind employees they should consult with the court or their legal representation before attempting to make a change to their elections.

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McGohan Brabender

REIMAGINING EMPLOYEE BENEFITS