

# COMPLIANCE CHRONICLE

REGULATIONS | POLICIES | STANDARDS | REQUIREMENTS | LAWS

**Compliance questions rarely show up one at a time, and the challenge is usually figuring out how all the rules connect. Whether it's seasonal employees, contribution strategies, Medicare coordination, or what happens during an acquisition, the details matter and so does the order in which you think about them.**

**Our April Compliance Chronicle pulls it all together in a way that makes it easier to follow, so you can cut through the noise and give clear, confident guidance to your groups.**

## WORKFORCE-SPECIFIC APPLICATIONS

### ACA Rules for Seasonal Workers (2026 Guidance)

#### Definition of a Seasonal Employee

Under ACA and IRS rules, a seasonal employee is someone hired into a position in which:

- The customary annual employment is six months or less, and
- The work occurs during approximately the same part of the year each year (e.g., holiday retail, etc.)

A worker can still be “seasonal” even if they work many hours per week. The definition is tied to the position’s expected duration, not hours worked.

#### Seasonal Workers and Applicable Large Employer (ALE) Status

The ACA employer mandate applies only to Applicable Large Employers (ALEs) – those averaging 50 or more full-time (FT) and/or full-time-equivalent (FTE) employees in the previous calendar year.



#### Seasonal Worker Exception (ALE Determination Only)

When counting toward ALE status:

- If an employer’s workforce exceeds 50 FTEs for 120 days or fewer during the prior calendar year
- AND the employees above 50 during that period are all seasonal workers,
- THEN the employer is NOT considered an ALE and is not subject to the employer mandate for that year

This rule applies only for determining ALE status, not benefit eligibility.



## Seasonal Employees and the Requirement to Offer Coverage

Once an employer is an ALE, seasonal employees are treated like any other employee for health coverage.

### Full-Time Status Requirement

An employee is ACA full-time if they average 30 hours/week, or 130 hours/month.

Seasonal employees who meet full-time thresholds must be offered coverage unless the employer uses the look back measurement method (**below**).

### Using the Look-Back Measurement Method For Seasonal Employees

Employers may use the look-back measurement method specifically to address variable-hour or seasonal employment patterns.

### Key Elements for Seasonal Employees

Seasonal employees are expressly included as eligible for the look-back method.

- Employers can place new seasonal employees into an IMP of 3-12 months to determine whether they average full-time hours.
- If the seasonal employee does not average 30 hours/week during the measurement period, the employer is not required to offer coverage during the subsequent stability period.

This is the primary ACA mechanism employers use to avoid offering coverage to short-term seasonal hires.

## Distinguishing Seasonal Employees From Temporary Employees

Seasonal vs. temporary employees differ under ACA:

- **Seasonal employees** work in roles lasting **six months or less** and recurring annually in the same season.
- **Temporary employees** may work finite periods but **not tied to a specific season**; they do **not** receive the seasonal exception.

Both categories, however, must be offered coverage if they are full-time (unless look-back rules apply).

## Practical Employer Implications

**If NOT an ALE:** There is no ACA mandate to offer coverage – even if seasonal workers work full-time hours.

### If an ALE:

- Seasonal employees who immediately qualify as full-time (30+ hours/week) under the monthly method must be offered coverage by the first day of the fourth full calendar month of employment unless they are being measured under the look-back method.
- Use of the look-back method can defer the need to offer coverage until completion of the measurement period.

## PLAN DESIGN CONSIDERATIONS

### Did You Know Employer Contributions For Small Groups Can Vary Based on Class?

Employers can vary employer contribution levels by employee class, as long as the classes are based on legitimate, bona fide employment classifications and do not discriminate based on protected characteristics (e.g., age, gender, health status, etc.).

For example, paying 100% of EE-only premium for owners/executives and 50% of EE-only for all other employees is generally allowed for **Fully-Insured** Small Group and Large Group plans, with some important rules to follow (detailed below).



#### What Employers **CAN** Do

Employers may differentiate benefits or employer contribution levels among classes, such as:

- Owners/partners/officers
- Executive management
- Full-time vs. part-time (if eligible)
- Hourly vs. salaried
- Union vs. non-union
- Geographic location
- Length of service (within IRS rules)

These are considered bona fide employment-based classes, which carriers and regulators allow. This flexibility applies as long as:

- The distinction is employment-based
- It does not relate to health status or a prohibited discrimination category
- The insurance carrier approves the class structure
- The plan complies with ACA requirements (e.g., no discrimination based on health status)

#### What Employers **CANNOT** Do

Employers may *not* vary contributions or benefits based on:

- Health status
- Claims history
- Gender
- Age (beyond age-banded rating rules set by the carrier)
- Genetic information
- Any protected EEOC class

These would violate HIPAA nondiscrimination rules and federal anti-discrimination laws.

#### Key Regulatory References

##### HIPAA / ACA Nondiscrimination Rules

These rules prohibit discrimination based on health factors, but do not prohibit offering different benefits or contributions to separate employment-based classes.

- HIPAA nondiscrimination rules: 26 CFR §54.9802-1
- ACA fully incorporates HIPAA's rules

They explicitly allow distinctions if based on employment classification and not health status.

## Insurance Carrier Rules

Small Group carriers typically require:

- Clear, documented classes
- Consistent treatment within each class
- Minimum participation requirements based on the blended group

Some carriers will want classes like:

- Owners
- Executive management
- All other eligible employees

## IRS Section 125 (if the plan is pre-tax)

Varied employer contributions are allowed, as long as all employees in the same class are treated the same. But different contribution levels can affect Section 125 nondiscrimination testing if: The plan is run through a Cafeteria Plan (pre-tax payroll deductions), AND owners/executives are considered Highly Compensated Employees (HCEs) or Key Employees for testing purposes.

**So the truth is:** Different employer contributions between classes are allowed, but they *can* increase the likelihood of failing Section 125 nondiscrimination tests if not structured carefully.

## Why Section 125 Tests Contribution Differences

Section 125 nondiscrimination testing focuses on whether HCEs or Key Employees receive better benefits than non-HCEs under the cafeteria plan. The three required tests are:

- 1. Eligibility Test:** Are enough non-HCEs eligible?
- 2. Benefits/Contributions Test:** Do HCEs receive greater employer contributions or better access to benefits?
- 3. Key Employee Concentration Test:** Do Key Employees take more than 25% of total plan benefits?

# SECTION 125 NONDISCRIMINATION TESTING: HOW TO PASS



## Does Paying 100% for Owners/ Executives Create a Risk?

**Yes**, it can create a risk under the Benefits and Contributions Test. Because you're offering:

- 100% employer-paid premium for owners/executives (likely HCEs or Keys)
- 50% employer-paid premium for rank-and-file employees

A Section 125 auditor will look to see whether:

- HCEs are receiving disproportionately richer benefits (they are)
- Non-HCEs have "meaningful" access to pre-tax benefits (they do)

This does not automatically fail the test but it does raise the risk.

### Here's the Crucial Nuance:

The nondiscrimination rules test the Cafeteria Plan, not the insurance plan. Meaning:

- The employer *can* offer different contribution tiers
- What gets tested is whether HCEs/Key Employees are receiving tax-favored treatment that is disproportionately higher

So even though carriers allow class-based contributions, the Section 125 plan may need design adjustments to pass.

### Ways Employers Commonly Stay Compliant

Most employers who want richer contributions for executives use one of these approaches:

- Make the employer contribution taxable for owners/executives
- If the 100% employer-paid premium for executives is added to their W-2 as taxable income,
  - » it no longer flows through the Section 125 plan
  - » and is excluded from nondiscrimination testing altogether

This is the most common fix and is fully compliant.

### Keep the Richer Benefit, but Run Annual Section 125 Tests

Many small groups pass anyway because:

- The total number of HCEs/Key Employees is small
- Non-HCEs still get access to meaningful pre-tax benefits

But this needs to be tested annually.

### Create a “Carve-Out” Class for Executives That Sits Outside the Cafeteria Plan

Their employer-paid premiums simply aren't run through Section 125. Again, this avoids creating testing issues.

## SPECIAL COMPLIANCE SITUATIONS

### Employer Pressure to Decline Group Coverage in Favor of Medicare: Why It's Prohibited (Even for Groups <20 Employees)



Even when an employer has fewer than 20 employees, making Medicare primary under the MSP rules, there are still strict federal protections preventing an employer from influencing an employee's decision to enroll in Medicare instead of the employer's group health plan. Below is an explanation of the rules and the risks.

#### Federal Law Strictly Prohibits Employers From Steering Employees Toward Medicare

Under the **MSP anti-incentive rules**, employers **may not:**

- Pressure an employee to drop group health coverage
- Offer incentives (cash, premium reimbursement, raises, bonuses) to get the employee to take Medicare instead
- Create enrollment materials, scripts, or conversations that suggest Medicare is “better,” “cheaper,” or “preferred”
- Design their plan in a way that targets or disadvantages Medicare-eligible employees

This prohibition applies to *all employers*, regardless of size, even if Medicare is primary for that employer. The difference in group size changes who pays first but does not change the anti-discrimination rules that protect Medicare-eligible workers.

## For Small Employers (<20 Employees), Medicare Is Primary But That Does Not Remove the Anti-Steering Rules

When an employer has fewer than 20 employees, Medicare becomes the primary payer if an employee enrolls in Medicare. But the employer **still cannot influence that decision.**

The employee must be allowed to:

- Remain on the group health plan, and
- Make their own choice about whether to enroll in Medicare

The employer's obligation is to offer coverage on the same terms as to younger employees in similar positions.

## What Employers Cannot Do

Employers **may not**:

- Suggest the employee would be better off taking Medicare
- Tell the employee that coverage will be more expensive or less comprehensive if they stay on the group plan
- Pay or reimburse Medicare premiums (Part B, Part D or Medigap)
- Give any financial advantage for choosing Medicare
- Create any special opt-out programs for Medicare-eligible employees
- Treat Medicare-eligible employees differently in eligibility, premiums, contributions or benefits

All of these are considered **prohibited incentives.**

The Internal Revenue Service, Centers for Medicare & Medicaid Services, and Department of Labor have all enforced penalties for these behaviors, including **\$5,000 per violation** in some cases, plus civil monetary penalties, excise taxes, and required corrective action.

## Why the Rules Exist: Equal Treatment and No Discrimination

The government wants to prevent situations where employers attempt to "off-load" older or higher-risk employees onto Medicare to lower group plan costs.

Therefore:

- Employers must offer older employees the same access to group health coverage
- Employers must not differentiate based on Medicare eligibility or age

The decision to enroll in Medicare must be 100% voluntary and without employer influence.



**SAFE ZONE**

## What Employers May Do (The Safe Zone)

These actions are **allowed**:

- Provide the standard Medicare Part D Creditability Notice
- Provide general, neutral educational information from CMS (e.g., "Medicare & You" booklet)
- Respond factually to an employee's Medicare questions when the employee initiates the conversation
- Continue offering the same group plan to all eligible employees
- Allow an employee to make their own independent decision

If the employee independently chooses Medicare, the employer may process the enrollment or disenrollment as usual – without providing any incentives.

## Medicare-Eligible Employee (Group >20): What's the Compliant Approach?

Because the employer has 20+ employees, the group health plan is primary, and Medicare is secondary (Medicare Secondary Payer (MSP) rules). This means you cannot encourage, pressure or steer an employee off the group plan and onto Medicare. But you can provide neutral, factual information about Medicare options.

### Compliant Ways to Start the Conversation

1. Send a neutral Medicare education notice to all Medicare-eligible employees, or even to all employees. Many employers send an annual Medicare eligibility letter that includes:
  - Statements that the group plan remains primary
  - Acknowledgment that the employee may be eligible for Medicare
  - Non-steering, factual guidance on how Medicare works with employer coverage
  - Instructions to contact Social Security or Medicare for personalized advice
2. Provide CMS-approved materials, such as:
  - "Medicare & You" handbook
  - CMS fact sheet: "Who Pays First?"

### Avoid anything that sounds like:

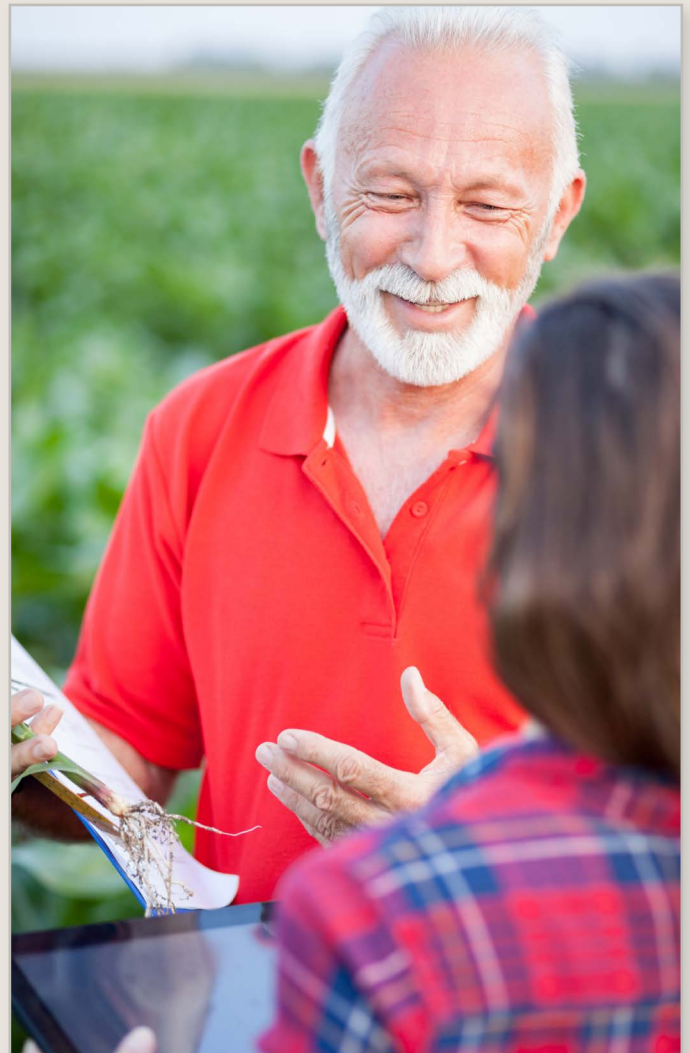
- "You should go on Medicare."
- "The group plan is expensive for older employees."
- "We prefer if you move to a Medicare supplement."

These statements violate MSP anti-steering rules and can trigger civil penalties.

## Compliant Sample Script You Can Give the Employer:

"We noticed you may now be eligible for Medicare. Because our group has more than 20 employees, your employer coverage remains primary and Medicare is secondary. You are not required to enroll in Medicare, but some employees choose to review their options. If you would like more information, Medicare and Social Security can explain how Medicare works with employer coverage and what your choices are."

What happens if they DO want a Medicare Supplement or more information about Medicare options? The employer can refer them to Medicare and Social Security, and can tell them that their broker may also be able to provide assistance.



## TRANSACTIONAL EVENTS

### Asset Purchase vs. Stock Purchase: Employee Benefits COBRA Obligations Shift Depending on Deal Structure

#### COBRA Obligations Shift Depending on Deal Structure

##### Stock Purchase

- The target company continues to exist as the same employer
- COBRA responsibility stays with the target's plan
- No qualifying event occurs solely because of the acquisition
- Employees remain covered under the same plan unless the buyer terminates it

##### Asset Purchase

- The seller is generally responsible for COBRA unless:
  - » The buyer continues the group health plan, and
  - » The buyer hires enough of the seller's employees to be considered a "successor employer"
- If the buyer is a successor employer, COBRA responsibility transfers to the buyer

This is one of the most commonly misunderstood areas in M&A benefits compliance.

#### Plan Termination Triggers COBRA

If the seller terminates its group health plan (common in asset deals), that termination is a COBRA-qualifying event for all covered employees and dependents.

But COBRA can only be offered if:

- The plan continues to exist, and
- At least one active employee remains covered

If the plan ends entirely with no active employees, **COBRA cannot be offered**, and the buyer must consider transition coverage options.



#### Controlled Group Status Changes After the Acquisition

Once the acquisition closes:

- The buyer and seller become part of the same controlled group
- For ACA purposes, they are treated as one employer going forward
- This affects:
  - » ALE status (future years)
  - » 1094-C/1095-C reporting
  - » Employer-mandate penalties
  - » Measurement periods for variable-hour employees

But controlled group status does not require the buyer to put everyone on the same health plan.



## ACA Employer Mandate Responsibilities

If the buyer is an ALE:

- Newly acquired full-time employees must be offered affordable, minimum-value coverage by the first day of the month after they become employees of the ALE.
- If the seller had a look-back measurement period in place, the buyer must honor it.

This is another area where employers often slip; resetting measurement periods is not allowed.

## Plan Document and SPD Updates

Acquisitions often require:

- Updating eligibility definitions
- Revising controlled group language
- Updating employer name and Employer Identification Number (EIN)
- Amending wrap documents
- Updating SBCs and ERISA notices

## Nondiscrimination Testing

If the buyer maintains separate plans for different entities within the controlled group:

- Self-funded plans must pass §105(h) nondiscrimination testing across the entire controlled group.
- This can be a problem if executives are concentrated in one entity.

Fully-insured plans are not subject to §105(h), but they still must comply with ACA rules.

## Service Bridging

Buyers must decide whether to credit prior service for:

- Waiting periods
- PTO
- Retirement plan vesting
- Eligibility for benefits

For health plans, ACA prohibits waiting periods longer than **90 days**, so service bridging is necessary.

## FSA, HSA and HRA Considerations

### FSAs

- In a stock purchase, the FSA continues
- In an asset purchase, the buyer must decide whether to:
  - » Take over the FSA or require employees to forfeit unused funds (if allowed)

### HSAs

- Employer change does not affect HSA ownership
- But plan design changes may affect HSA eligibility

### HRAs

- Must be amended or terminated, depending on whether the buyer continues the plan

## Retirement Plan Issues

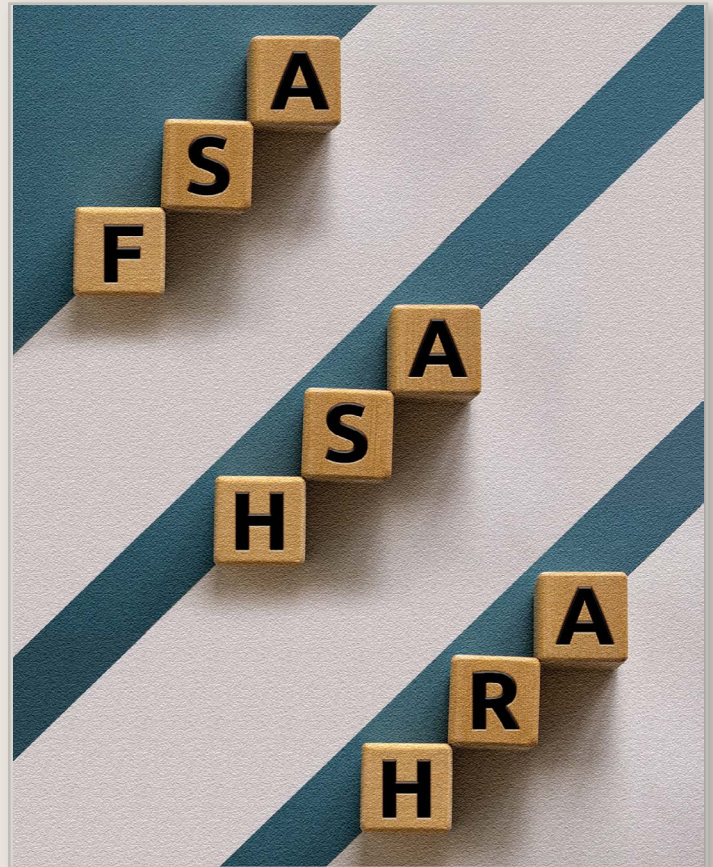
Not health-plan specific, but important:

- Successor employer rules may require the buyer to assume the seller's 401(k) plan
- Failure to merge or terminate properly can create major compliance issues

## Employee Communications

Acquisitions require:

- New hire packets
- SBCs
- HIPAA special enrollment notices
- Marketplace notices
- Plan change notices (60-day advance notice for material reductions)



## SIDE-BY-SIDE SUMMARY OF KEY ISSUES

### What Happens to the Employer/EIN?

Topic	Asset Purchase	Stock Purchase
<b>Employer identity</b>	Buyer becomes a <i>new</i> employer for acquired employees	Employer remains the <i>same legal entity</i>
<b>EIN</b>	Buyer's EIN applies to employees hired by buyer	EIN stays the same; nothing changes legally
<b>Impact on benefits</b>	Employees are treated like <b>new hires</b>	Employees remain in the <b>same employer's plan</b>

### Group Health Plan Treatment

Topic	Asset Purchase	Stock Purchase
<b>Does the seller's health plan continue?</b>	Usually <b>no</b> – seller often terminates the plan	<b>Yes</b> – plan continues unchanged
<b>Do employees stay on the same plan?</b>	Only if buyer chooses to adopt the plan (rare)	<b>Yes</b> , unless buyer later merges or replaces it
<b>Are employees treated as new hires?</b>	<b>Yes</b> – buyer must apply its own eligibility rules	<b>No</b> – employment is continuous

### ACA Employer Mandate

Topic	Asset Purchase	Stock Purchase
<b>Are acquired employees considered full-time for ACA?</b>	Buyer must consider as new employees, unless it adopts seller's measurement periods	Yes – buyer must <b>honor existing measurement periods</b>
<b>Controlled group impact</b>	Buyer and seller become a controlled group <b>after closing</b>	Same – controlled group applies immediately
<b>Must buyer offer coverage immediately?</b>	If buyer is an ALE, coverage must start <b>by the 1st of the month after hire</b>	No change – employees already have offers

### Measurement Periods (Look-Back Method)

Topic	Asset Purchase	Stock Purchase
<b>Must buyer honor seller's measurement periods?</b>	<b>No</b> , unless buyer voluntarily adopts them	<b>Yes</b> , required – employment is continuous
<b>Can buyer reset measurement periods?</b>	Yes	No

## SIDE-BY-SIDE SUMMARY OF KEY ISSUES

### Waiting Periods

Topic	Asset Purchase	Stock Purchase
Can buyer impose a new waiting period?	Yes, but cannot exceed <b>90 days</b>	No – employees are not new hires

### Retirement Plans (401(k), Pension)

Topic	Asset Purchase	Stock Purchase
Does buyer inherit the seller's plan?	No, unless buyer chooses to assume it	Yes – plan remains with the entity
Must the seller terminate its plan?	Often yes, to avoid successor liability	No – plan continues
Service crediting	Buyer chooses whether to credit	Must credit past service

### FSA, HSAs, HRAs

Topic	Asset Purchase	Stock Purchase
FSA	Buyer may or may not take over FSA obligations	FSA continues unchanged
HSA	No change – HSAs are individually owned	No change
HRA	Buyer must decide whether to assume or terminate	HRA continues

### Nondiscrimination Testing

Topic	Asset Purchase	Stock Purchase
§105(h) testing for Self-Funded plans	Buyer tests its own plan only	Entire controlled group must be tested together
Risk of failure	Lower	Higher if executives are concentrated in one entity

### Employee Communications

Topic	Asset Purchase	Stock Purchase
New hire packets	Required	Not required
SBCs, HIPAA notices	Required for buyer's plan	Only required if plan changes
60-day advance notice for material reductions	Applies if buyer changes plan	Applies if buyer changes plan



## Summary: The Big Picture



### Asset Purchase

- Employees become employees of a new employer
- Buyer chooses whether to adopt seller's plans
- COBRA often triggered
- ACA rules reset unless buyer adopts seller's measurement periods
- More flexibility, more administrative work



### Stock Purchase

- Nothing changes legally for employees
- All benefit plans continue automatically
- Buyer inherits all plan obligations
- ACA measurement periods and waiting periods must continue
- Cleaner transition but more inherited liability

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Check out all of our compliance and legislative resources at [warnerpacific.com](https://www.warnerpacific.com).

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