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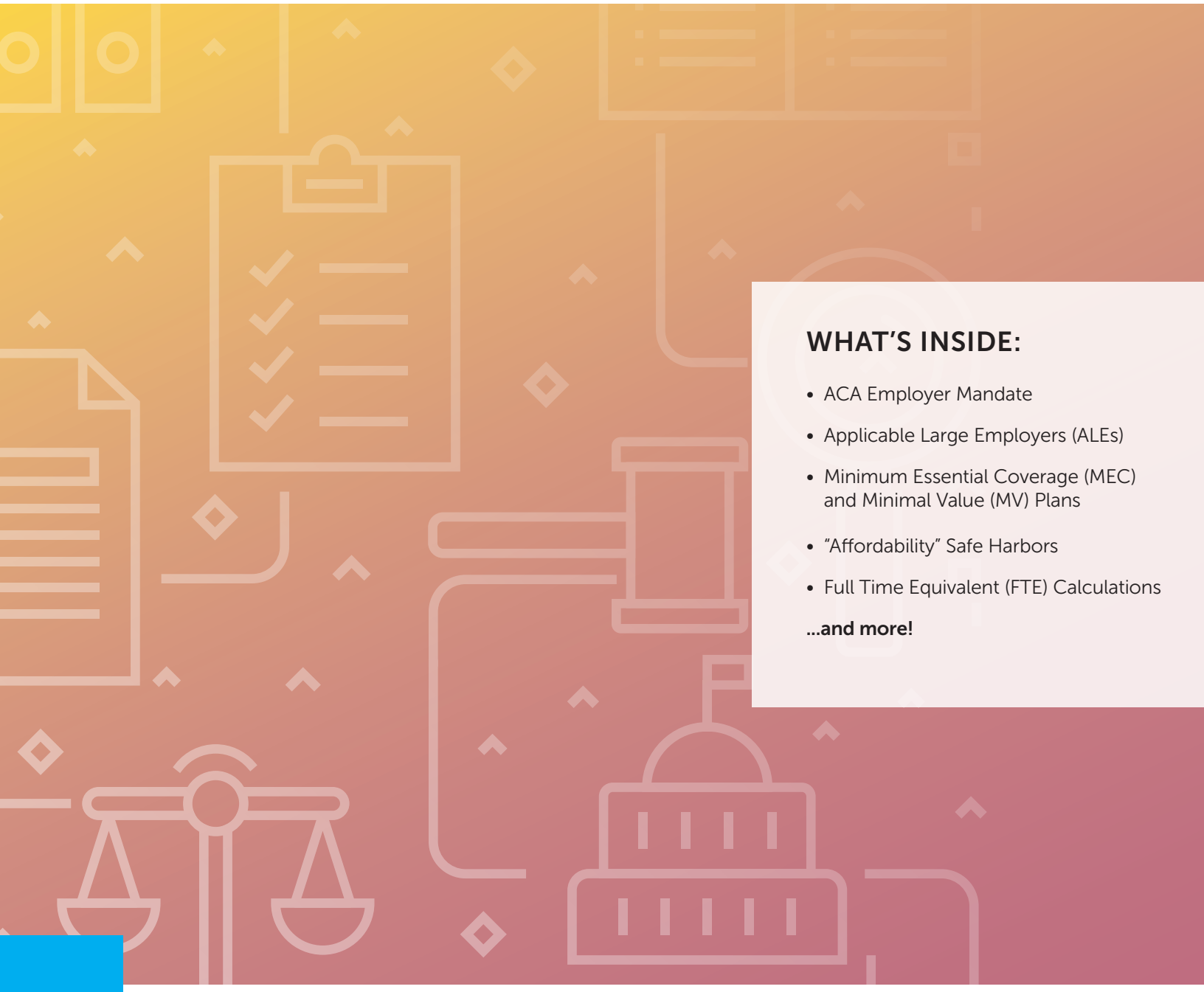

WHAT'S INSIDE:

- ACA Employer Mandate
- Applicable Large Employers (ALEs)
- Minimum Essential Coverage (MEC) and Minimal Value (MV) Plans
- "Affordability" Safe Harbors
- Full Time Equivalent (FTE) Calculations

...and more!

ACA QUICK REFERENCE GUIDE

2024 COMPLIANCE

For California and Nevada employers

WB.102220_9.23

Table of Contents

Listed below are questions addressed in this ACA Quick Reference Guide:

Which employers must comply with the ACA's employer mandate?

The ACA's employer mandate applies to **Applicable Large Employers (ALEs)**. Employers determine their ALE status annually on or around January 1st, by evaluating the average size of their workforce during the preceding calendar year.

See related question, "How do I determine if I am an Applicable Large Employer (ALE)?" on page 5 for further information.

What does the ACA require of Applicable Large Employers (ALEs)?

Applicable Large Employers (ALEs) must offer affordable major-medical health insurance coverage — that provides Minimum Value and is at least Minimum Essential Coverage (MEC) — to all Full Time (FT) employees. ALEs must also offer at least MEC to FT employees' dependent children up to age 26.

What is Minimum Essential Coverage (MEC)?

Minimum Essential Coverage is the type of coverage an individual must have in order to satisfy the individual mandate of the ACA. (*Note: The non-compliance penalty at the federal level is $0.00; however, the mandate is still a part of the law*.)

MEC also satisfies California's Individual Health Care Mandate (effective 1/1/2020), which requires Californians to have qualifying health insurance or pay a fine to the California Franchise Tax Board.

MEC is also the type of coverage an ALE must offer to Full Time (FT) employees and their dependents to avoid the ACA's non-compliance penalties.

Broadly, MEC is any type of medical group benefit offered to employees by an employer, in addition to other types of medical health plans.

MEC INCLUDES:

- **Job-based Medical coverage**
- Individual and Family market Health Insurance policies (Marketplace plans)
- Medicare
- Medicaid
- CHIP (Children's Health Insurance Program)
- TRICARE or Veterans Administration (Military coverage)

MEC does not include: vision-only, dental-only, workers' compensation, plans that offer only discounts on medical services, or coverage only for a specific disease or condition.

What is Minimum Value (MV) coverage?

A plan meets the minimum value (MV) requirement if it has an actuarial value of at least 60%. This means that the plan pays for at least 60% of the total cost of covered benefits. See additional information below.

The ACA requires Individual and Family Plans (IFP) and Small Group plans to adopt metal tiers, according to their actuarial value, as follows:

Metal Tier Name	Actuarial Value
Platinum	Plan pays 90% of the costs for covered benefits in-network (Higher premiums, lower out-of-pocket costs)
Gold	Plan pays 80% of the costs for covered benefits in-network
Silver	Plan pays 70% of the costs for covered benefits in-network
Bronze	Plan pays 60% of the costs for covered benefits in-network (lower premiums, higher out-of-pocket costs)

What are Essential Health Benefits (EHBs)?

The ACA requires all (fully insured) non-grandfathered Small Group and IFP policies to include the following 10 categories of care, at standard levels of generosity.

Large Group and self-funded plans are not required to cover any specific EHBs. But if they do, they cannot have lifetime or annual limits imposed on them. Plans that provide Minimum Value (MV) pay these benefits at a minimum 60% or better.

1. Outpatient care
2. Emergency services
3. Hospitalization
4. Pregnancy, maternity, newborn care
5. Mental health and substance use disorder services; counseling and psychotherapy
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventive care, wellness services, and chronic disease management
10. Pediatric services, including dental and vision for children

How do I determine if I am an Applicable Large Employer (ALE)?

An employer should make this calculation annually on or around January 1st, by evaluating its average employee group size in the preceding calendar year.

For each month of the preceding calendar year, the employer calculates:

(Number of Full Time [FT] employees) + (Number of Full Time Equivalent [FTE] employees)

Then, the employer will calculate an average of all 12 months' results:

(Sum of each month's results) ÷ 12

If the employer has a result of **50+**, then the employer is an ALE for the entire new calendar year. This means, the ALE must comply with the ACA's employer mandate in the new year, and must later report offers of employee coverage to the IRS at the beginning of the next calendar year.

The employer remains in the ALE (or non-ALE) category for the entire year, regardless of group size fluctuations throughout the calendar year.

What does a sample ACA Timeline look like for ALEs?

In January 2024, the employer counts FT + FTE employees for each month of 2023. Then, the employer averages the count of all 12 months. If the employer has a result of 50+ FT + FTE employees, it ***is*** an ALE for all of 2024, and must comply with the ACA's employer mandate for the entire year.

SAMPLE CALCULATION:

- January count = 78 FT + FTE
- February count = 61 FT + FTE
- March count = 63 FT + FTE
- April count = 59 FT + FTE
- May count = 59 FT + FTE
- June count = 57 FT + FTE
- July count = 52 FT + FTE
- August count = 49 FT + FTE
- September count = 48 FT + FTE
- October count = 48 FT + FTE
- November count = 51 FT + FTE
- December count = 47 FT + FTE

(78 + 61 + 63 + 59 + 59 +57 + 52 + 49 + 48 + 48 + 51 + 47) ÷ 12 = **56 FT + FTE employees**

In this scenario, the employer averaged 56 FT + FTE employees for all months of 2023. Thus, it is considered an ALE for all of 2024. The ALE must therefore *offer* all eligible FT employees *affordable* Minimum Essential Coverage (MEC) that provides Minimum Value (MV) [including at least MEC for dependent children to age 26] in 2024.

Then, in Q1 of 2025, the ALE employer must report on its compliance (or non-compliance) with the employer mandate to the IRS for the 2024 year. Also, on January 1st of 2025, the employer re-starts the process by evaluating its group size again, looking back on the 2024 year. And the cycle continues.

Refer to Word & Brown's exclusive ACA Group Size calculator for help in making this annual determination.

What is "Full Time" under the ACA?

The ACA considers an employee to be Full Time (FT) if the employee averages either:

- 30 *hours of service* per week, ***or***
- 130 *hours of service* per month

"Hours of service" includes most hours paid, including paid time off (PTO), sick time, paid jury leave, etc. It is more than simply "hours worked." Note: Payments under workers' compensation or state disability generally do not count as hours of service.

ALEs must *offer* all eligible FT employees *affordable* Minimum Essential Coverage (MEC) that provides Minimum Value (MV) [including at least MEC for dependent children to age 26].

What is "Full Time Equivalent" (FTE) under the ACA?

The ACA aims to ensure that all employers with an average workforce of 50+ *full-time equivalent* employees comply with the mandate. Because of this, employers must consider their non-FT employees in their ALE calculation. A Full Time Equivalent (FTE) is a sum of part time employees' hours that, when totaled together, equals the equivalent of a full-time employee – using a divisor of 120 hours.

For each month, the employer totals all Part Time (PT) employees' hours of service, and divides by 120. Each 120 hours accumulated by PT employees counts as one FTE.

For a PT employee who provides 121-129 hours of service, employers should enter a maximum of 120 hours in the monthly calculation, so one PT employee does not get counted as more than one FTE. (Example: 129 hours/120 = 1.075 FTE).

Remember, any employee who provides less than 30 hours of service a week, or 130 hours of service a month, is considered PT by ACA standards.

Refer to Word & Brown's exclusive ACA Full Time Equivalent (FTE) calculator for help making this determination.

How are seasonal employees calculated?

A seasonal employee must generally be included in the group count if the seasonal employee is employed for more than 120 days during the calendar year.

What if a business is owned by multiple people or entities?

Employers that are commonly owned may be considered a single group for purposes of determining their ACA group size and ALE status. The IRS refers to these groups as "controlled groups" or "aggregate groups." Even if employers in a controlled group or aggregate group have separate tax IDs,

different groups of employees, different locations, or different industries, they can still be combined for determining compliance responsibility. This is because the ACA is concerned with the overall size and composition of an employer's total workforce, even when otherwise split among commonly-owned entities.

A determination of common ownership and "controlled group" status must be made by a CPA, tax professional, or legal counsel in accordance with Internal Revenue Code § 414 (b) (c) (m) or (o).

Note: Groups with common ownership are not usually required to have the same health plan, but doing so often simplifies ACA reporting.

What is considered "affordable" under the ACA's employer mandate?

Affordability for individuals purchasing coverage on the ACA state exchanges is based on the individual's household income (and certain other factors). ALEs, however, cannot base affordability on employees' household incomes. This is because employers typically do not know their employees' household incomes, nor are employers entitled to know their employees' private household income amounts. Because of this, the ACA allows ALEs to set premiums according to information the employer does have. These are called the **ACA's affordability "safe harbors" for employers**.

Affordability is based on the employee's contribution for the lowest-cost MEC/MV plan offered to the employee — at the "employee only" rate. It is not based on the plan the employee actually enrolls in, but instead on the lowest-cost MEC/MV plan *offered*.

Additional rates for spouse or dependents are not considered in this calculation. As long as the employee's contribution does not exceed a certain threshold percentage per year (on a monthly basis), based on any of the three safe harbors, the plan is considered affordable.

Affordability for *plan years* beginning in 2024 is 8.39%.

Affordability for *plan years* beginning in 2023 is 9.12%.

Affordability is based on plan year, not calendar year. For example, a plan with a 12/1/2023 effective date will use the 9.12% ratio for 12/1/2023 – 11/30/2024. Then on 12/1/2024, the 8.39% ratio will be used through 11/30/2025.

AFFORDABILITY SAFE HARBORS ARE AS FOLLOWS:

Employees' Rate of Pay

- Employers calculate affordability under this scenario in one of two different ways, according to whether the employee is paid on an hourly or salary basis.
- For **salaried employees**, ALEs can use employees' actual monthly salaries as of the first day of the coverage period. That monthly amount is multiplied by the plan year's affordability percentage threshold to determine the maximum monthly premium (contribution) an employee can be charged for the plan, at the employee-only rate, under this safe harbor. This safe harbor is not available to use if the monthly salary is reduced, including a reduction of work hours.
- For **hourly employees**, affordability must be calculated using the employee's rate of pay at the beginning of the plan year. However, the employer should make an adjustment to this calculation during the plan year if an employee experiences a decrease in pay. Furthermore, the employer

must calculate an hourly employee's rate of pay under this safe harbor at 130 hours/month, even if the hourly employee provides more than 130 hours of service per month (including overtime, if applicable) — which is very common. This is because the ACA considers a FT employee as one who averages 130 hours of service/month.

- Example: Hourly employee earns $16/hour and normally works 40 hours/week (160-170 hours/month)
  - $16 x 130 hours = $2,080
  - $2,080 x 8.39% = $174.51
  - As long as the employee's contribution (at the "employee only" rate) for the lowest-cost plan *offered* does not exceed a monthly cost of $174.51 for the 2024 plan year, then the offer is considered "affordable" for this employee under the Rate of Pay safe harbor.

W-2 Box 1 Income for the Corresponding Year

- Employers can base affordability on an employee's W-2 Box 1 income for the corresponding tax year. This safe harbor option is intended to be utilized only at the end of the calendar/tax year, as a way of evaluating affordability on a "look back" basis when preparing ACA reporting forms for the IRS.

Federal Poverty Level (FPL)

- Employers can use the FPL to set contributions for all employees. The employer should use the FPL as of six months prior to the beginning of the plan year. This is because the FPL isn't published until January/February of a given calendar year.

When an ALE reports its offers of coverage to the IRS, it must indicate which affordability safe harbor it used to determine affordability. The employer should seek to ensure affordability when setting employer contributions before the policy's effective date/renewal.

An ALE can use whichever affordability safe harbor it prefers when reporting to the IRS. For example, an ALE may initially set contributions based on employees' rates of pay. However, when the ALE completes its ACA IRS reporting, it can use the W-2 Box 1 income safe harbor or the Federal Poverty Level safe harbor. The ACA requires ALEs to use the same safe harbor method for any "reasonable category of employees."

Most ALEs desire to use the Federal Poverty Level safe harbor — if the employer can afford to do so. Use of this specific safe harbor can potentially simplify ACA reporting to the IRS.

Important: ALEs should be aware that different employees may be offered different health insurance plans, depending on the employee's geographic location. When determining affordability, ALEs must make sure that the plan they use is actually available to the employee. For example, a bronze HMO plan may be the cheapest plan for most employees, but it is not available to out-of-state employees, who can only use the PPO plan. In this case, the ALE must use the lowest-cost (minimum value) PPO plan for the out-of-state employees because the HMO plan is not available to them.

Refer to Word & Brown's exclusive ACA Affordability Calculator for help making this determination.

What are the noncompliance penalties with the ACA's employer mandate?

The IRS can impose a penalty under two circumstances as follows:

A. The ALE fails to provide MEC to "substantially all" of its FT employees + their dependent children during a month. "Substantially all" = all but the greater of 5% or 5 FT employees.

a. This penalty for calendar year 2023 is $2,880/year for all employees, minus the first 30 employees. It is assigned on a monthly basis of 1/12th of $2,880, or $240.00/month per employee — minus the first 30.

b. This penalty for calendar year 2024 is $2,970/year for all employees, minus the first 30 employees. It is assigned on a monthly basis of 1/12th of $2,970, or $247.50/month per employee — minus the first 30.

B. The ALE fails to offer affordable, Minimum Value coverage.

a. This penalty for calendar year 2023 is $4,320/year for each employee in receipt of a Premium Tax Credit (PTC) subsidy from the exchange. It is not applied to all employees in the organization; it is only assessed per employee receiving a PTC. Like penalty A, it is assigned on a monthly basis of 1/12th of $4,320, or $360.00/month.

b. This penalty for calendar year 2024 is $4,460/year for each employee in receipt of a Premium Tax Credit (PTC) subsidy from the exchange. It is not applied to all employees in the organization; it is only assessed per employee receiving a PTC. Like Penalty A, it is assigned on a monthly basis of 1/12th of $4,460, or $371.67/month.

ALEs can only be penalized for failing to comply with the employer mandate if a full-time employee who is eligible for benefits did not receive an offer of required coverage *and* receives a Premium Tax Credit (PTC) from the state exchange to pay for qualified, ACA-compliant individual or family coverage.

Either Penalty A or Penalty B may apply in a given month, but not both. Penalty B cannot exceed the amount of Penalty A, ensuring that an ALE that offers MEC but does not meet affordability or minimum value criteria never pays more than it would have if it had not offered MEC at all.

What do I need to report to the IRS?

At the conclusion of a calendar year, each ALE must report the coverage it offered (or did not offer) to any person employed FT for at least one calendar month to the IRS, for that previous calendar year.

The ACA IRS reporting determines two major items:

1. The ALE's compliance with the ACA employer mandate
   - Potential non-compliance penalty assessments on the ALE by the IRS
   - Must report on the ***coverage offered*** – or ***not offered*** – to FT employees and their dependents, but at the employee-only rate (after the employer's contribution) for coverage
   - ALEs only report on the lowest-cost MEC/MV plan offered (at the "employee only" rate), not the plan in which the employee is enrolled.
2. Employees' eligibilities for Premium Tax Credits (PTCs) on the state exchange (i.e., Covered California, Nevada Health Link)
   - Taxpayers are not eligible for federal PTCs from the health insurance exchange if they have been offered affordable, minimum-value MEC by an employer, regardless of the employer's size and ALE status.
   - When individuals enroll for coverage on the state exchange, they self-report their household incomes and disclose whether they have been offered employer-sponsored coverage to determine their eligibility for PTCs.
   - Additionally, when a full-time employee of an ALE waives their employer's offer of affordable MEC/MV coverage, the ALE reports this to the IRS using a safe harbor code. The IRS uses this information to understand the offers (or non-offers) of coverage made by employers. The IRS also uses this information to determine eligibility for PTCs based on these factors. Any person who erroneously accepts an advanceable Premium Tax Credit must repay it in full. Consultation with a CPA and/or tax counsel is recommended.

Health insurance carriers must separately report coverage actually maintained by Americans, which demonstrates individual compliance with the Individual Mandate at the federal level, as well as at the state level in California. Employers of any size with self-funded insurance must also report coverage maintained to the IRS, since there is no insurance carrier in place to do so.

Note: Most other states, including Nevada, do not have state individual mandates. There are currently six "states" that have individual insurance mandates: California, District of Columbia (D.C.), Massachusetts, New Jersey, Rhode Island, and Vermont.

What do the IRS ACA Reporting Forms look like?

Only ALEs with fully insured coverage are required to complete ACA IRS reporting. All employers with self-funded coverage must complete ACA IRS reporting, regardless of size and ALE status. The information in this guide relates to employers with *fully insured* coverage.

IRS Form 1094-C contains company information. The ALE completes one of these forms, which tells the IRS who the employer is, how many reports it is submitting, certificates of eligibility, affiliated companies, employee count, etc.

IRS Form 1095 contains employee information, related to the coverage offered by the ALE. An ALE must complete one form for any person employed FT for one full calendar month of the reporting year. State health insurance exchanges and health insurance carriers also use form 1095 to report coverage held/maintained by the taxpayer. There are three versions of IRS form 1095, and copies of each form must be given to the IRS as well as to the taxpayer whose information is reported.
Note: Some carriers release 1095-B forms by request and/or online portal, in accordance with a recent ACA change.

Most taxpayers receive multiple Forms 1095 from different entities as follows:

- **IRS Form 1095-A** is used by the state exchanges, which demonstrates possession of MEC to the IRS as part of the ACA's individual mandate. Anyone with coverage from the state individual exchange (Covered California, Nevada Health Link, etc.) will get this form.
- **IRS Form 1095-B** is used by health insurance carriers, which demonstrates possession of MEC to the IRS as part of the ACA's individual mandate. This form tells the IRS what coverage was elected and held by the taxpayer.
- **IRS Form 1095-C** is used by ALEs (both fully insured and self-funded policies). It demonstrates the ALE's compliance with the employer mandate, and reports on coverage offered to employees. For self-funded employers, additional reporting is required that demonstrates possession of MEC coverage to the IRS for enforcement of the ACA's individual mandate.

When are ACA IRS reporting forms due?

Who Reports?	Plan Type	Forms	Purpose	Copy to Employees (IRS Forms 1095 only)	Paper Submission to IRS*	Electronic Submission to IRS*
Carriers, and Non-ALE employers with self-funded plans	All carriers with fully insured plans, Non ALEs with Self-Funded plans	1094-B 1095-B	Enforce **individual** mandate	On/before March 2 (For the 2023 reporting year, the deadline is **March 1, 2024** because of the leap year.)	On/before last day of February	On/before last day of March (For the 2023 reporting year, the deadline is **April 1, 2024** because March 31, 2024 is a Sunday.)
Applicable Large Employers (ALEs)	Fully-Insured	1094-C 1095-C (Parts I & II)	Enforce **employer** mandate			
	Self-Funded	1094-C 1095-C (Parts I, II, III)	Parts I & II: Enforce **employer** mandate Part III: Enforce **individual** mandate			

*Employers filing 10 or more information returns, including Forms 1094/1095, W-2, and 1099, are required to file electronically.

What are the non-compliance penalties for ACA IRS reporting?

Time of Filing	Penalty Rate	IRS Forms Due 1/1/2024 – 12/31/2024
Not more than 30 days late	Per return	$ 60
	Maximum – Gross receipts less than/equal to $5M*	$ 220,500
	Maximum – Gross receipts over $5M*	$ 630,500
31 days late – August 1st	Per return	$ 120
	Maximum – Gross receipts less than/equal to $5M*	$ 630,500
	Maximum – Gross receipts over $5M*	$ 1,891,500
After August 1st	Per return	$ 310
	Maximum – Gross receipts less than/equal to $5M*	$ 1,261,000
	Maximum – Gross receipts over $5M*	$ 3,783,000
Intentional disregard	Per return	**$ 630**
	Maximum – Gross receipts less than/equal to $5M*	**No Limitation**
	Maximum – Gross receipts over $5M*	**No Limitation**

*Based on average annual gross receipts for the most-recent three taxable years.

What limitations does the ACA set on waiting periods for benefits?

The ACA limits employers *of any size* (ALEs and non-ALEs alike) from imposing a waiting period that exceeds 90 calendar days.

- Most employers elect a waiting period that is "first of the month following 30 days of employment" or "first of the month following 60 days of employment" to comply with this requirement.

What are Summaries of Benefits and Coverage (SBCs)? And what is the ACA Uniform Glossary?

The ACA requires all employers that sponsor group health plans (regardless of size and ALE status) to provide Summaries of Benefits and Coverage (SBCs) to all applicants upon initial eligibility and again at renewal or Open Enrollment. These SBCs are uniform across all carriers and virtually all plans in the individual and small group markets. The uniformity of these documents allows consumers to compare plans logically to others. Health insurance carriers are responsible for creating SBCs for their health plans. Employers with self-funded plans are generally required to create their own SBCs.

In addition to the Summary of Benefits and Coverage (SBC), employers (of any size) sponsoring group health plans are required to distribute a Uniform Glossary of Coverage and Medical Terms to help employees and consumers understand all items and information listed in the SBC. The Uniform Glossary is available from the Department of Labor at DOL.gov.

In addition to ACA requirements, most employers sponsoring health plans are also required to create and distribute Summary Plan Descriptions (SPDs) for plans under ERISA law.

How are ACA-compliant plans rated in the small employer market?

The small employer market in California applies to employers with 1-100 FT + FTE. The small employer market in Nevada applies to employers with 1-50 FT + FTE.

The Small Group market uses a "Member Level Rating" structure. Every member is rated individually: 0-14, 15, 16, 17, 18, 19, 20, 21… 62, 63, 64+.

Plans can only charge for the three oldest dependent children under the age of 21. The ACA applies a 3:1 ratio, which limits the premium that can be charged to a 64-year old to three-times the amount charged to a 21-year-old.

The following chart contains an illustration of how this rating structure works:

Enrollee	Age	Rate
Employee	45	$ 659
Spouse	40	$ 583
Son	21	$ 456
Son	18	$ 416
Daughter	16	$ 392
Son	10	$ 349
Daughter	07	$ 0

What are Medical Loss Ratios (MLRs)? What do I do if I get a MLR rebate check?

The ACA requires fully insured group health plans to spend a minimum percentage of premium dollars on members' health care expenses and services. This requirement is known as a plan's Medical Loss Ratio (MLR). If an insurance issuer fails to meet the applicable MLR standard in any given year, the issuer is required to provide a rebate to its customers.

In the Small Group market, the law requires an MLR of 80%. That is, at least 80% of premium dollars must be spent on health care-related expenses, and no more than 20% of premium dollars may be spent on administrative expenses. In the Large Group market, the MLR rises to 85%. MLR requirements do not apply to self-funded plans.

Any year a fully-insured health plan does not meet its MLR requirements, the health insurance carrier has until the end of September of the following year to distribute MLR rebate funds. Employers have several options when it comes to utilizing or dispersing the MLR rebate funds, but the law gives them just 90 days to take action.

The Department of Labor provides three options for distributing rebates:

1. Reduce subscribers' portions of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan.
2. Reduce subscribers' portions of the annual premium for the subsequent policy year for only those subscribers covered by the health policy on which the rebate is based.
3. Provide a cash refund only to subscribers who were covered under the group health policy on which the rebate is based.

The law does not require employers to track down former employees for MLR rebates, but COBRA participants must be included in any premium rebates, if applicable.

Refer to the Word & Brown newsroom and ACA calculator references for additional information and detail about MLR rebates.

What is the ACA's "60-Day Notice of Material Modification?"

The ACA requires an employer offering group health coverage to provide a notice of plan modification to enrollees at least 60 days prior to the effective date of any modification. Material modifications generally include changes to anything listed in the plan's SBC and changes to the employer contribution.

This 60-Day Notice of Material Modification rule applies to employers that make changes to their health plans in the middle of the plan year. This requirement *does not* pertain to carrier-issued renewal modifications.

Where can I go for extra help?

The Word & Brown General Agency has more than 38 years of experience in the employee benefits industry, working alongside health insurance brokers, their employer clients, and individual clients, providing legendary *Service of Unequalled Excellence*. Word & Brown is passionate about compliance, education, and helping health insurance brokers and their clients excel in all facets of the employee benefits industry.

Word & Brown General Agency hosts an annual ACA IRS reporting series, aimed to help employers understand the depths of ACA IRS reporting; this series takes place during the annual reporting season.

In addition to your Word & Brown sales representative and field sales managers, Word & Brown has a compliance team on stand-by, ready to help health insurance brokers address any and all situational compliance needs. The team can be reached via email at ComplianceSupport@wordandbrown.com.

Word & Brown is passionate about, and strongly committed to, ensuring that individuals and families have access to quality health care while experiencing the highest level of customer service. Word & Brown's mission is to provide brokers access to better health insurance choices for their clients through service-based, company-focused relationships and education, backed by technology. Word & Brown is here for you, and is proud to partner with you, and lead you through all aspects of the industry and your business.

To keep up with changing, ongoing employee benefits health insurance compliance items including ACA, ERISA, COBRA, and more, check out the WBCompliance blog in the Word & Brown Newsroom.