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GRS INSIGHT

SECURE 2.0: Operational Guidance for 2024

IN THIS ISSUE

Since its enactment in late December 2022, the SECURE 2.0 Act of 2022 (Secure 2.0) has raised numerous questions about operational compliance. While the Internal Revenue Service (IRS) has issued some limited guidance, little insight has been provided for sections of the statute that impact governmental defined benefit plans. The IRS did release guidance on plan corrections under the Employee Plans Compliance Resolution System (EPCRS), which is helpful for all plans, but the other guidance is generally applicable to defined contribution plans.

Notice 2023-43

As discussed in the September 2023 issue of *GRS Insight*, the IRS issued Notice 2023-43[1] on June 1, 2023, which provided guidance on the changes to the EPCRS. Immediate reliance on the guidance in this Notice is available, though this reliance will end when the IRS issues an updated EPCRS, which is anticipated sometime in 2024.

Notice 2023-62

On August 5, 2023, the IRS released Notice 2023-62.[2] In this Notice, the IRS provided transition relief with respect to Section 603 of SECURE 2.0, effectively providing a two-year delay in the effective date for implementing the Roth catch-up contribution requirements. This provision is not applicable to governmental defined benefit plans.

Notice of Proposed Rulemaking

The IRS issued a Notice of Proposed Rulemaking on November 24, 2023,[3] providing proposed regulations for "long-term, part-time employees." This is yet another provision that is not applicable to governmental defined benefit plans.

Notice 2024-2

On December 20, 2023,[4] the IRS released Notice 2024-2, considered a "grab-bag" notice that provides guidance on twelve provisions of SECURE 2.0. Generally, the guidance would not impact governmental defined benefit plans. However, the Notice did provide some guidance on distributions for terminal illness and further extended the deadline to adopt a number of amendments (including under the CARES Act, the SECURE Act, and SECURE 2.0) until December 31, 2029.

SECURE 2.0 Operational Compliance: 2024 Chart

In response to this landscape of shifting timelines and requirements, it is easy to lose track of what is required in operating a governmental defined benefit plan, and when these requirements take effect. The following charts on pages 2 and 3 detail the most common operational requirements for governmental defined benefit plans in 2024, including those provisions that were first effective prior to 2024, noting which changes are required and which are optional.

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1 https://www.irs.gov/pub/irs-drop/n-23-43.pdf
2 https://www.irs.gov/pub/irs-drop/n-23-62.pdf
3 https://public-inspection.federalregister.gov/2023-25987.pdf
4 https://www.irs.gov/pub/irs-drop/n-24-02.pdf

SECURE 2.0 Operational Compliance: 2024 Chart

Bill Section	SECURE 2.0 Change	Operational Considerations	Effective Date
Required Changes			
Increase in Required Minimum Distribution (RMD) age (Section 107)	The RMD age is increased to: i) age 73 for a member who attains age 72 after December 31, 2022 and age 73 before January 1, 2033; and ii) age 75 for a member who attains age 74 after December 31, 2032.	A plan amendment will be needed to reflect the change. Additional guidance will be needed regarding individuals born in 1959, as they currently fall under both the age 73 and age 75 rules. The 402(f) notice should be updated to reflect the new age requirement.	For distributions required to be made after December 31, 2022 (for those who attain age 72 after that date)
Reduction in excess accumulation excise tax (Section 302)	Reduces the excise tax for failure to take RMDs from 50% of the deficiency to 25%. The excise tax is reduced further, to 10%, if the deficiency is corrected quickly (generally, within a two-year correction window).	This tax is imposed on the individual who did not take a RMD. Voluntary Correction Program (VCP) filings and excise tax returns to request abatement of the excise tax continue to be available.	Taxable years beginning after December 29, 2022
Substantially equal periodic payment clarification (Section 323)	The exception to the 10% early withdrawal penalty in the case of substantially equal periodic payments made over the account owner's life expectancy continues to apply after certain rollovers and for certain annuities.	For rollovers, a plan may rely on an employee's self-certification that the substantially equal periodic payment requirements are met, such that no additional taxes need to be reported (as long as there is no actual knowledge to the contrary). For annuities, the plan needs to ensure these payments comply with the required minimum distribution rules.	For transfers, rollovers, and exchanges after December 31, 2023, and for annuity distributions on or after December 29, 2022
Section 72(t) exception for individuals with a terminal illness (Section 326)	Creates a new exception to the 10% early withdrawal penalty for distributions to individuals with an illness or condition that is reasonably expected to result in death in 84 months or less.	The employee must be otherwise eligible for a distribution, as no in-service distribution right is created. The member's physician must provide a certification of terminal illness. Notice 2024-2 provides the required contents of the certification. The withdrawal may be repaid within three years from the day after the date of distribution. The 402(f) notice should be updated to reflect this exception.	For distributions after December 29, 2022
Surviving spouse treatment as employee (Section 327)	Allows a spouse beneficiary to elect treatment as the employee for RMD purposes.	If the spouse is the member's sole designated beneficiary, the applicable distribution period after the member's year of death is determined under the uniform life table.	For calendar years beginning after December 31, 2023
Section 72(t) exception for 25 years of service (Section 329)	Provides an exception to the 10% early withdrawal penalty for those qualified public safety employees who have separated from service and have completed 25 years of service.	The plan must confirm the service requirement is met. The 402(f) notice should be updated to reflect this Section 72(t) exception.	For distributions made after December 29, 2022
Section 72(t) exception expansion of Qualified Public Safety Employee (QPSE) definition (Section 330)	Expands the definition of QPSE to include certain corrections officers and forensic security employees.	Members in these categories are now eligible for the age 50 and 25 years of service exceptions to the 10% early withdrawal penalty. The plan must confirm the member is in an eligible job classification.	For distributions made after December 29, 2022

SECURE 2.0 Operational Compliance: 2024 Chart

Bill Section	SECURE 2.0 Change	Operational Considerations	Effective Date
Optional Changes			
Plan overpayment corrections (Section 301)	A governmental defined benefit plan will not jeopardize its tax-favored status solely due to a determination not to recover an "inadvertent benefit overpayment" or otherwise to amend the plan to permit the increased benefit.	If an overpayment falls within the definition of "inadvertent benefit overpayment," there is no collection required and, therefore, it is reasonable to forego all collection efforts. In certain cases, the overpayment is also treated as an eligible rollover distribution. To the extent that Code Section 401(a)(17) or 415 is implicated by the overpayment, the overpayment generally falls outside the exception. State fiduciary standards may impact a plan's ability to forego recoupment.	December 29, 2022 (with certain retroactive good faith relief)
Expansion of Employee Plans Compliance Resolution System (EPCRS) (Section 305)	Eligible inadvertent failures may be self-corrected under EPCRS at any time unless: i) the IRS identified the failure before self-corrective measures commenced; or ii) the self-correction was not completed in a reasonable period after the failure was identified.	Although future IRS guidance may limit this provision, it provides plans with additional rights and flexibility in self-correcting a number of failures. The Treasury Department is directed to expand EPCRS to add preapproved correction methods and general principles of correction.	December 29, 2022
Expansion of exclusion from gross income for health and long-term care insurance distributions from governmental plans (Section 328)	The plan may now distribute funds to pay for qualified health and long-term care insurance premiums directly to the member.	A plan amendment will be needed, if implemented. If payments are made to the member, the member must include a self-certification with their tax return that such funds did not exceed the amount paid for premiums in the year of the distribution.	For distributions made after December 29, 2022
Increased distribution and loan rights due to qualified federally declared disasters (Section 331)	Provides permanent special rules governing plan distributions (including a new exception to the Section 72(t) tax) and loans in cases of qualified federally declared disasters.	The plan should consider procedures to confirm eligibility (e.g., the member's primary residence is in a federally declared disaster area). The withdrawal may be repaid within three years from the day after the date of distribution. The amount may be included in gross income over a three-year period. The 402(f) notice should be updated to reflect this Section 72(t) exception (if implemented).	For disasters occurring on or after January 26, 2021

Limits on Eligibility for Purchase of Permissive Service Credit

In accordance with the requirements of Internal Revenue Code (Code) Section 415(n), many governmental plans allow employees to purchase service credit to be used in calculating and potentially in determining their eligibility for benefits under the plan. On November 3, 2023, the IRS issued a rare Private Letter Ruling (PLR) concerning the purchase of permissive service credit, drawing a fairly hard line on eligibility to purchase permissive service credit.

As noted in the ruling (PLR 202344010),[5] the plan at issue is a defined benefit plan that is a governmental plan under Code Section 414(d), and which permits the purchase of permissive service credit in accordance with Code Section 415(n). When the plan at issue was established, there were designated election periods during which certain employees who were hired prior to the plan's effective date were able to elect whether or not to participate. Any impacted employee who failed to make an election during the designated election periods was automatically defaulted to nonparticipation status.

[5] https://www.irs.gov/pub/irs-wd/202344010.pdf

Some impacted employees who did not make a participation election (and, therefore, were defaulted to nonparticipation) have since terminated service with the employer. In addition, they have claimed that they did not receive explicit notification of their eligibility to participate in the plan and now want to purchase service credit in order to receive a benefit under the plan.

The employer sought rulings from the IRS on three potential paths that would allow a purchase of service by these former employees:

1. Whether allowing a former employee to purchase service under the plan with after-tax contributions qualifies as a purchase of permissive service credit under Code Section 415(n)?
2. Whether allowing a former employee to transfer funds from another qualified plan to the plan to obtain a benefit under the plan is a permissive rollover distribution under Code Section 402(c), and not subject to the permissive service credit rules under Code Section 415(n)?
3. Whether allowing a former employee to transfer funds from a Section 403(b) or 457(b) plan to obtain a benefit under the plan is an eligible transfer under Code Section 415(n)(3)(D)?

In each case, the IRS found that former employees that are not and have never been participants in a plan cannot purchase service credit. In fact, this theme ran through their rulings addressing each request.

In each case, the IRS found that former employees are not eligible to purchase service under the plan, regardless of whether such purchase would have been affected through the: 1) contribution of after-tax amounts; 2) rollover of amounts from another qualified plan; or 3) transfer of amounts from a Section 403(b) or 457(b) plan.

The fact that the former employees were at one point eligible to elect to participate in the plan, notwithstanding their allegation that they did not receive explicit notification of their eligibility, and would have been purchasing service that would have been plan-eligible service had a timely election been made, did not sway the IRS. Since they were never actually participants in the plan, the impacted employees are not eligible to purchase service under the plan.

Return to Work After Retirement Considerations

Background

In the event an employee returns to work after retirement, any distributions from the plan to such employee will be subject to additional scrutiny. If the IRS believes that the employee and/or employer intended at the time of retirement that the employee would be rehired, the IRS may determine that the employee never had a “bona fide termination.” If the employee has not had a bona fide termination (and the plan does not permit in-service distributions), any distributions made are generally impermissible in-service distributions, which raises the risk of plan disqualification.

The IRS considers whether an employee had a bona fide termination, based on the facts and circumstances of each situation. For example, the IRS may consider various factors such as the length of time between the employee’s retirement and rehire, the terms of the employee’s reemployment, and any other evidence that the employee and/or employer intended for the employee to be rehired.

To date, the IRS has not provided formal guidance on what circumstances qualify as a bona fide termination. In the Private Letter Rulings (PLRs) on the subject, the IRS has opted to provide a facts-based analysis rather than a bright-line test. According to the IRS, the “facts and circumstances” dictate whether there has been a bona fide termination of employment.

The most comprehensive guidance can be found in PLR 201147038[6] (dating back to April 20, 2010), which applies the definition of “termination of employment” under Internal Revenue Code (Code) Section 409A to a Section 401(a) qualified plan. While this ruling may not be cited as precedent, other than by the taxpayer who requested it, the ruling reflects the views of the IRS on what constitutes a bona fide termination.

The primary focus of the ruling was whether it is permissible for an employer and employee to agree that the employee will retire, with the understanding that the employee will immediately be rehired. In one of the few clear lines in the return to work analysis, the IRS held unequivocally that “an employee who ‘retires’ with the explicit understanding between the employer and employee that upon retirement the employee will immediately return to

[6] https://www.irs.gov/pub/irs-wd/1147038.pdf

service with the employer has not legitimately retired."

The IRS has been unwilling to give a specific time period which must elapse, or any additional bright-line rules, to determine whether there was a bona fide retirement. However, a short break in service (i.e., between the time of the employee's retirement and subsequent rehire) is not a helpful factor. Due to the lack of clear rules, there continues to be wide variance in the methods that governmental plans utilize to handle return to work policies.

Risk Mitigation Strategies

In light of the ambiguous standards for what qualifies as a bona fide termination, many governmental plans have turned to risk mitigation. While there is no bright-line threshold for how much time must elapse between an employee's retirement and rehire, many jurisdictions consider mandatory service breaks or the suspension or forfeiture of benefits on rehire. While some states may require a thirty-day lapse in employment, many states may alternatively take the route of suspending or forfeiting (or requirement repayment of) benefits if the prescribed break in service under the plan is not met.[7]

Providing for a minimum separation period that must be met prior to rehire supports the argument that there was no intent to rehire the retiree (which argument could be bolstered by showing that there were efforts expended to replace the employee). The shorter the amount of time between retirement and rehire, the less weight this argument is likely to carry in showing the IRS that there was no intent to rehire at the time of the employee's termination. While perhaps the most commonly used method to support a bona fide termination finding, mandatory service breaks are likely not sufficient on their own and, fortunately, are not the only mitigation method available.

Another potential method to support a finding that there has indeed been a bona fide termination is, at the time of severance, to have the employer co-sign a statement with the employee acknowledging that neither party intends or expects the employee's return to employment. While not a standalone method, showing that neither the employer nor the employee intended or anticipated that the employee would be rehired helps support the argument that there was no intent to return.

The IRS has acknowledged that rehiring a retiree due to unforeseen hiring needs would not negate an otherwise bona fide termination. While this interpretation was provided in light of hiring issues caused by the COVID-19 pandemic, it may be reasonable to extend the premise to other unexpected business circumstances.

In addition, whether the individual continued to be treated as an employee following retirement could be a factor in the analysis. For example, if the benefit program offered to current employees (and generally limited to active employees) is extended to certain retirees, that could weigh against a finding of a bona fide termination. Therefore, looking beyond the treatment of the retiree under the pension plan is beneficial.

Conclusion

As noted, a finding of a bona fide termination is based on a facts and circumstances analysis, and the IRS has been hesitant to provide a bright-line test. Therefore, in any such situation, it is helpful to document any actions, policies, and procedures that support a finding of no pre-arrangement to return at the time of retirement.

No Surprises Act Update

The *No Surprises Act* (NSA) generally prohibits balance billing[8] by out-of-network providers and creates an Independent Dispute Resolution (IDR) process for use by providers and health insurance issuers or group health plans to resolve payment disputes.

The NSA utilizes "baseball-style" arbitration to resolve these payment disputes whereby each party submits a proposed payment amount and explanation to an arbitrator, and the arbitrator selects one of the payment amounts (referred to as the out-of-network rate) based on several considerations. The Qualifying Payment Amount (QPA), defined generally as the median of the contracted rates recognized by the plan or issuer, is one of the considerations enumerated in the NSA. The Departments of Labor, Health and Human Services, and Treasury (collectively, the Departments) issued Interim Final Rules (IFR) regarding the IDR process in July 2021. Immediately, health care providers challenged several provisions of the IFR, including those relating to how the arbitrator chooses the correct out-of-network rate and the calculation of the QPA.

[7] See, e.g., 5 M.R.S. § 17859 (https://legislature.maine.gov/statutes/5/title5sec17859.html); MCL 38.1361(7) (https://www.legislature.mi.gov/(S(xr0otaayqpvqs0gkrrw5xroz))/mileg.aspx?page=GetObject&objectname=mcl-38-1361); Tex. Gov't Code § 852.108 (https://statutes.capitol.texas.gov/Docs/GV/htm/GV.852.htm#852.108); O.R.C. § 145.38 (https://codes.ohio.gov/ohio-revised-code/section-145.38).

[8] "Balance billing" refers to a practice where an out-of-network provider bills the patient any remaining amounts on a bill after receiving a partial payment for a covered service from a health insurance issuer or group health plan.

The July 2021 IFR created a rebuttable presumption that the arbitrator should select the QPA as the out-of-network rate, unless "creditable information" clearly demonstrated that the QPA is materially different from the out-of-network rate. In the initial lawsuit (TMA I), providers successfully argued that this rebuttable presumption violated the express statutory text.

Following this decision, the Departments issued a second set of rules in August 2022 regarding the vacated provisions of the IFR. The same providers challenged the new provisions, and in a subsequent decision, (TMA II), the court again vacated the newly drafted provisions of the final rule as improperly limiting the discretion of arbitrators in selecting an out-of-network rate.

Providers then challenged the methodology for calculating the QPA in a separate lawsuit. In TMA III, decided in August 2023, the court held that the NSA "requires calculating the QPA using only rates for items and services that are actually furnished or supplied by a provider." Therefore, the IFR impermissibly allowed issuers and plans to calculate the QPA using so-called "ghost rates," (i.e., rates for items and services that a provider does not actually provide).

The Departments issued FAQ Part 62 in response to TMA III in October 2023. FAQ Part 62 directs issuers and plans to use a "good faith, reasonable interpretation of applicable statutes and regulations" to calculate the QPA consistent with the court's decision which vacated certain provisions of the July IFR. Furthermore, for items and services furnished before May 1, 2024, the Departments will exercise enforcement discretion when insurers and plans calculate the QPA using the methodology under the July 2021 IFR for the purposes of patient cost sharing, providing required disclosures with an initial payment or notice of denial of payment, and submissions under the IDR process.

In addition, air ambulance providers challenged a provision of the July IFR interpreting a requirement under the NSA to send an initial payment decision to a provider within 30 calendar days. Under the July IFR, this deadline begins when the plan or issuer receives a "clean claim" for service; however, the court set aside this interpretation as contrary to the NSA.

The Departments responded to this aspect of TMA III in FAQ Part 62 as well. Notably, the Departments still expect issuers and plans to make reasonable efforts to determine coverage and provide an initial payment or a notice of denial of payment within 30 calendar days. Furthermore, the Departments remind insurers and plans that the ERISA internal claims and appeals regulations direct an issuer or plan to notify the claimant of specific information necessary to complete a claim where it does not receive sufficient information to make a claim determination. Accordingly, before denying a claim because the provider does not submit sufficient information, issuers and plans should communicate with providers to obtain the missing information. Importantly, FAQ Part 62 directs issuers and plans to issue a notice of benefit denial due to an adverse benefit determination when an issuer or plan cannot determine coverage within 30 calendar days.

Tri-Agencies Request for Information Regarding Coverage of Over-the-Counter Preventive Services

On October 4, 2023, the Internal Revenue Service (IRS), Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, the Tri-Agencies) released a Request For Information (RFI) seeking feedback on the potential impact associated with requiring group health plans and health insurance issuers to cover Over-the-Counter (OTC) preventive care items or services without cost sharing and without a prescription from a medical provider.

The RFI solicited comments from stakeholders to understand the potential impact this requirement could have from different perspectives. In response, numerous interested parties commented before the close of the comment period on December 4, 2023.

Background

Under Section 2713 of the Public Health Service Act (PHSA), non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage are required to provide coverage without cost-sharing for eligible preventive services.[9] The Tri-Agencies have interpreted the PHSA's coverage requirement to mean that preventive services that are usually accessible OTC and without a prescription (e.g., folic acid, tobacco cessation pharmacotherapy, etc.) must be covered without cost sharing only when prescribed by a health care provider.[10]

[9] 42 U.S. Code § 300gg–13 - Coverage of preventive health services | U.S. Code | US Law | LII / Legal Information Institute (cornell.edu); 45 CFR 147.130 (eCFR :: 45 CFR Part 147 -- Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets).

[10] *See* FAQs about Affordable Care Act Implementation Part XII (Feb. 20, 2013), Q4 and Q15, available at dol.gov and cms.gov.

Request for Information

The Tri-Agencies considered four Executive Orders (EO) when issuing this RFI: EOs 14009 and 14070 which direct the Tri-Agencies to ensure policies comply with the Affordable Care Act (ACA) and that health care is accessible and affordable for all Americans;[11] EO 14076 which requires the Secretary of the HHS to expand access to reproductive health care services and products such as emergency contraception;[12] and EO 14101 which urges the Tri-Agencies to issue guidance that would provide greater access to OTC contraceptives without cost sharing in furtherance of the ACA.[13] This RFI is, in part, in response to the U.S. Food and Drug Administration (FDA) announcement in July 2023 approving the first daily oral contraceptive for use in the United States without the need for a prescription.

The RFI poses a series of questions to stakeholders to help the Tri-Agencies understand the potential benefits and risks the requirement could have to cover OTC preventive services without a prescription, if implemented.

One area of particular interest includes the experience of plans, issuers, pharmacy benefit managers, and other similar parties when they were required to provide OTC COVID-19 diagnostic tests without cost sharing under the *Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act*.[14]

By the close of the comment period, EBSA received a total of 391 comments in response to its RFI.[15] From the health plan and service provider perspective, comments were focused on operational changes that would have to be made if plans and issuers are required to provide OTC preventive care without any cost sharing and without a prescription.

The next likely step in the process is that the Tri-Agencies will issue a rule or FAQ guidance in response to the RFI.

Recent Court Ruling Impacts Whether Plans Must Count Drug Coupons Towards the MOOP

On September 29, 2023, the District Court for the District of Columbia issued an opinion in *HIV and Hepatitis Policy Institute et al. v. U.S. Department of Health and Human Services* that vacated the 2021 Notice of Benefit and Payment Parameters' (2021 NBPP) updates to the Affordable Care Act (ACA) regulations.[16]

The 2021 NBPP permitted, but did not require, health insurance issuers and group health plans to count certain financial assistance provided to enrollees by drug manufacturers (Coupons) towards the Maximum Out-Of-Pocket limit (MOOP).

The Court concluded that the 2021 NBPP's interpretation of "cost-sharing" conflicts with the statutory and regulatory definition of "cost-sharing" under the ACA. The Court remanded the rule back to the Department of Health and Human Services (HHS) for further consideration.

Subsequent Court Actions

Following the decision, HHS filed an appeal to the United States Court of Appeals for the District of Columbia. HHS also filed a motion asking the court to clarify its order and stated that it intends to address this issue through future rulemaking, but will not take enforcement action against issuers or plans until the final rule is issued.

On December 22, 2023, the court ruled that the 2020 Notice of Benefit and Payment Parameters (2020 NBPP) is now in effect. The court did not interpret the 2020 NBPP or rule on the legality of any nonenforcement policy because those issues were not before the court.

In a surprising turn of events, on January 16, 2024, HHS dropped its appeal.

[11] E.O. 14009, known as the "Strengthening Medicaid and the Affordable Care Act," was issued on January 28, 2021. E.O. 14070, known as "Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage," was issued on April 5, 2022.

[12] E.O. 14076, known as "Protecting Access to Reproductive Healthcare Services," was issued on July 8, 2022.

[13] E.O. 14101, known as "Strengthening Access to Affordable, High-Quality Contraception and Family Planning Services," was issued June 23, 2023.

[14] The Tri-Agencies released guidance in January 2022 which required plans and issuers to cover OTC COVID-19 diagnostic tests for free and without a prescription by a healthcare provider until the end of the public health emergency. FAQ Part 51 is available at dol.gov.

[15] Comments can be found at regulations.gov.

[16] *HIV and Hepatitis Policy Inst. et al. v. U.S. Dep't of Health and Hum. Svcs.*, No. 22-2604, 2023 WL 6388932 (D.D.C. Sept. 29, 2023).

Current State of the Law

Based on the court’s December 22, 2023 ruling, the 2020 NBPP is now in effect. Notably, the 2020 NBPP regulatory text merely states that plans are not required to count Coupons towards the ACA MOOP where there is a medically appropriate generic available. It does not specifically say that Coupons are required to be counted if there is not a medically appropriate generic. However, HHS does specifically state that in the preamble.

Notwithstanding that the 2020 NBPP is currently in effect, HHS was clear in its motion and reply to the court that it does not intend to take enforcement action. Therefore, it is reasonable for plans to continue to exclude Coupons from the ACA MOOP.

Note that one reason that HHS changed the rule in the 2021 NBPP from the 2020 NBPP is that the 2020 NBPP’s requirement to count the Coupons towards the MOOP could raise HSA-compatible HDHP issues.

Thus, it seems likely that HHS’ future rulemaking will implement a rule different from the 2020 NBPP, but will also need to consider the court’s ruling that the definition of “cost-sharing” must be consistent with the ACA statutory and regulatory definition.

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