AFFORDABLE CARE ACT UPDATES
PAY-OR-PLAY FOR LARGE COMPANIES 100+ BEGINS

Most "non-grandfathered" employers with at least 100 full-time equivalent (FTE) employees will be subject to penalties in 2015 if they have not complied with the employer mandate. In theory, they were subject to the mandate this year, but will not pay a penalty for ignoring it. If a company is in the 50-99 FTE bracket, they have a reprieve until 2016.

For 2015, they’re required to offer coverage to 70 percent of their employees and their dependents, or pay the penalty. That jumps to 95 percent in 2016 and thereafter. Alternatively, they'll be subject to a penalty if their plan does provide "minimum essential coverage," but that coverage is unaffordable. This is based on the employee's share of the cost in relationship to household income, or based on paying less than 60 percent of the plan's value.

As defined by section 4980H of the Internal Revenue Code, a full-time employee is an individual employed an average of at least 30 hours of service per week. An employer that meets the 50 full-time employee threshold is referred to as an applicable large employer.

If these employers do not offer affordable health coverage providing a minimum level of coverage to their full-time employees (and their dependents), the employer may be subject to an Employer Shared Responsibility payment if at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on one of the new Affordable Insurance Exchanges, also called a Health Insurance Marketplace (Marketplace).

Employers Subject to the Employer Shared Responsibility Provisions
An employer must have employed at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 during the previous calendar year to be subject to the Employer Shared Responsibility provisions.

Seasonal workers are to be taken into account in determining the number of full-time employees. Seasonal workers are workers who perform labor or services on a seasonal basis as defined by the Secretary of Labor, and retail workers employed exclusively during holiday seasons.

If an employer's workforce exceeds 50 full-time employees (including full-time equivalents) for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal workers, the employer is not considered an applicable large employer.

Employers will determine each year, based on their current number of employees, whether they will be considered an applicable large employer for the next year. For example, if an employer...
has at least 50 full-time employees (including full-time equivalents) for 2014, it will be considered an applicable large employer for 2015.

Employers average their number of employees across the months in the year to see whether they will be an applicable large employer for the next year. The final regulations provide additional information about how to determine the average number of employees for a year, including information about how to take account of salaried employees who may not clock their hours.

**New Employers**

An employer that was not in existence on any business day in the prior calendar year is considered an applicable large employer in the current year if the employer is reasonably expected to employ an average of at least 50 full-time employees (including full-time equivalents) on business days during the current calendar year, and it actually employs an average of at least 50 full-time employees (including full-time equivalents) on business days during the calendar year. In contrast, for the next year (the year after the first year the employer was in existence), the employer will determine its status as an applicable large employer based on the number of full-time employees and full-time equivalents that the employer employed in the preceding year.

**Combining Businesses with Common Owners**

Companies with a common owner or that are otherwise related are combined and treated as a single employer, and so would be combined for purposes of determining whether or not they collectively employ at least 50 full-time employees (including full-time equivalents). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to meet the threshold.

**Parent-Subsidiary Controlled Group of Corporations**

Under Code Section 414(b), a parent-subsidiary controlled group is one or more chains of corporations connected through stock ownership with a common parent if:

- 80% or more of the total combined voting power of all classes of stock entitled to vote (or 80% or more of the total value of all shares of all classes of stock) of each of the corporations, except the common parent corporation, is owned, directly or indirectly, by one or more of the other corporations.

- The common parent corporation owns, directly or indirectly, 80% or more of the total combined voting power of all classes of stock entitled to vote (or 80% or more of the total value of shares of all classes of stock) of at least one of the other corporations.

**A Brother-Sister Controlled Group of Corporations**
Under Code Section 414(b), a brother-sister controlled group of corporations is a group where five or fewer persons who are individuals, estates, or trusts own, directly or indirectly, stock possessing:

- 80% or more of the total combined voting power of all classes of stock entitled to vote (or 80% or more of the total value of all shares of all classes of stock) of each corporation.
- More than 50% of the total combined voting power of all classes of stock entitled to vote (or more than 50% of the total value of all shares of all classes of stock) of each corporation, taking into account the stock ownership of each owner only to the extent that the level of ownership interest is identical with respect to each corporation.

The five or fewer individuals, estates, or trusts with respect to whom stock ownership is considered must be the same individuals, estates, or trusts whose stock ownership is considered for purposes of the greater-than-50% requirement. Thus, the brother-sister controlled group should be of concern where five or fewer shareholders (who are individuals, estates, or trusts) -(a) own at least 80% of each corporation and (b) own more than 50% of all corporations taking into account identical ownership interests with respect to each corporation.

**Combined Group of Corporations**

Under Code Section 414(b), a controlled group of corporations also may comprise an overlapping parent-subsidiary controlled group and a brother-sister controlled group of corporations. This occurs if both of the following are met:

- Each corporation is a member of either a parent-subsidiary controlled group or a brother-sister controlled group.
- At least one of the corporations is the common parent of the parent-subsidiary controlled group and also is a member of a brother-sister controlled group.

**Large Employers, For Profit Business, Government Entities, Medicaid, Etc.**

All large employers are subject to the Employer Shared Responsibility provisions, including for-profit, non-profit, and government entity employers. This includes federal, state, local, and Indian tribal government employers.

**Federally-facilitated Exchange, Medicare & Medicaid**

An applicable large employer is subject to an Employer Shared Responsibility payment if at least one of its full-time employees receives a premium tax credit. A premium tax credit is only available to eligible individuals who obtain coverage through a Marketplace, which includes a State Based Exchange, regional Exchange, subsidiary Exchange, or the Federally-facilitated Exchange established on behalf of a state.
All employees are counted (subject to a limited exception for certain seasonal workers), regardless of whether the employees are eligible for health coverage from another source, such as Medicare, Medicaid, or a spouse's employer. Thus, an applicable large employer with full-time employees who are eligible for health coverage through another source, such as Medicare, Medicaid, or a spouse's employer, will be subject to the Employer Shared Responsibility provisions regardless of whether those employees are eligible for coverage from another source. But, employees who are eligible for Medicare or Medicaid are not eligible for a premium tax credit. If no full-time employee receives a premium tax credit (for example, because all of an employer's full-time employees are eligible for Medicare or Medicaid), the employer will not be subject to an Employer Shared Responsibility payment.

However, if an applicable large employer does not offer coverage to its full-time employees (and their dependents) or offers coverage to fewer than 95% of its full-time employees (and their dependents) and a full-time employee receives a premium tax credit, the employer will be liable for an Employer Shared Responsibility payment, which will be calculated based on the employer's number of full-time employees. For this purpose, the number of full-time employees includes full-time employees who are eligible for coverage from another source.

**Employees Working Outside the United States**
An applicable large employer generally takes into account only work performed in the United States. Employees working only abroad, whether or not U.S. citizens, generally will not be taken into account for purposes of determining whether an employer is applicable large employer or for purposes of determining whether the employer owes an Employer Shared Responsibility payment or the amount of any such payment.

**Identification of Full-Time Employees**
An employer's number of full-time employee’s matters both for purposes of whether the Employer Shared Responsibility provisions apply to an employer and whether an Employer Shared Responsibility payment is owed by an employer (and the amount of that payment). An employer identifies its full-time employees based on each employee's hours of service. For purposes of the Employer Shared Responsibility provisions, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week. Under the final regulations, for purposes of determining full-time employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.

The final regulations provide two measurement methods for determining whether an employee has sufficient hours of service to be a full-time employee. One method is the monthly measurement method under which an employer determines each employee's status as a full-time employee by counting the employee's hours of service for each month. The other method is the look-back measurement method under which an employer may determine the status of an
employee as a full-time employee during a future period (referred to as the stability period),
based upon the hours of service of the employee in a prior period (referred to as the measurement
period). The look-back measurement method for identifying full-time employees is available
only for purposes of determining and computing liability for an Employer Shared Responsibility
payment, and not for purposes of determining if the employer is an applicable large
employer. The final regulations describe approaches that can be used for various circumstances,
such as for employees who work variable hour schedules, seasonal employees, and employees of
educational organizations.

These methods prescribe minimum standards for the identification of full-time employee
status. Employers always may make additional employees eligible for coverage, or otherwise
offer coverage more expansively than required.

**Difficulty Tracking Hours of Service**
The Treasury and the IRS continue to consider additional rules for the determination of hours of
service for certain categories of employees whose hours of service are particularly challenging to
identify or track, or for whom the general rules for determining hours of service may present
special difficulties (including adjunct faculty, commissioned salespeople and airline employees)
and certain categories of work hours associated with some positions of employment, including
layover hours (for example for airline employees) and on-call hours. For this purpose, until
further guidance is issued, employers are required to use a reasonable method of crediting hours
of service that is consistent with section 4980H. The preamble to the final regulations includes
examples of methods of crediting these hours that are reasonable and that are not reasonable,
including a method that is considered reasonable for crediting hours of service for adjunct faculty
members.

**Liability for the Employer Shared Responsibility Payment**
For 2015 and after, an applicable large employer will be liable for an Employer Shared
Responsibility payment only if they meet one of the following:

- The employer does not offer health coverage or offers coverage to fewer than 95% of its
  full-time employees and the dependents of those employees, and at least one of the full-
  time employees receives a premium tax credit to help pay for coverage on a Marketplace.
- The employer offers health coverage to all or at least 95% of its full-time employees, but
  at least one full-time employee receives a premium tax credit to help pay for coverage on
  a Marketplace, which may occur because the employer did not offer coverage to that
  employee or because the coverage the employer offered that employee was either
  unaffordable to the employee or did not provide minimum value.

**Determining Affordable Coverage**
If an employee's share of the premium for employer-provided coverage would cost the employee more than 9.56% of that employee's annual household income, the coverage is not considered affordable. Because employers generally will not know their employees' household incomes, employers can take advantage of one or more of the three affordability safe harbors set forth in the final regulations that are based on information the employer will have available, such as the employee's Form W-2 wages or the employee's rate of pay. If an employer meets the requirements of any of these safe harbors, the offer of coverage will be deemed affordable for purposes of the Employer Shared Responsibility provisions regardless of whether it was affordable to the employee for purposes of the premium tax credit.

The three affordability safe harbors are:

- The Form W-2 wages safe harbor, generally based on the amount of wages paid to the employee that are reported in Box 1 of that employee's Form W-2.
- The rate of pay safe harbor, generally based on the employee's rate of pay at the beginning of the coverage period, with adjustments permitted, for an hourly employee, if the rate of pay is decreased (but not if the rate of pay is increased).
- The federal poverty line safe harbor generally treats coverage as affordable if the employee contribution for the year does not exceed 9.56% of the federal poverty line for a single individual for the applicable calendar year.

These safe harbors are all optional. An employer may use one or more of the safe harbors only if the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that provides minimum value for the self-only coverage offered to the employee. If employers offer multiple healthcare coverage options, the affordability test applies to the lowest-cost self-only option available to the employee that also meets the minimum value requirement.

**Determining Minimum Value of Coverage**

A plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. The Department of Health and Human Services (HHS) and the IRS have produced a minimum value calculator. By entering certain information about the plan, such as deductibles and co-pays, into the calculator employers can get a determination as to whether the plan provides minimum value.

**The Impact of Employees Purchasing Health Insurance through the Marketplace, Medicare or Medicaid**

An applicable large employer will not be subject to an Employer Shared Responsibility payment solely because one, some, or all of its employees purchase health insurance coverage for themselves of their dependents through a Marketplace or enroll in Medicare or Medicaid.
An employer will not be liable for an Employer Shared Responsibility payment unless at least one full-time employee receives a premium tax credit. In general, an employee will not be eligible for a premium tax credit if the employer has offered that employee health coverage that is affordable and that provides minimum value, even if that employee rejects the offer of coverage and instead enrolls in coverage through a Marketplace or enrolls in Medicare or Medicaid. If no full-time employee receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment.

An applicable large employer must offer health coverage that is affordable and provides minimum value to its full-time employees and must offer health coverage to the dependents of those employees, but a spouse is not considered a dependent. An applicable large employer will not be subject to an Employer Shared Responsibility payment solely because it does not offer health coverage to an employee's spouse or if the spouse purchases health insurance coverage through a Marketplace or enrolls in Medicare or Medicaid.

**Calculating the Employer Shared Responsibility Payment**

If an applicable large employer does not offer coverage or offers coverage to fewer than 95% of its full-time employees (and their dependents), it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the year (minus up to 30) multiplied by $2,000, as long as at least one full-time employee receives the premium tax credit. (Note that for purposes of this calculation, a full-time employee does not include a full-time equivalent).

For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30) multiplied by 1/12 of $2,000. If the employer is related to other employers, then the 30-employee exclusion is allocated among all the related employers in proportion to each employer's number of full-time employees.

For an employer that offers coverage to at least 95% of its full-time employees (and their dependents), but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. See question 33 for transition relief with respect to offers of coverage to dependents for 2015. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 30) multiplied by 1/12 of $2,000. (The cap ensures that the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer coverage.)
Employer Shared Responsibility Payment Increases
The Employer Shared Responsibility provisions provide an inflation adjustment mechanism beginning in years after 2014. The transition relief announced in Notice 2013-45 that section 4980H will not be applied for 2014 does not affect the statutory inflation adjustment mechanism beginning in years after 2014.

Making an Employer Shared Responsibility Payment
The IRS will adopt procedures that ensure employers receive certification that one or more employees have received a premium tax credit. The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after the due date for employees to file individual tax returns for that year claiming premium tax credits and after the due date for applicable large employers to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

If it is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the Employer Shared Responsibility payment on any tax return that they file.

Transition Relief
Notice 2013-45, provides as transition relief that no Employer Shared Responsibility payment applies for 2014. The Employer Shared Responsibility provisions are effective for 2015.

The preamble to the final regulations provides pieces of transition relief addressing non-calendar year plans:

- Pre-2015 eligibility transition relief, generally addressing employees that are already eligible to participate in the non-calendar year plan. Specifically the pre-2015 eligibility transition relief provides that for any employees (whenever hired) who are eligible for coverage on the first day of the 2015 plan year under the eligibility terms of the plan as of Feb. 9, 2014, (whether or not they take the coverage) and who are offered affordable coverage that provides minimum value effective no later than the first day of the 2015 plan year, the employer will not be subject to a potential Employer Shared Responsibility payment until the first day of the 2015 plan year.

- Significant percentage transition relief, split into two subcategories of all employees and full-time employees. They generally address employees that have not been eligible to participate in the non-calendar year plan. They provide that if the employer meets certain requirements generally related to the portion of the employer’s employees already
eligible for or participating in the non-calendar year plan, the relief may be extended to those employees that have not been eligible to participate. The preamble to the final regulations provides additional information on the rules for determining whether an employer is eligible for this relief. All of this transition relief applies for the period before the first day of the first non-calendar year plan year beginning in 2015 (the 2015 plan year) but only for employers that maintained non-calendar year plans as of Dec. 27, 2012, and only if the plan year was not modified after Dec. 27, 2012, to begin at a later calendar date.

Transition relief is available to assist employers that are close to the 50 full-time employee threshold in determining if they are an applicable large employer for 2015. Rather than being required to use the full twelve months of 2014 to measure whether it has 50 full-time employees (or equivalents), an employer may measure during any consecutive six-month period (as chosen by the employer) during 2014. For example, an employer could use a period of at least six months through August 2014 to determine its applicable large employer status and, if it is an applicable large employer, the period from September through December 2014 to make any needed adjustments to its plan (or to establish a plan).

For employers with fewer than 100 full-time employees (including full-time equivalents) in 2014, that meet the conditions described below, no Employer Shared Responsibility payment under section 4980H(a) or (b) will apply for any calendar month during 2015. For employers with non-calendar-year health plans, this applies to any calendar month during the 2015 plan year, including months during the 2015 plan year that fall in 2016.

In order to be eligible for the relief, an employer must certify that it meets the following conditions:

(1) Limited Workforce Size. The employer must employ on average at least 50 full-time employees (including full-time equivalents) but fewer than 100 full-time employees (including full-time equivalents) on business days during 2014. (Employers with fewer than 50 full-time employees (including full-time equivalents) on business days during the previous year are not subject to the Employer Shared Responsibility provisions.) The number of full-time employees (including full-time equivalents) is determined in accordance with the otherwise applicable rules in the final regulations for determining status as an applicable large employer.

(2) Maintenance of Workforce and Aggregate Hours of Service. During the period beginning on February 9, 2014 and ending on Dec. 31, 2014, the employer may not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief. However, an employer that reduces workforce size or overall hours of service for bona fide business reasons is still eligible for the relief.
(3) Maintenance of Previously Offered Health Coverage. During the period beginning on Feb. 9, 2014 and ending on Dec. 31, 2015 (or, for employers with non-calendar-year plans, ending on the last day of the 2015 plan year) the employer does not eliminate or materially reduce the health coverage, if any, it offered as of Feb. 9, 2014. An employer will not be treated as eliminating or materially reducing health coverage if (i) it continues to offer each employee who is eligible for coverage an employer contribution toward the cost of employee-only coverage that either (A) is at least 95 percent of the dollar amount of the contribution toward such coverage that the employer was offering on Feb. 9, 2014, or (B) is at least the same percentage of the cost of coverage that the employer was offering to contribute toward coverage on Feb. 9, 2014; (ii) in the event of a change in benefits under the employee-only coverage offered, that coverage provides minimum value after the change; and (iii) it does not alter the terms of its group health plans to narrow or reduce the class or classes of employees (or the employees' dependents) to whom coverage under those plans was offered on Feb. 9, 2014.

For new employers that would be applicable large employers under the general rules in the final regulations, the special transition relief applies if the employer certifies that it (i) reasonably expects to employ and actually employs fewer than 100 full-time employees (including full-time equivalents) on business days during 2015; and (ii) reasonably expects to meet and actually meets the standards relating to maintenance of workforce and aggregate hours of service and of previously offered health coverage, as measured from the date the employer is first in existence.

Offering Coverage in 2015
Generally, if an employer fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not offered coverage during the entire month. Solely for purposes of January 2015, if an employer offers coverage to a full-time employee no later than the first day of the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.

As for employee’s dependents, under this transition relief, an employer that takes steps during its 2014 plan year toward offering dependent coverage will not be subject to an Employer Shared Responsibility payment solely on account of a failure to offer coverage to dependents for that plan year.

This extended transition relief applies to employers for the 2015 plan year for plans under which (1) dependent coverage is not offered, (2) dependent coverage that does not constitute minimum essential coverage is offered, or (3) dependent coverage is offered for some, but not all, dependents.
The transition relief is not available to the extent the employer had offered dependent coverage during either the plan year that begins in 2013 (2013 plan year), or the 2014 plan year and subsequently dropped that offer of coverage. The transition relief, as extended, applies only for dependents who were without an offer of coverage from the employer in both the 2013 and 2014 plan years and if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both).

Ineligible Employers and Employer Shared Responsibility Payments for 2015

For 2015 (and for employers with non-calendar-year plans, any calendar months during the 2015 plan year that fall in 2016), an employer that (a) had at least 100 full-time employees (including full-time equivalents) in 2014, or (b) had at least 50 but fewer than 100 full-time employees (including full-time equivalents) but does not qualify for the relief described in question 34, will be liable for an Employer Shared Responsibility payment only if one of the following apply:

- The employer does not offer health coverage or offers coverage to fewer than 70% of its full-time employees and (unless the employer qualifies for the 2015 dependent coverage transition relief) the dependents of those employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on a Marketplace.
- The employer offers health coverage to at least 70% of its full-time employees and (unless the employer qualifies for the 2015 dependent coverage transition relief) the dependents of those employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on a Marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee or did not provide minimum value.

After 2015, 95% should be substituted for 70% in the bullets above (see question 18).

Employers with at least 100 Employees and less than 70% Coverage

For any calendar month in 2015 or any calendar month in 2016 that falls within an employer’s non-calendar 2015 plan year, if an applicable large employer with at least 100 full-time employees (including full-time equivalents) does not offer coverage to at least 70% of its full-time employees (and their dependents), it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the month (minus 80) multiplied by 1/12 of $2,000, provided that at least one full-time employee receives a premium tax credit for that month.

Employers with at least 100 Employees and more than 70% Coverage

For an employer with at least 100 full-time employees (including full-time equivalents) that offers coverage to at least 70% of its full-time employees in 2015, but has one or more full-time
employees who receive a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 80) multiplied by 1/12 of $2,000.

**Basics for Small Employers**

Employers that employ fewer than 50 full-time employees (including full-time equivalents) in their businesses are not subject to the Employer Shared Responsibility provisions. The vast majority of businesses fall below this threshold.

In addition, the preamble to the final regulations for the Employer Shared Responsibility provisions provides transition relief for 2015. Employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents) in 2014 that meet conditions described in the preamble to the final regulations will not be subject to any Employer Shared Responsibility payments for 2015 (or for the 2015 plan year in the case of an employer with a non-calendar-year health plan).

If additional employees are hired, an employer determines if it is subject to these provisions for a current year by counting how many full-time employees and full-time equivalents it employed during the prior calendar year.

First, for each month of the prior year, the employer counts its employees working an average of 30 or more hours per week as full-time employees and, if it has employees working less than that, adds the number of full-time equivalents (determined by simply adding up the hours that are worked by these less-than-full-time employees for the month, but no more than 120 hours per employee, and then dividing by 120).

Second, the resulting totals for each month in the prior year are added together and then divided by 12 to get an average for the prior year. If the result is less than 50, the employer is not subject to these rules for the current year and need not take any other action.

(If the result is 50 or more but some of the employees are seasonal workers, certain adjustments may still bring the average down to less than 50.)

Two transition rules apply in 2015 that are particularly relevant for small employers close to the 50 full-time employee (including full-time equivalents) threshold. First, employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents) in 2014 that meet conditions described in the preamble to the final regulations will not be subject to any Employer Shared Responsibility payments for 2015 (or for the 2015 plan year in the case of an employer
with a non-calendar-year health plan. These employers determine if they have 100 or more employees in the same manner as described above. And, second, rather than being required to use the full twelve months of 2014 to measure if it has 100 full-time employees (including full-time equivalents), an employer may measure during any consecutive six-month period (as chosen by the employer) during 2014. For example, an employer could use a period of at least six months through August 2014 to determine its applicable large employer status and, if it is an applicable large employer, the period from September through December 2014 to make any needed adjustments to its plan (or to establish a plan).

**Buying or Starting Another Business Separate from Existing Businesses**

Section 4980H provides for common ownership and control “aggregation” rules that may apply. These are similar to rules that have applied to 401(k) and other retirement plans for years. Under these rules, the employees of businesses that are under common control are added together to determine if an employer employs the equivalent of at least 50 (or 100 under the 2015 transition rule noted above) full-time employees (including full-time equivalents).

For example, if an individual owns 80% or more of two businesses that are separate legal entities, the total number of full-time employees of that employer is based on the full-time employees (including full-time equivalents) in both businesses combined together. If the employees in the combined businesses add up to fewer than 50 full-time employees (including full-time equivalents) in a year, the Employer Shared Responsibility provisions will not apply to those businesses for the following year.

**When Employees can receive a Premium Tax Credit**

The premium tax credit is generally available to help pay for coverage for employees who have household income between 100% and 400% of the federal poverty line and enroll in coverage through a Marketplace, are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value.

**Employees’ Eligibility for a Premium Tax Credit**

The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer is subject to the Employer Shared Responsibility provisions.

**Additional Information on Reporting Requirements**

Treasury and the IRS have issued proposed regulations on information reporting on health coverage for employers and information reporting on health coverage for providers of minimum essential coverage.
More information on the Marketplace for Employees
The Department of Health and Human Services administers the requirements for the Marketplace and the health plans offered in the Marketplace. For more information about your coverage options, financial assistance, and the Marketplace, visit HealthCare.gov.

Employment-Based Orientation Periods Cannot Exceed One Month for Purposes of ACA 90-Day Waiting Period Limit, effective for plans on or after Jan. 1, 2015.

Under the Affordable Care Act (ACA), eligibility conditions for group health plan coverage that are based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility are generally allowed, including a requirement that employees successfully complete a reasonable and bona fide employment-based orientation period.

RULES FOR ORIENTATION AND WAITING PERIODS
Consistent with prior guidance, final rules issued by the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) provide that group health plans will be considered in compliance with the law if the employment-based orientation period does not exceed one month and the maximum 90-day waiting period begins on the first day after the orientation period.

The proposed regulations had provided that one month would be the maximum allowed length of any reasonable and bona fide employment-based orientation period. The Departments stated that, during an orientation period, an employer and employee could evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. Under the proposed regulations, if a group health plan conditions eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period, the eligibility condition would not be considered to be designed to avoid compliance with the 90-day waiting period limitation if the orientation period did not exceed one month and the maximum 90-day waiting period would begin on the first day after the orientation period.

One month would be determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage or, if there is not a corresponding date in the next calendar month, the last day of the next calendar month. (For example, if an employee's start date is May 3, the last permitted day of the orientation period is June 2; if the employee's start date is August 31, the last permitted day of the orientation period is September 30.) If there is not a corresponding date in the next calendar month upon adding a calendar month, the last permitted day of the orientation period is the last day of the next calendar month. For example, if the employee's start date is January 30, the last permitted day of the orientation period is February 28 (or February 29 in a leap year). Similarly,
if the employee's start date is August 31, the last permitted day of the orientation period is September 30.

The final regulations continue to provide that if a group health plan conditions eligibility on an employee's having completed a reasonable and bona fide employment-based orientation period, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the orientation period does not exceed one month and the maximum 90-day waiting period begins on the first day after the orientation period.

But compliance with these final regulations is not determinative of compliance with Section 4980H of the Code (employer mandate), under which an applicable large employer may be subject to an assessable payment if it fails to offer affordable minimum value coverage to certain newly-hired full-time employees by the first day of the fourth full calendar month of employment.

For example, an applicable large employer that has a one-month orientation period may comply with both PHS Act section 2708 and Code section 4980H by offering coverage no later than the first day of the fourth full calendar month of employment. However, an applicable large employer plan may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to an assessable payment under Code section 4980H.

As another example, if an employee is hired as a full-time employee on January 6, a plan may offer coverage May 1 and comply with both provisions. However, if the employer is an applicable large employer and starts coverage May 6, which is one month plus 90 days after date of hire, the employer may be subject to an assessable payment under Code section 4980H.

These final regulations apply to group health plans and health insurance issuers for plan years beginning on or after January 1, 2015. Until these final rules are applicable, as stated in the preamble to the proposed rules, the Departments will consider compliance with the proposed regulations to constitute compliance with PHS Act section 2708.

A copy of the final regulations can be obtained by clicking on the link below:


EVIDENCE OF CREDITABLE COVERAGE NO LONGER REQUIRED
Final regulations permanently remove the requirement to provide Evidence of Creditable Coverage for all plans, regardless of plan year, effective Dec. 31, 2014. Plans must continue to provide HIPAA Certificates of Creditable Coverage until this time.
For the HIPAA Creditable Coverage provisions, final regulations apply effective Dec. 31, 2014. All other technical amendments apply for the first plan year beginning on or after April 25, 2014.

**DATA COLLECTION AND REPORTING REQUIREMENTS FOR 2015**

Most self-insured health plan sponsors need to start collecting certain health plan data in 2015 to report to the IRS in 2016. Data requirements are governed by two Internal Revenue Code sections: 6055 and 6056. IRS regulations have been issued describing these requirements in detail. Draft copies of the reporting forms are also available.

The IRS forms require Taxpayer Identification Numbers (TINs, which are typically Social Security numbers) not only for employees but also for covered spouses and dependents. The IRS will give employers a one-year pass if they can't gather all the TINs for the minimum essential coverage form, so long as they have made a "good faith effort" to get them.

The IRS recently released draft forms to help employers prepare for the new information reporting provisions under the ACA. Because of transition relief provided for 2014, **reporting entities will not be subject to penalties if they first report beginning in 2016 for 2015.**

The Affordable Care Act requires insurers, self-insuring employers, and other parties that provide minimum essential health coverage (MEC) to report information on this coverage to the IRS and to covered individuals. Large employers (generally those with **50 or more full-time employees**, including full-time equivalents) are also required to report information to the IRS and to their employees about their compliance with the employer shared responsibility provisions ("pay or play") and the health care coverage they have offered. Final rules regarding MEC reporting and large employer reporting are currently available.

**Draft Forms**

As a general method, large employers will file Form 1094-C (a transmittal) and Form 1095-C (an employee statement). Entities reporting as health insurance issuers or sponsors of self-insured group health plans that are not reporting as large employers will generally report on Form 1094-B and Form 1095-B. The following forms are now available:

- Draft Form 1094-C (transmittal)
- Draft Form 1095-C
- Draft Form 1094-B (transmittal)
- Draft Form 1095-B

The applicable forms will be required to be **electronically filed** only if the reporting entity is required to file **at least 250 of the specific form.**
Draft instructions relating to the forms are expected to be posted to IRS.gov this month, and the IRS intends to finalize both the forms and instructions later this year. For more information on the reporting requirements, click here.

IRS has issued drafts of the Affordable Care Act forms required for employer shared-responsibility (ESR) and minimum essential coverage (MEC) reporting. It's expected that issuers of health insurance and certain employers will use Form 1094-B and Form 1095-B for MEC reporting, while large employers will use Form 1095-C and Form 1094-C for ESR reporting and, in some cases, MEC reporting. IRS also has posted a draft of Form 8941 for claiming the small employer tax credit for offering health insurance through a SHOP exchange. Draft instructions for the forms are not available yet.

Form 1094-B, Transmittal of Health Coverage Information Return:


Form 1095-A, Health Insurance Marketplace Statement:


Form 1095-C, Employer Provided Health Insurance Offer and Coverage:

Form 8941, Credit of Small Employer Health Insurance Premiums:

**COLLECTION OF REINSURANCE CONTRIBUTIONS**

HHS has implemented a streamlined process for the collection of reinsurance contributions where a contributing entity, or a third party administrator (TPA) or administrative-services only (ASO) contractor on behalf of the contributing entity, can complete all required steps for the reinsurance contribution submission process on Pay.gov, including: registration, submission of the annual enrollment count via the 'ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form' (the Form), and remittance of contributions.

Data can be submitted and the Form can be found at www.pay.gov.

HHS offers contributing entities two options:
• Pay the entire 2014 benefit year contribution in one payment no later than January 15, 2015, reflecting $63.00 per covered life
• Pay in two separate payments for the 2014 benefit year, with the first remittance due by January 15, 2015 reflecting $52.50 per covered life, and the second remittance due by November 15, 2015, reflecting $10.50 per covered life.

**ACA IMPLEMENTATION FAQs - PART XXI**

In October the Departments of Labor, Health and Human Services (HHS), and the Treasury jointly released FAQs about Affordable Care Implementation (Part XXI). The new FAQs set forth specific factors departments should consider when evaluating whether a non-grandfathered plan that utilizes reference-based pricing (or similar network design) is using a reasonable method to ensure it provides adequate access to quality providers at the reference-based price.

Medium-sized employers have until 2016 before they must offer health insurance to their full-time workers. Firms with at least 100 employees will have to start offering this coverage in 2015. Even the nation's largest employers can avoid fines by offering coverage to 70 percent of their full-time employees in 2015 and 95 percent in 2016. Businesses that fail to offer coverage face a fine of up to $2,000 for each employee that is not covered, though workers are not required to sign up for the benefits.

The coverage must encompass a core set of benefits and be affordable, which the law defines as premiums costing no more than 9.5 percent of an employee's income, and the employer must pay for the equivalent of 60 percent of the cost of coverage for workers but not their dependents.


**IRS INCREASES ACA’s AFFORDABILITY PERCENTAGES FOR 2015**

IRS Revenue Procedure 2014-37 indexes the ACA’s affordability percentages for 2015 under the employer mandate, and adjusts the income level under which employees are exempt from the ACA’s individual mandate.

**Employer Mandate Adjustment**

Applicable large employer's health coverage will be considered affordable for plan years beginning in 2015 under employer mandate if the employee's required contribution to the plan does not exceed 9.56 percent of the employee's household income for the year, up from 9.5 percent. This increase also applies to the three safe harbors the IRS created in the regulations.

The employer mandate was originally meant to take effect in 2014 but was delayed until 2015 or 2016, depending on employer size.
**Individual Mandate Adjustment**

For plan years beginning in 2015, coverage is unaffordable for purposes of the individual mandate if it exceeds 8.05% of household income, up from 8%.

The IRS must adjust the affordability percentage to reflect the excess of the rate of premium growth over the rate of income growth for the preceding calendar year, with each subsequent plan year being adjusted accordingly.

For a copy of Revenue Procedure 2014-37, please click on the link below:


**NEW OUT-OF-POCKET MAXIMUMS**

The maximum out-of-pocket expense allowed has increased by about 1.6 percent, combining employee deductibles, co-pays and coinsurance, cannot exceed $6,600 for employee-only and $13,200 for family coverage. Ceilings on deductibles for high-deductible health plans offered in conjunction with a health savings account rose to $6,450 and $12,900, respectively. If you have a separate pharmacy benefit plan, employee maximum costs under that plan must be added to the basic health plan in calculating maximum employee cost-sharing.

**NEW GUIDELINES REGARDING PATIENT HOSPITALIZATION COVERAGE**

The IRS recently released Notice 2014-69 which provides that health plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services (or for both) referred to as Non-Hospital/Non-Physician Services Plan) do not provide the minimum value intended by the minimum value requirements for the employer mandate.

For an employers who has entered into a binding written commitment to adopt, or have begun enrolling employees in, a Non-Hospital/Non-Physician Services Plan prior to November 4, 2014 based on the employer's reliance on the results of use of the MV Calculator (a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan), they will not be penalized for not meeting the employer mandate for the 2015 plan year if that plan year begins not later than March 1 2015.

For employers who have not entered in to a written commitment to adopt or have begun enrolling employees in a Non-Hospital/Non-Physician Services Plan on or after November 4, 2014 or have a plan year that begins after March 1,2015, no relief will be given.

Pending issuance of final regulations, in no event will an employee be required to treat a Non-Hospital/Non-Physician Services Plan as providing MV for purposes of an employee's eligibility for a premium tax credit under Code section 36B, regardless of whether the plan is a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan.

An employer that offers a Non-Hospital/Non-Physician Services Plan (including a Pre-November 4, 2014 Non-Hospital/Non-Physician Services Plan) to an employee:
(1) must not state or imply in any disclosure that the offer of coverage under the Non-Hospital/Non-Physician Services Plan precludes an employee from obtaining a premium tax credit, if otherwise eligible, and

(2) must timely correct any prior disclosures that stated or implied that the offer of the Non-Hospital/Non-Physician Services Plan would preclude an otherwise tax-credit-eligible employee from obtaining a premium tax credit.

Without such a corrective disclosure, a statement (for example, in a summary of benefits and coverage) that a Non-Hospital/Non-Physician Services Plan provides minimum value will be considered to imply that the offer of such a plan precludes employees from obtaining a premium tax credit. However, an employer that also offers an employee another plan that is not a Non-Hospital/Non-/Physician Services Plan and that is affordable and provides MV is permitted to advise the employee that the offer of this other plan will or may preclude the employee from obtaining a premium tax credit.

For a copy of the Notice, click on the link below:


**PROPOSED CHANGES TO CAFETERIA PLAN ELECTIONS & LOOK-BACK PERIOD**

In September the IRS issued two notices regarding the Affordable Care Act.

**Notice 2014-49** describes a proposed approach for applying the look-back measurement method used to determine full-time employee status for purposes of IRS Code § 4980H in situations when the measurement period applying to an employee changes. This change may occur because the employee transfers within the same applicable large employer (or within the same applicable large employer member) from a position to which one measurement period applies to a position to which a different measurement period applies. This situation may also arise when the applicable large employer member modifies the measurement period applicable to a position.

**Notice 2014-55** expands the application of the permitted change rules for health coverage under a § 125 cafeteria plan. This notice addresses two specific situations in which a cafeteria plan participant may wish to revoke, during a period of coverage (commonly a plan year), the employee’s election for employer-sponsored health coverage under the cafeteria plan in order to purchase a Qualified Health Plan through an ACA Marketplace. The first situation involves a participating employee whose hours of service are reduced so that the employee is expected to average less than 30 hours of service per week but for whom the reduction does not affect the eligibility for coverage under the employer’s group health plan. (This may occur, for example, under certain employer plan designs intended to avoid any potential assessable payment under § 4980H of the Internal Revenue Code.) The second situation involves an employee participating in an employer’s group health plan who would like to cease coverage under the group health plan...
and purchase coverage through a Marketplace without that resulting either in a period of duplicate coverage under the employer’s group health plan and the coverage purchased through a Marketplace or in a period of no coverage.

This notice permits a cafeteria plan to allow an employee to revoke his or her election under the cafeteria plan for coverage under the employer’s group health plan (other than a flexible spending arrangement) during a period of coverage in each of those situations provided specified conditions are met. The Treasury Department and the IRS intend to modify the regulations under § 125

**AMENDMENTS TO EXCEPTED DENTAL AND VISION BENEFITS/EAPs**

In September the IRS, Department of Labor, and the Centers for Medicare and Medicaid Services issued final regulations addressing the treatment of dental and vision benefits and employee assistance programs (EAPs) as limited excepted benefits, which are generally exempt from the ACA’s market reform requirements. The rules apply to group health plans and group health insurance issuers for plan years starting in 2015. The rules finalize some, but not all, of the proposed rules issued on December 24, 2013, with some modifications.

The small business health care credit is available to certain employers who purchase health insurance for their employees. Businesses must employ fewer than 25 full-time employees who are paid an average annual wage of more than $50,000 in order to qualify. A business must also make non-elective contributions to a health insurance plan at a "uniform percentage" equal to at least 50 percent of the cost of premiums.

For 2014, the maximum credit is equal to 50 percent of the cost of your concern's contributions. However, a full credit is available only if your organization has ten or fewer full-time employees and pays them average wages that don't exceed $25,000 (indexed to $25,400 for 2014). Otherwise, the credit is subject to a reduction (see right-hand box).

Full-time employees do not include any of the following or their family members:

- Owners of the business, such as sole proprietors.
- Partners in a partnership.
- Shareholders of more than 2 percent in an S corporation.
- Individuals owning more than 5 percent of another business.

If these individuals and their relatives are paid much higher salaries than other employees, the average annual wages will not increase.

Effective this year, you may claim the credit for no more than two consecutive tax years, beginning with the first year in which you offer health insurance through a Small Business
Health Options Program (SHOP) Exchange (assuming one is available). The requirement to acquire health insurance through a SHOP Exchange is new for 2014.

The new regulations add the following provisions:

1. **Average premium limit:** The employer's premium payments are limited by the average premium in the small group market in the rating area in which the employee enrolls for coverage through a SHOP Exchange.

2. **Payroll tax limit:** For a tax-exempt entity, the amount of the credit can't exceed the amount of payroll taxes during the calendar year in which the tax year begins.

3. **Two-consecutive-tax-year rule:** The first year of the two-consecutive-tax year credit period begins the year your organization claims the credit by filing Form 8941 (Credit for Small Employer Health Insurance Premiums) of Form 990-T (Exempt Organization Business Income Tax Return), with an attached Form 8941. This is the case even if you are eligible to claim only the credit for part of the first year.

4. **Uniform percentage requirement:** The final regulations incorporate the uniform percentage requirement provisions from the proposed regulations, but also provide detailed rules for how to apply the provisions if SHOP dependent coverage is offered.

5. **Wellness programs:** If your organization offers a wellness program with a premium discount for participation (or a surcharge for non-participation), the difference in employer contributions won't violate the uniform percentage requirement as long as your concern contributes at least 50 percent of the premium (including any surcharge) for non-participants. Employer subsidies under the wellness program count in the credit calculation.

6. **Seasonal workers:** Employees who work on a seasonal basis for no more than 120 days aren't considered employees for small employer status and average annual wages, although employer contributions for premiums count in determining an employer's tax credit. The final regulations have added a "reasonable, good faith" standard for identifying seasonal workers.

7. **Claiming the credit:** Similar to the provisions in the proposed regulations, the final regulations prescribe rules for claiming the credit on Form 8941, reflecting the credit in estimated tax payments and offsetting the employer's alternative minimum tax (AMT) liability. In addition, the final regulations clarify that no deduction is allowed as a business expense under Section 162 for the portion of the premiums attributable to the claim for the credit.
Finally, the new regulations include a slew of transitional rules. You can find more information here.

Varying interpretations of the law, as well as other challenges to the ACA can be expected. Consult with your advisers to ensure that your business is in full compliance, while keeping an eye out for new developments.

**SMALL BUSINESS HEALTH INSURANCE CREDITS**
A small business health insurance credit is reduced for an employer if:

- It has more than ten, but no more than 25, full-time employees. The number is found by dividing the total hours the employer pays wages to employees during the year by 2,080. The total hours can't exceed 2,080 for any employee.
- The average wage for each employee falls between $25,000, or $25,400 for 2014, and $50,000, or $50,800 for 2014. Divide the total wages paid to employees during the tax year by the number of full-time employees for the year. The result is rounded down to the nearest $1,000.

If an employer has more than ten full-time employees and average annual wages exceed $25,000 ($25,400 for 2014), the credit reduction is the sum of the amount of the two reductions.

**AFFORDABLE CARE ACT FAQs**
Below are additional Frequently Asked Questions (FAQs) regarding implementation of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments).

These FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

Compliance of Premium Reimbursement Arrangements
On September 13, 2013, DOL and the Treasury published guidance on the application of the market reforms and other provisions of the Affordable Care Act to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements.(1) HHS issued contemporaneous guidance to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in the DOL and Treasury Department guidance.(2) Subsequently, on May 13, 2014, two FAQs were made available on the IRS website addressing employer health care arrangements.(3)

The Departments' prior guidance explains that employer health care arrangements, such as HRAs and employer payment plans, are group health plans that typically consist of a promise by an employer(4) to reimburse medical expenses up to a certain amount. The Departments' guidance
clarifies that such arrangements are subject to the group market reform provisions of the Affordable Care Act, including the prohibition on annual limits under Public Health Service Act (PHS Act) section 2711 and the requirement to provide certain preventive services without cost sharing under PHS Act section 2713. The Departments' guidance further clarifies that such employer health care arrangements will not violate these market reform provisions when integrated with a group health plan that complies with such provisions. However, an employer health care arrangement cannot be integrated with individual market policies to satisfy the market reforms. Consequently, such an arrangement may be subject to penalties, including excise taxes under section 4980D of the Internal Revenue Code (Code).

**Q1: My employer offers employees cash to reimburse the purchase of an individual market policy. Does this arrangement comply with the market reforms?**

No. If the employer uses an arrangement that provides cash reimbursement for the purchase of an individual market policy, the employer's payment arrangement is part of a plan, fund, or other arrangement established or maintained for the purpose of providing medical care to employees, without regard to whether the employer treats the money as pre-tax or post-tax to the employee. Therefore, the arrangement is group health plan coverage within the meaning of Code section 9832(a), Employee Retirement Income Security Act (ERISA) section 733(a) and PHS Act section 2791(a), and is subject to the market reform provisions of the Affordable Care Act applicable to group health plans. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code. Under the Departments' prior published guidance, the cash arrangement fails to comply with the market reforms because the cash payment cannot be integrated with an individual market policy.(6)

**Q2: My employer offers employees with high claims risk a choice between enrollment in its standard group health plan or cash. Does this comply with the market reforms?**

No. PHS Act section 2705,(7) which was incorporated by reference into ERISA section 715 and Code section 9815, as well as the nondiscrimination provisions of ERISA section 702 and Code section 9802 originally added by the Health Insurance Portability and Accountability Act (HIPAA), prohibit discrimination based on one or more health factors. Offering, only to employees with a high claims risk, a choice between enrollment in the standard group health plan or cash, constitutes such discrimination. While the Departments' regulations implementing this provision(8) permit more favorable rules for eligibility or reduced premiums or contributions based on an adverse health factor (sometimes referred to as benign discrimination), in the Departments' view, cash-or-coverage arrangements offered only to employees with a high claims risk are not permissible benign discrimination. Accordingly, such arrangements will violate the
nondiscrimination provisions, regardless of whether (1) the cash payment is treated by the employer as pre-tax or post-tax to the employee, (2) the employer is involved in the selection or purchase of any individual market product, or (3) the employee obtains any individual health insurance.

Such offers fail to qualify as benign discrimination for two reasons. First, if an employer offers a choice of additional cash or enrollment in the employer's plan to a high-claims-risk employee, the opt-out offer does not reduce the amount charged to the employee with the adverse health factor. Rather, the employer's offer of cash to a high-claims-risk employee who opts out of the employer's plan effectively increases the premium or contribution the employer's plan requires the employee to pay for coverage under the plan because, unlike other similarly situated individuals, the high-claims-risk employee must accept the cost of forgoing the cash in order to elect plan coverage. For example, if the employer's group health plan requires all employees to pay $2,500 toward the cost of employee-only coverage under the plan, but the employer offers a high-claims-risk employee $10,000 in additional compensation if the employee declines the coverage, for purposes of discrimination analysis, the effective required contribution by that high-claims-risk employee for plan coverage is $12,500 - that is, the $2,500 required employee contribution for employee-only coverage under the employer's plan plus the $10,000 of additional compensation that the employee would forgo by enrolling in the plan. Because a high-claims-risk employee must effectively contribute more to participate in the group health plan, the arrangement violates the rule that a group health plan may not on the basis of a health factor require any individual (as a condition of enrollment) to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan.

Second, the Departments' regulations generally permit providing, based on an adverse health factor, enhancements to eligibility for coverage under the plan itself but not cash as an alternative to the plan. In particular, the regulations permit providing plan eligibility criteria that offer extended coverage within the plan and subsidization of the cost of coverage within the plan based on an adverse health factor.(9) An example in the Departments’ regulations illustrates that a plan may have an eligibility provision that provides coverage to disabled dependent children beyond the age at which non-disabled dependent children become ineligible for coverage.(10) Another example in the regulations illustrates that a plan may provide coverage free of charge to disabled employees, while other employees pay a participant contribution towards coverage.(11) However, in the Departments' view, providing cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the group health plan. This type of arrangement differentiates based on a health factor and is outside the scope of the Departments’ regulations on benign discrimination, which permit only discrimination that helps individuals with adverse health factors to participate in the health coverage being offered to other plan participants. The Departments intend to initiate rulemaking in the near future to clarify the scope of the benign discrimination provisions.
Finally, because the choice between taxable cash and a tax-favored qualified benefit (the election of coverage under the group health plan) is required to be a Code section 125 cafeteria plan, imposing an effective additional cost to elect coverage under the group health plan could, depending on the facts and circumstances, also result in discrimination in favor of highly compensated individuals in violation of the Code section 125 cafeteria plan nondiscrimination rules.

Q3: A vendor markets a product to employers claiming that employers can cancel their group policies, set up a Code section 105 reimbursement plan that works with health insurance brokers or agents to help employees select individual insurance policies, and allow eligible employees to access the premium tax credits for Marketplace coverage. Is this permissible?

No. The Departments have been informed that some vendors are marketing such products. However, these arrangements are problematic for several reasons. First, the arrangements described in this Q3 are themselves group health plans and, therefore, employees participating in such arrangements are ineligible for premium tax credits (or cost-sharing reductions) for Marketplace coverage. The mere fact that the employer does not get involved with an employee's individual selection or purchase of an individual health insurance policy does not prevent the arrangement from being a group health plan. DOL guidance indicates that the existence of a group health plan is based on many facts and circumstances, including the employer's involvement in the overall scheme and the absence of an unfettered right by the employee to receive the employer contributions in cash. (12)

Second, as explained in DOL Technical Release 2013-03, IRS Notice 2013-54, and the two IRS FAQs addressing employer health care arrangements referenced earlier, such arrangements are subject to the market reform provisions of the Affordable Care Act, including the PHS Act section 2711 prohibition on annual limits and the PHS Act 2713 requirement to provide certain preventive services without cost sharing. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will violate PHS Act sections 2711 and 2713, among other provisions, which can trigger penalties such as excise taxes under section 4980D of the Code.