OVERVIEW OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT:

What “Large Employer” NACS Members Need to Know About Obamacare

The Association for Convenience & Fuel Retailing

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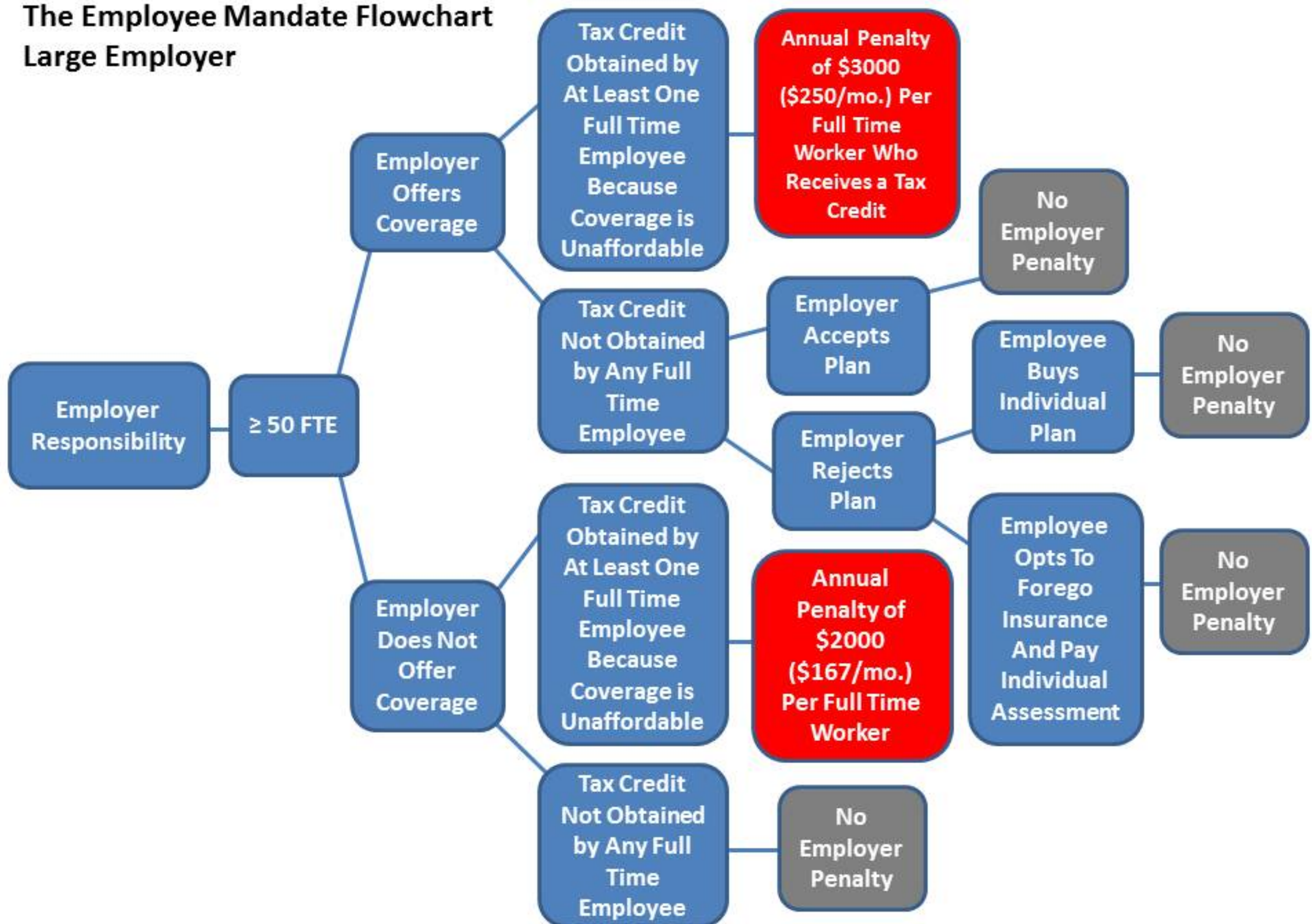
I. The Employer Mandate

Preliminary Note

In January 2013, the Obama Administration proposed rules to implement the Affordable Care Act's (also known as "Obamacare") employer mandate provisions starting January 1, 2014. On July 2, 2013, however, the Administration announced that it would delay enforcement of the employer mandate provisions until January 1, 2015 because of concerns "about the complexity of the [law's] requirements and the need for more time to implement effectively." The IRS issued final rules implementing the employer mandate provisions of Obamacare on Monday, February 10, 2014. The final rules, as a general matter, contain few changes from the proposed rules. There are, however, some key differences.

Most significantly, the final rule delays the employer mandate's effective date for businesses with between 50 and 99 full-time employees, including full-time equivalents ("FTEs") until 2016. The final rule also extends transition relief for non-calendar year plans, enabling employers with such plans to avoid mandate exposure until the first day of their plan year in 2015 (or, if the employer has between 50-99 FTEs, 2016).

Beginning January 1, 2015 employers with 100 or more full time employees that do not offer (1) "affordable" health plans that meet the law's (2) "minimum value" requirements to all of their (3) "full-time" employees (and their dependents) may be subject to a penalty if at least one of their full-time employees receives a premium tax credit for purchasing coverage on one of the new Affordable Insurance Exchanges. (These requirements will apply to employers with 50 to 99 full time employees beginning January 1, 2016.) This is the "employer mandate," and is perhaps the most important aspect of Obamacare for the convenience store industry. This section provides details on the employer mandate, but the flow chart below presents a relatively simple way for NACS members to determine the mandate's applicability to their businesses.



Note that Obamacare does not require all employers to offer coverage to their employees. It does, however, penalize "large" employers if at least one of their full-time employees receives a premium tax credit for coverage on one of the exchanges the law creates where employers (a) do not offer coverage to full-time employees and their dependents, or (b) offer coverage to full-time employees that does not meet the laws "affordability" or "minimum value" standards.

This section is organized as follows:

First, it provides an overview as to how large employers may be penalized for failing to meet the employer mandate's requirements. (Note, this document assumes that you are a large employer.) This is important because the penalty's severity will necessarily dictate the employer's decision as to whether it will "pay" (the penalty) or "play" (*i.e.*, offer coverage).

Second, it addresses how employers can determine whether an employee is "full-time." This is important because large employers are only required to offer coverage to "full-time" employees.

Third, it briefly addresses the ways in which Obamacare affects how employers treat part-time employees for purposes of health coverage.

Fourth, it discusses how employers should treat employees that change jobs, whether from part-time to full-time or vice-versa.

Fifth, it addresses how employers can determine whether the plans they offer (a) are "affordable"; (b) satisfy the "minimum essential coverage" requirements; and (c) satisfy the law's "minimum value" standard.

This is important because all offers of coverage must meet these requirements for employers to avoid penalties under the employer mandate.

Sixth**,** it addresses the law's logistics regarding *enforcement* of the employer mandate, and how employees go about obtaining coverage through an exchange.

A. What is a "full-time employee"?

Obamacare only requires large employers to provide coverage to "full-time" employees. Thus, it is important for employers to know which of their employees are full-time. A "full-time employee" is an employee that works an average of 30 or more hours in a week. Under Obamacare, 130 hours per month is treated as the monthly equivalent to 30 hours per week, so an employee who works 128 hours in a calendar month would be classified as part-time for that month. (Note that for purposes of determining whether an employer is a "large" employer, the law considers what are known as "FTEs," effectively pro-rating part-time workers. Thus, 100 half-time employees (who work an average of 15 hours per week) equal 50 full-time employees. However, even though these "FTEs" count toward determining whether an employer is "large," large employers only need to offer coverage to actual full-time employees to avoid the penalty.)

1. Determining full-time status for employees who have fluctuating hours

The IRS provides a safe harbor to allow for a measuring period for "variable hour employees." An employee is a "variable hour employee" if, "based on the facts and circumstances at the employee's start date," the applicable large employer "cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period" because the employee's hours are variable or uncertain. The safe harbor does not apply to employees who are expected to be full-time.

Before discussing the safe harbor's mechanics, it is useful to consider some important terms. It might be useful to refer back to this explanation of terms while reading about the employer mandate:

- "*Standard measurement period*" – This is a period of time for employers to measure whether *ongoing* employees are full-time, *i.e.*, work an average of 30 hours/week or 130 hours/month. A standard measurement period can be between 3 and 12 months, though most employers are expected to use a 12 month period for ease of administration.

- *Initial measurement period* – A period of time for employers to measure whether *new* employees are full-time. An initial measurement period can be between 3 and 12 months and can be different than the employer's standard measurement period.

- *Stability period* – A period of time during which employers must treat employees as full-time if the employees averaged 30 hours/week (or 130 hours/month) during the measurement period leading up to it. Conversely, employers may treat employees as not full-time if the employees do not average those hours during the measurement period. A stability period can be between 6 months and one year, and must be at least as long as the standard measurement period. For ease of administration, most employers are expected to use a 12 month stability period.

As a practical matter, we anticipate few – if any – NACS members subject to the mandate will use anything other than a 12-month measurement period followed by a corresponding 12-month stability period. The human resources and accounting logistics easily lend themselves to this type of structure and any deviations from it will likely result in significantly more administrative work to comply with the employer mandate without any offsetting benefit. Moreover, while penalties are calculated on a monthly basis, the IRS is likely to collect the amount owed on annual basis.

Safe Harbor's Mechanics – The safe harbor involves an initial "measurement period" to gauge an employee's hours, and a subsequent "stability period" during which coverage must be offered if the employee is full-time during the measurement period (and need not be offered if the employee is not full-time during the measurement period). This process then continues so long as the employee's full-time status is unclear. Thus, an employee could be full-time after *one* measurement period (and thus must be offered coverage during the associated stability period), but part-time after a *subsequent* measurement period (and thus would *not* need to be offered coverage during that measurement period's associated stability period.

Note that a stability period also operates—on a prospective basis – as a measurement period. For example, suppose an employer opts for a twelve-month measurement period and a twelve-month stability period; if after a twelve-month measurement period an employee is found to be part-time, the employer does not need to offer that employee coverage during the subsequent stability period of twelve months. But, if during that stability period the employee works an average of more than 30 hours per week, once it lapses, the stability period effectively is treated as a new measurement period, meaning the next twelve months are a new stability period during which time the employer must offer that employee coverage.

The rules provide for an optional administrative period not to exceed 90 days between the standard measurement period and the associated stability period to determine which employees are eligible for coverage, and notify and enroll them if they choose to be covered. For ongoing employees, the administrative period will overlap with the previous stability period to avoid creating any gaps in coverage. For newly hired variable hour employees, the combined length of the initial measurement period and administrative period is effectively limited to no more than 13 months. In other words, no more than13 months after a variable hour employee is hired, he or she should begin being treated as an ongoing employee for purposes of measuring full-time status. Thus, employers that utilize a twelve month stability period should be aware that they will only be permitted a 30 day administrative period (to avoid exceeding the maximum 13 months).

Importantly, safe harbor rules do not apply to those who are "reasonably expected to be a full-time employee" (*i.e.*, work 30 hours per week or 130 hours per month). If in the large employer's "reasonable, good faith" belief the employee will be full-time, the employer is obligated to offer to that employee affordable coverage that satisfies the minimum value requirement in order to avoid the penalty. If the employee accepts the offer, the coverage generally must become effective within 90 days in order to comply with a separate, related rule governing permissible waiting periods before coverage must begin.

The employer mandate provides employers the option of measuring whether certain employees are full-time over a period of three to 12 months in exchange for a stability period of coverage. The final rules provide for transitional measurement periods for stability periods that begin in 2015. Thus, large employers who intend to utilize the look-back measurement method for determining full-time status for 2015 will need to begin their measurement periods in 2014 to have corresponding stability periods beginning in 2015. The final rule permits such employers, on a one-time basis, in 2014 preparing for 2015, to use a measurement period of six months even with respect to a stability period of up to 12 months.

The final rules also provide a second option for determining full-time status: the monthly measurement method. Under the monthly measurement method, employees are treated as full-time if they actually work full-time during a particular month. That is, 130 hours for a month, or alternatively, 120 hours for a four-week period or 150 hours for a five-week period.

In addition, the final rules allow employers with non-calendar year plans to begin compliance with the employer mandate at the start of their plan years in 2015, rather than on January 1, 2015, provided that the employer maintained a non-calendar year plan as of December 27, 2012, and the plan year was not modified after that date to begin at a later date. (This transition relief permits otherwise eligible employers with 50 to 99 employees to begin compliance at the start of their plan years in 2016.) The following three options for transition relief, each with their own prerequisites, will be available for such employers:

- Pre-2015 Eligibility – Transition relief is available with respect to employees who would be eligible for coverage effective beginning on the first day of the 2015 plan year under the eligibility terms of the plan as in effect on February 9, 2014.

- Significant Percentage (1/4, 1/3 Test) (all employees) – The final rule extends the proposed rule's transition relief from the mandate requirements until the first day of the plan year in 2015, provided the employer had: (1) as of any date in the 12 months ending on February 9, 2014, at least one quarter of its employees covered under those non-calendar year plans, or (2) offered coverage under those plans to one third or more of its employees during the open enrollment period that ended most recently before February 9, 2014.

- Significant Percentage Test (1/3, 1/2 Test) (Full-Time Employees) – Because the transition relief described in the preceding bullet applies based on the total number of employees (including part-time), the final rules contains additional transition relief accounting only for full-time employees that was not in the proposed rules. Under this relief, employers with non-calendar year plans will not be subject to the mandate requirements if they: (1) had, as of any date in the 12 months ending on February 9, 2014, at least one third of their full-time employees covered under those non-calendar year plans, or (2) offered coverage under those plans to one half or more of its full-time employees during the open-enrollment period that ended most recently before February 9, 2014.

a. The role of the safe harbor during the stability period

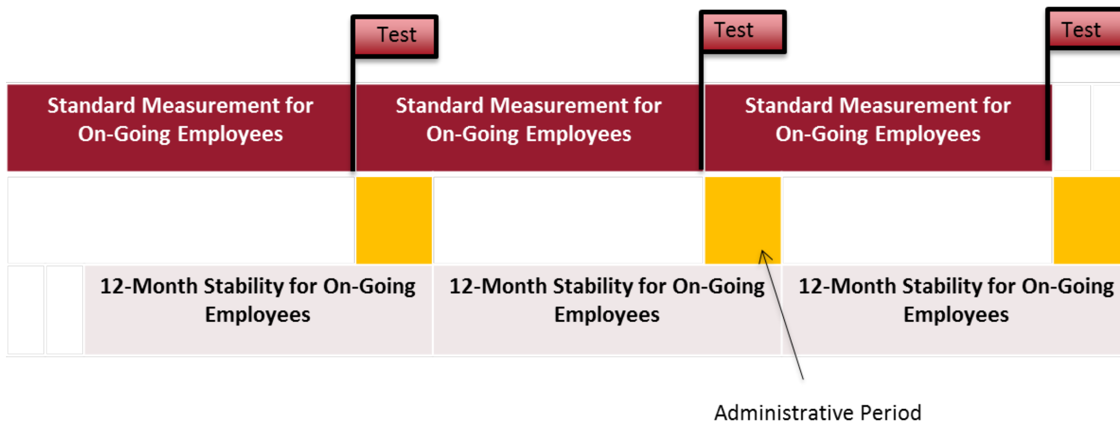
The status of the employee as ongoing or newly hired is the key.

(1) Ongoing Employees and the safe harbor

For ongoing employees, employers can choose a standard measurement period of 3-12 months. After the standard measurement period, employees determined to be full-time would be eligible for coverage during an associated stability period that must be equal to or greater than the standard measurement period, but cannot be less than six months. Employees determined to be part-time, however, may be treated as part-time during an associated stability period. For these employees, the stability period may not exceed the length of the standard measurement period. (However, this latter restriction is of little practical significance because most employers will utilize a twelve-month measurement period and a twelve-month stability period.)

Employers may use measurement periods and stability periods that differ either in length or in their starting and ending dates only for the following categories of employees:

- Collectively bargained employees and non-collectively bargained employees;
- Salaried employees and hourly employees;
- Employees of different entities; and
- Employees located in different states.



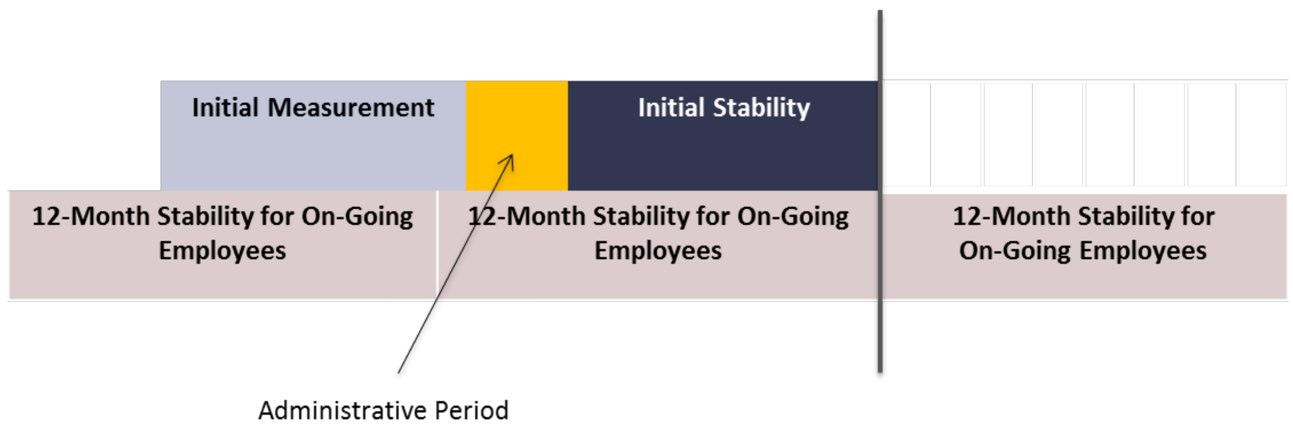
(2) Newly Hired Employees and the safe harbor

The rules become somewhat complex for newly hired employees whose full-time status is unclear. Chances are these employees will not begin work at the beginning of the standard measurement period for ongoing employees; thus, the rules allow an employer to utilize a different, "initial" measurement period of up to one year. Employers need not offer coverage until it is determined whether that employee qualifies

as full-time at the end of that measurement period. The associated stability period for newly hired variable hour employees must be the same length as the stability period for ongoing employees.

If a newly hired employee is determined to be full-time during the initial measurement period, his employer must offer him coverage during the associated stability period to avoid a penalty. If a newly hired employee is determined to be part-time during the initial measurement period, he may be treated as such during an associated stability period. This stability period cannot exceed the length of the initial measurement period by more than one month.

At some point during the initial measurement period, the employer's standard measurement period for ongoing employees will begin. The new employee must be tested at the conclusion of this standard measurement period (in addition to after the initial measurement period). Once a new employee has been employed for an initial measurement period and an entire standard measurement period, the employee must be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees. Therefore, because the stability period for the new employee is unlikely to synchronize with the standard measurement period for ongoing employees, it cannot exceed the remainder of the standard measurement period.



(3) Examples

Example 1

(i) Facts. For new variable hour employees, Employer B uses a 12-month initial measurement period that begins on the start date. Employer B applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the initial measurement period ends. Employer B hires Employee Y on May 10, 2015. Employee Y's initial measurement period runs from May 10, 2015, through May 9, 2016. Employee Y has an average of 30 hours of service per week during this initial measurement period. Employer B offers coverage to Employee Y for a stability period that runs from July 1, 2016 through June 30, 2017.

(ii) Conclusion. Employee Y has an average of 30 hours of service per week during his initial measurement period and Employer B uses an initial measurement period that does not exceed 12 months; an administrative period totaling not more than 90 days; and a combined initial measurement period and administrative period that does not last beyond the final day of the first calendar month beginning on or

after the one-year anniversary of Employee Y's start date. Accordingly, from Employee Y's start date through June 30, 2017, Employer B is not subject to any payment under the employer mandate with respect to Employee Y, because Employer B complies with the standards for the initial measurement period and stability periods for a new variable hour employee. Employer B must test Employee Y again based on the period from October 15, 2015 through October 14, 2016 (Employer B's first standard measurement period that begins after Employee Y's start date).

Example 2 (Continuous Full-Time Employee)

(i) Facts. Same as Example 1; in addition, though, Employer B tests Employee Y again based on Employee Y's hours of service from October 15, 2015 through October 14, 2016 (Employer B's first standard measurement period that begins after Employee Y's start date), determines that Employee Y has an average of 30 hours of service a week during that period, and offers Employee Y coverage for July 1, 2017 through December 31, 2017. (Employee Y already has an offer of coverage for the period of January 1, 2017 through June 30, 2017 because that period is covered by the initial stability period following the initial measurement period, during which Employee Y was determined to be a full-time employee.)

(ii) Conclusion. Employer B is not subject to any payment under the employer mandate for 2017 with respect to Employee Y.

Example 3 (Initially Full-Time Employee, Becomes Non-Full-Time Employee)

(i) Facts. Same as Example 1; in addition, Employer B tests Employee Y again based on Employee Y's hours of service from October 15, 2015 through October 14, 2016 (Employer B's first standard measurement period that begins after Employee Y's start date), and determines that Employee Y has an average of 28 hours of service a week during that period. Employer B continues to offer coverage to Employee Y through June 30, 2017 (the end of the stability period based on the initial measurement period during which Employee Y was determined to be a full-time employee), but does not offer coverage to Employee Y for the period of July 1, 2017 through December 31, 2017.

(ii) Conclusion. Employer B is not subject to any payment under the employer mandate for 2016 with respect to Employee Y, provided that it offers coverage to Employee Y from July 1, 2016 through June 30, 2017 (the entire stability period associated with the initial measurement period).

B. How does Obamacare impact how employers treat part-time employees?

Obamacare does not require employers to offer coverage to part-time employees (those that work less than 30 hours per week or 130 hours per month). For those employers that choose to offer coverage to part-time employees, the maximum 90-day waiting period prior to coverage applies. Other conditions for eligibility under the plan are permissible as long as the conditions do not avoid compliance with the 90-day waiting period. For example, employers may utilize a cumulative hours of service requirement of no more than 1,200 hours for part-time employees before the maximum 90-day waiting period applies. Also, employers should be aware that certain insurance market reforms apply, such as free preventive care, and no annual lifetime limits on Essential Health Benefits, may apply as well. *See* Section II, Market Reforms.

C. Do I treat variable hour employees that change jobs based on new or old job status?

How employers treat them will depend on whether the employee: (a) is newly hired or ongoing, and (b) is moving from full-time to part-time, or part-time to full-time.

Newly hired variable hour employees → Full-time employees – When these employees experience a "material change" in job status (such as a transfer or promotion) during the initial measurement period such that they are now expected to be full-time, they must be offered coverage on the first of:

- The first day of the fourth month following the change in status; or
- The first day following the end of the initial measurement period if the employee averaged 30 hours per week during such period.

Example 4 (Change in employment from new variable hour employee to non-variable hour employee).

(i) Facts. For new variable hour employees, Employer A uses a 12-month initial measurement period that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the initial measurement period ends. Employer A hires Employee Z on May 10, 2015. Employer A's initial measurement period runs from May 10, 2015, through May 9, 2016, with the optional administrative period ending June 30, 2016. At Employee Z's May 10, 2015 start date, Employee Z is a variable hour employee. On September 15, 2015, Employer A promotes Employee Z to a position that can be expected to average at least 30 hours of service per week.

(ii) Conclusion. For purposes of determining Employer A's potential liability under the employer mandate, Employee Z must be treated as a full-time employee as of January 1, 2016, because that date is the earlier of the first day of the fourth calendar month following the change in position (January 1, 2016) or the first day of the calendar month after the end of the initial measurement period plus the optional administrative period (July 1, 2016).

Ongoing variable hour employees → Full-time employees – If the employee was considered part-time, the employer may continue to treat the employee as part-time for the remainder of that stability period. Once that stability period closes, the employer is required to offer coverage to the employee because the employer knows that the employee will be full-time. If the employee was considered full-time, the employee must continue its offer of coverage once the stability period ends.

Ongoing full-time employees → variable-hour employees – The employer must continue to treat the employee as full-time for the remainder of the stability period. At that point, the employee's hours during the previous standard measurement period will dictate how he is treated for the associated stability period.

Example 5 (Change in employment from ongoing full-time employee to ongoing part-time employee).

(i) Facts. Employer W chooses to use a 12-month stability period that begins January 1 and a 12-month standard measurement period that begins October 15. Consistent with the terms of Employer W's group health plan, only employees classified as full-time employees using the look-back measurement method are eligible for coverage. Employer W chooses to use an administrative period between the end of the standard measurement period (October 14) and the beginning of the stability period (January 1). Employee B has been employed by Employer W for several years, continuously from his start date. Employee B was employed on average 30 hours of service per week during the standard measurement period that begins

October 15, 2014 and ends October 14, 2015 and for all prior standard measurement periods. By contrast, Employee B also was not employed on average 30 hours of service per week for the standard measurement period that begins October 15, 2015 and ends October 14, 2016.

(ii) Conclusion. Because Employee B did not work full-time during the 2015-2016 standard measurement period, Employee B is not required to be offered coverage for the stability period in 2017 (including the administrative period from October 15, 2017 through December 31, 2017). However, because Employee B was employed on average 30 hours of service per week during the prior standard measurement period in 2014-2015, Employee B is offered coverage through the end of the 2016 stability period and, if enrolled, would continue such coverage during the administrative period from October 15, 2016 through December 31, 2016.

Newly hired full-time employees → variable-hour employees – Unfortunately, there is no clear guidance on this specific scenario. From a practical perspective, though, if the transition occurs within the first 90 days of hire, employers can treat the employee as a variable hour employee from day 1; if the transition occurs after that initial 90 day period, employers may want consider allowing that individual to stay on the plan (if they want to) until the first standard measurement period is complete unless the belief is that this is going to impact a lot of individuals. If it truly is the aberrational case (as it is likely to be) – there is no regulatory issue with allowing such an individual to continue to be enrolled until they can be appropriately measured.

D. How do I treat employees that have been terminated and re-hired?

IRS regulations provide that an employee who resumes working for an employer after a period during which the employee was not credited with any hours of services may be treated as having terminated employment and having been rehired (and thus be treated as a new employee upon resumption of employment) if the employee did not have an hour of service for a period of at least thirteen consecutive weeks. Notably, the final rule retains the "rule of parity," under which an employee may be treated as rehired after a shorter period of at least four consecutive weeks during which no hours of services were credited if that period exceeded the number of weeks of that the employee had worked for the employer.

E. If I am a large employer, how do I know that health plans I offer provide "affordable" coverage that satisfies "minimum value" requirements so I avoid the penalty?

As a general matter, large employers will face a penalty if an employee receives a tax credit for Exchange coverage because the employer-offered coverage (a) is unaffordable or (b) fails to provide minimum value (that is, the coverage must bear at least 60% of the total allowed cost of benefits the plan provides (including employee premiums)). Such a tax credit is only available to individuals whose family income falls below 400% of the Federal Poverty Level ("FPL"). (Thus, if none of a large employer's employees earn below 400% of FPL, that employer cannot be penalized under the employer mandate.) If an employee is enrolled in an eligible employer-sponsored plan, regardless of the cost or value of that plan, such employee will be ineligible for a premium tax credit. Similarly, Medicaid-eligible employees will not be eligible for tax credits; therefore, employers will not face taxes for those employees. While the U.S. Supreme Court struck down the PPACA provisions requiring states to expand Medicaid, states still have the option to expand Medicaid eligibility to 133% of the FPL. The result is that employers in states that expand Medicaid face reduced penalty exposure because more people will be Medicaid-eligible and thus ineligible for tax credits.

1. *Affordability*

As a general rule, an employee's share of the self-only premium for the employer's lowest-cost plan (that provides minimum value) cannot exceed 9.5% of household income. If the employee's share exceeds this amount, the employee may be eligible for a premium tax credit to purchase Exchange coverage (thereby subjecting the employer to penalties). In making this "affordability" calculation, the rules allow an employer to use one of three tests:

- A contemporaneous W-2 safe harbor test under which the affordability of coverage is assessed at the end of the calendar year and may not be based on prior-years' income;
- A "rate of pay" test under which affordability is measured by taking an amount equal to 130 hours multiplied by an employee's rate of pay (for hourly employees) or monthly salary (for salaried employees); or,
- A "federal poverty line" test under which the coverage must not exceed 9.5 percent of the monthly income at 100 percent of the federal poverty line for individuals.

Importantly, an employer needs only to make an "affordable" offer of coverage for that individual's own coverage (rather than affordably covering the individual's dependents, although *offers* of coverage must be made to dependents as well). This is significant because it means employers need not subsidize dependent-care coverage at all (although they must still offer it). Many employers are expected to shift much if not all of their subsidization onto the individual employee's coverage. The requirement that employers offer coverage to their full-time employees' dependents will not apply in 2015 unless an employer offered dependent coverage in either the plan year that began in 2013 or 2014 and subsequently dropped the offer of coverage. (Spouses, step-children, and foster children are not "dependents" for purposes of the mandate's offer of coverage requirement and need not be offered coverage at all.)

2. *Minimum Value*

To satisfy the minimum value requirement, an employer-sponsored plan must bear at least 60% of the total allowed cost of benefits the plan provides (including employee premiums). Essentially, this means that in order to provide minimum value, the plan cannot require the employee to pay more than 40% of the total predicted costs through non-premium payments such as co-pays, deductibles, or similar out-of-pocket costs. The final rule states that employers will be able to determine whether a plan meets this "minimum value" standard by using a so-called MV calculator, which the IRS has released. This calculator will rely on continuance tables and a standard population reflecting claims data of self-insured employer plans. Employers may also determine whether a plan meets the minimum value standard by using an array of design-based safe harbors the administration will publish in the form of a checklist. Importantly, HHS rules allow employer contributions to a health savings account to be taken into account in determining minimum value.

a. *Examples*

Example 1 (Form W-2 Safe Harbor):

(i) Facts. Employee 1 is employed by Employer C consistently from January 1, 2015 through December 31, 2015. Employer C offers Employee 1 and her dependents minimum essential coverage during that period that meets the minimum value requirements. The employee contribution for self-only coverage is $100 per calendar month, or $1,200 per calendar year. For 2015, Employee 1's Form W-2 wages with respect to employment with Employer C are $24,000.

(ii) Conclusion. Employee 1's contribution for self-only coverage to Employer C's plan is less than 9.5% of Employee 1's Form W-2 wages for 2015 ($1,200 is 5% of $24,000). Consequently, the coverage is treated as affordable with respect to Employee 1 for 2015. Employer C would not be subject to a penalty under the employer mandate with respect to employee 1 because Employer C's plan meets the minimum value requirements and is affordable to Employee 1.

Example 2 (Rate of Pay Safe Harbor):

(i) Facts. Employee 2 is employed by Employer X consistently from January 1, 2015, through December 31, 2015. Employer X offers Employee 2 and his dependents minimum essential coverage during that period that meets the minimum value requirements. The employee contribution for self-only coverage is $85 per calendar month. Employee 2 is paid at a rate of $7.25 per hour (the minimum wage in Employer X's jurisdiction) for the entire year 2015. For purpose of the affordability safe harbor, Employer X assumes that Employee 2 earned $942.50 per calendar month (130 hours of service multiplied by $7.25 per hour). Accordingly, affordability is determined by comparing the assumed income per month ($942.50) to the employee contribution per month ($85).

(ii) Conclusion. Employee 2's contribution for self-only coverage to Employer X's plan is less than 9.5% of Employee 2's assumed income Form W-2 wages for 2015 ($85 is 9.01% of $942.40). Consequently, the coverage is treated as affordable with respect to Employee 2 for 2015. Employer X would not be subject to a penalty under the employer mandate with respect to Employee 2 because Employer X's plan meets the minimum value requirements and is affordable to Employee 2.

Example 3 (Federal Poverty Line Safe Harbor):

(i) Facts. Employee 3 is employed by Employer J from January 1, 2015 through December 31, 2015. Employer J offers Employee 3 and his dependents minimum essential coverage during that period that meets the minimum value requirements. Employer J uses the look-back measurement method. Under that method as applied by Employer J, Employee 3 is treated as a fulltime employee for the entire calendar year 2015. Employee 3 is regularly credited with 35 hours of service per week but is credited with only 20 hours of service during the month of March, 2015 and only 15 hours of service during the month of August, 2015. Assume for this purpose that the Federal poverty line for 2015 for an individual is $11,170. With respect to Employee 3, Employer J determines the monthly employee contribution for employee single-only coverage for each calendar month of 2015 as an amount equal to 9.5% multiplied by $11,170, which is $1,061.15, and that amount is then divided by 12, and the result is $88.43.

(ii) Conclusion. Regardless of Employee 3's actual wages for any calendar month, including the months of March, 2015 and August, 2015 when Employee 3 has lower wages because of significantly lower hours of service, the coverage under the plan is treated as affordable with respect to Employee 3.

F. *How will the government enforce the employer mandate?*

Obamacare imposes a number of reporting obligations on employers to enable the IRS to enforce the employer mandate. At a high level, the entire process can be summarized in six steps:

- First, the employer provides employees with information about coverage and the availability of exchanges;
- Second, the employee provides the Exchange with information to determine eligibility for the premium tax credit;
- Third, the Exchange verifies information and makes a preliminary eligibility determination regarding the premium tax credit;
- Fourth, the Exchange notifies the employer that the employee may receive a premium tax credit. The employer has a right at this time to appeal the Exchange's determination of the employee's eligibility;
- Fifth, the employer files information with the IRS and the employee, and the employee files his personal tax return;
- Sixth, the IRS assesses employer tax penalties as applicable, and the employer has a right to appeal tax liability to the IRS.

1. *<u>Process for employees to obtain credits or subsidies for Exchange coverage</u>*

Because employers may receive requests for information from employees who apply for tax credits for exchange coverage, it will be helpful for employers to be moderately familiar with the workings of the Exchanges and Obamacare's requirements for individuals to maintain minimum essential coverage.

Employed individuals who seek credits or subsidies for Exchange coverage because they are (a) ineligible for employer-sponsored coverage or (b) assert that employer-sponsored coverage is unaffordable or is not of minimum value, must provide the government certain information. For example, the employee must provide detailed identification information about their employer; full-time/part-time status; and whether their employer provides minimum essential coverage. If the employee claims he cannot afford an employer's coverage, he must verify his tax filing status and gross income.

Obamacare further requires Exchanges to inform employers when an employee is eligible for a credit or subsidy. Exchanges will also notify employers if the employers might be liable for tax penalties. The inaugural open enrollment in state-based exchanges ran from October 1, 2013 through March 31, 2014. For coverage starting in 2015, the proposed open enrollment period is November 15, 2014 through February 15, 2015. In subsequent years, open enrollment will run from October 15 through December 7.

G. *<u>Penalties for violating the Employer Mandate</u>*

Any penalties depend on which aspect of the Employer Mandate is violated, and the extent of the violation. However, before discussing these variations, it is important to note that penalties are triggered only if an employee receives a subsidy for purchasing health coverage through an Exchange. Therefore, it is

important to understand how employees may be eligible for such a subsidy. The following conditions must be met:

- The employee's family income falls below 400% of the Federal Poverty Level (For the 48 contiguous states and DC, the 2013 FPL is $23,550 for a family of four and $11,490 for an individual (Alaska and Hawaii are slightly higher).);
    - Note that even though a full-time employee may not be entitled to a subsidy, the employee is still entitled to an *offer* of coverage from the employer. Without such an offer, the employer could face a penalty if the employee's *household* income (rather than individual income) entitles the employee to a subsidy (*i.e.*, the W-2 affordability safe harbor would not apply).
- The employee's employer did not offer him an affordable health plan that satisfies the law's minimum value standard; and
- The employee is not eligible for Medicaid.

If at least one full-time employee satisfies these conditions, a large employer may be vulnerable to a penalty under the employer mandate. That penalty will depend upon which aspect of the employer mandate is violated and the extent of the violation. As a general matter, the proposed regulation implementing the penalty draws a bright line between employers who offer adequate coverage to ≥ 95% of their employees, and employers who offer adequate coverage to <95% of employees. The penalties are exceedingly larger for those who do not meet that 95% threshold.

NOTE: For 2015 only, the 95% threshold is lowered to 70%.

1. Failure to offer affordable coverage that meets the minimum value standard to full-time employees

If a large employer does not offer affordable coverage to *any* of its full-time employees, the employer is liable for a penalty equal to $2,000 per year multiplied by all of its full-time employees (less thirty employees pursuant to a statutory exemption) once *any* full-time employee receives a subsidy for purchasing coverage from an exchange.

If a large employer makes affordable offers of coverage to some but not all of its full-time employees, the penalty depends upon how many full-time employees were offered coverage:

- If an employer does not make an affordable offer of coverage to at least 95% (70% in 2015 only) of its eligible full-time employees, then it will be subject to a $2,000 per year penalty multiplied by *all of its full-time employees* (less thirty). In other words, employers who do not offer affordable coverage that meets the minimum value standard to at least 95% of their employees will be penalized as though it did not offer coverage to *any* employees. This is generally known as the "A" penalty.
- If an employer offers coverage to at least 95% (70% in 2015 only) of its eligible full-time employees, it will be subject to a $3,000 per year penalty for each full-time employee *that*

did not receive a coverage offer that is affordable and provides minimum value and receives a premium credit when enrolling in a plan through an exchange. This is known generally as the "B" penalty. (Note, this penalty cannot be greater than what the employer would pay under the "A" penalty.)

2. *Dividing a company into several different companies to avoid being penalized under the employer mandate*

For purposes of the employer mandate, the so-called "controlled business rule" (promulgated by the IRS) applies in terms of deciding whether a group of companies are considered separate entities or a single entity. Generally, the IRS rules say that if companies are under common control, they will be considered a single entity. So if the different businesses have separate tax identification numbers but are under common control, expect them to be treated as a single employer for employer mandate purposes. (Note that the controlled business rule's nuances are complex. NACS members are advised to seek professional counsel to determine how it might apply to their companies.)

However, even if they cannot avoid being labeled a "large employer," a business might consider forming several companies in order to mitigate penalties. This is because in calculating the penalty, each commonly owned/controlled employer within a corporate group (known as a "control group") pays its own penalties (and is not consolidated with the other members of the group in making those assessments). But, each individual employer within that control group only gets the benefit of its pro rata share of the 30 employee mandate penalty exemption referenced above.

a. *Example*

(i) Facts. Corporation A owns 100% of Corporation B. Corporation A employs 40 full-time employees in each calendar month of 2016. Corporation B employs 35 full-time employees in each calendar month of 2016. For 2016, the excise tax for a calendar month is $2,000 divided by 12. Corporation A does not sponsor an employer-sponsored plan for any calendar month of 2016, and receives a certification that at least one of its full-time employees has acquired health care coverage on an Exchange with the benefit of a premium tax credit. Corporation B sponsors an eligible employer-sponsored plan under which all full-time employees are eligible for minimum essential coverage that is affordable and meets the minimum value standard.

(ii) Conclusion. Corporation A and B are members of a controlled group that employs 50 or more full-time employees and, therefore, are large employers subject to the employer mandate. However, the tax liability is applied separately. Corporation A is subject to a tax for 2016 equal to $48,000, which is equal to 24 x $2,000 (40 full-time employees reduced by 16 – its allocable share of the 30-employee offset ((40/75 x 30 = 16)) and then multiplied by $2,000. Corporation B is not subject to any tax under the employer mandate for 2016.

II. Market Reforms

Obamacare contains a number of insurance market reforms applicable to all plans employers offer. Obligations can vary based on whether the plan is a "grandfathered" or "non-grandfathered" plan.

A. *What is a "Grandfathered Plan?"*

Obamacare provides that group health plans and health insurance coverage in existence as of March 23, 2010 are exempt from some of the law's market reform provisions. It is important for all employers to determine whether or not the plan(s) they offer employees are grandfathered in order to ensure compliance with the law.

1. *What exactly can a "Grandfathered Plan" do and not do in order to stay a "Grandfathered Plan"?*

Grandfathered plans CANNOT:

- Eliminate all benefits to diagnose or treat a particular condition;
- Increase % co-insurance charges;
- Co-pays, fixed amount cost-sharing cannot be "significantly" (med. infl. + 15%);
- "Significantly" (> 5%) reduce their employer contribution rate;
- Implement new or decreased annual limits;
- Change carriers (for insured plans);
- Switch employee's plans or undertake corporate mergers or sale to avoid compliance

Grandfathered plans CAN (pending future final rules):

- Change premiums;
- Make structural adjustments;
- Change provider networks;
- Change the prescription drug formulary;
- Add new employees, enrollees, and dependents to the plan; and
- Make "normal adjustments" to comply with Obamacare or other applicable state laws

B. *Are there any other obligations applicable to employer plans?*

Yes. The following new plan obligations apply to all employer plans:

- New summary disclosure rules governing the summary of benefits and coverage;
- For insured plans, non-discrimination in favor of highly compensated employees. (This requirement does not apply to the few "grandfathered" plans currently in the market;
- No lifetime coverage limits for "essential health benefits";
- No annual coverage limits on "essential health benefits";
- No pre-existing condition exclusions;
- A ban on policy rescissions (except in cases of fraud);
- Extension of dependent coverage until the dependent turns 26 years old; and
- A bar on imposing waiting periods on plan participation in excess of 90 days.

Non-grandfathered plans are subject to mandatory compliance with the following ten new requirements imposed on new plans under Obamacare:

- Mandated offering of free preventative services;
- Out-of-pocket limitations (equal to the out-of-pocket limits for high deductible health plans for Health Savings Accounts);
- Primary care physician designation right for plan participants;
- Clinical trial participation right;
- Mandatory appeals process rights/notice;
- Premium increase reviews (does not apply to self-insured plans);
- Plan quality reporting obligation to enrollees/HHS;
- A ban on discrimination in favor of highly compensated employees (applies to insured plans only and is not effective until rules are issued);
- All non-grandfathered small group (<100) and individual plans also must comply with the following two new requirements:
    - Provide an "essential health benefits" package and 60% minimum plan value, and
    - "Community Rating" – Issuers may use only the following variances in formulating rates:

- whether the coverage is for an individual or a family;
- whether the geographic rating area established by the state meets the standard under the rule, meaning there is either one rating area for the entire state or there are no more than seven total rating areas based on counties, zip codes, or metropolitan areas in a state;
- age: a prescribed rate variance of not more than 3:1 for like individuals of different age who are aged 21 years and older, and any variation must be actuarially justified for individuals under age 21. The age bands are: a single uniform age band for children (0-20 years old); one-year age bands for adults 21-63 years old; and a single age band for older adults (64 years and older); and
- tobacco use: a rate variance of 1.5:1 for like individuals.

States are permitted to impose narrower ratios for age and tobacco than those stated above. HHS believes the community rating will promote the transparency, predictability, and accuracy of risk adjustment because the risk adjustment methodology would account for rating as it is applied by issuers.

C. What are "Essential Health Benefits"?

Under Obamacare, issuers offering coverage in the individual and small group markets must ensure that coverage includes statutorily defined essential health benefit ("EHB") items and services. Importantly, large group plans (≥100, though most states have lowered that number to as little as 50 for plan years that start prior to 2016) and grandfathered plans are not required to cover the ten EHB categories. (Such plans may not, however, impose lifetime or annual limits on any EHB they do offer.)

Beginning in 2014, plans offered in individual and small group markets must cover essential health benefits as determined by each state in accordance with rules issued by the Department of Health and Human Services. HHS required that states select a benchmark plan from the following four options:

1. The largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. Any of the largest three State employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employee Health Benefits Program plan options by enrollment; or
4. The largest insured commercial non-Medicaid Health Maintenance Organization ("HMO") operate in the state.

For states that have not made a selection, HHS selected the largest small-group product in the state as the default benchmark.

III. Reporting and Notice Obligations

Under Obamacare, employers face a host of new reporting requirements to (1) demonstrate the value of coverage offered to employees, (2) communicate to employees their coverage options, and (3) certify compliance with employer coverage provisions. Below is a general overview of these obligations.

- W-2s – Health Insurance Value (≥250 employees)
  - Under PPACA, employers with 250 or more employees must submit a W-2 health insurance value report to the IRS. This was optional for the 2011 tax year, but became mandatory starting with tax year 2012 W-2 forms (i.e., the ones that are provided to employees in January 2013. Small employers remain exempt (ones that file fewer than 250 W-2s in the preceding calendar year) until further notice from the IRS.
- Employees and New Hires – Exchange and Subsidies Notice
  - Obamacare amended the Fair Labor Standards Act ("FLSA") to require employers to inform employees of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance. It also requires employers to inform employees that employees might be eligible for premium assistance tax credits and cost-sharing subsidies for exchange coverage if the employer plan covers less than 60% of the total allowed costs of benefits (*i.e.*, does provide "minimum value"). The notice also must inform employees that if they purchase Exchange coverage, they may lose the employer contribution (if any) to any health benefits plan the employer offers and that all or a portion of such contribution may be excludable from income for federal tax purposes.
  - Employers are required to provide the notice to current employees by 10/1/2013. For new hires on or after 10/1/2013, employers have 14 days from the hire date to provide the notice. Employers are only required to provide the notice to employees—not to dependents or any other individuals that may be eligible for coverage. In addition, notice must be provided regardless of full-time or part-time status, and regardless of plan enrollment status.
- Comprehensive Information Regarding Coverage Provided and Who Is Covered (2014)
  - Beginning in tax year 2014, large employers with 250 or more employees will be required to report to the IRS information about the coverage they offer to full-time employees. Self-insured employers beginning in tax year 2014 will also be required to provide the IRS information about employees' enrollment in health insurance coverage.
- Cadillac Taxes – Report Amounts To Carriers & HHS (2018)
  - Employers with self-insured plans will have to pay an excise tax of 40% on any "excess benefits" provided to employees. The tax is triggered when the excess benefits for self-only or family coverage exceed the cost of coverage that the employer would charge for the same coverage under COBRA.
- Self-insured employers must also comply with the following notice obligations:

- Notice of summary of benefits and coverage ("SBC") to employees that provides a basic outline of the employee's coverage.

- 60-Day advance notice to employees of any material plan changes not reflected in the most recently provided SBC and not in connection with coverage renewal.

- Notice to employees of the plan's appeals process and contact information for their state's consumer assistance office. This requirement does not apply to grandfathered plans, however.

- Notice to HHS and employees about quality of care measures and wellness programs used by the plan. This requirement does not apply to grandfathered plans, however.

- Data privacy compliance certification to HHS (two times: in 2013 and in 2015).

- IRS regulations implementing 26 USC § 6055 and 6056 require all large employers and most entities that provide minimum essential coverage – including self-insured group plans – to report annually to the IRS and to covered individuals certain information regarding that coverage.

  Information reporting to the IRS is intended to facilitate administration of the employer mandate, individual mandate, and premium assistance tax credits under the ACA. As a general matter, large employers must file a return with the IRS and provide a statement to each full-time employee with information regarding the offer of employer-sponsored health care coverage. Large employers generally must begin collecting information on January 1, 2015, to report to employees and the IRS beginning in January 2016. The final 6055 and 6056 regulations exempt from the reporting requirements employers with between 50 and 99 FTEs for calendar year 2015, consistent with the one-year delay in employer mandate obligations for such employers.

IV. Exchanges

A health insurance exchange is a government-regulated insurance marketplace akin to an on-line health insurance mall. The exchanges are intended to offer a menu of standardized health care plans for individuals to choose from and, depending on different factors, the individual may be eligible for subsidies to help pay for their exchange coverage. Exchanges in Obamacare fall into several categories:

- Federally-facilitated exchange ("FFE");
- State-based exchange; or
- Federal-State partnership exchange.

A. What are the differences between these exchanges?

In an FFE, the federal government assumes all control for implementing and running the exchange in a particular state. This occurs when a state has not met requisite deadlines for establishing its own exchange. HHS has allowed several states that defaulted to an FFE, however, to retain authority for certain plan management functions, including the ability to review and approve qualified health plans sold in the exchange.

In a state-based exchange, the state retains all authority for running its own exchange. With Federal-State partnership exchanges, the federal government ultimately will be responsible for exchange implementation and operations, but states will have the option of managing certain limited functions. HHS, as the party responsible for exchange implementation, will hopefully provide as much flexibility as possible; however, HHS will need to ratify "inherently governmental" decisions made by the state partner.

B. Do the exchanges have any features designed specifically for small businesses?

Obamacare requires states to set up a Small Business Health Options Program, more commonly referred to as a "SHOP" Exchange. The SHOP Exchange is designed to assist small employers (≤100 for purposes of the SHOP Exchanges, but the exact number may vary in each state) in facilitating coverage in their respective state's small group health insurance market. (Note, that in the context of determining whether an employer is subject to the employer mandate, small employers are defined as those with less than 50 employees.)

The type of exchange each state selects will dictate the contours of how each SHOP Exchange will operate.

- State Exchanges
    - For 2014, the HHS rules require a state exchange to allow employers to offer:
        - all plans at the selected level; or
        - any other selection method, including a single plan at the level of coverage the employer selects.

- Beginning January 1, 2015, state exchanges must allow employers to offer all plans at a given level, and may allow (or not allow) employers to offer only one plan at a given level. NOTE: HHS has given state exchanges the option of requesting a one-year delay of the requirement to allow employers to offer all plans at a given level.

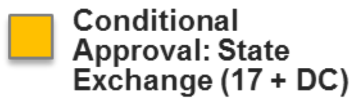
- States may also elect to maintain responsibility for their SHOP exchange while the federal government simultaneously maintains overall responsibility for that state's individual market exchange. This is often referred to as a "SHOP-only" exchange.

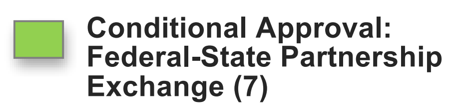
- Federally-Facilitated SHOPS
    - For 2014, FF-SHOPs must limit employers' options to offering a single plan at a given level.
    - Beginning January 1, 2015, FF-SHOPs must allow employers to select:
        - a metal level and allow their employees to select any health plan offered on the exchange at that level; or
        - a single health plan at a given level for its employees.

C. How can I determine which state has implemented which type of exchange?

The following exchange implementation map details each state's current exchange selection. Currently, about half of the fifty states have defaulted to an FFE. Unsurprisingly, most of these states have Republican governors that have staunchly opposed Obamacare and its implementation. Another seven states have received conditional approval to run a state-partnership exchange. The remaining states either have operational state-based exchanges or have received conditional approval from HHS to do so.

Federally-Facilitated Exchange (26)


Conditional Approval: State Exchange (17 + DC)


Conditional Approval: Federal-State Partnership Exchange (7)

V. Wellness

Wellness programs present an opportunity for employers to save money on health coverage costs. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") generally prohibits group health plans from charging employees different premiums based on their health status. However, it allows employers to establish such discounts and financial incentives if the employer only offers the incentives to employees who participate in wellness programs. Obamacare further encourages employer wellness initiatives in a number of ways. For example, it increases the permissible reward employers can offer employees from 20% of coverage costs to 30%. Further, if the wellness program is designed to reduce or prevent tobacco use, this number can jump to 50%. Note that the wellness rules can operate as a carrot or a stick, in that employers can both *reward* employees for more positive health choices, and *punish* (via higher costs) employees for less positive health choices.

A. What types of wellness programs can I offer?

Wellness programs are divided into two general categories: Participatory programs and health factor-based programs.

1. Participatory Programs

Participatory programs are programs made available to similarly situated individuals and that do not provide a reward based on a health factor. Common examples of these programs include:

- programs that reimburse all or part of the cost for fitness club memberships;
- diagnostic testing programs that provide a reward for participation but do not base any part of the reward on outcomes;
- programs that encourage preventative care (e.g., prenatal care or annual physicals) through waiver of the copayment or deductible requirement for such care; and
- programs that provide a reward to employees for attending a monthly health seminar.

2. Health Factor-Based Programs

HIPAA generally prohibits group health plans from discriminating on the basis of health factors, which would appear to preclude a wellness program from providing discounted copays for non-smokers or participants with a particular cholesterol level because these standards relate to the participant's medical status. HIPAA's non-discrimination provision, however, contains a specific exception for health factor-based wellness programs. This type of wellness program will comply with the HIPAA exception if it meets all five of the following criteria:

1. The reward for all applicable health-contingent wellness programs with respect to a plan must not exceed 30 percent of the total cost of employee-only coverage under the plan, or 50 percent if the program is designed to prevent or reduce tobacco use;
2. The program must be reasonably designed to promote health and prevent disease, and not appear to be a pretext for discriminating against employees based on health factors. This means

the program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease.;

3. The program must give participants at least one chance per year to qualify for the reward;

4. The program must provide a reasonable alternative means to obtain the reward for those who cannot meet the program's standard due to a medical problem or condition, or it must allow waiver of the standard for such people; and

5. The plan must disclose in all plan materials describing the terms of the program the availability of other means of qualifying for the reward or the possibility of waiver of the otherwise applicable standard.

In addition, health factor-based programs must be offered to all similarly-situated individuals.

Perhaps the most significant requirement listed above is that health factor-based programs provide "reasonable alternatives" to obtain the reward for individuals who are medically unable to satisfy the program's standards. Wellness regulations issued pursuant to Obamacare provided much-needed clarity as to when individuals are entitled to be offered a reasonable alternative, and what such alternatives should be.

Whether an alternative standard is "reasonable" is a facts-and-circumstances test that will look at the specific context of a given situation. The final rule sets forth four criteria that will be considered:

1. If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require the individual to pay for the cost of the program.

2. The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

3. If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

4. If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan must provide a different reasonable alternative standard that accommodates the personal physician's recommendations with regard to medical appropriateness. (Plans may impose standard cost-sharing under the different reasonable alternative.)

Specifically, the new regulations divide health factor-based wellness programs into two categories and the category a program falls into impacts the type of "reasonable alternative standards" that must be offered.

- *Activity-Only Wellness Programs* – An activity-only wellness program requires an individual to perform or complete an activity related to a health factor in order to obtain a reward, but does not require the individual to attain or maintain a specific outcome. Activity-only programs can be distinguished from non-health factor programs because, with the latter, health conditions are not relevant. For example, a program that reimburses employees' gym memberships would be a non-health factor program because anyone, regardless of health condition, can belong to a gym, and the reward is not contingent upon exercising at the gym. In contrast, a program that provides lower premiums for individuals who walk for thirty minutes three days per week is an activity-only wellness program, because an individual's health condition (*e.g.*, being wheel-chair-bound or physically unable to walk for thirty minutes) could preclude the individual from participating in the program.

- Outcome-Based Wellness Programs – An outcome-based wellness program requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward.

Whether a health factor-based program is *activity only* or *outcome based* is significant with regard to the requirement that such programs offer "reasonable alternative standards" to certain individuals: For activity-only programs, the reasonable alternative standard requirement is triggered by a *medical need for an alternative*: it must be unreasonably difficult due to a medical condition to satisfy the standard, or medically inadvisable to attempt to satisfy the standard. Outcome-based programs, on the other hand, must offer a reasonable alternative to any individual who does not meet the initial standard *regardless of medical need*.

Wellness guidance has generally been favorably received. In addition to the host of participatory wellness programs that employers can offer, the increase in reward or penalty amount for health factor-based programs means employers can offer stronger monetary incentives (or disincentives) for employees to participate in these programs. Because participation often correlates with an increase in employee health, employers are more likely to see a reduction in health costs for their participating employees. This may also benefit an employee that enjoys the program's reward and any corresponding health improvements.

B. If I choose to use a wellness program, how will it impact affordability?

A number of groups, including NACS, have urged regulators to base the determination of whether or not a plan is "affordable" on the lowest possible premium available to the employee wellness; penalties should be excluded from the affordability determination (because they are in excess of the lowest possible premium) and wellness rewards should be included (because a reward actually decreased the amount paid by the plan participant).

Unfortunately, regulators have generally not adopted this position. In regulations pertaining to "minimum value" for employer-sponsored coverage, the IRS provides that for plan years beginning on or after January 1, 2015, a plan's "affordability" is determined by assuming each employee fails to satisfy the requirements of an employer's wellness program, *except* for tobacco-prevention programs. For plans beginning before that date, employers may assume employees *do* satisfy wellness program's requirements.

C. Examples

Example 1 (Cholesterol screening with reasonable alternative standard to work with personal physician):

(i) Facts. A group health plan offers a reward to participants who achieve a count under 200 on a total cholesterol test. If a participant does not achieve the targeted cholesterol count, the plan allows the participant to develop an alternative cholesterol action plan in conjunction with the participant's personal physician that may include recommendations for medication and additional screening. The plan allows the physician to modify the standards, as medically necessary, over the year. (For example, if a participant develops asthma or depression, requires surgery and convalescence, or some other medical condition or consideration makes completion of the original action plan inadvisable or unreasonably difficult, the physician may modify the original action plan.) All plan materials describing the terms of the program include the following statement: "Your health plan wants to help you take charge of your health. Rewards are available to all employees who participate in our Cholesterol Awareness Wellness Program. If your total cholesterol count is under 200, you will receive the reward. If not, you will still have an opportunity to qualify for the reward. We will work with you and your doctor to find a Health Smart program that is right for you." In addition, when any individual participant receives notification that his or her cholesterol count is 200 or higher, the notification includes the following statement: "Your plan offers a Health Smart program under which we will work with you and your doctor to try to lower your cholesterol. If you complete this program, you will qualify for a reward. Please contact us at [contact information] to get started."

(ii) Conclusion. The program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain cholesterol level) to obtain a reward. The program satisfies all the requirements for an outcome-based wellness program because 1) the cholesterol program is reasonably designed to promote health and prevent disease; 2) it makes available to all participants who do not meet the cholesterol standard a reasonable alternative standard to qualify for the reward; and 3) the plan also discloses in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard the availability of a reasonable alternative standard (including contact information and the individual's ability to involve his or her personal physician).

Example 2 (Tobacco use surcharge with smoking cessation program alternative):

(i) Facts. In conjunction with an annual open enrollment period, a group health plan provides a premium differential based on tobacco use, determined using a health risk assessment. The following statement is included in all plan materials describing the tobacco premium differential: "Stop smoking today! We can help! If you are a smoker, we offer a smoking cessation program. If you complete the program, you can avoid this surcharge." The plan accommodates participants who smoke by facilitating their enrollment in a smoking cessation program that requires participation at a time and place that are not unreasonably burdensome or impractical for participants, and that is otherwise reasonably designed based on all the relevant facts and circumstances, and discloses contact information and the individual's option to involve his or her personal physician. The plan pays for the cost of participation in the smoking cessation program. Any participant can avoid the surcharge for the plan year by participating in the program, regardless of whether the participant stops smoking, but the plan can require a participant who wants to avoid the surcharge in a subsequent year to complete the smoking cessation program again.

(ii) Conclusion. The program is reasonably designed because the plan provides a reasonable alternative standard to qualify for the reward to all tobacco users (a smoking cessation program). The plan also

discloses, in all materials describing the terms of the program, the availability of the reasonable alternative standard (including contact information and the individual's option to involve his or her personal physician). Thus, the program satisfies wellness program requirement.

Example 3 (Activity-only Wellness Program):

(i) Facts. A group health plan provides a reward to individuals who participate in a reasonable specified walking program. If it is unreasonably difficult due to a medical condition for an individual to participate (or if it is medically inadvisable for an individual to attempt to participate), the plan will waive the walking program requirement and provide the reward. All materials describing the terms of the walking program disclose the availability of the waiver.

(ii) Conclusion. The program is reasonably designed to promote health and prevent disease. The program's reward is available to all similarly situated individuals and accommodates individuals for whom it is unreasonably difficult to participate in the walking program due to a medical condition (or for whom it would be medically inadvisable to attempt to participate) by providing them with the reward even if they do not participate in the walking program (that is, by waiving the condition). The plan also complies with the rule's disclosure requirement. It therefore meets all the requirements for activity-only wellness programs.

VI. Miscellaneous Issues

A. Auto-Enrollment

Under Obamacare, employers with more than 200 full-time employees that offer one or more health benefit plan options must automatically enroll new full-time employees in one of these plans unless employees choose to "opt out." In guidance, regulators advised the auto-enrollment requirement will not take effect until the Secretary of Labor issues rules to implement it. The Labor Department has been vague about when it expects to issue these regulations, and recently advised that the guidance will not be ready to take effect by 2014. In all likelihood, this requirement is several years away from actual implementation.

B. 90 Day Waiting Period

Under Obamacare, if employers offer healthcare coverage to their employees, then employers are not allowed to impose a waiting period of more than 90 days before coverage becomes effective. This means that eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. Other conditions for eligibility under the plan's terms (such as being in an eligible job classification or fulfilling job-related licensure requirements specified in the plan) are generally permissible unless the condition is designed to avoid compliance with the 90-day waiting period limitation. For example, employers may utilize a cumulative hours of service requirement of no more than 1,200 hours for part-time employees before the 90-day waiting period applies. Furthermore, if under the terms of a plan, an employee may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, the 90-day waiting period limitation is considered satisfied. Accordingly, a plan or issuer will not be considered to have violated the 90 day waiting period limitation merely because employees take additional time to elect coverage.

C. *Employee Additional Medicare Tax*

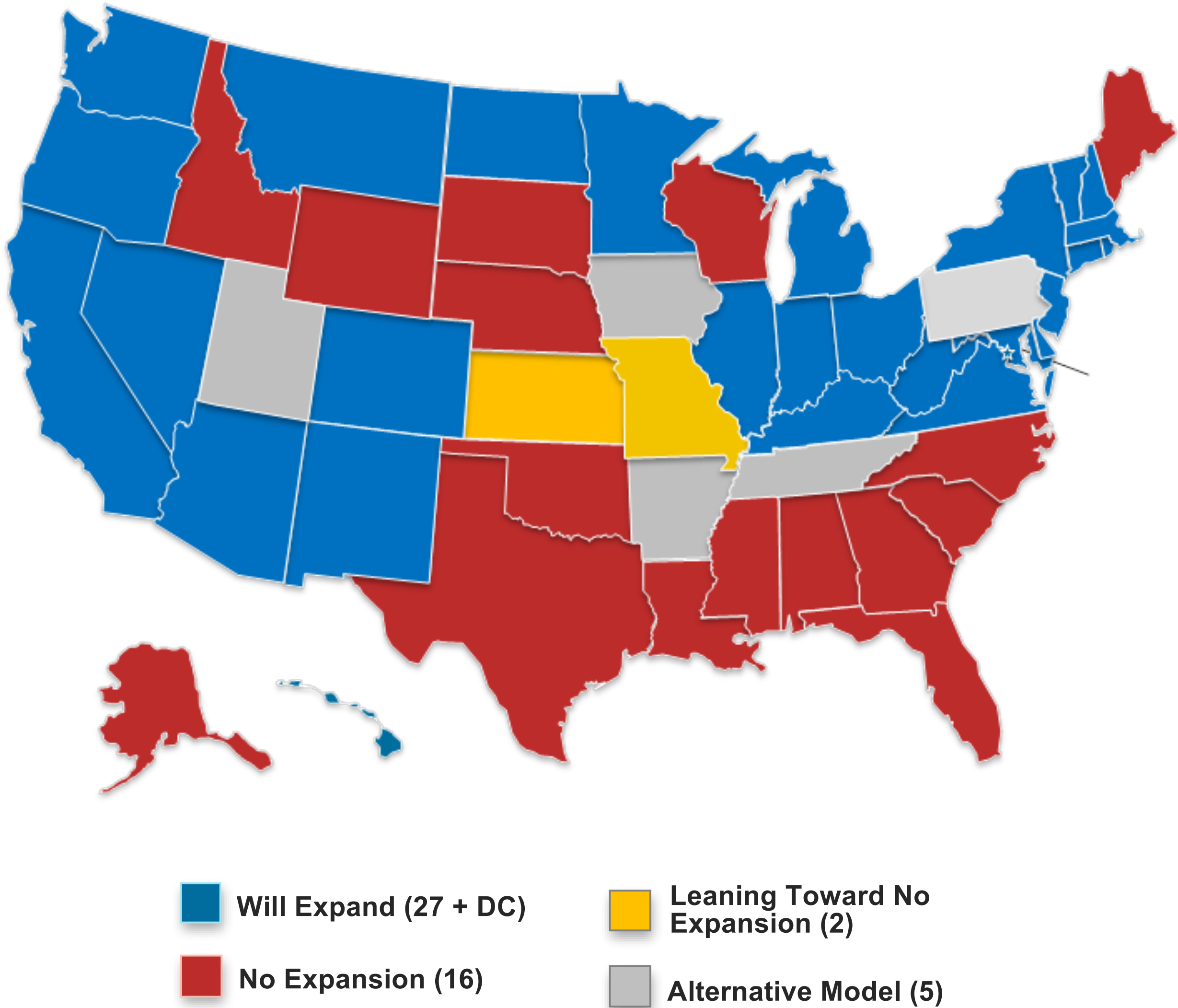
Under recently released IRS guidance, individuals that earn more than $200,000 and married couples filing joint tax returns that earn more than $250,000 will be subject to a new 0.9% annual tax. Similar to employer requirements to withhold Social Security and other Medicare taxes, employers will be required to withhold this additional 0.9% from its employees' paychecks. It is anticipated that the IRS will finalize this requirement in 2013 or early 2014.

D. *Medicaid Expansion*

Obamacare dramatically expanded the Medicaid program, which addresses the health care needs of the poor. Beginning in 2014, the law extends Medicaid coverage to all individuals between ages 19 and 64 with incomes up to 133 percent of the federal poverty level, or $11,490 for an individual and $23,550 for a family of four (based on the 2013 federal poverty level). For example, an uninsured 55-year old clerk with no children that works at a convenience store where insurance is not offered could qualify for Medicaid under this provision if he earns less than $11,400 in a year.

Under the Supreme Court ruling upholding Obamacare against a constitutional challenge, states are not *required* to participate in this expansion of the program, and some have already announced that they will not. The Medicaid expansion issue is significant because employees eligible for Medicaid are not eligible for a subsidy to purchase coverage on an exchange. Therefore, employers will be less exposed under the employer mandate because they are only penalized when employees receive a subsidy for exchange coverage.

__Map: Medicaid Expansion By State__



VII. APPENDIX - GLOSSARY OF KEY HEALTH CARE TERMS

<u>Affordable Care Act (a/k/a The Patient Protection and Affordable Care Act or "Obamacare")</u>:
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by

the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Affordable Coverage (as it relates to Premium Tax Credit):
Employer coverage is considered affordable if the employee's share of the annual premium for self-only coverage is no greater than 9.5% of annual household income. Starting in 2014, individuals offered employer-sponsored coverage that's affordable and provides minimum value won't be eligible for a premium tax credit.

Benefits:
The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Children's Health Insurance Program (CHIP):
Insurance program jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage.

Community Rating:
A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Cost Sharing:
The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Deductible:
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Dependent Coverage:
Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Disability:
A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Because different programs may have different disability standards, please check the program you're interested in for its disability standards. The list of activities mentioned above isn't exhaustive. A legal definition of disability can be found here: http://www.ada.gov/pubs/ada.htm. For the proposed EEOC ADA Amendments Act regulations, and related resources, *see* http://edocket.access.gpo.gov/2009/E9-22840.htm.

Employer Shared Responsibility Payment:
The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.

Essential Health Benefits:
A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014. Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual spending limits for these services by 2014.

Exchange:
See Health Insurance Marketplace.

Federal Poverty Level (“FPL”):
A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Flexible Spending Account (“FSA”):
An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don’t have to pay taxes on this money. Your employer’s plan sets a limit on the amount you can put into an FSA each year. There is no carry-over of FSA funds. This means that FSA funds you don’t spend by the end of the plan year can’t be used for expenses in the next year. An exception is if your employer’s FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

(Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

Full-Time Employee
An employee who works an average of at least 30 hours per week.

Grandfathered:
As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.

Grandfathered Health Plan:

As used in connection with the Affordable Care Act: A group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

Health Insurance Marketplace (the Exchanges):
A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. The Marketplace will offer a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through the Marketplace and you will be able buy your insurance through the Marketplace too.

Health Maintenance Organization ("HMO"):
A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Reimbursement Account ("HRA"):
Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account ("HSA"):
A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account ("FSA"), funds roll over year to year if you don't spend them.

High-Cost Excise Tax ("Cadillac Tax"):
Under the Affordable Care Act starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

Individual Responsibility:
Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay an assessment. You won't have to pay an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay an assessment if you don't qualify automatically.

Medicaid:

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies by state and may have a different name in your state.

Medicare:
A Federal health insurance program for people age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Minimum Essential Coverage:
The type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Minimum Value:
A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. Starting in 2014, individuals offered employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit.

Navigators
An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

New Plan:
As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act. In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan. In the group health insurance market, a plan an employer offers for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is "new to you" and your family may still be a grandfathered plan. In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Nondiscrimination:
A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also can't be charged more because of your health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

Out-of-Pocket Costs:

Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Part-Time Employee
An employee who works an average of less than 30 hours per week.

Plan Year:
A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

Pre-Existing Condition (Job-based Coverage):
Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Premium Tax Credit:
The Affordable Care Act provides a new tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Qualified Health Plan:
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Seasonal Employee:
The Employer Mandate final regulations define a "seasonal employee" as an employee who is hired into a position for which the customary annual employment is six months or less.

Seasonal Worker:
The Employer Mandate final regulations define a "seasonal worker" as a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) workers covered by 29 CFR 500.20(s)(1), and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term seasonal worker and a reasonable good faith interpretation of 29 CFR 500.20(s)(1).

Self-Insured Plan:
Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Summary of Benefits and Coverage ("SBC"):
An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" ("SBC") when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Waiting Period (Job-based coverage):
The time that must pass before coverage can become effective for an employee or dependent, who is otherwise eligible for coverage under a job-based health plan.

Wellness Programs:
A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

**** Source: U.S. Department of Health and Human Services' HealthCare.Gov website. These are not intended as formal, legal definitions of the foregoing terms.*

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