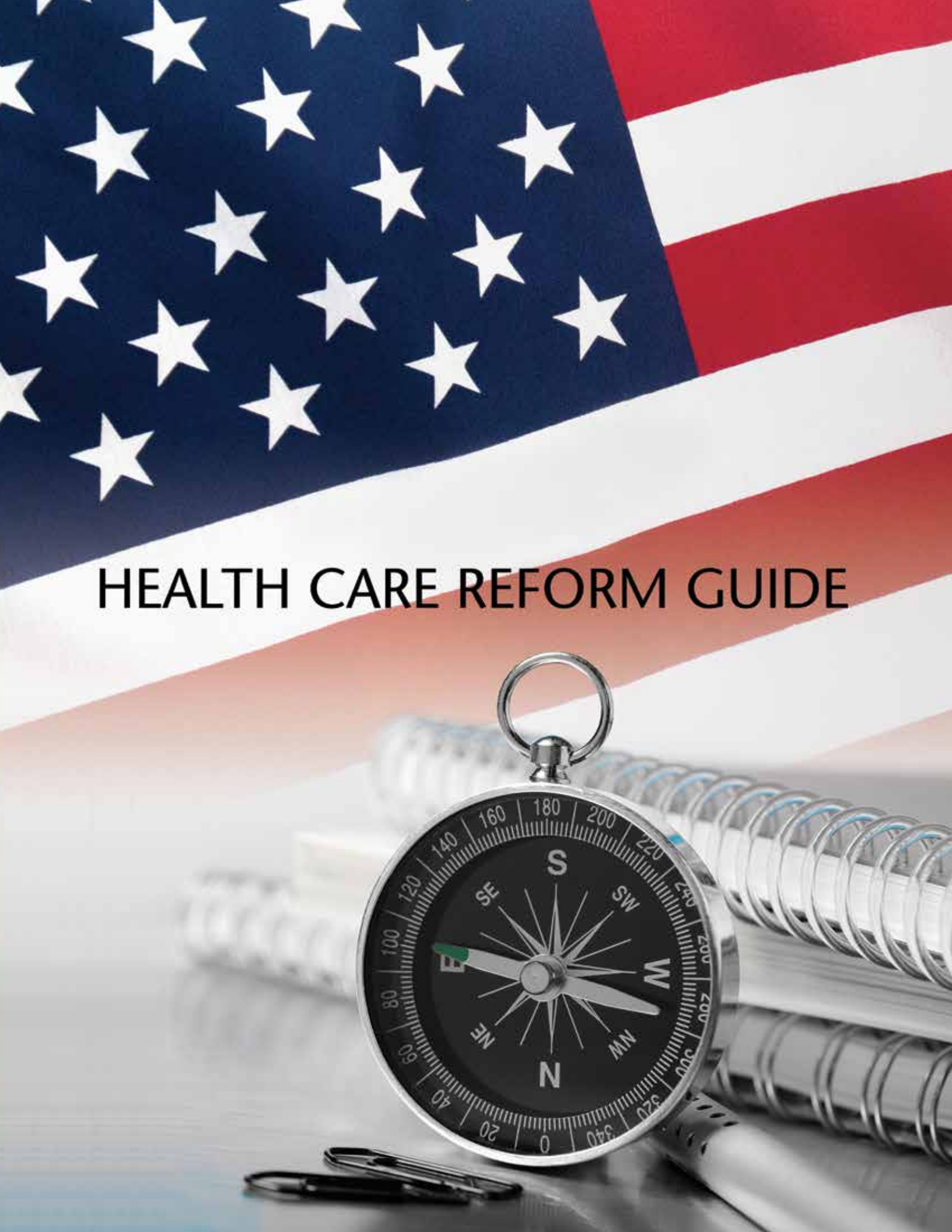
HEALTH CARE REFORM GUIDE



HEALTH CARE REFORM GUIDE

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INSURANCE
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Burdt Northrup

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AN INTRODUCTION: HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act or ACA, is the landmark health care reform legislation that was passed by Congress and signed into law by President Obama in March of 2010.

The intention of the ACA is to extend coverage to millions of uninsured Americans, implement measures that will lower health care costs and improve system efficiency, and eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions.

This legislation has and will continue to have a substantial impact on employers and their approach to employee medical benefits. It is our hope that this Guide will help you to answer questions and assist you with navigating any changes and adjustments as you endeavor to comply with the law.

As you read through this Guide, you will find extensive details concerning all aspects of the ACA and its implications. For your convenience, we have included helpful boxes labeled "HCR Tip" and "HCR Snapshot." These segments are designed to provide you with examples and at-a-glance highlights of information that we will examine in more detail in subsequent sections of the Guide.

You can also quickly identify if a provision applies to you, as an employer, by following the visual indicators below:

Throughout this Guide, it will be indicated whether the provision applies to:

SG Small Group (1–50 FT EEs) | LG Large Group (51+ FT EEs) | SG LG Both as defined by the ACA

Many government and industry resources were used to create the material provided herein. This document is not intended to be exhaustive nor should any information be construed as tax or legal advice. Readers should contact a tax professional or attorney if legal advice is needed. Although we have made every effort to provide complete, up-to-date, and accurate information in this document, such information is meant to be used for reference only. LISI makes no warranty or guarantee concerning the accuracy or reliability of the information within this document. If there is any inconsistency between the information contained in this document and any applicable law, then such law will control.

Defining Individual, Small Group and Large Group

Individual

Individual Mandate

Beginning January 1, 2014, all U.S. citizens, with a few exceptions, will be required to have health insurance for themselves and their dependents or be subject to a tax penalty. Initial open enrollment will occur from October 2013, through March 2014. Subsequently, individuals must purchase coverage during open enrollment periods, which are expected to take place annually from October to December with coverage effective on the 1st of January.

Individuals will have special enrollment opportunities due to "triggering" events, such as loss of employer health coverage, loss of Medicaid coverage due to income changes, marriage, divorce, and the birth or adoption of a child.

Guaranteed Availability of Coverage

As of 2014, insurance carriers will be prohibited from denying coverage to individuals because of pre-existing conditions or any other factors.

Health Insurance Exchanges

Individuals will be able to purchase health insurance in state- or federally-operated exchanges and may qualify for a tax credit/subsidy. California's Exchange is called "Covered California" and offers individuals the ability to purchase health insurance, starting in October 2013, with coverage effective January 1, 2014, through its website, www.CoveredCA.com, or by calling its Consumer Help Line at (888) 975-1142.

Coverage for Essential Health Benefits (EHBs)

All individual health insurance plans are required to cover EHBs (see section on EHBs within this Guide).

Small Group

Small group employers will be defined as 1 to 50 full-time employees. In California, this definition will remain in place until 2016, when it will increase to 100 full-time equivalent (FTE) employees or fewer.

Small Business Tax Credit

If an employer has fewer than 25 employees, pays average annual wages below $50,000, and provides health insurance, it may qualify for a small business tax credit of up to 35% (up to 25% for non-profits) to offset the cost of insurance. In 2014, the tax credit goes up to 50% (up to 35% for non-profits) for qualifying businesses.

Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance. The credit is claimed on the employer's annual income tax return as a non-refundable general business tax credit. Eligible small employers can claim the current credit through 2013, and the enhanced credit can be claimed for any two consecutive taxable years beginning in 2014 through the Small Business Health Options Program (SHOP) Exchange.

Defining Individual, Small Group and Large Group *(cont.)*

Health Insurance Exchanges

Small businesses with fewer than 50 employees will be able to purchase coverage through the SHOP Exchanges with open enrollment beginning on October 1, 2013.

Probationary Waiting Periods Limited to 60 Days

Eligibility waiting periods for small group health insurance cannot exceed 60 calendar days in California.

Non-Discrimination Rules

Employers will be prohibited from providing better eligibility, health benefits, or employer contribution to highly-compensated individuals. This provision is delayed pending further guidance.

Coverage for Essential Health Benefits (EHBs)

All group health insurance plans are required to cover EHBs (see section on EHBs within this Guide).

Large Group

Large group employers will be defined as more than 50 full-time employees. In California, this will remain in place until 2016, when it will increase to more than 100 full-time equivalent (FTE) employees.

Coverage for Essential Health Benefits (EHBs)

Large groups are not required to offer EHBs. If a large group chooses to cover EHBs, then both the annual and lifetime dollar limits will be eliminated for those benefits.

Maximum Out-of-Pocket Limits

Upon renewal in 2014, the member cost-sharing limit on any health plan can be no greater than those in a health savings account (HSA). Currently, the individual limit is $6,250 and is indexed annually. This limit is estimated to increase to $6,350 in 2014. The family limit is twice that of the individual limit.

Probationary Waiting Periods Limited to 60 Days

In California, eligibility waiting periods for large group health insurance cannot exceed 60 calendar days.

Employer-Shared Responsibility—Play or Pay

This regulation requires certain large employers to provide health coverage or incur a federal tax penalty. Penalties have been delayed until 2015. Awaiting further guidance.

Non-Discrimination Rules

Employers will be prohibited from providing better eligibility, health benefits, or employer contribution to highly-compensated individuals. Delayed pending further guidance.

Essential Health Benefits

All individual and small group health insurance plans must include the following 10 categories of care, known as Essential Health Benefits (EHBs).

- Emergency Services
- Ambulatory Patient Services
- Hospitalization
- Laboratory Services
- Maternity and Newborn Care
- Mental Health and Substance Abuse Disorder Services, including Behavioral Health Treatment
- Pediatric Services, Including Oral and Vision Care
- Prescription Drugs
- Preventive and Wellness Services, and Chronic Disease Management
- Rehabilitative and Habilitative Services and Devices

HCR SNAPSHOT

Provisions Prior to 2014

- **Automatic Enrollment** (pending further guidance): Employers covered under the Federal Labor Standards Act (FLSA) with more than 200 employees must automatically enroll employees.
- **Exchange Open Enrollment:**
  - Initial Period: October 2013, through March 2014
  - Subsequent Periods: October through December annually
- **Flexible Spending Account (FSA) Plan Updates:** Contributions into an FSA must be limited to a maximum of $2,500 per year.
- **Grandfather Plan Status Notification:** Must include a notification in plan materials that a plan is grandfathered.
- **Medicare Part A Tax Increase on High-Income Earners:** Tax increasing from 1.45% to 2.35% on employee portion of FICA.
- **Medicare Part D Subsidies No Longer Deducted:** Cannot deduct Medicare Part D drug subsidies for retirees.
- **Non-Discrimination and Coverage**: Employer-provided benefit plans cannot discriminate in eligibility, waiting period, benefits or contributions in favor of highly-compensated employees. This provision is delayed pending further guidance.

HCR SNAPSHOT

Provisions Prior to 2014 *(cont.)*

- **Notice of Material Modifications:** Employers must give enrollees 60 days advance notice of any Summary of Benefits Coverage (SBC) material modifications.
- **Notice to Employees of State Exchanges:** Employers must inform employees about the coverage options available through their state's Exchange by October 1, 2013. Sample model notices are available at the DOL web site: www.dol.gov/ebsa/pdf/FLSAwithplans.pdf and www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf.
- **Patient-Centered Outcomes Research Institute (PCORI) Fee:** Employers sponsoring self-insured plans will pay a fee that equals $1 in the first year ($2 in the following years), multiplied by the average number of lives covered by the group health plan.
- **Small Business Tax Credit:** Tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.
- **Summary of Benefit Coverage (SBC) and Uniform Glossary:** A SBC must be provided to each participating employee and beneficiary during the annual open enrollment to each participant and beneficiary who is eligible to participate.
- **W-2 Reporting:** Employers who file more than 250 W-2 forms must report the value of each **employee's**

HCR SNAPSHOT

Provisions Coming Up in 2014

- **Employer-Shared Responsibility—Play or Pay:** Large employers must offer affordable, minimum value (MV) coverage to all full-time employees or be subject to an excise tax/penalty. Penalties have been delayed until 2015. Awaiting further guidance.
- **Information Reporting to IRS:** A report must be filed with the IRS containing specific information on the offer of health insurance to each employee.
- **Minimum Essential Health Benefits (EHBs):** All individual and small group health insurance plans must include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse 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.
- **Plan Deductible and Out-of Pocket-Maximums:** Small groups may not impose annual deductibles greater than $2,000 for single coverage and $4,000 for family coverage unless it would be necessary to achieve a qualification as a bronze, silver, gold or platinum plan. These "metallic" plans must provide coverage that meet minimum actuarial value (AV) requirements. AV is defined as the percentage of health care expenses a plan would cover on average for the standard population and will range between 60–90% based on the coverage tier, and therefore, some SHOP plans may also have deductibles greater than these limits. Out-of-pocket maximums for a HSA-qualified plan in 2013 is $6,250 for single coverage and $12,500 for family coverage. The out-of-pocket limitations are subject to annual inflationary adjustments and apply to all non-grandfathered plans for both small and large groups.
- **Waiting Periods:** In California, the waiting period for eligibility may not exceed 60 calendar days for small and large groups.

ACA Provisions Grid

The following provisions of the ACA have already been implemented or soon will be. This grid provides you with an outline of the actions that will be required of employers by group size.

Note: Regulations are outlined in alphabetical order.

Throughout this Guide, it will be indicated whether the provision applies to:

SG Small Group (1–50 FT EEs) | LG Large Group (51+ FT EEs) | SG LG Both as defined by the ACA

PPACA REGULATION	EFFECTIVE DATE	EMPLOYER ACTION REQUIRED
Automatic Enrollment LG	Delayed; awaiting further regulatory guidance	Must inform employees of opportunity to opt out of automatic health plan enrollment. Applies to employers who are covered under FLSA with more than 200 employees.
Employer-Shared Responsibility—Play or Pay LG	January 1, 2014 Penalties have been delayed until 2015. Awaiting further guidance	Employers will need to calculate if they are small or large group under the ACA guidelines. Large groups will need to offer at least one plan to full-time employees that is affordable and of minimum value. If not, the large group will pay an excise tax/penalty.
Essential Health Benefits (EHBs) SG	Plan years beginning January 1, 2014 or later	All plans offered by small employers must include the ACA-established EHBs.
Exchange Open Enrollment SG	October 1, 2013	The SHOP Exchange and Individual Exchange will begin accepting enrollments October 1 through March 2014, for coverage effective January 1, 2014.
Flexible Spending Account (FSA) Plan Updates SG LG	Plan years beginning on or after January 1, 2013	Contributions into an FSA must be limited to a maximum of $2,500 per year. The employer should contact its FSA administrator to ensure plan documents are in compliance.

ACA Provisions Grid (cont.)

PPACA REGULATION	EFFECTIVE DATE	EMPLOYER ACTION REQUIRED
Grandfather Plan Status Notification SG LG	First plan year beginning on or after September 23, 2010	Must include a notification in plan materials that a plan is grandfathered and must provide contact information for questions. Sample language is available on the DOL web site: *www.dol.gov/ebsa/healthreform*. **Note:** A grandfathered plan is a plan that was in existence on or before March 23, 2010, and has continuously covered at least one person since that time. Any reduction in benefits or increase in coinsurance or copays, deductibles, etc. will cause a plan to lose its grandfathered status. The employer should check with its carrier to ensure the plan is still grandfathered.

Information Reporting to IRS
LG
	For tax year 2014 and beyond	A report must be filed with the IRS containing:
		• The name, address, and employee identification number (EIN) of the applicable large employer.
		• A certification as to whether the employer offers full-time employees the opportunity to enroll in minimum essential coverage and, if so, certify:
		  • The duration of the waiting period;
		  • The months of the calendar year coverage was available;
		  • The monthly premium of the lowest cost option;
		  • The employer's share of the cost of coverage;
		  • The number of full-time employees in each month of the year;
		  • The name, address, and TIN (or social security number) of each employee (and any dependents) covered under the plan; and
		  • Any other information requested by the Secretary of Treasury.
		For all employees listed on the report, the employer must provide a written statement to the employee regarding reported information with respect to that employee.

Medicare Part A Tax Increase on High-Income Earners SG LG	Taxable years beginning January 1, 2013	Tax increasing from 1.45% to 2.35% on the employee portion of FICA. The employer should contact its payroll vendor to ensure the new tax is being applied.

ACA Provisions Grid *(cont.)*

PPACA REGULATION	EFFECTIVE DATE	EMPLOYER ACTION REQUIRED
Medicare Part D Subsidies No Longer Deducted SG LG	January 1, 2013	Employers will no longer be able to deduct the cost of prescription drugs to the extent reimbursed by the federal subsidy on their federal tax returns.
Non-Discrimination and Coverage SG LG	Delayed; awaiting further regulatory guidance	• It is required that employer-provided plans cannot discriminate in eligibility, waiting period, benefits or contributions in favor of highly-compensated employees. • PPACA references the self-funded employer non-discrimination requirements of section 105(h) of the IRS code and applies them to insured group health plans. • Failure to comply carries a penalty of $100 per individual for each day the plan does not comply.
Notice to Employees of State Exchanges SG LG	Beginning October 1, 2013	Must inform employees about coverage options available through their state's Exchange. Sample model notices are available at the DOL web site: *www.dol.gov/ebsa/pdf/FLSAwithplans.pdf* *www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf*
Notice of Material Modifications SG LG	After SBC goes into effect on September 23, 2012	Must give enrollees 60 days advance notice of any SBC material modification.
Patient-Centered Outcomes Research Institute (PCORI) Fee SG LG	For the plan year ending after September 30, 2012, there will be a $1 per enrollee tax on fully-insured and self-funded group health plans to fund PCORI. For plan years ending after September 30, 2013, the fee increases to $2 per enrollee. This fee expires September 30, 2019.	• Fully-Insured plans: Insurance carriers will pay a fee that equals $1 in the first year ($2 in the following years), multiplied by the average number of lives insured under a group health plan policy. • Self-Insured plans: The plan sponsor (generally the employer) of a self-insured plan will pay a fee that equals $1 in the first year ($2 in the following years), multiplied by the average number of lives covered by the group health plan.

ACA Provisions Grid *(cont.)*

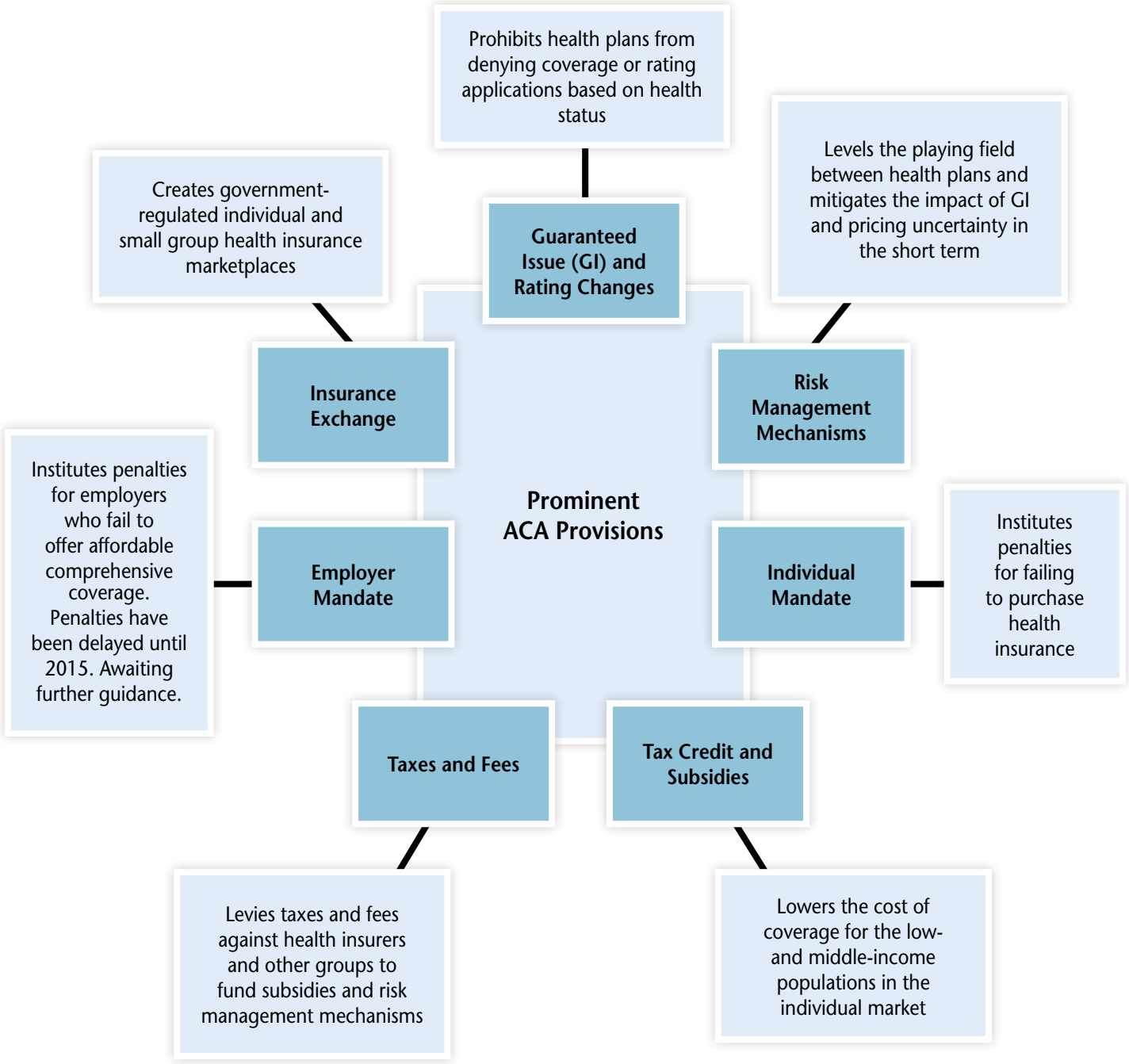
PPACA REGULATION	EFFECTIVE DATE	EMPLOYER ACTION REQUIRED
Plan Deductible and Out-of-Pocket Maximums SG	Plan years beginning January 1, 2014	Small groups may not impose annual deductibles greater than $2,000 for single coverage and $4,000 for family coverage unless it would be necessary to achieve a qualification as a bronze, silver, gold or platinum plan. Some SHOP plans may also have deductibles greater than these limits. Out-of-pocket maximums for a HSA-qualified plan in 2013 is $6,250 for single coverage and $12,500 for family coverage. The out-of-pocket limitations are subject to annual inflationary adjustments and apply to all non-grandfathered plans for both small and large groups.
Summary of Benefit Coverage (SBC) and Uniform Glossary SG LG	First plan year beginning on or after September 23, 2012, and for any initial enrollment, special enrollment and upon request regardless of plan year.	A SBC must be provided to each employee and beneficiary who is eligible to participate during the annual open enrollment. This does not replace the Summary Plan Description (SPD). A Uniform Glossary of commonly used terms must also be distributed. Templates are available on the DOL web site: *www.dol.gov/ebsa/healthreform*.
Small Business Tax Credit SG	For tax years beginning in 2010 through 2013. Starting in 2014, the Small Business Tax Credit will only be available in the SHOP Exchange.	If an employer has fewer than 25 employees, pays average annual wages below $50,000, and provides health insurance, it may qualify for a small business tax credit of up to 35% (up to 25% for non-profits). In 2014, the tax credit goes up to 50% (up to 35% for non-profits) for qualifying businesses.
W-2 Reporting Only applies to employers who issue 250 or more W-2s. LG	For tax years beginning on or after January 1, 2012. Further guidance is pending for employers issuing less than 250 W-2s.	For informational purposes only, employers must report the value of each employee's health coverage.

ACA Provisions Grid *(cont.)*

PPACA REGULATION	EFFECTIVE DATE	EMPLOYER ACTION REQUIRED
Waiting Periods SG LG	January 1, 2014. To be redefined in 2016.	A "waiting period" is defined as "the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan." California's AB 1083 requires the eligibility waiting period for non-grandfathered plans to be no greater than 60 days of employment for both small and large group employers. As the ACA Limitation on Waiting Periods is 90 days, AB 1083 is in conflict with the ACA regulations and may require further legislation. In contrast to the employer responsibility rule under Code § 4980H, the rules governing waiting periods do not distinguish between full-time and part-time employees. The ACA does not intend to "require the employer to offer coverage to any particular employee or class of employees."
Wellness Programs SG LG	From 2011 to 2015	Employers can apply for federal grant funds available to assist small employers with the implementation of wellness programs. The cost of coverage may be discounted up to 30%–50% under some circumstances.

Prominent ACA Provisions in 2014

These provisions, which will become effective in 2014, will have a significant impact on the health insurance marketplace:



Employer-Shared Responsibility—Play or Pay

Notice: As of 7/3/2013, the Federal Government has delayed the penalties associated with the Employer Mandate until 2015. We are awaiting further guidance on the other aspects of the provision.

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Employer-Shared Responsibility is also known as the Employer Mandate or "Play or Pay" and goes into effect January 1, 2014. This provision only applies to large employers which is defined under the ACA as an employer that employed at least 50 full-time employees (including full-time equivalent employees) on business days in the preceding calendar year. This is important to note because businesses previously thought to be small employers may now, because of the ACA, be considered large employers and are subject to this Responsibility. Penalties have been delayed until 2015. Awaiting further guidance.

From now until 2016, states can define the size of small and large groups:

- In California, small employers are currently defined as 50 or fewer employees until 2016.
- Large employers are currently defined as 51 or more employees.

Beginning in 2016, the following ACA definitions will apply:

- Small employers are those who had, on average, 1 to 100 full-time equivalent (FTE) employees in the preceding calendar year and at least one employee on the first day of the plan year.
- Large employers are those who had, on average, 101 or more full-time equivalent (FTE) employees in the preceding calendar year and at least one employee on the first day of the plan year.

NOTE: The terms large and small employers are used at several different places in the ACA with respect to the mandate, the Exchanges, and several of the insurance reforms (the essential health benefits, limits on deductibles, etc.).

For purposes of the Employer Mandate, a small employer is defined as 50 or fewer employees. For other purposes, it is defined as 100 or fewer, but until 2016, states can define it as 50 or fewer (and all or almost all are, including California).

Penalties for Employers Not Offering Affordable Coverage

Penalties have been delayed until 2015. Awaiting further guidance.

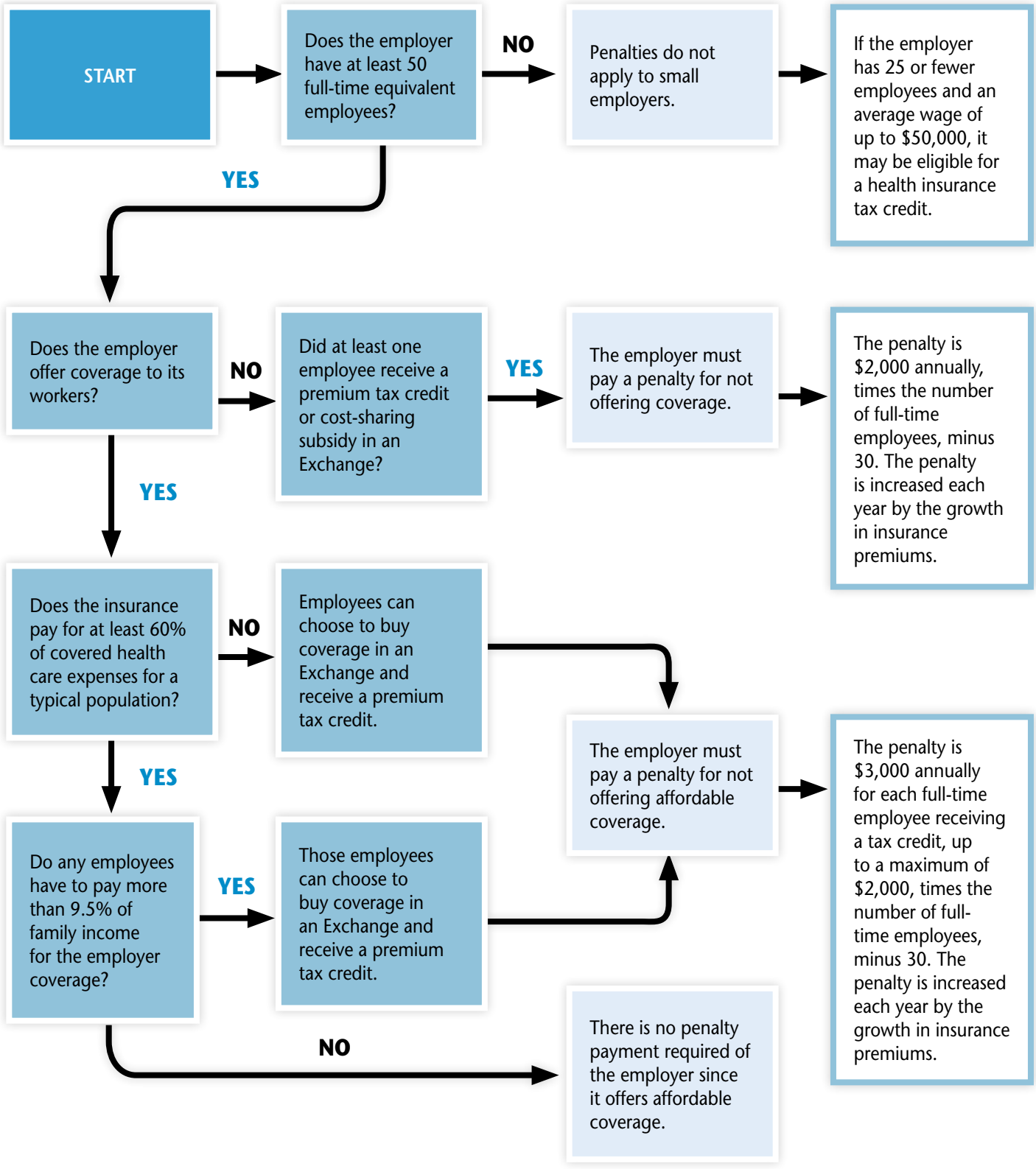


Chart information provided by The Henry J. Kaiser Family Foundation.

What Is the Employer Mandate?

Notice: As of 7/3/2013, the Federal Government has delayed the penalties associated with the Employer Mandate until 2015. We are awaiting further guidance on the other aspects of the provision.

Beginning in 2015, large employers may be subject to an excise tax/penalty if they:

- Fail to offer any coverage to full-time employees and their dependents or,
- Offer coverage to full-time employees (and their dependents):
  - That does not meet the law's affordability standard (employee's cost for self-only coverage must not exceed 9.5% of household income or 9.5% of employee's W-2 wages) or
  - That does not meet minimum value standards, and
  - At least one full-time employee receives a premium tax credit in the Exchange.

Excise Tax/Penalties

If at least one full-time employee receives a premium tax credit for coverage in the Exchange:

- The penalty for not offering coverage is equal to the number of full-time employees employed during the year, minus 30, multiplied by $2,000.
- The penalty for providing coverage that is not affordable or does not comply with minimum value (MV) coverage under ACA guidelines is equal to the lesser of $3,000 per employee who qualifies for a subsidy in the Exchange, or $2,000 per full-time employee.

> *NOTE: This was deemed a "tax" by the Supreme Court rather than a "penalty" and, therefore, it is not deductible as a business expense.*

Defining Full-Time and Full-Time Equivalent Employees

The ACA defines large employers as employers who have 50 or more full-time and/or full-time equivalent employees, which are defined as follows:

- **Full-Time (FT) Employee: An employee who works on average 30 hours per week or 130 hours of service per calendar month.**
- **Full-Time Equivalent (FTE) Employee: Two or more part-time employees whose combined hours per week add up to a single full-time employee.**
- **Hour of Service: Each hour for which an employee is paid or entitled to payment for the performance of duties, including vacation, leave, holiday, illness, incapacity, layoff, jury duty, military duty or other leave of absence.**

HCR TIP

FTE Example

Frank works an average of 20 hours per week and Betty works an average of 10 hours per week. Together, Frank and Betty work an average of 30 hours per week, which is equivalent to one full-time employee's hours. Therefore, Frank and Betty together equal one full-time equivalent, or FTE, employee.

> *NOTE: These calculations are only used to determine whether or not the employer is a large or small employer and are not used in calculating penalties or premium costs.*

Look-Back Transition Relief for Smaller Employers

Employers can determine whether they are large employers based on a period of three to six consecutive calendar months in the 2013 calendar year as chosen by the employer, rather than based on the entire 2013 calendar year. The 2014 compliance deadline is not delayed for smaller employers determined to be large employers based on the three- to six-month calculation.

Full-Time Equivalent Employee Number Calculation

For each calendar month of the preceding calendar year, employers must:

1. Count the number of full-time employees (including seasonal employees) who work on average 30 hours per week per month.
2. Calculate the number of full-time equivalent employees (including seasonal employees) by aggregating the number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not employed on average at least 30 hours of service per week for that month and dividing by 120.
3. Add the number of full-time employees and full-time equivalents calculated in steps 1 and 2 for each of the 12 months in the preceding calendar year.
4. Add the monthly totals and divide by 12. If the average exceeds 50 full-time equivalents, determine whether the seasonal employee exception applies.

Seasonal Employee Exception

HCR TIP

FT + FTE Example

ABC Company has 30 full-time employees each working at least 30 hours a week. The company also has 30 part-time employees who all work 25 hours a week (a total of 100 hours per month). The part-time employees would be treated as an equivalent of 25 full-time employees. Here's how:

30 part-time employees x 100 hours = 3,000/120 = 25 full-time equivalent employees

As a result, ABC Company would be considered a large employer since they have a total of 55 full-time equivalent employees.

FTE Calculator: *www.healthlawguideforbusiness.org/fte-calculator*

The penalties do not apply to employers whose workforce exceeds 50 full-time equivalent employees for no more than 120 days or four calendar months during a calendar year if the employees in excess of 50 who were employed during that period were seasonal employees. The 120 days or four calendar months are not required to be consecutive.

For purposes of determining large employer status until further guidance is issued, employers may apply a reasonable, good-faith interpretation of the statutory definition of Seasonal Employee, including a reasonable, good-faith interpretation of the standard set forth under the DOL regulations at 29 CFR 500.20(s)(1).

Worksheet—Counting Full-Time Equivalent (FTE) Employees

	1	2			3
MONTH	FULL-TIME (FT) (Working > 30 hours/week or 130 hours/month)	PART-TIME (PT) (Working < 30 hours/week with a recognized maximum of 120 hours/month)			TOTAL EMPLOYEES
	Enter the # of FTs for each month	Enter the # of hours worked by all PTs for each month		Total FTEs	FTs + FTEs
January			÷ 120 =		
February			÷ 120 =		
March			÷ 120 =		
April			÷ 120 =		
May			÷ 120 =		
June			÷ 120 =		
July			÷ 120 =		
August			÷ 120 =		
September			÷ 120 =		
October			÷ 120 =		
November			÷ 120 =		
December			÷ 120 =		
4	Sum of month 1 through month 12				
5	Divide by 12 to determine the company's average (drop the fraction)				

What Can Cause an Employer to Be Subject to Play or Pay?

If an employer does not have at least 50 full-time employees, it still can be subject to the Play or Pay Rule if:

- the employer is part of a "controlled group" or "affiliated service group" and the total full-time employees or full-time equivalent (FTE) employees of the controlled group is at least equal to 50. Multiple companies under single ownership must add all FTEs from all businesses together to determine if the employer is a large group employer; but that is only for calculating group size. The employer can offer different plans or choose to Play or Pay for each company separately.
- the employer is a new employer and expects to employ an average of at least 50 full-time employees in the current calendar year.
- the employer is deemed to be a large group due to a predecessor employer.
- the employer has enough FTE employees to cause the employer to be treated as a large employer.

What if an Employer Cannot Reasonably Determine if an Employee Will Be Full-Time?

The shared responsibility penalties are calculated on a monthly basis. The potential liability of a large employer for the Play or Pay penalty is determined by the number of full-time employees it had during a calendar month, while the liability under the Play or Pay penalty is determined by the number of full-time employees who enrolled in Exchange coverage and received a premium tax credit or cost-sharing reduction during the calendar month.

The IRS acknowledged the difficulties employers may have with making monthly determinations of full-time status. Concerned that monthly determinations could result in employees moving in and out of employer coverage, and possibly Exchange coverage, as frequently as monthly, the proposed regulations include an optional "look-back measurement" method that employers can use as an alternative to making a monthly determination. The look-back measurement method varies for different groups of employees.

HCR TIP

Controlled Group Example

One owner has three businesses which

- A: has 20 employees,
- B: has 40 employees, and
- C: has 5 employees.

When combined, this equals 65 full-time employees, which designates them as a large employer under the law.

If the employer is subject to a penalty, they are allowed to subtract 30 total employees from that number, but, those 30 employees will be split up among the three businesses based on the number of employees in each business.

The employer may decide to not offer coverage to business A and C. In that case, the penalties would only apply to A and C, and not B.

Assuming that the coverage offered at B is minimum value and affordable (and rounding to nearest whole number), then the penalty reductions for each business are:

- A: 9 (20 is 31% of 65, 31% of 30 is 9) and
- C: 2 (5 is 8% of 65, 8% of 30 is 2).

The total penalty is:

- A: (20 - 9) x 2,000 = 22,000 and
- C: (5 - 2) x 2,000 = 6,000.

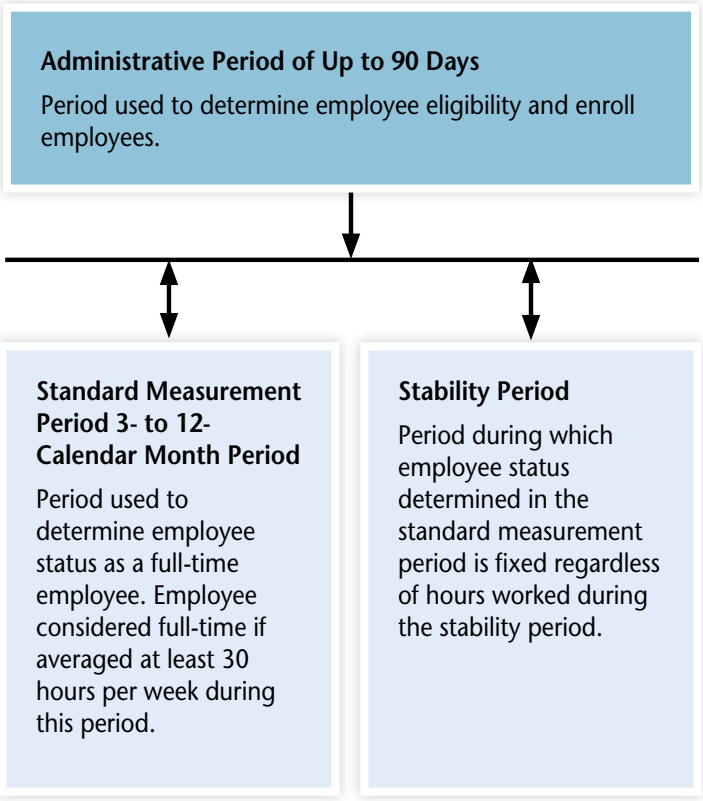
Employee Measurement Periods

Ongoing Employees

Ongoing Employees are employees who have been employed for at least one "standard measurement period." To determine an ongoing employee's full-time status, the employer may look back over a standard measurement period that is not less than three months or more than 12 months. As an administrative accommodation, the proposed regulations permit employers to use the beginning and end of payroll periods as the beginning and end of the measurement period, provided the payroll periods are one week, two weeks or semi-monthly in duration.

If the employer determines that an employee averaged at least 30 hours of service over the standard measurement period, the employee must be treated as a full-time employee over a subsequent "stability period." The employer has the option of including an "administrative period" of up to 90 days between the standard measurement period and the stability period. This administrative period would be used by the employer to determine the employee's full-time status and to offer health coverage to those determined to be full-time. These periods are illustrated below.

Look-Back Method for Ongoing Employees



HCR TIP

ABC Company has one category of workers that work in a retail setting with hours that vary from week to week.

- The company has a health plan with a plan date of January 1.
- For this category of workers, ABC sets up a measurement period to monitor employees that begins on October 1 of each year and ends on September 30.

  Note: This is called the Ongoing Employees Measurement Period. It recurs during the same time period every year.
- From the 1st of October through the end of December, ABC determines who averaged 30 hours per week during the measurement period, offers coverage to them, and enrolls those who want to participate in the plan. This is the Administrative Period.

  Note: During this administrative period, a new measurement period has begun for all variable hour workers since an employee who averaged 30 hours a week one year may do the same in a subsequent year.
- ABC must continue to offer coverage to these employees during the following year of coverage, even if the employees slip to part-time status.

Measurement Periods *(cont.)*

New Full-Time Employees

If a new employee is reasonably expected to be employed on average at least 30 hours a week, then coverage must be offered within three months of his or her start date (the date the employee is first required to be credited with an hour of service with the employer).

Note: This time limit is 90 days maximum, not the first day of the month after three months of employment.

New Variable Hour or Seasonal Employees

A new employee is considered a Variable Hour Employee if, at the start date, it cannot be determined that the employee is reasonably expected to be employed on average at least 30 hours per week. The proposed regulations do not define Seasonal Employee, and employers are permitted to use a reasonable good-faith interpretation of the term through 2014. The preamble to the proposed regulations specifies that educational organizations may not treat employees who work only during the active portions of the academic year as seasonal employees.

The method of determining the full-time employee status of new variable hour employees and seasonal employees is similar in concept to that used for ongoing employees, but it is more complicated. An employer may use an "initial measurement period" of between 3 and 12 months that begins on any date between the employee's start date and the first day of the calendar month following the start date. An administrative period of up to 90 days is also allowed. But, the combination of the initial measurement period and the administrative period "may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date."

Determined to Be a Full-Time Employee

An employer must treat an employee who is determined to be a full-time employee during the initial measurement period as a full-time employee during the subsequent stability period. In this case, the duration of the stability period must be the same length as the stability period for ongoing employees.

Determined to Be a Non-Full-Time Employee

If the employee is determined to be a non-full-time employee during the initial measurement period, then the employee would be treated as a non-full-time employee during the subsequent stability period. In this case, the stability period can be no more than 1 month longer than the initial measurement period.

Using the previous example, ABC Company has 1 category of workers that work in a retail setting with hours that vary from week to week.

New variable hour employees are treated slightly differently because a new employee could be hired at any time. This means that the measurement period for a new employee will be different than the employer's ongoing employee measurement period.

- For example, Employee X is hired by ABC Company on April 1, and that ABC has decided to use a 12-month initial measurement period for new employees.
- For new employees of employers that use a 12-month initial measurement period, the administrative period is shortened and can be no longer than 1 month.

  Note: During this initial measurement period, which would start on April 1 and end on March 31, X also entered the ongoing employee measurement period (Reminder: For ABC Company, this runs October 1 through September 30).

Identifying Full-Time Employees—Transition Relief for 2014

Stability Periods

In order to use the look-back measurement method for determining full-time employees for 2014, employers will need to **start their measurement periods in 2013**. Employers who want to use a 12-month measurement period with a corresponding 12-month stabilization period will face time constraints in doing so. Therefore, solely for the purposes of stability periods beginning in 2014, employers can use a transition measurement period that meets these conditions:

- Is shorter than 12 months, but no less than six months.
- Begins no later than July 1, 2013.
- Ends no earlier than 90 days before the first day of the plan year beginning on or after January 1, 2014.

Other Transition Relief

In general, the Play or Pay Rule is effective for calendar months beginning January 2014. However, the Play or Pay Rule regulation contains a delayed effective date for some non-calendar year health plans (e.g., those that operate on a basis other than January 1 through December 31) and for certain other purposes, such as when a dependent must be offered coverage.

Summary of Transition Relief Rules

Notice: As of 7/3/2013, the Federal Government has delayed the penalties associated with the Employer Mandate until 2015. We are awaiting further guidance on the other aspects of the provision.

TRANSITION RELIEF	DESCRIPTION
Dependents Who Must Be Offered Coverage	In order to avoid a Play or Pay Rule penalty, an employer must offer coverage to full-time employees and their "dependents." The regulation requires that coverage be offered to an employee's child who has not yet attained age 26. However, "dependent" does not include a spouse or, presumably, a domestic partner. Under a special transitional rule, an employer does not need to offer dependent coverage in 2014, as long as it "takes steps" in 2014 to provide such coverage for the 2015 plan year.
Determination of Large Employer Status	Some employers will be close to 50 full-time (and full-time equivalent) employees and may need extra time to determine if they are subject to the Play or Pay Rule. The IRS has provided a transition rule for these employers that allows them the option to determine their "large employer" status with respect to a period of at least 6 consecutive calendar months in the 2013 calendar year (rather than the entire 2013 calendar year).

Other Transition Relief *(cont.)*

TRANSITION RELIEF	DESCRIPTION
Salary Reduction Elections	The regulation provides relief for certain cafeteria plan changes (e.g., if an employee wishes to drop employer-provided health plan coverage and enroll in an Exchange) for a non-calendar year plan. It is only available with respect to a cafeteria plan that operates on a non-calendar year basis. It also only applies to the plan year that begins in 2013, and does not apply to any benefits other than an election for accident and health coverage. The amendment must be made by December 31, 2014, to be effective retroactively to the date of the first day of the 2013 plan year of the cafeteria plan.
Short Measurement Period, Long Stability Period	The IRS noted that employers who wish to adopt a 12-month Measurement Period and a 12-month Stability Period will have "time constraints" due to the regulation being published in January 2013. The transition rule allows an employer to adopt a shorter Measurement Period (such as 6 months) but keep the longer Stability Period (such as 12 months). To rely on this transition rule, the transition Measurement Period must be at least 6 months long, must begin no later than July 1, 2013, and must end no earlier than 90 days before the first day of the plan year beginning on or after January 1, 2014. The effect of this rule is surprisingly difficult to succinctly summarize due to the varying length of the Administrative Period an employer could select (0 to 90 days) and the varying length of the Measurement Period the employer could select (apparently, 6 months to 11 months, although 11 months is reduced in some situations). It appears that periods in 2013, which are a few months after July 2013, will not be able to rely upon the transitional relief and must follow the typical rule that the Measurement Period is equal in length to the Stability Period.
Variable Hour Employee Definition	A new employee will be a Variable Hour Employee if, based on the facts and circumstances as of the start date, it cannot be determined that the employee is reasonably expected to be employed on average at least 30 hours per week. In addition, solely for periods prior to January 1, 2015, a variable hour employee also includes an employee who: • is expected to be employed initially at least 30 hours per week, • is reasonably expected to be of limited duration, and • cannot be determined to be employed on average at least 30 hours per week over the Initial Measurement Period. Thus, effective January 1, 2015, except for seasonal employees, an employer will not be permitted to take into account the likelihood that the employee's employment will terminate before the end of the initial measurement period.

Other Transition Relief *(cont.)*

TRANSITION RELIEF	DESCRIPTION
When Penalty Under Play or Pay Rule Is Effective (Additional Relief)	The second transitional rule seems to be designed to allow a fiscal-year plan additional time to expand its eligibility provisions and offer coverage to those who were not previously eligible for coverage. Under the second transitional rule, if an applicable large employer member had, with respect to its non-calendar year plan: • offered the plan to at least one-third of its employees (full-time and part-time) at the most recent open enrollment period, or • covered at least one-quarter of its employees, then the employer will not be subject to the Play or Pay Rule penalty until the first day of the fiscal plan year starting in 2014, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day. This relief only applies with respect to employees who would not have been eligible for coverage under any group health plan maintained by the applicable large employer member as of December 27, 2012. **Example:** If during an open enrollment preceding December 27, 2012, an employer offered coverage under a fiscal-year plan with a plan year starting on July 1, 2013, to at least one-third of its employees, the employer could likely avoid liability for a Play or Pay Rule penalty if, by July 1, 2014, it expanded the plan to offer coverage that satisfies the Play or Pay Rule provisions to the full-time employees who had not been offered coverage. For purposes of determining whether a plan covers at least one-third (or one-quarter) of an employer's employees, the employer may look at any day between October 31, 2012, and December 27, 2012.
When Penalty Under Play or Pay Rule Is Effective (General)	No Play or Pay Rule penalty will be imposed against an employer with a non-calendar year plan with respect to any employees who are eligible to participate in a fiscal-year plan under its terms as of December 27, 2012 (whether or not they take the coverage). This relief is available until the first day of the non-calendar plan year starting in 2014 and is only available if an employee described therein is offered affordable, minimum value (MV) coverage no later than the first day of the 2014 plan year.

What Happens if a Large Employer Does Not Offer Coverage?

A large employer that fails to offer Minimum Essential Coverage (MEC) to all "full-time employees (and their dependents)" may be subject to the Play or Pay penalty beginning in 2015. The guidance confirms that employers must also offer dependents the opportunity to enroll in MEC or be subject to this penalty.

Dependents include the employee's children under age 26 as defined under Section 152(f)(1), but importantly does not include the employee's spouse. The definition of child includes son, daughter, stepson, stepdaughter, adopted child, child placed for adoption, and foster child.

The penalty for not offering coverage is equal to the number of full-time employees employed during the year, minus 30, multiplied by $2,000.

The proposed regulations alleviate employers' concerns that they might be subject to a penalty based on their entire full-time population if they inadvertently failed to offer MEC to some of their full-time employees. If an employer offers MEC to all but 5% of its full-time employees (or, if greater, 5 employees) it will be treated as offering coverage to its full-time employees. However, to be considered offered to an employee, it must also be offered to the employee's dependents. Importantly, this relief applies "regardless of whether the failure to offer was inadvertent."

Minimum Value (MV) Coverage

An employee could potentially receive an Exchange subsidy if the employer's health plan does not provide "minimum value." The statute states that a plan does not provide "minimum value" if the "plan's share of the total allowed cost of benefits provided under the plan is less than 60% of such costs."

HHS has issued an "actuarial value calculator" and a "minimum value calculator" and they are available on the Center for Consumer Information & Insurance Oversight (CCIIO) web site: *www.cms.gov/cciio/index.html*. The employer can input information about the plan's benefits, coverage of services and cost-sharing terms to determine if a plan has MV coverage.

The penalty for providing coverage that is not affordable or does not comply with MV coverage under ACA guidelines is equal to the lesser of $3,000 per employee who qualifies for a subsidy in the Exchange, or $2,000 per full-time employee.

HCR TIP

"No Coverage" Example

In 2014, XYZ Company has a total of 60 full-time equivalent (FTE) employees: 50 of them work at least 30 hours while the rest work 25 hours a week as part-time employees.

Since the company does not offer coverage, several of its full-time (FT) employees went to the Exchange and received a premium credit.

Result: The Company was fined $40,000 for failure to provide annual coverage.

The Math: (50 FT employees - 30) x $2,000 = $40,000

HCR TIP

"Not Affordable" or "Not MV Coverage" Example

In 2014, JKL Company has 100 FT employees. The company plan was unaffordable or not of minimum value, so 10 of its FT employees went to the Exchange and received a premium credit.

The annual penalty is the lesser of the following calculations:

(100 FT - 30) x $2,000 = $140,000 annual penalty

or

10 FT x $3,000 = $30,000 annual penalty

The Result: Because $30,000 is less than the $140,000, the employer will pay $30,000.

Note: An employer would not be fined a penalty if it has 30 or fewer FT employees, since the penalty is based on the lesser of two calculations.

MV Calculator:
http://blog.lisibroker.com/wp-content/uploads/2013/04/mv-calculator-final-2-20-2013.xlsm

Minimum Value (MV) Coverage *(cont.)*

It should be noted that these penalties are only triggered if an employee goes into the Exchange and qualifies for a subsidy. If all employees accept the employer's plan, whether affordable or providing MV coverage or not, the plan will be deemed in compliance and the employer will not be subject to penalties.

Affordability

As stated previously, the ACA's affordability standard is that the employee's cost for self-only coverage must not exceed 9.5% of household income. Obviously, it is going to be difficult for an employer to know household incomes of all their employees, so the law has allowed several "Safe Harbors" for employers.

SAFE HARBOR	DESCRIPTION
Federal Poverty Line (FPL) Safe Harbor	Coverage will be affordable for a calendar month if the employee's required contribution for lowest-cost, self-only coverage that provides minimum value under the plan does not exceed 9.5% of a FPL Safe Harbor. The FPL Safe Harbor is determined by calculating the FPL for a single individual (where individual is employed) for applicable calendar year, divided by 12. **Current FPL:** *http://aspe.hhs.gov/poverty/13poverty.cfm* **Foundation for Health Coverage Education (FHCE) FPL Chart:** *http://coverageforall.org/wordpress/wp-content/uploads/2013/04/FHCE_FedPovertyLevel2013.pdf*
Form W-2 Safe Harbor	Verifies whether the employee's required contribution for the calendar year for the employer's lowest-cost, self-only coverage that provides minimum value during the entire calendar year does not exceed 9.5% of that employee's Form W-2 wages from the employer for the calendar year. COBRA and other continuation coverage are excluded.
Rate of Pay Safe Harbor	Coverage will be affordable for a calendar month if the employee's required contribution for the month for lowest-cost, self-only coverage that provides minimum value does not exceed 9.5% of a Rate of Pay Safe Harbor Amount. This Rate of Pay Safe Harbor Amount equals 130 hours, multiplied by employee's hourly rate of pay as of the first day of the coverage period (generally first day of plan year). For salaried employees, monthly salary is used instead of hourly rate of pay. An employer can use any reasonable method to convert payroll periods to monthly salary.

Employee Categories

There are several categories of employees that need to be considered when determining employer size and penalty liability:

EMPLOYEE CATEGORY	DEFINITION	SUBJECT TO PENALTY?
Full-Time	Employee working 30 hours per week	Yes
Part-Time	Prorated	No
Seasonal	Not counted, working less than 120 days in a year	Yes, for the month they work full-time
Temporary Agency	Generally counted as working for the temporary agency	Yes, for those counted working for the temporary agency [e.g., a professional employer organization (PEO)]

NOTE: The tax penalty is calculated on a monthly basis. $2,000 and $3,000 represent the annual fee per employee. To calculate the monthly fee, divide the annual fee amount by 1/12.

Individual Mandate

It is important to note that as of January 1, 2014, the Individual Mandate provision of the ACA will be implemented. The law says that all American citizens and legal residents are required to purchase qualified health insurance coverage.

Exceptions are religious objectors, undocumented immigrants, persons who are incarcerated, and those persons who have incomes less than 100% of the poverty level. Also excluded are members of Native American tribes, and persons who have been without coverage for less than 3 months. Individuals who

HCR SNAPSHOT

Premiums for health insurance bought through Exchanges vary by age. The Congressional Budget Office estimates that the national average annual premium for Bronze coverage in an Exchange in 2016 will be $4,500–$5,000 for an individual and $12,000–$12,500 for a family.

If an employee has an affordable offer for self-only coverage, that employee's dependents are not eligible to receive a tax credit to purchase insurance through the Exchanges. A spouse that is not offered coverage (or dependents who are not offered coverage through a small employer) would be eligible for tax credits.

Requirement to Buy Coverage Under the ACA Beginning in 2014

START

Do any of the following apply?

- You are part of a religion opposed to acceptance of benefits from a health insurance policy.
- You are an undocumented immigrant.
- You are a member of an Indian Tribe.
- Your family income is below the threshold for filing a tax a return (in 2013, $10,000 for an individual and $20,000 for a family).
- You have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

YES → There is no penalty for being without health insurance.

NO

Were you insured for the whole year through a combination of any of the following sources?

- Medicare.
- Medicare or the Children's Health Insurance Program (CHIP).
- TRICARE (for service members, retirees, and their families).
- The veteran's health program.
- A plan offered by an employer.
- Insurance bought on your own that is at least at the Bronze level.
- A grandfathered health plan in existence before the ACA was enacted.

YES → The requirement to have health insurance is satisfied and no penalty is assessed.

NO

There is a penalty for being without health insurance.

2014

Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.

2015

Penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2.0% of family income, whichever is greater.

2016 and Beyond

Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

NOTE: Income is defined as total gross income in excess of the filing threshold (in 2013, $10,000 for an individual and $20,000 for a family). The penalty is prorated by the number of months in a year. The penalty cannot be greater than the national average premium for Bronze coverage in an Exchange. After 2016, penalty amounts are increased annually by the cost of living.

The Exchanges

Starting January 1, 2014, the ACA requires all states to have a health insurance exchange where individuals and small employers can purchase insurance coverage. In California, the Exchange—Covered California—will offer 1 option for individuals to enroll, as well as a SHOP.

Coverage Tiers

Exchange plans will be offered in a tiered format. The tiers are named after metals: bronze, silver, gold and platinum. Each tier will have several plans to choose from and will include essential health benefits. Bronze plans will have the lowest monthly premium, but cost shares will be more when health care services are provided. Platinum plans will have the highest monthly premium, but cost shares will be less.

TIER	COVERAGE
Platinum	90%
Gold	80%
Silver	70%
Bronze	60%

Essential Health Benefits (EHBs)

All plans offered both inside and outside of the Exchange must include EHBs as defined by the ACA. For a list of the 10 categories of care, see the section on EHBs within this Guide.

> *NOTE: Employers can still get a Small Business Tax Credit in the Exchange. Employers may get a tax credit for 50% of their share of health insurance coverage, but it is only available to employers who purchase through the SHOP Exchange, and it is only available for two years.*

Other Items of Interest

Not all provisions of the ACA will affect employers directly, but there are some regulations that employers should be aware of in case employees come to them with questions.

PPACA REGULATION	EMPLOYER ACTION REQUIRED
Annual Limits SG	As of January 1, 2014, all plans—grandfathered and non-grandfathered—are prohibited from issuing annual dollar limits on coverage of EHBs.

Other Items of Interest *(cont.)*

PPACA REGULATION	EMPLOYER ACTION REQUIRED
Community Rating SG	Beginning in 2014, issuers that offer coverage in the small group market will no longer apply Risk Adjustment Factors (RAF) since the overall health of a group will not be taken into account. All insurers selling personal or small group products must also use the Adjusted Community Rating (ACR). With ACR (sometimes called Modified Community Rating), insurers calculate the Community Rating and can adjust their cost based only on family size, location of residence, tobacco-usage, and age with limitations. An example of these limitations are: Cannot charge the oldest individuals they insure more than 3 times what they charge the youngest person. Cannot charge tobacco users more than 50% more than what they charge non-tobacco users. **Note:** Grandfathered health plans and self-insured plans are exempt from this requirement.
Coverage for Adult Children Up to Age 26 SG LG	Implemented in 2011, this provision allows coverage for adult-aged children to age 26 if no other employer-sponsored coverage is available (including grandfathered plans). Only plans providing dependent coverage of children are required to adopt the Age 26 Requirement. If a plan does not offer dependent coverage, the plan does not need to cover an employee's children. Dependents cannot be subject to requirements, such as being a full-time student, being the employee's tax-dependent or being single. However, until 2014, grandfathered plans that are not materially changed may deny coverage to a child who is eligible to be covered under another group health plan. Also, a child is not required to be covered unless the employee-parent is covered. Plans are not required to cover a child's spouse or child.
Guaranteed Issue (GI) SG LG	Starting January 1,2014, carriers must guarantee coverage regardless of pre-existing conditions.
Limited Medical Expense Deductions SG LG	This regulation is already implemented. The threshold for including itemized medical expenses as income tax deductions increases from 7.5% to 10% of adjusted gross income.
Unearned Income Tax Increase on High-Income Earners SG LG	This regulation is already implemented. This 3.8% tax is calculated by multiplying the tax rate by the lower of either the net investment income for the year or the modified adjusted gross income over the threshold amounts.

Online Resources

We have put together these resources to help you make informed decisions while navigating the waters of Health Care Reform.

Web Sites

- **Department of Health and Human Services (HHS) HealthCare.gov:** www.healthcare.gov
- **IRS ACA Tax Provisions:** www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions
- **Department of Labor ACA Portal:** www.dol.gov/ebsa/healthreform
- **Center for Consumer Information & Insurance Oversight:** www.cms.gov/cciio/index.html
- **California Health & Human Services:** www.healthcare.ca.gov
- **California Exchanges:** www.healthexchange.ca.gov/Pages/Default.aspx
- **Covered California (Exchange):** www.coveredca.com
- **Foundation for Health Coverage Education (FHCE):** coverageforall.org
- **NAHU:** www.nahu.org
- **CAHU:** www.cahu.org

Carrier Health Care Reform Web Sites

- **Aetna:** www.aetna.com/health-reform-connection/index.html
- **Anthem:** www.makinghealthcarereformwork.com/healthcarereform
- **CIGNA:** www.cigna.com/aboutus/health-care-reform
- **Health Net:** www.healthnet.com
- **Humana:** www.humana.com/resources/healthcare_reform
- **Kaiser Family Foundation:** kff.org/health-reform
- **UnitedHealthcare:** www.uhc.com/news_room/health_care_reform.htm

Calculators

- **Full-Time Equivalent (FTE) Calculator:** www.healthlawguideforbusiness.org/fte-calculator
- **Small Business Tax Credit Calculator:** www.smallbusinessmajority.org/tax-credit-calculator
- **Health Reform Subsidy Calculator:** healthreform.kff.org/SubsidyCalculator.aspx#incomeAgeTables
- **Actuarial Value Calculator:** www.cciio.cms.gov
- **Minimum Value (MV) Calculator:** www.cciio.cms.gov
- **Medical Loss Ratio (MLR) Rebate Tool:** www.bcnepa.com/Brokers/MlrRebate.aspx
- **Covered California (Exchange) Health Insurance Cost-Estimate Calculator:** www.coveredca.com/calculating_the_cost.html

Glossary

Accountable Care Organization (ACO): A group of health care providers that have entered into a formal arrangement to assume collective responsibility for the care of a specific group of patients and that receive financial incentives to improve the quality and efficiency of health care.

Actuarial Value (AV): A mathematical calculation used to determine the monetary value of benefits.

Additional Hospital Insurance Tax: The Medicare Hospital Insurance Tax, also known as the Medicare Tax, increased the employee portion of the hospital insurance tax part of FICA starting in January 2013, by .09% for certain high-income earners ($250,000 for a joint return or surviving spouses; $125,000 for a married individual filing in a separate return; and $200,000 for all other cases). The employee's portion is withheld each pay period and paid with the employer-match by the employer to the IRS.

This additional assessment also applies to self-employed workers.

Administrative Period: The period up to 90 days used to determine employee eligibility for benefits and to enroll employees.

Adult Dependents: Individuals ages 22 to 26 who, under the PPACA, can remain covered under their parents' employer-sponsored or individually-purchased health benefit plans.

Affiliated Service Group: Defined as a type of group of related employers and refers to two or more organizations that have a service relationship and, in some cases, an ownership relationship. They can be categorized as:

- **A-Organization groups (referred to as A-Org): Consist of an organization designated as a First Service Organization (FSO) and at least one "A organization."**
- **B-Organization groups (referred to as B-Org): Consists of an FSO and at least one "B organization."**
- **Management groups.**

Affordability (as it relates to Affordable Coverage): A term used in the ACA to designate coverage available to individuals and the level of family income that is considered available to pay health insurance premiums.

Affordable Care Act (ACA): See **Patient Protection and Affordable Care Act (PPACA)**.

American Health Benefit Exchanges: The ACA-designated name for the state- and federally-operated Health Information Exchanges where individuals can purchase health insurance, guarantee issue, starting in 2014.

Basic Health Programs: A health insurance program for low-income individuals who are ineligible for Medicaid, yet whose incomes do not exceed twice the Federal Poverty Level (FPL). This was created as an option under the PPACA for states to be able to cover their low-income population directly, rather than through an Exchange. States choosing to implement a Basic Health Program will receive direct federal assistance for the cost of establishing and administering such programs equal to the premium support available were low-income individuals to enroll into an Exchange-qualified health plan.

Cadillac Health Plan: A term used to describe health coverage available through employee health benefit plans where the value of the coverage exceeds a stated annual dollar threshold.

Center for Consumer Information & Insurance Oversight (CCIIO): The CCIIO is charged with both overseeing and assisting with the implementation of the ACA both for public and private health insurance.

CLASS Act: A federal program of voluntary long-term care insurance. This is delayed and awaiting further regulatory guidance.

Glossary *(cont.)*

Controlled Group: A combination of two or more corporations that are under common control. It can be categorized as:

- Parent-Subsidiary
- Brother-Sister
- Combination of the Above

Department of Health and Human Services (HHS): The federal cabinet-level agency that administers federal health, welfare, and human services programs and activities. HHS has lead-agency responsibility for significant aspects of the ACA. HHS is home to the following agencies involved with the ACA: Center for Medicare and Medicaid Innovation, the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), the HHS Office of Inspector General (OIG), the HHS Office for Civil Rights (OCR), the HHS Office of Minority Health (OMH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Indian Health Service (IHS).

Department of Labor (DOL): The federal cabinet-level agency responsible for administration and enforcement of the Employee Retirement Income Security Act (ERISA), a federal law that sets requirements for private employer-sponsored health benefit plans, both self-insured and fully-insured plans.

Discrimination Based on Health Status: This is the practice by insurers to deny coverage both prior to or following enrollment in a plan. This term applies to both total coverage denial and the imposition of waiting periods or exclusionary periods for individuals with pre-existing condition following enrollment. Post-enrollment discrimination can involve the use of flat limits on treatment (expressed either on a dollar or quantitative basis) that are aimed at limiting coverage for costlier conditions.

Discrimination in Health Care: Typically used to define providers differing patient treatment based on race, gender, age, ability to pay for care, disability, language, or severity of illness. The ACA extends the definition to also apply to employer's inability to discriminate in eligibility, waiting period, benefits or contributions in favor of highly-compensated employees. Delayed pending further guidance.

Employee Benefits Security Administration (EBSA): A division of the DOL charged with enforcing the rules governing the conduct of plan managers, the investment of plan assets, the reporting and disclosure of plan information, the fiduciary provisions of the law, and workers' benefit rights.

Employer Mandate: See **Employer-Shared Responsibility**.

Employer-Shared Responsibility (Play or Pay): Requires large employers to assist workers and their dependents with coverage costs, either through the provision of a health plan or through a contribution toward coverage via a payment on the individual's behalf to an Exchange.

Essential Health Benefits (EHBs): The ACA-required minimum level of coverage that must be offered by qualified health plans in order to operate in an Exchange. There are 10 categories that must be covered:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices

Glossary *(cont.)*

Essential Health Benefits (cont.)

- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

Excessive Waiting Periods: The period of time before an employee is eligible to sign up for health coverage under an employer's plan. The ACA limits waiting periods to no more than 90 days. In California, the maximum waiting period is 60 days for small and large groups.

Exchange-Eligible Employer: An employer that is permitted to obtain coverage for its employees through an Exchange.

Exchange-Eligible Individual: An individual who is permitted to obtain coverage through a state health insurance exchange.

Exchanges: State health insurance "marketplaces" created by the ACA that will begin coverage in 2014 with open enrollment beginning October 2013. There are two types of Exchanges: the Individual Exchange and the Small Business Health Options (SHOP) Exchange. It is the responsibility of the Exchanges to calculate and determine premiums subsidies, enrollment, quality oversight, certification of qualified health plans that can be sold in the exchange, and other matters.

Excise Tax: A tax on health insurance and health benefit plans whose annual dollar value exceeds a specified limit, as well as on the sale of certain health care items and services, such as medical devices and equipment. See also **Cadillac Health Plan**.

Federal Labor Standards Act (FLSA): Federal legislation that protects U.S. workers from unfair labor practices, such as unequal pay, excessive work hours, lack of over-time compensation, and unsafe working conditions.

Federal Poverty Level (FPL): Income criteria, published annually by the HHS, most commonly used to determine eligibility for government-sponsored health coverage programs, such as Medicaid and CHIP. Incomes between 138% and 400% of the FPL have been deemed eligible by the ACA for coverage subsidies if insurance is purchased through an Exchange.

Flexible Spending Account (FSA): A type of savings account that provides the account holder with specific tax advantages. FSAs are set up by an employer for an employee. Employees can choose to contribute a portion of their paychecks to pay for qualified medical and dependent care expenses.

Full-Time (FT) Employee: According to the ACA, an employee who works an average of 30 hours per week or 130 hours per month.

Full-Time Equivalent (FTE) Employee: Two or more part-time employees whose combined hours per week add up to a single full-time employee.

Grandfathered Plan: A grandfathered plan is any plan in which an individual was enrolled—either directly or through any group plan—on March 23, 2010. A plan loses its grandfathered status if changes are made to the plan's coverage that significantly decrease the benefits, materially increase cost sharing by participants or substantially increase the cost of coverage paid by participants.

Guaranteed Issue (GI) and Renewal: When an insurer can no longer deny enrollment or drop health coverage for reasons other than fraud or non-payment of premiums. The ACA mandates that all health insurance plans be guaranteed issue, as they relate to pre-existing health conditions. Insurers, therefore, cannot deny enrollment or drop coverage due to an individual having a pre-existing condition.

Glossary *(cont.)*

HealthCare.gov: The web site maintained by the CCIIO and HHS that is tasked with providing individuals with information on the ACA, available insurance options, data on care quality, and resources for disease prevention.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that regulates health information privacy, health insurance portability and non-discrimination, and health insurance simplification, and whose provisions have been broadly expanded by the ACA.

Individual Mandate: The ACA requirement that all individuals obtain health insurance or incur a tax penalty. This is also referred to as "individual responsibility."

Large Employers: Defined as more than 50 full-time employees. In California, this will remain in place until 2016, when it will increase to more than 100 full-time equivalent (FTE) employees.

Medical Loss Ratio (MLR): MLR is the proportion of premium dollars that an insurer spends on health care services and certain recognized plan administration costs relative to health insurance premium paid by subscribers. Permissible levels are 80% in the individual market and 85% in the group market.

The ACA requires all health insurers to submit an annual report to the Secretary of HHS regarding their MLR and to provide rebates in circumstances in which losses exceed the stated percentages. MLR and rebate requirements apply to both new and grandfathered insurance plans and went into effect for plan years beginning September 23, 2010.

Medicare Donut Hole: The uncovered portion of a Medicare beneficiaries' Part D prescription drug benefit plan that leaves them financially obligated for the cost of covered prescription drugs once a certain level of expenditures is reached during an enrollment year.

The ACA is proposed to gradually eliminate the donut hole.

Medicare Part D: The out-patient prescription drug benefit component of Medicare that gives beneficiaries the option of paying a premium and enrolling in an out-patient prescription drug plan that will pay a portion of their prescription drug costs.

Minimum Essential Coverage (MEC): All U.S. citizens, under the ACA, must be enrolled in a minimum insurance package, defined as follows:

- Coverage under a specified government-sponsored program (i.e., Medicare, Medicaid, etc.)
- Coverage under an eligible employer-sponsored plan
- Coverage under a health plan offered in the individual market either outside of or within an Exchange
- Coverage under a grandfathered health plan (this is not required to comply with the ACA's EHB requirements)
- Other health benefits coverage that the Secretaries of the Departments of HHS and the Treasury recognize

Minimum Value (MV): ACA-imposed rule on employer group plans that states if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs," then it fails to offer MV.

Navigator Programs: ACA-established programs that employ willing participants (who may not work for insurers or be paid by insurers for plan enrollments) to assist individuals and small employers with evaluating their insurance options within an Exchange.

Glossary *(cont.)*

New Tax on Investment Income: A 3.8% Investment Tax assessed on investment income earned by individuals whose income from wages and investments exceed the above thresholds. Investment income includes interest (except municipal bond interest), dividends, rents, royalties, capital gains on sales of investment instruments and bonds, taxable portion of insurance annuity payouts (unless from a company pension plan), passive income from rents and businesses the taxpayer does not actively participate in, and taxable gain on the sale of a home over the $500,000 exclusion ($250,000 for single filers).

When applying the additional Medicare Tax and the Investment Tax to a hypothetical married couple filing jointly who earns $400,000 of income ($200,000 from wages and $200,000 from investments) in 2013, we see that although that couple would not owe any additional Medicare Tax, because their wages are within the threshold, they would owe an additional income tax: [$400,000 Adjusted Gross Income (AGI) - $250,000 threshold = $150,000 x 3.8%].

If another married couple filing jointly earned $500,000 of income in 2013 ($300,000 from wages and $200,000 from investments), they would owe an additional $9,950.00 in taxes: ($300,000 - $250,000 = $50,000 x 0.9% = $450 for the Medicare Tax) and ($500,000 - $250,000 = $250,000 x 3.8% = $9,500.00 for the Investment Tax).

If the additional Medicare Tax is not withheld by an employer, an employee is liable to pay it with the 1040 filing. Both the additional Medicare Tax and the Investment Tax should also be taken into account when determining whether or not an employee should pay estimated taxes to avoid penalties and interest.

Patient-Centered Outcomes Research Institute (PCORI): A federal authority created by the ACA that operates as a non-profit corporation with the purpose of advancing the quality and relevance of evidence that can be used by patients, clinicians, purchasers, and policymakers to make informed health care decisions.

The PCORI must be governed by the following, according to the ACA: a Board of Governors consisting of the Director of the Agency for Healthcare Research and Quality; the Director of the National Institutes of Health and 17 members appointed by the U.S. Comptroller General; patients; providers; drug and device manufacturers; health services researchers; experts in quality improvement; and additional federal and state government officials.

Patient-Centered Outcomes Research Trust Fund: A dedicated trust fund that provides support for comparative clinical effectiveness research between Fiscal Year (FY) 2010 and 2019. Funding is derived from general revenues, fees, and Medicare Parts A and B.

Patient Protections: Certain laws establishing protections for patients, such as the right to health information, choice of provider, access to care, the right to file a grievance, or the right to appeal a denied health benefit claim.

Patient Protection and Affordable Care Act (PPACA): The formal name of the health reform law enacted in 2010. Also known as the ACA, Obamacare, and The Act.

Plan Disclosure: A requirement in the PPACA to provide consumers with information on the terms and conditions of health insurance policies and the relationships between insurers, providers, pharmacy benefit managers, and other third-party benefit providers.

Premium Tax Credits: Refundable tax credits, paid in advance, that are used for the purchase of health insurance through a state health insurance exchange. Individuals with family incomes greater than 133% of the FPL, but below 400% of the FPL will be eligible for premium credits beginning in 2014.

Glossary *(cont.)*

Rating Regions: AB 1083 established 19 rating regions in the State of California.

- **Rating Region 1:** Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne
- **Rating Region 2:** Napa, Sonoma, Solano, and Marin
- **Rating Region 3:** Sacramento, Placer, El Dorado, and Yolo
- **Rating Region 4:** San Francisco
- **Rating Region 5:** Contra Costa
- **Rating Region 6:** Alameda
- **Rating Region 7:** Santa Clara
- **Rating Region 8:** San Mateo
- **Rating Region 9:** Santa Cruz, Monterey, and San Benito
- **Rating Region 10:** San Joaquin, Stanislaus, Merced, Mariposa, and Tulare
- **Rating Region 11:** Fresno, Kings, and Madera
- **Rating Region 12:** San Luis Obispo, Ventura, and Santa Barbara
- **Rating Region 13:** Mono, Inyo, and Imperial
- **Rating Region 14:** Kern
- **Rating Region 15:** Los Angeles (North)
- **Rating Region 16:** Los Angeles (South)
- **Rating Region 17:** San Bernardino and Riverside
- **Rating Region 18:** Orange
- **Rating Region 19:** San Diego

Rescission: The cancellation or refusal to renew a health insurance policy following issuance, typically after the filing of medical claims. A policy may be rescinded in cases in which an individual made material misrepresentations of health status at the time of enrollment. Insurers have been found liable for rescinding policies simply because medical claims were filed and in the absence of any fraud on the part of the enrollee.

SHOP Exchanges: See **Small Business Health Option Program.**

Small Business Employer Health Plan: A plan offered by an employer with fewer than 50 full-time employees.

Small Business Health Options Program (SHOP): The state-based insurance exchanges created by the ACA through which small employers will be able to purchase health insurance for their employees starting in 2014.

Small Business Tax Credit: A tax credit for small employers to help offset the cost of health insurance coverage provided to their employees. Eligible small businesses consist of those with 25 or fewer employees whose employees' average annual wages do not exceed specified limits.

Glossary *(cont.)*

Small Employers: Employers that, on an average business day, employ 50 employees or fewer. In California, this definition will remain in place until 2016, when it will increase to 100 full-time equivalent (FTE) employees or fewer.

Stability Period: The period during which employee status determined in the standard measurement period is fixed regardless of hours worked during the stability period.

Standard Measurement Period: 3- to 12-month period used to determine employee status for a full-time employee. An employee is considered full-time if work averaged at least 30 hours per week during this period.

State Health Insurance Exchanges: State-based marketplaces for the sale and purchase of health insurance established in federal law and operated in accordance with federal requirements. Health insurers that sell products in the exchanges to small employers and individuals will be required to meet federal standards of coverage, fair practices, and plan administration.

Summary of Benefit Coverage (SBC): A summary of a health plan's benefits and coverage. It must be included with the enrollment materials provided during annual open enrollment to each participant and beneficiary who is eligible to participate. Model language and templates are available on the DOL web site: *www.dol.gov/ebsa/healthreform*.

Wellness Programs: Special services and benefits offered by employers to employees in addition to coverage under health benefit plans. First authorized in HIPAA, wellness programs offer participation "incentives," such as premium or cost-sharing discounts, as a means of encouraging employees to lose weight, quit smoking, follow health-maintenance regimens, and generally adopt healthier lifestyles.

Notes

Do you have questions or need further assistance?
Please contact me today!

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