

Affordable Care Act's Employer Mandate: Deciding Whether Your Organization Should Pay or Play

Editor's Note: On April 17, 2013, WorldatWork hosted the second webinar of a three-part town-hall series event aimed to educate benefits practitioners on key elements of the Patient Protection and Affordable Care Act of 2010 (PPACA). Following are the questions asked and submitted during the second town hall, "Employer Mandate: Deciding Whether Your Organization Should Pay or Play?" These FAQs are for educational purposes only and are not intended, and should not be relied upon, as legal or accounting advice.

Background:

In January 2013, the U.S. Department of Treasury and Internal Revenue Service (IRS) issued comprehensive guidance in the form of a Notice of Proposed Rulemaking (NPRM) and a question-and-answer (Q&A) document regarding the employer shared-responsibility provisions under the Affordable Care Act. While this guidance was issued in the form of an NPRM, it specifically states that employers can rely on this NPRM for compliance until final rules are issued. It also said that outstanding issues will be addressed in future regulations. In January, the U.S. Department of Health and Human Services also issued proposed rules on exchange eligibility appeals and other provisions. All of the answers to the questions below can be attributed to these three documents.

- Department of Treasury and IRS [NPRM Shared Responsibility for Employers Regarding Health Coverage](#)
- [IRS Q&As on Employer Shared Responsibility Provisions Under the Affordable Care Act](#)
- [HHS Proposed Rules on Exchange Eligibility Appeals and Other Provisions](#)

[FAQs](#) are also available from March 20, 2013, town hall "Large or Small: How Is Your Company Defined Under the Affordable Care Act?"

Grandfathered Plans

1. *How do these rules apply to grandfathered plans that might remain grandfathered in 2014?*

Most health insurance plans that existed on March 23, 2010, are eligible for grandfathered status and, therefore, do not have to meet all the requirements of the health-care law. But if an insurer or employer makes changes to a plan's benefits or how much members pay through premiums, co-pays or deductibles, then the plan loses that status. A grandfathered plan has to follow some of the same rules other plans do under the Affordable Care Act. For example, the plans:

Cannot impose lifetime limits on how much health-care coverage people may receive
Must offer dependent coverage for young adults until they reach age 26 (although until 2014, a grandfathered group plan does not have to offer such coverage if a young adult is eligible for coverage elsewhere).

- Cannot retroactively cancel coverage because of a mistake made by the member when applying, a practice known as a rescission.
- However, there are many rules grandfathered plans do not have to follow. For example, the plans:
 - Are not required to provide preventive care without cost-sharing.
 - Do not have to offer a package of "essential health benefits" that individual and small group plans must offer beginning in 2014. (Large employer plans are not required to offer the essential benefits package even if they are not grandfathered.)

Although the law requires all health plans to provide important new benefits to consumers, it allows plans that existed on March 23, 2010, to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status. Changes made to a plan cannot:

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- Significantly cut or reduce benefits. For example, if a plan covers care for people with diseases such as diabetes, cystic fibrosis or HIV/AIDS, coverage for those diseases cannot be eliminated.
- Raise co-insurance charges. For example, a plan cannot increase a member's share of a hospital bill from 20% to 25%.
- Significantly raise co-payment charges. For example, a plan cannot raise its copayment from \$30 to \$50 in the next 2 years.
- Significantly raise deductibles. For example, it cannot raise a \$1,000 deductible by \$500 in the next 2 years.
- Significantly lower employer contributions by more than 5%. For example, it cannot increase its workers' share of the premium from 15% to 25%.
- Add or tighten an annual limit on what the insurer pays. Some insurers cap the amount they will pay for covered services each year. If the insurer wants to retain its status as a grandfathered plan, the plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).

Employee Subsidy Eligibility

1. *Employer-1 offers PPACA compliant coverage at 9.5% to husband and Employer-2 offers PPACA compliant coverage at 9.5% to wife. However, husband and wife don't want to spend 18% for their combined coverage and need coverage for their children, too. Can they qualify for assistance to purchase coverage in the exchange? Will any penalties be triggered as a result?*
 - In this situation, the whole family (husband, wife, dependents) could qualify for a federal subsidy through an exchange only if the family income is between the federal poverty line and four times the federal poverty line (federal poverty line = \$11,170 individual, \$23,050 family of four). However, because PPACA-compliant coverage was offered through their employers, the employers are not liable for any penalties.
2. *If an employer plan is deemed "affordable" for an individual to purchase coverage (based on the employee-only rate) but requires family coverage and an employee can't afford the employer premium for family coverage, and goes into the online marketplace*

(public exchange) to purchase family coverage, is the employee eligible for a federal subsidy?

- He/she could be. In this situation, the employee could accept coverage under the employer's plan, and the individual family members (including dependents) could qualify for a federal subsidy through the exchange only if the family income is between the federal poverty line and four times the federal poverty line (federal poverty line = \$11,170 individual, \$23,050 family of four). This is allowed because the affordability calculation for employer coverage is based on self-only coverage for the employee, not the family.
3. *Does an employer plan have to offer coverage to children to the age of 26, but not spouses? If an employer does this, can the spouse then be eligible for a federal subsidy in the exchange?*
 - Yes, if the spouse is not offered minimum coverage through his/her employer, then he/she could be eligible for a federal subsidy, depending on the family income. The spouse could qualify for a federal subsidy through exchange if the family income is between the federal poverty line and four times the federal poverty line (federal poverty line = \$11,170 individual, \$23,050 family of four).

Employer Offer of Coverage Requirements

1. *If I offer affordable health care to an employee, but he declines and goes through the exchange, will I still be fined?*
 - Not if you meet the affordability standard and minimum essential coverage requirements (4980H(a) and (b), referred to as the "A and B requirements"). As long as the employer offers both affordable and minimum-value coverage, the employer will not be fined if the employee elects to enroll in health coverage through another venue such as the exchanges. In this case, if the employee is full time, he/she would not receive any assistance/subsidy for the exchange because affordable minimum value coverage is available through his/her employer.
2. *Can I offer PPACA-compliant coverage only to certain employee classifications/groups and not to others (and let them go into the public exchange)?*
 - To avoid paying the penalties, employers must offer PPACA-compliant coverage to "substantially all" (95%) full-time employees and their dependents. The only

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classification that matters is whether an employee is full time.

3. *As long as one of my plans meets the affordability test and the 60% rule, I could offer other plans that don't comply with PPACA, correct?*
 - As long as an employer actually offers coverage that meets both requirements to “substantially all” (95%) of full-time employees and their dependents, that employer is meeting the requirements and can offer plans that do not comply. As long as the employer meets the requirements, full-time employees can enroll in any coverage they choose and the employer is not liable for a penalty.
4. *Does the law now require me to offer coverage to contract employees?*
 - Just like in the full-time equivalent calculations, independent contractors are not required to be covered under the employer shared-responsibility provisions, but this definition likely will be addressed in the future. Additionally, the IRS is very aware of workers being misclassified for tax purposes and employers should expect increased enforcement from regulators to ensure workers are classified correctly.
5. *Our company currently offers a plan that covers both active employees and retirees. Is it true that if I carve out the retirees into a separate stand-alone plan, then under PPACA I do not need to cover the dependent children of retirees?*
 - That is correct. The Affordable Care Act requires large employers to cover employees. It does not extend this coverage requirement to retirees.
6. *If an applicable large employer offers qualifying health-care coverage to employees and dependents but makes classification errors resulting in not offering coverage to “substantially all” (95% for more than 100 employees or all but five for fewer than 100 employees), the employer is liable for the employer shared-responsibility “A” penalty for not providing coverage (in addition to the premiums that they did pay) Is this in addition to any employer shared-responsibility “B” penalty for unaffordable coverage, or is it in lieu of the “B” penalty?*
 - No. First, the employer is only liable in this case if an employee receives a subsidy to enroll in an exchange. In this situation, the employer is only liable for the “A” penalty, not both, because coverage was not offered to “substantially all” full-time employees. The “B” penalty would only be in effect if the employer offered coverage to all, but it was deemed unaffordable or not providing minimum value. You cannot be hit with both!
7. *Regarding the “substantially all” (95%) rule: If an employee is not covered because he/she is under 26 and covered by a parent's health-care plan, Medicare, or he/she meets two or three other exceptions, is that employee treated as having been offered coverage? Meaning he/she doesn't have to be offered coverage through his/her own employer?*
 - As long as the employer offered coverage that meets all the requirements to substantially all full-time employees, regardless of age, any employee can go with whatever coverage he/she wants, even through the exchange (although he/she won't be eligible for a subsidy) and the employer is not liable for a penalty. The only time an employer is liable for a penalty is if it does not provide insurance that meets the affordable and minimum-value requirements and a full-time employee receives a subsidy to buy in the exchange.
8. *If an employer offers coverage to employees and their dependents, but employees only choose to cover themselves and not their dependents, is the employer responsible for paying a penalty?*
 - No, an employer penalty would not apply as long as affordable, minimum-value coverage is made available to dependent(s). Even if a dependent receives assistance to purchase through the exchange, as long as PPACA compliant coverage was offered, no penalty will be assessed.
9. *Can an employer offer coverage at the time the verification is received from the exchange if it is determined that the employee is in fact eligible for coverage (but wasn't offered coverage previously)?*
 - If the HHS/exchange verifies that an employee is eligible for a subsidy to enroll in the exchange and therefore his/her employer is liable for a penalty, then the employer will be notified of the liability regardless of whether coverage is offered after the fact.
 - HHS indicated that the appeal procedures in its proposed regulations are “separate and distinct” from

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the IRS process for assessing tax penalties under the employer mandate. A separate appeal procedure through the IRS will be available to address whether an employer will be subject to a tax penalty.

10. Does the mandate require employers to offer coverage to interns, co-ops and temporary staff?

- Only full-time employees and their dependents must be offered minimum, affordable coverage. Please refer to FAQs from the first town hall for details on who qualifies as a full-time employee.

11. Do employers have to do a look-back on hours to see if seasonal or temporary employees might be eligible for coverage?

- You have the option to use one of the safe harbor look-back methods to determine who is full time. Once you determine who is full time, only those employees must be offered PPACA-compliant coverage or the employer is liable for penalties. Although, according to recent guidance, seasonal and temporary employees are not required to be counted in the safe harbor methods. The safe harbors were covered in the first webinar that is available for download, along with FAQ's.

12. Do employers have to offer COBRA to independent contractors once their assignment is completed?

- True independent contractors, by definition, typically would not be offered health-care coverage, so COBRA would not be available.

13. You have to combine employee populations for companies with common ownership in determining the number of full-time employees and whether the company is an eligible large employer, but what about in respect to the "substantially all" requirement of offering PPACA compliant coverage? When using the "substantially all" provision, do you have to offer PPACA compliant coverage to 95% or more of all your parent and subsidiary companies combined or can you treat subsidiary companies separately for compliance?

- You can treat the parent company and all subsidiaries separately in respect to the "substantially all" requirement. The proposed regulations covering the employer shared responsibility include a specific rule that provides that, although applicable large employer status is determined on an aggregate basis,

the determination of whether each separate member entity within the controlled group (i.e., each applicable large-employer member) is in compliance with the employer play-or-pay mandate, and the amount of any play-or-pay penalty, is determined on a member-by-member basis. Therefore, the liability for, and the amount of, any play-or-pay penalty is computed and assessed separately for each member entity within the controlled group, taking into account that separate member entity's offer of affordable/minimum-value coverage (or lack thereof) and based on that separate entity's number of full-time employees. In other words, each member entity within a controlled group can decide whether to "play" or "pay" and its decision in this regard will not impact whether other member entities within the controlled group are deemed to be in compliance with the play-or-pay mandate.

- For example, if a parent corporation owns 100% of all classes of stock of 20 subsidiary corporations, and the controlled group in the aggregate is an applicable large employer, then each of the 21 members of this controlled group (the parent corporation plus 20 subsidiary corporations) is considered separately in computing and assessing a play-or-pay penalty (if any). In addition, each of the 21 group members is liable only for its separate compliance and penalty.

Penalty Questions

■ "The Big Penalty": 4980H(a)

- If an eligible large employer offers no minimum coverage to "substantially all" full-time employees (and their dependents) and at least one full-time employee receives assistance under Exchange:
 - A Must pay annual fee of \$2,000 for each full-time employee minus first 30 employees.
 - A Example: *If employer has 100 full-time employees and one is eligible and receives assistance for premium assistance under the Exchange, employer must pay \$2,000 x 70 employees or \$140,000.*

■ "The Lesser Penalty":

- If employer does offer minimum coverage to full-time employees (and their dependents) and a full-time employee receives assistance under Exchange, employer must pay fee if either test met:
 - A Employer coverage not affordable; or
 - A Does meet minimum value
- Annual fee is the lesser of: \$3,000 for each full-time

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employee receiving premium assistance; or \$2,000 for each full-time employee, minus first 30 employees.

1. *Is it true that if an employee at Company A waives coverage because he/she has health coverage through his/her spouse's Company B, Company A does not have to pay the \$2,000 or \$3,000 for that employee because they are covered?*
 - The penalties will only be assessed to an employer if an employee applies for and receives a subsidy to purchase coverage through the exchanges. In this situation, the employer is relying on the employee to not have a life change that would affect his/her health insurance coverage.
 - The only way to confidently avoid being hit with a penalty is to offer affordable, minimum-value coverage to substantially all full-time employees and their dependents. As long as employers meet these requirements, they should not be liable for the shared responsibility penalties, regardless of the coverage the full-time employee decides to enroll in, whether it's through spouse's employer, Medicare or the exchanges. Although, in that situation, the employee will not be eligible for assistance in the exchanges.
2. *What is the difference between the 9.5% calculation of household income and the 8% calculation that applies to the individual mandate?*
 - The 9.5% calculation refers to how employers determine whether the plans they offer are affordable and, therefore, meet their responsibility to the shared mandate. To be affordable, a full-time employee's premium share for self-only coverage must not exceed 9.5% of household income. There are three safe harbors: W-2 wages, hourly pay multiplied by 130, or the most recent federal poverty level for single individual. Because employers would not have access to this information for the whole family, employers would just use the employee's information.
 - This is only in respect to the employer portion of the mandate; any other percentage calculation should be treated as separate and unrelated to the employer mandate.
 - With regard to the individual mandate, an individual will not be required to pay the tax for not having qualifying health insurance if the health insurance premiums in the exchanges exceed 8% of their family income.
3. *Because the exchanges verify income, and the IRS would only have the latest tax return filing (2012), is the 9.5% calculation based on the prior year W-2 wages or projected wages for the current year?*
 - It is based on the current year's eligibility for coverage. So, in applying the safe harbor rule, an employer would want to use the projected W-2 wages for the current year.
4. *Do overtime hours count towards the 30-hour rule?*
 - Yes, all hours worked must be included. It is safe to say that all hours worked under FLSA apply in the calculation.
5. *How will an employer know if an employee receives a tax credit to purchase coverage through an exchange?*
 - If an individual is determined to be eligible for advance payment of tax credits or cost-sharing subsidies, the exchange will notify the employer of the potential tax penalty.
6. *Are variable pay employees (i.e., full-time sales personnel who are paid on draws/commissions and able to select medical benefits) considered exceptions?*
 - Again, there are specific safe harbors to determine status of employees with optional measurement periods, preceding a stability period. If an employee is deemed full-time during a measurement period, he/she must be treated as a full-time employee and offered coverage, regardless of what occurs with salary or hours worked, during the entire stability period. These safe harbors were covered in the first webinar that is available for download, along with FAQ's.
7. *Set-up: Employer has full-time, part-time and variable-hour employees and is going to use the safe harbor for variable-hour employees. Question: When the pay or play "A" penalty (not offering coverage to full-time employees) is calculated, are variable-hour employees determined to be eligible for health-care coverage included with the full-time employees in the penalty calculation?*
 - Yes. When calculating the penalty, and in the case of setting off a penalty, only full-time employees need to be considered. So, if the variable-hour employee is

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determined to be a full-time employee during the safe harbor look-back and treated as such in the following stability period, then he/she needs to be included in the penalty calculation.

- For clarity, the full-time equivalent calculation is separate and only used to determine if a company is an “applicable large employer” and, therefore, liable under the employer mandate/must offer coverage or pay a penalty. The full-time equivalent number (total hours/month/120) is not considered.
- For penalty purposes, all that matters is who is full time. PPACA-compliant coverage must be offered to all full-time employees, and the employer is liable only if a full-time employee receives assistance to purchase in the exchange.

Reporting Requirements

1. *What are my reporting requirements to the government?*
 - Employer requirements such as the timing, format, content and reporting process have not been finalized by the federal agencies, and numerous outstanding issues remain. Currently, the only thing that has been released in respect to this is verification for eligibility for assistance to purchase through the exchange and the employee/employer appeals process. Regulations regarding the verification and appeals process only describe the process, not what is required to be reported. HHS says the exchanges will verify information through certain means themselves, so currently the employer is not required to report anything. Although, without necessary information needed to appeal a decision, the burden would fall on the employer when they are verified as being liable for a penalty.

Miscellaneous Questions

1. *We have 29 full-time employees; however, we participate in a benefits trust that includes 4,000 employees. Are we considered a large employer?*
 - a. Large employer status only depends on the number of full-time equivalent employees an employer has working for them. It is based on hours, not benefits.
2. *If the 2014 initial open enrollment period for the public exchanges closes March 31, 2014, how does this work for employers with open enrollment periods that end way before that date? Under a Section 125 plan, is it allowable for an employee to opt out of the company plan at any time during the first quarter?*
 - Yes. The Treasury Department and IRS concluded that it is appropriate to provide transition relief from the election rules with respect to salary reduction elections under a cafeteria plan for an employer-provided accident and health plan with a fiscal year beginning in 2013. Specifically, the transition rules say employers can allow changes in elections on or after the first day of the plan year without regard to whether the employee experienced a change in status event. If an employer wants to permit this change in rule under the transition relief for fiscal plan years, it must incorporate these rules in its written cafeteria plan.
3. *How do the rules affect employers if they have their medical plans bundled with their dental and vision plans? Should employers make them separate? Will dental and vision be offered through the public exchanges and have available subsidies?*
 - With regard to employer responsibility, dental and vision plans don't need to be taken into account and will not be considered when evaluating whether an employer is liable for a penalty. The law has left the decision whether to offer dental and vision coverage through the exchanges to the states themselves.



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