What Every Business
Needs to Know About the

Patient Protection and Affordable Care Act

By Alden J. Bianchi

Mintz, Levin, Cohn, Ferris, Glovsky
and Popeo, P.C.

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Letter From the CEO

Dear Employer,

Robert Half is pleased to provide you with this comprehensive guide to the Patient Protection and Affordable Care Act (ACA).

As a specialized staffing firm, we are well attuned to the issues important to employers. This year, a chief concern for businesses has been assessing the costs and complexities of complying with the ACA.

With the assistance of Alden Bianchi, a leading ACA expert from the law firm of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., we have designed this guide to address the key questions our clients, including companies like yours, are likely to have about their responsibilities in complying with the ACA.

Robert Half offers its clients flexibility in meeting their variable human resources needs. If your business is or will be planning to hire additional employees, we may be able to help you evaluate your staffing options, including legitimate workforce strategies to minimize costs under ACA. Temporary or project professionals you engage through Robert Half are employees of Robert Half and not counted as your employees. We are responsible for providing health care coverage to our qualifying temporary employees in accordance with ACA guidelines.

We hope that this guide is helpful to you as you assess your staffing situation with regard to the ACA. We have attempted to provide you with a one-stop resource for better understanding the Act. To learn more and to follow further developments as new regulations are released this year, please visit our Small and Midsize Business Resource Center.

There are many advantages to using temporary or project staff, of course. The flexibility they provide can help your firm cost-effectively staff up or down in response to business demand. If you would like to discuss your options in person, please contact one of our Robert Half staffing professionals at 1.800.803.8367.

Sincerely,

Harold M. Messmer, Jr.
Chairman and CEO
Robert Half International

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Introduction

For employers, the deadlines for complying with the Patient Protection and Affordable Care Act (ACA) are fast approaching.

If your firm employs more than 50 full-time *and* full-time equivalent (FTE) employees, you must offer health insurance to your full-time employees and their eligible dependents by **January 1, 2014**, or face the possibility of penalties. Under a special transition rule, businesses have until **July 1, 2013**, to begin counting. (See also *Checklist: Important Dates for Businesses* at the end of this guide.)

Employers and the group health plans they sponsor are key components of the ACA, yet many employers — especially small businesses — are challenged by the Act's complex and still-emerging regulations. This guide addresses the design, operation and, perhaps most importantly, the costs to businesses of providing (or not providing) group health insurance coverage to their employees and families and dependents.

Note: This publication is not intended to offer legal advice. You should consult your own legal, tax and benefits professionals for advice on how the ACA affects your particular situation.

5 Things Every Business Needs to Know About the Affordable Care Act

1. **What's changing:**

   The ACA's "employer mandate" (also known as "pay or play" rules) imposes new rules on businesses with 50 or more full-time and full-time equivalent employees, which the Act refers to as "applicable large employers." Beginning in 2014, applicable large employers must offer health insurance coverage to their full-time employees and their eligible dependents or face the prospect of a penalty.

2. **Which small businesses qualify for tax credits:**

   The ACA provides a tax credit to certain small businesses with no more than 25 full-time and full-time equivalent employees that choose to offer health insurance to their employees. The credits are as large as 35 percent today and increase to 50 percent in 2014.

3. **Which plans are "grandfathered in":**

   Group health plans that existed on March 23, 2010, and that satisfied certain procedural requirements ("grandfathered" plans) are exempt from some of the ACA's requirements.

4. **What kind of coverage must be provided:**

   Large fully insured plans and self-funded arrangements have wide latitude in designating which benefits to cover, with some limits on out-of-pocket maximums. In contrast, small groups must offer a set of "essential health benefits" that are subject not only to a limit on out-of-pocket maximums but also to separate limits on deductibles.

5. **How health insurance exchanges work:**

   The ACA creates public health insurance exchanges or marketplaces to facilitate the purchase of health insurance coverage by individuals and small groups. Coverage choices under the small group marketplace — the Small Business Health Options Program (SHOP) — will be available in 2014 for some state-run exchanges and in 2015 for all state- and federal-run exchanges.

Overview of the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act overhauls the regulation and financing of health insurance in the United States. Each of the federal government, state governments, health insurance issuers (i.e., state-licensed carriers), employers and individuals are subject to and affected by the Act's provisions. Among other things, the law makes far-reaching changes that impact health insurance in the individual and group markets and employer-sponsored group health plans, whether fully insured or self-funded.

What follows is a comprehensive list of frequently asked questions (FAQs) and responses to help businesses better understand the implications of the Act. While we believe this list of questions to be comprehensive, you should consult an attorney and/or tax specialist familiar with your particular business before making any decisions.

1. **What is the Patient Protection and Affordable Care Act?**

   The Patient Protection and Affordable Care Act is a 2010 law, the purpose of which is to improve the availability, quality and affordability of health insurance coverage in the United States. Among other things, it is designed to simplify the process of obtaining health insurance, particularly for individuals and small groups.

2. **Is the Patient Protection and Affordable Care Act the same as Obamacare?**

   Yes. The Patient Protection and Affordable Care Act is sometimes referred to as Obamacare, PPACA or ACA. For the purposes of this FAQ guide, we will refer to it as the "ACA."

3. **When does the Patient Protection and Affordable Care Act go into effect?**

   Various components of the ACA become effective each year from 2010 through 2018. The provisions of greatest interest to employers take effect in 2014.

4. **Why was the Patient Protection and Affordable Care Act passed?**

   The stated purpose of the ACA is to improve the availability, quality and affordability of health insurance coverage in the United States.

5. **Who is affected by the ACA?**

   The federal government, state governments, health insurance carriers, employers and individuals, among others, are subject to the ACA's provisions.

6. Can you explain the ACA's insurance market reforms that impact these plans?

Following are the fundamental insurance market reforms that apply to employers and the group health plans they sponsor:

- Required coverage of adult children up to age 26
- Before 2014, prohibition of pre-existing-condition exclusions for children under age 19 (after 2014, this includes all adults)
- Required coverage of preventive health services with no cost-sharing (i.e., deductibles and co-pays)
- No lifetime limits or annual limits on essential health benefits (except, for years before 2014, restricted annual limits are permitted)
- Prohibition on discrimination under an insured group health plan in favor of highly compensated individuals
- Additional choice of health care providers and access to certain services
- Use of a uniform explanation of coverage and standardized definitions (commonly referred to as a Summary of Benefits and Coverage, or SBC) and a uniform glossary
- Required appeals process for benefit denials, including an internal appeal and external review
- Prohibition on the rescission of coverage, except in the case of fraud or intentional misrepresentation of material fact, and required advance notice of cancellation of coverage
- Premium rebates for purchasers of health insurance (not self-insured coverage), if a specified percentage of premiums is spent on health care and activities that improve health care quality (commonly referred to as medical loss ratio or "MLR" rebates)
- Access to additional data about the particular health coverage, such as claims denials

7. Why does the ACA make so many requirements of businesses?

While the ACA is a massive piece of legislation, it works within and reforms existing market structures, the two most important of which are employment-based health insurance coverage and the provision of health insurance by private sector, state-licensed carriers. As sponsors and potential sponsors of group health plans, employers are significantly affected. While the Act imposes new rules on employers, it also requires U.S. citizens and green card holders to maintain health insurance coverage (see *Individual Coverage Mandate*, starting with FAQ 57).

8. I own a small business. Will my business pay more or less in health insurance costs as a result of the ACA?

With the enactment of the ACA, Congress sought to help small businesses gain a more equal footing with large corporations in their ability to offer affordable health benefits to their employees.

There are many variables that significantly affect the cost and availability of group health insurance products for small businesses. (Many of these variables are described in this guide.) How businesses choose to comply with the law will affect their costs. There are many factors beyond the control of small businesses that will impact costs, however, and many of these are currently unknown. It is therefore too soon to predict whether Congress' goal will be realized and small businesses will be on more equal footing with their big-company counterparts in terms of the affordability of employee health care coverage.

Key Insurance and Employer Terms Used in the ACA

Group Market

The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

Individual Market

The market for health insurance coverage offered to individuals that isn't in connection with a group health plan.

Large Group Market

The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by **a large employer**.

Small Group Market

The health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by **a small employer**.

Large Employer

The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. **This term should not be confused with "applicable large employer."**

Applicable Large Employer

A business that employed an average of at least 50 full-time and full-time equivalent (FTE) employees on business days during the preceding calendar year.

Small Employer

The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Employer Shared Responsibility (Employer Mandate)

The most fundamental aspect of the ACA as far as employers are concerned is called "employer shared responsibility." It is also termed the **"employer mandate"** and the **"pay or play mandate."**

9. What does employer shared responsibility entail?

In simplest terms, it means that, effective January 1, 2014, an "applicable large employer" (see FAQ 10) must offer to its full-time employees and their eligible dependents health care coverage under an employer-sponsored plan that is "affordable" (see FAQ 22) and provides "minimum value" (see FAQ 21), according to the provisions of the ACA, or face a possible penalty (see FAQ 14).

10. What does the ACA consider an "applicable large employer"? In other words, at what size do these rules kick in for a small firm?

The ACA defines an "applicable large employer" as a business that employed an average of at least 50 full-time and full-time equivalent (FTE) employees "on business days during the preceding calendar year." As explained in FAQ 11 below, a "full-time employee" is an employee who is employed, on average, for at least 30 hours of service per week (or 130 hours in any month). The number of FTEs for a given month is determined by calculating the aggregate number of hours of service (up to 120 hours of credited service per employee) for all employees (including seasonal workers [FAQ 12]) with less than 30 hours of credited service per week and dividing the total hours of service by 120. The number of employees employed on average "on business days during the preceding calendar year" is determined by adding the number of full-time employees and FTEs for each calendar month in the preceding calendar year and dividing by 12 and, if necessary, rounding down to the nearest whole number.

11. I'm not sure I understand. What are full-time equivalent (FTE) employees, and how are they different from my full-time employees?

The concept of an FTE (for the purposes of the ACA) arises because the Act requires employers to take into account hours worked by **both full-time and full-time equivalent employees** in its calculations for the 50-employee minimum.

- **A full-time employee** is employed an average of 30 hours of service or more per week or 130 hours of service or more per calendar month (52 x 30 ÷ 12 = 130).
- **A full-time equivalent employee (or FTE)** is a combination of employees, each of whom individually is not a full-time employee, counted as a full-time employee equivalent. For example, 100 employees who work half time are the equivalent of 50 full-time employees. An employer determines its number of FTEs by aggregating all its non-full-time employees, taking into account no more than 120 hours in a month, then dividing by 120.

No-Coverage Penalty

Incurred by a business with at least 50 full-time or full-time equivalent (FTE) employees that *fails to offer* to at least 95 percent of its full-time employees (and their eligible dependents) the opportunity to enroll in a group health plan offered by the business; **and** any of its full-time employees have received a premium-assistance tax credit or cost-sharing reduction.*

Penalty:

The employer must pay an annual penalty of $2,000 for each of its full-time employees (excluding the first 30).

Coverage Penalty

Incurred by a business with at least 50 full-time or full-time equivalent (FTE) employees that *offers* to at least 95 percent of its full-time employees (and their eligible dependents) the opportunity to enroll in a group health plan of the business that is either **"unaffordable"** or fails to provide **"minimum value," and** any of its full-time employees have received a premium-assistance tax credit or cost-sharing reduction.*

Penalty:

The employer must pay an annual penalty of $3,000 for each of its full-time employees who qualify for a premium-assistance tax credit or cost-sharing reduction.

*See also *Premium-Assistance Tax Credits and Cost-Sharing Reductions for Low-Income Individuals*, beginning with FAQ 60.

Neither of these penalties is tax deductible.

12. How are seasonal workers counted in determining whether my business is an "applicable large employer"?

If the sum of your full-time and full-time equivalent (FTE) employees exceeds 50 for 120 days (or four calendar months) or less during the preceding calendar year, and the employees in excess of 50 employed during that period are "seasonal workers," your business is not considered to be an "applicable large employer." A seasonal worker for this purpose is a worker who performs labor or services on a seasonal basis, e.g., retail workers employed exclusively during holiday seasons.

FTEs and seasonal workers are important in determining whether an employer is subject to the employer shared responsibility rules, i.e., whether an employer is an applicable large employer. **Once it is established that an employer is an applicable large employer, penalties are determined based only on the employer's full-time employees.** Seasonal workers are not of concern when determining penalties, but there are rules that govern offers of coverage to newly hired "seasonal employees."

13. I'm pretty sure my business has close to 50 full-time and FTE employees, but January 1, 2013, has long passed, and I need extra time to be sure of my applicable large employer status in 2014. Is there any transition relief for companies in a bind like mine?

Yes, but you don't have much time. Rather than being required to use the full 12 months of 2013 to measure whether you have 50 full-time and full-time equivalent employees, applicable large employer status for 2014 may be determined based on *any* consecutive six-month period in 2013. After measuring, companies must still find the time to analyze the results; determine whether they need to offer a plan; and, if so, choose and establish a plan.

14. What is the *penalty* employers must pay if they fail to comply with the ACA's employer shared responsibility rules?

"Applicable large employers" must pay a penalty if:

The business *fails to offer* to at least 95 percent of its full-time employees and their eligible dependents the opportunity to enroll in a group health plan offered by the business; **and** any full-time employee is certified to the business as having received a premium-assistance tax credit or cost-sharing reduction (see *Premium-Assistance Tax Credits and Cost-Sharing Reductions for Low-Income Individuals*, beginning with FAQ 60).

We refer to this as the *no-coverage penalty*; the Internal Revenue Service (IRS) calls it the *4980H(a) penalty*.

No-coverage penalties can add up quickly. For example, the annual penalty for a firm with 50 full-time employees could be $40,000, **and it is not tax deductible**.

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or

The business *offers* to at least 95 percent of its full-time employees and their eligible dependents the opportunity to enroll in a group health plan of the business that is either **"unaffordable"** or fails to provide **"minimum value," and** one or more full-time employees is certified to the business as having received a premium-assistance tax credit or cost-sharing reduction (see *Premium-Assistance Tax Credits and Cost-Sharing Reductions for Low-Income Individuals*, beginning with FAQ 60).

We refer to this as the *coverage penalty*; the IRS calls it the *4980H(b) penalty*.

Neither of these penalties is tax deductible.

When an employer makes an offer of coverage under an eligible employer-sponsored plan that is both affordable and provides minimum value, there is **no penalty.**

Nothing in the ACA *requires* employers to offer health insurance to their employees. But employers that are subject to the employer shared responsibility rules and fail to make an offer of coverage are subject to "no-coverage" penalties, which in most cases are much higher than the corresponding "coverage" penalties.

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15. Do temporary or contract workers I engage through a staffing firm count toward my total number of full-time and FTE employees?

No. Temporary and contract workers retained through a third-party staffing firm for legitimate business reasons are considered employees of the staffing firm. The staffing firm is responsible for complying with the mandates of the ACA for its eligible full-time employees.

16. I need more skilled workers at my company to keep up with customer demand. Could I avoid going over the 50-employee threshold by hiring on an interim basis through a staffing firm rather than bringing them on my payroll?

Yes. Since temporary professionals are generally employees of the staffing firm, not your company, it is the staffing firm that must comply with the employer shared responsibility rules.

17. By bringing on temporary workers, won't I run the risk of having my business — and the staffing firm — be viewed as trying to get around the law?

By using a staffing firm to assist with a valid business purpose (other than avoiding the pay-or-play rules), companies should not be viewed as circumventing the law. The staffing firm in this case is the party responsible for complying with the employer mandate and offering health insurance for its temporary employees who qualify for company-provided health care coverage.

18. What if I don't know for certain whether an employee is a full-time employee for a given month until after the month is over and the work has been done?

This is a conundrum the law does not address. Recognizing that an employer faces something of a dilemma, the regulators have provided a comprehensive set of rules governing full-time determinations both for "ongoing" employees and for "new variable hour" and "new seasonal" employees. These rules are referred to as the "look-back measurement period method."[1]

- An employee is a **"variable hour employee"** if based on the facts and circumstances at the start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week.
- A **"seasonal employee"** is generally defined as an employee working no more than 120 days during the year, but the regulators have not yet fully defined the term for ACA purposes. Instead, employers are permitted to apply a reasonable, good faith interpretation of the term until further notice. For example, a ski instructor in Vermont will not likely qualify as a "seasonal worker," since the ski season in Vermont typically lasts more than four months. As a consequence, for purposes of determining whether his or her employer is an applicable large employer, the ski instructor's hours may not be excluded. But this same individual may well qualify upon hire as a new variable hour employee, whose offer of coverage can be deferred under the look-back measurement period method.

19. My business often uses employees with non-traditional work schedules, and the number of these workers can change quickly throughout the year. Will I be subject to a penalty if I can't offer health insurance right away to those who turn out to be classified as full time during the look-back period?

The look-back measurement period method is ideally suited to businesses whose workforces include employees with irregular hours or unpredictable schedules, such as temporary workers. Generally, employers are permitted to delay any offering of group health plan coverage for a period of up to 12 months (referred to as a "measurement period") without incurring any penalties in order to give the employer the opportunity to determine whether an employee is a full-time employee. If an employee is determined to be full-time during a measurement period, then he or she must be offered coverage during a corresponding stability period, even if he or she is no longer a full-time employee, so long as he or she remains employed with the company.

20. Who is considered an eligible dependent?

A "dependent" for ACA purposes means the employee's son, daughter, stepson, stepdaughter or eligible foster child, in each case up to age 26.

“Grandfathered” Plans: Exceptions to Some ACA Employer Requirements

What is a “grandfathered” group health plan?

The ACA exempts most health plans that existed on March 23, 2010 — the day the law was enacted — from many changes required by the ACA. This preserves consumers’ rights to keep the coverage they already had before health reform. The concept originated with President Obama’s campaign promise that “if you like the coverage you have, you can keep it.” Future hires can be covered without jeopardizing grandfathered status.

A grandfathered plan is a group health plan, whether fully insured or self-funded, that was adopted on or before March 23, 2010. A plan may qualify for grandfathered group health plan status provided that it has not made any plan changes since March 23, 2010, that would cause grandfathered status to be lost. Plan changes that can cause loss of grandfathered status include: elimination of benefits, increasing co-insurance, increasing fixed-dollar cost-sharing (co-pays, deductibles and out-of-pocket limits) beyond allowed amounts, and the plan sponsor’s decrease in its contributions toward the cost of coverage by more than 5 percent. Regulations have been issued specifying how much an existing plan could change over time without losing its grandfathered status. An employer (or insurer) offering coverage that was in effect on March 23, 2010, can elect to have the plan grandfathered and can continue to operate it even after 2014, subject to limitations. A grandfathered plan is exempt from some, but not all, of the key requirements of the ACA, including:

- Appeal requirements
- Choice of provider requirements
- Nondiscrimination requirements
- Preventive services requirements

In addition, until 2014, a grandfathered plan does not have to provide coverage to an adult child up to age 26 unless other employer-provided coverage is not available. Grandfathered status is also conditioned on certain notice requirements.

21. The ACA uses the term “minimum value.” How do I know if my plan provides “minimum value”?

Minimum value is a measure of the comprehensiveness and generosity of a plan’s benefits. (It has nothing to do with who pays premiums.) A health care plan meets the ACA’s “minimum value” requirements if the plan pays at least **60 percent** of the total benefits under the plan. The balance is paid by the employee in the form of deductibles, co-payments, co-insurance and other cost-sharing features.

A plan’s “minimum value” is tested against a plan that provides essential health benefits (see FAQ 39). A plan that provides minimum value will offer major medical coverage. Plans with minimum value closer to the 60 percent threshold will, however, have high out-of-pocket costs. Thus, they will provide, principally, catastrophic coverage.

The regulators have prescribed four ways for plans to demonstrate the "minimum value" standard:

- **Minimum value (MV) calculators.** Employer-sponsored plans may determine their MV by entering information about the cost-sharing features of the plan for different categories of benefits into calculators made available by the Department of Health and Human Services (HHS).
- **Design-based safe harbor checklists.** If the employer-sponsored plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan would be treated as providing minimum value.
- **Actuarial certification.** The calculator may not work for plans with "non-standard features," e.g., quantitative limits, such as a limit on the number of physician visits or covered days in the hospital. In these instances, employers will be permitted to determine minimum value by first using the HHS online calculator, then **engaging a certified actuary** to make appropriate adjustments that take into consideration the nonstandard features. Employer-sponsored plans with nonstandard features of a certain type and magnitude would also have the option of engaging a certified actuary to determine the plan's actuarial value without the use of a calculator.
- **Small group plans.** Plans offered in the small group market (see sidebar *Key Insurance and Employer Terms Used in the ACA* on Page 4) are deemed to provide minimum value by virtue of their mandated plan design.

Employer contributions to a Health Savings Account (HSA) and amounts made available under a Health Reimbursement Account (HRA) are included in determining minimum value. For example, a plan with a $1,000 annual HRA contribution and a $1,000 deductible is treated as a $0 deductible.

22. The ACA also refers to coverage that is "affordable." What specifically does the ACA consider "affordable" coverage?

Coverage is considered **"affordable"** by the ACA if the employee portion of the self-only premium (meaning not including the employee's dependents) for the employer's lowest-cost coverage that provides minimum value does not exceed **9.5 percent** of the employee's household income. Stated another way, if an employee's share of the premium for employer-provided coverage would cost the employee more than 9.5 percent of his or her annual household income, the coverage is not considered affordable for that employee.

Recognizing that employers neither know nor want to know their employees' household income, the regulators have provided three alternative affordability safe harbors: W-2 income, rate of pay and Federal Poverty Guidelines:

- *The W-2 safe harbor* refers to wages from the employer reported in Box 1 of the Form W-2. If the cost of the coverage to an employee would not exceed 9.5 percent of the wages the employer pays that employee that year, as reported in Box 1 of Form W-2, coverage is said to be "affordable."
- *The rate of pay safe harbor* takes the hourly rate of pay for each hourly employee who is eligible to participate in the health plan as of the beginning of the plan year and multiplies it by 130 hours per month.
- *The Federal Poverty Guidelines safe harbor* deems coverage offered to an employee affordable if the employee's cost for *self-only* coverage under the plan does not exceed 9.5 percent of the Federal Poverty Guidelines for a single individual ($11,170 for 2013). (See *Federal Poverty Guidelines for 2013 for the 48 Contiguous States and the District of Columbia* in *Additional Tables* at the end of this guide)

23. My understanding is that an employer is penalized in either the coverage or no-coverage scenario *only* if one or more of its full-time employees are certified to the employer as having received an applicable premium-assistance tax credit or cost-sharing reduction. Is that right?

That is correct.

24. What is the purpose of providing premium-assistance tax credits and cost-sharing reductions?

These provisions of the ACA seek to make health insurance affordable for low- and moderate-income individuals.

25. What does the ACA mean by "cost-sharing"?

"Cost-sharing" means and includes co-pays, deductibles, co-insurance and other employee-contribution arrangements by which an employee pays a share of plan costs out of his or her own pocket.

26. How are the coverage and no-coverage penalties calculated?

Both penalties are assessed monthly, but they are easiest to understand when expressed as an annual amount. The *no-coverage penalty* (first scenario in FAQ 14) is determined by multiplying the number of all of the employer's full-time employees (excluding the first 30) by $2,000. The *coverage penalty* (second scenario in FAQ 14) is determined by multiplying the number of the employer's full-time employees who qualify for a premium-assistance tax credit or cost-sharing reduction by $3,000. **And neither penalty is tax deductible.**

27. How are the coverage and no-coverage penalties paid, and when?

The IRS will contact employers to advise them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The information on which the IRS will rely to make its preliminary assessment will include information that the employer provides to the government. If it is determined that an employer is liable for an assessable payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment.

28. "Unaffordable" or under-minimum-value plans are much cheaper for employers. Could taking this route sometimes offset the penalty?

There are situations in which there may be an advantage to offering a plan that is unaffordable or one that fails to provide minimum value. These plans are inexpensive, and they get the employer out from under the no-coverage penalty, which is generally acknowledged as being far more onerous than the coverage penalty.

29. Can I simply drop health insurance coverage altogether? And, if so, what are the consequences?

Nothing in the ACA requires an employer to offer coverage. In other words, it is not illegal to not offer coverage. Employers can choose to pay the no-coverage penalty — which some might well do. It appears, however, that employers will in most cases be better served if they offer coverage of some kind, even if that coverage is "unaffordable" or fails to provide "minimum value" (FAQs 21 and 22). This will, of course, result in penalties, but not as steep as those for companies that offer no coverage at all.

30. Could there be a *disadvantage* to my employees if I offer affordable coverage that provides minimum value?

Possibly, yes.

In cases where employer coverage is both affordable and provides minimum value, an otherwise eligible low-income employee is barred from receiving a premium-assistance tax credit. Premium subsidies can lower an individual's premium cost to as low as 3 to 4 percent of household income (for incomes between 138 percent and 150 percent of the Federal Poverty Guidelines). In addition, individuals with incomes under 250 percent of the Federal Poverty Guidelines who have access to affordable, minimum value employer coverage would not be eligible for valuable cost-sharing reductions. Compounding the problem for these individuals is that the coverage available through a public exchange (see *Public and Private Health Insurance Marketplaces ["Exchanges"] and the Small Business Health Options Program [SHOP]*, beginning with FAQ 44) must satisfy the generous benefits requirements and limits on cost-sharing that comprise an "essential health benefits package" (see *Premium-Assistance Tax Credits and Cost-Sharing Reductions for Low-Income Individuals*, beginning with FAQ 60, and *Essential Health Benefits*, starting with FAQ 39). Public exchange coverage may, as a result, be more attractive than the coverage offered by the employer.

31. Can I just provide a fixed-dollar amount to my employees and let them purchase their own coverage on the individual market?

No. These arrangements — which are sometimes referred to as "defined contribution" health plans — are technically referred to and regulated as Health Reimbursement Arrangements. For purposes of implementing the ACA's ban on annual limits, these arrangements are technically referred to and regulated as "stand-alone" HRAs. According to the regulators, stand-alone HRAs run afoul of certain ACA insurance market reforms, including the ban on lifetime and annual limits.

32. Can I offer coverage to just my employees, or must I also offer family coverage?

To avoid paying penalties based on the failure to make an offer of coverage to 95 percent of all of an employer's full-time employees (see FAQ 14), the offer must include dependents, but it does not need to include spouses. The regulators have provided a transition rule that applies to plans that do not currently offer dependent coverage. If an employer takes steps to add dependent coverage during its plan year that begins in 2014, it will not be liable for the employer penalty solely for failing to offer dependent coverage for that plan year.

33. For purposes of the ACA, are there any special rules for collectively bargained employees?

At least through 2014, an employer will not be treated as failing to make an offer of coverage to a full-time employee (and will not be subject to a penalty) if:

- The employer is required to make a contribution to a multi-employer plan with respect to its full-time employee pursuant to a collective bargaining agreement or an appropriate related participation agreement;
- Coverage under the multi-employer plan is offered to full-time employees (and their dependents); and
- The coverage offered to full-time employees is affordable and provides minimum value.

34. What is the difference between a fully insured plan and a self-funded plan?

A fully insured plan is a health care plan issued by a health insurance company. A self-funded plan is a health care plan issued by an employer using its own funds. Employers with self-funded plans may outsource plan administration to a third party, such as an insurance company or other vendor, or handle administration internally with their own employees.

Frequently Confused ACA Terms

Essential health benefits:

A series of 10 categories of health benefits and services prescribed by the ACA.

Minimum essential coverage:

Health insurance coverage obtained from a list of qualified sources, which generally include any employer-sponsored coverage as well as coverage from Medicare and Medicaid, certain types of coverage for veterans and uniformed service members and their families, and insurance offered through exchanges (see FAQ 58).

Minimum value:

A measure of the comprehensiveness and generosity of a plan's benefits. A health care plan meets the ACA's "minimum value" requirements if the plan pays at least 60 percent of the total benefits under the plan. The balance is paid by the employee in the form of deductibles, co-payments, co-insurance and other cost-sharing features (see FAQ 21).

35. Does it matter if my group health plan is fully insured or self-funded as far as the ACA goes?

Generally, no. The principal advantages of self-funding are threefold: state mandates, rating restrictions and other rules don't apply; the plan is not subject to state insurance taxes; and the plan sponsor enjoys greater control over plan design.

Under the ACA, self-funded plans remain exempt from state mandates, rating restrictions and other rules. Nor are they subject to the ACA's medical loss ratio standards. (These rules generally require fully insured plans to spend 80 to 85 percent of every incoming dollar on claims while retaining 15 to 20 percent for administrative costs and profits.)

Beyond ACA considerations, however, both methods have their advantages and disadvantages. Self-funded plans require the employer to assume the risk for payment of the claims for benefits, for example, whereas in fully insured plans, the insurance carrier assumes this responsibility.

36. If I purchase an insured product, can I rely on my insurance carrier to comply with the ACA on my behalf?

No. For fully insured plans, the ACA's insurance market reforms are imposed on both the health insurance issuer and the employer-sponsored group health plan. For this purpose, it helps to keep in mind that the insurance contract is not the plan. Rather, the carrier is a vendor to the plan for purposes of offloading risk, providing network access and the processing of claims, among other things. The U.S. Supreme Court has said that the plan is the set of promises the employer makes to its employees regarding health benefits, together with the accompanying administrative scheme. At the same time, the Court acknowledged that terms of the contract may provide evidence of the terms of the plan.

Self-funded plans are treated in a similar fashion, with two exceptions: They are subject to a different set of nondiscrimination rules, and they are exempt from the essential benefits requirements, and the separate limits on deductibles, irrespective of size. (See *Essential Health Benefits*, beginning with FAQ 39, and *Nondiscrimination*, beginning with FAQ 64.)

37. If my company's plan is self-funded, can we rely on our third-party administrator to comply with the ACA on our behalf?

An employer is free to enter into a contract with a third-party administrator to assist with compliance with all or any portion of the ACA's requirements, **but the legal obligation to comply remains with the employer.** Thus, if the third-party administrator fails to comply, the employer is subject to penalties.

38. Are there exceptions to the January 1, 2014, effective date for the ACA's employer shared responsibility rules?

Yes. Recognizing that "fiscal year" plans — plans that have plan years other than the calendar year — would be required to comply midyear, the regulators have provided some transition relief based on the terms of the plan in effect as of December 27, 2012. There are two such transition rules:

- For any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), the employer will not be subject to a potential payment until the first day of the fiscal plan year starting in 2014. Under this rule, full-time employees to whom coverage was offered are excluded from the penalty calculation, but only if they are offered coverage that is both affordable and provides minimum value as of the first day of the 2014 fiscal year.

- If the fiscal year plan (including any other fiscal year plans that have the same plan year) was offered to at least one-third of the employer's employees (full-time and part-time) at the most recent open season *or* the fiscal year plan covered at least one-quarter of the employer's employees, then the employer also will not be subject to the employer shared responsibility payment with respect to any of its full-time employees until the first day of the 2014 fiscal plan year, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day.

Essential Health Benefits

To achieve its goal of ensuring that Americans have access to quality, affordable health insurance, the ACA stipulates that health plans offered in the individual and small group markets offer a core package of items and services known as "essential health benefits." The core packages are called "essential health benefits packages."

39. What are "essential health benefits" and why should small employers care about them?

"Essential health benefits" are a series of 10 categories of health benefits and services prescribed by the ACA. They represent a basic list of items and services to help consumers shop for and compare health insurance options in the individual and small group markets. **The ACA requires that "essential health benefits" be equal in scope to benefits offered by a "typical employer plan" in the state in which it is offered.**

> The ACA requires businesses that purchase health insurance in the small group market to purchase *only* policies that provide "essential health benefits."

The ACA broadly defines "essential health benefits" to include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care

Congress left it to the Department of Health and Human Services (HHS) to flesh out the particulars of essential health benefits. In response, HHS has issued rules under which essential health benefits are determined state-by-state under designated "benchmark" plans.

Essential health benefits are important from an employer standpoint because the ACA requires businesses that purchase health insurance in the **small group market** to purchase *only* policies that provide essential health benefits starting January 1, 2014. **Large group and self-funded plans** are required to meet the cost-sharing limits, but are not required to provide essential health benefits. A plan that fails to offer a sufficient level of at least *some* essential health benefits will, however, in all likelihood fail to provide minimum value.

40. What guidance does the ACA give employers in ensuring their plans contain "essential health benefits" that are equal in scope to the benefits offered by a "typical employer plan" in every state?

While the ACA specifies which categories of benefits are included under the heading of "essential health benefits," it does not identify the specific services that must be covered, or the amount, duration or scope of covered services. As indicated in FAQ 39, this task is left to HHS and it **depends on the state(s) in which the employer operates.**

To meet the ACA requirement that "essential health benefits" are equal in scope to the benefits offered by a "typical employer plan" in every state, HHS further defines "essential health benefits" based on a **state-specific benchmark plan.** States can select a benchmark plan from among several options, including:

- The largest plan based on enrollment in any of the three largest small group products in the state;
- Any one of the three largest state employee health plans;
- Any one of the three largest federal employee health plan options; or
- The largest Health Maintenance Organization (HMO) plan offered in the state's commercial market.

HHS also has prescribed as a default the small group plan with the largest enrollment in the state.

41. What is the mechanism by which businesses contact HHS to learn what the state-specific benchmark plan is for the state(s) in which they are located?

There is no such mechanism. The standards governing essential health benefits benchmark plans are published in regulations and other publicly available written guidance.

42. What is an "essential health benefits *package*"?

The term "essential health benefits package" means coverage that does three things:

- Provides "essential health benefits"
- Limits cost-sharing
- Is available in four discrete coverage levels (bronze, silver, gold or platinum)

These four coverage levels correspond to four levels or tiers of actuarial value. A plan with an actuarial value of 100 percent would cover the costs of all benefits provided by the plan with no cost-sharing. **Anything below 100 percent simply means that the covered employee or family member will pay a portion of the costs for covered services.** The lower the actuarial value, the more the employee will need to pay by way of co-pays, deductibles, co-insurance and other cost-sharing requirements. The levels of coverage established by the ACA are as follows:

Coverage Level	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

To qualify as an "essential health benefits package" the policy or contract also must comply with the following out-of-pocket maximums and deductible limits:

- The out-of-pocket maximum (OOPM) ceiling will be $6,350 (for self-only coverage) and $12,700 (for other than self-only coverage) in 2014, with future increases indexed for inflation. All cost-sharing for essential health benefits must accumulate to the OOPM. For plans that have in- and out-of-network benefits, however, only the in-network benefits are subject to the OOPM ceiling.
- The deductible caps for small group plans in 2014 have been set at $2,000 for single coverage and $4,000 for family coverage. As with the out-of-pocket maximum ceiling, the deductible caps will be indexed for inflation.

43. Are there any exceptions to a business having to offer an essential health benefits package?

Yes. Large group fully insured and self-funded plans are exempt.

Public and Private Health Insurance Marketplaces (“Exchanges”) and the Small Business Health Options Program (SHOP)

Public insurance marketplaces (often called “exchanges”) provide access to health insurance that meets ACA standards for individuals and small groups and make it easier to compare competing health insurance products on an apples-to-apples basis.

44. If I determine that it is advantageous for my business to provide health insurance, am I on my own to build an “essential health benefits package,” or is there any help the government is offering small businesses?

You’re not on your own. The ACA envisions the establishment of “public health insurance exchanges” for this purpose — and to help individuals meet their individual mandate to maintain coverage as well.

Employers with between 50 and 100 employees have additional incentive to consider participating in a SHOP exchange beginning in 2017.

45. Specifically, what are “public health insurance exchanges,” and what does a small employer need to know about them?

“Public health insurance exchanges,” sometimes called “public insurance marketplaces,” are designed to facilitate the purchase of health insurance coverage by individuals and small groups. One of the purposes of the exchanges is to put small businesses on a more equal footing with large companies in getting better choices and lower prices in obtaining health insurance for their employees. Open enrollment begins October 1, 2013.

Specifically, the ACA encourages (but cannot require) each state to establish:

- An **“American Health Benefit Exchange”** through which individuals can purchase coverage under “qualified health plans” by January 1, 2014
- A **“Small Business Health Options Program (SHOP)”** exchange through which small employers can offer coverage under qualified health plans for their employees and their dependents by January 1, 2015

Public exchanges must be organized as nonprofit or government agencies.

Oct. 1, 2013: Exchanges begin open enrollment

46. What does the ACA consider to be a “small employer” with regard to establishing “public health insurance exchanges,” such as SHOP?

For 2014 and 2015, states may define a “small employer” as having up to 50 employees. Commencing in 2017, however, a small employer for this purpose is an employer with between one and 100 employees in both a calendar year and a benefits plan year.

While the ACA does not expressly *require* small employers to provide insurance to their employees, those with 50 or more full-time and full-time equivalent employees will face a penalty if they don't. Thus, employers with between 50 and 100 employees have additional incentive to consider participating in a SHOP exchange beginning in 2017.

Small employers can select the level of coverage for their employees (i.e., bronze, silver, gold or platinum) (see FAQ 42). Each employee would then be allowed to choose any plan within that level. Alternatively, the employer could pre-select one or more plans on behalf of its employees. To qualify for SHOP coverage, an employer must make all of its full-time employees eligible for one or more "essential health benefits package."

There is at least one disadvantage to participating in a SHOP exchange: Low-income subsidies and cost-sharing reductions are available only in the individual market; they are not available to low-income employees of small groups under a SHOP exchange.

47. What if the state(s) where my business is located objects to setting up a public exchange? Is it a federal requirement?

If a state fails or refuses to establish an American Health Benefit Exchange and a SHOP Exchange, the Department of Health and Human Services (HHS) will do so on its behalf, under a "Federally Facilitated Exchange." States may also enter into a partnership under which the federal government performs some of the duties of the exchange with the state retaining responsibility for the rest, under a "Partnership Exchange." **Before 2016, only individuals and small group employers are eligible to participate in an exchange.** From and after 2017, states may permit employers in the large group market to participate.

Coverage choices under the Small Business Health Options Program (SHOP) are set to begin in 2014 on some state-run exchanges and in 2015 for all state- and federal-run exchanges. It currently appears that 17 states and the District of Columbia will run their own insurance exchanges. The federal government is likely to operate "Federally Facilitated Exchanges" in 26 states, while seven states will partner with the federal government.[2]

48. What is a qualified health plan?

A qualified health plan means a health plan that:

- Is certified by an exchange as meeting the ACA's requirements;
- Provides an "essential health benefits package"; and
- Is offered by a state-licensed insurance issuer in good standing that agrees to offer at least one such plan in the "silver level" and at least one in the "gold level" at the same rates and upon the same terms as offered outside the exchange.

49. What do I need to tell my employees about the availability of public exchanges, and when?

The ACA originally required employers to provide a notice of the availability of coverage through public exchanges by March 1, 2013. However, the regulators delayed the requirement until **"late summer or fall of 2013"** to coincide with the open enrollment period for exchanges. The U.S. Department of Labor (DOL) has since issued a set of notices of ACA coverage options.

50. What are "*private* health insurance exchanges" and what does an employer need to know about them?

As the name suggests, "private" exchanges are exchanges established and maintained by entities in the private sector. For the most part, sponsors are health insurance issuers or carriers, health care providers, or large and midsize benefits consulting firms. While the ACA enumerates a number of *public* exchange functions (including the requirement of providing web-based tools to assist consumers in selecting coverage, certifying qualified health plans, and administering premium-assistance tax credits and cost-sharing reductions for low-income individuals), *none of these apply to private exchanges*. Instead, private exchanges simply provide another mechanism for organizing the health insurance marketplace, but without any mandates as to form or structure.

51. How does a *private* exchange benefit my employees?

It's too soon to tell. Public exchanges propose to be able to offer a broad array of health insurance options and choices to employers that they can make available to employees and their dependents. Ideally, this might include product offerings from multiple carriers in a manner similar to a menu of investment options under a 401(k) plan. But public exchanges and private exchanges serve very different functions and populations — the former primarily assisting low-income individuals to access subsidized coverage and providing small groups with access to pre-packaged product offerings; the latter serving (at least currently) primarily large groups. It is not yet clear whether private exchanges will work as advertised. A key drawback to the private exchange model is the risk that these exchanges will attract more older and sicker employees than carriers offering richer plans. While the ACA addresses this issue in public exchanges with robust "premium stabilization" rules, there is no counterpart in the private exchange market. **Moreover, even if the private exchange model gains traction, it is still not clear whether it benefits small employers.**

Small Business Tax Credit

To address the problem of small businesses that are financially unable to offer health coverage to their workers, the ACA includes a new tax credit. The smallest businesses may be eligible for the credit, which can help them meet employee health insurance expenses.

52. What is the "small business tax credit"?

The ACA makes available to small employers with no more than 25 full-time equivalent employees (FTEs) for the taxable year a tax credit, provided the business contributes a uniform percentage of at least 50 percent toward its employees' health insurance. Businesses eligible for the full amount of the credit are those with 10 or fewer FTEs and whose *average* taxable employee wages are $25,000 or less. (The tax credit is phased out as the number of FTEs increases from 10 to 25 and as average employee compensation increases from $25,000 to $50,000.) The credit takes the form of a general business tax credit against an employer's federal tax liability or, for tax-exempt organizations, a reduction in employment taxes.

53. What is the amount of the tax credit?

Through 2013, the maximum credit is up to 35 percent of a qualified for-profit employer's contributions to health insurance, but beginning in 2014, the maximum credit is up to 50 percent of the employer's contribution toward premiums (35 percent for nonprofit organizations). The small business tax credit that is available beginning in 2014 is available to an employer for two consecutive tax years only.

54. How do I count FTEs and calculate their wages for purposes of the tax credit?

Average taxable employee wages are determined by dividing the aggregate amount of wages paid to all employees and FTEs during the year by the number of FTEs and then rounding to the nearest $1,000. The term "employees" excludes seasonal workers (working no more than 120 days during the year). But the term "employee" does not include a sole proprietor, a partner in a partnership, or a 2-percent S corporation shareholder, and his or her family members.

55. If my business qualifies for a portion of the full amount of the tax credit, what does this mean for me in practical terms? Do you have any examples?

The IRS offers these examples: If you pay $50,000 a year toward workers' health care premiums — and if you qualify for a 15 percent credit — you save $7,500. If you save $7,500 a year from tax year 2010 through 2013, that's a total savings of $30,000. If, in 2014, you qualify for a slightly larger credit, say 20 percent, your savings go from $7,500 a year to $12,000 a year.

56. How do I apply for the credit?

Eligible small businesses can access the small business tax credit by filing IRS Form 8941, Credit for Small Employer Health Insurance Premiums. The credit amount is general business credit on the business income tax return.

Tax exemptions include the amount of the credit on line 44f of the Form 990-T, Exempt Organization Business Income Tax Return. This requires the filing of a Form 990-T, even for organizations that don't ordinarily do so. The credit may be carried back or forward, as appropriate.

Individual Coverage Mandate

Individuals and employers each have a shared responsibility under the terms of the ACA. While employers must provide health insurance to qualifying employees, *individuals themselves* also are responsible for maintaining health coverage, or they must pay a tax. This is referred to as "individual shared responsibility" or the "individual mandate."

57. What is the ACA's "individual mandate"?

The ACA provides nonexempt U.S. taxpayers (citizens and green card holders) with a choice. Either maintain "minimum essential coverage" for themselves and any nonexempt family members claimed as dependents for a taxable year or pay a tax. (See FAQ 59 for a description of what the ACA means by "nonexempt," i.e., who is exempt from this ACA provision.)

This requirement is referred to as the ACA's "individual shared responsibility," "individual coverage mandate" or simply the "individual mandate." The potential tax is called the *shared responsibility payment*.

Married taxpayers filing a joint return for any taxable year are jointly liable for any shared responsibility payment imposed for the year.

58. What is "minimum essential coverage"?

"Minimum essential coverage" is health insurance coverage obtained from a list of qualified sources, which generally include any employer-sponsored coverage as well as coverage from Medicare and Medicaid, certain types of coverage for veterans and uniformed service members and their families, and insurance offered through exchanges.

The term "minimum essential coverage" is potentially misleading in that it refers to the source of the coverage rather than its content. (See *Essential Health Benefits*, starting with FAQ 39, and the sidebar *Frequently Confused ACA Terms* on Page 13.)

Minimum essential coverage includes, at a minimum, all of the following:[3]

- Employer-sponsored coverage (including Consolidated Omnibus Budget Reconciliation Act [COBRA] coverage and retiree coverage)
- Coverage purchased in the individual market
- Medicare coverage (including Medicare Advantage)
- Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veteran's health coverage
- TRICARE (the health care program serving uniformed service members, retirees and their families worldwide)

Minimum essential coverage does not include specialized coverage, such as coverage only for vision care or dental care, workers' compensation, disability policies, or coverage only for a specific disease or condition.

The Department of Health and Human Services (HHS) has authority to designate additional types of coverage as minimum essential coverage.

59. Who is exempt from the individual mandate?

Exempt individuals include those who do not have an affordable health insurance coverage option available to them. More specifically, this refers to an individual whose required contribution (determined on an annual basis) for minimum essential coverage exceeds a percentage (**8 percent for 2014**) of the individual's household income. The household income is increased by any required contribution made through a cafeteria plan that is excluded in calculating the individual's gross income.

For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the required contribution is affordable based on the employee's share of the annual premium for self-only coverage. For a "related individual," i.e., an individual who is eligible for coverage under an eligible employer-sponsored plan because of a relationship to an employee (and for whom a personal exemption deduction is claimed), the determination of whether the related individual's coverage is affordable is made with reference to the employee's required contribution for family coverage.

Premium-Assistance Tax Credits and Cost-Sharing Reductions for Low-Income Individuals

Low-income individuals may qualify for financial assistance, in the form of premium subsidies, to help pay for the health insurance coverage purposed through public exchanges or marketplaces. Certain individuals may also qualify for cost-sharing reductions to help with out-of-pocket costs.

60. What is the premium-assistance tax credit, and what is a cost-sharing reduction?

Beginning in 2014, the ACA provides subsidies to help individuals and families afford health insurance coverage.

The **premium-assistance tax credit** is made on a monthly basis to reduce insurance premiums. **Cost-sharing reductions** are designed to limit an individual's or family's maximum out-of-pocket costs.

The tax credit is "refundable," which means it is available to individuals who don't owe any income tax. It is also "advanceable," which means that it is paid up front to the carrier rather than month-by-month.

61. Who is eligible for the premium-assistance tax credit?

To be eligible for a premium-assistance tax credit, an individual must:

- Have household income between 100 percent and 400 percent of the Federal Poverty Guidelines for the taxpayer's family size;
- Not be claimed as a dependent by another taxpayer; and
- File a joint return if married.

The Federal Poverty Guidelines for 2013 for the 48 Contiguous States and the District of Columbia are listed in Additional Tables *at the end of this guide.*

Household income is defined as "modified adjusted gross income of all individuals included in family size who are required to file an income tax return." ("Modified adjusted gross income" means adjusted gross income increased by foreign-source income and exempt interest a taxpayer receives or accrues during the taxable year.)

Importantly, while eligibility for premium-assistance tax credits commences at 100 percent of the Federal Poverty Guidelines, **individuals who are eligible for Medicaid are not** eligible for premium-assistance tax credits. As a result of the 2012 U.S. Supreme Court ruling on the ACA, whether an individual is Medicaid-eligible depends on whether the state in which the individual resides has elected to accept the Act's Medicaid expansion. In states that accept the Act's Medicaid expansion, the range of individuals with household incomes of between 138 percent and 400 percent of the Federal Poverty Guidelines are eligible for premium-assistance tax credits. In states that do not accept the Act's Medicaid expansion, the range of individuals with household incomes of between 100 percent and 400 percent of the Federal Poverty Guidelines are eligible for premium-assistance tax credits.

62. What is the amount of the premium-assistance tax credit?

Premium-assistance tax credits are based on a percentage of income that a low-income individual will be required to pay toward the second-lowest-cost silver plan (see FAQ 42) offered by the public exchange serving the rating area in which the individual resides. The percentage amounts start at 2 percent for individuals with household incomes of 100 percent of the Federal Poverty Guidelines and climb to 9.5 percent of household income for individuals with family incomes of 400 percent of the Federal Poverty Guidelines.

63. How do the availability of premium-assistance tax credits and/or cost-sharing reductions affect *an employer's* decision to offer health insurance coverage?

For employers *not* subject to the ACA's employer shared responsibility (employer mandate) rules (because they employ on average fewer than 50 full-time and full-time equivalent employees) (see *Employer Shared Responsibility* section, beginning with FAQ 9), the rules governing the availability of premium-assistance tax credits are of limited interest. The chief concern is the extent to which the employer desires or feels compelled to help employees gain access to affordable health coverage.

For employers subject to the employer shared responsibility (employer mandate) rules, the stakes are much higher. The employer shared responsibility rules operate *in tandem* with the rules governing premium-assistance tax credits. In simplest terms, employer penalties increase in proportion to the amount of federal tax dollars expended to subsidize health care premiums and benefits accessed by the employer's low-income employees who seek subsidized coverage. Employers can limit employees' access to premium subsidies and cost-sharing benefits, thereby reducing exposure to penalties, by offering coverage that is both "affordable" and provides "minimum value" (see FAQs 21 and 22). But this approach will likely increase the employer's cost of coverage.

Nondiscrimination

Enforcement of the ACA's newly created standards governing group health plan nondiscrimination has been suspended while the regulators determine how these rules will work. Once implemented, however, the nondiscrimination rules will have much to say about the ways in which employers design and determine the scope of the health plans they offer their employees.

64. Must I offer the same benefits to all of my employees?

While there is no rule requiring that the same benefits be offered to all employees, there are rules that bar discrimination on the basis of eligibility or benefit in favor or against highly compensated participants. Prior to the ACA, these nondiscrimination rules applied only to self-funded group health plans. The ACA imposes on fully insured group health plans nondiscrimination rules that are "similar to" the rules that currently apply to self-funded arrangements, but enforcement of these latter rules has been delayed pending the issuance of regulations.

65. Must I pay the same amount toward the cost of coverage for all employees?

There is no rule requiring that the employer pay the same amount toward the cost of coverage for all employees. But where highly paid individuals are systematically treated more generously than rank-and-file employees under a self-funded plan, the plan may run afoul of the applicable nondiscrimination rules. Enforcement of the ACA's nondiscrimination rules has been delayed pending the issuance of regulations.

66. Does it matter whether my company's group health plan is self-funded or fully insured?

Currently, yes. As explained in FAQ 69, self-funded plans already bar discrimination in favor of highly compensated individuals based on eligibility or benefits. A highly compensated individual is defined as:

- One of the five highest-paid officers of a company;
- A shareholder who owns more than 10 percent in value of the stock of the employer (taking into account rules requiring the counting of stock owned by certain family members); or
- A non-officer employee who is among the highest-paid 25 percent of all employees.

When a self-insured medical reimbursement plan fails the nondiscrimination requirements, "excess reimbursements" paid to highly compensated individuals are taxable. In the case of a violation of the eligibility requirement, the excess reimbursement is the full amount of the benefit. In the case of a violation of the benefits requirement, the excess reimbursement is the amount of the benefit multiplied by a fraction, the numerator of which is the total reimbursements paid to all highly compensated individuals for the plan year, and denominator of which is the total reimbursements paid to or on behalf of all participants for the plan year.

In applying the nondiscrimination tests, employers may exclude:

- Employees who have not completed three years of service;
- Employees who have not attained age 25;

- Part-time or seasonal employees;
- Employees not included in the plan who are included in a unit of employees covered by an agreement between employee representatives and one or more employers which the Secretary of the Treasury finds to be a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers; and
- Employees who are nonresident aliens and receive no U.S. earned income.

Similar rules will likely apply at some future date to fully insured plans, once the regulators issue regulations.

67. What is the penalty for violating the fully insured plan nondiscrimination rule?

The penalty for violating the fully insured plan nondiscrimination rule that is prescribed by the ACA is **$1,000 per day** for each individual with respect to which a failure to comply has occurred. While this standard has not yet been fleshed out in regulations, the regulators have signaled their view that the reference is to individuals who are discriminated against. (The imposition of this penalty has been delayed pending the issuance of regulations.)

68. How will the nondiscrimination rule apply to "two-tier" plans common among small employers?

Under the typical two-tier plan, owners and senior managers might be provided robust major medical coverage with a generous employer subsidy, while other full-time employees may be offered lesser (or no) coverage, or the same coverage with a higher employer premium. These types of plans are permitted under current law where benefits are provided on a fully insured basis. While it's a safe bet that these sorts of arrangements will not pass muster once the ACA's insured-plan nondiscrimination rules take effect, the extent to which changes will be required is not yet known.

Recognizing that the ACA's insured plan nondiscrimination rules are likely to prove disruptive, the regulators have promised to provide ample time for employers to understand and implement the new rules.

69. What is the relationship between the employer shared responsibility rules and the group health plan nondiscrimination rules?

There is none. **Compliance with one does not ensure compliance with the other.** For example, an employer might make an offer of coverage that complies with the nondiscrimination rules to *less than* 95 percent of its full-time employees. Because this plan does not satisfy the 95 percent rule, it would be subject to the no-coverage penalty (see FAQ 14). Conversely, an employer might offer a relatively rich plan to its senior management and a lesser plan to its rank-and-file that together might constitute an offer of coverage to all its full-time employees. There would be no employer shared responsibility penalty, but the plan would be discriminatory.

Wellness Programs

For employers, providing wellness programs to employees can help contain rising health care costs. With these programs in place, businesses anticipate healthier employees who will have fewer doctor's visits and hospital stays. Although wellness programs pre-date the ACA, the ACA expressly recognizes and expands these arrangements.

70. What is a "wellness program," and what are some examples?

A wellness program is a program designed to promote health or prevent or manage disease. For example, some employers may choose to provide or subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage employee walking and exercise, pay for gym memberships, or ban smoking on employer facilities and campuses. Wellness programs that are regulated by the ACA are limited to those that operate in conjunction with employer-sponsored group health plans. These programs constitute a limited exception to the bar under prior law (i.e., the Health Insurance Portability and Accountability Act of 1996 or "HIPAA") on discrimination based on an individual's health status. The HIPAA wellness plan exception allows premium discounts or rebates or modification to otherwise applicable cost-sharing (including co-payments, deductibles, or co-insurance) where certain requirements are satisfied.

Wellness programs fall into two categories:

- **Participatory wellness programs** — Programs that do not require an individual to meet a standard related to a health factor in order to obtain a reward. They are not considered to discriminate under HIPAA and are therefore permissible without conditions. Examples include a fitness center reimbursement program, a diagnostic testing program that does not base rewards on test outcomes, a program that waives cost-sharing for prenatal or well-baby visits, a program that reimburses employees for the cost of smoking cessation aids regardless of whether the employee quits smoking, and a program that provides rewards for attending health education seminars.
- **Health-contingent wellness programs** — Programs that require individuals to satisfy a standard related to a health factor in order to obtain a reward. Health-contingent wellness programs are further subdivided into "activity-only wellness programs" and "outcome-based wellness programs."
    - An **activity-only wellness program** means a health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome. Examples include walking, diet, or exercise programs.
    - An **outcome-based wellness program** means a health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. Examples include a program that requires an individual to obtain or maintain a certain health outcome in order to obtain a reward (such as being a non-smoker, attaining certain results on biometric screenings, or exercising a certain amount).

Health-contingent wellness programs are subject to the following requirements:

- *Frequency of Opportunity to Qualify*. Health-contingent wellness programs must give an individual the opportunity to qualify for the reward at least once per year.
- *Size of Reward*. Rewards may be up to 30 percent of the cost of coverage, except that programs designed to prevent or reduce tobacco use may be up to 50 percent of the cost of coverage.
- *Notice*. Health-contingent wellness plans must disclose, in all plan materials describing the terms of a health-contingent wellness program, the availability of a reasonable alternative standard (see FAQ 71) (and, if applicable, the possibility of a waiver), contact information for obtaining the alternative, and a statement that recommendations of the employee's personal physician will be accommodated.

Model health-contingent wellness program notice:

"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at *[insert contact information]* and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

- *Reasonable Design*. The program must have a reasonable chance of improving the health of participating individuals, and must not be a subterfuge for discrimination.
- *Uniform Availability*. The full reward must be available to all similarly situated individuals under all health-contingent wellness programs. Health-contingent wellness programs are not considered to be uniformly available to all similarly situated individuals unless reasonable alternative standards are made available. (see FAQ 71)

71. What changes, if any, will I need to make to our company's wellness program to comply with the ACA?

Under prior law, health-contingent wellness program rewards were capped at 20 percent of the cost of coverage. Under the ACA, the cap rises to 30 percent (or 50 percent in the case of smoking cessation). While employers are not required to adopt these changes, they are free to do so. But perhaps the most challenging aspect of the ACA wellness program rules is implementing the "reasonable alternative standard" requirement:

- For activity-only wellness programs, the program must allow a reasonable alternative method for obtaining the reward (or waive the applicable standard) for any individual for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard or unreasonably difficult due to a medical condition to satisfy the standard. The plan may seek verification and require a doctor's note for this purpose.

- An outcome-based wellness program must offer a reasonable alternative method for obtaining the reward to (or waive the applicable standard for) *any* participant who does not meet the initial standard. Thus, for example, any individual who fails to satisfy a targeted biometric (or similar standard) must be provided with an alternative method of obtaining the reward, regardless of any medical condition or other health issue.

72. What should I know about nondiscrimination issues with regard to my business's wellness plan?

A wellness program is subject to the HIPAA nondiscrimination rules described in FAQ 71 **only if it is, or is part of, a group health plan.** If an employer operates a wellness program as an employment policy separate from its group health plan(s), the program may be covered by other federal or state nondiscrimination laws, but it is not subject to the HIPAA nondiscrimination regulations. For example, a policy of providing access to a health club without monitoring enrollment or participation would not be subject to the HIPAA nondiscrimination rules.

Reporting and Disclosure

The ACA imposes a series of new reporting and disclosure rules on employers. Some are already in force, such as reporting of the value of employer-sponsored health coverage on an employee's Form W-2. Others are pending, such as the notice to employees relating to exchange availability. Still others are yet to come, such as reporting by employers and carriers that offer group health plan coverage.

73. What do I need to tell employees about the availability of group health plan coverage?

The ACA does not alter the notice requirements under the Employee Retirement Income Security Act (ERISA) that have been the law for nearly 40 years. ERISA requires that the terms of a plan be included in a written plan document. In addition, the material terms of the plan document must be communicated to employees in a summary plan description (SPD) that summarizes the material terms of the plan in language that can be understood by the average plan participant. Department of Labor regulations establish detailed rules governing SPD content. Generally, the SPD will include the following information:

- The name of the plan administrator
- A designation of any named fiduciaries in addition to the plan administrator under the claims procedure for deciding benefit appeals
- A description of the benefits provided
- The standard of review for benefit decisions
- Who is eligible to participate, e.g., classes of employees, employment waiting period and hours per week
- The effective date of participation, e.g., next day or the first of the month following satisfaction of the eligibility waiting period
- How much the participant must pay toward the cost of coverage
- Plan sponsor's amendment and termination rights and procedures, and what happens to plan assets, if any, in the event of plan termination
- Rules restricting and regulating the use of Personal Health Information (PHI), if plan sponsor uses PHI
- Subrogation, coordination of benefits and offset provisions
- Procedures for allocating and designating administrative duties to a third-party administrator or in-house benefits committee
- How the plan is funded, whether from employer and/or employee contributions, only if it has assets
- How insurer refunds (e.g., dividends, demutualization) are allocated to participants

- Information regarding the Consolidated Omnibus Budget Reconciliation Act (COBRA), HIPAA, other federal mandates such as the Women's Health Cancer Rights Act, pre-existing condition exclusion, special enrollment rules, mental health parity, coverage for adopted children, Qualified Medical Support Orders, and minimum hospital stays following childbirth

Employers should revisit their plan documents and SPDs to ensure that they reflect the ACA's various requirements.

74. What information must I include on my employees' W-2 forms relating to health benefits?

The ACA requires employers to report the "aggregate cost" of applicable employer-sponsored group health plan coverage on their employees' Form W-2, Wage and Tax Statement, for taxable years beginning on or after January 1, 2011. (This requirement was subsequently made optional for 2011.) The aggregate cost of applicable employer-sponsored coverage is to be determined under rules similar to the rules that apply in the case of COBRA and SPD health care continuation coverage. For the 2012 tax year, employers who issued fewer than 250 W-2s were excused from mandatory reporting.

The Internal Revenue Service has published a helpful chart that details the type of coverage taken into account for W-2 reporting purposes.

Employers should revisit their plan documents to ensure that they reflect the ACA's various requirements.

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75. What information will I need to provide to the IRS about my group health plan, and when?

The ACA requires health insurance issuers of fully insured group health plans and employers that sponsor self-funded plans that provide group health plan coverage to report certain information to the government. This reporting requirement goes into effect in 2014, and the report must include the following information:

- Name, address and tax identification number of the primary insured and the name of each dependent covered;
- Dates during which the individual(s) was covered under minimum essential coverage;
- Whether the coverage is a qualified health plan offered through an exchange;
- The amount (if any) for premium credits and cost-sharing subsidies; and
- Any other information required by the Treasury.

In the case of fully insured coverage, the carrier must provide the following additional information:

- Name, address and employer identification number of the employer maintaining the plan;
- The portion of the premium (if any) required to be paid by the employer; and
- Certain other information relating to health insurance coverage under a qualified health plan in the small group market offered through a public exchange.

Lastly, each "applicable large employer" must report the following information:

- Name, date and employer identification number of the employer;
- A certification as to whether the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; and

- If the employer certifies that the employer did offer to its full-time employees the opportunity to enroll:
  - The length of any waiting period;
  - The months during the calendar year for which coverage under the plan was available;
  - The monthly premium for the lowest-cost option in each of the enrollment categories under the plan;
  - The applicable large employer's share of the total allowed costs of benefits provided under the plan;
  - The number of full-time employees for each month during the calendar year;
  - The name, address and tax identification number of each full-time employee during the calendar year and the months (if any) during which the employee (and any dependents) were covered under any health benefit plan; and
  - Other information the government may require.

76. What is a Summary of Benefits and Coverage (SBC)?

A key ACA reform is the creation of a uniform explanation of coverage and standardized definitions. Commonly referred to as a Summary of Benefits and Coverage (SBC) and a uniform glossary, these documents "accurately describe" the benefits and coverage under an applicable plan or coverage. The ACA requires these to be developed and compiled by fully insured and self-funded group health plans (including grandfathered arrangements).

The SBC document must not exceed four double-sided pages, must use only words that are understandable to the average consumer, and must be presented in a culturally and linguistically appropriate manner. It must detail the following aspects of the plan:

- Premium
- Coverage features
- Patient cost-sharing for each essential benefits category
- Rules regarding the use of network providers

From and after 2014, the SBC must indicate whether the plan meets standards for minimum coverage. Final regulations implementing this requirement prescribe in great detail SBC form and content.

Taxes and Fees

The ACA includes myriad reform-financing provisions that affect employers, in addition to the employer shared responsibility rules. These include the Comparative Effectiveness Research (CER) fee, transition reinsurance fees, a "health insurance tax," and a tax on "Cadillac" health plans.

77. What is Comparative Effectiveness Research (CER)?

The ACA includes provisions intended to promote "comparative effectiveness research" (CER). This is the direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harm.

78. Why is there a CER fee?

The fee funds CER activities. Fees collected are paid to a new nonprofit organization established by the ACA called the Patient-Centered Outcomes Research Institute (PCORI).

79. Who will be required to pay the CER fee?

Health insurance issuers and sponsors of self-insured group health plans will be required to pay the CER fee.

80. What determines which businesses (or health plans) must pay the fee?

In the case of a "specified health insurance policy" the health insurance carrier is liable for a fee. The fee is imposed for policy years ending on or after October 1, 2012, and before October 1, 2019. In the case of "applicable self-insured health plans," the plan administrator (usually, the employer) pays the fee.

81. What is a "specified health insurance policy"?

The term "specified health insurance policy" is defined broadly to mean and include "any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States." It includes certain prepaid health coverage arrangements (e.g., HMOs), but excludes HIPAA-excepted benefits, such as:

- Stand-alone dental or vision plans
- Long-term care plans
- Coverage for a specific disease or illness offered as a separate policy
- On-site medical clinics
- Coverage of accident and/or disability insurance
- Workers' compensation
- Automobile payment insurance

Also excluded are plans covering expatriate employees, and stop-loss coverage for self-funded plans.

82. What is an "applicable self-insured health plan"?

An applicable self-insured health plan is defined to mean and include "a plan that provides for accident or health coverage … if any portion of the coverage is provided other than through an insurance policy." An applicable self-insured health plan does not, however, include HIPAA-excepted benefits, nor does it include the following:

- Medical flexible spending arrangements (FSAs), if the employer offers other health plan coverage to employees and the maximum annual benefit of the FSA is not more than two times the participant's salary reduction election for the year;
- Health savings accounts (HSAs);
- Self-funded Employee Assistance Programs (EAPs) (i.e., wellness programs and disease management programs that do not provide significant benefits in the nature of medical care or treatment);
- Stop-loss insurance policies and reinsurance policies; and
- Expatriate plans (i.e., plans that cover workers outside the United States).

83. When are the CER fees due?

For calendar year plans, the first annual payment is due **July 31, 2013.**

84. How much will the CER fee be?

In the first year it applies, the fee will be $1 multiplied by the average number of persons covered under the plan (including dependents).

In subsequent years, the multiplier is $2 times the average number of covered persons, but this number will be reviewed annually and could change.

85. How do affected employers calculate their average number of covered persons?

Plan sponsors must use one method for the entire plan year but may use different methods in different plan years. The methods permit an actual count, a snapshot approach and (for ERISA plan sponsors only) an approach using the Form 5500. Special rules allow flexibility in the counting method for the first year of the fee.

The CER fees are reported and paid using IRS Form 720, which is due by July 31 for plan years ending in the preceding calendar year.

86. What is the "transitional reinsurance fee"?

The transitional reinsurance fee funds the transitional reinsurance program, one of a number of programs established by the ACA to minimize the effects of adverse selection that may occur in the initial years of operation of public exchanges and during implementation of market-wide insurance reforms. These fees are imposed for a three-year period from 2014 through 2016 on all group health plans, whether fully insured or self-funded. The first year per-enrollee amount is expected to be about $63.

87. What is adverse selection?

Adverse selection is the tendency of higher health risk individuals to seek health insurance. In response, insurance companies may limit coverage or raise premiums on their products.

88. How is the "transitional reinsurance fee" paid?

The ACA plans to fund these programs through assessments on group health plans, whether fully insured or self-funded (including grandfathered arrangements). States may, however, elect to continue a reinsurance program after the end of the three-year period. Health insurance issuers and group health plans are required to make contributions to the transitional reinsurance program. The following types of coverage are excluded, however:

- Limited-scope dental and vision plans, accident-only or disability-only plans, and on-site clinics; a dental or vision plan will be deemed to be excepted if provided under a separate policy, certificate, or contract of insurance, or if participants may decline coverage and participants must pay an additional contribution to elect the coverage.
- Coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance, provided coverage is offered as independent non-coordinated benefits
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability and automobile
- Workers' compensation
- Credit-only insurance
- Long-term care
- Health flexible spending accounts that meet the definition of an excepted benefit
- Employee Assistance Programs, disease management or wellness programs as long as the programs do not provide for significant medical care or treatment
- Medicare and Medicaid programs

89. What is the health insurance provider fee, and how is it paid?

The Act imposes an annual fee on each "covered entity" engaged in the business of providing health insurance. The fee is due no later than September 30 of each calendar year. A covered entity is any entity that provides health insurance for any United States health risk during each fee year, except for the following entities:

- Any employer to the extent that the employer self-insures its employees' health risks;
- Any governmental entity;
- Certain tax-exempt entities, including tax-exempt entities that serve low-income, elderly or disabled populations; and
- Voluntary employees' beneficiary associations (VEBAs).

Liability is imposed on a controlled group basis.

No fee is imposed on any insurance coverage that consists solely of excepted benefits (see FAQs 77-85).

The aggregate fee amount for all covered entities is $8 billion for calendar year 2014, $11.3 billion for calendar years 2015 and 2016, $13.9 billion for calendar year 2017, and $14.3 billion for calendar year 2018. Covered entities include most state-licensed commercial and other carriers with aggregate net premiums that exceed a designated threshold.

90. What is the tax on "Cadillac" health plans?

Beginning in 2018, the ACA imposes an excise tax on "high-cost" health plans. This tax is commonly referred to as a tax on "Cadillac" health plans. The tax must be paid if the aggregate value of employer-sponsored health insurance coverage for an employee (including a former employee, surviving spouse and any other primary insured individual) exceeds a threshold amount. The tax is equal to 40 percent of the "aggregate value" that exceeds a "threshold amount." For 2018, the threshold amount is $10,200 for individual coverage and $27,500 for family coverage, as adjusted for cost of living increases, age and gender.

The excise tax is imposed pro rata on the issuers of the insurance or coverage. In the case of a self-insured group health plan, a health Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), the excise tax is paid by the entity that administers the benefits under the plan or arrangement (the "plan administrator"). Employer-sponsored health insurance coverage is health coverage under any group health plan offered by an employer to an employee without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's gross income) or the employee pays for the coverage with after-tax dollars.

In determining the amount by which the value of employer-sponsored health insurance coverage exceeds the threshold amount, the aggregate value of all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a health FSA or an HRA, contributions to an HSA or Archer Medical Savings Account or "Archer MSA," and certain other supplementary health insurance coverage other than excepted benefits. (An Archer MSA is a savings account that earns tax-deductible interest for medical expenses. Archer MSAs are often used by small businesses or self-employed individuals as a way to pay for health care services to employees.[4])

In general, an individual threshold for a "Cadillac" plan applies to any employee covered by employer-sponsored health insurance coverage, and a family threshold applies to an employee if he or she and at least one other beneficiary are enrolled in coverage other than self-only coverage under an employer-sponsored health insurance plan.

91. How does the ACA impact the amount paid by employees for the Medicare hospital insurance (HI or FICA-HI) portion of their payroll taxes?

The Federal Insurance Contributions Act (FICA) imposes tax on employers based on the amount of wages paid to an employee during the year. The tax imposed is composed of two parts:

- The old age, survivors and disability insurance (OASDI) tax equal to 6.2 percent of covered wages up to the taxable wage base ($113,700 for 2013); and
- The health insurance (HI) tax amount equal to 1.45 percent of covered wages. Generally, "covered wages" means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash.

In addition to the tax on employers, each employee is subject to FICA taxes equal to the amount of tax imposed on the employer.

Beginning in 2013, the employee portion of the HI tax is increased by an additional tax of 0.9 percent on wages received in excess of the threshold amount. But unlike the general 1.45 percent HI tax on wages, this additional tax is on the combined wages of the employee and the employee's spouse, in the case of a joint return.

The threshold amount is $250,000 in the case of a joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case. In determining the employer's requirement to withhold and liability for the tax, only wages that the employee receives from the employer in excess of $200,000 for a year are taken into account.

Similar rules apply to self-employed individuals under the Self-Employment Contributions Act (SECA). SECA imposes taxes on the net income from self-employment of self-employed individuals. Thus, an additional tax of 0.9 percent is imposed on every self-employed individual on self-employment income in excess of the threshold amount. As in the case of the additional HI tax on wages, the threshold amount for the additional SECA HI tax is $250,000 in the case of a joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case.

92. What new limits apply to medical flexible spending accounts?

A flexible spending arrangement for medical expenses under a cafeteria plan ("health FSA") gives employees the option to reduce their current cash compensation and instead have the amount of the salary reduction contributions made available for use in reimbursing the employee for his or her medical expenses. Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that amounts remaining under a health FSA at the end of a plan year must be forfeited by the employee (the "use-it-or-lose-it" rule).

Rather than offering a health FSA through a cafeteria plan, an employer could instead specify a dollar amount that is available for medical expense reimbursement. HRAs are entirely employer-funded; they cannot be funded on a salary reduction basis. Nor does the use-it-or-lose-it rule apply to HRAs. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.

Prior to the ACA, there was no limit to the amount that an employer could allow an employee to defer under a health FSA, nor was there a cap on annual HRA amounts.

Under the ACA, commencing in 2013, in order for a health FSA to be a qualified benefit, the maximum amount available for reimbursement of incurred medical expenses of an employee, the employee's dependents and any other eligible beneficiaries with respect to the employee, under the health FSA for a plan year (or other 12-month coverage period), must not exceed $2,500. This limitation is indexed for future increases in the cost of living. HRAs are not subject to this rule.

Checklist: Important Dates for Businesses

July 1, 2013:

Last date for businesses using the special transition rule permitting a six-month (rather than calendar year) determination period for measuring full-time and FTE headcounts

Oct. 1, 2013:

Exchanges begin open enrollment; employers must provide employees a notice of the availability of coverage through the exchanges

Jan. 1, 2014:

Main provisions commence. "Applicable large employers" must offer to their full-time employees and their eligible dependents health care coverage under an eligible employer-sponsored plan, or face the prospect of a penalty

Jan. 1, 2015:

Each state must establish a Small Business Health Options Program (SHOP)

Jan. 31, 2015:

Employer reporting to IRS on employee coverage due

2016:

Transitional reinsurance fee ends

Jan. 1, 2017:

Employers with more than 100 FTEs can purchase health coverage through exchanges

Jan. 1, 2018:

Forty percent excise tax on high-cost ("Cadillac") health plans begins

Glossary of Key ACA Definitions

For a more comprehensive glossary of terms used in the ACA, please see www.healthcare.gov/glossary/a/. The U.S. Department of Health & Human Services (HHS) released this uniform glossary in September 2012 to define "insurance and medical terms in standard, consumer-friendly terms."

Applicable large employer

A business that employed an average of at least 50 full-time and full-time equivalent (FTE) employees on business days during the preceding calendar year.

"Cadillac" health plan

A high-cost health plan, upon which the ACA imposes an excise tax beginning in 2018.

Comparative Effectiveness Research (CER)

Government-operated research efforts to directly compare existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harm.

Cost-sharing

The share of costs not covered by employees' health insurance that they pay out of their own pockets, e.g., deductibles and co-pays.

Cost-sharing reductions

Reductions for low-income individuals that limit maximum out-of-pocket health insurance costs for them or their families.

Coverage penalty

A penalty incurred by a business with at least 50 full-time or full-time equivalent (FTE) employees that offers at least 95 percent of its full-time employees (and their eligible dependents) the opportunity to enroll in a group health plan of the business that is either "unaffordable" or fails to provide "minimum value," and any of its full-time employees have received a premium-assistance tax credit or cost-sharing reduction.

Employer shared responsibility

Effective January 1, 2014, an "applicable large employer" must offer its full-time employees and their eligible dependents health care coverage under an employer-sponsored plan that meets ACA standards, or pay a penalty. Also known as the employer mandate or "pay or play" mandate.

Essential health benefits

A basic list of items and services to help consumers shop for and compare health insurance options in the individual and small group markets. What constitutes essential health benefits is determined state-by-state through the designation of benchmark plans (or under a default plan in states that fail to designate a benchmark plan).

Essential health benefits package

A health plan that provides "essential health benefits" as defined by the state(s) in which the employer operates, limits cost-sharing and is available in four discrete coverage levels (bronze, silver, gold or platinum).

Full-time employee

An employee who is employed an average of 30 hours of service or more per week.

Full-time equivalent (FTE) employee

A combination of employees, each of whom individually is not a full-time employee (because he or she is not employed, on average, for at least 30 hours of service per week with an employer), who are counted as the equivalent of a full-time employee. An employer determines its number of FTEs by aggregating all its non-full-time employees, taking into account no more than 120 hours in a month, then dividing by 120.

Fully insured plan

A health care plan issued by a state-licensed health insurance company.

Grandfathered plan

Group health plans that existed on March 23, 2010, and are exempted from most ACA requirements.

Individual mandate

U.S. taxpayers (citizens and green card holders) must either maintain "minimum essential coverage" for themselves and any family members, or pay a tax. Also known as the "individual shared responsibility" and "individual coverage mandate."

Minimum essential coverage

Includes government-sponsored coverage such as Medicare, Medicaid, CHIP, TRICARE and veterans' health care. It also includes most types of employer-provided coverage.

Minimum value

A business's health plan is said to provide minimum value if it pays at least 60 percent of the total cost of the benefits under the plan (the employer's contribution), while the company's employees pay 40 percent or less of the cost of benefits under the plan (the employee's contribution). The plan must also cover at least four categories of benefits: physician and midlevel practitioner care; hospital and emergency room services; pharmacy benefits; and laboratory and imaging services.

No-coverage penalty

A penalty incurred by a business with at least 50 full-time and full-time equivalent (FTE) employees that fails to offer to at least 95 percent of its full-time employees and their eligible dependents the opportunity to enroll in a group health plan offered by the business; and any of its full-time employees have received a premium-assistance tax credit or cost-sharing reduction.

Patient Protection and Affordable Care Act

A 2010 law that overhauls the regulation and financing of health insurance in the United States.

Premium-assistance tax credit

A tax credit made on a monthly basis to reduce low-income individuals' insurance premiums.

Public health insurance exchange

An online marketplace where individuals and small businesses can compare policies and premiums and purchase health insurance and where certain low-and moderate-income individuals and families can obtain federal subsidies on a sliding scale.

Self-funded plan

A health care plan issued by an employer using its own funds. Self-funded plans have some advantages under ACA, but require the employer to assume the risk for payment of the claims for benefits.

Shared responsibility payment

The tax U.S. citizens must pay if they do not satisfy the individual mandate.

Small business tax credit

A federal tax credit available to businesses with no more than 25 full-time equivalent employees for the taxable year that contribute a uniform percentage of at least 50 percent toward their employees' health insurance.

Summary of Benefits and Coverage (SBC)

A uniform explanation of coverage and standardized definitions that accurately describe the benefits and coverage under an applicable plan or coverage.

Additional Tables

Private Health Insurance Requirements in the Internal Revenue Code, the Public Health Service Act and ERISA

The ACA's penalty structure is complex in large part because the insurance market reforms are imposed under three different laws. Carriers are subject to amendments made to the ACA in the Public Health Service Act, while employers are subject to parallel provisos under the Internal Revenue Code and ERISA. The following table summarizes the penalties under each law.

Statute	Application	Enforcement
ERISA	Group health plans (including self-insured plans) of private sector employers and health insurance issuers	Civil monetary penalties against group health plans; employee right to sue
Public Health Service Act	Health insurance issuers and self-insured governmental plans	States have primary enforcement responsibility against health insurance issuers; Secretary of HHS can impose civil monetary penalties
Internal Revenue Code	Group health plans, including church plans	A group health plan that fails to comply with the pertinent requirements in the IRC may be subject to a tax of $100 for each day in the noncompliance period. Limitations on a tax may be applicable under certain circumstances (e.g., if the person otherwise liable for such tax did not know or if exercising reasonable diligence would not have known that such violation existed).

Federal Poverty Guidelines for 2013 for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guideline
1	$11,490
2	$15,510
3	$19,530
4	$23,550
5	$27,570
6	$31,590
7	$35,610
8	$39,630

For families/households with more than eight persons, add $4,020 for each additional person.

About the Author

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The author of this guide, Alden J. Bianchi, is Practice Group Leader of the Employee Benefits & Executive Compensation Practice at Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C. Resident in the firm's Boston office, Mr. Bianchi represented the Romney administration in connection with the historic 2006 Massachusetts health care reform act, and he testified before the Senate Finance Committee on the subject of health care reform as part of the development of the Affordable Care Act. More recently, he testified on behalf of the ERISA Industry Committee (ERIC) before the Treasury Department/IRS at its April 23, 2013, hearing on the employer shared responsibility proposed regulations.

Mr. Bianchi is the author of more than a half-dozen books and more than 100 articles on various benefits-related topics. His most recent work, the *Bloomberg/BNA Health Care Reform Advisor*, is a comprehensive treatment of the impact of the Affordable Care Act on employers and employer-sponsored group health plans.

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Endnotes

[1] www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

[2] www.advisory.com/Daily-Briefing/2013/02/19/Feds-will-run-most-of-new-health-insurance-exchanges

[3] www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

[4] www.investopedia.com/terms/a/archer-msa.asp

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