EMPLOYER BENEFIT SOLUTIONS FOR YOUR INDUSTRY

School Districts and the Future of the Affordable Care Act

A toolkit for navigating Health Care Reform

Prepared for the members of

ASSOCIATION OF
SCHOOL BUSINESS OFFICIALS
INTERNATIONAL

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a different opinion

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Objectives

The purpose of this toolkit is to help employers understand their options and develop their strategies going forward in connection with the Employer Mandate. This toolkit includes summaries of the rules, applicable calculation formulas, and information on possible strategies for employers to consider to help assess the impact of the Employer Mandate on their organizations; design their contribution, eligibility, and plan sponsorship strategies going forward; and prepare for collective bargaining discussions.

Tip: It is important to document all of the decisions and assumptions used in connection with the Employer Mandate. Keeping detailed notes of your final decisions in this toolkit is a great way to start. For example, if you use a Monthly Measurement Period Method for calculating full-time status for some employees, and a Look Back Measurement Period Method for other classes of employees, it will be important to have a record of those decisions in case of audit.

Disclaimer

AFAS does not provide tax or legal advice. Given the complexity of the Affordable Care Act rules, we always recommend working with your own legal counsel to discuss how your plans could be affected and to review guidance provided by our consultants.

AFAS consultants provide information for plan sponsors about health and welfare benefit plans but do not provide guidance on specific insurance products; we can provide a referral to an insurance agency if you would like assistance implementing or revising an insurance product.

This is only a brief summary that reflects our current understanding of select provisions of the law, often in the absence of regulations. All of the interpretations contained herein are subject to change as the appropriate agencies publish additional guidance. Furthermore, the information provided is based on the requirements of Federal health and welfare benefit laws and does not take other Federal laws (such as labor law) or any state law considerations into account.

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Executive Summary

Why Do You Need This Toolkit?

What's Inside?

Who Is This Toolkit For?

Why Do You Need This Toolkit?

Navigating our nation's health care laws can be tricky, and many employers find themselves with questions about the intricacies of the Affordable Care Act. From understanding who qualifies for coverage to knowing how to report your activities to the Internal Revenue Service (IRS), this toolkit will equip you with the fundamental information you need to help make sound decisions for your organization.

What's Inside?

In these pages, you'll find a thorough overview of the major employer benefit-related provisions of the law as they stand today, and guided decision points to help you identify and record your organization's approach to some of the most critical areas of the law.

Who Is This Toolkit For?

The information in this toolkit can be used by members of your human resources team, your payroll administrator, your benefits specialist, and your executive leadership. School boards and superintendents will find the big-picture approach useful in strategically allocating resources, and the clear, thorough explanations will benefit anyone tasked with keeping your organization compliant with Federal law.

The Future of the ACA

Congressional Repeal Efforts
How Did We Get Here?
What's The Bottom Line?

Congressional Repeal Efforts

In early March, Congress introduced the American Health Care Act (AHCA), which would begin the process of repealing and replacing the Patient Protection and Affordable Care Act (ACA).

Facing near-certain failure in the House of Representatives, House Speaker Paul Ryan pulled the AHCA from consideration.

Six weeks after their first attempt to hold a vote on the AHCA, Congressional Republicans passed the bill in a 217 to 213 vote May 4, moving forward with their campaign promises to repeal and replace the ACA.

Following are highlights of some of the bill's most significant provisions that would impact employers:

- Eliminate the Individual and Employer Mandate penalties retroactive to January 1, 2016;
- Eliminate the requirement to obtain a prescription for over-the-counter health care items to qualify for reimbursement from a Health Flexible Spending Account (Health FSA) or Health Savings Account (HSA);
- Repeal the ACA's limitation on contributions to Health FSAs, currently capped at $2,600 per year;
- Expand use of HSAs to match the out-of-pocket limits that apply to qualified high deductible health plans (HDHPs), along with making several other HSA improvements;
- Delay the "Cadillac" tax (a 40% excise tax on the excess value of high cost coverage) from 2020 to 2026;
- Continue the employer Forms 1094 and 1095 reporting until 2020, then migrate to Form W-2 reporting and verification of plan eligibility; and
- Retain ACA's market reforms, such as the ban on pre-existing condition exclusions, the prohibition on lifetime and annual limits, and the requirement to cover preventive care at zero cost.

How Did We Get Here?

Republican lawmakers took the first steps toward repealing portions of the ACA when they opened the 115th Congress by passing a budget resolution intended to begin dismantling the ACA through the process of budget reconciliation. The bare-bones budget instructed four congressional committees to make changes to laws under their purview and reserved funds for future health care legislation. In short, GOP leaders were trying to make good on their many promises to act quickly to repeal the ACA.

A budget reconciliation bill can be passed by a simple majority, which the Republicans hold in both houses of Congress; budget measures cannot be filibustered, negating the last remaining option for Democrats to halt the repeal process. In order to use the reconciliation process, the legislation must be limited to provisions directly impacting budgetary issues. As such, any repeal legislation, like the AHCA, could have only targeted the Employer Mandate, the individual mandate penalty for not purchasing health coverage, the ACA expansion of Medicaid, tax credits to purchase Public Exchange (Marketplace) coverage, and other tax-related changes from the ACA.

Complete repeal of the ACA, and most replacement proposals, would require a 60-vote supermajority in the Senate, which the Republicans cannot achieve without the aid of at least eight Democrats.

What's The Bottom Line?

While changes may be on the horizon, the ACA remains the law today. Top of mind for many Large Employers (with 50+ Full-Time Equivalent Employees) is the requirement to report information about their Full-Time Employees, their offer of coverage, and coverage received during the 2016 calendar year using Forms 1094 and 1095. For other employers, tracking ACA status of their Variable-Hour Employees may be their primary concern.

The Basics of the Affordable Care Act

Public Exchanges (Marketplaces)
Individual Mandate
Premium Tax Credits

Flow Chart: Employer Mandate – For Plan Years Beginning in 2015

During business days of the previous year, did the employer have an average of 100+ Full-time Equivalent employees?

- NO → The employer is not subject to the Employer Mandate penalty requirements.
- YES ↓

Does the employer sponsor a group major medical plan?

- NO → If one employee receives a Premium Tax Credit to buy Exchange coverage, the employer owes a non-deductible, monthly Employer Mandate penalty of 1/12x $2,000[1] x the total number of Full-Time Employees (minus 80).
- YES ↓

Is at least one plan available to substantially all (95%) Full-Time Employees (30+ hrs/wk, 130+ hrs/mo) and Dependent Children?

- NO → If one employee receives a Premium Tax Credit to buy Exchange coverage, the employer owes a non-deductible, monthly Employer Mandate penalty of 1/12x $2,000[1] x the total number of Full-Time Employees (minus 80).
- YES ↓

Is at least one plan offered by the employer affordable (is an eligible employee required to pay 9.69% (2017) or less of household income to participate)?

- NO → The employer owes a non-deductible, monthly Employer Mandate penalty of 1/12x $3,000[2] x the total number of Full-Time Employees qualifying to receive a Premium Tax Credit, capped at the amount the employer would have paid if the employer did not offer any coverage.
- YES ↓

Is the affordable coverage adequate (is the actuarial value of the coverage at least 60%)?

- NO → The employer owes a non-deductible, monthly Employer Mandate penalty of 1/12x $3,000[2] x the total number of Full-Time Employees qualifying to receive a Premium Tax Credit, capped at the amount the employer would have paid if the employer did not offer any coverage.
- YES ↓

The employer does not owe an Employer Mandate Penalty, even if an employee opts out and purchases coverage through an Exchange (Marketplace).

[1] The 4980H(a) penalty is $2,260 in 2017. [2] The 4980H(b) penalty is $3,390 in 2017. These numbers are indexed annually by the IRS.

The Public Exchanges (Marketplaces), Individual Mandate, and Premium Tax Credits are integral to the operation of the Employer Mandate. Therefore, understanding these rules is essential to developing an Employer Mandate strategy. These provisions work together to advance Congress's goal of expanding access to health coverage.

Public Exchanges (Marketplaces)

To help enhance the individual and small group insurance markets, Federal and State Exchanges (Marketplaces) offer private insurance choices to individuals and small employers (generally with 100 or fewer employees, but 50 or fewer in some state and all Federally established Exchanges (Marketplaces)). Effective 2017, it is possible larger employee groups will be able to participate in the Public Exchanges as well. If a state does not establish a State Exchange (Marketplace), the federal government will operate a Federal Exchange (Marketplace) in that state on the state's behalf.

A variety of plans are available at different coverage levels, namely the bronze, silver, gold, and platinum level options. Private insurance companies have submitted bids to offer qualified health plans in one or more of those categories. The Exchange (Marketplace) itself is essentially an online marketplace for buying health insurance coverage. The Exchanges (Marketplaces) are intended to make coverage more accessible because of the following:

- Generally, all individuals who live in the United States and are not incarcerated may enroll in Exchange coverage;
- Exchange (Marketplace) coverage is guaranteed to be available regardless of health condition and may not exclude coverage for preexisting conditions; and
- Premium rates for individual Exchange (Marketplace) coverage will vary only based on age, tobacco use, and family size, and no medical underwriting is permitted.

> **Tip:** All individuals who are legal U.S. residents are eligible to purchase Exchange (Marketplace) coverage. Employer-sponsored coverage does not have to be Unaffordable, for example, before an individual will qualify for Exchange (Marketplace) coverage.

Individual Mandate

In order for insurance companies to be able to offer these coverage guarantees, Congress adopted the Individual Mandate to ensure all individuals were in the risk pool. Effective January 1, 2014, all individuals must obtain minimum essential coverage or pay a tax.

- The tax for any month is 1/12th the greater of a flat dollar amount ($695 per adult, $347.50 per child under 18, Maximum: $2,085 in 2017) or a specified percentage of Household Income (2.5% in 2017).
- The tax is 50% for children under age 18.
- The maximum family tax is three times the tax that applies for adults.
- The tax is capped at the amount the individual or family would have to pay for the average cost of bronze level Exchange(Marketplace) coverage.

The tax is applied for each month during which an individual doesn't have minimum essential coverage. There are exceptions if coverage is Unaffordable (costs more than 9.69% (for 2017) of Household Income), for low income tax payers (such as for individuals who have so little household income that they are not required to file a federal income tax return), and for short coverage gaps (up to three months).

Premium Tax Credit

Because Congress requires all individuals to purchase coverage, they adopted a Premium Tax Credit to help certain individuals with Household Income up to 400% of the federal Poverty Line to purchase Public Exchange (Marketplace) coverage.

Individuals who are eligible for Adequate and Affordable employer-sponsored coverage or are eligible for government provided coverage (such as Medicare or Medicaid) are not eligible for a tax credit. Under current regulations, an employee need only attest that the coverage is either Unaffordable or Inadequate, subject to random verifications by an Exchange (Marketplace).

> Tip: Note that if an employee is eligible for Adequate and Affordable employer-sponsored coverage at the employee-only level, no one in the family will qualify for a Premium Tax Credit to purchase Exchange (Marketplace) coverage.

High-Cost Plan Excise Tax

How The Tax Works
What Is Included In Cost Of Coverage To Which The Tax Applies?
IRS Guidance
Next Steps For Employers

On December 18, 2015, Congress passed a two-year delay of the 40% Excise tax on High-Cost Plans (also referred to as the "Cadillac" plan tax). The President subsequently signed this into law as part of a year-end government funding package. The delay extends the effective date of the application of the tax from 2018 to 2020.

However, what many may not recall is that this was not the first time this provision of the Patient Protection and Affordable Care Act (ACA) was delayed. In 2009, before the ACA was signed into law, this provision of the then proposed legislation was set to take effect in 2013. This provision caused much concern among employers and unions alike. Before the law was passed, the leaders of many of the major U.S. unions met with President Obama and the result was a revision to the proposed legislation to extend the application of this excise tax for 5 years from 2013 to 2018. The legislation was passed by Congress in early 2010 and signed into law by President Obama on March 23, 2010.

The delays may raise questions about the long-term sustainability of this provision of the law. However, it is a major funding source of the ACA and extending the delay is much easier than a full repeal of this provision without any source of replacement revenue. As a result, employers are encouraged to understand this provision and keep abreast of regulations from the Internal Revenue Service (IRS) so that the risks associated with this provision can be managed before it becomes effective. The two-year delay gives employers a little more time, especially when many are dealing with the complex requirements to provide forms to employees and the IRS in early 2016 regarding the availability and cost of employer-sponsored coverage. Anticipating and making necessary changes in plan design and costs in advance of 2020 will be a key to any organization's successful management of this provision.

How the Tax Works

Before the most recent delay, the cost of employer-sponsored health coverage was to be compared against set limits in 2018. Any amount over these set limits would be taxed at a rate of 40%. The tax will be paid by the Insurer if the plan is insured and by the employer if the applicable coverage consists of coverage under which the employer makes contributions (like to an HSA), or the "person that administers the plan benefits." The definition of the "person that administers the plan benefits" is currently left to the IRS to define but would be either the employer that sponsors the plan or the third-party plan administrator (TPAs). The definition is likely moot for employers, as insurers and TPAs are likely to pass any additional tax on to the employer that sponsors the plan. Thus, it is imperative that employers take responsibility for managing the cost of the health care benefits offered to employees regardless of their administrative duties or funding arrangement.

The annual limits for 2018, before the delay, were $10,200 per self-only (i.e., individual) coverage and $27,500 for other than self-only (i.e., family) coverage. For most health plans, a quick check against current health plan costs and applying a typical health care trend into 2018 would suggest that more than half of employers would exceed these limits in 2018. Keep in mind that the limits apply to the total cost of health plan coverage (think of premiums charged by the insurer or the COBRA rates developed by employers) so the amount employees pay to participate in the plan have no effect on the calculation of the tax.

Employees in high-risk professions and retirees age 55 and older, but before reaching Medicare eligibility, will have

higher limits applied. The limits for regular employees will be increased by $1,650 for self-only coverage and $3,450 for other than self-only coverage for high risk professions and pre-Medicare retirees. High-risk professions include law enforcement officers, employees in fire protection activities, individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is alongshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries.

Employers will also be able to adjust the limits upward if their age and gender distribution would suggest a greater cost than that of the "National Workforce." Regulations have yet to be issued to determine how an employer can compare their specific age and gender make-up to a national workforce. However, the IRS did indicate that the limits would only increase and not decrease based on this adjustment. That is good news for employers.

What Is Included In Cost Of Coverage To Which The Tax Applies?

The ACA provides that "applicable employer-sponsored coverage" means "with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under [Internal Revenue Code] Section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)." The ACA further provides that the term "group health plan" for purposes of the tax means "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families."

In addition to the employer-sponsored health plan, the ACA provides a list of applicable coverage where the associated costs will be combined for comparison against the stated limits. Applicable coverage to which the tax applies include:

- Health Flexible Spending Accounts (Health FSAs), including both employer and employee contributions;
- Archer Medical Savings Accounts (MSAs) Future guidance is expected to exclude employee after-tax contributions from applicable coverage for Archer MSA's;
- Health Savings Accounts (HSAs) Future guidance is expected to exclude employee after-tax contributions from applicable coverage for HSAs;
- Governmental plans, defined as "coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government";
- Coverage for an on-site medical clinic unless it provides only de minimis medical care;
- Retiree coverage;

- Multi-employer plans; and
- Coverage for a specified disease or illness and hospital indemnity or other fixed indemnity insurance, if the payment for the coverage or insurance is excluded from gross income or a deduction under § 162(l) is allowed.

Future guidance is also expected to provide that executive physical programs and Health Reimbursement Arrangements (HRAs) are applicable coverage.

The ACA also lists certain types of coverage that are excluded from applicable coverage including:

- Coverage whether through insurance or otherwise, including:
    - Accident or disability income insurance, or any combination thereof;
    - As a supplement to liability insurance;
    - Liability insurance, including general liability insurance and automobile liability insurance;
    - Workers' compensation or similar insurance;
    - Automobile medical payment insurance;
    - Credit-only insurance; and
    - Other insurance coverage similar to the coverage under which benefits for medical care are secondary or incidental to other insurance benefits.
- Coverage, whether through insurance or otherwise, for long-term care;
- Any coverage under a separate policy, certificate, or contract (whether insured or self-funded) which provides benefits substantially all of which are for treatment of the mouth (including any organ structure within the mouth) or for treatment of the eye; and
- Specified disease or illness and hospital indemnity or other fixed indemnity, if payment for the coverage is included in gross income.

The IRS is also contemplating excluding Employee Assistance Plans (EAPs) from applicable coverage subject to the High-Cost Plan Excise Tax.

IRS Guidance

In 2015, the IRS released two notices, Notice 2015-16 and Notice 2015-52. Both notices provided approaches to the administration of the High-Cost Plan Excise Tax about which the IRS was interested in receiving comments.

In Notice 2015-16 (issued February 23, 2015) the IRS addressed issues primarily related to the definition of "applicable employer-sponsored coverage" (discussed previously), the determination of the cost of "applicable employer-sponsored coverage," and the application of the annual statutory dollar limit to the cost of "applicable employer-sponsored coverage."

Determining the applicable cost may not be as straightforward as one might think, especially when you begin to consider costs for benefits for which the employee pays nothing to participate. Most employers simply included such benefits as a cost of operations and did not develop single and family rates like they do for group health plans.

An additional complication results from the fact that each entity that insures or administers the benefit is responsible for the tax to the extent that all benefits combined subject to the tax exceed the applicable limits. Each entity then pays a portion of the tax based on a pro-rata share of the cost of the coverage it insures or administers in comparison to the total cost of all coverage subject to the tax. The employer-sponsor is responsible for making this determination. For example, the tax would be pro-rated between the vendors and employer for a health plan comprised of medical coverage insured by one vendor, pharmacy coverage administered by another vendor, and a HSA plan administered by the employer.

Employers will also have to determine different costs for each employee who is covered under different benefit plans. Unlike the Affordability Test under the ACA's Employer Mandate provision, the tax will be based on the actual plan each employee elected as opposed to the lowest-cost plan offered to that employee. This may mean employers start to eliminate higher-cost plans or provide greater financial incentives for employees to participate in the lower cost plans.

In Notice 2015-16, the IRS also put forth the concept that costs for each benefit plan be determined on its own experience. This may become a big issue for employers with multiple self-funded plan options for employees. Some plans may not have enough employees to accurately use the experience of that plan only to develop costs. Most self-funded employers have combined the experience of all plans and then used actuarial factors to assess the cost for each plan, such that in total the rates equaled the experience. If the IRS continues down this path, we will see significant changes in employer pricing approaches for health coverage.

Other issues raised by Notice 2015-16 include:

- How costs should be developed for self-only and other than self-only coverage;
- How to handle situations where an employee has self-only coverage for one benefit and other than self-only coverage for another;
- Disaggregation of costs by employment categories or geographical location of employees;
- Determining the costs under COBRA (Actuarial Basis or Past Cost Basis methods) when no regulations for these methods have been issued by the IRS;
- Whether other methods to determine costs would be allowable;
- Whether costs can be determined in advance of the plan year so that an expected tax liability is estimable or determined after the plan year ends;
- How to coordinate costs between benefit plan years and the calendar year for which the tax is due;
- The ability to change between COBRA methods from year to year;
- How to develop costs for HRAs if included as applicable coverage; and
- How the Age and Gender adjustment coordinate with any adjustment for high risk individuals or retirees.

On July 30, 2015, the IRS issued Notice 2015-52. This notice supplemented Notice 2015-16 by addressing additional issues, including the identification of the taxpayers who may be liable for the excise tax, employer aggregation, the allocation of the tax among the applicable taxpayers, and the payment of the applicable tax. This notice appears to suggest that the approach being strongly considered by the IRS is one that would require the tax to be determined after the end of the tax year using claim and other experience available after the tax year ends. This would make it harder for employers to estimate their tax liability in advance of the year and make decisions on managing costs.

Issues raised by Notice 2015-52 include:

- The taxability of the income received by a vendor providing service to an employer for the amount reported by the employer to cover the tax owed under the plan;
- How costs are allocated for FSAs, HSA, MSAs, and HRAs taking into account current year contributions and rollover amounts;
- What standard should be used to determine the Age and Gender adjustment based on a "national workforce" (as required under language in the ACA), especially when employer costs are the result of both the employees who represent the "workforce" and other participants (spouse and dependents) whose age and gender would not be reflected in a national workforce database;
- What type of form will be required to notify outside vendors of their tax liability associated with the employer's health plans (and what administrative burden that will entail for employers, insurers, and TPAs);

The IRS is clearly trying to determine an approach that meets the legislative requirements as stated in ACA, while maintaining a system that can be administered by all parties and audited by the IRS.

Next Steps for Employers

Employers should make sure they stay abreast of regulations issued by the IRS and the implications these regulations provide. Additionally, employers should use the 2-year delay to gain a better understanding of the requirements and potential tax liability associated with the High-Cost Plan Excise Tax. While the tax will not be first due until 2020 or later, organizations that plan in advance will be in a better situation to manage costs and the associated administrative burden. When you consider that many employee benefit decisions for a plan year are made 6 to 12 months in advance of the plan year, this suggests employers will need to have a strong understanding of the risks no later than early 2019. If the steps required are dramatic in nature to avoid or limit the tax, then planning well in advance of 2019 is highly recommended. Taking steps now to understand these risks is advisable.

Even though final regulations have yet to be issued, there is enough information available now to make informed decisions as to the risks associated with the current benefit plan structure that will allow for long-term strategic planning. This could avoid significant changes in years leading into the tax and managing employee dissatisfaction with employer health and welfare benefit offerings.

Employer Mandate

Application of the Employer Mandate
Who Is Subject to These Rules?
Which Entities Are Considered Part of the Same Employer?
Who Is an Employee?
What Hours Do We Count?
Is Our Organization a Large Employer?

Application of the Employer Mandate

Under Internal Revenue Code (IRC) Section 4980H, Large Employers that do not offer health coverage to Full-Time Employees and their Dependent Children, or offer coverage that is not "Adequate" or "Affordable," and have at least one employee enrolled in Exchange (Marketplace) coverage and qualify for a federal Premium Tax Credit or cost-sharing reduction, must pay a non-deductible Penalty.

While generally effective January 1, 2015, the final IRC regulations under IRC Section 4980H (final regulations) provided transition relief for non-calendar year plans in existence on December 27, 2012; for any employee for whom the employer offered "Adequate" and "Affordable" coverage by the first day of the plan year beginning in 2015, no Penalty was due prior to the beginning of the plan year beginning in 2015. Note that an employer was not eligible for this transition if it modified its plan year after December 27, 2012 to begin at a later date.

> **Tip:** The final regulations provide that employers with 50-99 Full-Time Equivalent Employees are not subject to the Penalty until the first day of the plan year that begins on or after January 1, 2016. More information on which employers qualify as Large Employers is included later in this section.

Bottom Line: Effective Date

For our organization, we will implement our Employee Mandate strategy by:	**Date**

Who Is Subject to These Rules?

The Employer Mandate applies only to Large Employers. A Large Employer generally is one that employed an average of at least 50 Full-Time Equivalent Employees on business days during the preceding year. All members of a Controlled Group are treated as a single employer. In order to perform the required calculation, an employer will need to capture both the number of Full-Time Employees and the number of hours worked by part-time employees. Of course, this also requires an understanding of who qualifies as an employee for this purpose and how to count hours worked. Ultimately, a Large Employer would only potentially pay an Employer Mandate Penalty for employees who meet the federal definition of Full-Time Employees (working 30+ hours per week).

30-hour Rule

What makes a Full-Time Employee? The Department of Labor (DOL) doesn't actually define the term, leaving that designation to the employer, since regulations largely apply the same way to all employees, no matter how employers define them. Over time, many employers came to consider the 40-hour workweek a full-time load.

The same does not hold true under the provisions of the ACA.

The ACA considers any employee who works an average of 30 hours per week or more (or 130 hours a month) to be a Full-Time Employee. As discussed in greater detail in this toolkit, employers may use either a Monthly Measurement Method or a Look Back Measurement Method to determine an employee's full-time status.

What does that mean for employers? These 30-hour-per-week employees may need to be offered health benefits by their employer to avoid potential ACA penalties.

Who Is an Employee?

As a general rule, all common law employees (as opposed to individuals who perform some service for the employer but are not considered employees) must be considered in connection with the Employer Mandate. An employer should analyze all of the individuals who perform services for the organization to determine how they should be properly classified and then determine whether each of those classifications is included for purposes of the Employer Mandate.

> **Tip:** The IRS and DOL closely monitor whether an employer has properly classified an individual as an employee (versus an independent contractor, for example) so it's important to work with your legal counsel to determine how certain individuals should be classified.

Employees vs. Independent Contractors

An employer must include all common law employees. An individual is a common law employee (and not an independent contractor, for example) if the employer has the right to direct and control the individual's work, such as what needs to be done and how it should be done.

> **Tip:** Individuals who receive a Form W-2 are currently being treated as your employees. Individuals who receive a Form 1099 are currently being treated as non-employees. However, you may want to confirm that individuals who receive a Form 1099 should not be receiving a Form W-2 (and treated as employees) instead.

Bottom Line: Independent Contractors

The following are groups of individuals who we consider to be contractors but probably need to be treated as employees:	**Include**
The following are groups of individuals who we can exclude as independent contractors:	**Exclude**
The following groups will require further analysis to determine whether they should be considered employees or contractors:	**Analyze**

Leased Employees and Employees from Staffing Agencies

Leased employees are individuals who are paid by a staffing firm but whose working conditions are generally controlled in whole or in part by the employer-clients to whom they are assigned, typically for a short period of time. If the employee is a common law employee of the staffing firm, it appears that the IRS meant to exclude leased employees as employees of the employer-client. However, it is unclear whether leased employees who work for the client for less than 12 months may be excluded. In the absence of clear guidance, an employer should work with its legal counsel to determine who will be considered the employer.

> **Tip:** A staffing agency and its employer-clients may want to resolve this issue on their own by making a contractual agreement about which entity will be responsible for the Employer Mandate.

The final regulations also provide that, if a staffing agency or professional employer organization (PEO) is not considered the common law employer and the staffing firm offers health coverage to the employee on behalf of the employer-client, the employer will be treated as having offered coverage, but only if the fee the employer-client would pay to the PEO/staffing agency for an employee enrolled in the health plan is higher than the fee that would be paid for an employee not enrolled in the health plan.

Bottom Line: Leased/Staffing Agency Employees

The following are groups of individuals who we hire from staffing agencies and for whom the staffing agency has assumed responsibility for the Employer Mandate:	**Exclude**
The following are groups of individuals we hire from staffing agencies who may require further analysis:	**Analyze**

Owners, Partners, Elected Officials, and Board Members

Sole proprietors, partners of a partnership, and 2% shareholders of S corporations are not considered common law employees. Elected officials are deemed to be employees for income tax purposes and are typically considered common law employees; the IRS has noted that very few elected officials could be considered independent contractors. Serving as a board member does not automatically mean an individual is an employee, although some board members do perform services that qualify them as employees in addition to their other roles.

> **Tip:** Just because board members are eligible for benefits does not automatically mean they are employees.

Bottom Line: Owners, Partners, Elected Officials , and Board Members

The following board members and elected officials are considered employees (and therefore would be included):	**Include**
The following board members will be excluded (and do not need to be eligible for Adequate and Affordable coverage):	**Exclude**
The following individuals may be excluded because they are owners, partners, or 2% shareholders (and our organization is an S corporation):	**Exclude**

Individuals Paid a Stipend

In many cases, individuals who are paid a flat stipend for a particular service will be considered employees. For example, school sports coaches or truck drivers paid per trip are often considered employees, although in some cases may be able to be classified as contractors.

Bottom Line: Individuals Paid a Stipend

The following groups of individuals are paid a stipend and probably need to be treated as employees:	**Include**
The following groups of individuals are paid a stipend and we can exclude them because they are not employees:	**Exclude**
The following groups of individuals will require further analysis to determine whether they should be considered employees:	**Analyze**

Seasonal Employees/Seasonal Workers

The terms "Seasonal Employees" and "Seasonal Workers" are both used in the Employer Mandate provisions but in two different contexts.

The employer is required to include hours worked by Seasonal Workers in determining whether it is a Large Employer. If an employer's workforce exceeds 50 Full-Time Employees for 120 days or fewer during a calendar year, and the employees in excess of 50 during that period were Seasonal Workers, the employer will not be considered a Large Employer. An employer may use a period of four calendar months (whether or not consecutive) or a period of 120 days (whether or not consecutive) to determine whether the Seasonal Worker exception applies for purposes of determining Large Employer status.

The term Seasonal Employee is relevant for determining an employee's status as a Full-Time Employee under the Look Back Measurement Period. A Seasonal Employee is an employee who is hired into a position for which the customary annual employment is six months or less and for which the period of employment coincides with a particular season of the year.

> **Tip:** While the general rule is that an employee who is reasonably expected to work 30+ hours per week must be immediately treated as a Full-Time Employee, an employer may use a Look Back Measurement Period to determine whether a Seasonal Employee would need to be treated as a Full-Time Employee.

Bottom Line: Seasonal Workers and Seasonal Employees

The following are types of employees who qualify as Seasonal Workers when determining whether we qualify as a Large Employer:	**Treat as Seasonal Workers**
The following groups probably should not be treated as Seasonal Workers, even though we hire them for intermittent positions:	**Treat as Regular Employees**
The following groups will require further analysis to determine whether they may be considered Seasonal Workers for purposes of qualifying for the Large Employer Exception:	**Analyze**
The following groups of employees may qualify as Seasonal Employee when first hired, for purposes of applying the Look Back Measurement Period:	**May Apply the Look Back Measurement Period Method**

What Hours Do We Count?

An employer is required to count actual hours worked and, in some cases, to give employees credit for non-work time.

> **Tip:** All hours worked must be included. For example, if a bus driver routinely works 20 hours per week but occasionally is hired to drive for a field trip or perform an administrative task, all of those hours must be added together.

A change from the proposed Treasury regulations under IRC 4980H (proposed regulations) is that, under the final regulations, hours of service must be counted across all members of the Controlled Group. For example, if an employee works 25 hours per week for one employer and 15 hours per week for another employer within the same Controlled Group, the employee would be credited with 40 hours worked.

Bottom Line: Crediting Hours for Employees across the Controlled Group

We will need to adopt the following processes to gather hours-worked data from other Controlled Groups members:	**Action Item**

Hours Worked: Hourly Employees

For employees paid on an hourly basis, an employer will count actual hours of service from records of hours worked.

Bottom Line: Crediting Hours for Hourly Employees

We may need to gather data from other sources, update our time-keeping procedures, or take other steps in order to be able to count actual hours from service records:	**Action Item**

Hours Worked: Non-Hourly Employees

For employees not paid on an hourly basis (such as salaried employees or employees paid on a daily basis) employers are permitted to calculate the number of hours of service under any of the following three methods:

- Counting actual hours of service;
- Using a days-worked equivalency method whereby the employee is credited with 8 hours of service for each day for which the employee would be required to be credited with at least one hour of service; or
- Using a weeks-worked equivalency of 40 hours of service per week for each week for which the employee would be required to be credited with at least one hour of service.

An employer may apply different methods for different classifications of non-hourly employees, so long as they are reasonable and consistently applied. The final regulations clarify that if an employee is entitled to be paid for a single hour in a day or week, the employee must be credited with the full 8 hours for the day (or 40 hours if using the weeks worked equivalency).

> **Tip:** Many school districts whose employees are contracted to work a certain number of hours per day, such as 6, were hoping they could use a 6-hour equivalency for employees paid a flat amount per day, such as substitutes. The final regulations do not allow any equivalency other than eight hours per day or 40 hours per week, which could result in a greater number of employees being considered full-time under the law than if the employer begins tracking actual hours worked. For example, if someone is contracted to work 6.5 hours per day, the employer would need to either have service records documenting that the employee actually worked 6.5 hours on a given day or credit the employee with 8 hours for each day worked.

May Not Use Equivalency If It Would Understate Hours Worked

An equivalency method may not be used if it would understate an employee's hours such that the employee would not be considered full-time. For example, if an employee works three days per week, 10 hours per day, the employee should be considered full-time, but using an 8 hours per day equivalency would result in the employee being considered part-time. In that situation, the employer would not be allowed to use a days-worked equivalency.

Bottom Line: Crediting Hours for Non-Hourly Employees

Our organization will use the days/weeks equivalency for the following groups of employees:	**Equivalency Method**
We may need to create procedures to track and credit actual hours worked for the following groups of employees:	**Action Item**

Hours Worked: Employees Receiving a Stipend, Including Adjunct Faculty

The proposed regulations discussed the challenges with determining how many hours certain individuals have worked, such as adjunct professors. Similar issues arise for sports coaches or drivers paid a set amount per trip, for example.

The final regulations provide that adjunct faculty may be credited with 2.25 hours of service for every credit hour they teach (or, to put it another way, an additional 1.25 hours for every credit hour taught). For other categories, employers are instructed to make reasonable, good faith interpretation.

Bottom Line: Crediting Hours for Employees Receiving a Stipend

For individuals who are paid a stipend and treated as employees, we will need to determine how to calculate hours worked for the following groups:	**Action Item**

Non-Work Time For Which Pay Is Due

The final regulations clarify that full-time status is based on "hours of service," which include non-work time for which pay is due, such as paid time off for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. There is no limit on the amount of paid leave that must be taken into account.

> **Tip:** The employer would include disability leave for which the employer pays while the individual remains an active employee, but not payments from a long-term disability insurance policy, for example, after the individual has terminated employment.

Bottom Line: Non-Work Time To Be Included

We need to remember to capture the following non-work time:	**Include**

> **Tip:** Categories of non-work time may vary based on worker classification.

Volunteers

Hours contributed by Bona Fide Volunteers for a government or tax-exempt entity, such as Volunteer firefighters and emergency responders, will not cause them to be considered Full-Time Employees even if the Volunteer receives some payment for the Volunteer work, so long as that is the only work the individual does for the entity and the pay is nominal or just intended to cover the Volunteer's expenses. Similarly, hours worked by a Volunteer who does not receive compensation from the entity does not need to be credited.

The exemption for Volunteer hours is potentially very helpful for government and tax-exempt entities. It is unclear from the final regulations what amount of pay would be considered nominal. However, the Department of Labor's Wage and Hour Division presumes that fees paid to Volunteers are nominal as long as the fee does not exceed 20% of what an employer would otherwise pay to hire a full-time employee for the same services. (See Wage and Hour Opinion Letters FLSA2006-28 [Aug. 7, 2006] and FLSA2005-51 [Nov. 10, 2005].) For example, a lay coach paid a stipend by a school district to coach football season may qualify as a Volunteer under these rules, which means the district would not have to determine or include the number of hours that were worked by that individual. Remember, that exception only applies if the only compensation the employee receives from the district is for such Bona Fide Volunteer activities.

Bottom Line: Volunteers

The following individuals qualify as Bona Fide Volunteers, so we will not need to capture hours worked:	**Exclude**
The following individuals hold volunteer roles in the organization, although do not meet the requirements for Bona Fide Volunteers, so we will need to capture their hours worked:	**Include**
We will need to do additional work to determine whether these individuals qualify as Bona Fide Volunteers:	**Action Items**

Staffing Agencies

As discussed above, future guidance is expected to clarify the rules for when individuals hired from staffing agencies must be treated as employees. Under an anti-abuse rule, if an individual performs services as an employee of an employer, and also performs the same or similar services for the employer under a contract with a staffing agency, then all of the individual's hours must be combined when counting hours of service.

Bottom Line: Dual Employees

The following individuals work for us through a staffing agency and also work for us directly as employees, so we will need to capture hours worked in both roles:	**Include**

Other Specific Employee Groups

The final regulations provide some clarity with respect to the treatment of a few specific categories of employees and the hours that must be captured:

Student Workers: The general rule is that hours worked by employees who are also students of an educational institution must be captured. However, service performed by students under federal or state-sponsored work-study programs will not be counted in determining whether they are Full-Time Employees.

On-call Employees: The IRS continues to consider additional rules for determining hours of service that need to be credited for on-call hours. Until further guidance is issued, employers are instructed to use a reasonable method. The final regulations clarify that it is not reasonable to fail to credit an employee with an hour of service for any on-call hour for which payment is due by the employer, for which the employee is required to remain on-call on the employer's premises, or for which the employee's activities while remaining on call are subject to substantial restrictions that prevent the employee from using the time effectively for the employee's own purposes.

Layovers: The IRS cites examples where it would be unreasonable to not provide any hours of credit such as if an airline employee receives compensation for a layover or is required to have an overnight layover away from home.

Sales People: Similarly, the final regulations note that it would not be a reasonable method of crediting hours to fail to take into account travel time for a traveling salesperson compensated on a commission basis.

Bottom Line: Specific Categories of Employees

We will be able to exclude hours worked by the following categories of employees:	**Exclude**
We need to remember to include hours worked for the following categories of individuals:	**Include**
The following individuals may qualify for an exemption; we will need to perform an additional assessment:	**Action Item**

Is Our Organization a Large Employer?

The Employer Mandate applies only to Large Employers. A Large Employer generally is one that employed an average of at least 50 Full-Time Equivalent Employees on business days during the preceding year. However, the final regulations provide that employers with 50-99 Full-Time Equivalent Employees are not subject to the Penalty until the first day of the plan year that begins on or after January 1, 2016. In order to qualify, the employer could not reduce the size of its workforce or overall hours of service after February 9, 2014, unless for a bona fide business reason, and the employer must maintain any health coverage (including benefits and eligibility) in effect on February 9, 2014. Employees who qualify for the delay must provide certification to the IRS that they meet the eligibility requirements.

An employer's number of Full-Time Employees is based on actual hours of service in the prior year. However, for purposes of determining whether an employer is a Large Employer in 2015, an employer may use a period of at least six consecutive calendar months, chosen by the employer, in the 2014 calendar year (rather than having to use the entire 2014 calendar year). In addition, the first year an employer qualifies as a Large Employer, the employer will not owe a Penalty as long as adequate and affordable coverage is offered by April 1.

How Do We Calculate Our Number of Full-Time Equivalent Employees?

> **Tip:** Remember to include employees from all members of the Controlled Group and from all classes of employees.

For purposes of determining whether an organization is a Large Employer, the employer calculates its number of Full-Time Equivalent Employees by adding the following:

- The number of Full-Time Employees (working 30 or more hours per week) for each month during the year; and
- For all employees who were not Full-Time Employees for any month during the year, the actual hours worked during each month (up to 120 per person) divided by 120.

Divide the total by 12 and the result is the number of Full-Time Equivalent Employees for the year. If the number is greater than 50, then the employer is considered a Large Employer and will be subject to the Employer Mandate.

> **Tip:** Remember that a possible Seasonal Worker exemption may be available when determining whether you are a Large Employer. If an employer's workforce exceeds 50 Full-Time Equivalent Employees for 120 days or fewer during a calendar year, and the employees in excess of 50 during that period were Seasonal Workers, the employer will not be considered a Large Employer.

Bottom Line: Subject to the Employer Mandate Rules

Our organization **will / will not** be subject to the Employer Mandate Rules in 2017. (circle one)
Our organization **will / will not** be subject to the Employer Mandate Rules in 2018. (circle one)

Strategic Decision Point

If your organization is not subject to the Employer Mandate rules, you will not owe a Penalty regardless of whether you sponsor a health plan or whether you make Adequate and Affordable coverage available to your employees. Remember to calculate your number of Full-Time Equivalent Employees each year.

Full-Time Employees

What Methods May We Use to Calculate Total Hours Worked?
How Do We Use the Monthly Measurement Period Method?
How Do We Use the Look Back Measurement Period Method?
Who and When Do We Measure for New Employees?

An employer will potentially owe a Penalty only for Full-Time Employees. An employee who averages 30 or more hours a week (or 130 or more hours in a calendar month) is considered a Full-Time Employee. The regulations include specific rules on which hours of service must be captured and how to measure those hours to determine whether someone worked Full-Time.

What Methods May We Use to Calculate Total Hours Worked?

The final regulations clarify that there are two methods for calculating whether an employee has worked Full-Time:

- The Monthly Measurement Period Method—the employer offers coverage to any employee for any month during which the employee works Full-Time.
- The Look Back Measurement Period Method—the employer may determine whether an employee averaged 30 or more hours of service per week over a period of 3 to 12 months. If an employee was considered Full-Time during this "Measurement Period," the employee must be treated as a Full-Time Employee for benefits purposes for a subsequent "Stability Period" regardless of the employee's number of hours worked during the Stability Period.

An employer may only choose to use different methods (i.e., the Monthly Measurement Period or Look Back Measurement Period) between the following categories of employees:

- Salaried versus hourly employees;
- Employees with primary places of employment in different states;
- Collectively bargained versus non-bargained employees; or
- Each group of collectively bargained employees covered by a different agreement.

For example, the employer could use the Monthly Measurement Period Method for all salaried employees and the Look Back Measurement Period Method for all employees who are paid hourly. However, the final regulations make it clear that these are the only permissible categories; an employer is not allowed to create categories of employees other than these for purposes of applying different measurement methods. In other words, the employer could not use the Monthly Measurement Period Method for employees who are Full-Time and the Look Back Measurement Period Method for employees who are Part-Time.

Tip: From a practical standpoint, using the Monthly Measurement Period Method may be more challenging for employers to administer than the Look Back Measurement Period Method if the employer has any variable-hour employees. The Look Back Measurement Period Method would allow an employer to line up the Stability Period with the plan year, for example, and avoid potentially having to move employees in and out of coverage on a monthly basis. The Monthly Measurement Period Method could also create a challenge if the employer does not know how many hours a certain employee will work in the upcoming month. Let's say the employer thought the employee was going to work 100 during the month but, by the end of the month, it turned out the employee actually worked 140 hours. At that point it is too late to offer coverage for the month that has just ended.

Bottom Line: Measurement Method

We will use the Monthly Measurement Period Method for the following classifications of employees (see above for allowable categories):	**Monthly Method**
We will use the Look Back Measurement Period Method for the following classifications of employees (see above for allowable categories):	**Look Back Method**

How Do We Use the Monthly Measurement Period Method?

The Monthly Measurement Period Method is very straightforward. If you know an employee is going to work Full-Time for the upcoming month, you offer the employee health coverage for that month.

> **Tip:** The Monthly Measurement Period Method would work well for an employer that currently offers coverage to all employees, or for an employer whose employees' hours have little variation from month to month.

The final regulations include several rules that are unique to the Monthly Measurement Period Method.

Offer Coverage by the Fourth Month: An employer will not trigger a Penalty for failing to immediately offer coverage to a newly-hired Full-Time Employee as long as the employee is offered coverage within three full calendar months of first becoming eligible.

Special Leave of Absence: While the Look Back Measurement Period Method requires the employer to credit employees with hours of service during special leaves, such as FMLA (family medical leave), USERRA (uniformed military service), and jury duty, no credit for these types of unpaid leave is required when using the Monthly Measurement Period Method.

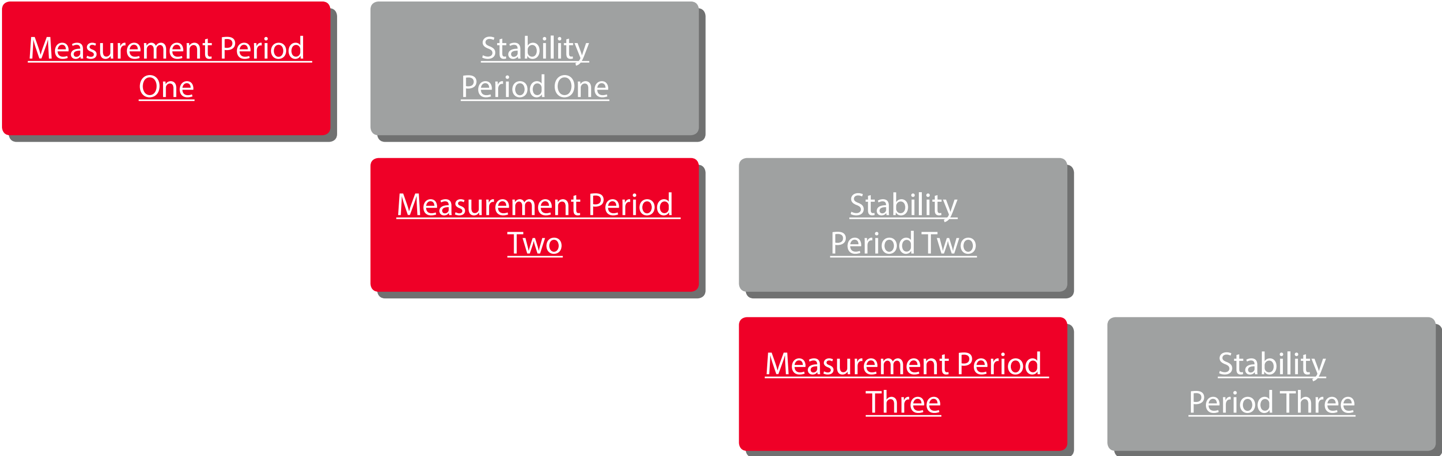
Weekly Rule: Employers can measure weekly rather than monthly in order to coordinate more effectively with their payroll cycles. Under this optional method, Full-Time Employee status for certain calendar months is based on hours of service over four-week periods and for certain other calendar months on hours of service over five-week periods. In general, the period measured for the month must contain either the week that includes the first day of the month or the week that includes the last day of the month, but not both. For calendar months using four-week periods, an employee with at least 120 hours of service is a Full-Time Employee, and for calendar months using five-week periods, an employee with at least 150 hours of service is a Full-Time Employee.

Offer Coverage for the Full Month: Coverage must be offered for the entire calendar month in order to avoid a Penalty. This rule applies even if the employer is using the Weekly Rule.

How Do We Use the Look Back Measurement Period Method?

The Look Back Measurement Period Method is ideal for an employer with some employees whose hours vary periodically. The employer will set a standard Measurement Period of 3 to 12 months to use for all employees in the categories who will be measured using the Look Back Measurement Period Method (see above for the permissible categories). If an employee averaged 30 or more hours per week during this Measurement Period, the employee must be treated as a Full-Time Employee for benefits purposes for a subsequent "Stability Period" regardless of the employee's number of hours worked during the Stability Period, so long as the individual remains an employee. If the employee was considered part-time during the Measurement Period, the employee may be treated as part-time for benefits purposes throughout the Stability Period.

Example: Measurement and Stability Periods



In addition, in certain circumstances, the employer may use an Initial Measurement Period to determine whether certain newly-hired employees are required to be offered coverage.

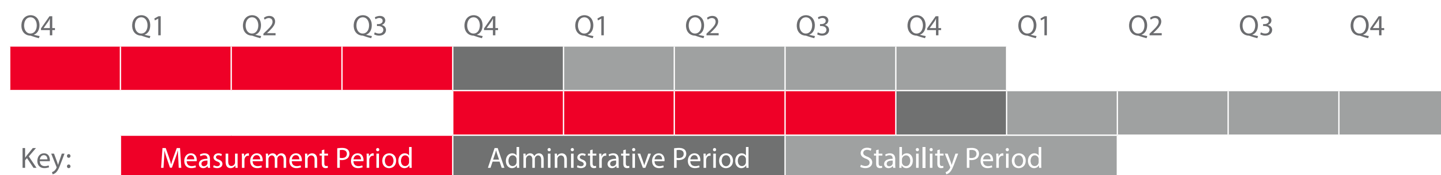
> **Tip:** The final regulations make it clear that the Look Back Measurement Period Method may only be used for purposes of determining who is Full-Time in connection with offering health coverage. These rules may not be used for the purpose for determining whether the employer is considered a Large Employer.

When Do We Measure for Ongoing Employees?

Length: The employer may select a Measurement Period of between 3 and 12 calendar months. The Stability Period must be at least as long as the Measurement Period, and not shorter than 6 months. If the employee was considered part-time during the Measurement Period, the Stability Period cannot be longer than the Measurement Period. The regulations allow an employer to adjust the starting and ending dates of the Measurement Period in order to avoid splitting employees' regular payroll periods. For example, an employer using the calendar year as the Measurement Period could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire period that included December 31 (the end of the same year). However, Stability Periods must always include full calendar months.

Administrative Period: An employer may also utilize an Administrative Period of up to 90 days following the Measurement Period to allow time to make coverage options available to those employees who worked a Full-Time schedule during the preceding Measurement Period and to allow employees to make coverage elections for the subsequent Stability Period. For ongoing employees, the Administrative Period must overlap the Stability Period.

Example: Administrative Period for Ongoing Employees



Tip: Some employers had been hoping to use a three-month Administrative Period, which may be more convenient than 90 days. (Three calendar months may be up to 92 days.) However, the final regulations confirm that the Administrative Period may not be longer than 90 calendar days.

Start Date: The employer has the flexibility to determine the dates in which the Measurement and Stability Period start and end, which must be applied consistently for all employees in the same category. The permissible categories are the same as those described above for selecting whether to use either the Monthly or Look Back Measurement Period Methods. Remember that the start date for a Stability Period must be the first day of a calendar month.

Bottom Line: Measurement and Stability Periods for Ongoing Employees

Our plan year is:	
For ongoing employees, we will use the following periods beginning in 2014 (remember the Administrative Period must overlap the Stability Period, and the Stability Period must be at least 6 months starting no later than July 1, 2014):	Measurement Period ____________ to ____________ (month/day) (month/day)
	Administrative Period ____________ to ____________ (month/day) (month/day)
	Stability Period ____________ to ____________ (month/day) (month/day)
On an ongoing basis, we will use the following periods:	Measurement Period ____________ to ____________ (month/day) (month/day)
	Administrative Period ____________ to ____________ (month/day) (month/day)
	Stability Period ____________ to ____________ (month/day) (month/day)

Who and When Do We Measure for New Employees?

New Employees – Reasonably Expected to Work Full-Time

If an employee is reasonably expected at his or her start date to work a Full-Time schedule under the 30-hour definition (and the employee is not a Seasonal Employee), the employee must be treated as Full-Time when hired. The final regulations include factors that should be taken to account when determining reasonableness, such as whether the new employee is replacing an employee who was Full-Time, whether employees in similar positions are Full-Time, and whether the job was advertised as requiring 30 or more hours per week. An educational institution cannot take into account the potential for employment breaks in determining the expectation of future hours. Similarly, an employer cannot take into account that a position has typically had high turnover.

New Employees – Variable Hour or Seasonal Employees

For Variable Hour Employees who are not reasonably expected to work a Full-Time schedule, and for Seasonal Employees, the employer may use a Look Back Measurement Period to determine whether an employee averaged 30 or more hours of service per week.

The final regulations define Seasonal Employees to be individuals in positions for which the customary annual employment is six months or less that coincides with a particular season of the year. The benefit of being considered a Seasonal Employee is that the employer can use the Look Back Measurement Period to calculate hours worked rather than having to treat the individual as Full-Time when first hired.

> **Tip:** From a practical standpoint, if the employer is using a 12-month Measurement Period, Seasonal Employees will not end up qualifying as Full-Time. For example, if a Seasonal Employee works for the employer for a full six months at 40 hours per week, and then does not do any other work for the employer, the employee will only have worked an average of 20 hours per week across the year.

Start Date for Measuring: The start date for an employee's Initial Measurement Period can be the employee's date of hire, the first of the month following date of hire, or the first day of the first payroll period following date of hire.

Start Date for Offering Coverage: For new employees, the Measurement and Administrative Periods combined may not extend longer than 13 months from the employee's start date, plus the time remaining until the first day of the next calendar month (if the employee's start date is not the first day of a calendar month). An employer using a 12-month Stability Period is allowed to use an Initial Measurement Period of 11 months with a 2-month Administrative Period.

Include New Hires in Ongoing Measurement Period Calculation: During a new Variable Hour Employee's Initial Measurement Period, the employer is also required to calculate Full-Time status under the Measurement Period that applies to ongoing employees. If the employee worked Full-Time during the Measurement Period used for all ongoing employees, the employer must treat the individual as a Full-Time Employee as of the start of the next Stability Period that applies to ongoing employees, even if the Initial Stability Period that applies to the new employee has not yet expired.

Bottom Line: Initial Measurement Period for Variable-Hour or Seasonal New Hires

We will plan to start measuring for new hires on the following date (i.e., date of hire, first of the month following date of hire, or first payroll beginning after date of hire):	
For new hires, we will use the following periods (remember the Measurement Period and Administrative Period together cannot exceed 13 months):	Measurement Period
	Administrative Period
	Stability Period
On an ongoing basis, we will use the following periods:	Measurement Period
	Administrative Period
	Stability Period

What If Someone Changes from a Variable-Hour to a Full-Time Position?

In the event a new Variable-Hour or Seasonal Employee has a material change in the position of employment or other employment status that, had the employee begun employment in the new position or status, would have resulted in the employee being reasonably expected to be employed on average at least 30 hours of service per week during the Measurement Period, the employee must be treated as a Full-Time Employee as of the first day of the fourth month following the change in employment status, or, if earlier and the employee averages more than 30 hours of service per week during the initial Measurement Period, the first day of the first month following the end of the Initial Measurement Period. The final regulation applies this change in status rule only to new Variable-Hour and Seasonal Employees. A change in employment status for an ongoing employee does not change the employee's status as a Full-Time Employee or otherwise during the Stability Period.

How Do We Treat Leaves of Absence and Employment Breaks for Educational Organizations?

If an employee has a Special Unpaid Leave due to FMLA (family medical), USERRA (military service), or jury duty, or an Employment Break (a period of at least four consecutive weeks during which an employee of an educational organization is not credited with an hour of service), an averaging method is used to determine hours of service:

- Compute average hours after excluding any Special Unpaid Leave or Employment Break and use that average for the entire period; or
- Treat the employee as credited with hours of service for any periods of Special Unpaid Leave or an Employment Break at the rate the employee was credited with hours of service during the non-leave or Employment Break periods. An employer is not required to credit more than 501 hours during this time.

An employer is not required to credit service for periods of time that an employee is not paid or entitled to pay and which is not either Special Unpaid Leave or an Employment Break. For example, an educational organization would not be required to credit breaks such as winter or spring break if the breaks are unpaid and less than four weeks.

> **Tip:** The final regulations include an anti-abuse rule that an educational institution cannot schedule hours or pay someone simply to avoid crossing the four-week threshold in order to not have to credit the employee with hours of service during the employment break (e.g., summer break).

How Do We Treat Breaks in Service?

If an employee has a break in service (including unpaid leave of absence) of at least 13 consecutive weeks (26 weeks for educational institutions), the employer does not have to count any service prior to the break. If the break was less than 26/13 weeks (as applicable), the employer may choose to apply a rule of parity; the employee will be treated as a new hire after the break if the break was at least four weeks long and was longer than the period of work immediately preceding the break. If the rule of parity does not apply, the break is counted as part of the Measurement Period calculation (with no hours credited during that time).

4980H(a) Penalty

Will We Continue Offering Health Coverage?
Who Must Be Eligible to Avoid Paying a Penalty?
When Do We Have to Offer Full-Time Employees Coverage to Avoid a Penalty?
How Will We Demonstrate That We Offered Coverage to Substantially All Full-Time Employees?
What Will Our Strategy Be for Offering Health Coverage?

There are two potential Employer Mandate Penalties a Large Employer could trigger. The Penalty under Code section 4980H(a) applies if a Large Employer does not offer health coverage to Substantially All Full-Time Employees (and their Dependent Children) and at least one Full-Time Employee (working 30 or more hours per week or 130 hours per month) enrolls in Exchange coverage and qualifies to receive a Premium Tax Credit. (Employees with Household Income of up to 400% of the Federal Poverty Line are eligible for a Premium Tax Credit.) This monthly Penalty is 1/12 times $2,000 times the number of Full-Time Employees. The first 80 employees are excluded from the calculation of the 4980H(a) Penalty for the 2015 plan year, decreasing to 30 employees beginning in 2016.

> **Tip:** Note that the amount of the Penalties will be indexed annually by the IRS.

Will We Continue Offering Health Coverage?

The Employer Mandate is also called the "Play or Pay" mandate because an employer has a choice to offer minimum essential coverage or pay a Penalty. Employees of employers that choose the option to simply pay the 4980H(a) Penalty will be able to obtain coverage through an Exchange (Marketplace) or other source, such a spouse's employer's plan. Note that while Exchange (Marketplace) coverage will be available, unless the employee qualifies for a Premium Tax Credit, the coverage could be very expensive.

Minimum essential coverage is defined as employer-sponsored major medical coverage. The employer is only required to offer access to major medical coverage in order to avoid a 4980H(a) Penalty. The employer is not required to offer dental coverage, for example.

Bottom Line: Play or Pay

Check one of the following:

We plan to offer health coverage in 2017 and will seek to structure eligibility so as to avoid the 4980H(a) Penalty.	**PLAY**
We will not offer health coverage and will instead plan to pay the 4980H(a) Penalty of 1/12 times $2,000[1] times the number of Full-Time Employees each month (minus 30 employees).	**PAY**

[1] *The 4980H(a) penalty is estimated to be $2,260 in 2017.*

Strategic Decision Point

If you choose the Pay option, there is nothing further you need to do in connection with developing an Employer Mandate strategy.

You may want to review the information at the end of this toolkit on the logistics of paying the Penalty. If you have more than 50 employees you will be required to report certain information to the IRS each year.

Who Must Be Eligible to Avoid Paying a Penalty?

Substantially All Full-Time Employees

If an employer wants to avoid paying a 4980H(a) Penalty, the employer must offer health coverage to Substantially All Full-Time Employees. For the 2015 plan year, an employer will have satisfied the requirement to offer coverage to Substantially All Full-Time Employees if they offer coverage to 70% of their Full-Time Employees, which is decreased from 95% in the proposed regulations. Beginning in 2016, the Substantially All threshold increased to 95%. Whether coverage has been offered to Substantially All Full-Time Employees is determined separately with regard to each member of a Controlled Group.

It's critical to understand that, in 2016, for example, the employer must offer coverage to 95% of employees who are considered Full-Time under the law. Let's say an employer currently offers coverage to certain classes of employees working 20 hours per week, but does not offer coverage at all to other classes of employees. The first step is to determine which employees are considered Full-Time under the law, and that becomes the denominator. The second step is to determine which of those employees are eligible for coverage, which becomes the numerator. An employer may not include anyone in the numerator who works less than 30 hours per week, even if the employer offered them coverage.

Tip: The 4980H(a) Penalty includes an all-or-nothing threshold. An employer cannot divide its number of Full-Time Employees in half and choose to simply pay the $2,000[1] for the group of employees who are not eligible. However, it may be possible to exclude coverage for up to 30% of Full-Time Employees in 2015, and up to 5% (or 5 employees, if greater) Full-Time Employees in 2016 and thereafter. Relying on this margin of error to avoid triggering a Penalty would require an employer to be diligent in monitoring its number of Full-Time Employees and the number of hours worked by Variable Hour employees and employees paid a stipend.

Bottom Line:

We **may / probably will not want to** intentionally limit eligibility for up to 5% of Full-Time Employees in 2017. (circle one)

We may want to consider the following in order to monitor our number of Full-Time Employees on an ongoing basis to ensure we offer coverage to Substantially All Full-Time Employees:	**Action Item**

[1] The 4980H(a) penalty is estimated to be $2,260 in 2017. The amount of the penalties will be indexed annually by the IRS.

Tip: Employers should work with legal counsel to ensure they will not create labor law or nondiscrimination issues before adopting a strategy to exclude eligibility for only certain employees.

Dependent Children

In order to avoid the 4980H(a) Penalty, coverage must be offered to Full-Time Employees and their Dependent Children up to the age 26. The proposed regulations required plans to cover biological, adopted, step, and foster children. The final regulations only require employers to offer coverage to biological and adopted children.

In addition, the final regulations clarify that the employer must offer coverage through the end of the calendar month in which the child turns age 26. This is a change from the regulations covering the plan design mandate, which require coverage to be offered only until the day the child turns age 26.

Tip: Under the Health Care Reform plan design mandate that took effect for plan years beginning on or after September 23, 2010, the only requirements an employer may impose on a child's eligibility are whether the child has the appropriate relationship with the employee (such as a child or adopted child) and whether the child has reached his or her 26th birthday. Plans may no longer limit eligibility to children who are full-time students, live with their parents, receive the majority of their financial support from their parents, can be claimed as dependents on their parents' income tax returns, etc.

Bottom Line: Coverage for Dependent Children

We will need to make the following amendments to our plan to extend eligibility for Dependent Children:	**Action Item**

Tip: The final regulations do not require an employer to offer coverage to an employee's spouse or domestic partner, just the children.

When Do We Have to Offer Full-Time Employees Coverage in Order to Avoid a Penalty?

Within 90 Days of Becoming Eligible

Under an ACA plan design mandate, for plan years beginning on or after January 1, 2014, a health plan may not impose an eligibility waiting period of greater than 90 days. If the employer's plan conditions eligibility on having worked a specified number of hours during a period (or working Full-Time), and it cannot be determined whether a newly hired employee is reasonably expected to work the required number of hours, the employer may utilize a Look Back Measurement Period to determine whether the employee worked Full-Time over the Measurement Period. The Measurement Period is not considered a waiting period if coverage can become effective no later than 13 months from the employee's date of hire, plus the time remaining until the first day of the next calendar month (if the employee's start date is not the first day of the calendar month).

The final regulations allow for requirements to be in an eligible job classification, achieve a job-related licensure requirement, or the satisfaction of an employment-based orientation period before the application of the 90-day waiting period. The proposed regulations provide that one month is the maximum length of any bona fide employment-based orientation period where an employer and employee could evaluate whether the employment situation is satisfactory for each party, and standard orientation and training would occur. One month would be determined by adding one calendar month and subtracting one day from the employee's start date. For example, if the employee's start date is May 3 (and in an eligible class for health plan coverage) the last permitted day of the orientation period is June 2. If there is not a corresponding date in the next calendar month then the last day of the orientation period is proposed to be the last day of the next calendar month (e.g., start date of January 31 would result in the last day of the orientation period being February 28 in a non-leap year or February 29 in a leap year).

Tip: While the Employer Mandate rules do not require employers to offer coverage to part-time employees, if part-time employees are eligible for coverage, the waiting period may not exceed 90 days.

Bottom Line: Waiting Periods

We will need to make the following amendments to our plan's waiting period requirements:	**Action Item**

While an Active Employee

In order to avoid a 4980H(a) Penalty, coverage must be offered to active Full-Time Employees. An employer generally does not have to provide coverage during a Stability Period beyond termination of employment. The regulations discuss challenges that staffing agencies have in determining whether someone has actually terminated because the

individual could simply stop accepting new assignments. The same could be true for substitute teachers, for example. The IRS has requested comments on how to address that situation.

> **Tip:** For an employer subject to COBRA, any covered employee (including a Variable Hour employee) who loses health coverage due to a qualifying event (such as termination of employment) has a right to continue coverage via COBRA.

Bottom Line: Employee Termination

We may want to adopt the following procedures to help us better identify when certain employees have terminated employment:	**Action Item**

How Will We Demonstrate We Offered Coverage to Substantially All Full-Time Employees?

The final regulations do not include any specific rules on how to demonstrate that the employer offered coverage. One question to consider is, in case of audit, how will you demonstrate to the IRS that you offered the coverage to the minimum percentage of Full-Time Employees?

> **Tip:** Many employers are planning to collect a signed form from each employee who waives coverage during their initial or annual enrollment periods acknowledging that they were offered coverage.

Electronic Offer of Coverage

The final regulations clarified that an employer may make the offer of coverage electronically so long as the safe harbor method for use of electronic media is satisfied. Under the IRS and DOL safe harbor rules, an employer may distribute information about employee benefits electronically, such as via email, to employees who have regular access to a computer and the use of the computer is an integral part of their job duties.

For employees who do not have work-related computer access, the plan sponsor must obtain informed consent prior to sending information electronically. For consent to be "informed," it must occur after the individual has been provided notice of certain information, such as a statement about the participant's right to request a hard copy of the electronic information at any time without charge, and the right to withdraw their consent and start receiving information in hard copy.

If the employer sends benefits information via email, such as notice of opportunity to enroll, the rules also require the employer to utilize features such as return-receipt and undeliverable mail options, and the employer must conduct periodic reviews or surveys to confirm receipt.

> **Tip:** Courts have clarified that simply placing notice on the company intranet or a computer kiosk will not establish that the information is received and, therefore, will not satisfy the safe harbor. Instead, the employer can post the notice online and then, for example, mail a postcard with the link to the online information.

Bottom Line: Making an Offer of Coverage

We will adopt the following procedures in order to demonstrate that we have properly made an offer of coverage:	**Action Items**

Opportunity to Accept or Decline

The final regulations provide that an employer must provide Full-Time Employees with an effective opportunity to accept or decline coverage, or the employee will not be treated as having been offered the coverage for purposes of avoiding the 4980H(a) Penalty. If an employee is not offered an effective opportunity to accept coverage at least once a year, he or she will not be treated as having been offered coverage. In other words, by declining coverage, the employee cannot be locked out of an opportunity to enroll the following year.

In a very limited situation, the employer may require the employee to accept coverage that is both Adequate and Affordable. As per the final regulations, Affordability for this purpose is based on the amount the employee has to pay for employee-only coverage as a percentage of the Federal Poverty Level (FPL) for a single individual, and cannot exceed 9.69%. In 2017, FPL for a single individual is $11,880. In other words, the coverage will be deemed to be affordable if the employee has to pay less than $1,139.29 for major medical coverage for the year, in 2017 dollars.

> **Tip:** This rule makes it clear that if the employer pays the full cost of employee-only coverage (such that the coverage is free to the employee), the employer could require employees to enroll in the coverage.

Bottom Line: Opportunity to Elect or Decline Coverage

We will need to make the following amendments to our eligibility and election rules to ensure employees may elect to enroll in coverage at least once a year:	**Opportunity to Elect**
We will need to make the following amendments to our eligibility and election rules to ensure employees may opt out of Inadequate or Unaffordable coverage:	**Opportunity to Decline**

What Will Our Strategy Be for Offering Health Coverage?

If you want to avoid a Penalty for failing to offer health coverage, the following are steps to consider when analyzing your options:

Step 1: Determine who your Full-Time Employees are.

The first step is to make sure you know who will be considered Full-Time Employees. Include all of the categories of employees and hours worked as described in the section on Full-Time Employees.

Step 2: Determine whether all of your current employees who will be considered Full-Time are currently eligible for health coverage.

Once you know who your Full-Time Employees are, the next step is to identify which of them are currently eligible for coverage and which are not.

Tip: In order to avoid the 4980H(a) Penalty, Full-Time Employees (and their Dependent Children) simply need to be eligible for coverage. The employer does not have to contribute a certain (or any) amount toward the cost of coverage.

Bottom Line: Eligibility Issues

The following groups of employees will likely have some individuals who will be considered Full-Time under the federal definition but are not currently eligible for health coverage:	**Classes of Employees**
In total, we have exposure with approximately:	**Scope of Exposure** ___________________ **employees**

Step 3: If you have Full-Time Employees who are not currently eligible for benefits, decide what to do next.

If you do have individuals who will be considered Full-Time Employees under the federal definition but who are not currently eligible for benefits, this is where you need to make a decision about how to proceed.

Strategic Decision Point

For those not currently eligible, will you restructure the workforce so they will not be able to work 30 hours?

One option is to restructure your workforce to limit hours employees may work to less than 30 per week. However, that could create other issues.

Bottom Line: Restructuring Our Workforce

We could make the following changes in our workforce:	**Options**
Logistical issues we will want to consider:	**Logistics**
The following are next steps to consider:	**Action Items**

Tip: An employer should work with legal counsel on potential federal or state labor law issues before making changes in its workforce.

Strategic Decision Point

For those not currently eligible, will you restructure eligibility and/or available coverage options?

For an employer seeking to avoid paying a 4980H(a) Penalty, other options to consider are how to extend eligibility for current health coverage options to Substantially All Full-Time Employees (and their Dependent Children) and/or revising current health coverage options or offering a new coverage option.

Bottom Line: Changes in Coverage Options

We could make the following changes to our current health coverage:	**Options**
Logistical issues we will want to consider:	**Logistics**
The following are next steps to consider:	**Action Items**

Tip: The Employer Mandate rules do not require an employer to offer the exact same coverage to all Full-Time Employees. So, for example, an employer may want to consider adding a low-cost option (that is still considered Adequate) to offer Full-Time Employees who are not currently eligible for coverage. However, it is important to work with your legal counsel to review the various nondiscrimination rules to ensure such a strategy does not trigger other types of penalties. As a general matter, self-funded health plans and fully insured major medical plans may not discriminate in favor of highly compensated individuals.

4980H(b) Penalty

Inadequate Coverage

Unaffordable Coverage

What Will Be Our Strategy for Offering Adequate and Affordable Coverage?

A Penalty applies if the employer does offer health coverage to Full-Time Employees and their Dependent Children, but the coverage is either Inadequate or Unaffordable and at least one Full-Time Employee qualifies to receive a Premium Tax Credit to purchase coverage through an Exchange.

- Inadequate: Coverage is considered Inadequate if the plan pays less than 60% of the allowable costs covered by the plan.
- Unaffordable: Coverage is considered Unaffordable if the premium contribution for employee only coverage in at least one option in the employer's plan costs the employee more than 9.69% (2017) of Household Income (this figure is adjusted annually).
- Ineligible: This Penalty could also be triggered for any Full-Time Employee under the federal definition who is not offered coverage in the situation where the employer satisfies the "Substantially All" requirements (70% in 2015 and 95% in 2016) but some employees are not offered coverage and thus fall in the gap (30% for 2015 and 5% for 2016).

This monthly Penalty under Code Section 4980H(b) is 1/12 times $3,000[1] times the number of Full-Time Employees receiving a Premium Tax Credit, capped at the maximum Penalty the employer would pay under Code section 4980H(a). The $3,000[1] will be adjusted for inflation annually.

> **Tip:** If an employee has access to Adequate and Affordable employer-sponsored coverage, the employee may purchase Exchange coverage but will not qualify for a Premium Tax Credit (and the employer will not owe an Employer Mandate Penalty).

1 The 4980H(b) penalty is $3,390 in 2017. The amount of the penalties will be indexed annually by the IRS.

Inadequate Coverage

Coverage is considered Inadequate if the plan pays less than 60% of the allowable costs covered by the plan. This 60% threshold is also referred to as the Minimum Value required for the plan. Minimum Value may be determined using any of the following:

- Minimum Value Calculator;
- Safe harbor plan designs; or
- Actuarial Certification.

The determination of which safe harbor to use must be applied on a uniform and consistent basis. Plans offered in the small-group market that meet the requirements of Exchange coverage are all considered Adequate.

> **Tip:** Only one plan option must be considered Adequate and Affordable in order for the employer to avoid triggering a 4980H(b) Penalty. A "plan option" is an HMO, PPO, or high deductible health plan, for example.

Minimum Value Calculator

The federal agencies have published a calculator that employers can use to determine whether the coverage provides the Minimum Value required.

Example: Minimum Value Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☒
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Grandfathered Plan?	☐

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)						
Coinsurance (%, Insurer's Cost Share)						
OOP Maximum ($)						
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2				Service Not Covered?	
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Tier 1	Tier 2
Medical	☒ All	☒ All			☒ All	☒ All				
Emergency Room Services	☒	☒			☒	☒			☐	☐
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	☒	☒			☒	☒			☐	☐
Specialist Visit	☒	☒			☒	☒			☐	☐
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒			☐	☐
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒			☐	☐
Rehabilitative Speech Therapy	☒	☒			☒	☒			☐	☐
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00	☐	☐
Laboratory Outpatient and Professional Services	☒	☒			☒	☒			☐	☐
X-rays and Diagnostic Imaging	☒	☒			☒	☒			☐	☐
Skilled Nursing Facility	☒	☒			☒	☒			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☒	☒			☒	☒			☐	☐
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒			☐	☐
Drugs	☒ All	☒ All			☒ All	☒ All				
Generics	☒	☒			☒	☒			☐	☐
Preferred Brand Drugs	☒	☒			☒	☒			☐	☐
Non-Preferred Brand Drugs	☒	☒			☒	☒			☐	☐
Specialty High-Cost Drugs	☒	☒			☒	☒			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:

Minimum Value:

Employers can input certain information about the plan, such as deductibles and copayments. Employer Health Savings Account (HSA) contributions and amounts newly credited under an integrated Health Reimbursement Arrangement (HRA) (if the HRA may only be used for Cost-Sharing) may be included when calculating Minimum Value. Plans that offer nondiscriminatory wellness programs designed to prevent or reduce tobacco usage may also be included when calculating Minimum Value (assuming that every eligible individual satisfied the terms relating to the prevention and reduction of tobacco use).

Minimum Value Safe Harbor

IRS, DOL, and HHS have published safe harbors that an employer can use to determine whether their coverage provides Minimum Value without having to using the Minimum Value Calculator. As long as the plan design is consistent with one of the safe harbors, the coverage will be considered Adequate. Additional safe harbors may become available as further guidance is issued. The safe harbors must be applied on a reasonable and consistent basis for all employees in a category.

Safe Harbor Examples:

- A plan with a $3,500 integrated medical and drug deductible, 80% plan Cost-Sharing, and a $6,000 maximum out-of-pocket limit for employee Cost-Sharing.
- A plan with a $4,500 integrated medical and drug deductible, 70% plan Cost-Sharing, a $6,400 maximum out-of pocket limit, and a $500 employer contribution to an HSA.
- A plan with a $3,500 medical deductible, $0 drug deductible, 60% plan medical expense Cost-Sharing, 75% plan drug Cost-Sharing, a $6,400 maximum out-of-pocket limit, and drug co-pays of $10/$20/$50 for the first, second, and third prescription drug tiers, with 75% coinsurance for specialty drugs.

Actuarial Certification

Plans with nonstandard plans that are incompatible with the Minimum Value Calculator or safe harbors may determine Minimum Value through an actuarial certification from a member of the American Academy of Actuaries after performing an analysis in accordance with generally accepted actuarial principles.

> **Tip:** An employer may want to consider adding a Minimum Value plan option.

Bottom Line: Minimum Value

The following method for determining whether our coverage has the required Minimum Value is likely to work the best for us:	**Calculation Method**
The value of our plans are as follows:	**Minimum Value**
We may want to make the following plan design changes so that we will have at least one plan option that is consistent with the Minimum Value safe harbors:	**Action Item**
Therefore, we have at least one plan option that **is / is not** considered Adequate (60%+). (circle one)	
We will confirm that we have a plan option with the required Minimum Value each year in:	**Action Item** ____________________ **(month)**

Tip: The Department of Health and Human Services (HHS) estimates that over 98% of plans will be considered Adequate, so the real issue for most employers is whether coverage is Affordable.

Unaffordable Coverage

Coverage is considered "Unaffordable" if the amount the employee has to pay is more than 9.69% (2017) of Household Income in order to participate in employee-only coverage in at least one plan option offered by the employer.

> **Tip:** Only one plan option has to be considered Affordable in order for the employer to avoid triggering an Employer Mandate Penalty.

Employee Cost for Employee-Only Coverage

Affordability is based on how much the employee has to pay toward the cost of health coverage; the total cost (e.g., the total premium including employer contribution) is not taken into account. The Affordability calculation can include nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan (to the extent the incentives relate to tobacco use). Employer-sponsored HRA contributions that are integrated with an eligible employer-sponsored plan can also be counted towards the employee's required contribution.

Affordability is based solely on the cost of employee-only coverage.

> **Tip:** Even though the employer needs to make coverage available to Dependent Children to avoid the 49080H(a) Penalty, it's only the cost of employee only coverage that must be Affordable.

Household Income

The regulations provide three safe harbors employers may use as a substitute for Household Income:

- The employee's current box 1 W-2 wages from the employer;
- The employee's monthly rate of pay as of the first day of the plan year (for salaried employees, the monthly salary; and for hourly employees, the lower of the hourly rate of pay on the first day of the year x 130 or the employee's lowest hourly rate of pay during the calendar month x 130); or
- The Federal Poverty Line for a single individual ($11,670 per year in 2014).

Bottom Line: Affordability

We will use the following safe harbor substitute for Household Income:	**Household Income** $ ______________________	
Class of Employees For each of the following classes of employees (who have to pay different amounts for their health coverage):	**Employee Contribution** The lowest amount an employee has to pay for employee-only health coverage for the year is:	**Affected Income** Coverage will be Unaffordable for Full-Time Employees under the federal definition with Household Income up to (use calculator at HCReducation.com/affordable):
Therefore, we **do / do not** offer coverage that is Affordable for all Full-Time Employees under the federal definition. (circle one)		
In total, we have exposure with approximately:	**Scope of Exposure** ______________ **employees**	

Tip: Coverage is always considered Affordable if the employer pays the full cost of employee-only coverage.

What Will Be Our Strategy for Offering Adequate and Affordable Coverage?

Because the Penalty for failing to offer Adequate and Affordable coverage is assessed on a per-employee basis, the employer has a lot of flexibility when designing a go-forward strategy.

Step 1: Explore your options for ensuring coverage is Adequate and Affordable.

The first step is to consider the various ways to ensure Full-Time Employees under the federal definition could have access to at least one coverage option that is both Adequate and Affordable. Such options could include changes in coverage or contribution strategies, among others.

> **Tip:** If at least one Adequate and Affordable coverage option is already available for all Full-Time Employees under the federal definition, you do not need to do any further analysis in order to avoid paying a 49080H(b) Penalty. However, you may still want to explore alternative strategies, which could help reduce costs.

Brainstorming: Changes in Coverage Options and Contributions

We could make the following changes to our current health coverage:	**Options**
We could make the following changes to our contribution amount and/or structure:	**Options**
The following are next steps to consider:	**Action Items**

Step 2: Analyze the cost impact of the different scenarios.

The next step is to understand how your costs could be impacted as a result of the different options you are considering. This will likely require making some assumptions about who is eligible for other coverage (such as through a spouse's employer, Medicare, or Medicaid), who will take Exchange (Marketplace) coverage and qualify for a Premium Tax Credit, whether other employers will stop offering coverage, and how claims and health care costs overall could be impacted by the ACA in the coming years.

Brainstorming: Potential Cost Impact of Alternative Options

We will assume the following, which could affect our plan enrollment and costs in the future:	**Assumptions**
The following are the scenarios we would like to analyze further:	**Scenarios**
We may need to consider the following issues:	**Other issues**

Bottom Line: Cost Impact

We would like to perform a detailed cost analysis of the following scenarios:	**Analyze**
The following is the scenario we are most likely to adopt if we plan to try to avoid triggering a 49080H(b) Penalty:	**Likely Scenario**
Under that scenario, our cost increase would be:	**Cost Increase for Likely Scenario** **$ ______________________ per year**
The potential Penalty if we do not make any changes could be as much as:	**Potential Penalty Without Changes** **$ ______________________ per year**
The following are some options we would consider for either paying for or seeking to offset the additional cost:	**Cost Management**
The following are the next steps we need to consider:	**Action Items**

Step 3: Understand the impact to employees of different scenarios.

Federal agency guidance clarified that, if the employee has access to Affordable employee-only coverage, then no one in the family is eligible for a Premium Tax Credit to buy Exchange coverage. Some employers are considering whether it may actually be better for a lower-income employee if the employer does not offer Affordable coverage. Instead, the employee may be able to qualify for a Premium Tax Credit to buy Exchange coverage for his or her entire family for the year for less than what they would have had to pay for employer-sponsored coverage.

Illustration: Estimated Amount of Premium Tax Credits

The following illustrates how much individuals with three levels of Household Income and various numbers of family members would have to pay out of pocket for Exchange coverage for 2017[2].

Number of people in household	Single Adult	Family of 4
Annual Household Income	$25,000	$25,000
Youngest adult	25	25
Estimated monthly premium w/o subsidy	$283	Medicaid
Premium Tax Credit	$141	Medicaid
Total annual premium due	**$142**	**Medicaid**

Number of people in household	Single Adult	Family of 4
Annual Household Income	$45,000	$45,000
Youngest adult	35	35
Estimated monthly premium w/o subsidy	$345	$1,048
Tax credit	$0	$833
Total annual premium due	$345	$215

Number of people in household	Single Adult	Family of 4
Annual Household Income	$75,000	$75,000
Youngest adult	50	50
Estimated monthly premium w/o subsidy	$504	$1,366
Premium Tax Credit	$0	$761
Total annual premium due	$504	$606

[2] Information calculated using Kaiser Family Foundation's "Health Reform Subsidy Calculator," accessed on Jan. 24, 2017, and available at http://healthreform.kff.org/SubsidyCalculator.aspx.

Bottom Line: Plan Comparison

Complete the following table in order to compare how much the employees in the examples above would have to pay to enroll in your coverage for the 2016 plan year. You may want to use information for either the lowest cost plan option or the most popular plan option you currently offer. Note the name of the plan used for each sample employee.

Plan Option:		
Number of people in household	**Single Adult**	**Family of 4**
Annual Household Income	$25,000	25,000
Total premium due	$	$
Maximum out of pocket	$	$
The Exchange (Marketpace) Plan / Our Plan is better for this employee. (circle one)		

Plan Option:		
Number of people in household	**Single Adult**	**Family of 4**
Annual Household Income	$45,000	$45,000
Total premium due	$	$
Maximum out of pocket	$	$
The Exchange (Marketpace) Plan / Our Plan is better for this employee. (circle one)		

Plan Option:		
Number of people in household	**Single Adult**	**Family of 4**
Annual Household Income	$75,000	$75,000
Total premium due	$	$
Maximum out of pocket	$	$
The Exchange (Marketpace) Plan / Our Plan is better for this employee. (circle one)		

Tip: If different classes of employees pay different amounts for their coverage, you may want to complete the charts above for multiple plans. In addition, if your state is planning to sponsor their own Exchange and has a calculator available, you may want to recreate the Premium Tax Credit illustrations.

Step 4: Decide what changes you want to make, then design and implement (and communicate) your strategy.

The final step is to confirm whether you will make changes and, if so, what changes you plan to make. You will likely also want to consider how you will pay for those changes and how you will communicate them to employees.

Strategic Decision Point

Do you plan to make changes in coverage or contributions in order to ensure some or all Full-Time Employees under the federal definition have access to Adequate and Affordable coverage?

Bottom Line: Offering Adequate/Affordable Coverage

We **will / will not** seek to ensure coverage is Adequate/ Affordable for all Full-Time Employees. (circle one)	
We will plan to make the following changes to coverage and/or contributions:	**Strategy**
The following are the next steps:	**Action Items**
The following are the key messages we want to convey to employees:	**Employee Communications**
The following are the primary methods we plan to use to communicate with employees:	**Communications Strategy**

Employer Reporting

What Information Do We Need to Report to the IRS?

What Are the Mechanics of Paying an Employer Mandate Penalty?

What Information Do We Need to Report to the IRS?

Employers with 50 or more Full-Time Employees must submit Forms 1094 and 1095 to the IRS with extensive details about the employer's health coverage and the employer's workforce. Under the regulations, the following must be reported to the IRS:

- The name, address, and Employer Identification Number (EIN);
- The name and telephone number of the Applicable Large Employer's contact person;
- The calendar year for which the information is reported;
- A certification whether the employer provided its Full-Time Employees (and Dependents) an opportunity to enroll in Minimum Essential Coverage, by calendar month;
- The months during the calendar year for which coverage under the plan was available;
- Each Full-Time Employee's share of the lowest-cost monthly premium (self-only) for coverage providing minimum value;
- The number of Full-Time Employees for each month during the calendar year;
- The name, address, and taxpayer identification number for each full-time employee during the calendar year and the months, if any, during which the employee was covered under the plan; and
- Any other information the IRS requires on the form and instructions.

As discussed above, hours of service must be counted across all members of the Controlled Group. The employer for whom the employee worked the greatest number of hours in a calendar month is considered the employer for purposes of determining if any penalties are due and complying with the IRS reporting obligations.

An employer must also provide a written statement to each Full-Time Employee named in the return.

The return must be filed with the IRS by February 28 (or March 31 if filed electronically). The employee statement must be provided by January 31. Employers failing to file these returns are subject to penalties.

Tip: Employers will also need to provide certain information to employees and/or Exchanges in connection with employees' applications for Premium Tax Credits for Exchange coverage. The rules for providing such verification of eligibility have not yet been published.

What Are the Mechanics of Paying an Employer Mandate Penalty?

After an employer files a return, the IRS will contact employers to inform them of their potential liability. Such notice for a given calendar year will not occur until after employees' individual tax returns are due for that year claiming Premium Tax Credits and after the due date for employers to file information about their employees and health coverage.

Employers will then have an opportunity to respond. If the IRS determines the employer owes an Employer Mandate Penalty, the IRS will send a notice and demand for payment. The notice will instruct the employer how to make the payment. Employers will not include the payment with their tax returns, but no other detail has been provided yet.

> **Tip:** If you offered Adequate and Affordable coverage to all Full-Time Employees under the federal definition but are still assessed an Employer Mandate Penalty by the IRS, good records may be your best defense.

Bottom Line: Recordkeeping Matters

We will adopt the following processes to demonstrate that we offered coverage to all Full-Time Employees under the federal definition:	**Action Items**
We will adopt the following processes in connection with billing, monitoring, and collecting payment of premiums (outside of payroll deduction):	**Action Items**
We will need to make changes to ensure we are capturing the following information to report to the IRS:	**Action Items**
We will adopt the following processes to ensure we are maintaining good records in connection with the Employer Mandate:	**Action Items**

Logistical Matters

What If The Required Employee Contribution Is More Than The Employee Earns?

Choosing the Right Path

What If The Required Employee Contribution Is More Than The Employee Earns?

If an employee enrolls in coverage but does not have enough wages in a given payroll period to cover the required contribution, the employer can require the employee to pay his or her share of the required premium out of pocket. If the employee fails to pay his or her share of the premium on a timely basis (in instances where contributions are not collected through payroll reduction but rather are billed to the employee), the employer does not have to provide coverage for the period for which the employee did not pay. However, the regulations adopt a rule from the COBRA regulations with regard to payment of premiums, and therefore incorporates both a 30-day grace period and rules regarding timely payments that are less than (but not significantly less) than the amount due.

> **Tip:** This scenario is common today in certain industries where employees routinely work Variable Hours, such as restaurant and retail workers. It is easy to envision an increased occurrence in other industries, particularly in connection with the employees who work full-time during a Measurement Period and then fewer hours during the subsequent Stability Period.

Choosing the Right Path

The Patient Protection and Affordable Care Act creates a number of challenges for employers. The bottom line is, what will you do with your health plans now? Generally speaking, there are four options for employers to consider long term:

Path 1 **Maintain current plan without significant changes.**	An employer can maintain its current major medical plan options without significant changes. Plan changes may need to be made in order to comply with ACA plan design mandates, but the employer's overall strategy for sponsoring employee benefits would remain unchanged.
Path 2 **Transition to a lower cost plan design, like a high deductible health plan.**	An employer can either add or transition to a lower-cost option, such as a high deductible health plan offered with Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs).
Path 3 **Sponsor an Exchange Plan.**	An employer may be able to sponsor a group Exchange (Marketplace) plan. The employer will be able to select the level of coverage to make available (e.g., bronze, silver, gold, or platinum) and the amount the employer will contribute to the cost. Eligible employees will be able to select among the policies offered by private insurance carriers in that category and will enroll online via state web portals or other methods offered by the Exchange (Marketplace).
Path 4 **Do not sponsor a plan - employees would be able to buy individual coverage.**	An employer could choose to not sponsor any major medical plan. Instead, employees would be able to buy individual Exchange coverage. An employer with 50+ Full-Time Equivalent Employees would likeley owe an annual Employer Mandate Penalty.

Glossary

Common Terms

Adequate/Inadequate: For purposes of the Employer Mandate Penalty, health coverage must have a Minimum Value of at least 60% in order to be considered Adequate. If coverage is Inadequate, a Large Employer may owe an Employer Mandate Penalty and Full-Time Employees under the federal definition may be entitled to receive Premium Tax Credits to purchase Exchange coverage.

Administrative Period: In connection with determining whether Variable-Hour employees worked full time hours, an employer may utilize an Administrative Period of up to 90 days following the Measurement Period. The purpose is to allow time to make coverage options available to those employees who worked a full-time schedule during the preceding Measurement Period and to allow employees to make coverage elections for the subsequent Stability Period.

Affordable/Unaffordable: Under the Employer Mandate Penalty, coverage is Affordable if a Full-Time Employee under the federal definition does not have to pay more than 9.69% (2017) of Household Income in order to participate in at least one health coverage option offered by the employer. If coverage is Unaffordable, a Large Employer may owe an Employer Mandate Penalty and Full-Time Employees may be entitled to receive Premium Tax Credits to purchase Exchange coverage.

In connection with the Individual Mandate, if an employee only has access to employer-sponsored health coverage that is Unaffordable (the lowest cost option available costs more than 8% of the employee's Household Income), the individual will not owe a tax for failing to obtain minimum essential coverage.

Bona Fide Volunteer: An employee of a government or tax-exempt entity whose only compensation is nominal compensation for being a volunteer or reimbursement of expenses.

Controlled Group: If two or more organizations have a certain percentage of common ownership (generally 80%) and have a parent-subsidiary or brother-sister relationship, or are members of an affiliated service group, they will be considered members of the same Controlled Group. Members of the same Controlled Group are treated as a single organization for purposes of determining whether the employer is a Large Employer.

Cost-Sharing: Cost-Sharing includes the amounts plan participants must pay toward the cost of medical expenses incurred, such as deductibles, copayments, and coinsurance.

Dependent Children: For purposes of the Employer Mandate Penalty, Dependent Children include an employee's blood and adopted children up to age 26.

Employment Break: An Employment Break is a period of at least four consecutive weeks during which an employee of an educational organization is not credited with an hour of service.

Exchange (Marketplace): Public Health Insurance Exchanges offer private insurance choices to individuals and small employers (generally with 100 or fewer employees). Effective 2017, it is possible larger employee groups will be able to participate in the Exchanges as well. If a state does not establish a State Exchange (Marketplace), the Federal government operates a Federal Exchange (Marketplace) in that state.

Family and Medical Leave Act (FMLA): FMLA is a Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member.

Federal Poverty Line (FPL): The Federal Poverty Lines are thresholds used for administrative purposes, such as determining financial eligibility for certain Federal programs (including premium assistance to purchase Exchange coverage). The levels are issued each year by HHS and published in the Federal Register.

Employer Mandate Penalty/ Penalty: An Employer Mandate Penalty is an excise tax a Large Employer will have to pay beginning in 2015 for either not offering Full-Time Employees (and their Dependent Children) under the federal definition health coverage or offering coverage that is either Unaffordable (the premium contribution to receive employee only health coverage from the employer costs the employee more than 9.69% (2017) of Household Income) or Inadequate (the coverage has a Minimum Value of less than 60%). A Large Employer will only owe an Employer Mandate Penalty if at least one employee receives a Premium Tax Credit to purchase Exchange coverage.

Full-Time Employee/ Full-Time: For purposes of the Employer Mandate, a Full-Time Employee is one who works 30 or more hours per week (or 130 or more hours per month).

Full-Time Equivalent Employees: For purposes of determining whether an organization is a Large Employer, the employer calculates its number of Full-Time Equivalent Employees by adding the following:

- The number of Full-Time Employees (working 30 or more hours per week) for each month during the year, and
- For all employees who were not Full-Time Employees for any month during the year, the actual hours worked during each month (up to 120 per person) divided by 120.

Divide the total by 12 and the result is the number of full-time equivalent employees for the year. If the number is greater than 50, then the employer is considered a Large Employer and will be subject to the Employer Mandate Penalty. The general rule is that an employer must calculate the number of full-time equivalent employees based on actual hours of service in the business days of the preceding calendar year.

Health Reimbursement Arrangement (HRA): An HRA is an IRS-sanctioned program funded entirely by an employer to reimburse qualified medical expenses for participating employees and their spouse and children. An HRA is typically offered in conjunction with a high deductible health plan or for retirees. The employer may choose the amount to

make available, how the funds can be used, if unused funds can be rolled over from year to year, and whether funds will be available after termination of employment.

Health Savings Account (HSA): An HSA is an individual savings account established by a participant in a qualified high deductible health plan (HDHP). An HSA provides a triple tax advantage for those savings: tax-free contributions, earnings, and withdrawals used to pay for qualified medical expenses. Internal Revenue Code section 223 establishes qualification requirements for the HSA, HDHP, and individuals eligible to contribute to an HSA.

Household Income: For purposes of the Employer Mandate Penalty, Household Income is defined as the modified adjusted gross income of the employee and any members of the employee's family (including spouse and dependents) who are required to file an income tax return.

The regulations provide three safe harbors that employers may use as a substitute for Household Income:

- The employee's current box 1 W-2 wages from the employer;
- The employee's monthly rate of pay as of the first day of the plan year (for salaried employees the monthly salary and for hourly employee's the hourly rate of pay x 130); or
- The Federal Poverty Line for a single individual ($11,670 per year in 2014).

Individual Mandate: Effective January 1, 2014, all individuals must obtain minimum essential coverage or pay a tax. The tax applies for each month during which an individual doesn't have minimum essential coverage. Exceptions are available for Unaffordable employer coverage (the lowest cost option available costs more than 9.69% (2017) of the individual's Household Income), for low-income taxpayers, and for coverage gaps up to three months.

Initial Measurement Period: For an employer using the Look Back Measurement Period Method, the Initial Measurement Period is the period used for newly-hired Variable Hour or Seasonal Employees to determine whether they averaged more than 30 hours week of service and therefore qualify for health coverage.

Large Employer: A Large Employer is one that employed an average of at least 50 Full-Time Equivalent Employees on business days during the preceding calendar year.

Look Back Measurement Period Method: The employer may determine whether an employee averaged 30 or more hours of service per week over a period of 3 to 12 months. If an employee was considered Full-Time under the federal definition during this "Measurement Period," the employee must be treated as a Full-Time Employee for benefits purposes for a subsequent "Stability Period" regardless of the employee's number of hours worked during the Stability Period.

Measurement Period: For an employer using the Look Back Measurement Period Method, the Measurement Period is the number of months over which an employer will average employees' hours to determine which employees will be considered Full-Time.

Monthly Measurement Period Method: An alternative to the Look Back Measurement Period Method, under the Monthly Measurement Period Method, the employer offers coverage to any employee for any month during which the employee works full time.

Minimum Value: Coverage is considered Inadequate if the plan pays less than 60% of the allowable costs covered by the plan, also referred to as the Minimum Value required for the coverage. The Federal agencies have provided a calculator employers can use to calculate Minimum Value.

Premium Tax Credit: A refundable Federal income tax credit is available to help certain individuals who have Household Income between 133% and 400% of the Federal Poverty Line pay for health insurance premiums for Exchange coverage. (Individuals with Household Income under 133% FPL are eligible for Medicaid coverage, if a state has expanded its Medicaid eligibility rules; otherwise, it generally is 100% FPL.) Reduced Cost-Sharing for Exchange coverage is also available for certain low-income individuals. Individuals who are eligible for employer-sponsored coverage are not eligible for premium assistance unless the employer's coverage is Unaffordable (the premium contribution to receive health coverage from the employer costs the employee more than 9.69% (2017) of Household Income) or Inadequate (the coverage has a value of less than 60%).

Seasonal Employee: A Seasonal Employee is an employee who is hired into a position for which the customary annual employment is six months or less and for which the period of employment is six months or less and coincides with a particular season of the year. The term is relevant for determining an employee's status as a Full-Time Employee under the Look Back Measurement Period.

Seasonal Worker: A Seasonal Worker is relevant for determining whether an employer is an applicable Large Employer. If an employer's workforce exceeds 50 Full-Time Employees for 120 days or fewer during a calendar year, and the employees in excess of 50 during that period were Seasonal Workers, the employer will not be considered a Large Employer. An employer may use a period of four calendar months (whether or not consecutive) or a period of 120 days (whether or not consecutive) to determine whether the Seasonal Worker exception applies for purposes of determining Large Employer status.

Special Unpaid Leave: Leave due to FMLA, USERRA, jury duty, or an Employment Break is treated as a Special Unpaid Leave for purposes of the Free Ride Penalty. For Variable Hour employees, an averaging method is used to determine hours of service during a Special Unpaid Leave that need to be credited during an employee's Measurement Period.

Stability Period: For employers using the Look Back Measurement Period Method, if an employee worked an average of 30 or more hours per week during a Measurement Period, the employee must be treated as a Full-Time Employee for benefits purposes for a subsequent Stability Period regardless of the employee's number of hours worked during the Stability Period, so long as the individual remains an employee. If the employee was considered part-time during the Measurement Period, the employee may be treated as part-time for benefits purposes throughout the Stability Period.

Substantially All: If an employer offers coverage to all but 5% (or 5 if greater) of its Full-Time Employees, it has met the requirement to offer health coverage to Substantially All Full-Time Employees. For 2015 only this standard was relaxed to 30%.

Uniformed Services Employment and Reemployment Rights Act (USERRA): USERRA is a Federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard, or other "uniformed services:" (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service.

Variable Hour Employee: An individual may be treated as a Variable Hour employee if, based on the facts and circumstances at the employee's start date, it cannot reasonably be determined whether the employee is expected to work an average of at least 30 hours per week because the employee's hours are expected to be variable or otherwise uncertain.

Volunteer: See Bona Fide Volunteer