Health Care Reform

Expanded Guidance

Cottingham & Butler

Employee Benefits Consulting

www.CottinghamButler.com | 800 Main Street | Dubuque Iowa 52001

"Pay or Play" Identifying Full Time Employees

Effective Jan. 1, 2014, the Affordable Care Act (ACA) imposes a penalty on large employers that do not offer minimum essential coverage to "substantially all" full-time employees and dependents. Large employers that do offer coverage may still be liable for a penalty if the coverage is unaffordable or does not provide minimum value.

On Jan. 2, 2013, the Internal Revenue Service (IRS) released long-awaited proposed regulations on ACA's employer penalty provisions. Although the proposed regulations are not final, employers may rely on them until further guidance is issued.

The proposed regulations provide guidance on an optional method for identifying full-time employees for purposes of determining and calculating an employer's potential liability for a shared responsibility payment.

The proposed regulations also include important transition relief. Employers that intend to utilize the look-back measurement method for determining full-time status for 2014 will need to begin their measurement periods in 2013 to have corresponding stability periods in 2014. The IRS recognizes that employers that intend to adopt a 12-month measurement period and a 12-month stability period will face time constraints.

Under the proposed regulations' transition relief, solely for purposes of stability periods beginning in 2014, employers may adopt a transition measurement period that:

- Is shorter than 12 months, but not less than 6 months long; and
- Begins no later than July 1, 2013, and ends no earlier than 90 days before the first day of the first plan year beginning on or after Jan. 1, 2014.

For example, an employer with a calendar year plan could use a measurement period from April 15, 2013, through Oct. 14, 2013 (six months), followed by an administrative period ending on Dec. 31, 2013. An employer with a fiscal year plan beginning April 1 that also elected to implement a 90-day administrative period could use a measurement period from July 1, 2013, through Dec. 31, 2013 (six months), followed by an administrative period ending on March 31, 2014.

LIABILITY FOR PENALTIES

ACA's employer penalty is referred to as the "employer shared responsibility payment." It requires large employers to either "play" by offering health coverage to their full-time employees and dependents that is affordable and provides minimum value or "pay" a substantial excise tax. The amount of the excise tax generally depends on whether or not an employer offers coverage to substantially all of its full-time employees and dependents.

- In 2014, the monthly penalty assessed on employers that do not offer coverage to substantially all of their full-time employees and dependents will be equal to the number of full-time employees (minus 30) multiplied by 1/12 of $2,000.
- In 2014, the monthly penalty assessed on employers that offer health coverage to at least 95 percent of their full-time employees and dependents will be 1/12 of $3,000 for each full-time employee who receives a premium tax credit or cost-sharing reduction under an exchange plan for any applicable month. However, the total penalty for the employer would be limited to the total number of the company's full-time employees (minus 30) multiplied by 1/12 of $2,000 for any

applicable month. This penalty is triggered when a full-time employee is not offered coverage or when the coverage is unaffordable or does not provide minimum value.

A large employer is only liable for a shared responsibility payment under ACA if one or more of its full-time employees receive an applicable premium tax credit or cost-sharing reduction for coverage under a state-based insurance exchange.

WHO IS ALL A FULL-TIME EMPLOYEE?

A full-time employee is an employee who was employed on average at least **30 hours of service per week**. The proposed regulations treat **130 hours of service in a calendar month** as the monthly equivalent of 30 hours per service per week.

To determine an employee's hours of service, an employer must count:

- Each hour for which the employee is paid, or entitled to payment, for the performance of duties for the employer; and
- Each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military leave or leave of absence.

Under the proposed regulations, all period of paid leave must be taken into account; there is no limit on the hours of service that must be credited.

Also, all hours of service performed for entities treated as a single employer under the Code's controlled group and affiliated service group rules must be taken into account.

Hourly Employees

For employees paid on an hourly basis, an employer must calculate hours of service from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Non-hourly Employees

For employees not paid on an hourly basis, employers are permitted to calculate hours of service by:

- Counting actual hours of service from records of hours worked and hours for which payment is made or due;
- Using a days-worked equivalency method under which an employee is credited with eight hours of service for each day with an hour of service; or
- Using a weeks-worked equivalency method under which an employee is credit with 40 hours of service per week for each week with an hour of service.

Employers may use different methods for non-hourly employees based on different classifications of employees if the classifications are reasonable and consistently applied. Employers may change methods each calendar year. However, employers may not use the days-worked or weeks-worked equivalency methods if those methods would substantially understate employees' hours of service.

Service Performed Outside the United States

The proposed regulations provide that the hours of service that must be taken into account in determining an employee's full-time status do not include any hours to the extent that compensation for those hours constitutes foreign source income. This rule applies regardless of the employee's citizenship or residency status. Thus, U.S. citizens working abroad generally will not qualify as full-time employees for purposes of calculating and determining ACA's shared responsibility penalty. However, all hours of service for which

an individual receives U.S. source income are hours of service for purposes of the employer shared responsibility rules.

OPTIONAL SAFE HARBOR METHOD

ACA suggests that the determination of full-time employee status, and application of the pay or play penalty, involves a month-to-month analysis. However, the IRS recognizes that applying these rules on a monthly basis could cause practical difficulties for employers, particularly with respect to employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.

To address these concerns, and to give employers flexible and workable options and greater predictability, the IRS proposed an optional look-back measurement method as an alternative to the month-to-month method for determining full-time employee status. This safe harbor method was described in previous IRS guidance, such as IRS Notice 2012-58. The proposed regulations incorporate this guidance, with some modifications.

This safe harbor method involves a measurement period for counting hours of service, a stability period when coverage may need to be provided depending on an employee's full-time status and an administrative period that allows time for enrollment and disenrollment. An employer has discretion in deciding how long these periods will last, subject to specified IRS parameters.

The details of the safe harbor vary based on whether the employees are ongoing or new, and whether new employees are expected to work full-time or are variable or seasonal employees.

Ongoing Employees

For ongoing employees, an employer determines each employee's full-time status by looking back at a measurement period lasting between 3 to 12 consecutive calendar months, as chosen by the employer, to determine whether the employee averaged at least 30 hours of service per week during this period. The measurement period selected by the employer is referred to as the standard measurement period. Employers may make certain adjustments to the beginning and end of the standard measurement period to accommodate weekly, bi-weekly or semi-monthly payroll periods.

If the employee was employed for at least 30 hours of service per week during the standard measurement period, he or she is considered a full-time employee for a set period into the future, known as the stability period. The stability period must be at least six calendar months following the measurement period and must be at least as long as the standard measurement period. The employee would be treated as a full-time employee during the stability period, regardless of the hours worked during that period, as long as he or she remained employed.

If an employer determines that an employee did not work full-time during the standard measurement period, the employer may treat the employee as not a full-time employee during the stability period that follows (but is not longer than) the standard measurement period.

Because employers may need time between the measurement and stability periods to determine which ongoing employees are eligible for coverage and to notify and enroll employees, employers may use an administrative period between the standard measurement and stability periods. The administrative period following a standard measurement period can last up to 90 days. The administrative period must overlap with the prior stability period to prevent any gaps in coverage for employees enrolled in coverage because of their full-time status during a prior measurement period.

As a general rule, the standard measurement period and stability period selected by the employer must be uniform for all employees. However, employers may apply different measurement periods, stability periods and administrative periods for the following categories of employees:

- Each group of collectively bargained employees covered by a separate collective bargaining agreement;
- Collectively bargained and non-collectively bargained employees;
- Salaried employees and hourly employees; and
- Employees whose primary places of employment are in different states.

New Employees Expected to Work Full Time

An employer will not be subject to a penalty for not offering coverage to new full-time employees during the first **three calendar months** of employment. This rule applies where an employee is reasonably expected at his or her start date to work full time and the employer sponsors a group health plan (that meets ACA's affordability and minimum value standards) and offers coverage to the employee at or before the conclusion of the employee's initial three calendar months of employment.

New Variable Hour or Seasonal Employees

If an employer uses a look-back measurement period for its ongoing employees, the employer may also use a similar method for new variable hour or seasonal employees.

Definitions of Variable Hour and Seasonal Employees

A new employee is a variable hour employee if, based on the facts and circumstances at the start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week.

For 2014, a new employee who is expected to be employed initially at least 30 hours per week may be a variable hour employee if the employee's period of employment at 30 or more hours per week is reasonably expected to be of limited duration and it cannot be determined whether it will last for the initial measurement period. Effective as of Jan. 1, 2015, employers must assume that employees will be employed for the entire initial measurement period.

Through at least 2014, employers are permitted to use a reasonable, good faith interpretation of the term "seasonal employee."

Initial Measurement, Stability and Administrative Periods

If an employer maintains a group health plan that would offer coverage to an employee only if he or she is determined to have full-time status, the employer may use an "initial measurement period" lasting between 3 and 12 months (the same as allowed for ongoing employees) to determine whether new variable hour or seasonal employees are full-time employees. The employer measures the hours of service completed by the new employee during the initial measurement period and determines whether the employee completed an average of 30 hours of service per week or more during this period. During this measurement period, the employer would not be subject to a shared responsibility penalty under ACA with respect to these employees.

The employer may also use an administrative period of up to 90 days. However, the initial measurement period and the administrative period combined cannot extend beyond the last day of the first calendar

month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

As in the case of a standard measurement period for ongoing employees, if an employee is determined to be a full-time employee during the initial measurement period, the stability period must be a period of at least six consecutive calendar months that is no shorter in duration than the initial measurement period and that begins after the initial measurement period (and any associated administrative period).

If a new variable hour or seasonal employee is determined not to be a full-time employee during the initial measurement period, the employer may treat the employee as not a full-time employee during the stability period that follows the initial measurement period. This stability period must not be more than one month longer than the initial measurement period and must not exceed the remainder of the standard measurement period (plus any associated administrative period) in which the initial measurement period ends.

Once a new variable hour or seasonal employee has been employed for an entire standard measurement period, the employee must be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees.

Short-term Employees and High Turnover Positions

The proposed regulations do not contain special rules for new short-term employees or employees hired into high-turnover positions. Although the IRS is still accepting comments on these types of employment, rules were not provided in the proposed regulations due to the potential for abuse.

As noted above, however—solely for 2014—an employer may take into account an employee's likely short-term employment. Also, as a general rule, ACA's pay or play penalty does not apply to full-time employees who have been employed for three months or less.

MORE INFORMATION

For more information on ACA's pay or play requirements, please contact Cottingham & Butler.

"Pay or Play" Penalty – Example for Determining Full Time Status

Under section 4980H of the Affordable Care Act (ACA), large employers may be subject to a penalty if they do not offer health coverage, or if they offer coverage that is unaffordable or does not provide minimum value, effective in 2014. Employers with **50 or more full-time employees**, including full-time equivalents, on business days during the preceding calendar year are considered large employers. ACA defines a full-time employee as an employee who is employed on average for at least **30 hours** of service per week.

On Jan. 2, 2013, the Internal Revenue Service (IRS) issued proposed regulations on ACA's employer penalty provisions. Although the proposed regulations are not final, employers may rely on them until further guidance is issued. The proposed regulations provide guidance on an optional safe harbor method for identifying full-time employees for purposes of determining and calculating an employer's potential liability for a shared responsibility payment.

The proposed regulations also include important transition relief. Employers that intend to utilize the look-back measurement method for determining full-time status for 2014 will need to begin their measurement periods in 2013 to have corresponding stability periods in 2014. The IRS recognizes that employers that intend to adopt a 12-month measurement period and a 12-month stability period will face time constraints.

Under the proposed regulations' transition relief, solely for purposes of stability periods beginning in 2014, employers may adopt a transition measurement period that:

- Is shorter than 12 months, but not less than 6 months long; and
- Begins no later than July 1, 2013, and ends no earlier than 90 days before the first day of the first plan year beginning on or after Jan. 1, 2014.

For example, an employer with a calendar year plan could use a measurement period from April 15, 2013, through Oct. 14, 2013 (six months), followed by an administrative period ending on Dec. 31, 2013. An employer with a fiscal year plan beginning April 1 that also elected to implement a 90-day administrative period could use a measurement period from July 1, 2013, through Dec. 31, 2013 (six months), followed by an administrative period ending on March 31, 2014.

To help explain the optional method for identifying full-time employees, the proposed regulations include numerous examples. The examples address the methods for ongoing employees and new variable hour and seasonal employees.

EXAMPLE – ONGOING EMPLOYEES

Facts - Employer W, a large employer, chooses to use a 12-month stability period that begins Jan. 1 and a 12-month standard measurement period that begins Oct. 15. Consistent with the terms of Employer W's group health plan, only employees classified as full-time employees using the look-back measurement method are eligible for coverage. Employer W chooses to use an administrative period between the end of the standard measurement period (Oct. 14) and the beginning of the stability period (Jan. 1) to:

- Determine which employees were employed on average 30 hours of service per week during the measurement period;

- Notify them of their eligibility for the plan for the calendar year beginning on Jan. 1 and of the coverage available under the plan;
- Answer questions and collect materials from employees; and
- Enroll those employees who elect coverage in the plan.

Previously-determined full-time employees already enrolled in coverage continue to be offered coverage through the administrative period. Employee A and Employee B have been employed by Employer W for several years, continuously from their start date. Employee A was employed on average 30 hours of service per week during the standard measurement period that begins Oct. 15, 2015 and ends Oct. 14, 2016 and for all prior standard measurement periods. Employee B also was employed on average 30 hours of service per week for all prior standard measurement periods, but is not a full-time employee during the standard measurement period that begins Oct. 15, 2015 and ends Oct. 14, 2016.

Conclusions - Because Employee A was employed for the entire standard measurement period that begins Oct. 15, 2015 and ends Oct. 14, 2016, Employee A is an ongoing employee with respect to the stability period running from Jan. 1, 2017 through Dec. 31, 2017. Because Employee A was employed on average 30 hours of service per week during that standard measurement period, Employee A is offered coverage for the entire 2017 stability period (including the administrative period from Oct. 15, 2017 through Dec. 31, 2017).

Because Employee A was employed on average 30 hours of service per week during the prior standard measurement period, Employee A is offered coverage for the entire 2016 stability period and, if enrolled, would continue such coverage during the administrative period from Oct. 15, 2016 through Dec. 31, 2016.

Because Employee B was employed for the entire standard measurement period that begins Oct. 15, 2015 and ends Oct. 14, 2016, Employee B is also an ongoing employee with respect to the stability period in 2017. Because Employee B did not work full-time during this standard measurement period, Employee B is not required to be offered coverage for the stability period in 2017 (including the administrative period from Oct. 15, 2017 through Dec. 31, 2017). However, because Employee B was employed on average 30 hours of service per week during the prior standard measurement period, Employee B is offered coverage through the end of the 2016 stability period and, if enrolled, would continue such coverage during the administrative period from Oct. 15, 2016 through Dec. 31, 2016.

Employer W complies with the proposed regulations' methodology for ongoing employees because the measurement and stability periods are no longer than 12 months, the stability period for ongoing employees who work full-time during the standard measurement period is not shorter than the standard measurement period, the stability period for ongoing employees who do not work full-time during the standard measurement period is no longer than the standard measurement period, and the administrative period is no longer than 90 days.

EXAMPLES OF NEW VARIABLE HOUR AND SEASONAL EMPLOYEES

The examples that follow illustrate how the safe harbor rules apply to variable hour employees and seasonal employees. In all of the following examples, the large employer offers all of its full-time employees (and the dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. The coverage is affordable within the meaning of § 36B(c)(2)(c)(i) (or is treated as affordable coverage under one of the affordability safe harbors) and that provides minimum value within the meaning of § 36B(c)(2)(c)(ii).

New Variable Employees with an Administrative Period

In Examples 1-8, the new employee is a new variable hour employee. The employer has chosen to use a 12-month standard measurement period for ongoing employees starting Oct. 15 and a 12-month stability period associated with that standard measurement period starting Jan. 1. Thus, during the administrative period from Oct. 15 through Dec. 31 of each calendar year, the employer continues to offer coverage to employees who qualified for coverage for that entire calendar year based upon working on average at least 30 hours per week during the prior standard measurement period. Also, the employer offers health plan coverage only to full-time employees (and their dependents).

Example 1 (12-Month Initial Measurement Period Followed by 1+ Partial Month Administrative Period)

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

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

Accordingly, from Employee Y's start date through June 30, 2017, Employer B is not subject to any payment under section 4980H with respect to Employee Y, because Employer B complies with the standards for the initial measurement period and stability periods for a new variable hour employee. Employer B must test Employee Y again based on the period from Oct. 15, 2015 through Oct. 14, 2016 (Employer B's first standard measurement period that begins after Employee Y's start date).

Example 2 (11-Month Initial Measurement Period Followed by 2+ Partial Month Administrative Period)

Facts - Same as Example 1, except that Employer B uses an 11-month initial measurement period that begins on the start date and applies an administrative period from the end of the initial measurement period until the end of the second calendar month beginning after the end of the initial measurement period. Employer B hires Employee Y on May 10, 2015. Employee Y's initial measurement period runs from May 10, 2015, through April 9, 2016. Employee Y has an average of 30 hours of service per week during this initial measurement period. Employer B offers coverage to Employee Y for a stability period that runs from July 1, 2016 through June 30, 2017.

Conclusion - Same as Example 1.

Example 3 (11-Month Initial Measurement Period Preceded by Partial Month Administrative Period and Followed by 2-Month Administrative Period)

Facts - Same as Example 1, except that Employer B uses an 11-month initial measurement period that begins on the first day of the first calendar month beginning after the start date and applies an administrative period that runs from the end of the initial measurement period through the end of the second calendar month beginning on or after the end of the initial measurement period. Employer B hires

Employee Y on May 10, 2015. Employee Y's initial measurement period runs from June 1, 2015, through April 30, 2016. Employee Y has an average of 30 hours of service per week during this initial measurement period. Employer B offers coverage to Employee Y for a stability period that runs from July 1, 2016 through June 30, 2017.

Conclusion - Same as Example 1.

Example 4 (12-Month Initial Measurement Period Preceded by Partial Month Administrative Period and Followed by 2- Month Administrative Period)

Facts – For new variable hour employees, Employer B uses a 12-month initial measurement period that begins on the first day of the first month following the start date and applies an administrative period that runs from the end of the initial measurement period through the end of the second calendar month beginning on or after the end of the initial measurement period. Employer B hires Employee Y on May 10, 2015. Employee Y's initial measurement period runs from June 1, 2015, through May 31, 2016. Employee Y has an average of 30 hours of service per week during this initial measurement period. Employer B offers coverage to Employee Y for a stability period that runs from Aug. 1, 2016 through July 31, 2017.

Conclusion - Employer B does not satisfy the standards for the look-back measurement method under the proposed regulations because the combination of the initial partial month delay, the 12-month initial measurement period, and the two month administrative period means that the coverage offered to Employee Y does not become effective until after the first day of the second calendar month following the first anniversary of Employee Y's start date. Accordingly, Employer B is potentially subject to a payment under section 4980H.

Example 5 (Continuous Full-Time Employee)

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

Conclusion - Employer B is not subject to any payment under section 4980H for 2017 with respect to Employee Y.

Example 6 (Initially Full-Time Employee, Becomes Non-Full-Time Employee)

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

Conclusion - Employer B is not subject to any payment under section 4980H for 2016 with respect to Employee Y, provided that it offers coverage to Employee Y from July 1, 2016 through June 30, 2017 (the entire stability period associated with the initial measurement period).

Example 7 (Initially Non-Full-Time Employee)

Facts - Same as Example 1, except that Employee Y has an average of 28 hours of service per week during the period from May 10, 2015 through May 9, 2016 and Employer B does not offer coverage to Employee Y in 2016.

Conclusion - From Employee Y's start date through the end of 2016, Employer B is not subject to any payment under section 4980H, because Employer B complies with the standards for the measurement and stability periods for a new variable hour employee with respect to Employee Y.

Example 8 (Initially Non-Full-Time Employee, Becomes Full-Time Employee)

Facts - Same as Example 7; in addition, Employer B tests Employee Y again based on Employee Y's hours of service from Oct. 15, 2015 through Oct. 14, 2016 (Employer B's first standard measurement period that begins after Employee Y's start date). Employer B determines that Employee Y has an average of 30 hours of service per week during this standard measurement period, and offers coverage to Employee Y for 2017.

Conclusion - Employer B is not subject to any payment under section 4980H for 2017 with respect to Employee Y.

New Variable Hour Employees with an Administrative Period and Six-Month Standard Measurement Period and Stability Period

In Examples 9 and 10, the new employee is a variable hour employee and the employer uses a six-month standard measurement period, starting each May 15 and Nov. 15, with six-month stability periods associated with those standard measurement periods starting Jan. 1 and July 1.

Example 9 (Initially Full-Time Employee)

Facts - For new variable hour employees, Employer C uses a six-month initial measurement period that begins on the start date and applies an administrative period that runs from the end of the initial measurement period through the end of the first full calendar month beginning after the end of the initial measurement period. Employer C hires Employee Z on May 10, 2015. Employee Z's initial measurement period runs from May 10, 2015, through Nov. 9, 2015, during which Employee Z has an average of 30 hours of service per week. Employer C offers coverage to Employee Z for a stability period that runs from Jan. 1, 2016 through June 30, 2016.

Conclusion - Employer C uses an initial measurement period that does not exceed 12 months; an administrative period totaling not more than 90 days; and a combined initial measurement period and administrative period that does not last longer than the final day of the first calendar month beginning on or after the one-year anniversary of Employee Z's start date. From Employee Z's start date through June 30, 2016, Employer C is not subject to any payment under section 4980H, because Employer C complies with the standards for the measurement and stability periods for a new variable hour employee with respect to Employee Z. Employer C must test Employee Z again based on Employee Z's hours of service during the period from Nov. 15, 2015 through May 14, 2016 (Employer C's first standard measurement period that begins after Employee Z's start date).

Example 10 (Initially Full-Time Employee, Becomes Non-Full-Time Employee)

Facts - Same as Example 9; in addition, Employer C tests Employee Z again based on Employee Z's hours of service during the period from Nov. 15, 2015 through May 14, 2016 (Employer C's first standard measurement period that begins after Employee Z's start date), during which period Employee Z has an average of 28 hours of service per week. Employer C continues to offer coverage to Employee Z through June 30, 2016 (the end of the initial stability period based on the initial measurement period during which Employee Z has an average of 30 hours of service per week), but does not offer coverage to Employee Z from July 1, 2016 through Dec. 31, 2016.

Conclusion - Employer C is not subject to any payment under section 4980H with respect to Employee Z for 2016.

Seasonal Employees

Example 11 (Seasonal Employee, 12-Month Initial Measurement Period; 1+ Partial Month Administrative Period).

Facts - Employer D offers health plan coverage only to full-time employees (and their dependents). Employer D uses a 12-month initial measurement period for new variable hour employees and seasonal employees that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the end of the initial measurement period.

Employer D hires Employee S, a ski instructor, on Nov. 15, 2015 with an anticipated season during which Employee S will work running through March 15, 2016. Employer D determines that Employee S is a seasonal employee based upon a reasonable good faith interpretation of that term. Employee S's initial measurement period runs from Nov. 15, 2015, through Nov. 14, 2016. Employee S is expected to have 50 hours of service per week from Nov. 15, 2015 through March 15, 2016, but is not reasonably expected to average 30 hours of service per week for the 12-month initial measurement period.

Conclusion - Employer D cannot determine whether Employee S is reasonably expected to average at least 30 hours of service per week for the 12-month initial measurement period. Accordingly, Employer D may treat Employee S as a variable hour employee during the initial measurement period.

Variable Hour Employees

Example 12 (Variable Hour Employee)

Facts - Employer E is in the trade or business of providing temporary workers to numerous clients that are unrelated to Employer E and to one another. Employer E is the common law employer of the temporary workers based on all of the facts and circumstances. Employer E offers health plan coverage only to full-time employees (including temporary workers who are full-time employees) and their dependents. Employer E uses a 12-month initial measurement period for new variable hour employees and new seasonal employees that begins on the start date and applies an administrative period from the end of the initial measurement period through the end of the first calendar month beginning after the end of the initial measurement period.

Employer E hires Employee T on Jan. 1, 2015 and anticipates that it will assign Employee T to provide services for various clients. As of the beginning of the initial measurement period, Employer E reasonably expects that, over the initial measurement period, Employee T is likely to be offered short-term

assignments with several different clients, with significant gaps between the assignments and that the assignments will differ in the average hours of service per week (meaning averaging both above and below 30 hours of service per week), all depending on client needs and Employee T's availability. The number of actual assignments that Employee T will be offered, the number that Employee T will accept, the duration of assignments, the length of the gaps between assignments, and whether various assignments will result in Employee T being employed on average at least 30 hours of service per week during the assignment, are all uncertain.

Conclusion - Employer E cannot determine whether Employee T is reasonably expected to average at least 30 hours of service per week for the 12-month initial measurement period. Accordingly, Employer E may treat Employee T as a variable hour employee during the initial measurement period.

Example 13 (Variable Hour Employee)

Facts - Employee A is hired on an hourly basis by Employer Y to fill in for employees who are absent and to provide additional staffing at peak times. Employer Y expects that Employee A will average 30 hours of service per week or more for A's first few months of employment, while assigned to a specific project, but also reasonably expects that the assignments will be of unpredictable duration, that there will be gaps of unpredictable duration between assignments, that the hours per week required by subsequent assignments will vary, and that A will not necessarily be available for all assignments.

Conclusion - Employer Y cannot determine whether Employee A is reasonably expected to average at least 30 hours of service per week for the initial measurement period. Accordingly, Employer Y may treat Employee A as a variable hour employee.

Change in Employment Status

Example 14 (Change in employment from variable hour employee to non-variable hour employee)

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

Conclusion - For purposes of determining Employer A's potential liability under section 4980H, Employee Z must be treated as a full-time employee as of Jan. 1, 2016, because that date is the earlier of the first day of the fourth calendar month following the change in position (Jan. 1, 2016) or the first day of the calendar month after the end of the initial measurement period plus the optional administrative period (July 1, 2016).

Source: Internal Revenue Service

"Pay or Play" Penalty – Coverage for Substantially All Full Time Employees and Dependents

Effective Jan. 1, 2014, the Affordable Care Act (ACA) imposes a penalty on large employers that do not offer minimum essential coverage to full-time employees and their dependents. Large employers that offer this coverage may still be liable for a penalty if the coverage is unaffordable or does not provide minimum value.

ACA's employer penalty is referred to as an employer shared responsibility payment. It requires large employers to either "play" by offering health coverage that meets certain standards to full-time employees and their dependents OR "pay" a substantial excise tax. ACA's pay or play penalty provisions are contained in Internal Revenue Code section 4980H.

On Jan. 2, 2013, the Internal Revenue Service (IRS) released long-awaited proposed regulations on ACA's employer shared responsibility provisions. Although the proposed regulations are not final, employers may rely on them until further guidance is issued.

The IRS' proposed regulations address who a large employer must offer coverage to in order to avoid an ACA penalty. Under the proposed regulations, the requirement to offer coverage to full-time employees is relaxed to a "substantially all" standard. Also, the proposed regulations identify the dependents who must be offered coverage to avoid an ACA penalty.

Employer penalties

Under the proposed regulations, the amount of the excise tax generally depends on whether or not an employer offers coverage to substantially all full-time employees and their dependents.

- In 2014, the monthly penalty assessed on employers that do not offer coverage to substantially all full-time employees and their dependents will be equal to the number of full-time employees (minus 30) multiplied by 1/12 of $2,000. This penalty is called the **4980H(a) penalty**.

- In 2014, the monthly penalty assessed on employers that offer health coverage to substantially all full-time employees and their dependents will be 1/12 of $3,000 for each full-time employee who receives a premium tax credit or cost-sharing reduction under an insurance exchange for any applicable month. However, the total penalty would be limited to the total number of full-time employees (minus 30) multiplied by 1/12 of $2,000 for any applicable month. This penalty, which is called the **4980H(b) penalty**, is triggered when a full-time employee is not offered coverage or when the coverage is unaffordable or does not provide minimum value.

Substantially all

Under the proposed rules, the 4980H(a) penalty will not apply to a large employer that intends to offer coverage to all of its full-time employees but fails to offer coverage to a few of these employees, regardless of whether the failure to offer coverage was inadvertent.

The proposed regulations provide that an employer will satisfy the requirement to offer minimum essential coverage to "substantially all" of its full-time employees and their dependents if it offers coverage to **at least 95 percent** of its full-time employees and dependents.

Under the regulations, an employer will not be liable for a penalty for a calendar month if it offers coverage to all but 5 percent (or, if greater, five) of its full-time employees and dependents for that month. According to the IRS, the alternative margin of five full-time employees is designed to accommodate relatively small employers because a failure to offer coverage to a handful of full-time employees might exceed 5 percent of the employer's full-time employees.

Dependents

The proposed regulations define "dependents" for purposes of ACA's employer penalty to include only an employee's child (that is, son, daughter, stepchild, adopted child or child placed for foster care) under the age of 26. Employers may rely on employees' representations regarding the identity and ages of their children.

Under the proposed regulations, "dependent" does not include an employee's spouse. Thus, an employer is not required to offer minimum essential coverage to employees' spouses in order to avoid ACA's pay or play penalty.

In addition, the proposed regulations contain a transition rule for employers that currently offer coverage only to employees. Any such employer that takes steps during its 2014 plan year to satisfy ACA's requirement to offer coverage to full-time employees' dependent children will not be liable for a penalty based solely on the failure to offer coverage to dependent children for that plan year.

More information

Please contact your Cottingham & Butler representative for more information on ACA's pay or play penalty.

Proposed Guidance Issued on 90-day Waiting Period Limit

For plan years beginning on or after Jan. 1, 2014, the Affordable Care Act (ACA) prohibits group health plans and group health insurance issuers from applying any waiting period that exceeds 90 days. ACA's 90-day waiting period limit applies to both non-grandfathered and grandfathered group health plans and health insurance coverage.

ACA's 90-day waiting period limit does not require an employer to offer coverage to any particular employee or class of employees, including part-time employees. It only prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage under a group health plan becomes effective.

On March 21, 2013, the Departments of Labor, Health and Human Services and the Treasury (Departments) issued a proposed rule on ACA's 90-day waiting period limit. The proposed rule would apply to plan years beginning on or after Jan. 1, 2014.

Although the rule is not in final form, the Departments will consider compliance with the proposed rule as compliance with ACA's 90-day waiting period limit at least through the end of 2014. To the extent a final rule or other guidance is more restrictive on plans and issuers than the proposed rule, the final rule or other guidance will not be effective prior to Jan. 1, 2015.

This Legislative Brief summarizes ACA's 90-day waiting period limit and the guidance provided in the proposed rule. It also discusses how the waiting period limit relates to ACA's shared responsibility provisions that will apply to large employers beginning in 2014.

WAITING PERIOD

A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll in the plan becomes effective. If an individual enrolls as a late enrollee or special enrollee, any period before the individual's late or special enrollment is not a waiting period.

An employee or dependent is eligible for coverage when he or she has met the plan's eligibility conditions, such as being in an eligible job classification or achieving job-related licensure requirements specified in the plan's terms.

Also, if a plan allows an employee to elect coverage that would begin on a date that does not exceed the 90-day waiting period limit, ACA's 90-day waiting period limit is considered satisfied. Thus, a plan or issuer does not violate ACA merely because employees take additional time to elect coverage.

The following examples help explain these rules:

Example 1

Facts - A group health plan provides that full-time employees are eligible for coverage under the plan. Employee A begins employment as a full-time employee on Jan. 19.

Conclusion - Any waiting period for A would begin on Jan. 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

Example 2

Facts – A group health plan provides that only employees with job title M are eligible for coverage under the plan. Employee B begins employment in job title L on Jan. 30.

Conclusion – B is not eligible for coverage under the plan, and the period while B is working in job title L and therefore not in an eligible class of employees is not part of a waiting period under the proposed rule.

Example 3

Facts – Same facts as Example 2, except that B transfers to a new position with job title M on April 11.

Conclusion – B becomes eligible for coverage on April 11, but for the waiting period. Any waiting period for B begins on April 11 and may not exceed 90 days. Coverage under the plan must become effective no later than July 10.

Example 4

Facts – A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee C is hired on May 3 and meets the plan's eligibility criteria on Sept. 22.

Conclusion – C becomes eligible for coverage on Sept. 22, but for the waiting period. Any waiting period for C would begin on Sept. 22 and may not exceed 90 days. Coverage under the plan must become effective no later than Dec. 21.

Example 5

Facts – A group health plan provides that employees are eligible for coverage after one year of service.

Conclusion – The plan's eligibility condition is based solely on the lapse of time and, therefore, is impermissible under the proposed rule because it exceeds 90 days.

Example 6

Facts – Employer W's group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee's start date and may be completed within 90 days. Employee D is hired and starts on Oct. 31, which is the first day of a pay period. D completes the enrollment forms and submits them on the 90th day after D's start date. Coverage is made effective 7 days later, which is the first day of the next pay period.

Conclusion – Under the terms of W's plan, coverage may become effective as early as Oct. 31, depending on when D completes the applicable enrollment forms. Under the terms of the plan, when coverage becomes effective is dependent solely on the length of time taken by D to complete the enrollment materials. Therefore, under the terms of the plan, D may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with the proposed rule.

OTHER CONDITIONS FOR ELIGIBILITY

Under ACA, eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days. Other conditions for eligibility are permissible under ACA, as long as they are not designed to avoid compliance with the 90-day waiting period limit.

Variable Hour Employees

A special rule applies if a group health plan conditions eligibility on an employee regularly working a specified number of hours per pay period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time). In this type of situation, the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition. This may include a measurement period of not more than

12 months that begins on any date between the employee's start date and the first day of the first calendar month following the employee's start date.

The time period for determining whether a variable hour employee meets the plan's eligibility condition will comply with ACA's 90-day waiting period limit if coverage is made effective no later than 13 months from the employee's start date, except where a waiting period that exceeds 90 days is imposed after the measurement period. If an employee's start date is not the first of the month, the time period can also include the time remaining until the first day of the next calendar month.

Cumulative Service Requirement

Under the proposed rule, if a group health plan or issuer conditions eligibility on any employee's (part-time or full-time) having completed a number of cumulative hours of service, the eligibility condition does not violate ACA's 90-day limit on waiting periods if the cumulative hours-of-service requirement does not exceed 1,200 hours.

The proposed rule provides that the plan's waiting period must begin once the new employee satisfies the plan's cumulative hours-of-service requirement and may not exceed 90 days. Also, this provision is designed to be a one-time eligibility requirement. The proposed rule does not permit a plan or issuer to reapply the hours-of-service requirement to the same individual each year.

Example 7

Facts – Under Employer Y's group health plan, only employees who are full-time (defined under the plan as regularly averaging 30 hours of service per week) are eligible for coverage. Employee E begins employment for Employer Y on Nov. 26 of Year 1. E's hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability and E's availability. Therefore, it cannot be determined at E's start date that E is reasonably expected to work full-time.

Under the terms of the plan, variable-hour employees, such as E, are eligible to enroll in the plan if they are determined to be a full-time employee after a measurement period of 12 months that begins on the employee's start date. Coverage is made effective no later than the first day of the first calendar month after the applicable enrollment forms are received. E's 12-month measurement period ends Nov. 25 of Year 2. E is determined to be a full-time employee and is notified of E's plan eligibility. If E then elects coverage, E's first day of coverage will be Jan. 1 of Year 3.

Conclusion – The measurement period is permissible because it is not considered to be designed to avoid compliance with the 90-day waiting period limitation. The plan may use a reasonable period of time to determine whether a variable-hour employee is a full-time employee, provided the period of time is no longer than 12 months and begins on a date between the employee's start date and the first day of the next calendar month, provided coverage is made effective no later than 13 months from E's start date (plus if the employee's start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month) and provided that, in addition to the measurement period, no more than 90 days elapse prior to the employee's eligibility for coverage.

Example 8

Facts – Employee F begins working 25 hours per week for Employer Z on Jan. 6 and is considered a part-time employee for purposes of Z's group health plan. Z sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. F satisfies the plan's cumulative hours of service condition on Dec. 15.

Conclusion – The cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly,

coverage for F under the plan must begin no later than the 91st day after F completes 1,200 hours. (If the plan's cumulative hours-of-service requirement was more than 1,200 hours, the requirement would be considered to be designed to avoid compliance with the 90-day waiting period limitation.)

COUNTING DAYS

The proposed rule clarifies the method for counting days when applying a 90-day waiting period. Due to ACA's wording, the proposed rule provides that the waiting period may not extend beyond 90 days and all calendar days must be counted beginning on the enrollment date, including weekends and holidays. For a plan with a waiting period, the enrollment date is the first day of the waiting period.

If a plan or issuer imposes a 90-day waiting period and the 91st day is a weekend or holiday, the plan or issuer may choose to make coverage effective earlier than the 91st day for administrative convenience. Similarly, plans and issuers that do not want to start coverage in the middle of a month (or pay period) may choose to make coverage effective earlier than the 91st day for administrative convenience. For example, a plan may impose a waiting period of 60 days plus a fraction of a month (or pay period) until the first day of the next month (or pay period).

However, a plan or issuer may not make the effective date of coverage later than the 91st day. Thus, for example, under the proposed rule, a plan or issuer generally cannot wait until the first of month after the 90-day waiting period ends to make coverage effective.

INDIVIDUALS IN A WAITING PERIOD PRIOR TO EFFECTIVE

ACA's 90-day waiting period limit is effective for plan years beginning on or after Jan. 1, 2014. With respect to individuals who are in a waiting period for coverage when this ACA requirement becomes effective, the waiting period can no longer apply to the individual if it would exceed 90 days.

The following example helps clarify this rule:

Example 9

Facts – A group health plan is a calendar year plan. Prior to Jan. 1, 2014, the plan provides that full-time employees are eligible for coverage after a six-month waiting period. Employee A begins work as a full-time employee on Oct. 1, 2013.

Conclusion – The first day of A's waiting period is Oct. 1, 2013 because that is the first day A is otherwise eligible to enroll under the plan's substantive eligibility provisions, but for the waiting period. Beginning Jan. 1, 2014, the plan may not apply a waiting period that exceeds 90 days. Accordingly, A must be given the opportunity to elect coverage that begins no later than Jan. 1, 2014 (which is 93 days after A's start date) because otherwise, on Jan. 1, 2014, the plan would be applying a waiting period that exceeds 90 days. The plan is not required to make coverage effective before Jan. 1, 2014 under the proposed rule.

Employer Shared Responsibility Penalty

Under ACA's "pay or play" requirements large employers that do not offer health coverage to their full-time employees or that offer health coverage to their full-time employees that is either unaffordable or does not provide minimum value may be subject to a penalty. This penalty is also called a "shared responsibility payment" under ACA.

On Jan. 2, 2013, the Internal Revenue Service (IRS) issued proposed regulations that address ACA's shared responsibility provisions. Under these rules, if an employee is reasonably expected at his or her start date to work full time, an employer that sponsors a group health plan and offers coverage to the employee at or before the conclusion of the employee's initial three calendar months of employment will

not be subject to a shared responsibility penalty under ACA for not offering coverage during the initial three months.

However, if a large employer subject to ACA's shared responsibility penalty denies coverage to a full-time employee based on a substantive eligibility condition, such as being in an eligible job classification, the employer may be subject to a penalty under ACA.

Also, although a cumulative hours-of-service requirement up to 1,200 hours may be permissible under ACA's 90-day limit on waiting periods, denying coverage to full-time employees while they accumulate the necessary number of hours of service may trigger an employer penalty for large employers.

Source: Departments of Labor, Health and Human Services and the Treasury

Cost Sharing Limits for Health Plans

Beginning in 2014, the Affordable Care Act (ACA) requires certain health plans to comply with cost-sharing limits with respect to their coverage of essential health benefits. Under ACA, "essential health benefits" must be equal in scope to benefits covered by a typical employer plan and must include items and services in ten general categories, such as hospitalization, prescription drugs and maternity and newborn care.

The cost-sharing limits include both an overall annual limit, or an out-of-pocket maximum, and an annual deductible limit. On Feb. 20, 2013, the Department of Health and Human Services (HHS) issued a final rule on essential health benefits that addresses ACA's cost-sharing limits for health plans.

AFFECTED PLANS

Grandfathered plans are not subject to ACA's limits on cost sharing. There has been some uncertainty regarding which types of non-grandfathered plans must comply with ACA's cost-sharing limits that become effective in 2014. However, the final rule provides the following guidance on the types of health plans that must comply with each of these cost-sharing limits:

- ***Annual Deductible Limit:*** ACA states that the annual deductible limit applies to health plans offered in the small group market. In the final rule, HHS confirms that ACA's annual deductible limit applies only in the insured small group market. Thus, the annual deductible limit does not apply to self-insured plans or large group market plans.

- ***Out-of-pocket Maximum:*** Unlike ACA's annual deductible limit, which references health plans in the small group market, ACA's out-of-pocket maximum broadly refers to "health plans." The final rule provides that ACA's out-of-pocket maximum applies to *all* non-grandfathered health plans. This would include, for example, self-insured health plans and insured health plans of any size.

COST-SHARING LIMITS

Annual Deductible

Effective for plan years beginning in 2014, the annual deductible for a health plan in the small group market may not exceed **$2,000 for self-only coverage** and **$4,000 for family coverage**.

For plans using provider networks, the final rule provides that an enrollee's cost-sharing for out-of-network benefits does not count toward the annual deductible limit.

For plan years beginning after 2014, HHS will increase the annual deductible limits by the "premium adjustment percentage," which is set by HHS and will be announced by HHS annually. The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds the average per capita premium for health insurance for 2013.

ACA permits, but does not require, contributions to flexible spending arrangements (FSAs) to be taken into account when determining the annual deductible. In the final rule, HHS standardizes the maximum deductible for all group health plans in the small group market and does not increase the deductible levels for amounts available under FSAs. According to HHS, the final rule does not increase the deductible levels to take into account FSA contributions due to operational complications with this type of determination. However, HHS notes that it will revisit this policy in later years.

Also, the final rule provides that a health plan's annual deductible may exceed the ACA limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier - bronze, silver, gold or platinum) without exceeding the limit.

Out-of-pocket Maximum

Effective for plan years beginning on or after Jan. 1, 2014, ACA places annual limits on total enrollee cost-sharing for essential health benefits. Once the limitation on cost-sharing is reached for the year, the enrollee is not responsible for additional cost-sharing for essential health benefits for the remainder of the year. According to HHS, the annual limit on cost-sharing, or out-of-pocket maximum, ensures that health plans pay for significant health expenses and limits the risk of medical debt or bankruptcy for insured individuals.

Cost-sharing includes any expenditure required by or on behalf of an enrollee with respect to essential health benefits, such as deductibles, co-payments, co-insurance and similar charges. It excludes premiums and spending for non-covered services. Also, for plans using provider networks, the final rule provides that an enrollee's cost-sharing for out-of-network benefits does not count toward the cost-sharing limit.

ACA's cost-sharing limit is tied to the enrollee out-of-pocket maximum for HSA-compatible high deductible health plans (HDHPs). There are separate limits for self-only coverage and coverage other than self-only coverage (that is, family coverage). Because the HSA limits are adjusted annually for cost-of-living increases, the 2014 out-of-pocket maximums for HSA-compatible HDHP coverage are not currently available. However, for 2013, the HDHP out-of-pocket maximum cannot exceed $6,250 for self-only coverage and $12,500 for family coverage. Amounts for 2014 are expected to be released by the IRS in the spring of 2013.

For plan years beginning after 2014, HHS will increase the cost-sharing limits by the premium adjustment percentage, similar to increases in the annual deductible limit.

Transition Relief – Plans with Multiple Service Providers

A set of frequently asked questions (FAQs) issued in conjunction with the final rule address how ACA's out-of-pocket maximum applies to plans that utilize more than one service provider to help administer benefits (for example, a third-party administrator for major medical coverage, a separate pharmacy benefit manager and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. According to the FAQs, these processes will need to be coordinated to comply with the annual out-of-pocket maximum, which may require new regular communications between service providers.

The FAQs provide that, only for the first plan year beginning on or after Jan. 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual out-of-pocket maximum, the annual limit will be satisfied if both of the following conditions are met:

- The plan complies with the out-of-pocket maximum with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and

- To the extent there is an out-of-pocket maximum on coverage that does not consist solely of major medical coverage, this out-of-pocket maximum does not exceed the maximum dollar amount under ACA.

Reinsurance, Fee's, Risk Corridors, and Risk Adjustment

The Affordable Care Act (ACA) creates three risk-spreading mechanisms to mitigate the potential impact of adverse selection and stabilize premiums in the individual and small group markets as ACA's insurance reforms and Exchanges are implemented, starting in 2014. These risk-spreading mechanisms are in the form of the following programs:

- **Reinsurance Program -** A transitional reinsurance program will be established to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation. The reinsurance assessment impacts health insurance issuers and self-insured group health plans.
- **Risk Corridor Program -** The Department of Health and Human Services (HHS) must establish a temporary risk corridor program that will apply to qualified health plans (QHPs) in the individual and small group markets during the first three years of Exchange operation to protect against uncertainty in rate setting.
- **Risk Adjustment Program -** A permanent risk adjustment program will be established for all non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges to better spread the financial risk carried by issuers.

On March 23, 2012, HHS issued **final regulations** implementing ACA's standards for reinsurance, risk corridors and risk adjustment programs. On Dec. 7, 2012, HHS released **proposed regulations** to expand upon these standards and provide additional guidance on the operation of ACA's risk-spreading programs.

Reinsurance program

The transitional reinsurance program is intended to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016) when individuals with higher-cost medical needs gain insurance coverage.

Health insurance issuers and self-insured group health plans will be required to pay fees to the reinsurance program. Fees are not required for certain types of coverage, including plans or coverage that consist solely of excepted benefits (for example, stand-alone dental and vision plans).

Under the proposed regulations, the following plans and coverage would be excluded from reinsurance fees:

- Health reimbursement arrangements (HRAs) that are integrated with major medical coverage (although reinsurance fees would be required for the group health plan providing major medical coverage);
- Health savings accounts (HSAs) (although reinsurance fees would be required for an employer-sponsored high-deductible health plan);
- Health flexible spending accounts (FSAs);
- Employee assistance plans, wellness programs and disease management plans that provide ancillary benefits and not major medical coverage; and
- Stop-loss and indemnity reinsurance policies.

The final regulations provide that the contributions will be based on a national per capita contribution rate, which HHS will announce annually. For 2014, HHS proposes a national contribution rate of **$5.25 per month ($63 per year)**.

The proposed regulations provide that an issuer's or plan sponsor's reinsurance fee would be calculated by multiplying the average number of covered lives (employees and their dependents) during the benefit year for all of the entity's plans and coverage that must pay contributions, by the national contribution rate for the benefit year. Thus, the annual contribution for a group health plan with 150 covered lives would be $9,450 per year (150 x $63 = $9,450).

States may elect to collect additional contributions on top of the federal contribution rate to cover administrative expenses or additional reinsurance payments.

Under the proposed regulations, HHS would collect the reinsurance fees from issuers and plan sponsors in all states, including states that elect to operate their own reinsurance programs. The proposed regulations would require issuers and plan sponsors to submit an annual enrollment count to HHS no later than **Nov. 15** of 2014, 2015 and 2016. Within 15 days of this submission or by **Dec. 15**, whichever is later, HHS would notify each issuer or plan sponsor of the amount of its required reinsurance contribution. The issuer or plan sponsor would be required to remit this amount to HHS **within 30 days** after the date of HHS' notification.

Risk corridor program

The risk corridor program is a temporary one (2014-2016) that provides additional protection for issuers of QHPs in the Exchanges. The program, which will be administered by HHS, protects against uncertainty in rate setting for the first several years of the Exchanges by creating a mechanism for sharing risk between the federal government and QHP issuers. The final regulations provide that under the risk corridor program:

- QHPs with costs that are at least three percent less than their cost projections will remit charges for a percentage of those savings to HHS; and
- QHPs with costs at least three percent higher than cost projections will receive payments from HHS to offset a percentage of those losses.

The final regulations contain detailed information regarding the program's formula for sharing risk, including imposing a 20 percent cap on allowable administrative costs that may be taken into account in the target amount. The proposed regulations would provide more details on the risk corridor calculation and also establish a payment methodology for QHP issuers.

Risk adjustment program

Risk adjustment is a permanent ACA program. According to HHS, the primary goal of the risk adjustment program is to better spread the financial risk carried by health insurance issuers to make sure premiums remain stable. The program is intended to provide payments to issuers that attract higher risk populations by transferring funds from plans that enroll the lowest risk individuals to those plans that enroll the highest risk individuals.

This program applies to all non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges.

The final regulations provide that states that are certified to operate an Exchange may establish a risk adjustment program, but they are not required to do so. If a state does not establish a risk adjustment program, HHS will establish the program and perform the risk adjustment functions for that state. The proposed regulations include provisions regarding HHS' risk adjustment methodology. States operating their own risk adjustment programs may propose an alternative methodology for approval by HHS.

Also, the proposed regulations indicate that HHS intends to collect a user fee to support the administration of HHS-operated risk adjustment. This fee would apply to issuers in states in which HHS is operating the risk adjustment program. The proposed regulations provide that the user fee would not be more than $1 per enrollee per year.

Source: Department of Health and Human Services

Final Guidance Released on Research Fees

The Affordable Care Act (ACA) established a private, nonprofit corporation called the Patient-Centered Outcomes Research Institute (Institute). The Institute's task is to help patients, policymakers and health care providers make informed health decisions by advancing evidence-based medicine through comparative clinical effectiveness research.

ACA requires health insurance issuers and sponsors of self-insured health plans to pay fees to help finance the Institute's research. These fees are called comparative effectiveness research fees or **CER fees**. They may also be referred to as PCOR or PCORI fees.

On Dec. 5, 2012, the Internal Revenue Service (IRS) issued **final regulations** on the CER fees. The final regulations adopt the proposed regulations that the IRS issued on the CER fees in April 2012, with a few modifications.

When are the Fees Effective?

The CER fees apply for **plan years ending on or after Oct. 1, 2012**. The CER fees do *not* apply for plan years ending on or after Oct. 1, 2019. For calendar year plans, the research fees will be effective for the 2012 through 2018 plan years.

How much are the Fees?

For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee is **$1** multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014, the fee is **$2** multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2014, the CER fee amount will grow based on increases in the projected per capita amount of National Health Expenditures.

The CER fees are based on the average number of covered lives under the plan or policy. This generally includes employees and their enrolled spouses and dependents. The final regulations outline a number of alternatives for issuers and plan sponsors to determine the average number of covered lives.

Who pays the fees?

The CER fees generally apply to insurance policies providing accident and health coverage and self-insured group health plans. The final regulations contain some exceptions to this general rule and also clarify how the CER fees apply to certain types of health coverage arrangements.

For example, the final regulations explain that the CER fees do not apply if substantially all of the coverage under a plan or policy is for excepted benefits, as defined under HIPAA. The regulations also clarify that the CER fees may apply to retiree-only plans and policies, even though retiree-only coverage is exempt from many of ACA's other requirements.

Special Rule for HRAs and Health FSAs

The final regulations do not provide an overall exemption from the CER fees for health reimbursement arrangements (HRAs). However, the final regulations do state that an HRA is not subject to a separate research fee if it is integrated with another self-insured plan providing major medical coverage, as long as the HRA and the plan are established and maintained by the same plan sponsor and have the same plan year. This rule allows the sponsor to pay the CER fee only once with respect to each life covered under the HRA and the other plan.

If an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor.

The same analysis applies to health flexible spending accounts (FSAs) that do not qualify as excepted benefits.

How are the Fees Reported and Paid?

The final regulations direct issuers and plan sponsors to pay the CER fees once a year on IRS Form 720 (Quarterly Federal Excise Tax Return). Form 720 and full payment of the research fees will be due by **July 31** of each year. It will generally cover plan years that end during the preceding calendar year. Thus, the first possible deadline for filing Form 720 is July 31, 2013.

Please contact your Cottingham & Butler representative for additional information on CER fees.

Health Insurance Providers Fee

The Affordable Care Act (ACA) imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee, which is treated as an excise tax, is required to be paid by Sept. 30 of each calendar year **beginning in 2014**.

On March 1, 2013, the Internal Revenue Service (IRS) released **proposed regulations** that implement the ACA's health insurance providers fee.

Covered Entity

The health insurance providers fee applies to all "covered entities," defined as any entity that provides health insurance for any United States health risk. The fee will be assessed on health insurers' **premium revenue above $25 million**. Specifically, the fee applies to:

- Health insurers;
- Health maintenance organizations (HMOs);
- Providers of Medicare Advantage, Medicare Part D prescription drug coverage or Medicaid coverage; and
- Non-fully insured multiple employer welfare arrangements (MEWAs).

The term "health insurance" does not include coverage for specific diseases, accident or disability only, hospital indemnity or other fixed indemnity insurance. A "United States health risk" means the health risk of an individual who is a U.S. citizen, U.S. resident (whether or not located in the United States) or located in the United States, with respect to the period that the individual is located there.

Excluded Entities

The fee does not apply to companies whose net premiums written are $25 million or less. Additionally, the fee program specifically excludes all of the following entities:

- Self-insured employers;
- Governmental entities;
- Certain nonprofit entities; and
- Voluntary employees' beneficiary associations (VEBAs).

Employers who provide retiree's health care benefits under a self-insured arrangement generally would qualify for the exclusion for self-insured employers. The proposed regulations also clarify that a self-insured plan may use a third party, such as a commercial insurer, for administration and remain exempt from the fee, as long as there is no shifting of risk to the third party.

Although MEWAs that are not fully insured are subject to the fee, the proposed regulations note that a fully insured MEWA would *not* be subject to the fee even though it receives premiums, because it uses those premiums to pay an insurance company to provide the coverage being purchased. In this case, the insurance company is the covered entity because it, and not the MEWA, is providing health insurance.

Controlled Group Rule

To determine if a company is a "covered entity," a controlled group rule applies for companies that are related or commonly owned. The proposed regulations define a "controlled group" as a group of two or more persons, including at least one person that is a covered entity, that are treated as a single employer under the Internal Revenue Code (Code) sections 52(a), 52(b), 414(m) or 414(o).

A controlled group is treated as a single covered entity for purposes of the health insurance providers fee. For those that leave or enter a controlled group, the proposed rules clarify that a person is treated as a member of the controlled group if it is a member of the group at the end of the day on Dec. 31 of the data year.

The proposed regulations require each controlled group to have a "designated entity" that will be responsible for filing and reporting the group's net premiums written. For groups of entities filing consolidated returns, this will be the common parent of the group. In determining net premiums written of a controlled group, the controlled group generally must take into account the net premiums written for all members for the entire data year.

Although a single entity is responsible for the group's filings and payment of the fee, all group members are jointly and severally liable for the final fee for a given fee year.

Fee Amount

The aggregate annual fee for all covered entities (referred to as the "applicable amount") is expected to be:

- **$8 billion** for calendar year 2014;
- **$11.3 billion** for calendar years 2015 and 2016;
- **$13.9 billion** for calendar year 2017; and
- **$14.3 billion** for calendar year 2018.

Beginning in 2019, the cost of the fee will increase based on the rate of premium growth. The applicable amount will be apportioned among the covered entities according to their respective market shares, as measured by net premiums written. This means that the IRS will assess a portion of the applicable amount to each covered entity based on the ratio of:

- The covered entity's net premiums written during the preceding calendar year; to
- The aggregate net premiums of all covered entities during the preceding calendar year.

A covered entity's net premiums written during the calendar year that are not more than $25 million are not taken into account when allocating the fee. With respect to a covered entity's net premiums written that are more than $25 million but not more than $50 million, 50 percent are taken into account. One-hundred percent of net premiums written in excess of $50 million are taken into account.

Reporting Requirements and Penalties

A covered entity will be required to report to the IRS the amount of its net premiums written for health insurance of United States health risks by **May 1 of each fee year**, using Form 8963. A covered entity with net premiums written under the $25 million threshold is not liable for the fee, but still must report its net premiums written.

The IRS is considering making available to the public the information reported on Form 8963 (including the identity of the covered entity and the amount of its net premiums written) and invites comments on which information should be made publicly available.

Fee Determinations

Under the proposed regulations, the IRS will determine aggregate net premiums written for all covered entities based on reports submitted on Form 8963, and any other source of information available to the IRS. The IRS will send each covered entity a notice of preliminary fee calculation each fee year, and will allow for an error correction process prior to determining a covered entity's final fee for a given fee year. The IRS will issue further guidance regarding the error correction process.

Penalties

A penalty will apply to each covered entity for failure to timely file Form 8963, unless it is shown that the failure is due to reasonable cause. The penalty, which applies *in addition to* the fee amount, will be $10,000 plus the lesser of:

- $1,000 per day while the failure continues; or
- The amount of the fee imposed for which the report was required.

A penalty will also apply for underreporting of a covered entity's net premiums written. The penalty is equal to the amount of the fee that should have been paid in the absence of an understatement over the amount of the fee determined based on the understatement.

Shifting the Cost of the fee

Some industry groups have raised concern over whether covered entities will try to shift the cost of the fee onto policyholders. The concern is that covered entities will try to recover a large portion of the fee from policyholders by raising insurance premiums by a corresponding amount.

The IRS acknowledged these concerns in the proposed rules, and will accept comments for 90 days following publication of the proposed rules.

Proposed Rules on Workplace Wellness Programs

The Affordable Care Act (ACA) includes provisions to encourage appropriately designed, consumer-protective wellness programs in group health coverage. Effective for plan years beginning on or after **Jan. 1, 2014**, ACA essentially codifies the existing HIPAA nondiscrimination requirements for health-contingent wellness programs, while also increasing the maximum reward that can be offered under these programs.

On Nov. 26, 2012, the Departments of Health and Human Services, Labor and the Treasury (Departments) released **proposed regulations** regarding ACA's nondiscrimination requirements for wellness programs. The proposed regulations would increase the maximum reward under a health-contingent wellness program from 20 percent to **30 percent** of the cost of coverage and would further increase the maximum reward to **50 percent** for wellness programs designed to prevent or reduce **tobacco use**.

The regulations would apply to both grandfathered and non-grandfathered group health plans and group health insurance coverage for plan years beginning on or after Jan. 1, 2014.

Because the regulations are not in final form, they do not provide definitive guidance. However, they are an indicator of how the Departments will apply ACA's nondiscrimination requirements for wellness programs. Comments on the proposed regulations are due by Jan. 25, 2013.

Categories of wellness programs

Employment-based wellness programs can be divided into two general categories – participatory wellness programs and health-contingent wellness programs. This distinction is important because participatory wellness programs are not required to meet the nondiscrimination standards applicable to health-contingent wellness programs.

Participatory Wellness Programs

Participatory wellness programs do not require an individual to meet a standard related to a health factor in order to obtain a reward or do not offer a reward at all. Examples of these programs include a fitness center reimbursement program, a diagnostic testing program that does not base any reward on outcomes, a program that reimburses employees for the costs of smoking cessation programs, regardless of whether the employee quits smoking, and a program that provides rewards for attending a free health education seminar.

Participatory wellness programs comply with the nondiscrimination requirements without having to satisfy any additional standards, *as long as participation in the program is made available to all similarly situated individuals*. There is no limit on financial incentives for participatory wellness programs.

Health-contingent Wellness Programs

Health-contingent wellness programs require individuals to satisfy a standard related to a health factor in order to obtain a reward. This category includes wellness programs that require an individual to attain or maintain a certain health outcome in order to obtain a reward (for example, not smoking, attaining certain results on biometric screenings or meeting exercise targets).

To protect consumers from unfair practices, health-contingent wellness programs are required to follow certain standards related to nondiscrimination, including a standard that limits the maximum reward that can be offered.

Standards for health-contingent wellness programs

HIPAA currently prohibits group health plans and group health insurance issuers from discriminating against individual participants and beneficiaries in eligibility, premiums or benefits based on a health factor. An exception to this rule allows benefits (including cost sharing), premiums or contributions to vary based on participation in a wellness program, if the program complies with certain nondiscrimination standards.

In 2006, the Departments released final regulations regarding HIPAA's nondiscrimination and wellness provisions. The regulations prescribed five nondiscrimination standards for health-contingent wellness programs. ACA codified the existing HIPAA regulations for wellness programs, while also increasing the maximum permissible reward that can be offered under health-contingent wellness programs.

The proposed regulations include clarifications regarding the reasonable design of health-contingent wellness programs and provide guidance on the increased maximum reward size.

Standard #1 – Frequency of Opportunity to Qualify

Consistent with the HIPAA regulations, the proposed regulations would require health-contingent wellness programs to provide eligible individuals with an opportunity to qualify for the reward **at least once per year**.

Standard #2 – Size of Reward

Similar to the HIPAA regulations, the proposed regulations would limit the total amount of the reward for health-contingent wellness programs with respect to a plan, whether offered alone or coupled with the reward for other health-contingent wellness programs.

The total reward offered to an individual under an employer's health-contingent wellness programs could not exceed a specified percentage of the total cost of employee-only coverage under the plan, taking into account both employer and employee contributions towards the cost of coverage. If, in addition to employees, any class of dependents (such as spouses and dependent children) may participate in the health contingent wellness program, the reward could not exceed the specified percentage of the total cost of the coverage in which the employee and any dependents are enrolled (such as family coverage or employee-plus-one coverage).

In addition, the proposed regulations would implement ACA's changes by increasing the maximum permissible reward from 20 percent to **30 percent** of the cost of health coverage. In addition, the regulations propose to increase the maximum permissible reward to **50 percent** of the cost of health coverage for programs designed to prevent or reduce **tobacco use**.

Standard #3 – Uniform Availability and Reasonable Alternative

Consistent with the HIPAA regulations, the proposed regulations would require the reward under a health-contingent wellness program to be available to all similarly situated individuals. To meet this requirement, a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward must be provided to any individual for whom it is unreasonably difficult due to a medical condition to meet the otherwise applicable standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

The proposed regulations would clarify that plans and issuers are not required to establish an alternative standard in advance of an individual's specific request for one. However, a reasonable alternative standard would have to be provided upon an individual's request. Also, plans and issuers cannot cease to provide a reasonable alternative standard merely because one was not successful before. They must continue to offer a reasonable alternative standard, whether it is the same standard or a new one (such as a new weight loss class or a new nicotine replacement therapy).

In addition, the proposed regulations would include factors for determining whether a plan or issuer has provided a reasonable alternative standard. For example, if the reasonable alternative standard is completion of an educational program, the proposed regulations would provide that the plan or issuer must make the program available instead of

Requiring an individual to find this type of program unassisted and may not require an individual to pay for the program's cost.

The proposed regulations also would clarify that, if reasonable under the circumstances, a plan or issuer may seek verification (such as a statement from an individual's physician) that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard. It would not be reasonable for a plan or issuer to seek verification of a claim that is obviously valid based on the nature of the individual's medical condition that is known to the plan or issuer. However, the proposed regulations would permit plans and issuers to seek verification of claims that require the use of medical judgment to evaluate.

Standard #4 – Reasonable Design

The proposed regulations, like the HIPAA regulations, would require that health-contingent wellness programs be reasonably designed to promote health or prevent disease and not be overly burdensome for individuals or a subterfuge for discrimination based on a health factor. The proposed regulations would continue to give plans and issuers flexibility to consider innovative programs for encouraging wellness. However, to be considered reasonably designed to promote health or prevent disease, the proposed regulations would require the wellness program to offer a different, reasonable means of qualifying for the reward to any individual who does not meet the standard based on a measurement, test or screening related to a health factor (such as a biometric examination or health risk assessment).

Standard #5 – Notice of Other Means of Qualifying for the Reward

Consistent with the HIPAA regulations, the proposed regulations would require plans and issuers to disclose the availability of other ways to qualify for the reward in all plan materials describing the terms of the wellness program. If plan materials merely mention that a wellness program is available, without describing its terms, this disclosure is not required. For example, a summary of benefits and coverage that notes that cost sharing may vary based on participation in a diabetes wellness program, without describing the standards of the program, would not trigger the disclosure.

In addition, the proposed regulations include the following sample language intended to be simpler for individuals to understand and increase the likelihood that those who qualify for an alternative means of obtaining the reward will contact their plan or issuer:

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

APPLICATION TO GRANDFATHERED PLANS

ACA's nondiscrimination provisions for health-contingent wellness programs do not apply to grandfathered plans. However, these plans are required to comply with the 2006 HIPAA regulations, which essentially include the same requirements for wellness programs, but have a lower maximum reward.

However, because the Departments believe that the provisions of the proposed regulations would be authorized under either HIPAA or ACA, they propose to apply the same set of standards to both grandfathered and non-grandfathered plans. According to the Departments, this approach is intended to avoid inconsistency across group health coverage and to provide grandfathered plans the same flexibility to promote health and prevent disease as non-grandfathered plans.

Source: Departments of Health and Human Services, Labor and the Treasury

Enrollment in Health Insurance Exchange

The Affordable Care Act (ACA) calls for the creation of state-based competitive marketplaces, known as **Affordable Health Insurance Exchanges** (Exchanges), for individuals and small businesses to purchase private health insurance. According to the Department of Health and Human Services (HHS), the Exchanges will allow for direct comparisons of private health insurance options based on price, quality and other factors and will coordinate eligibility for premium tax credits and other affordability programs.

ACA requires the Exchanges to become operational in 2014. Enrollment in the Exchanges for individuals and small businesses is expected to begin on **Oct. 1, 2013**. This Legislative Brief describes the periods during which individuals can enroll in a health plan through an Exchange.

Enrollment Periods

The ACA requires Exchanges to have an initial open enrollment period, an annual open enrollment period and certain special enrollment periods. Individuals will only be able to enroll in a "qualified health plan" (QHP) through an Exchange **during one of the permitted enrollment periods**.

Initial Enrollment Period

The initial open enrollment period is expected to run from **Oct. 1, 2013, through March 31, 2014**. Coverage must be offered effective Jan. 1, 2014, for qualified individuals whose QHP selections are received by the Exchange on or before Dec. 15, 2013. For selections received between the first and 15th day of January, February or March 2014, coverage must be provided effective the first day of the following month. For those received between the 16th day and the last day of any month between December 2013 and March 31, 2014, the Exchange must ensure coverage is effective the first day of the second following month.

Special Enrollment Periods

Qualified individuals and enrollees may be allowed a "special enrollment period" under certain circumstances (such as marriage or birth of a child), during which they could enroll in QHPs or change enrollment from one QHP to another. Each special enrollment period will be **60 days from the date of the triggering event**. The effective date of any coverage elected during a special enrollment period follows rules similar to those applicable during initial enrollment. This means that coverage would be effective as of the first day of the month for elections made by the 15th of the preceding month, and on the first day of the second following month for elections made between the 16th and the last day of a given month. However, coverage would be effective on the date of birth, adoption or placement for adoption, when that is the special enrollment triggering event.

Annual Enrollment Periods

The annual enrollment period for 2015 and subsequent years will begin **October 15 and extend through December 7 of the preceding calendar year**. Starting in 2014, the Exchange must provide advance written notice to each enrollee about annual open enrollment no earlier than September 1, and no later than September 30

FAQs on Exchanges, Market Reforms, and Medicaid

The Affordable Care Act (ACA), which was enacted on March 23, 2010, includes significant changes related to health care coverage. Among other things, the ACA calls for the creation of state-based Affordable Health Insurance Exchanges (Exchanges) to facilitate the purchase of insurance, requires insurers to comply with a new set of market reforms and expands the Medicaid program.

On Dec. 10, 2012, the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) issued Frequently Asked Questions (FAQs) to answer questions regarding the implementation of the Exchanges and the Medicaid expansion.

Medicaid Expansion

The ACA calls for a nationwide expansion of Medicaid eligibility, set to begin in 2014. Under the expansion, nearly all adults under 65 with family incomes of up to 133 percent of the federal poverty level (FPL) would qualify for Medicaid.

Originally, the ACA required states to comply with the new Medicaid eligibility requirements, or risk losing their federal funding. The Supreme Court's ruling in the ACA case, however, limited the federal government's ability to penalize states that don't comply, effectively making the expansion optional. Even if they choose not to expand their Medicaid program, states will continue to receive their standard federal contributions for individuals who were already eligible for Medicaid coverage in their state.

States are not under a deadline for deciding to expand Medicaid and can drop out of the expansion program later if they participate initially.

Federal Matching Funds

For states that implement the Medicaid expansion, the federal government will cover 100 percent of the cost of the first three years of the expansion (2014-2016), gradually phasing down to a 90 percent share. The FAQs clarify that states must *fully* expand Medicaid eligibility up to 133 percent of the FPL to receive the 100 percent federal matching funds. This means that states that implement partial Medicaid expansions (that is, expansions to less than 133 percent of the FPL) will not receive the full federal funding.

The FAQs note that states do have the option of implementing a partial Medicaid expansion. However, any partial expansion would be subject to the regular federal matching rate (that is, the federal match that states received before the expansion). Additionally, HHS intends to allow states significant discretion as to the "benchmark" benefit plans they will offer the Medicaid expansion population, as long as they cover the 10 categories of essential health benefits. States will also have some control over the cost sharing they will impose, particularly for recipients with incomes above 100 percent of the FPL.

Effect of the Supreme Court Ruling

The FAQs further clarify that the Supreme Court ruling releases the states only from the Medicaid expansion requirement. States must still coordinate Medicaid eligibility with the exchanges if they wish to stay in the Medicaid program. They must also convert their income eligibility standards for most groups to the modified adjusted gross income (MAGI) standard used for premium tax credit eligibility.

Health Insurance Exchanges

The ACA also requires each state to have an Exchange to provide a competitive marketplace where individuals and small businesses will be able to purchase private health insurance coverage. The Exchanges are scheduled to be operational by **Jan. 1, 2014**, with enrollment expected to begin on **Oct. 1, 2013**.

States have three options with respect to their Exchanges. A state may:

- Establish its own state-based Exchange;
- Have HHS operate a federally facilitated Exchange (FFE) for its residents; or
- Partner with HHS so that some FFE Exchange functions can be performed by the state.

State-based and State Partnership Exchanges

States that intend to pursue a state-based Exchange or a state partnership Exchange must submit a short declaration letter and an Exchange blueprint to HHS for approval. In November 2012, HHS extended the deadline for states to submit this notification and blueprint to:

- **Dec. 14, 2012**, for states that intend to establish their own Exchange; or
- **Feb. 15, 2013**, for states that would like to partner with HHS to establish an Exchange.

The FAQs clarify that HHS will not further extend the deadline beyond the current date. Additionally, the FAQs outline federal funding that is available to states that establish a state-based or state partnership exchange, and describe a federal data hub that states will be permitted to use, free of charge for exchange, Medicaid and Children's Health Insurance Program (CHIP) activity.

Federally Facilitated Exchanges

HHS will operate federally facilitated Exchanges in each state that does not move forward with implementing its own Exchange or select the partnership model. The FAQs state that HHS intends to work with these states to preserve the traditional responsibilities of state insurance departments when establishing FFEs. HHS plans to coordinate with the states to take advantage of regulatory efficiencies, such as relying on states with effective rate review programs for rate review of qualified health plans.

The FAQs also reiterate that the FFEs will be funded through monthly user fees. Although HHS previously proposed that the rate for these fees will be 3.5 percent of the premium, the FAQs note that this rate may be adjusted to take into account state-based Exchange rates.

Other Topics

The FAQs address a number of other topics that states have expressed concern about, including, but not limited to:

- ***Bridge Plans*** – The FAQs endorse a "Medicaid bridge plan" that states could use to ease the transition for consumers out of Medicaid or CHIP coverage. A bridge plan would be certified as a Medicaid managed care plan, but could continue to offer coverage through a single insurer and provider network to households transitioning out of Medicaid, or that have children in Medicaid or CHIP and adults in the Exchange.

- ***The Navigator Program*** – The FAQs also describe in greater detail how the navigator program will work. Navigators are organizations, or in some instances individuals, that will receive grants from the Exchanges to educate and assist consumers to better understand their insurance options.

Cottingham & Butler will continue to monitor health care reform developments and will provide updated information as it becomes available