PriorityHealth

Health care reform:
A guide for employers

Updated October 2014

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This guide was developed by Priority Health to help answer employers' questions regarding health care reform. The summaries and examples are based on information provided in federal regulation.

This is an educational tool only. Information provided by Priority Health about health care reform should not be considered legal or tax advice. Please note, federal regulation is released regularly.

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Getting ready for 2015: A timeline

There are provisions for employers to consider throughout the year. Here's a checklist of what you need to think about and when. For more information, visit *understandinghealthreform.com*.

Now through early fall

Pay Patient-Centered Outcomes Fee

Insurers and self-funded employers must file this on an excise tax return by July 31 of each year immediately following the calendar year to which the fee applies. The IRS provides three to four different ways of determining the number of lives to count for the payment calculation. Note: Priority Health will file this fee on behalf of our fully-funded customers. Employers with self-funded plans, including Health Reimbursement Arrangements (HRAs), must submit this fee directly to the IRS via an excise tax form.

key:

- = Applies to ALL employers
- = Applies to SMALL employers
- = Applies to LARGE employers

Marketplace notification to employees

The Affordable Care Act (ACA) required employers to notify their employees of the existence of the Health Insurance Marketplace by Oct. 1, 2013. New hires should be given the notice within 14 days of their employment.

The Department of Labor has made a template available on its website, which employers can download, complete and issue to employees. Find more information—including a link to the templates—at *understandinghealthreform.com*.

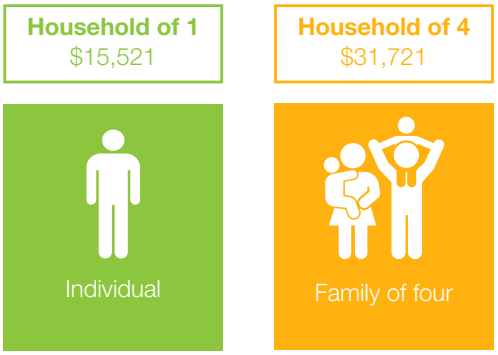
Priority Health has developed an easy-to-understand notification that satisfies the requirement. Contact your account manager for a copy.

Note: There is no penalty for failing to issue this notification.

Educate employees about Medicaid options

Individuals and families with incomes at or below 133% of the federal poverty level (FPL) are eligible for the Healthy Michigan Plan — a Medicaid expansion program operated through the State of Michigan that offers the same essential benefits offered on the Marketplace with minimal cost to the enrollee. Individuals who enroll in Healthy Michigan satisfy their requirement to have health insurance. Plus, employers are not fined when their employees enroll in this program. Healthy Michigan is an important option for people who cannot afford benefits or don't qualify for employer benefits.

133% FPL for 2014:



Taxes and fees

Prepare for new taxes and fees under the ACA. Only two of these apply to self-funded plans.

Five new taxes and fees are included with the purchase of health benefits beginning Jan. 1, 2014. These taxes and fees were added to employer-sponsored coverage beginning Jan. 1, 2014.

	Self-Funded	Small Group	Large Group	Individual	Medicare Advantage
Annual Fee on Health Insurance Carriers	N/A	HMO/POS: 0.84% PPO: 1.5%			0.79%
Transitional Reinsurance Program	$63 PMPY for all plans beginning Jan. 1, 2014 $44 PMPY for all plans beginning Jan. 1, 2015				N/A
Risk Adjustment Admin Fee*	N/A	$1 PMPY	N/A	$1 PMPY	N/A
Patient-Centered Outcomes Research Institute Fee	2015: $2.08 PMPY 2016-2019 $2 PMPY + medical inflation				N/A
Marketplace User Fee	N/A	0.35%	N/A	1.75%	N/A

PMPY = per member per year
** Does not apply to grandfathered plans.*

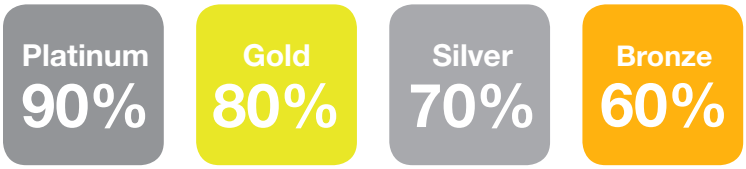
Upon renewal: January 2014 and after

Small employers must choose a new plan*

Beginning at renewal in 2014, all fully-insured small employers must choose a new plan that complies with the following health reform requirements (self-insured plans do not have to comply):

- **Essential health benefits** – coverage must include 10 categories and services mandated by law, including:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including dental and vision

- **Actuarial value** – To make shopping for health coverage easier for small employers, all plans must be assigned to a metal category—platinum, gold, silver or bronze. The metal tier indicates the value of the health plan; with platinum plans having richer coverage than bronze plans, for example.
  - The platinum plan has a 90% actuarial value (AV). AV is a measure of the percentage of expected health care costs a health plan will cover for a standard population and can be considered a general summary of health plan generosity. It only measures essential health benefits covered at the in-network level.



What is a small employer?

For 2014 and 2015, 'small' is defined as less than 50 full-time and full-time equivalent employees. In 2016, 'small' is defined as up to 100.

"If you like the plan you have, you can keep it."

In November 2013, the federal government announced it would allow individuals and small employers to keep their existing health plan even if it didn't comply with the ACA. Priority Health is one of the few insurers to allow our individual and small business customers to renew their 2013 plans. Known as "transitional" or "as-is" plans, these plans may continue through 2016, with a possibility for a 2017 extension.

**Grandfathered and transitional plans do not have to comply with these requirements.*

Uniform rating rules apply to small employer health plans*

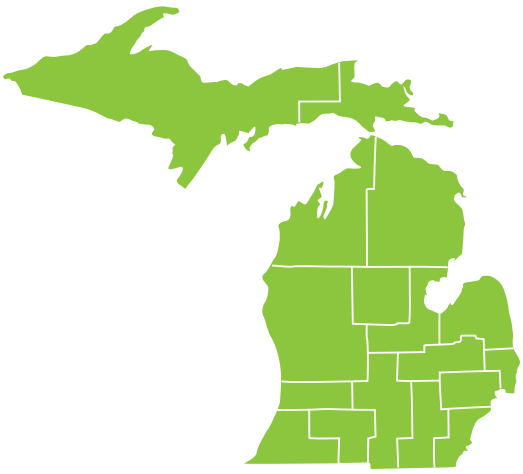
Changes in rating rules impact many small employers in ACA-compliant plans. Under the ACA, plans are no longer allowed to rate based on industry codes, duration of coverage, health status, claims experience or gender. Insurance carriers can set prices in the small group market based on three things: age, tobacco use and geography.

3:1

- **Age** – By law, the highest to lowest age rate cannot exceed a 3-to-1 ratio. For example, if a 21-year-old healthy male today receives an $80 premium, the 64-year-old male in the same region cannot pay more than $240 for the same plan (3 X $80 = $240). Prior to the ACA, the cost of a premium for the 64-year-old was likely as much as $960 (4 X $240) based on the cost of health care services used by older adults. Therefore, the premium cost for the young, healthy male will increase to allow plans to collect a more reasonable premium for the older population. Age factors and bands will be determined based on age at policy issuance and renewal so that increases are not introduced in the middle of the policy year.

- **Tobacco use (optional)** – Insurers are allowed to increase rates by up to 50% for tobacco use. Federal regulators have defined tobacco use as using any tobacco product at least four times per week on average within the last six months. However, regulations require insurance carriers to permit employees to reduce their rate by participating in a tobacco cessation wellness program.

- **Geography** – The cost of health care services vary from community to community. The law makes allowances for this by permitting rating based on geography. Michigan has adopted 16 geographic factors. In the case of a multi-location employer, the geographic rating will be based on the employer's primary location.



There are 16 defined geographic areas in Michigan

**Grandfathered and transitional plans do not have to comply with these requirements.*

Standard rating tiers are no longer allowed for small employers*

Insurers must charge for each person on the plan. Single, double and family rating tiers are no longer allowed. The family rate is derived by adding up the per-member rates of each person in the plan—husband plus wife plus daughter plus son. What this means is that each family rate will be different in most cases. A married couple in their 20s, for example, will have a lower rate than a married couple in their 40s.

Family rates will be capped at a maximum of three children.

The regulations indicate that it's up to the employer to decide to blend the per-member rate into a composite rate for the purposes of determining employee contribution levels.

A new place to purchase coverage for small employers – the SHOP

The Small Business Health Options Program (SHOP) provides a new channel for employers to select employee benefits. From Jan. 1, 2014 through Nov. 14, 2014, employers will purchase a SHOP plan with the help of an agent and/or directly from an insurer. The online SHOP Marketplace will open on Nov. 15, 2014.

For 2015 effective dates, employers will enroll and pay invoices via the online SHOP. All billing and payments will be handled by the SHOP. Plans purchased with 2014 effective dates will continue to be invoiced by the insurer.

Michigan opted to delay employee choice until 2016. Employers will continue to select a single carrier and a single health plan option for their employees in 2015.

Small businesses can continue to purchase plans with the assistance of an agent or directly from an insurer outside of the SHOP.

Tax benefits of the SHOP

The SHOP is the only place where the small business tax credit can be accessed in 2014 and after. However, the number of small employers that qualify for this credit is very low. A government analysis found that less than 20% of the expected employers have filed for this credit.

**Grandfathered and transitional plans do not have to comply with these requirements.*

New out-of-pocket maximum imposed*

All medical plans must have an annual limitation on cost-sharing for covered services upon renewal.

Known as an out-of-pocket maximum, it is designed to limit what the enrollee pays for deductibles, coinsurance or copayments for the policy year. It is a true out-of-pocket limit, meaning that enrollees will stop paying copayments for all covered services (including prescription drugs) once the out-of-pocket maximum is met. This may increase the premium if other off-setting benefit changes are not made, depending on plan design.

The amount is set annually. For 2014, these amounts are $6,350 for single coverage and $12,700 for family coverage. The amounts increase in 2015 to $6,600 for single coverage and $13,200 for family coverage. Beginning in 2015, these amounts vary from the maximum for high-deductible health plans (HDHPs). The HDHP maximums in 2015 are $6,450 for single coverage and $12,900 for family coverage.

Out-of-pocket maximums		
2014	Single	$6,350
	Family	$12,700
2015	Single	$6,600
	Family	$13,200

Out-of-network services do not apply to this annual limit.

In 2015, employers with a separate pharmacy benefits manager must ensure that their medical costs and pharmacy costs track to a single out-of-pocket limit. The safe harbor in 2014 that allowed employers with a separate PBM to delay the out-of-pocket maximum rule is not available for 2015 and beyond.

Implement changes to waiting periods

Group health plans cannot impose a waiting period that exceeds 90 days from the date that an employee becomes eligible to participate in the plan. Employers can condition eligibility on: the completion of a specified number of hours (not to exceed 1,200), attainment of job-specific certification or licensure or the completion of an orientation period (not to exceed 30 days). All calendar days are counted toward the 90 days including weekends and holidays.

Plans don't have to offer coverage to all groups of employees (part-time, etc.), but when it is offered, the waiting period rule applies.

This provision is effective for plan years beginning on or after Jan. 1, 2014.

**Grandfathered plans do not have to comply with these requirements.*

New rules for wellness programs

New rules governing wellness programs alter how rewards can be granted. These changes apply to both insured and self-funded group health plans as well as plans considered grandfathered by ACA standards. New wellness requirements are effective beginning Jan. 1, 2014. Highlights of the new provisions include:

- **An increase in the maximum allowable reward** from 20% to 30% of the total cost of employee-only coverage. Programs whose primary objective is to "prevent or reduce tobacco use" can provide a maximum reward amount of up to 50% of the total cost of employee-only coverage.
- **Clarification on the types of wellness programs** including classifying health contingent wellness programs as activity only or outcomes based.
- **Relaxed qualification requirements** will ensure "similarly situated individuals" can earn the same reward by satisfying a reasonable alternative to the defined activity or outcome.

Other 2014 reminders

W-2 reporting requirement

Employers must report the cost of employer-sponsored health coverage on their employees' W-2 forms beginning with the 2012 statements, which were issued in January 2013. The reporting requirement is informational and seeks to provide employees with greater transparency into health care costs. The amounts reported are not taxable. Employers that issue fewer than 250 W-2s were not subject to this requirement in 2013 but it may be required in future years.

Begin to prepare for 2015 & 2016

Expand coverage to avoid $2,000 penalty*

Where needed, large employers must adjust their employee benefits eligibility requirements to cover employees who work 30 hours per week and the variable-hour employees who are benefits eligible beginning in 2015. Doing so will ensure the employer avoids the $2,000 per employee (less the first 30 employees) penalty. For more information on eligibility, see page 23.

Confirm affordability to avoid $3,000 penalty*

Large employers must review the affordability of their plans to ensure employees' premium contribution is affordable under the law. Keeping employee premium contributions affordable will ensure the employer isn't penalized $3,000 when an employee receives federal subsidies on the Health Insurance Marketplace. For more information, see page 18.

Employers with 200+ employees must provide automatic benefits enrollment

Employers with more than 200 employees must auto-enroll their eligible employees in health benefits. The employees can disenroll but the onus is on the employee to do so. Final regulation is still pending on this requirement.

Review benefits against discrimination rules

Nondiscrimination rules will be established to ensure benefits don't favor highly-compensated employees. Under similar rules in place in the self-funded market, employers cannot offer better or richer benefits to their highly-compensated staff. The rules, as in place in the self-funded market, not only look to see if the benefits are offered equally, but also measures benefit participation. For example, if only the highly-compensated participate in the benefit package, the plan could be discriminatory. Grandfathered groups are not subject to nondiscrimination rules. Final regulation is still pending on this requirement.

How to address affordability issues: Add a lower cost minimum value plan *to your offerings (a 60% plan) or* ***modify your contribution strategy*** *so that the lower-income employees pay less for coverage.*

Prepare for annual reporting requirements

The ACA established a process requiring employers and insurers to submit information to the IRS so that the penalties and tax credits can be enforced.

Both small and large employers, or insurers in the case of fully funded plans, will send a statement to employees covered by a plan and submit a full report to the IRS. In addition, large employers must also report to the IRS on their entire workforce indicating employee by employee and month by month if the employee was eligible, ineligible, in a waiting period or enrolled in a plan. There are four reports to be filed. This requirement is also called Section 6055 and 6056 reporting.

Because the reporting for large employers covers their entire workforce, rather than covered lives, insurers will not be able to assist with these reports. Large employers may want to begin discussions with their payroll services firms to find out what support, if any, they can lend to Section 6056 reporting.

Considerations for 2015

Employer reporting is optional in 2015 (for the 2014 calendar year). However, the individual mandate is in place and employees must self-report whether (or not) they had coverage throughout 2014 when filing their tax returns in spring 2015. Employers should consider the following when determining if they will file in 2015:

**Unless transition relief applies. See page 22.*

- Burden on human resources/benefits staff
- Questions from employees when completing individual tax filings
- Ability to secure employees' permission to send statements electronically in subsequent years
- Benefits to understanding nuances of filing before it becomes mandatory

	Group size	Who files	Sent to	Due	Information collected	Purpose
Section 6055 Information Reporting of Minimum Essential Coverage (MEC)	Small, large	• Fully-funded groups filed by insurer • Self-funded groups must file for their business	Employees enrolled in coverage	Jan. 31, 2016 and annually thereafter	• Contact information for employer and insurer (if filed by insurer) • Employees' names, addresses, SSNs and DOBs • Dependents' names and SSNs • Months the individual and dependents, if any, were enrolled • Months eligible for coverage	Allows individuals to prove they had coverage and therefore not subject to individual penalty
			IRS	Feb. 28, 2016 (or March 31, 2016 if filed electronically) and annually thereafter		Allows the IRS to administer premium tax credits and subsidies and assess penalties on individuals without coverage
Section 6056 Information Reporting for Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans	Large	Employer is responsible	All employees	Jan. 31, 2016 and annually thereafter	• Contact information for employer • Employees' names, addresses and SSNs • Whether employee (and dependents) were offered MEC by month • Whether employee (and dependents) were enrolled in MEC by month • Each full-time equivalents (FTE's) share of lowest-cost monthly premium • Number of FTEs for each month	Allows the IRS to identify noncompliance with the employer mandate and assess penalties on employers that do not comply
			IRS	Feb. 28, 2016 (or March 31, 2016 if filed electronically) and annually thereafter		

Penalties for failing to report

Reporting is required for all employers beginning in 2016 (for the 2015 calendar year) and for those who are eligible for transition relief in 2015. While an employer may have transitional relief for 2015 under the Play or Pay Rule, they could be subject to fines for not complying with the reporting requirements. The fines are the same as those associated with W-2 filings, which is $100 per report.

Looking ahead to 2016

Add coverage for dependents

The ACA requires large employers to offer coverage to full-time employees and their dependents. (Note: Spouses are not considered dependents.) Employers that don't currently include dependent coverage in their benefits have until their renewal in 2016 to do so. Employers that offered dependent coverage in 2013 or 2014 cannot remove the coverage and reinstate in 2016 without penalty.

Determining employer size

Employers must determine if they are large, annually. Employers that can easily determine if they are large can skip this section and continue to page 18.

What's a large employer?

"Large" is defined as 50 or more full-time and full-time equivalent employees. Notice: it's not just full-time employees, but equivalents. An equivalent is derived when the hours of service of two or more employees equals 30.

So, how do you calculate if an employer is large? Add the full-time employees to the full-time equivalents to get the number. An employer needs to look at the last calendar year and do the math for each month. So, look at January and count the number of full-time employees and full-time equivalents, then February, and so on.

Am I a small or large employer under shared responsibility?

1 - 49 = Small

50+ = Large

What is an employee?

The shared responsibility regulations look to existing common law standards to define who is an employee. Under this standard, an "employment relationship exists if an employee is subject to the will and control of the employer not only as to what shall be done, but how it shall be done." (See IRS Publication 15-A.)

Under the definitions for Section 54.4980H-1, the following are not considered to be employees:

- A leased employee
- A partner in a partnership
- A 2-percent S-corp shareholder

Therefore, these individuals are not counted in determining if an employer is a large employer.

Can I avoid the shared responsibility requirements if I divide my business up into smaller companies?

Not necessarily. All employees of a controlled group or an affiliated service group are taken into account.

(Under §414 (b), (c) or (m) of the Internal Revenue Code)

Who is full-time?

Full-time means any employee who works 30 or more hours, on average, per week or 130 hours per month.

What's a full-time equivalent?

To identify the full-time equivalents, the employer needs to total (or add) the number of service hours by all employees who are not full time and divide by 120.

Do not count more than 120 hours for any one employee. For example, disregard hours above 120 for any employee who may have worked overtime. In addition, the government has indicated that **service hours** rather than work hours must be used for this calculation. Therefore, if an employer pays a part-time employee vacation time, those hours of service would count toward the calculation. **This must be done for every month in the prior calendar year.**

Example: Employer XYZ

1. 100 part-time employees work 6,000 hours collectively (15 hours / week)
   6,000 ÷ 120 = 50 full-time equivalents (FTE)
2. 25 full-time employees
3. **50 FTE + 25 FT = 75 employees**

RESULT: Employer XYZ is a LARGE group

Employers with less than 50 employees are not required to offer employee benefits.They do have to comply with new rating rules, EHB and other small market reforms.

Seasonal employer exception

The seasonal employer exception indicates employers are not large if they exceed the 50 employee count for 120 days (or four months) or fewer during the preceding calendar year (the 120 days or four months do not have to be consecutive).

Employer can use shorter period to determine status as large

Transitional relief allows an employer to use any six consecutive months in 2014 (rather than the full calendar year) to determine if it employed, on average, 50 employees or more.

Counting employees (employer size)

Case study: A produce farm

This employer has 120 employees. Only 30 employees are full-time. Part-time employees' hours worked are noted below.

	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Step 1: Enter how many full-time employees (30+ hours per week) you had for each month												
	30	30	30	30	30	30	30	30	30	30	30	30
Step 2: Determine full-time equivalents (FTEs) for each month												
Enter total hours worked by non-full-time employees for each month	0	0	10,800	10,800	10,800	8,400	6,000	6,000	0	0	0	0
Divide by 120	÷120	÷120	÷120	÷120	÷120	÷120	÷120	÷120	÷120	÷120	÷120	÷120
Total FTEs	0	0	90	90	90	70	50	50	0	0	0	0
Step 3: Total employees (Add Step 1 and Step 2)												
	30	30	120	120	120	100	80	80	30	30	30	30

Step 4: Find your average number of employees

Add together all 12 monthly totals from Step 3	840
Divide by 12	÷12
Annual average number of employees	70
Are you a large employer	YES

Or, to use the 6 month transition relief, total number of employees from any 6 consecutive months of the preceding year

Transition relief	
Add together total from July through December	280
Divide by 6	÷6
Annual average number of employees	47
Are you a large employer	NO

Affordability and minimum value

In 2015*, large employers must offer full-time employees (and their dependents) an opportunity to enroll in minimum essential coverage under an employer-sponsored plan.

*(*unless transition relief applies)*

There are two tests that apply — minimum value and affordability

What is minimum essential coverage?

By law, the plan must offer **minimum value**, which is defined as satisfying a 60% minimum value test—this means that a plan would pay for at least 60% of medical expenses, on average, for a standard population. The Department of Health and Human Services has released a minimum value calculator to use for this testing. Most employer-sponsored plans today will easily pass this requirement.

The affordability test looks at each employee uniquely, not the aggregated population, to check for affordability. It compares what employees pay for coverage to each employee's wages.

The employee's premium contribution for self-only coverage for the lowest-cost plan cannot exceed 9.5% of an employee's household income. If it does, the plan is not affordable and the employer has failed the responsibility to provide minimum essential coverage for that employee.

Because employers cannot easily determine an employee's household income, the law provides three options for this calculation: Box 1 of Form W-2, rate of pay or using federal poverty level.

To use the rate of pay for the affordability test:

Hourly rate X 130 = Monthly wages

Employee's monthly wages X 9.5% = Maximum monthly employee contribution

When employers offer multiple minimum value plan options, the rules say that one of them must be affordable—they don't all have to be. The rules do not pay regard to the plan the employee chooses, just to the fact that an affordable choice is available.

If an employer charges $200 per month for single coverage, the annual cost of coverage would be $2,400. This plan would be unaffordable to employees with annual wages lower than $25,300.

To use the federal poverty level for the affordability test:

2014 FPL = $11,670

$$\frac{\$11,670}{12} = \$972.50 \times 9.5\% = \$92.39$$

Employee monthly contribution for premium cannot exceed $92.39.

Small employers and minimum essential coverage (MEC)

While small employers will not be penalized if their employee benefits don't meet minimum essential coverage, they should still understand if their plan satisfies these requirements. Employees are eligible for federal help, in the form of subsidies and tax credits, when their employer-sponsored benefits don't satisfy the minimum essential coverage requirements. For some employees, accessing federal help to purchase coverage from the Health Insurance Marketplace may be more affordable than their employer's plan.

The Pay-or-Play clause [DELAYED]

What if employers don't do any of this? What if they don't offer employee benefits? Or what if their employee benefits are too costly for eligible employees? There are two primary penalties large employers face if they fail to meet the ACA's Pay-or-Play requirements. We'll refer to these as the 95% Rule and MEC penalties.

The penalty applies only if one (or more) employee(s) goes to the Health Insurance Marketplace and receives a federal subsidy.

The 95% Rule penalty

Under the 95% Rule, large employers must offer coverage to 95% of their eligible full-time employees. If they fail to do so, they will be penalized $2,000 per employee above 30 employees.

Said another way, if the employer excludes one group of employees that comprises 6% or more of the benefits-eligible workforce, then the employer will be assessed the penalty against the entire workforce. Why is the IRS not requiring employers to offer coverage to 100% of full-time employees? They understand that employers need a 5% margin to accommodate administrative errors.

$2,000 X (Number of employees - 30*) = 95% Rule penalty

**unless transition relief applies*

Transition relief for employers > 100

Employers with 100 or more employees in 2015 who owe a penalty will see some relief in the penalty collection. For plan years beginning in 2015 only, the penalty calculation will forgive the first 80 employees (instead of 30 as noted in the law). This relief is available only if the employer did not move the plan year after Feb. 9, 2014.

$2,000 X (Number of employees - 80) = 2015 penalty

The minimum essential coverage (MEC) penalty

The MEC penalty applies if an employer continues to offer coverage but it is either unaffordable or does not cover 60% of services on average. The employer is penalized $3,000 in this case for each employee who receives a subsidy through the Health Insurance Marketplace. This penalty can be avoided by modifying the premium contribution paid by employees or by adding a low-cost plan option.

Employers are still subject to this penalty even if they are eligible for transition relief for the pay-or-play penalty.

$3,000 X Number of employees receiving federal subsidy = MEC penalty

Penalties will be determined through employer reporting

Not much is known about how the penalties will be collected, but they can be collected on a monthly, quarterly or annual basis. Penalties will be calculated based on annual reporting required of self-insured plans and insurers of fully-funded employer plans. (See page 13 for additional information.)

Employers are not penalized for their employees who enroll in Healthy Michigan. This Medicaid program is available for individuals and families making up to 133% of the federal poverty level (FPL).

Who is eligible for help to buy coverage?

- *U.S. citizens or legal aliens*
- *Those not incarcerated*
- *Those with incomes between 100% to 400% of the federal poverty level*
- *Those not offered a qualified employer plan (one that offers minimum value and is affordable)*

Penalties delayed until 2016 benefit year for some employers

The final regulations issued by the IRS may delay the onset of the Pay-or-Play rule for many employers.

Employers with 50-99 employees

Employers with 50 or more, but less than 100 employees, are not subject to the shared responsibility provisions in 2015. To be eligible, employers are prohibited from:

- Reducing the workforce or employees' hours of service from Feb. 9, 2014 until Dec. 31, 2014
- Reducing the percent the employer contributes to the premium cost of employee benefits offered as of Feb. 9, 2014

Employers will be required to certify that they have complied with the information above when they file their IRS report in 2016. (See page 13 for additional information on reporting requirements of the ACA.)

Pay-or-play will not be enforced during the 2015 benefit year for employers that meet the above transition relief.

Employers offering coverage to at least 70% of full-time employees

Large employers who offer coverage to at least 70% of their full-time employees will not be subject to the shared responsibility payment in 2015.

Under this guidance, employers can delay offering benefits down to employees who work 30 hours a week if they cover the majority of the full-time workforce. However, the employer could face a penalty if the coverage offered to 70% of its full-time employees does not meet MEC requirements. The law requires the employer to cover at least 95% of full-time employees or face a penalty. The rule requiring coverage for 95% of employees will begin in the 2016 benefit year.

Employers subject to penalties in 2015

Employers who don't meet the above requirements for transition relief will be subject to the shared responsibility penalty in 2015.

Determining employee eligibility

Under the ACA, 'full time' is defined as any employee who works 30 or more hours on average per week. This will likely be a big change for many employers who must now offer full-time employees (and their dependents) an opportunity to enroll in minimum essential coverage under an employer-sponsored plan.

Variable-hour employees (including seasonal employees)

The federal government has provided guidance on how to identify employees who may be full time, but not easily identified due to the irregularity in their schedules. The terms to understand this process are:

- **Standard measurement (or look-back) period** – A period of 3-12 months (the employer chooses how long to measure) in which an employee's hours are reviewed to determine if they work, on average, 30 or more hours and are eligible for benefits.
- **Administrative period** – This is a period of time afforded to the employer to perform the measurement calculations, communicate to employees and enroll eligible employees in the plan. This period cannot exceed 90 days. This period could include the open enrollment activities.
- **Stability period** – The period of time that the eligible employee is enrolled in benefits. The coverage is protected regardless of whether the employee works 30 hours per week, on average, until the stability period ends and eligibility is measured again. The stability period can last from six to 12 months and cannot be shorter than the measurement period. If the employee is determined to be employed, on average, at least 30 hours of service per week during the measurement period, then the employee must be treated as a full-time employee during a subsequent stability period, regardless of the employee's hours of service during the stability period, so long as he or she remains an employee.

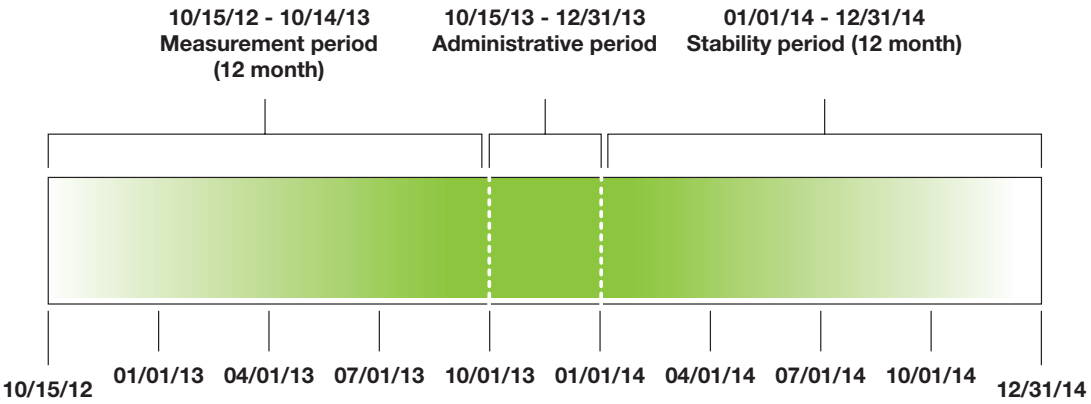
A 130-hour standard may be used as a monthly equivalent of 30 hours per week.

Who is full time?

Case study: **A restaurant**
Employees: 15 management staff, 125 variable-hour employees
Plan renews: Jan. 1, 2015

This restaurant must determine which of its employees are eligible for benefits. The employer is considering a 12-month measurement period and would like to allow for a 2.5 month administrative period to conduct open enrollment meetings and enroll employees in the plan.

There are special rules in the draft guidance on how the federal government proposes handling employees with variable hours.



Meet Jane:
Jane works at the restaurant, but her hours vary week to week and the restaurant management cannot determine that Jane is reasonably expected to work 30 hours, on average, per week.

Jane's hours during a 12-month measurement (Jane is full time):

OCT '13	NOV	DEC	JAN '14	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	AVG.
130	130	155	120	170	100	136	120	70	150	150	130	**130**

The employer chooses the measurement period duration. Different periods can result in different outcomes. If a six-month measurement period is used, the stability period cannot be less than six months.

If the six-month measurement is used (Jane is part time):

APR	MAY	JUN	JUL	AUG	SEP	AVG.
136	120	70	150	150	130	**126**

Jane's administrative period
The employer communicates to Jane and allows her to enroll in the plan.

Jane's 12-month stability period

On Jan. 1, 2015, the stability period begins and Jane is covered under the plan *regardless of whether the hours she works in 2015 meet the full-time definition.* During the stability period, Jane is locked-in to benefits for the full 12 months, unless employment is terminated.

OCT '14	NOV	DEC	JAN '15	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	AVG.
130	130	155	120	100	100	80	75	60	75	100	100	102

In 2014, Jane's hours dip below the 130 per month, full-time measurement. Jane is ensured benefits for 2014, but the hours worked in 2014 are being measured for 2015 eligibility. The measuring and stabilizing don't end after a one-year cycle. Based on the new measurement period, Jane would be excluded from coverage during the 2015 stability period.

Once the first measurement period ends, the second will begin. Employers with variable hour employees will constantly be measuring to determine eligibility for coverage under the next stability period.

Rules for new employees

If the new employee is in a variable hour/seasonal position, their eligibility must also be measured the same way as the other variable-hour employees. The employer must use the same measurement and stability period duration that is used for ongoing employees. The initial measurement period and the administrative period for newly-hired variable-hour employees cannot exceed 13 months after their hire date (last day of the first month of their anniversary).

Other little-known facts

- For non-hourly employees that don't track hours worked, employers can use a reasonable method for determining hours worked. There are three ways to do this: track actual hours worked, use a days-worked equivalency (8 hours) or weeks-worked equivalency (40 hours) method.
- These provisions are designed to protect the employees, so employers are advised to not use methods that would understate the employees' hours.
- Employers do not have a responsibility to offer minimum essential coverage to part-time employees. They can offer benefits, but will not be penalized if they choose not to do so.
- Employers may use a transitional measurement period of less than 12 consecutive months for plan years beginning in 2014 (or if relief applies, for plan years beginning in 2015). The transitional measurement period must include at least six consecutive months and must begin no later than July 1, 2014 and end no earlier than 90 days before the first day of the plan year beginning on or after Jan. 1, 2015.

The same measurement and stability period duration must be used for both ongoing and new employees.

Frequently asked questions

Q/A I augment my staff with resources from a temporary staffing agency. Do I have to measure these employees to assess full-time status? Do I have a responsibility to them?

Under the final regulations, the staffing agency would be responsible for offering the employee coverage.

Temporary staffing firms can use various factors in determining whether a new hire is a variable hour employee, including whether employees in the same position:

- have the right to reject temporary placements
- have periods during which no offer of temporary placement is made
- are offered temporary placements for differing periods of time
- are typically offered temporary placements that do not extend beyond 13 weeks (only pertains to employees in the same position with a temporary staffing firm)

However, there is more information to come on this topic. The IRS is concerned that that employers could use staffing agencies to avoid the shared responsibility rules. The specific case referenced in the final regulations is an employer hiring an employee for 20 hours and then renting the same employee from an agency for another 20 hours. The IRS promises to prevent these types of workforce tactics. Additional guidance will be published in an Internal Revenue Bulletin.

Q/A I'm a large employer, do I have to offer benefits to my employees' dependents?

Yes, employers are responsible for offering coverage to full-time employees and their dependents. Employers do not, however, have to offer coverage to spouses.

HHS has issued transition relief and employers will not be penalized for not offering coverage to dependents in the first year. In 2016, employers will be penalized for failing to offer coverage to dependents of full-time employees.

Q/A Are there record-keeping requirements to prove coverage was offered?

The Employer Shared Responsibility Regulations do not propose any specific rules for demonstrating that an act of coverage was made beyond applicable substantiation and record-keeping requirements. (26 CFR Section 6001, Rev. Proc. 98-25, Notice 99-1)

What about schools and educational institutions?

For schools and educational institutions, there are special rules related to counting employee hours because of the length of employment breaks during the summer months. If the summer months are included when averaging hours worked, educational staff may not hit the full-time threshold. And so, employment breaks of four weeks or longer must not be included in the measurement period.

Until further guidance is issued, employers of adjunct faculty are required to use a reasonable method of crediting hours of service. A reasonable method would be (but is not limited to) crediting 2.25 hours of service for every one hour of teaching or classroom time.

What if my full-time employees decline coverage that I offer?

If employees decline coverage, the employer is not responsible. The employee may face a penalty for not maintaining coverage, but the employer will not be penalized. If minimum value coverage is available, the employee is not eligible for federal subsidies to pay for coverage.

How do we calculate service hours for on-call employees?

A reasonable method may be used until further guidance is issued. However, the regulations indicate employers must credit any on-call hour that an employee is paid, or required to stay on the employer's premises. Further, on-call hours for which the employee's activities while remaining on-call are subject to substantial restrictions that prevent the employee from using the time for his own purposes must be credited.

Are employers required to treat employees uniformly during the measurement period?

Employers must treat employees uniformly in terms of the measurement period duration, but can use different look-back measurement periods for:

- Collectively bargained agreement employees versus non-CBAs
- Hourly versus salary
- Employees of different entities
- Employees in different states

My business is seasonal. What are the rules governing seasonal employees?

If your business exceeds 50 full-time employees and full-time equivalents for four or fewer months per year, you are a seasonal employer and exempt from the shared responsibility rules.

If you are a large employer that staffs up for a busy season, you must determine which of your seasonal employees are eligible for benefits. Seasonal employees hold positions for which the customary annual employment is six months or less, but the employee may return annually. Employers can use the look-back measurement period to identify full-time employees among seasonal staff in the same manner it is applied to variable hour employees.

Questions about reform?

- Learn more about health reform at our website, *understandinghealthreform.com.*
- Send an email to *askpriorityhealth@priorityhealth.com.*

Large employer checklist

Now through early fall 2014

- ☐ Confirm employer size
- ☐ Distribute Marketplace notification to employees
- ☐ Pay Patient-Centered Outcomes Research Institute fee
- ☐ Prepare for taxes and fees
- ☐ Educate employees about Medicaid options (Healthy Michigan Plan)

Renewal

- ☐ Implement waiting period changes
- ☐ Set plan out-of-pocket maximums to new limits
- ☐ Understand new rules for wellness programs
- ☐ Comply with W-2 reporting requirements

Begin to prepare for 2015

- ☐ Understand employee eligibility
- ☐ Expand coverage to employees working 30 hours
- ☐ Confirm affordability of lowest cost plan
- ☐ Set-up auto-enroll (if 200+ employees)**
- ☐ Review compliance with discrimination rules**
- ☐ Prepare for exchange reporting

Begin to prepare for 2016

- ☐ Add dependent coverage

***Regulation pending*

Small employer checklist

Now through early fall 2014

- ☐ Confirm employer size
- ☐ Pay Patient-Centered Outcomes fee, including HRA, if self-funded by July 31
- ☐ Distribute Marketplace notification to employees
- ☐ Prepare for taxes and fees
- ☐ Educate employees about Medicaid options (Healthy Michigan Plan)

Renewal

- ☐ Choose new plan design*
- ☐ Expect rating changes*
- ☐ Plan for per-member rate on bill*
- ☐ Implement waiting period changes
- ☐ Set plan out-of-pocket maximums to new limits

Begin to prepare for 2015

- ☐ Review compliance with discrimination rules**
- ☐ Prepare for exchange reporting**

** Unless transitional plan in place*

***Regulation pending*

Legal Disclaimer

This workbook provides a general overview of certain aspects of health care reform based on information currently available. It does not cover all of the requirements, and new information is released frequently. Information provided by Priority Health about health care reform should not be considered legal advice. This is an educational tool only and the effect of reform may differ depending on your circumstances.

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