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BACKGROUND

On Tuesday, March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590) (“the Act”). On Thursday, March 25, 2010, the House and Senate passed The Health Care and Education Reconciliation Act of 2010 (H.R. 4827) (the “Reconciliation Bill”) which amends several provisions of the Act. Together, the bills comprise the overall healthcare reform legislation package. President Obama signed the Reconciliation Bill into law on March 30, 2010.

EMPLOYER RESPONSIBILITIES

General

1. **Is there anything we have to do immediately?**

   Although the Act was effective on the date the President signed it, most of its provisions are not effective immediately. For example, certain coverage mandates don’t take effect until the first plan year starting on or after September 23, 2010. Other provisions are phased in between 2011 and 2018.

2. **Will I be required to offer health insurance coverage to my employees?**

   No. However, if you have at least 50 full-time employees, and you don’t offer coverage, you will owe a penalty if any full time employee is eligible for and purchases subsidized coverage through a Marketplace exchange.

3. **When will this requirement be effective?**

   The employer mandate and potential assessment of employer penalties was originally effective January 1, 2014. On July 2, 2013, the mandate was delayed for one year until January 1, 2015. On February 12, 2014, it was delayed until January 1, 2016 for large employers with between 50 and 99 full-time employees who meet certain criteria.

4. **We have between 50 and 99 full-time employees (including full-time equivalents). Will we have to do anything in order to qualify for the delay until 2016?**

   Yes. There are four conditions that have to be satisfied:

   1. During the period beginning on February 9, 2014, and ending on December 31, 2014, you are not able to reduce the size of your workforce or the overall hours of service of your employees solely in order to satisfy the condition of having between 50 and 99 full-time employees (including full-time equivalents). If a reduction in workforce size or overall hours of service was made for bona fide business reasons, it will not be considered to have been made in order to satisfy the workforce size condition (and thus would be permissible); and

   2. You cannot eliminate or materially reduce the health coverage, if any, you offered as of February 9, 2014 during either a) the period beginning on
February 9, 2014, and ending on December 31, 2015 if you have a calendar year plan; or b) for the period beginning on February 9, 2014, and ending on the last day of the plan year that begins in 2015 if you have a non-calendar year plan. This means that between the dates described above, you cannot narrow or reduce the class of employees (or dependents) eligible for coverage on February 9, 2014 and you must continue to make a contribution toward the cost of employee-only coverage that is either (a) at least 95% of the dollar amount contributed on February 9, 2014 or (b) was the same (or a higher) percentage of the cost contributed on February 9, 2014; and

3. Your plan year start date was not modified after February 9, 2014 to begin on a later calendar date (e.g. changing the start date of the plan from January 1 to December 1); and

4. You certify, on IRS Form 1094-C, that you meet the eligibility requirements set forth above.

5. Our plan is self-funded. Will we have to do anything as a result of this new law?

Self-funded plans are generally treated the same as fully-insured plans under the Act. You should be analyzing the coming changes for the impact they will have on your self-funded plan.

6. We are a governmental entity. Do we have to comply with this legislation?

Yes. There are no exceptions for nonfederal governmental plans so you should be analyzing the coming changes for the impact they will have on your plan.

7. As a self funded non-Federal governmental plan, can we still opt out of the requirements of HIPAA including Mental Health Parity?

Self-funded governmental plans can still opt out of some requirements including Mental Health Parity, but the opt-out election will no longer be available for other requirements.

PPACA made several significant changes to the Public Health Service Act (PHSA) which resulted in changes to HIPAA’s opt-out provision. Prior to enactment of PPACA, sponsors of self-funded nonfederal governmental plans could elect to “opt out” of all 7 of the following requirements:

1. Limitations on preexisting condition exclusion periods.

2. Requirements for special enrollment periods.

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the Genetic Information Nondiscrimination Act of 2008).

4. Standards relating to benefits for newborns and mothers.
5. Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act of 2008).

6. Required coverage for reconstructive surgery following mastectomies.

7. Coverage of dependent students on a medically necessary leave of absence.

Under the revised PHSA, you can no longer choose to exempt your plan from categories 1 through 3 listed above, but may continue to exempt the plan from requirement categories 4 through 7. This change is effective for plan years starting on or after September 23, 2010.


8. We are a church plan and our plan is not subject to ERISA. Do we still have to comply with this legislation?

Yes. The Act does not include a blanket exception for church plans so you should be analyzing the changes for the impact they will have on your plan. However, there are special rules or exceptions that may apply for certain provisions including contraceptive coverage, external claim reviews, medical loss ratio (MLR) rebates, and W-2 reporting. Those special rules or exceptions are discussed in later sections of these FAQs.

9. Does PPACA apply to expatriate plans?

Due to the special challenges in complying with certain provisions of PPACA, Congress enacted legislation in 2014 that exempts from most of PPACA's insurance market reforms expatriate health plans (whether insured or self-funded) that meet certain requirements. The changes are effective for plan years starting on or after July 1, 2015. In addition, several other changes were made including:

- Expatriate health plans are considered "minimum essential coverage" (MEC) for purposes of the individual mandate.
- Expatriate health plans are considered minimum essential coverage under an employer-sponsored plan for purposes of the employer mandate for certain foreign employees working in the U.S. and certain U.S. expatriates working overseas.
- Expatriate plans are not subject to the health insurance fee (after 2015), the transitional reinsurance fee, and the PCORI fee.

Prior to the passage of the legislation exempting expatriate plans from most of PPACA’s requirements, there were special transition rules that applied to insured expatriate coverage. The transition relief says that insured expatriate health plans with plan years ending on or before December 31, 2016 will be deemed to have
satisfied the requirements of PPACA if they are in compliance with the pre-PPACA version of the Public Health Service Act and other applicable law under ERISA and the Internal Revenue Code, including, for example, the mental health parity provisions, the HIPAA nondiscrimination provisions, the ERISA §503 requirements for claims procedures, and any reporting and disclosure obligations under ERISA Part 1.

For purposes of this temporary transitional relief, an expatriate health plan is defined as a plan that limits enrollment only to primary insureds who reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents. The 12-month period can fall within a single plan year or across two consecutive plan years.

To qualify as an expatriate health plan for purposes of the above exemptions for 2017 and later, an expatriate plan (whether insured or self-insured) must meet the following requirements:

1. The expatriate health plan or coverage must be underwritten or issued by an expatriate health plan issuer, or administered by an expatriate health plan administrator that:
   a. maintains network provider agreements that provide for direct claims payments (directly or through third-party contracts), with health care providers in eight or more countries;
   b. maintains call centers (directly or through third-party contracts) in three or more countries and accepts calls in eight or more languages;
   c. processes at least $1 million in claims in foreign currency equivalents each year;
   d. makes global evacuation/repatriation coverage available;
   e. maintains legal and compliance resources in three or more countries;
   f. has licenses to sell insurance in more than two countries; and
   g. reimburses for items or services in the local currency in eight or more countries.

2. Substantially all of the primary enrollees of an expatriate health plan must be qualified expatriates;

3. Substantially all of the benefits provided under a plan or coverage must be benefits that are not excepted benefits;

4. The coverage must provide coverage for inpatient hospital services, outpatient facility services, physician services, and emergency services. Also, coverage for these services must be provided in certain countries;

5. The plan sponsor must reasonably believe that benefits under the plan provide “minimum value”;

6. Dependent coverage of children, if offered under the expatriate health plan, must continue to be available until the individual attains age 26; and
7. The expatriate health plan must satisfy the HIPAA portability and nondiscrimination requirements.

10. Do I only have to “offer” the coverage, or do I also have to pay for the coverage to avoid a penalty?

You are not required to offer coverage nor pay any part of the coverage if you offer it.

However, you are subject to the employer mandate if you are a “large employer”. A large employer is an employer that employed at least 50 full-time employees (including full-time equivalent employees) on business days in the preceding calendar year.

11. How do I determine how many full time employees I have?

For purposes of determining if you employ at least 50 full-time employees (including full-time equivalent employees), they are defined as those common law employees who work on average 120 hours per month.

A common law employee/employer relationship exists when the employer for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. That is, 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. In this connection, it is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so. The right to discharge is also an important factor indicating that the person possessing that right is an employer. Other factors characteristic of an employer, but not necessarily present in every case, are the furnishing of tools and the furnishing of a place to work to the individual who performs the services. In general, if an individual is subject to the control or direction of another merely as to the result to be accomplished by the work and not as to the means and methods for accomplishing the result, he is not an employee.

Accordingly, a leased employee (as defined in Code § 414(n)(2)), a sole proprietor, a partner in a partnership, a worker described in Code §3508 (that is, real estate agents and direct sellers), or a 2-percent S corporation shareholder are not common-law employees.

Also, you do not have to count veterans as employees for any month in which a veteran has medical coverage provided by TRICARE or under certain other limited Veterans Affairs (VA) medical programs. This exemption is effective for months starting on or after January 1, 2014.
12. We employ about 40 full-time employees working 120 or more hours per month and about 25 part-time employees and seasonal workers. So we are not subject to the employer mandate penalties, right?

You may be. The health reform law does not require you to provide coverage for employees working on average less than 30 hours per week (“part-time”). However, the hours worked by part time employees are counted to determine whether you have at least 50 full-time employee equivalents and therefore are subject to the employer mandate. This is done by taking the total number of monthly hours worked by part time employees (but not to exceed 120 hours for any one part-time employee) and dividing by 120 to get the number of “full time equivalent” employees. You would then add those “full-time equivalent” employees to your 40 full-time employees.

The hours worked by seasonal workers are also counted to determine whether you have at least 50 full-time employee equivalents and therefore are subject to the employer mandate. For purposes of determining whether you are a large employer, seasonal workers are workers who perform labor or services on a seasonal basis (i.e. exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year). There is an exemption from the employer mandate that says you would not be considered to employ more than 50 full-time employees if:

- Your workforce only exceeds 50 full-time employees for 120 days, or fewer, during the calendar year; and
- The employees in excess of 50 who were employed during that 120-day (or fewer) period were seasonal workers.

13. Our workforce numbers go up and down during the year. How do we determine if we had at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year?

For purposes of determining if you are a large employer, the formula requires the following steps:

1. Determine the total number of full-time employees working at least 120 hours per month (including any full-time seasonal workers) for each calendar month in the preceding calendar year;

2. Determine the total number of full-time equivalents (including non-full-time seasonal employees) for each calendar month in the preceding calendar year;

3. Add the number of full-time employees and full-time equivalents described in Steps 1 and 2 above for each month of the calendar year;

4. Add up the 12 monthly numbers;

5. Divide by 12.

If the average per month is 50 or more, you are a large employer.
For 2015 only, there is a special transition rule that gives you the option to do the above calculation based on any 6 consecutive calendar months in 2014 (rather than the entire 2014 calendar year).

Note: The employer mandate has been delayed until January 1, 2015 for employers with 100 or more full-time employees and until January 1, 2016 for large employers with between 50 and 99 full-time employees who met certain criteria.

14. We are a subsidiary of a parent corporation with only 30 full-time employees. Are we exempt from the employer mandate?

In order to determine if the members of your controlled group constitute a large employer, you will have to count all the employees of the controlled group or affiliated service group together.

If the total for all the related employers within the controlled group is at least 50 full time employees, then each separate company, including those companies that individually do not employ enough employees to meet the threshold, is considered a large employer subject to the employer mandate. For example, if an applicable large employer is comprised of a parent corporation and 10 wholly owned subsidiary corporations, each of the 11 corporations, regardless of the number of employees, is considered a large employer.

15. If we are a large employer and don’t offer coverage to any full-time employee, how do we calculate the penalty?

If you don’t offer coverage to your full-time employees (and their dependents), you are subject to an employer shared responsibility penalty if at least one of your full-time employees purchases coverage at a Marketplace exchange with premium tax credits. Employees eligible for a premium tax credit are those whose household income is between 100% (133% in states that expanded Medicaid) and 400% of the federal poverty level and who are not eligible for employer-sponsored coverage that is affordable and meets minimum value. The monthly penalty you would have to pay would be 1/12 of $2,000 (this amount will be adjusted annually for inflation) multiplied by the number of full-time employees you have for that month (minus the first 30). The annual penalty of $2,000 is indexed each year as follows:

1. $2,080 for 2015.
3. $2,260 for 2017 (proposed)

Under a transition rule for 2015 for employers with 100 or more full-time employees (including full-time equivalents), the monthly penalty calculation would be 1/12 of $2,080 (indexed annually) multiplied by the number of full-time employees you have for that month minus the first 80 (instead of the first 30).
16. We are a large employer that offers coverage to our full-time employees except for a certain class of full-time employees. In that case, how do we calculate the penalty?

If you offer coverage to less than 95% of your full-time employees and their dependents, you are subject to an employer shared responsibility penalty if at least one of your full-time employees purchases coverage at a Marketplace exchange with premium tax credits. The monthly penalty you would have to pay would be 1/12 of $2,000 (indexed annually) multiplied by the number of full-time employees you have for that month (minus the first 30).

Under a transition rule, for your 2015 plan year and any months in 2016 that are within your 2015 plan year, you will only be required to offer coverage to 70% or more of your full-time employees (rather than 95%) if you did not modify your plan year start date after February 9, 2014 to begin on a later calendar date (for example, changing the start date of the plan year from January 1 to December 1). In addition, for employers with 100 or more full-time employees (including full-time equivalents), if you offer coverage to less than 70% of your full-time employees, the monthly penalty calculation for 2015 would be 1/12 of $2,080 (indexed annually) multiplied by the number of full-time employees you have for that month minus the first 80 (instead of the first 30).

17. So if we offer coverage to our full-time employees, will we be exempt from the employer mandate penalties?

Not necessarily. If you have at least 50 full-time employees and you offer coverage to at least 95% (70% for the 2015 plan year if certain criteria are met) of your full-time employees, you are still subject to a penalty if:

1. A full-time employee’s contribution for employee-only coverage exceeds 9.5% of the employee’s household income (note: see below regarding three affordability “safe harbors”) or the plan’s value is less than 60%; and

2. The employee’s household income is less than 400% of the federal poverty level; and

3. The employee waives your coverage and purchases coverage at a Marketplace exchange with premium tax credits.

The penalty will be calculated separately for each month in which the above applies. The amount of the penalty for a given month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. This amount will be adjusted annually for inflation. The annual penalty of $3,000 is indexed each year as follows:

1. $3,120 for 2015.
2. $3,240 for 2016.
3. $3,390 for 2017 (proposed)
18. If our employee qualifies for tax credits with respect to one of his dependent children, will we be liable for a penalty?

No. An employee’s receipt of a premium tax credit or cost sharing reduction with respect to coverage for a dependent will not result in liability for you.

19. Our plan year starts on July 1 every year. Does the employer mandate apply to us on January 1, 2015 or does it start on July 1, 2015?

The employer shared responsibility mandate is generally effective on January 1, 2015. However, transition rules apply that may delay the assessment of penalties until the first day of your first plan year that starts on or after January 1, 2015. The transition rules say that if 1) you maintained a non-calendar year plan as of December 27, 2012; 2) your plan year was not modified after December 27, 2012 to begin at a later calendar date; 3) at least 95% (70% if certain criteria as described above are met) of your full-time employees are offered coverage no later than that first day of the plan year that starts in 2015; and 4) your employees would not be eligible for coverage under any other of your group health plans that has a calendar year plan year, penalties will not be assessed for the months prior to the first day of the plan year that starts in 2015 for:

A. Any employee (whenever hired) that would be eligible for coverage, as of the first day of the first plan year that begins in 2015 under the eligibility terms of the plan as in effect on February 9, 2014; and

B. Any other employees that are not eligible under the terms of the plan in effect on February 9, 2014 if:

i. your non-calendar year plan covered at least one quarter of your employees (full-time and part-time) as of any date in the 12 months ending on February 9, 2014 or your plan offered coverage to at least one third of your employees (full-time and part-time) during the open enrollment period that ended most recently before February 9, 2014; OR

ii. your non-calendar year plan covered at least one third of your full-time employees as of any date in the 12 months ending on February 9, 2014 or your plan offered coverage to one half or more of your full-time employees during the open enrollment period that ended most recently before February 9, 2014.

Therefore, if the four criteria described above are met, for any of your employees who are eligible to participate in the plan under its terms as of February 9, 2014 (whether or not they take the coverage), you will not be subject to a penalty for those employees until July 1, 2015 if they are offered affordable coverage that provides minimum value no later than July 1, 2015.

For any other of your employees that were not eligible to participate under the terms of the plan in effect on February 9, 2014, you can avoid liability for a penalty for those non-eligible employees until July 1, 2015 if they are offered affordable, minimum value coverage on July 1, 2015 and:
1. Your plan covered at least one quarter of all your full-time and part-time employees as of any date in the 12 months ending on February 9, 2014 or offered coverage under your non-calendar year plan to at least one third of your full-time and part-time employees during the open enrollment period for your July 1, 2013 renewal; OR

2. Your plan covered at least one third of your full-time employees as of any date in the 12 months ending on February 9, 2014 or offered coverage to one half or more of your full-time employees during the open enrollment period for your July 1, 2013 renewal.

20. As the parent corporation of several subsidiary corporations, do the transitions rules described above apply on a controlled group basis or do they apply separately to each member of our controlled group?

The transition rules generally are applied separately to each member company of your controlled group in determining eligibility for the transition relief.

Example – A parent corporation sponsors a single health plan that is also available to two additional controlled group members. The parent corporation and controlled group member 1 independently qualify for the transition relief; however, controlled group member 2 does not qualify for the transition relief. Controlled group member 2 would be subject to the affordability and minimum value requirements on January 1, 2015 while the parent corporation and controlled group member 1 could wait until the first day of the 2015 plan year to comply.

21. We have more than 50 full-time employees so we are subject to the employer mandate penalties. How do we know which of our employees is considered “full-time” requiring us to pay a penalty if they qualify for premium tax credits at an exchange (if the employee has a variable work schedule or is seasonal)?

For purposes of the employer mandate penalties, the guidance permits you to use two methods to determine if an employee is a full time employee. The first is a “look-back measurement period/stability period” method where you may use a standard measurement/stability period for ongoing variable hour employees, while using a different initial measurement/stability period for new variable hour and seasonal employees. The second method is the “monthly” method where full-time employee status is determined on a month-to-month basis.

22. If we use the look-back measurement period/stability period method, how long can the measurement and stability periods be?

For ongoing employees, the standard measurement period must be at least 3 but not more than 12 consecutive months. The stability period for employees that are determined to be full-time must be the greater of six consecutive calendar months or the length of the standard measurement period. If an employee did not work full time, the stability period cannot be longer than the standard measurement period.
23. If we use a measurement/stability period safe harbor, which hours do we have to count when calculating the number of hours worked in the measurement period?

For hourly employees, you must calculate actual hours of service 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.

For non-hourly employees, you are permitted to calculate the number of hours of service using one of three methods. You may apply different methods for different classifications of non-hourly employees, so long as the classifications are reasonable and consistently applied. The three methods are:

1. Counting actual hours of service (as in the case of hourly employees) 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; or

2. Using a days-worked equivalency method whereby the employee is credited with eight hours of service for each day the employee is credited with at least one hour of service (including hours of service for which no services were performed); or

3. Using a weeks-worked equivalency of 40 hours of service per week for each week, the employee is credited with at least one hour of service (including hours of service for which no services were performed).

However, you cannot use the days-worked or weeks-worked equivalency method if the result would be to substantially understate an employee’s hours of service (e.g. employees working three 10-hour days).

24. Do we have to calculate hours of service for payments made to an employee under a short or long-term disability plan?

Periods during which an employee is receiving payments due to short-term disability or long-term disability do result in hours of service for any part of the period during which the recipient remains an employee of the employer, unless the payments are made from an arrangement to which the employee paid the full cost of the coverage and the employer did not contribute directly or indirectly. For this purpose, a disability arrangement for which the employee paid the full cost of the coverage with after-tax contributions (so that the benefits received under the arrangement are excluded from income) would be treated as an arrangement to which the employer did not contribute, and payments from the arrangement would not result in hours of service.

25. Do we have to calculate hours of service for payments made to an employee as a result of workmen’s compensation, or unemployment or state temporary disability insurance laws?

No. An hour of service does not include an hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a payment made or due under a plan maintained solely for the purpose of complying with applicable workmen’s compensation, or unemployment or state temporary disability insurance laws.
26. We have full-time employees that work outside the U.S. Do their hours have to be counted when determining if they are full-time employees?

No. Hours worked outside the United States do not have to be counted.

27. Do we have to use the same method of counting hours for all of our non-hourly employees?

No. You are not required to use the same method of calculating a non-hourly employee’s hours of service for all non-hourly employees, and may apply different methods of calculating a non-hourly employee’s hours of service for different categories of non-hourly employees, provided that the categories are reasonable and consistently applied.

You may also change the method of calculating a non-hourly employee’s hours of service for one or more categories of non-hourly employees for each calendar year.

28. If we use a measurement/stability period safe harbor for our variable hour employees, is there a formula we can use to determine whether they worked 30 or more hours per week during the measurement period?

Employees would be deemed to be full-time employees if they work on average at least 130 hours per month. For example, using a 12-month measurement period you would count up the number of hours worked in those 12 months and divide by 12. If the hours worked per month averages 130 or more, that employee would be a full-time employee for the ensuing stability period.

29. For our school district plan, can we use a 12-month measurement period by counting only the hours of service that were incurred during the school year (and no hours for the summer break)?

No. For employees of educational institutions, a 12-month measurement period is permitted but a special averaging rule applies that says for employment break periods (e.g. summer break) of four or more consecutive weeks, you must either:

1. Determine the average hours of service per week for the employee during the measurement period excluding the employment break period and use that average as the average for the entire measurement period; or

2. Credit the employee with hours of service for the employment break period at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not part of an employment break period (but no more than 501 hours of service are required to be credited).

Also, you cannot treat your employees who work during the active portions of the academic year as seasonal employees.
30. We generally do not track the full hours of service of our adjunct faculty, but instead compensate them on the basis of credit hours taught. How should we count hours of service for our adjunct faculty?

You must use a reasonable method for crediting hours of service that is consistent with the purposes of the employer mandate. For example, a method of crediting hours would be reasonable if it took into account all of your adjunct professor’s hours of service including classroom or other instruction time and other hours that are necessary to perform the employee’s duties, such as class preparation time, faculty meetings, or office hours.

Until further guidance is issued, one method that is reasonable for this purpose would credit an adjunct faculty member of an institution of higher education with (a) 2 1/4 hours of service (representing a combination of teaching or classroom time and time performing related tasks such as class preparation and grading of examinations or papers) per week for each hour of teaching or classroom time, and separately, (b) an hour of service per week for each additional hour outside of the classroom the faculty member spends performing duties he or she is required to perform (such as required office hours or required attendance at faculty meetings).

For example, assume an adjunct professor teaches a course load of twelve credit hours and is required to hold office hours for 2 hours per week and attend a one-hour faculty meeting each week. Under the method above, the university would credit the adjunct professor with 27 hours of service per week (12 x 2.25) for teaching time, an additional 2 hours per week for the office hours, and 1 hour for the faculty meeting. This would result in a total credit of 30 hours of service per week, and the adjunct would be a full-time employee for purposes of PPACA.

31. As an educational organization, we frequently employ students. Do their hours have to be counted?

It will depend on the situation. The hours of students in positions subsidized through the federal work study program or a substantially similar program of a State or political subdivision do not have to be counted. However, all hours of service for which a student employee is paid or entitled to payment in a capacity other than through the federal work study program (or a State or local government’s equivalent) are required to be counted as hours of service.

32. Do we have to count the hours of our unpaid interns?

No. Services performed by an intern do not count as hours of service to the extent that the intern does not receive, and is not entitled to, payment in connection with those hours.

However, hours of service for which interns receive, or are entitled to receive, compensation are counted and are subject to the general rules, including the option to use the look-back measurement or monthly method for determining full-time employee status.
33. How do we count hours when an employee works for more than one employer member of our controlled group?

In determining hours of service and status as a full-time employee, you must combine all the hours of service for all of the employer members of the controlled group.

In cases where a full-time employee works for more than one member of your controlled group, the full-time employee is treated as the employee of the employer member for whom the employee had the greatest number of hours of service for the calendar month. If the full-time employee works an equal number of hours for two or more members of your controlled group, the employer members have discretion to designate who the employee worked for during the calendar month.

34. Our city has a volunteer fire department and other volunteer positions where the volunteers are nominally paid for their expenses or may receive cash awards. Do we have to count their hours?

No. Hours of service do not include hours worked as a “bona fide volunteer.” Bona fide volunteers include any volunteer (including a volunteer firefighter) who is an employee of a government entity or an organization described in section 501(c) that is exempt from taxation under section 501(a) whose only compensation from that entity or organization is in the form of (i) reimbursement for (or reasonable allowance for) reasonable expenses incurred in the performance of services by volunteers, or (ii) reasonable benefits (including length of service awards), and nominal fees, customarily paid by similar entities in connection with the performance of services by volunteers.

35. Do our members of a religious order have to be treated as full-time employees of their orders?

There are no special rules for members of a religious order but until further guidance is issued, you do not have to count as an hour of service any work performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

36. Do we have to count hours that an employee is on-call when determining if they are full-time employees?

It will depend on the situation. Generally, you will be required to use one of the reasonable methods for crediting hours of service for any on-call hour for which payment is made or due, for which the employee is required to remain on-call on your premises, or for which the employee’s activities while remaining on-call are subject to substantial restrictions that prevent the employee from using the time effectively for the employee’s own purposes.
37. If an employee takes an unpaid FMLA leave or goes on unpaid military leave during their measurement period, how do we account for that time upon their return to work?

For periods of special unpaid leave including under FMLA, USERRA or on account of jury duty, you must determine the average hours of service per week for the employee during the measurement period – excluding the special unpaid leave period – and use that average as the average for the entire measurement period. Alternatively, you can choose to credit employees with hours of service during the leave at a rate equal to the employee’s average weekly rate during the weeks in the measurement period that were not special unpaid leave.

The rule for special unpaid leave does **not** apply if you are using the monthly method to determine full-time employee status.

38. So, if an employee meets the 30 hours per week requirement over the measurement period, do we need to enroll them the day after the measurement period ends?

For ongoing employees, you can build in an “administrative period” after the measurement period ends and before the associated stability period begins. This administrative period can’t reduce or lengthen the measurement period or the stability period; it can’t be longer than 90 days; and it must overlap with the prior stability period; so that, during the administrative period, you continue to offer coverage to ongoing employees until the new stability period begins.

For new variable or seasonal employees, you can build in an administrative period before the start of the stability period. This administrative period must not exceed 90 days in total. For this purpose, the administrative period is counted from the date of hire to the date the employee is first offered coverage under your group health plan, other than the initial measurement period. Thus, for example, if you begin the initial measurement period on the first day of the first month following the employee’s start date, the period between the employee’s start date and the first day of the next month must be taken into account in applying the 90-day limit on the administrative period. Similarly, if there is a period between the end of the initial measurement period and the date the employee is first offered coverage under your plan, that period must be taken into account in applying the 90-day limit on the administrative period.

In addition, you are limited in how long the initial measurement period and the administrative period combined can be for a new variable or seasonal employee. Specifically, your initial measurement period and administrative period together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee’s start date. For example, if you use a 12-month initial measurement period for a new variable hour employee, and begin that initial measurement period on the first day of the first calendar month following the employee’s start date, then the administrative period before coverage starts cannot be longer than one month, assuming, of course, the employee met the full-time hours requirement during the initial measurement period.
39. How does the full-time employee safe harbor work for ongoing employees?

For ongoing employees with variable hours, you have the option to determine each ongoing employee’s full-time status by looking back at a standard measurement period between 3 and 12 consecutive calendar months (as chosen by you). You can choose the months in which the standard measurement period starts and ends, provided that you are uniform and consistent in applying it for all employees in the same category. (See below in this section for permissible categories.) For example, if you chose a standard measurement period of 12 months, it could be the calendar year, a non-calendar plan year, or a different 12-month period, such as one that ends shortly before the start of the plan’s annual open enrollment season. If you determine that an employee averaged at least 30 hours per week during the standard measurement period, then you must treat the employee as a full-time employee during a subsequent “stability period”, regardless of the employee’s number of hours of service during the stability period, so long as he or she remained an employee. The stability period would have to be at least six consecutive calendar months and no shorter than the standard measurement period. If you determine that the employee did not work full-time during the standard measurement period, you would not have to treat the employee as a full-time employee during the stability period that follows and you would not incur an employer mandated penalty.

Example – Facts: You choose a 12-month stability period that begins January 1 and a 12-month standard measurement period that begins October 15. Consistent with the terms of your group health plan, only an ongoing employee who works full-time (an average of at least 30 hours per week) during the standard measurement period is offered coverage during the stability period associated with that measurement period. You also choose to use an administrative period between the end of the standard measurement period (October 14) and the beginning of the stability period (January 1) to determine which employees worked full-time during the measurement period, notify them of their eligibility and of the coverage available under the plan for the calendar year beginning on January 1, 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 until January 1.

Situation: Phil and Cara have been employees for several years, continuously from their start date. Phil worked full-time during the standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2 and for all prior standard measurement periods. Cara also worked full-time for all prior standard measurement periods, but is not a full-time employee during the standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2.

Conclusions: Because Phil was employed for the entire standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2, he is an ongoing employee with respect to the stability period running from January 1 through December 31 of Year 3. Because Phil worked full-time during that standard measurement period, he must be offered coverage for the entire Year 3 stability period (including the administrative period from October 15 through December 31 of Year 3). Because Phil worked full-time during the prior standard measurement period, he would have been offered coverage for the entire Year 2 stability period,
and if enrolled would continue such coverage during the administrative period from October 15 through December 31 of Year 2.

Because Cara was employed for the entire standard measurement period that begins October 15 of Year 1 and ends October 14 of Year 2, Cara is also an ongoing employee with respect to the stability period in Year 3. Because Cara did not work full-time during this standard measurement period, she is not required to be offered coverage for the stability period in Year 3 (including the administrative period from October 15 through December 31 of Year 3). However, because Cara worked full-time during the prior standard measurement period, she would be offered coverage through the end of the Year 2 stability period, and if enrolled would continue such coverage during the administrative period from October 15 through December 31 of Year 2.

In this example, you would comply with the standards because your 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 not longer than the standard measurement period; and the administrative period is not longer than 90 days.

Phil:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Measurement Period</td>
<td>Oct 15, Year 1-Oct 14, Year 2</td>
<td>Phil averages 30 hpw</td>
</tr>
<tr>
<td>Administrative Period</td>
<td>Oct 15-Dec 31, Year 2</td>
<td></td>
</tr>
<tr>
<td>Stability Period</td>
<td>Jan 1, Year 2-Dec 31, Year 2</td>
<td>Phil continues coverage for Year 2, including Admin Period</td>
</tr>
<tr>
<td>Stability Period</td>
<td>Jan 1, Year 3-Dec 31, Year 3</td>
<td>Phil offered coverage for all of Year 3, including Admin Period</td>
</tr>
</tbody>
</table>

Cara:

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Measurement Period</td>
<td>Oct 15, Year 1-Oct 14, Year 2</td>
<td>Cara averages less than 30 hpw</td>
</tr>
<tr>
<td>Administrative Period</td>
<td>Oct 15-Dec 31, Year 2</td>
<td>Cara’s coverage terminates on Dec 31</td>
</tr>
<tr>
<td>Stability Period</td>
<td>Jan 1, Year 2-Dec 31, Year 2</td>
<td>Cara continues coverage for Year 2, including Admin Period</td>
</tr>
<tr>
<td>Stability Period</td>
<td>Jan 1, Year 3-Dec 31, Year 3</td>
<td>Cara not offered coverage for Year 3, including Admin Period</td>
</tr>
</tbody>
</table>
40. How are new employees classified?

New hires are generally classified based on the employee’s hours worked, or, the amount of hours the employee is reasonably expected to work as of their hire date.

- **New employee reasonably expected to work full-time (i.e. 30 or more hours per week)** - If you reasonably expect an employee to work full-time when you hire them, and coverage is offered to the employee before the end of the employee’s initial 90 days of employment, you will not be subject to the employer mandate payment for that employee, if the coverage is affordable and meets the minimum required value.

- **New employee reasonably expected to work part-time (i.e. less than 30 hours per week)** - If you reasonably expect an employee to work part-time and the employee’s number of hours do not vary, you will not be subject to the employer mandate penalty for that employee if you don’t offer them coverage.

- **New variable hour and seasonal employees** – If based on the facts and circumstances at the date the employee begins working (the start date), you cannot determine that the employee is reasonably expected to work on average at least 30 hours per week, then that employee is a variable hour employee. A “seasonal employee” is defined for purposes of the employer mandate as an employee who is hired into a position for which the “customary” annual employment is six months or less. Customary means that by the nature of the position an employee typically works for a period of six months or less, and that period should begin each calendar year in approximately the same part of the year, such as summer or winter.

Factors to consider in determining if a new hire is or is not a full-time employee as of their start date include, but are not limited to, whether the employee is replacing an employee who was or was not a full-time employee, the extent to which employees in the same or comparable positions are or are not full-time employees, and whether the job was advertised, or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description), as requiring hours of service that would average 30 (or more) hours of service per week or less than 30 hours of service per week.

41. If we use the look-back measurement period/stability period method for new variable hour, part-time, or seasonal employees, how long can the initial measurement and stability periods be?

Once hired, you have the option to determine whether a new variable hour, part-time, or seasonal employee is a full-time employee using an “initial measurement period” of between three and 12 months (as selected by you). You would measure the hours of service completed by the new employee during the initial measurement period to determine whether the employee worked an average of 30 hours per week or more during this period. If the employee did work at least 30 hours per week during the measurement period, then the employee would be treated as a full-time employee during a subsequent “stability period,” regardless of the employee’s number of hours of service during the stability period, so long as he or she remains an employee. The stability period must be a period that is the same length as the
stability period for ongoing employees, must be for at least six consecutive calendar months, and cannot be shorter than the initial measurement period. If the employee didn’t work on average at least 30 hours per week during the measurement period, you would not have to treat the employee as a full-time employee during the stability period that followed the measurement period. That stability period could not be more than one month longer than the initial measurement period and must not exceed the remainder of the first entire standard measurement period (plus any associated administrative period) for which a variable hour employee, seasonal employee, or part-time employee has been employed.

**Example – Facts:** For new variable hour employees under a calendar year plan, you use a 12-month initial measurement period that begins on the start date and apply 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.

**Situation:** Dianna is hired on May 10, 2015. Dianna’s initial measurement period runs from May 10, 2015, through May 9, 2016. Dianna works an average of 30 hours per week during this initial measurement period. You offer affordable coverage to Dianna for a stability period that runs from July 1, 2016 through June 30, 2017.

**Conclusion:** Dianna worked an average of 30 hours per week during her initial measurement period and you had: (1) an initial measurement period that does not exceed 12 months; (2) an administrative period totaling not more than 90 days; and (3) 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 Dianna’s start date. Accordingly, from Dianna’s start date through June 30, 2017, you are not subject to an employer mandate penalty with respect to Dianna because you complied with the standards for the initial measurement period and stability periods for a new variable hour employee. However, you must test Dianna again based on the period from October 15, 2015 through October 14, 2016 (your first standard measurement period that begins after Dianna’s start date) to see if she qualifies to continue coverage beyond the initial stability period.
42. Do we have to make the measurement period and stability period the same for all employees?

No. You may use measurement periods and stability periods that differ either in length or in their starting and ending dates for the following categories of employees:

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

43. At what point would we stop using the initial measurement/stability period and transition an employee to ongoing status?

Once a new employee, who has been employed for an initial measurement period, 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.

**Example:** If you have a calendar year standard measurement period that also uses a one-year initial measurement period beginning on the employee’s start date, you would test a new variable hour employee whose start date is February 12 for full-time status first based on the initial measurement period (February 12 through February 11 of the following year) and again based on the calendar year standard measurement period (if the employee continues in employment for that entire standard measurement period) beginning on January 1 of the year after the start date.

If you determine the employee is a full-time employee during the initial measurement period or standard measurement period, then he or she must be treated as a full-time employee for the entire associated stability period. This is the case even if the employee is determined to be a full-time employee during the initial measurement period but determined not to be a full-time employee during the overlapping or immediately following standard measurement period. In that case, you may treat the employee as a part-time employee only after the end of the stability period associated with the initial measurement period. Thereafter, the employee’s full-time status would be determined in the same manner as that of other ongoing employees.

In contrast, if you determine the employee is not a full-time employee during the initial measurement period, but IS determined to be a full-time employee during the overlapping or immediately following standard measurement period, you must treat the employee as a full-time employee for the entire stability period that corresponds to that standard measurement period (even if that stability period begins before the end of the stability period associated with the initial measurement period). Thereafter, the employee’s full-time status would be determined in the same manner as that of other ongoing employees.
44. How is a new full-time employee’s status determined for the months before the employee has worked one full standard measurement period?

The employee’s status as a full-time employee for that period is based on the employee’s hours of service for each calendar month. If the employee’s hours of service for the calendar month equal or exceed an average of 30 hours of service per week, the employee is a full-time employee for that calendar month. Once the new employee has worked one full standard measurement period and becomes an ongoing employee, their status as a full-time employee will be determined based on their average hours of service under that standard measurement period.

45. We intend to adopt a 12-month measurement period and a 12-month stability period but are facing time constraints in getting our systems set up in order to be ready to enroll full-time employees on January 1, 2015. Are there any other options?

Yes. Solely for purposes of stability periods beginning in 2015, you may adopt a transition measurement period that is shorter than 12 months but that is no less than 6 months long and that begins no later than July 1, 2014 and ends no earlier than 90-days before the first day of the plan year beginning on or after January 1, 2015 (90 days being the maximum permissible administrative period). For example, you could use a measurement period from April 15, 2014 through October 14, 2014 (six months), followed by an administrative period ending on December 31, 2014 with a 12-month stability period starting on January 1, 2015.

46. Can we change the timing or duration of our standard measurement and stability periods?

You may change your standard measurement period and stability period for subsequent years, but you may not change them once the standard measurement period has begun.

47. If one of our new variable hour, part-time, or seasonal employees is promoted to a permanent full-time position during their initial measurement period, how should their eligibility for coverage be treated?

For a new variable hour, part-time, or seasonal employee who changed employment status to full-time during their initial measurement period, you should treat her as a full-time employee on the earlier of:

1. The first day of the fourth month following the change in employment status; or

2. If the employee averages 30 or more hours of service per week during the initial measurement period, the first day of the initial stability period that would have applied had the employee not had a change in employment status.

48. What happens if the change in employment status occurs during a stability period?

An ongoing employee’s change in employment status during his or her stability period would not affect the employee’s status as a full-time employee or non full-time employee for the remainder of that stability period.
49. What happens if an employee fails to make a timely contribution (e.g., tipped employees, reduced work schedules, and leaves of absence) during the stability period?

If your employee’s payment is late, you must provide the employee with a 30-day grace period in order to make the payment. If your employee does not make the payment within the grace period, you are not required to provide coverage for the period for which the premium is not timely paid and may terminate coverage. In addition, you are treated as having offered that employee coverage for the remainder of the coverage period (typically the remainder of the plan year) and cannot be penalized for terminating coverage if the premium is not paid. Similarly, if the employee makes a partial payment that is "not significantly less" than the total amount due (the lesser of 10% of what is due or $50), you must either accept the deficient payment as payment in full or notify the employee in writing of the underpayment and give the employee a reasonable amount of time to pay the remaining balance.

50. If an employee reduces their hours during their stability period and wants to terminate their coverage, can we let them do so?

At your discretion, you may choose to amend your §125 cafeteria plan to allow an employee to prospectively revoke coverage under your plan provided the following conditions are met:

- The employee was reasonably expected to average at least 30 hours of service per week and there is a change in that employee’s status so that the employee will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the employee losing eligibility under the group health plan (this may occur, for example, if a full-time employee is in a stability period); and
- The employee’s election to revoke your group health plan corresponds to the employee’s intended enrollment (and any covered dependents), in another plan that provides minimum essential coverage (MEC). The new coverage must be effective no later than the first day of the second month following the month that includes the date your coverage is revoked. For example, if the employee revokes coverage effective on May 31st, they must intend to enroll in any other minimum essential coverage that is effective no later than July 1st. You may rely on a certification from the employee that the employee and related individuals have enrolled or intend to enroll in new MEC coverage by the required deadline.

To allow these new permitted election changes, you must amend your §125 cafeteria plan. You must adopt the amendment on or before the last day of the plan year in which you allow the new election changes and you must inform participants of the plan amendment. For your plan year that starts in 2014, you may amend your plan to adopt the new permitted election changes at any time on or before the last day of the plan year that begins in 2015.

Please note: These new events do not apply to an employee’s health FSA elections. The employee cannot be allowed to also revoke or change their Health FSA election.
Also, you should verify that your insurer or stop loss insurer will allow employees to make a mid-year election change to drop the coverage under these circumstances.

51. We frequently have variable hour employees whose contracts are terminated and then they are rehired at a later date. Can we treat them as new employees and start the measurement period over again for purposes of determining if they are a full-time employee?

It will depend on the length of the non-employment period. If the period of non-employment is at least 13 weeks (26 weeks for employees of educational organization), you may treat the rehired employee as a new employee.

You can also use the “rule of parity” that says an employee may be treated as a new employee if the period of non-employment of less than 13 weeks (for an employee of an educational organization employer, a period that is shorter than 26 weeks) is at least four weeks long and is longer than the employee’s period of employment immediately preceding the period of non-employment. For example, if an employee works six weeks, terminates employment, and is rehired ten weeks later, that rehired employee is treated as a new employee because the ten-week period of non-employment is longer than the immediately preceding six-week period of employment.

52. What happens if the break in service is less than 13 weeks (26 weeks for an educational organization) and the “rule of parity” does not apply?

For employees that are treated as continuing employees (as opposed to an employee who is treated as terminated and rehired), the measurement and stability period that would have applied to the employee had the employee not experienced the period of non-employment would continue to apply upon the employee’s resumption of service. For example, if the continuing employee returns during a stability period in which the employee is treated as a full-time employee, the employee is treated as a full-time employee upon return and through the end of that stability period and must be offered coverage again as of the first day that employee is credited with an hour of service, or, if later, as soon as administratively practicable. For this purpose, offering coverage by no later than the first day of the calendar month following resumption of services is deemed to be as soon as administratively practicable.

53. If we transfer an employee out of the U.S., is that considered a termination of employment?

You may treat an employee as having terminated employment if the employee transfers to a position outside the U.S. if the position is anticipated to continue indefinitely or for at least 12 months and if substantially all of the employee’s compensation will constitute income from sources outside the United States.

54. What if we bring an employee into the US from one of our foreign locations?

You may treat an employee transferring to the US from a position outside the U.S. (with compensation from sources outside the U.S.) as a new hire. However, if the employee previously had hours of service at your U.S. location, then the rules related
to rehired employees would apply (i.e. breaks in service of more or less than 13 weeks).

55. When we have large projects to complete, we occasionally hire temporary employees who may be hired to work a 40-hour per week schedule when initially employed, but may not work at least 30 hours per week thereafter. How should we classify them in order to determine if we should be offering them coverage?

A new non-seasonal employee that is expected to be employed initially at least 30 hours per week can be classified as a variable hour employee if, based on the facts and circumstances at the start date, the period of employment at more than 30 hours per week is reasonably expected to be of limited duration and it cannot be determined that the employee is reasonably expected to be employed on average at least 30 hours per week over your entire initial measurement period. **NOTE:** You must assume that the temporary employee will work for the entire duration of the initial measurement period—you may not consider their limited duration to automatically classify them as variable hour.

For example, say you hire an employee to fill in for employees who are absent and to provide additional staffing at peak times. You expect that this employee will average 30 hours of service per week or more for the first few months of employment, while assigned to a specific project, but you also reasonably expect that the assignments will be of unpredictable duration, that there will be periods of unpredictable duration between assignments, that the hours per week required by subsequent assignments will vary, and that the employee will not necessarily be available for all assignments.

In this example, you must assume that the temporary employee will work for the entire duration of the initial measurement period. But because you cannot determine whether this employee is reasonably expected to average at least 30 hours of service per week over the duration of the initial measurement period, you may treat this employee as a variable hour employee.

If the temporary employee is hired as a full-time employee for an indefinite period that is longer than three months, then they should be offered coverage consistent with waiting period rules. A temporary employee who would otherwise be eligible for coverage but has a tenure of under three months generally should not raise issues under the employer mandate, since penalties do not apply until the first day of the fourth month after the individual is hired. If temporary employees are excluded under the terms of the plan, then a temporary employee who is hired to work a full-time schedule and is not offered coverage could result in penalties if that employee were to purchase coverage at a Marketplace with premium tax credits.

56. If we hire temporary workers from a temporary staffing agency for short assignments, will we be required to offer them coverage if they average 30 or more hours per week?

No. Employees of temporary staffing agencies are generally considered common-law employees of the temporary staffing agency. So the staffing agency has the obligation to determine if they are full-time employees of the agency.
57. We occasionally use employees from a PEO or other staffing firm. Are we required to offer them coverage if the PEO or staffing firm is already offering them coverage?

No, if certain conditions are met. If the PEO or staffing firm offers coverage to your employee that is performing services for you as your common-law employee, the PEO or staffing firm’s offer is treated as an offer of coverage made by you if the fee you pay to the PEO or staffing firm for an employee enrolled in the staffing firm’s plan is higher than the fee you would pay to the staffing firm for the same employee if the employee did not enroll in the staffing firm’s plan.

58. If we contract with a school district to provide them with workers for school cafeterias or as bus drivers, do the special averaging rules for educational organizations apply to them?

Yes, in certain circumstances. The special averaging rules would apply to any employee providing services primarily to any educational organizations if a meaningful opportunity to obtain a work assignment during the entire year (to an educational organization or any other type of service recipient) is not made available.

For example, the special averaging rule would apply with respect to your employee who is placed as a bus driver or cafeteria worker if they are not provided a meaningful opportunity to obtain a work assignment during one or more months of the calendar year (for example, during the summer recess period). In contrast, the special averaging rules would not apply to your employee if the employee is offered a meaningful opportunity to obtain a work assignment during all months of the year (for example, in the case of a school cafeteria worker, by working at a hospital cafeteria during the school’s summer recess period).

59. As a home care agency, we do not generally direct and control our workers. Do we have to count them as full-time employees for either determining if we are a large employer or for offering coverage?

Each case will have to be evaluated to determine whether you or the service recipient is the common law employer of the provider. If the service recipient has the right to direct and control the home care provider as to how they perform the services, including the ability to choose the home care provider, select the services to be performed, and set the hours of the home care provider, these facts would indicate that the service recipient may be the employer under the common law standard rather than your agency. In that case, you would not be subject to penalties with respect to that particular provider.

60. We are an agricultural operation that frequently employees workers with H-2A and H-2B visas. Are these workers counted as employees for purposes of the employer mandate?

Yes. There are no special rules for H-2A or H-2B workers though in many cases they can be classified as seasonal employees and thus would be subject to your measurement method.
61. If we elect not to use the look-back measurement method to determine our employee’s status, is there any other method we can use?

There is another method that is referred to as the "monthly method." Under the monthly method, the determination of the employee’s status is based on hours of service in each month and is not based on averaging over a prior period. However, IRS representatives have informally indicated that this method was intended to be used simply as a method used at the end of the year to determine whether penalties would apply for any months of the year.

62. As a member employer of a controlled group, do we have to use the same method for determining our employee’s status as the other employer members of the controlled group?

No. You may use different measurement methods (the look-back measurement method or the monthly measurement method) and/or different starting and ending dates and lengths of measurement and stability periods.

63. We pay 100% of the employee-only cost but only pay 50% of the family cost. Is our plan considered “affordable”?

Yes. For 2014, your plan would be affordable because the determination of affordability is based on the employee’s required contribution for employee-only coverage. Because your employees pay less than 9.5% of their household income (indexed annually) towards the cost of employee-only coverage, the plan is considered affordable. This is the case even if the employee contribution for family coverage exceeds 9.5% of the employee’s household income.

For years after 2014, the affordability threshold is indexed as follows:

- 9.56% for 2015
- 9.66% for 2016
- 9.69% for 2017

64. If we decide to implement an employee contribution for employee-only coverage, how will we know if the contribution exceeds 9.5% (indexed annually) of the employee’s household income?

If you offer minimum value coverage to your full-time employees and their dependents, there are three affordability “safe harbors” that will allow you to easily determine if the cost of your group health plan is affordable. The three safe harbors are:

1. **Form W-2 safe harbor**— If you offer full-time employees and their dependent children the opportunity to enroll in your plan, you can compare the employee contribution of self-only coverage for your lowest cost plan that meets the minimum value against the employee’s current W-2 wages as reported in box 1 of Form W-2. If the cost of the coverage for self-only coverage does not exceed 9.5% (9.56% for 2015, 9.66% for 2016, and 9.69% for 2017) of the employee’s wages as described above, the coverage is affordable. Application of this safe harbor is determined after the end of the calendar year on an employee-by-employee basis, taking into account the Form W-2 wages and the required
employee contribution for that year. In addition, to qualify for this safe harbor, the employee’s required contribution must remain a consistent amount or percentage of all Form W-2 wages during the calendar year (or during the plan year for plans with non-calendar year plan years) so that you are not permitted to make discretionary adjustments to the required employee contribution for a pay period.

2. **Rate of pay safe harbor** – For hourly employees, you would on a monthly basis (1) take the lower of the employee’s hourly rate of pay as of the first day of the coverage period (generally the first day of the plan year) or the employee’s lowest hourly rate of pay during the calendar month, (2) multiply that rate by 130 hours per month, and (3) determine affordability based on the resulting monthly wage amount. Specifically, the employee’s monthly contribution amount (for the self-only premium of the employer’s lowest cost coverage that provides minimum value) is affordable if it is equal to or lower than 9.5% (9.56% for 2015, 9.66% for 2016, and 9.69% for 2017) of the computed monthly wages (that is, the employee’s applicable hourly rate of pay x 130 hours). For non-hourly employees (e.g. salaried employees), you would compare the employee contribution to the employee’s monthly salary as of the first day of the coverage period. This safe harbor cannot be used for non-hourly employees if the monthly compensation is reduced, including due to a reduction in work hours.

3. **Federal poverty line safe harbor** – Your coverage will be affordable if the employee’s cost for self-only coverage under your plan does not exceed 9.5% (9.56% for 2015, 9.66% for 2016, and 9.69% for 2017) of a monthly amount determined as the federal poverty line for a single individual in the state in which the individual is employed, divided by 12. You are permitted to use the federal poverty line guidelines in effect six months prior to the beginning of the plan year.

You may choose to use one or more of these safe harbors for all of your employees or for any reasonable category of employees, provided you do so on a uniform and consistent basis for all employees in a category. Reasonable categories generally include specified job categories, nature of compensation (for example, salaried or hourly), geographic location, and similar bona fide business criteria.

65. **Some of our employees are paid on a commission-only basis. How should we determine if coverage is affordable for those employees?**

Recognizing that the rate of pay safe harbor cannot be used for employees who are compensated solely on the basis of commissions, the final regulations indicate that you should use the two other affordability safe harbor methods, Form W-2 wages and federal poverty line, for determining affordability for your employees whose compensation is not based on a rate of pay.

66. **We have several employees whose main source of income is tips. How should we determine if coverage is affordable for these employees?**

Similar to commission-only employees, you would have to use either the Form W-2 wages or the federal poverty line affordability safe harbors for determining affordability for employees whose compensation is not based on a rate of pay.
67. If we use the W-2 affordability safe harbor, how do we determine affordability for employees that work only part of the year?

For an employee not offered coverage for an entire calendar year, the Form W-2 safe harbor is applied by adjusting the Form W-2 wages to reflect the period for which coverage was offered, then determining whether the employee’s required contribution for the employer’s lowest cost self-only coverage that provides minimum value, totaled for the periods during which coverage was offered, does not exceed 9.5% (9.56% for 2015, 9.66% for 2016, and 9.69% for 2017) of the adjusted amount of Form W-2 wages.

To adjust Form W-2 wages for this purpose, the Form W-2 wages are multiplied by a fraction equal to the number of calendar months for which coverage was offered over the number of calendar months in the employee’s period of employment during the calendar year.

Example: Cathy is employed from May 15, 2015, through December 31, 2015. In addition, Cathy and her dependents are offered coverage during the period from August 1, 2015, through December 31, 2015. Cathy’s contribution for self-only coverage is $100 per calendar month, or $500 her period of employment. For 2015, Cathy’s Form W-2 wages are $15,000. For purposes of applying the affordability safe harbor, the Form W-2 wages are multiplied by 5/8 (5 calendar months of coverage offered over 8 months of employment during the calendar year). Accordingly, affordability is determined by comparing the adjusted Form W-2 wages ($9,375 or $15,000 x 5/8) to the employee contribution for the period for which coverage was offered ($500).

Conclusion: Because the employee contribution of $500 is less than 9.56% of $9,375 (Cathy’s adjusted Form W-2 wages for 2015), the coverage offered is treated as affordable for 2015 ($500 is 5.33% of $9,375).

68. How are our wellness incentives taken into account when determining if our employee’s contribution for employee-only coverage exceeds 9.5% (9.56% for 2015, 9.66% for 2016, and 9.69% for 2017) of the employee’s household income?

If your plan charges a higher contribution for tobacco users, the affordability of the coverage will be determined by using the lower contribution that is charged to non-tobacco users, or tobacco users who complete the related wellness program. In other words, the plan may assume that each employee has earned the tobacco-related incentive and would be paying the lower contribution. However, wellness program incentives that do not relate to tobacco use are treated as not earned in calculating affordability. In other words, the affordability of a plan that charges a higher contribution for participants who do not complete the related wellness program will be determined based on the higher contribution.

There is temporary transition relief for plan years beginning before January 1, 2015 if certain requirements are met. The transition rule says you will not be subject to an assessable penalty payment with respect to an employee who received a premium tax credit because your offer of coverage was not affordable or did not satisfy minimum value, if it would have been affordable or satisfied minimum value based on the employee contribution for your plan that would have applied if the employee...
had satisfied the requirements of your wellness plan that was in effect as of May 3, 2013.

69. Are contributions to an integrated HRA taken into account for purposes of determining whether our coverage is affordable?

Yes, if the amounts you make available for the current plan year under an integrated HRA may be used by an employee to pay premiums for your plan, or used to pay both premiums for your plan and also for cost-sharing and/or for other health benefits not covered by the plan. The HRA contributions are counted toward the employee’s required contribution (and thus reduce the dollar amount of the employee’s required contribution). Your contribution to an HRA (and any resulting reduction in the employee contribution) is treated as made pro-rata for each month of the plan year.

Example: The employee contribution for health coverage under the major medical plan is generally $200 per month. For the current plan year, you make $1,200 newly available under an integrated HRA that the employee may use to pay their share of contributions for the major medical coverage, pay cost-sharing, or pay towards the cost of vision or dental coverage.

Conclusion: Your $1,200 employer contribution to the HRA reduces the employee’s required contribution for the coverage. The employee’s required contribution for the major medical plan is $100 ($200 - $100) per month because 1/12 of the $1,200 HRA amount per month is taken into account as an employer contribution whether or not the employee uses the HRA to pay their share of contributions for the major medical coverage.

70. If we provide employees with a flex contribution that they can spend on benefits, would our flex contributions be treated as reducing the employee’s contribution for affordability purposes?

The amount of the flex contribution is treated as reducing the amount the employee has to contribute only if:

1. the employee may not opt to receive the amount as a taxable benefit (e.g. cash),
2. the employee may use the amount to pay for minimum essential coverage, and
3. the employee may use the amount exclusively to pay for medical care, within the meaning of Code §213.

If your flex contribution can also be used to pay for any non-health care benefits under the § 125 cafeteria plan (such as disability, dependent care, or group term life insurance), that contribution will not be treated as reducing the required employee contribution. Similarly, a flex contribution that is available to pay for health care but also could be received as cash does not reduce the employee’s required contribution.

Example (Health Flex Contribution Reduces Dollar Amount of Employee’s Required Contribution): An employee electing self-only coverage is required to contribute $200 per month toward the cost of coverage. You offer flex contributions
of $600 for the plan year that may only be applied toward the employee’s share of contributions or contributed to a health FSA.

**Conclusion:** Your $600 contribution reduces the employee’s required contribution. The $600 is taken into account as an employer contribution (and therefore reduces the employee’s required contribution) regardless of whether the employee elects to apply the health flex contribution toward the employee contribution for the group health coverage or elects to contribute it to the health FSA. The employee’s required contribution for purposes of affordability becomes $150 ($200 - $50) per month.

**Example (Employer Flex Contribution Does Not Reduce Dollar Amount of Employee’s Required Contribution):** An employee electing self-only coverage under the health plan contributes $200 per month toward the cost of coverage. You offer a flex contribution of $600 for the plan year that can be used for any benefit under the § 125 cafeteria plan (including benefits not related to health) or it can be taken as cash.

**Conclusion:** Because the $600 flex contribution is not usable exclusively for medical care, it is not treated as reducing the employee’s required contribution. Thus, the employee’s required contribution is still $200 per month.

**Note:** Under transition relief, for purposes of affordability calculations for plan years beginning before January 1, 2017, an employer flex contribution that may be used for non-health benefits or taken as cash, in addition to being used by the employee to pay for the health coverage, will be treated as reducing the amount of an employee’s required contribution. This relief does not apply to an employer’s flex contribution that includes non-health benefits that is adopted after December 16, 2015 or that substantially increases the amount of the flex contribution after December 16, 2015.

**71. We offer an opt-out bonus under our §125 plan to employees that waive our coverage. Do those amounts have to be included when determining if our coverage is affordable?**

Yes. An opt-out bonus will be treated as increasing an employee’s contribution for health coverage beyond the amount of any salary reduction contribution, including for those employees who elect coverage and don’t receive the bonus. For example, if you offer coverage through a §125 cafeteria plan, requiring employees who elect self-only coverage to contribute $200 per month toward the cost of that coverage, and offer an additional $100 per month in taxable wages to each employee who declines the coverage, the offer of $100 in additional compensation to waive coverage is treated as increasing the employee’s contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.

**Note:** Under transition relief, for purposes of affordability calculations for plan years beginning before January 1, 2017, an opt-out bonus will not be treated as increasing the amount of an employee’s required contribution. This relief does not apply to an opt-out bonus that is adopted after December 16, 2015.
72. If we make payment of the opt-out bonus also contingent on the employee proving that they have other employer-sponsored coverage (or Medicare, Tricare, etc.), then would the opt-out bonus still have to be treated as increasing the employee’s contribution?

It would unless certain requirements are met. For plan years that start on or after January 1, 2017, a conditional opt-out bonus will not affect the affordability calculation only if the payment of the opt-out bonus is conditioned on all of the following requirements:

1. The employee must decline to enroll in the employer-sponsored coverage; and

2. The employee must provide reasonable evidence that the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years that begin or end in or with the employer’s plan year to which the opt-out arrangement applies (“employee’s expected tax family”) have or will have minimum essential coverage (other than coverage in the individual market, whether or not obtained through the Marketplace) during the period of coverage to which the opt-out arrangement applies. Reasonable evidence of alternative coverage can include the employee’s attestation that the employee and all other members of the employee’s expected tax family, if any, have or will have minimum essential coverage, or any other reasonable evidence; and

3. The arrangement must also provide that any opt-out payment cannot be made if the employer knows or has reason to know that the employee or any other member of the employee’s expected tax family does not have (or will not have) the required alternative coverage; and

4. The opt-out arrangement must also require that the evidence of other coverage be provided no less frequently than every plan year to which the eligible opt-out arrangement applies, and that the evidence be provided no earlier than a reasonable period before the commencement of the period of coverage to which the eligible opt-out arrangement applies.

Assuming all the above requirements are met, a conditional opt-out payment may be excluded from the employee’s required contribution for the remainder of the plan year, even if the alternative coverage subsequently terminates for the employee or any other member of the employee’s expected tax family.

73. We make payments for fringe benefits pursuant to the Service Contract Act (SCA) or Davis-Bacon Act (DBRA). How are those payments taken into account for purposes of determining whether our coverage is affordable?

Until further guidance is issued, your fringe benefit payments (including flex credits or flex contributions) under the SCA or DBRA that are available to employees to pay for coverage under your plan (even if alternatively available to the employee in other benefits or cash) will be treated as reducing the employee’s required contribution for participation in the plan, but only to the extent the amount of your payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBRA.
Example: XYZ, Co offers employees subject to the SCA or DBRA coverage through a § 125 cafeteria plan, which the employees may choose to accept or reject. Under the terms of the offer, an employee may elect to receive self-only coverage under the plan at $200 per month, or may alternatively decline coverage under the health plan and receive a taxable payment of $700 per month. For the employee, $700 per month does not exceed the amount required to satisfy the fringe benefit requirements under the SCA or DBRA.

Conclusion: Until further guidance is issued, the required employee contribution for an employee who is subject to the SCA or DBRA is deemed to be $0.

74. How do we calculate whether our plan’s share of the total allowed cost of benefits is at least 60%?

The IRS released three possible methods for determining whether your coverage meets the 60% minimum value threshold. The three methods are:

1. **Minimum Value (MV) Calculator** – HHS and Treasury have developed an MV calculator for insured large group or self-funded plans to use to determine whether a plan provides the minimum 60% value. You can access the calculator and methodology at: [http://cciio.cms.gov/resources/regulations/index.html#pm](http://cciio.cms.gov/resources/regulations/index.html#pm)

2. **Design Based Safe Harbors** - The IRS would develop an array of design-based safe harbors in the form of checklists that would provide a simple, straightforward way for plan sponsors to determine minimum value – without the need of actuarial expertise or performing calculations. If your self-funded plan’s terms are consistent with or more generous than any one of the safe harbor checklists, your plan would be treated as providing minimum value.

3. **Actuarial Certification** - Plans with nonstandard features that are not able to use the MV calculator or the safe harbor checklists would have to obtain appropriate certification of the plan’s value by an actuary. An actuary performing an actuarial certification for a plan with nonstandard features must use the MV Calculator to determine the plan’s MV for plan coverage the MV calculator measures. The actuary would then add to that MV percentage the result of the actuary’s analysis of the nonstandard features.

In addition, all amounts you contribute for the current plan year to an employee’s HSA are taken into account in determining your plan’s share of costs for purposes of MV and are treated as amounts available for first dollar coverage. Amounts you newly made available under an HRA that is integrated with your major medical plan for the current plan year count for purposes of MV in the same manner if the amounts may be used only for cost-sharing and may not be used to pay insurance premiums. With respect to wellness plan incentives not related to tobacco use, your plan’s share of costs for MV purposes is determined without regard to reduced cost-sharing (e.g. lower or waived deductibles, coinsurance, copays) available under a wellness program (i.e. the higher, non-discounted cost-sharing is used). However, for wellness programs designed to prevent or reduce tobacco use, MV may be calculated assuming that every eligible individual satisfies the terms of the program.
relating to prevention or reduction of tobacco use (i.e. the lower, cost-sharing is used).

75. Can we satisfy the Minimum Value (MV) requirement if we offer a plan that does NOT include hospitalization and/or physician services benefits?

No. Your plan will not provide minimum value if it excludes substantial coverage for in-patient hospitalization services or physician services (or both), even if it shows a value of 60% when using the online Minimum Value Calculator. The agencies have issued guidance stating that they intend to propose regulations and update the MV Calculator so that employers will not be permitted to use the MV Calculator (or any actuarial certification or valuation) to demonstrate that a Non-Hospital/Non-Physician Services Plan provides minimum value for 2015 or later.

The guidance provides transitional relief, however, if you have already entered into a binding written commitment with a vendor to provide a Non-Hospital/Non-Physician Services MV Plan prior to November 4, 2014, or, you have begun enrolling employees in a Non-Hospital/Non-Physician Services MV Plan prior to November 4, 2014. If that is the case, then you can keep your plan for the 2015 plan year if two additional requirements are met:

1. Your plan year must begin no later than March 1, 2015; and
2. You must:
   - not state or imply in any disclosure to participants that your offer of coverage under the Non-Hospital/Non-Physician Services MV Plan precludes an employee from obtaining a premium tax credit, if otherwise eligible; and
   - timely correct any prior disclosures that stated or implied that the offer of the Non-Hospital/Non-Physician Services MV Plan would preclude an otherwise tax-credit-eligible employee from obtaining a premium tax credit.

76. I have heard we may have to provide “vouchers” which the employee can use to buy insurance through an exchange. Is that true?

No. A “free choice voucher” requirement was included in PPACA but that requirement was repealed upon passage of the Fiscal Year 2011 Federal Budget on April 17, 2011.

77. Do I have to “offer” and pay for dependent coverage also? What if the dependent (spouse or children) are covered by another employer’s plan?

The Act does not require you to offer or pay for health coverage that includes spouses and dependent children (but see section entitled "Dependents to Age 26" for the requirements that apply to plans that provide coverage for children). However, to avoid penalties under the employer mandate and to qualify for the Form W-2 affordability “safe harbor” described above, you will have to offer qualified coverage to all full-time employees and their dependent children until the end of the month in which the child turns 26. The regulations define an employee’s dependent children as the employee’s biological and adopted children. Thus, an offer of coverage to an
employee’s spouse, step-child or foster child is not required in order to comply with the employer mandate.

Also, the term dependent does not include a child who is not a citizen or national of the United States unless the child is a resident of the United States or a country contiguous to the United States (certain adopted children are excepted from this rule).

78. Our coverage does not currently include coverage for dependents. When will we have to start offering dependent coverage in order to satisfy the employer mandate?

If you did not offer dependent coverage (or only offered it to some dependents) during the plan year that begins in 2013 (2013 plan year) or the 2014 plan year, you will not be liable for penalties for your plan year that begins in 2015 if you can demonstrate that you are taking steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to the dependents that were not offered coverage during the 2013 or 2014 plan year.

79. We don’t know our employee’s household income. How will we know if an employee is eligible for a premium subsidy?

It will be up to the exchange in your state to determine if an individual is eligible for a premium subsidy. You will then be notified by the exchange if/when an employee has qualified.

80. Will we be able to file an appeal if we disagree with the exchange’s determination that our employee qualifies for premium tax credits or cost-sharing reductions because our plan does not offer qualifying coverage?

Yes. HHS intends to make an appeal process available that will allow you to appeal a determination that your employee is eligible for premium tax credits or cost-sharing reductions in part because your plan is either unaffordable or the plan’s share of the total allowed cost of benefits is less than 60%.

You will have 90 days from the date you are notified that one of your employees qualified for premium tax credits to file your appeal. You will be permitted to submit evidence to support your appeal including information pertaining to whether coverage was offered to the employee, whether the employee has elected such coverage, the employee’s portion of the lowest cost minimum value plan you offer, and whether or not the employee is in fact employed by you.

81. We offer coverage to most of our full-time employees but we have one class of full-time employees that are not eligible for coverage. Which prong of the penalty will apply to our plan?

If you offer coverage to at least 95% (70% if certain criteria are met) of your full-time employees (and their dependent children), you will be subject to a monthly penalty in 2015 of 1/12 of $3,120 (indexed annually) for each full-time employee that receives a premium tax credit or cost-sharing reduction for coverage purchased through a Marketplace exchange in that month because your coverage is unaffordable or does not meet a minimum value.
If coverage is not offered to at least 95% (70% if certain criteria are met) of your full-time employees (and their dependents), then you will be subject to the monthly “no coverage” penalty for 2015 which is 1/12 of $2,080 multiplied by the number of full-time employees you have for that month (minus the first 30) if at least one employee receives a premium tax credit or cost-sharing reduction through an exchange. For 2015 plan years only for employers with 100 or more full-time employees (including full-time equivalents), the penalty calculation would be 1/12 of $2,080 multiplied by the number of full-time employees you have for that month minus the first 80 (rather than 30).

82. As the parent corporation of several subsidiary corporations, are we responsible for a single penalty payment for all of the subsidiary corporations in the controlled group?

No. For any year that you are considered a large employer, the employer mandate standards generally are applied separately to each member company of the controlled group in determining liability for, and the amount of, any penalty payment. Further, each of the member companies cannot be held liable for the penalties of any other entity in the controlled group.

83. If we offer no coverage to our full-time employees and the penalty assessment is done separately for each subsidiary, does each subsidiary get the 30- or 80-employee reduction?

No. For a controlled group that is a large employer under the aggregation rules, only one 30-employee reduction is allowed. The 30- or 80-employee reduction must be allocated ratably among the member companies of the large employer based on each company’s number of full-time employees compared to the total number of employees within the controlled group.

84. If we offer coverage that is not affordable but require our full-time employees to enroll, thereby making them ineligible for a premium subsidy, will we avoid being penalized?

No. You cannot make your employees ineligible for a premium tax credit by providing them with mandatory coverage (i.e. where they are not offered an opportunity to decline) that is not affordable or does not meet minimum value. You must allow employee to decline your coverage unless the coverage meets both of the following requirements

1. It provides minimum value; and

2. It is offered either at no cost to the employee or at a cost, for any calendar month, of no more than 9.5% of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12.

85. What happens when we have employees that would like to drop our coverage outside of open enrollment and purchase a Marketplace plan?

At your discretion for plan years starting in 2014 and later, you may choose to amend your §125 cafeteria plan to allow an employee to prospectively revoke coverage under your group health plan provided the following conditions are met:
- The employee is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan (QHP) through a Marketplace, or the employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

- The employee's election to revoke your plan corresponds to his or her intended enrollment (including any dependents) in a Marketplace Qualified Health Plan effective beginning no later than the day immediately following the last day of the original coverage that is revoked. For example, if the employee revokes coverage effective on May 31st, they must intend to enroll in a Qualified Health Plan through a Marketplace with coverage that is effective no later than June 1st. You may rely on a certification from the employee that the employee and related individuals have enrolled or intend to enroll in the new QHP coverage by the required deadline.

To allow these new permitted election changes, you must amend your §125 cafeteria plan. You must adopt the amendment on or before the last day of the plan year in which you allow the new election changes and you must inform participants of the plan amendment. For your plan year that starts in 2014, you may amend your plan to adopt the new permitted election changes at any time on or before the last day of the plan year that begins in 2015.

Please note: These new events do not apply to an employee's health FSA elections. The employee cannot be allowed to also revoke or change their Health FSA election.

Also, you should verify that your insurer or stop loss insurer will allow employees to make a mid-year election change to drop the coverage under these circumstances.

86. If we contribute to a multiemployer union plan for our unionized employees, how will we know if we are subject to a penalty for the union members that work for us for 30 or more hours per week?

You will not be subject to a penalty with respect to a full-time union employee if:

1. You are required to make a contribution to a multiemployer plan pursuant to a collective bargaining agreement or an appropriate related participation agreement; and

2. Coverage under the multiemployer plan is offered to the full-time employee (and the employee’s dependents); and

3. The coverage offered to the full-time employee is affordable and provides minimum value.

For purposes of determining whether coverage under the multiemployer plan is affordable, you may use any of the affordability safe harbors. Coverage under a multiemployer plan will also be considered affordable if the employee’s required contribution, if any, toward self-only health coverage under the plan does not exceed 9.5% of the wages reported to the qualified multiemployer plan, which may be determined based on actual wages or an hourly wage rate under the applicable collective bargaining agreement.
87. I’ve been hearing about “exchanges”. Can you describe what they are?

A Marketplace (formerly known as an "Exchange") is an arrangement through which private and non-profit insurers offer small employers (up to 100 employees) and individuals the ability to purchase health insurance. The Act requires each state to set up a Marketplace exchange for the purchase of health insurance coverage. Coverage can be purchased through the Marketplace starting in 2014. States have the option to allow large employers (more than 100 employees) to begin purchasing coverage through a State Marketplace starting in 2017.

Regional or national Marketplaces could also be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the Marketplace.

It is expected that each Marketplace will offer four categories of plans plus a catastrophic plan including:

- **Bronze plan** – Essential health benefits covering 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);
- **Silver plan** – Essential health benefits covering 70% of the plan benefit costs, with HSA out-of-pocket limits;
- **Gold plan** – Essential health benefits covering 80% of the plan benefit costs, with HSA out-of-pocket limits;
- **Platinum plan** – Essential health benefits covering 90% of the plan benefit costs, with HSA out-of-pocket limits;
- **Catastrophic plan** – Available to individuals up to age 30, or to those who are exempt from the mandate to purchase coverage. Provides catastrophic coverage only, with the coverage level set at the current High Deductible Health Plan levels except that preventive benefits and coverage for three primary care visits would be exempt from the deductible.

88. Will I have to buy health insurance for my employees through one of the new Marketplace exchanges? Starting when?

No. Employers will not be required to purchase coverage through a Marketplace though it will initially be an option for small employers starting in 2014.

89. Am I considered a small employer for purposes of buying insurance through the Marketplace exchange?

A small employer for purposes of buying coverage through a State or federally facilitated SHOP Marketplace is defined as an employer with 50 or less full time equivalent employees. Starting in 2016, all SHOPs will be open to employers with up to 100 FTEs.
Federally facilitated SHOPs will use the same counting method that is used for determining if an employer is a "large employer" under the employer mandate. Both full-time employees and full-time equivalent employees will be counted. State-operated SHOPs are permitted to use the state’s own employee counting methods for determining the employer’s size and employee’s status as a full-time employee until 2016.

Starting in 2017, states can allow businesses with more than 100 employees to purchase coverage through a Marketplace.

**Note:** On November 27, 2013, HHS announced that online enrollment through the SHOP Marketplace in states that are using the federally-facilitated exchange had been delayed until 2015. However, for small businesses in those states, the small employer was still able to enroll their employees in a certified SHOP plan through an agent, broker, or insurer that offers a certified SHOP plan and has agreed to conduct enrollment according to HHS standards that apply for the Marketplace. In addition, for small businesses that wanted their employees’ coverage to begin on January 1, 2014, the enrollment deadline was extended to December 23, 2013 from December 15, 2013.

**90. We are a small employer. If we buy coverage through our state Marketplace, what information will we have to provide to our employees so that they can elect and enroll in a plan?**

You will be required to provide information to your employees about the timeframes for enrollment, instructions on how to access the exchange website and any tools available to compare plan options, and the exchange’s toll-free customer service hotline.

**91. If we have employees that are not offered or waive our coverage, when can they buy insurance at a Marketplace?**

Coverage can be purchased during the annual open enrollment period (the open enrollment period for 2017 was November 1, 2016–January 31, 2017) or if an individual experiences a special enrollment event. For 2018 and later, the annual enrollment period will be shortened to November 1–December 15. For special enrollment events, they will be able to purchase individual policies for up to 60 days following the event. These special enrollment events include:

- An individual or dependent loses minimum essential coverage due to losing job-based coverage, divorce, the end of an individual policy plan year, COBRA exhaustion, aging off a parent’s plan, losing eligibility for Medicaid or CHIP, and similar circumstances. Note: Voluntarily ending coverage doesn’t qualify for a special enrollment period;
- An individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- An individual’s enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of the Marketplace or HHS;
• An enrollee adequately demonstrates to the Marketplace that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
• An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
• An individual or enrollee gains access to new QHPs as a result of a permanent move;
• A member of a federally recognized American Indian tribe and Alaska Native Claims Settlement Act Corporation shareholders may enroll in a QHP at any time or change from one to another one time per month;
• An individual or enrollee demonstrates to the Marketplace that the individual meets other exceptional circumstances (as defined by the Marketplace); and
• The Marketplace determines that a qualified individual or enrollee (or his or her dependent) was not enrolled in QHP coverage, was not enrolled in the QHP selected by the qualified individual or enrollee, or is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct by a “non-Marketplace entity” (e.g. someone fraudulently claiming to be an Marketplace-approved navigator).

Under rules issued by HHS, individuals would have to provide proof documenting that any of the above events actually occurred before being allowed to enroll under a special enrollment opportunity.

92. Our plan is a non-calendar year plan renewing each July 1st. Will employees who waive our coverage at open enrollment be able to purchase coverage at a Marketplace at that time?

Yes. A Marketplace must allow an employee and his or her dependents to enroll in a qualified health plan under a special enrollment if the employee or his or her dependents fail to enroll in a non-calendar year group health plan, even if the employee or his or her dependents have the option to renew the coverage for the next plan year.

93. We have an employee who is leaving and her benefits don't begin with her new employer for 90 days. Is she able to opt out of COBRA coverage and go to the Marketplace to buy coverage?

Yes. She can either elect COBRA or go to the Marketplace to purchase coverage instead. The decision to not elect COBRA will not affect the determination of whether she is eligible for premium tax credits at a Marketplace.
94. If she elects COBRA, can she drop it at a later date to buy coverage at the Marketplace?

No. In order to buy coverage at the Marketplace, she would either have to wait until the next annual open enrollment period, or she would have to exhaust her full duration of COBRA to qualify for a special enrollment event at the Marketplace.

95. We pay the cost of the first 3 months of COBRA coverage for our employees who are laid off. Will that prevent them from buying coverage at a Marketplace after the subsidized period has ended?

Yes. Employees who accept the subsidized COBRA coverage would either have to wait until the next annual open enrollment period to enroll at a Marketplace, or they would have to exhaust the full duration of their COBRA coverage to qualify for a special enrollment event at the Marketplace.

96. How will our employees learn about the Marketplace exchanges and the possibility of receiving premium subsidies or cost-sharing reductions?

You must provide a written notice to each employee and to each newly hired employee, informing them of the following:

- The existence of the State’s Marketplace including a description of the services provided by the Marketplace, and the manner in which the employee may contact the Marketplace to request assistance.
- If your plan pays less than 60% of the total allowed costs of benefits provided under the plan, a statement that the employee may be eligible for a premium tax credit and a cost sharing reduction if the employee purchases a qualified health plan through the Marketplace.
- If the employee purchases a qualified health plan through the Marketplace, a statement that the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of any employer contribution may be excludable from income for Federal income tax purposes.

97. Who should receive the Marketplace notice? Can we include it in our health plan enrollment materials?

The Marketplace notice must be sent to all employees (including those working fewer than 30 hours per week and temporary and seasonal employees), regardless of their eligibility or enrollment in your medical plan. Distribution via health plan materials would therefore not satisfy the notice requirement.

The notice should also be distributed to employees not present at the workplace, such as those on FMLA or other leaves of absence.

98. Does the notice have to be provided to former employees who are COBRA qualified beneficiaries or retirees?

No. Only your current employees must receive the notice by October 1, 2013.
99. Do we have to provide the notice to new hires?

Yes. For employees hired on or after October 1, 2013, you must provide the notice within 14 days of their start date.

100. We have union employees that are covered by a collectively bargained multiemployer plan, not our company's group plan. Am I responsible for providing the notice to these employees?

Yes. You must furnish the notice to all of your employees – regardless of an employee’s benefit eligibility or enrollment status, full or part-time status, or union affiliation.

The requirement to provide the Marketplace notice can be satisfied if another entity (such as an issuer, multiemployer plan, or third-party administrator) sent the notice on your behalf. Although, you are not relieved of your obligation to provide the notice to all employees if the other entity only provides the notice to those employees enrolled in the plan, while not providing the notice to those employees not enrolled in the plan. You must therefore ensure the notice is provided to all employees.

101. Is there a deadline to provide the Marketplace notice?

The notice was originally scheduled to be distributed by March 1, 2013, but the requirement has been delayed until October 1, 2013, which coordinates with the first open enrollment period for the Marketplace.

For employees who are current employees before October 1, 2013, you are required to provide the notice not later than October 1, 2013. You are required to provide the notice to each new employee within 14 days of an employee’s start date beginning October 1, 2013.

102. Can we provide the notice electronically?

It may be provided electronically if the requirements of the Department of Labor’s electronic disclosure safe harbor are met.

103. Can we hand deliver the Marketplace notice?

The guidance only expressly permits first-class mail and electronic disclosure. However, it also refers to ERISA’s disclosure regulations, which allow hand delivery. As such, hand delivery appears to be acceptable as long as you take steps reasonably calculated to ensure actual receipt of the notice.

You will need however to distribute the notice by mail or electronically to employees not present at the workplace, such as those on FMLA or other leaves of absence.

104. Are there model Marketplace notices we can use to satisfy our notice obligation?

Two model notices were provided with the guidance. One model notice is for employers that offer health plan coverage and the other is a model notice for employers not offering plan coverage. The model notices can be accessed at the
DOL website at http://www.dol.gov/ebsa/healthreform/regulations/coverageoptionsnotice.html. The notices are available in both English and Spanish and in Word and PDF format.

105. Are any parts of the model notice optional?

According to the guidance, if you are using the model notice for employers that provide coverage to their employees, all the content on pages 2 and 3 of the model notice is optional. However, on the model notice itself, only the content on page three is expressly labeled as optional. At the minimum, we do recommend that you complete fields #3-12 of Part B on page two, as this is generic employer information that should not require customization for any specific employee.

106. My organization is a controlled group of corporations comprised of a number of affiliated member employers. Which employer name and EIN should be reflected on page two of the notice – the parent company or the member employer?

The guidance does not specify which employer name and EIN may or must be used on the Marketplace notice. It would likely be most reasonable to use the name and EIN of whichever employer could most easily answer questions related to the employees’ coverage eligibility, enrollment and costs. For example, if your parent company sponsors a single health plan for all employees of all member employers and enrollment is handled by a centralized Human Resource Department for all the member employers, use the parent company name and EIN. Alternatively, if the member employers in your controlled group each independently sponsor their own plans and handle enrollment for their own employees, use the member employer’s name and EIN.

107. Is there a fine or penalty for not providing the Marketplace notice?

The DOL released an FAQ verifying that you will not be fined or penalized if you fail to provide the notice, but the DOL also reiterated that employers should still provide the written Marketplace notice to its employees by October 1, 2013.

108. I’ve heard that existing plans may be “grandfathered”. What does that mean?

Existing plans, including plans maintained pursuant to a collective bargaining agreement, in operation as of March 23, 2010 are grandfathered if no significant changes have been made to the plan. However, certain benefit mandates included in the Act will apply.

109. It sounds like our plan is grandfathered. What benefit changes will we have to make? And by when?

The legislation includes the following mandates which all grandfathered group health plans, including collectively bargained plans, will have to comply with effective with the first plan year starting on or after September 23, 2010:
• Provide coverage to dependent children until they turn age 26 unless they are eligible for any other employer provided coverage that is not a group health plan of a parent
• Eliminate lifetime aggregate dollar limits on “essential benefits”
• Eliminate annual dollar limits on “essential benefits” (unless permitted by the Secretary)
• Eliminate preexisting condition exclusion for enrollees up to age 19
• Prohibit the rescinding of coverage except in the case of fraud, intentional misrepresentation, or nonpayment of premiums

Starting in 2014, grandfathered plans must:
• Eliminate annual aggregate benefit limits
  • Provide coverage of dependents to age 26 regardless of eligibility for other coverage
  • Eliminate preexisting condition limitations for adults
  • Eliminate waiting periods of greater than 90 days

110. Our plan is collectively bargained and we heard that we don’t have to make any changes until the last collective bargaining agreement expires. Has that changed?

Initially, it appeared that there was a delayed effective date for collectively bargained plans but that’s not the case. Insured and self-funded plans maintained pursuant to a collective bargaining agreement ratified before March 23, 2010 are deemed to be grandfathered plans. Because they are grandfathered plans, they are subject to the same reforms and effective dates as any other grandfathered plan.

For insured collectively bargained plans only, the plan will remain grandfathered until the last agreement expires, even if plan changes, including changing insurers, are made during the collective bargaining agreement that would normally result in a loss of grandfathered status.

After the last collective bargaining agreement expires, the determination of whether the plan is still grandfathered is made by comparing the coverage on the expiration date with the coverage that was in effect on March 23, 2010.

111. We also provide dental and vision coverage to our employees. Are we required to make these changes for those plans as well?

Maybe. The mandated changes for grandfathered plans only apply to your group health plans that are not “excepted benefits” as defined under HIPAA. If your dental and/or vision are excepted benefits, then you are not required to make any of the required changes for those coverages.

HIPAA excepted benefits include most health FSAs and limited scope dental and vision plans. Excepted benefits will be those dental and vision benefits that are either provided under a separate policy or contract of insurance or are not an integral part of the group health plan (i.e. employees can waive the dental or vision).
112. **We provide retiree health coverage for our retired employees. Will these benefit mandates apply to our retiree plan?**

It depends. There is an exception for retiree-only plans subject to ERISA that cover fewer than two active employees. For health insurers and nonfederal governmental plans subject to the Public Health Service Act, HHS has indicated they will apply a “non-enforcement” policy for insured retiree-only plans and retiree plans sponsored by non-federal governmental entities. In addition, HHS is encouraging states, which have enforcement authority over insurers, not to enforce the new health care reform provisions on these plans.

If your retiree plan covers both retirees and active employees under the same plan, then the exception will not apply and the health care reform provisions that apply to the plan will apply to both active and retired employees covered under the plan.

If your retiree plan also covers individuals on long-term disability, the answer is not clear. Until guidance is issued, HHS will treat these plans as satisfying the exception and will not apply either HIPAA or the health care reform mandates to this type of plan. However, HHS will be reviewing these types of plans and may release further guidance at a later date. If the guidance is more restrictive, it will be prospective, applying only to plan years that begin sometime after issuance. Pending such further guidance, if you choose to adopt any or all of the HIPAA or health care reform mandates, it will not prejudice your exemption.

113. **We made some plan design changes that are effective 7/1/10. Will they result in a loss of grandfathered status?**

It depends. Certain plan changes made after March 23, 2010 will result in a loss of your plan’s grandfathered status unless the changes were adopted or incorporated into a legally binding contract that was executed before June 14, 2010 (See the Q&A on “transition rules” later in this section). The changes that can cause a loss of grandfathered status are more specifically described below and include any decrease in the plan’s coinsurance amount, reductions in annual limits or employer contributions, reductions in benefits for the treatment or diagnosis of a particular condition, and in some cases, a change of insurers. Also, increases in coinsurance, copays, deductibles and out-of-pocket maximums can cause your plan to lose grandfathered status. If your plan changes are any of the increases described above, it will require an analysis of the amount of the increase compared to increases in medical inflation.

114. **Specifically, what are the changes that cause a plan to lose grandfathered status?**

Any of the following six plan design changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a plan to lose grandfather status:

1. Elimination of all or substantially all benefits for a particular medical condition.

2. Any increase in the employee’s coinsurance percentage.
3. A deductible or out-of-pocket maximum increase that exceeds medical inflation plus 15%.

4. A copayment increase that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation).

5. A decrease in the employer contribution towards the cost of coverage by more than 5%.

6. Imposition of annual limits on the dollar value of all benefits below specified amounts.

These six changes are the only plan design changes that will cause a cessation of grandfather status.

115. **How do we know what medical inflation is?**

Medical inflation is the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor. To calculate medical inflation, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI-U (unadjusted) published by the Department of Labor for March 2010) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

The CPI-U values can be found on the Bureau of Labor Statistics website at: [http://www.bls.gov/cpi/tables.htm](http://www.bls.gov/cpi/tables.htm)

116. **If all we are doing is changing insurers, that will cause a loss of grandfather status?**

It depends. If the change in insurers was effective after March 23, 2010 but prior to November 15, 2010, your plan has lost grandfathered status.

If you changed insurers and your new insurance policy was effective on or after November 15, 2010, your plan does not lose grandfathered status unless your new policy includes plan design changes that, when compared to the previous insurance policy, would exceed the allowable changes that generally cause a plan to lose grandfather status (e.g. increase in cost sharing, significant increases in copays, deductibles, etc.).

117. **Is there anything we have to provide to the new insurer regarding the benefits and contributions we had under the prior insurer?**

Yes. You must provide to your new health insurer documentation of the benefits, cost sharing, employer contributions, and annual limits under the prior insurer sufficient to determine whether any plan changes that would cause a loss of grandfathered status have been made.
118. Our plan is self funded and we are changing our third party administrator (TPA). Will that cause our self funded plan to lose its grandfathered status?

No. Changing third party administrators will not result in the loss of grandfathered status for your self funded plan.

119. Our plan is currently insured but we are considering a change to self funding and changing our PPO network. Would these changes cause our plan to lose grandfathered status?

The guidance we have does not address the effect of changing your plan’s funding mechanism from insured to self funding or changing networks. Further guidance is necessary on this question and it may also depend on the date you make the changes. What we do know is that changing from self funding to insured coverage will not cause a loss of grandfathered status if the new insurance policy is effective on or after November 15, 2010 and no changes are made to the contributions or benefits that would normally cause a loss of grandfathered status. If the change was effective prior to November 15th, the new insurance policy would not be grandfathered.

The agencies responsible for enforcing the rules have invited comments from the public regarding the effect of these types of changes (or any other changes) so we anticipate that further guidance will be forthcoming. However, it appears that any new standards subsequently published in the final regulations that are more restrictive than what was included in the interim final regulations would only apply prospectively to changes to plans made after the publication of final rules.

120. We are thinking of amending our plan to delete coverage for depression. If we make this change, will it cause our plan to lose its grandfathered status?

Yes. The elimination of all benefits or substantially all benefits to diagnose or treat a particular condition will cause a loss of grandfathered status.

121. Our plan currently pays 90% of covered services and the employee pays 10%. We want to reduce our share to 80%. Would that cause the loss of grandfathered status?

Yes. Any increase in the participant’s coinsurance amount will cause the plan to lose grandfathered status.

122. Our plan currently pays 90% of covered services but we want to reduce that to 50% for durable medical equipment only. Would that cause a loss of grandfathered status?

Yes. Because it is an increase in the participant’s coinsurance amount, it would cause the plan to lose grandfathered status.

123. Our plan is facing a significant premium increase this year so we want to raise the deductible. What effect will this have on our grandfathered plan status?

It depends. Employers are permitted to raise plan deductibles (or other fixed cost sharing amounts such as out-of-pocket limits) but your plan would cease to be a
grandfathered plan if the increase since 3/23/10 is greater than a percentage equal to medical inflation plus 15%.

**Example:** On March 23, 2010, a grandfathered health plan has a $300 deductible. The plan is subsequently amended to increase the deductible to $400. As of March 23, 2010, the medical care component of the CPI-U is 387.142. Within the 12-month period before the $400 deductible takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475.

**Conclusion:** The increase in the deductible from $300 to $400 is an increase of 33.33%. Medical inflation from March 2010 to the date of the change is 0.2269 (475 – 387.142 = 87.858; 87.858/387.142 = 0.2269). Therefore, the maximum percentage increase in the deductible permitted is 37.69% (0.2269 + 15% = 37.69%). Because a 33.33% increase does not exceed 37.69%, the change in the deductible would not cause the plan to lose its grandfathered status.

**124.** Our plan has a $10 office visit copay. We want to raise it to $20. Will this cause our plan to lose grandfathered status?

Maybe. The increase to your copay will result in a loss of grandfathered status if the increase is more than the greater of:

- $5 (adjusted for medical inflation); or
- A percentage equal to medical inflation plus 15%.

**Example:** On March 23, 2010, a grandfathered health plan has a $30 office visit copay. The plan is subsequently amended to increase the copay to $40. Within the 12-month period before the $40 copay takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 455.

**Conclusion:** The increase in the copayment from $30 to $40 is 33.33%. Medical inflation from March 2010 is 0.1753 (455 – 387.142 = 67.858; 67.858/387.142 = 0.1753). The maximum percentage increase permitted is 32.53% (17.53% + 15% = 32.53%). Because 33.33% exceeds 32.53%, the change in the copayment requirement at that time will cause the plan to lose its grandfathered status.

**125.** We want to raise the copayment for office visits, but leave all other copayments the same. Will that one change cause our plan to lose grandfathered status?

Yes. Any copayment increase that exceeds medical inflation plus 15% (or, if greater, $5 plus medical inflation) from March 23, 2010, will cause a plan to lose grandfatherer status, even if all other copayment amounts remain the same.

**126.** We have just received our renewal and we need to lower our contribution and increase the employee’s contribution percentage for family coverage. As of March 23, 2010, we paid 100% of the employee’s coverage and 80% of the family coverage and we now want to reduce the 80% to 50%. Will this change cause us to lose grandfathered status?

Yes. To retain grandfathered plan status, you cannot decrease the percentage of premiums you pay by more than 5 percentage points below your contribution rate on March 23, 2010. This rule applies to any tier of coverage (e.g. self-only, 2 person,
family, etc.) for any class of employee. Because the decrease in your contribution for family coverage would be 30%, your plan would lose grandfathered status.

127. We are going to significantly reduce benefits and increase employee contributions for our PPO option at next renewal but we are not changing our HMO option. Does our plan lose grandfathered status for both plan options or just the PPO option?

If the changes to the PPO result in a loss of grandfathered status, only the PPO option will be affected. The HMO option will remain grandfathered for as long as no changes are made to the HMO option that would result in a loss of grandfathered status.

128. If we implement a new wellness program that includes a smoker surcharge, could that cause our plan to lose its grandfathered status?

Yes. According to the DOL, adding a surcharge (such as contribution or cost-sharing surcharges) may implicate the grandfather plan rules and should be examined carefully before implementing. For example, if a contribution surcharge decreases the employer's contribution for a plan option by more than 5% for any tier of coverage (single, two-person, family, etc.), then it could cause the loss of grandfather status for that option.

129. We are going to change the tiers of coverage under our plan from self-only and family to a multi-tiered structure of employee-only, employee+one, employee+two and employee+three or more. Will our plan lose grandfathered status?

The determination of whether the change in employer contribution will cause a loss of grandfathered status is made on a tier-by-tier basis. So, if you change the tier structure from what was in place on March 23, 2010, your contribution for any new tier is tested by comparing it to the contribution rate for the corresponding tier on March 23, 2010. For example, if your contribution rate for family coverage was 50% on March 23, 2010, then your contribution rate for any new tier, other than employee-only, must be within 5% of 50% (or at least 45%). If it is lower than 45%, you would lose grandfathered status.

If, however, your new tier structure only adds a new coverage tier, without eliminating or modifying any other coverage tier, and those individuals eligible under the new tier were not previously covered under the plan, then the new tier would not be compared to those in place on March 23, 2010, and would not cause the plan to lose grandfathered status.

130. Our grandfathered plan operates on a calendar plan year but we are considering a plan amendment that will cause it to relinquish grandfather status. If we decide to make this amendment effective on July 1, 2016, does our plan relinquish grandfather status in the middle of the plan year?

Yes. Your plan will cease to be a grandfathered health plan when the plan amendment becomes effective on July 1, 2016. You would then have to make all the other plan changes that apply to nongrandfathered plans effective concurrent with the change that causes the loss of grandfathered status.
If you want to avoid relinquishing grandfathered status in the middle of a plan year, any changes you make that would cause your plan to relinquish grandfather status should be made effective the first day of the next plan year.

131. Before we knew what changes would affect grandfathered status, we made several plan changes for our May 1, 2010 renewal that will result in a loss of grandfathered status. Are there any exceptions that would allow us to keep these changes without losing our grandfathered status?

Yes. There are two “transition rules” that if applicable, may allow you to keep your plan changes without losing grandfathered status.

The first transition rule says that if the changes were adopted prior to March 23, 2010, they would be considered part of the plan as of March 23rd, even though they were effective at a later date. A change is deemed to be adopted if the changes were incorporated into a legally binding contract that was executed on or before March 23, 2010 or if a written plan amendment was adopted on or before March 23, 2010.

The second transition rule says that if plan changes were made prior to June 14, 2010 (the date regulations were released), the plan will not lose its grandfathered status if:

1. the plan changes that cause the loss of grandfathered status are revoked or modified effective by the first day of the first plan year beginning on or after September 23, 2010; and

2. the terms of the plan, as modified, would not otherwise cause the plan to lose grandfathered status.

132. We have to make changes due to Mental Health Parity for our next plan year starting on August 1, 2010. Will these changes cause our plan to lose grandfathered status?

No. Plan changes made to comply with Federal or State legal requirements will not cause a loss of grandfathered status unless the mandated changes exceed the allowable changes established in the grandfathered plan regulations.

133. If we lose our grandfathered status, what are the other health care reform requirements that will apply?

In addition to the changes required for grandfathered plans, any new plan or any plan that loses its grandfathered status will have to comply with the additional requirements listed below effective for plan years starting on or after September 23, 2010:

- Provide coverage to children to age 26 regardless of whether they are eligible for other employer-sponsored coverage;
- Provide coverage for recommended preventive services, without cost sharing
- For emergency room care:
- No pre-authorization permitted – in or out of network
- Identical coverage in and out of network
For Primary Care Physician Designations:

- Participants may designate any available participating primary care provider
- Parents may select pediatrician for child(ren)
- May not require authorization or referral for OBGYN care from participating obstetrician or gynecologist
- New claims appeal rules including both internal and external review
- Nondiscrimination rules for fully insured health plans under Code §105(h)
  - On December 22, 2010, it was announced that enforcement of this rule will be delayed until further guidance is issued.

For plan years starting on or after January 1, 2014, new plans or plans that have lost grandfathered status will have to comply with additional requirements including:

- No discrimination against individuals participating in clinical trials;
- No discrimination based on health status;
- Provide essential benefits (small group insured plans only);
- No discrimination against health care providers acting within the scope of their professional license and applicable State law;
- Prohibit out-of-pocket limits in excess of the applicable out-of-pocket limits for qualified high deductible health plans; and
- Prohibit out-of-pocket limits in excess of applicable out-of-pocket limits as determined by HHS for plan years starting on or after January 1, 2015.

134. We intend to keep our plan grandfathered as long as possible. Is there anything we have to do to verify we have not made any changes that would result in the loss of grandfathered status?

Yes. You will be required to maintain records of your plan's grandfathered status for as long as the plan takes the position that it is grandfathered. This means you must maintain records documenting the terms of the plan in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify your plan’s status as a grandfathered health plan. This should include intervening and current plan documents, health insurance policies, certificates or contracts of insurance, summary plan descriptions, documentation of premiums or the cost of coverage, and documentation of required employee contribution rates.

In addition, you must make these records available for inspection to participants or State or Federal agencies upon request.

135. Will we have to tell our employees about our plan’s grandfathered status?

Yes. To maintain status as a grandfathered plan, you must disclose, in any plan materials provided to participants, that your plan believes it is a grandfathered plan under PPACA. This includes SPDs, open enrollment materials, or materials provided upon opportunities to enroll in, renew or change coverage. The disclosure must also provide contact information for questions and complaints. The following model language can be used to satisfy the grandfathered plan disclosure requirement:
This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.]

136. Our plan currently covers children to age 23, so we'll have to extend that to age 26. When do we have to do that? Can we do it now?

For grandfathered plans, the change must be made by the first day of the first plan year that starts on or after September 23, 2010. For example, a calendar year plan would have to comply by January 1, 2011. However, the change can be made sooner. You should make sure the insurer or stop loss carrier approves the change if you intend to implement it prior to the required effective date.

For insured plans, many insurers are implementing this change ahead of the actual effective date. You can contact your insurer for more information on how this change will affect your plan.

137. Do we have to offer coverage to adult children even if the "child" already has coverage through their own employer's plan?

If your plan is not grandfathered, you are not able to deny coverage to adult children even if they have coverage through their own or any other employer’s plan.

If your plan is grandfathered, you would not have to offer the coverage until 2014. Before 2014, you must provide coverage to dependent children until they turn age 26, unless they are eligible to enroll for any other employer provided coverage that is not a group health plan of a parent. This could include coverage through their own employer’s plan or through a spouse’s employer’s plan.

While it is not entirely clear from the guidance we have, it appears that the child is not treated as eligible for other coverage until the first date the individual can actually
enroll and be covered under the plan. For example, if the child is eligible for other coverage but cannot be enrolled due to plan restrictions, they probably remain eligible under the parent's plan until such time they can actually enroll in the other plan. Also, coverage cannot be denied under the parent's plan if the child is only eligible to enroll for COBRA coverage under their former employer or spouse's former employer's plan.

Starting in 2014 and later, coverage under all plans must be available regardless of whether the child has any other coverage (but COB rules may still apply).

138. Our plan covers step children and in some cases grandchildren if they meet specific criteria. Will we now have to cover them to age 26 as well?

The DOL issued “safe harbor” guidance that says plans that cover the following categories of children to age 26 will be in compliance with this requirement:

- Biological children (sons, daughters);
- Stepchildren;
- Adopted children (including children placed for adoption); and
- Foster children who are placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Coverage can be discontinued for children in any of the above categories prior to age 26 if the applicable relationship no longer exists.

For an individual who is not in one of the four categories, such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

139. Can I just continue the children already on my plan, or do I have to go back and offer the coverage to those who have already aged out?

If the child’s coverage under your plan was ended (or if the child was not eligible for coverage) because, under the terms of the plan, coverage was not available to age 26, you are required to give children under age 26 a special enrollment opportunity of at least 30 days. This special enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010.

140. Am I required to tell employees about this opportunity? How do I do that and by when?

Yes. You must provide a written notice to employees describing the special enrollment opportunity. You can give or send the notice to the employee or it can be included with other enrollment materials, provided the statement describing the special enrollment opportunity is highlighted. This notice must be provided no later than the first day of the first plan year starting on or after September 23, 2010. For example, a calendar year plan would have to provide the notice and the 30-day special enrollment opportunity no later than January 1, 2011.
The DOL has issued a model notice for this purpose which can be downloaded in Word format from their website at: http://www.dol.gov/ebsa/healthreform/

141. **Do I have to offer the coverage to an adult child who has aged out, but is currently on COBRA?**

Yes. If the child who aged out has elected COBRA, the plan must allow the child to be enrolled as a dependent of an active employee. In addition, if the child subsequently loses eligibility due to a qualifying event, the child would have another opportunity to elect COBRA.

142. **Can I charge more for these adult children?**

In most cases, no. The employee cannot be required to pay more for a child’s coverage based on their age (e.g. adding a surcharge for children over age 18 or over age 23). However, an additional surcharge for adult children could be applied if that surcharge is applied for every new child added to the plan regardless of age.

143. **Can I offer a more limited benefit to these adult children?**

No. The benefits or coverage cannot vary based on the child’s age. It must be identical to the coverage that is provided to similarly situated children who are not adult children.

144. **If the adult child is married are they still allowed to have the coverage?**

Yes. Eligibility for coverage of children up to age 26 cannot be based on factors such as financial dependence, student status, residence, or marital status.

145. **Do I have to cover the spouse or child (the grandchild of the employee) of the adult child too?**

No. Plans that provide dependent coverage are only required to provide coverage to the employee’s children (e.g. biological or adopted children) until the age of 26. The plan is not required to provide coverage to the employee’s son-in-law or daughter-in-law or grandchildren.

146. **We have an employee whose child is 25 but is not a full time student, does this mean we will have to calculate imputed income for that employee?**

Not for federal tax purposes. The definition of a tax dependent in the Internal Revenue Code for group health plan purposes was amended as part of the health care reform package to include children until the end of the year they turn age 26. This change will also apply to children to age 26 who are covered under a plan that currently extends coverage to children to age 26 (or older).

The IRS has now issued Notice 2010-38 that offers guidance on the tax exclusion for these adult children. It clarifies several items including:

- Child is defined as son/daughter, step son/daughter, adopted child or eligible foster child, without regard to whether the child is financially supported by the employee or resides with the employee or is a full time student.
- Coverage for these adult children can be paid for on a pretax basis under a §125 cafeteria plan
- The change in status regulations will be amended so that employees can add coverage under a §125 plan for a newly-eligible adult child where the plan has been amended mid-year to add the adult child coverage.

147. Does the same change apply for state tax purposes?

In many cases, states have adopted the federal definition of gross income so that whatever is included (or not included) in income for federal purposes also applies at the state level. However, there were some states (e.g. California) where this was not the case and coverage for adult children was still taxable. Fortunately, all the states that were nonconforming with the federal rules have now either passed resolutions or legislation conforming the state tax treatment of adult dependent coverage with the federal tax treatment of adult dependent coverage.

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148. Our plan has a preexisting condition limitation. Will we have to change it or eliminate it?

Yes. Starting with your first plan year beginning on or after 9/23/10, a preexisting condition limitation cannot be applied to any enrollee who is under age 19. This includes employees and spouses under age 19 and dependents under age 19.

Starting with your first plan year beginning on or after 1/1/14, preexisting condition limitations will be prohibited for all plans and all covered individuals so you will have to eliminate it altogether by that date.

149. We have a plan provision that excludes coverage for services that are the result of an injury that occurred before the effective date of the employee’s coverage. Is this still permissible?

Because this provision operates to exclude benefits for a condition that was present before the effective date of coverage, it is considered a preexisting condition exclusion. Therefore, it will be subject to the same rules described above. Starting with your next plan year beginning on or after 9/23/10, it cannot be applied to enrollees under age 19, and then starting in 2014, it will have to be eliminated.

150. If our plan cannot apply a preexisting condition limitation to any covered person starting in 2014, will we still be required to provide HIPAA certificates of creditable coverage to individuals who lose coverage?

No. Effective January 1, 2015, you will no longer have to provide a HIPAA certificate of creditable coverage to individuals who lose coverage under your group health plan.
**Lifetime and Annual Maximums**

151. We have two plan options. One has a $1 million lifetime maximum and the other has a $2 million lifetime maximum. How will these maximums be affected?

Effective with your first plan year starting on or after 9/23/10, lifetime maximums that apply to essential benefits will have to be eliminated regardless of whether or not your plan is grandfathered.

152. Our plan is self-funded. How do we know what benefits are “essential benefits”?

The Act defines “essential benefits” to include the following categories of coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (services for individuals under 19 years of age)

Final regulations state that a self-funded plan would be in compliance if it used one of the following choices as a benchmark plan, reflecting the scope of essential health benefits offered by a typical employer plan and supplemented as needed to ensure coverage of all ten statutory categories:

1. Any EHB benchmark plan that has been selected, whether by active State selection or by default, to be the EHB benchmark plan for a State, including coverage of any additional required state-mandated benefits; or

2. Any of the three plan options that are the current base-benchmark plan options under the Federal Employees Health Benefit Program (FEHBP), supplemented, as necessary, to include coverage of any additional required state-mandated benefits.

153. Can we still keep our lifetime limit for benefits that are not considered “essential benefits”?

Yes. Lifetime limits on benefits that are deemed not to be essential benefits are permitted.
154. Does the prohibition on annual and lifetime dollar limits apply to expenses incurred out-of-network?

Yes. There is no exception for out-of-network benefits.

155. We have an employee who dropped coverage at our last open enrollment because her daughter’s claims exceeded the lifetime maximum and no further claims were going to be paid. Do we have to let her back on the plan?

Yes. If she is eligible for coverage, you must inform the employee in writing that the plan’s lifetime maximum no longer applies and she and her daughter are allowed to enroll in the plan and the daughter is eligible for benefits again.

156. Do we have to notify employees who exceeded the lifetime limit that they can return to the plan? How long can they have to reenroll?

Yes, you must provide them with at least 30 days to enroll and the enrollment opportunity must be provided no later than the first day of the first plan year starting on or after 9/23/10. If they enroll, the coverage must start no later than the first day of that plan year.

The DOL has issued a model notice for this purpose which can be downloaded in Word format from their website at: [http://www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/)

157. Can we require her to enroll in the plan option she was enrolled in when her daughter’s claims exceeded the lifetime maximum?

No. She must be offered all the benefit options available to similarly situated employees.

158. Our plan has no lifetime maximum but it has an annual maximum of $500,000. Will we have to change or eliminate the annual maximum?

Yes. Starting in 2014, plans cannot have annual maximums on essential benefits. For plan years beginning before 1/1/14, you can have an annual maximum on essential benefits provided the limit is no less than:

- $750,000 for a plan year beginning on or after September 23, 2010, but before September 23, 2011,
- $1,250,000 for a plan year beginning on or after September 23, 2011, but before September 23, 2012, and
- $2,000,000 for plan years beginning on or after September 23, 2012, but before January 1, 2014.

159. Our plan has an annual maximum of $10,000 for chiropractic care. Do we have to remove the limit?

Until HHS has provided more guidance on the specifics of what is an essential benefit and whether chiropractic care would fall under one of the categories of essential benefits, it’s not possible to answer this question. Until these regulations are issued, the agencies enforcing PPACA have said they will take into account good faith efforts to comply with a reasonable interpretation of the term “essential health benefits”.
An alternative to having annual dollar maximums might be to replace them with day or visit limits, which are not limited or restricted for chiropractic care at this time.

160. **We offer our employees a high deductible health plan combined with a Health Reimbursement Arrangement (HRA). We contribute $1,000 annually to each employee’s HRA. Does the elimination of annual limits mean we have to change our HRA?**

No. When HRAs are integrated with other coverage under a group health plan (e.g. with a high deductible major medical plan) and the employee is enrolled in both, the fact that the benefits are limited under the HRA does not cause it to violate PPACA if the major medical coverage is in compliance with all the applicable health insurance reform provisions.

161. **If we offer our employees an HRA that allows them to purchase coverage on the individual market, will the HRA be considered integrated with that individual market coverage and therefore satisfy the annual limit and/or preventive care requirements?**

No. An employer-sponsored HRA plan cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore it would violate the prohibition on annual dollar limits and the requirement to provide certain preventive services at 100%.

An HRA is integrated with a group health plan coverage that provides minimum value only if ALL the following conditions are met:

1. The HRA is available only to employees who are actually enrolled in the non-HRA group health plan coverage;

2. Any employee receiving the HRA is actually enrolled in a group health plan that provides minimum value;

3. Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

If an HRA is integrated with coverage that does not meet minimum value, then the same requirements described above apply but the HRA must be limited to reimbursement of only one or more of the following: co-payments; co-insurance; deductibles; and premiums under the non-HRA coverage, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits.

162. **If we offer to reimburse our employees for individual or Marketplace coverage premiums, will that arrangement satisfy the annual limit requirements?**

No. Your reimbursements cannot be integrated with individual market coverage. Therefore it would violate the prohibition on annual dollar limits because it would impose an annual dollar limit up to the cost of the individual market coverage.
**Rescissions**

163. **PPACA prohibits “rescissions”. What does this mean and how will it affect our plan?**

Rescissions are defined as a cancellation of coverage that has a retroactive effect. Rescissions are prohibited unless the termination is due to fraud, or an intentional misrepresentation of a material fact, and are permitted by the written terms of the plan. Therefore, effective for plan years starting on or after September 23, 2010, your group health plan will not be permitted to terminate coverage retroactively under any circumstances unless the employee performs an act of fraud, or the employee intentionally misrepresents a material fact and the plan has been drafted or amended to provide that such misrepresentations will result in a termination of coverage.

Retroactive cancellation of coverage due to a failure to pay timely premiums is not considered a rescission.

164. **We have several locations and sometimes we are not immediately notified by supervisors or managers when an employee loses eligibility for plan coverage when they are reassigned to a part time position. We can still terminate coverage retroactively in those cases, right?**

Yes, as long as you did not continue withholding contributions from the employee’s paycheck and paying claims. If you continued to withhold contributions and provide coverage, then the coverage can only be terminated prospectively.

**Example.** Joe has coverage under the plan as a full-time employee. The employer reassigns Joe to a part-time position and Joe is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from Joe’s paycheck and paying claims submitted by Joe. After a routine audit, the plan discovers that Joe is no longer eligible. The plan rescinds Joe’s coverage effective as of the date he changed from a full-time employee to a part-time employee.

**Conclusion.** The plan cannot rescind Joe’s coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may only cancel coverage for Joe prospectively.

165. **We only reconcile our bill or data feed for eligible employees and dependents once a month. Can we still retroactively terminate employees and dependents off our coverage on that reconciliation back to the end of the previous month?**

If you cover only active employees and families (and COBRA participants) and the individual who is no longer eligible for coverage pays no premiums for coverage after the termination (subject to COBRA), then it will not be considered a rescission, but rather a retroactive elimination of coverage back to the date of termination, due to delay in administrative recordkeeping.

166. **What if we have an employee who notifies us of his final divorce from his spouse. Are we allowed to terminate the coverage of the spouse retroactively to the date of the divorce?**

If your plan does not cover ex-spouses (other than under COBRA) and the COBRA premium is not paid by the employee or ex-spouse, then you are allowed to...
retroactively terminate coverage back to the date of divorce without it being an improper rescission. Of course, COBRA may require coverage to be offered for up to 36 months, if the COBRA premium is paid.

167. What are the special rules that will apply to our HMO option regarding the choice of primary care physicians (PCP)?

The new rules on PCPs are effective for plan years starting on or after September 23, 2010 but only apply to nongrandfathered plans. If your HMO option is not grandfathered, you must allow participants or beneficiaries to elect a PCP including:

- Designating any participating primary care physician who is available to accept the individual; and
- Designating any participating physician who specializes in pediatrics who is available as a child’s PCP.

168. We read that HMOs cannot require females to get authorization for OB/GYN services. How does that work?

This new rule applies only to nongrandfathered plans. If your HMO option is not grandfathered, it cannot require an authorization or a referral from the HMO or a PCP for a female seeking OB/GYN services from a participating health care professional (i.e. physician, physician assistant, midwife, etc.) who specializes in OB/GYN care.

169. Do we have to notify the employees enrolled in or enrolling in the HMO of these new rules?

Yes. If your nongrandfathered HMO plan requires the designation of a PCP, you must provide a notice informing each employee of the following:

- The plan requirements for electing a PCP;
- That any participating primary care physician who is available to accept the participant can be designated as a PCP;
- That any participating physician who specializes in pediatrics can be designated as a PCP for a child;
- The plan may not require authorization or referral for OB/GYN services provided by a participating professional who specializes in OB/GYN care.

This notice must be included in the plan’s SPD or any other similar description of the benefits under the plan. The DOL has issued a model notice for this purpose which can be downloaded in Word format from their website at: http://www.dol.gov/ebsa/healthreform/

170. There are new rules for emergency room services. How will they affect our plan?

These rules apply only to nongrandfathered plans. If your plan is not grandfathered, it must provide coverage for emergency room services in the following manner:
Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; and

If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers.

If the emergency services are provided out of network, the copays or coinsurance amounts imposed cannot exceed the amounts imposed for in network emergency room services.

Benefit payments for out-of-network emergency services (prior to imposing in-network cost sharing) must be paid in an amount at least equal the greatest of:

1. The median amount negotiated with in-network providers for the emergency service;
2. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or
3. The amount that would be paid under Medicare for the emergency service (minimum payment standards).

In addition, plans are required to disclose how it calculated the payable amount under the minimum payment standards for out-of-network emergency services (e.g., the UCR amount) upon request.

**Preventive Care**

171. **Our plan currently provides coverage for preventive services but we apply copays and deductibles to those services. I’ve heard we will have to eliminate these cost-sharing provisions. Is that true?**

The Act does require new plans to provide first dollar coverage to certain specified preventive services and immunizations for plan years beginning on or after September 23, 2010, but this requirement does not apply to grandfathered plans.

172. **We may have one plan option that is not grandfathered. What are the preventive services that the plan will have to cover without cost-sharing?**

- Evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
• With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A list of the required services can be found on the HHS website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1

173. Does the list of women’s evidence-informed preventive care and screenings include coverage for contraception?

Yes. Beginning with plan years starting on or after August 1, 2012, nongrandfathered plans will have to provide coverage with no cost-sharing for all FDA approved contraceptive methods, sterilization procedures, and contraceptive education and counseling for all women with reproductive capacity.

The full list of covered women’s preventive services can be found on the HHS website here: http://www.hrsa.gov/womensguidelines.

174. We are a church that believes contraception is contrary to our religious tenets so we do not currently cover them. Will we have to change our plan to add coverage for contraceptives?

No. Group health plans sponsored by religious employers, and group health insurance coverage provided in connection with such plans, are exempt from the requirement to cover contraceptive services.

A religious employer is defined as an employer that organized and operated as a non-profit entity and is referred to in §6033(a)(3)(A)(i) or §6033(a)(3)(A)(iii) of the Internal Revenue Code of 1986, as amended. Section 6033(a)(3)(A)(i) and (iii) of the Code refers to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order.

175. We are a religiously-affiliated organization (not a church) that currently excludes contraception because it is contrary to our religious beliefs. How does this rule apply to us?

Plans of certain nongrandfathered religiously-affiliated employers (schools, hospitals, charities, etc.) that are not “religious employers” as defined, are accommodated under an enforcement safe harbor until your first plan year starting on or after January 1, 2014. To qualify for the safe harbor, you must meet all of the following criteria:

• Your organization is organized and operates as a nonprofit entity.
• From February 10, 2012, onward, your group health plan has consistently not covered all or some subset of recommended contraceptive services, consistent with any applicable state law, because of the religious beliefs of the organization.
• Your group health plan (or another entity on behalf of the plan, such as a health insurance issuer or third party administrator) provides to participants a notice indicating that some or all contraceptive services will not be covered under your plan for the first plan year beginning on or after August 1, 2012.
- You self-certify that you satisfy the three criteria described above and you document your self-certification.


176. Once the safe harbor expires, will we have to provide contraceptive coverage at that time?

Not necessarily. Effective with plan years starting on or after January 1, 2014, there is an ongoing accommodation for plans of nongrandfathered, religiously-affiliated employers (schools, hospitals, charities, etc.) that meet the following criteria:

1. The organization opposes providing coverage for some or all of the contraceptive services required to be covered on account of religious objections;

2. The organization is organized and operates as a nonprofit entity;

3. The organization holds itself out as a religious organization;

4. The organization self-certifies that it satisfies criteria 1-3 above and specifies those contraceptive services for which the organization will not establish, maintain, administer, or fund coverage, and makes such certification available for examination upon request; and

5. The organization or plan administrator furnishes each insurer or TPA with a copy of the self-certification described in (4) above prior to the beginning of the first plan year that the accommodation applies.

Once you have furnished your self-certification to your insurer, they will expressly exclude contraceptives from your coverage and separately provide contraceptive coverage to your plan participants and beneficiaries without imposing any cost sharing requirement (such as a premium, copayment, coinsurance, or a deductible). In addition, they are prohibited from imposing any premium, fee, or other charge on you or your group health plan. The insurer of the contraceptive coverage will be required to provide to plan participants and beneficiaries a written notice of the availability of the contraceptive coverage, separate from but concurrent with (to the extent possible) materials you distribute in connection with enrollment or your annual open enrollment.

For self-funded plans, if you provide your self-certification to your TPA and the TPA agrees to enter into or remain in a contractual relationship with you, the TPA must provide or arrange payments for contraceptive services by either providing direct payments for contraceptive services for plan participants and beneficiaries on its own, or by arranging for an insurer or other entity to provide payments for contraceptive services for your plan. They cannot impose any cost-sharing requirements (such as a premium, fee, copayment, coinsurance, or a deductible) on your group health plan or the plan participants or beneficiaries. The TPA will be required to provide to plan participants and beneficiaries a written notice of the availability of the contraceptive coverage, separate from but concurrent with (to the
extent possible) materials you distribute in connection with enrollment or your annual open enrollment.


177. We are a religiously-affiliated, non-profit organization that believes providing a self-certification to our carrier or TPA makes us complicit in providing contraception. Are we required to provide the self-certification to our carrier or TPA?

No. In a decision issued on July 3, 2014, the U.S. Supreme Court ruled that a religiously-affiliated non-profit college was not required to provide the self-certification to their TPA or carrier. Instead, they only needed to provide a letter to HHS declaring their religious objection to the contraceptive mandate in order to avoid being penalized for not providing contraception coverage. In response to the Supreme Court decision, regulations have been issued allowing you to notify HHS of your objection to providing coverage for some or all contraceptive instead of providing it to the TPA or carrier.

The notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on sincerely held religious beliefs to covering some or all contraceptive services, as applicable (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (that is, whether it is a student health insurance plan or a church plan); and the name and contact information for any of the plan’s TPAs and health insurance carriers.

A model notice for informing HHS of your objection to providing contraceptive coverage is available at: http://www.cms.gov/cciio/resources/Regulations-and-Guidance/index.html#Prevention

After you have notified HHS of your objection, the Department of Labor or the Department of Health and Human Services will send a separate notification to your plan’s carrier or TPA informing them that HHS has received your notice and describing the obligations of the carrier or TPA to provide or arrange separate contraceptive coverage for plan participants and beneficiaries without imposing cost-sharing requirements.

178. Where do we send our HHS notice of objection to providing contraceptive coverage?

The notice to HHS, and any subsequent updates, should be sent electronically to: marketreform@cms.hhs.gov, or by regular mail to:

Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW, Room 739H
Washington, D.C, 20201
179. If we provide the self-certification to our TPA, are they required to provide or arrange for contraception coverage for our participants or beneficiaries?

No. The TPA is under no obligation to provide or arrange the contraceptive coverage, but if they refuse to provide contraceptive coverage, they are prohibited from entering into or remaining contracted with you or your plan to provide administrative services.

180. Are there any other exemptions from the contraceptive mandate?

Yes. The U.S. Supreme Court ruled on June 30, 2014 that the contraceptive mandate as applied to closely-held, for-profit corporations with "sincerely-held religious beliefs" against contraceptives violates the Religious Freedom Restoration Act (RFRA). Therefore, closely-held, for-profit corporations are not required to comply with the contraceptive mandate if complying means the mandate violates the owner’s sincerely held religious beliefs. Instead, the insurer or TPA would be required to provide or arrange separate contraceptive coverage for plan participants and beneficiaries without imposing cost-sharing requirements.

181. How is a closely-held corporation defined for purposes of this exemption?

A closely held for-profit entity entitled to the accommodation is an entity that --

1. The organization’s highest governing body (such as its board of directors, board of trustees, or owners, if managed directly by its owners) has adopted a resolution or similar action, under the organization’s applicable rules of governance and consistent with state law, establishing that it objects to covering some or all of the contraceptive services on account of the owner’s sincerely held religious beliefs;

2. Is not a nonprofit entity;

3. Has no publicly traded ownership interests, (for this purpose, a publicly traded ownership interest is any class of common equity securities required to be registered under §12 of the Securities Exchange Act of 1934); and

4. Has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar thereto, as of the date of the entity’s self-certification to their TPA or carrier or notice to HHS.

The organization must make its self-certification or notice available for examination upon request by the first day of the first plan year to which the accommodation applies. The self-certification or notice must be executed by a person authorized to make the certification or notice on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under §107 of ERISA.

182. What if we are unsure of our status as a closely-held corporation meeting that definition?

If you need further information regarding whether you qualify for the accommodation, you may send a letter describing your ownership structure to the Department of Health and Human Services. If you do not receive a response from the Department
of Health and Human Services to a properly submitted letter describing your current ownership structure within 60 calendar days, for as long as you maintain that structure, you will be considered to meet the requirements for the accommodation.

183. **If we have to cover contraceptives, can we cover only oral contraceptives?**

No. The guidelines require you to cover without cost sharing at least one form of contraception in each of the methods (currently 18) that the FDA has identified for women including, but not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. However, your plan is permitted to use reasonable medical management techniques to control costs and promote efficient delivery of preventive services.

184. **Can we cover only the generic versions of prescribed contraceptive drugs or impose cost-sharing on brand name drugs?**

You may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. To use this approach, your plan must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version.

Also, if a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then your plan or must provide coverage for the brand name drug without cost-sharing (but also subject to reasonable medical management).

185. **Do we have to cover over-the-counter contraceptives?**

Contraceptive methods that are generally available OTC must be covered only if they are an FDA-approved method and they are and prescribed for a woman by her health care provider.

186. **Is our non-grandfathered plan required to cover without cost sharing recommended women's preventive services for dependent children, including recommended preventive services related to pregnancy, such as contraceptives, preconception and prenatal care?**

Yes. Non-grandfathered health plans must cover specified preventive care services without cost sharing for all participants and beneficiaries under a group health plan. Thus, if a non-grandfathered health plan provides coverage for dependent children, it must also provide contraceptives, preconception and prenatal care for dependent children.

187. **Do we have to cover contraceptives for men?**

No. The preventive care guidelines do not include contraception for men.
188. Can our non-grandfathered health plan limit sex-specific recommended preventive services based on an individual’s sex assigned at birth, gender identity, or recorded gender?

No. The individual’s attending provider will determine whether a sex-specific recommended preventive service is medically appropriate for that individual. If an attending provider determines that a recommended preventive service is medically appropriate for an individual (e.g., a mammogram for a transgender male that has residual breast tissue) and the individual otherwise meets the criteria in the applicable recommendation or guideline, then your non-grandfathered health plan must provide coverage without cost sharing for that service.

189. Does our nongrandfathered option have to provide 100% coverage for both in-network and out-of-network services on the list?

No. You are only required to eliminate cost sharing provisions on in-network providers. You are permitted to impose cost-sharing on covered preventive services that are delivered by out-of-network providers.

If your plan does not have in its network a provider who can provide a particular preventive service, then your plan must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.

190. Our nongrandfathered option has a limit on well baby visits per year. Can we keep that or other limits on the applicable preventive services?

Yes. Nothing in the regulations prevents you from using reasonable methods to determine the frequency, method, treatment, or setting for an item or service on the list as long as it doesn’t conflict with specific recommendations in the guidelines. Reasonable medical management techniques may generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review or similar practices.

191. Is our plan permitted to impose cost-sharing for treatments arising from preventive services?

Yes. Your plan may apply cost sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service (subject to any applicable state laws).

192. If a colonoscopy is scheduled and performed as a screening procedure, may we impose cost-sharing for the cost of a polyp removal during the colonoscopy?

No. Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is considered an integral part of a colonoscopy. Accordingly, your plan may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. In addition, the plan may not impose cost sharing with respect to anesthesia services performed in connection
with the preventive colonoscopy if the attending provider determines that the anesthesia would be medically appropriate for the individual.

In addition, a plan cannot impose cost sharing for the bowel preparation medications prescribed for a colonoscopy performed as a screening procedure.

193. What if an employee goes to their doctor for an office visit but also gets one of the recommended preventive services at the same time. Can we still apply a copay to the office visit charge?

It will depend on the situation:

- If a preventive service is billed separately from the office visit and the primary purpose of the visit is not for preventive purposes, then you may impose cost-sharing requirements with respect to the office visit.
- If a preventive service is not billed separately from the office visit and the primary purpose of the office visit is for preventive services, then you may not impose cost-sharing requirements with respect to the office visit.
- If a preventive service is not billed separate from the office visit and the primary purpose of the office visit is not for preventive purposes, then you may impose cost-sharing requirements with respect to the office visit.

194. Some of the recommended preventive services include things like aspirin or other over-the-counter medications. Is our plan required to cover those items?

Aspirin and other over-the-counter recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.

195. The list of required preventive services requires us to cover tobacco-use counseling and provide tobacco cessation interventions. For employees who use tobacco products, what services are we expected to provide as preventive coverage?

You may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service (to the extent not specified in the recommendation or guideline). So, you would be in compliance if, for example, your plan covers without cost-sharing and without requiring individuals to get prior authorization:

1. Screening for tobacco use; and,

2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
   - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling); and
   - All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider.
196. What happens when there are changes to the recommendations or guidelines for covered preventive services?

If something new is added to the recommendations or guidelines, your plan will not have to cover it until the plan year that begins on or after one year after the date the recommendation or guideline is issued.

If a recommendation or guideline is eliminated after the start of your plan year, your plan is only required to provide that coverage through the last day of the plan year. However, if a preventive care recommendation or guideline is downgraded to a “D” rating, or any item or service associated with any recommendation or guideline is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency, there is no requirement to cover these items and services through the last day of the plan year.

197. Our non-grandfathered group health plan excludes weight management services for adult obesity. Is this still permissible?

No. Non-grandfathered plans must cover, without cost sharing, screening for obesity in adults. In addition, for adult patients with a body mass index (BMI) of 30 or higher, the preventive care recommendations include intensive, multicomponent behavioral interventions for weight management. The recommendation specifies that intensive, multicomponent behavioral interventions include, for example, the following:

- Group and individual sessions of high intensity (12 to 26 sessions in a year),
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes.

198. What are the new claims and appeals processes and how will they apply?

Starting with the first plan year beginning on or after September 23, 2010, both insured and self-funded plans that are not grandfathered must implement new claims and appeal procedures and an external review process. Nongrandfathered plans (and insurers) will have to incorporate the current ERISA claims and appeals requirements and update them based on additional changes in PPACA. In addition, adverse benefit determinations will be subject to an external review process.
199. Our plan is a governmental plan that is not subject to ERISA and does not follow the current ERISA guidelines. Will we have to update our internal claim and appeal process?

Yes, if your plan loses its grandfathered status. Because PPACA applies to all group health plans, you would have to incorporate the current ERISA claims and appeals processes as updated by PPACA for your plan.

This same rule will apply for church plans that are not currently subject to the ERISA claims and appeals process.

200. What changes did PPACA make to ERISA’s current claims and appeals rules?

The changes that have been made are:

1. An adverse benefit determination now includes any rescission of coverage;

2. The plan must provide, free of charge, any new or additional evidence or rationale used by the plan in connection with the claim determination. This evidence must be provided in advance to give the participant a reasonable opportunity to respond prior to the review date;

3. The plan must ensure that all claims and appeals are reviewed in a manner designed to ensure the independence and impartiality of the persons involved in making the decision;

4. The plan must provide notices of adverse benefit determinations to enrollees in a culturally and linguistically appropriate manner;

5. Additional content requirements apply for notices to claimants identifying the claim involved, including, for example, the denial code, a description of the plan’s available internal appeals and external review processes, and contact information for any office of health insurance consumer assistance;

6. The regulations emphasize completely following a full and fair process of review. Accordingly, failure to strictly adhere to the review requirements (except for errors that are minor and are nonprejudicial and attributable to good cause outside the plan’s control) will allow the participant to initiate an external review and pursue any available remedies under applicable law, such as judicial review.

On September 20th, 2010 the DOL announced a delay in enforcement of #4, #5 and #6 above until July 1, 2011, for group health plans that are working in good faith to implement the new standards.

On March 18, 2011, the DOL announced a further delay in enforcement of #4 and #6 until the first day of the first plan year starting on or after January 1, 2012. For the requirements of #5 (e.g. denial codes, description of the plan’s internal appeals and external review process, disclosure of the availability of an office of consumer assistance) the effective date has been changed from July 1, 2011 to the first day of the first plan year starting on or after July 1, 2011.
Note: Requirements in the interim final regulations including making urgent care claim determinations within 24 hours, providing diagnosis and treatments codes in all adverse determination notices, providing adverse benefit determinations in a culturally and linguistically appropriate manner, and requiring strict adherence to the internal appeals and external review process were dropped or significantly modified on June 24, 2011.

201. Are we required to include diagnosis and treatment codes in our adverse benefit determination notices?

No. However, plans are required to provide notification to claimants of their right to request the inclusion of diagnosis and treatment codes (and their meaning) in all adverse benefit determination notices.

202. What must our plan do to ensure our adverse benefit determination notices are provided in a culturally and linguistically appropriate manner?

If you have employees living in a county where 10% or more of the population residing in that county are literate only in the same non-English language, your plan must:

- Provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language;
- Include in any adverse benefit determination notice a one-sentence statement in the non-English language describing the plan’s language assistance services; and
- Provide a translation of adverse determination notices upon request.

Information on all counties meeting the 10% threshold will be made available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html.

203. If my plan is insured, will I have to do anything?

No. The claims and appeals regulations also apply to insurers and it will be up to the insurer to provide claims and appeals processes that comply with the requirements.

204. How will the external review process apply to my plan?

Your plan will have to comply with either a State external review process or a new Federal external review process.

If your plan is insured, a State external review process will apply, if the State has a process that complies with minimum standards established under PPACA. If no process exists or the State process does not meet the minimum standards, then the Federal external review process will apply.

For self funded plans, the Federal process will apply in most cases. However, the State process will apply to self funded plans in states where the state’s own external review process is binding on plans such as MEWAs or plans that are not subject to ERISA such as church and governmental plans.
205. How will the Federal external review process work?

Self-funded ERISA plans may choose to participate in the Federal external review process administered by HHS through an agreement with Maximus (a Federal contractor), or engage in the private accredited IRO process for plans subject to ERISA and/or the Code (see below). Alternatively, self-funded ERISA plans can voluntarily comply with a state external review process if it’s made available.

All insured plans and all self-insured nonfederal governmental health plans in States whose external review processes are found not to meet NAIC guidelines must also participate in a Federally-administered external review process. Plans and issuers may choose to participate in the Federal external review process administered by HHS through an agreement with Maximus (a Federal contractor), or engage in the private accredited IRO process for plans subject to ERISA and/or the Code.

206. Our self funded ERISA plan year begins on January 1, 2011, and we will be making plan changes that will result in a loss of grandfathered status. If there is no Federal external review process available by that date, how will we comply with the requirement?

Because the Federal process will not be ready by January 1, there are interim “safe harbor” guidelines you will have to follow. These include:

1. Allow at least 4 months for a claimant to file a request for external review.

2. Within 5 business days, complete a preliminary review of a request for external review to determine if the individual is or was covered under the plan at the time the service was incurred, whether the claimant has exhausted the plan’s internal appeal process, and whether the claimant has provided all the information and forms required to process the external review.

3. Within one day after completing the preliminary review, the plan must notify the claimant in writing of the outcome of the preliminary review. If you determine the claimant is not eligible for the external review process, the notice must include the reason for ineligibility. If the request for review is not complete, the notice must include the information needed to complete the request.

4. Assign an independent review organization (IRO) to conduct the external review.

207. Do we have to hire an independent review organization (IRO) to handle our external review process until the federal process is available?

Yes, in most cases. Under the safe harbor, you would have to contract with at least two IROs by January 1, 2012 and three IROs by July 1, 2012 that are accredited by URAC for assignments under the plan and then you must randomly rotate claims assignments among the IROs. In addition, you will have to have specific provisions in your contract with each IRO to ensure their compliance with all the steps of the external review process. A list of the required contract provisions can be found in DOL Technical Release 2010-01 at the DOL website here:
208. Is there any alternative to hiring three IROs for our self-funded plan?

Maybe. Because the safe harbor is just a guideline, plans that do not strictly comply with all the standards set forth in the technical release will be subject to a facts and circumstances analysis. Thus, a plan that does not satisfy all of the standards of the technical release’s safe harbor may in some circumstances nonetheless be considered to be in compliance with the guidance.

For example, one of the standards set forth in the technical release requires self-insured plans to contract with independent review organizations (IROs) and to rotate claims assignments among them (or to incorporate other independent, unbiased methods for selection of IROs, such as random selection). However, a self-insured group health plan’s failure to contract with at least two (or three) IROs does not mean that the plan has automatically violated the safe harbor. Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.

Another alternative is that you may choose to voluntarily comply with the provisions of that State external review process if the State chooses to expand access to their State external review process to self funded plans.

209. Our plan is a self-funded nonfederal governmental plan. What’s the process for participating in the Federally-administered external review process administered by HHS?

For elections made prior to June 15, 2015, you must submit the following information regarding your election of a Federal external review process to HHS via email at ExternalAppeals@cms.hhs.gov by the earlier of January 1, 2012 or the date by which your plans intended to use the Federal external review process:

1. Contact information for the plan administrator, including name, mailing address, telephone number, facsimile number, and electronic mail address.

2. A statement as to whether you will be complying with the HHS-administered process or the private accredited IRO process.

You must also notify HHS as soon as possible if any of the above information changes at any time after it is first submitted.

For elections made on or after June 15, 2015, you must submit information regarding your election of a Federal external review process to HHS via their Health Information Oversight System (HIOS) by the date on which you intend to begin using the Federal external review process.

210. How do we use the HIOS system to elect Federal external review?

211. Does the external review process apply to all adverse benefit determinations?

For plans subject to a state external review process (e.g. an insured plan), the state will determine the scope of claims subject to that state’s external review process.

For self-funded plans subject to the federal external review process, the external review process only applies to claims that involve:

1. Medical judgment (e.g. experimental, medical necessity) as determined by the external reviewer; or
2. Rescission of coverage.

The enforcing agencies have reserved the right to expand the scope of claims eligible for external review starting in 2014 but they indicated they will give sufficient advance notice to enable plans to comply if any new rules are issued at that time.

212. Are there any model notices we can use to develop our self-funded plan’s adverse benefit determination notices?

Yes. The following model notices are available at the DOL website:

- Model Notice of Adverse Benefit Determination
- Model Notice of Final Internal Adverse Benefit Determination
- Model Notice of Final External Review Decision

Updated model notices can be downloaded from the DOL website at: http://www.dol.gov/ebsa.

213. Will the new requirements for internal and external claims and appeals processes apply to my life or disability coverage?

No. The new changes under PPACA only apply to health insurers and group health plans.

214. Is it true that the maximum deductible we can have on our plan is $2,000/$4,000?

When PPACA was enacted, it included a provision limiting the maximum deductible amounts to $2,000/$4,000 for nongrandfathered, insured plans in the small group market effective January 1, 2014. On April 1, 2014 however, the deductible limit provision was repealed back to the original enactment date of PPACA. As a result, the deductible limits are no longer applicable to the small group insurance market.

215. Are there any other cost-sharing limits we need to be aware of?

Yes. For plan years starting on or after January 1, 2014, the out-of-pocket maximums for nongrandfathered plans (including both insured and self-funded plans of large and small employers) cannot exceed the self-only and family out-of-pocket maximums applicable to HSA-qualified high deductible health plans (HDHP). The annual out-of-pocket maximums for qualified HDHPs for 2014 were $6,350 for self-
only coverage and $12,700 for family coverage. For plan years starting after 2014, these amounts will be indexed by HHS using a specific methodology as described in PPACA that is different than the indexing applicable to HSA-qualified HDHPs. The indexed amounts for plans that are not high deductible health plans (HDHPs) are:

- 2015 - $6,600 and $13,200
- 2016 - $6,850 and $13,700
- 2017 - $7,150 and $14,300
- 2018 - $7,350 and $14,700

The out-of-pocket maximum is a total cost-sharing limit for essential health benefits. The out-of-pocket maximum includes deductibles, coinsurance, copayments, or similar charges and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the plan. The out-of-pocket maximum does not include premiums, costs for non-essential health benefits, balance billing amounts for non-network providers, or expenditures for non-covered services.

**216. If our deductible or out-of-pocket maximum for family coverage exceeds the annual out-of-pocket limit for self-only coverage ($6,850 for 2016), what do we need to do to ensure our plan is in compliance?**

For non-grandfathered plan years starting in 2016 or later, the self-only maximum annual limit on out-of-pocket costs applies to any individual who is enrolled in family coverage or other coverage that is not self-only coverage. Accordingly, if your plan has an annual family out-of-pocket or deductible limit that exceeds the self-only out-of-pocket limit, then your plan must include an “embedded” out-of-pocket limit for each covered individual. For example, if your plan has a family deductible or out-of-pocket limit of $10,000 in 2016 and one family member incurs an expense of $9,000, that family member would be responsible for expenses only up to the $6,850 self-only out-of-pocket limit for 2016, and the remaining $2,150 must be paid in full by your plan.

**217. Do the out-of-pocket cost sharing limits also have to apply to our out-of-network benefits?**

No. Cost-sharing amounts paid by the participant for services obtained from out-of-network providers do not have to count towards the out-of-pocket maximum limits.

**218. We have a separate pharmacy benefit manager for our self-funded medical plan with a separate prescription drug out-of-pocket maximum. Will we have to coordinate the two benefits so that the overall out-of-pocket maximum limits are not exceeded?**

If your plan is nongrandfathered, the two processes will need to be coordinated which may require regular communications between your service providers.

However, under a transition rule for plans that utilize more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums, the out-of-pocket rule will be satisfied for the first plan year starting on or after January 1, 2014 if both of the following conditions are satisfied:
1. The plan complies with the out-of-pocket requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage); and

2. To the extent the plan includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies to prescription drug coverage), the separate out-of-pocket maximums cannot exceed the same out-of-pocket dollar amounts that apply to the major medical coverage.

219. Can we divide the annual limit on out-of-pocket costs across multiple categories of benefits (e.g. medical and Rx), rather than reconcile those claims under a single out-of-pocket maximum across multiple service providers?

Yes. You are permitted to use separate out-of-pocket limits for different categories of benefits, provided that the combined amount of any separate out-of-pocket limits does not exceed the annual limitation on out-of-pocket maximums for that year.

220. We have a separate pharmacy benefit manager for our self-funded medical plan but our prescription drug benefit does not have an out-of-pocket maximum. Will we have to add one for 2014 that complies with the maximum out-of-pocket limit?

No. If your prescription drug benefit is administered by a separate service provider, and it currently has no out-of-pocket limit, you will not be required to add one for 2014, as long as your major medical coverage complies with the out-of-pocket requirement. For plan years starting in 2015 and after, the two processes will need to be coordinated so that the combined major medical and prescription drug out-of-pocket maximum does not exceed the statutory limits.

221. How are out-of-pocket costs determined if we are using a reference-based pricing model for certain procedures?

If your non-grandfathered plan utilizes reference-based pricing (or similar network design), it may treat providers that accept the reference based-price as the only in-network providers for purposes of determining what counts towards an individual's OOP limit as long as the non-grandfathered plan uses a reasonable method to ensure that it provides adequate access to quality providers at the reference-based price.

If your plan does not ensure that participants have adequate access to quality providers that will accept the reference price as payment in full, the plan is required to count an individual's out-of-pocket expenses for providers who do not accept the reference price toward the individual's OOP limit.

222. How do we know if we are providing adequate access to quality providers at the reference-based price?

Plans are encouraged to consider network adequacy approaches developed by the States, as well as reasonable geographic distance measures, and whether patient wait times are reasonable.
In addition, your plan should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:

a) Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance).

b) The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

223. Will we have to provide any other new notices or disclosures as a result of these bills?

Yes. Group health plans and insurers will have to provide a new four-page “Summary of Benefits and Coverage” (SBC) describing the benefits and limitations of the coverage available under your plan as well as simulated coverage example calculations for two common benefit scenarios - having a baby and managing diabetes. In addition, the summary must include:

- Contact information – such as a telephone number for customer service and an internet address – for obtaining a copy of the insurance policy or certificate;
- An internet address (or similar contact information) for obtaining a list of network providers;
- An internet address linking individuals to information about their prescription drug coverage if a formulary is used;
- An internet address linking individuals to a uniform glossary defining commonly used medical insurance terms; and
- For plan years beginning on or after January 1, 2014, a statement about whether the plan provides minimum essential coverage and minimum value requirements.

You may provide the SBC as a stand-alone document or in combination with other summary materials (for example, an SPD), if the SBC information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in an SPD) and in accordance with the timing requirements for providing an SBC. The SBC must: 1) use terminology understandable by the average plan enrollee; 2) not exceed four double-sided pages in length; and 3) not include print smaller than 12-point font.

The SBC must be provided in addition to the current SPD that is already required under ERISA.
224. We have three plan options, will we have to provide a separate SBC for each option?

Yes. A separate SBC must be created and distributed for each benefit option offered under your plan. An SBC for each option must be provided to any individual who is eligible for those options. If a newly eligible employee is eligible for all three options, then you must provide the employee an SBC for each option.

225. Is there a deadline for providing SBCs to our newly eligible employees?

Yes. For participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees), an SBC must be provided by the first day of the first open enrollment period that begins on or after September 23, 2012.

For participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), you must provide the SBC starting on the first day of the first plan year that begins on or after September 23, 2012.

The SBC must be distributed to newly eligible employees as part of any written enrollment/application materials that are distributed by your plan. Or, if your plan does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date the participant is eligible to enroll in coverage.

226. We have a self-funded PPO option but we also have an insured HMO option. Will our insurer help us with creating the SBC?

Yes. Your health insurer must provide the SBC to you for your insured HMO option though you may be responsible for distributing the SBC to your employees and their beneficiaries.

For your self-funded option, as the plan administrator you will be responsible for creating and distributing the SBC to your employees and beneficiaries. You are also allowed to hire a third party to create and/or distribute the SBC as long as it’s provided in a timely fashion and in accordance with the SBC form and content rules.

227. When will our insurer provide us with the SBCs so we can distribute them to our employees?

You should contact your insurer for information on when they will be available for distribution.

If you request information from any insurer, the insurer is required to provide you with an SBC no later than 7 business days following your request. If you subsequently apply for coverage with that insurer, they must provide a second SBC as soon as practicable after receiving your application but in no event later than 7 business days following receipt of the application. If there is a change in the SBC before the coverage is offered or becomes effective, an updated SBC must be provided no later than the first day of coverage.
When you renew with your insurer (for example, in a succeeding policy year), the insurer must provide you with a new SBC when the policy is renewed.

228. After our employee’s initial enrollment, at what other times does the SBC have to be distributed to participants and beneficiaries?

You will have to provide the SBC in several circumstances including:

- Within 90 days of enrollment pursuant to a HIPAA special enrollment opportunity.
- At open enrollment, if you require participants and beneficiaries to actively elect to maintain coverage, or provide them with the opportunity to change coverage options, you must provide the SBC at the same time you distribute open enrollment materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.
- Upon request, as soon as practicable, but in no event should it be sent later than seven business days following the request.

229. If our employee is eligible for a special enrollment opportunity, do we have to provide him with SBCs for all of our plan options?

No, but if an individual eligible for special enrollment is contemplating their coverage options and would like to receive SBCs before applying for coverage, they may request an SBC with respect to any particular benefit package and you must provide it as soon as practicable, but in no event later than seven business days following receipt of the request.

230. What happens if negotiations with our insurer are not completed until we are already within 30 days of the renewal date?

If the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than 7 business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of your intent to renew, whichever is earlier.

231. If we have more than one plan option, does that mean we have to provide every eligible employee with a new SBC for each option every year at open enrollment?

Not necessarily. You are required to provide a new SBC automatically at open enrollment, but only for the benefit option in which a participant or beneficiary is enrolled. You do not have to automatically provide SBCs for benefit options in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit option (or more than one other benefit option) for which the participant or beneficiary is eligible, the SBC (or SBCs) must be provided as soon as practicable but in no event later than 7 business days following the employee’s request.
232. Are we required to provide a separate SBC for each coverage tier (e.g., self-only coverage, employee-plus-one coverage, family coverage, etc.) within a benefit option?

No. You may combine information for different coverage tiers in one SBC provided the appearance is understandable, the coverage examples are completed assuming the cost sharing (e.g., deductible and out-of-pocket limits) for the self-only coverage tier, and this assumption is noted on the coverage examples.

233. Do we have to send each employee and dependent an SBC or can we just send it to the employee?

If an employee/participant and any beneficiaries are known to reside at the same address, you can send a single notice to that address. However, if you know that a spouse or dependent’s address is different than the employee/participant’s address, you must send a separate SBC to the spouse or dependent at their last known address.

234. Our coverage is structured in a way that is different than contemplated by the SBC templates (e.g. different network or drug tiers, or in denoting the effects of a health flexible spending account, health reimbursement arrangement, or wellness program). How do we describe those benefits in the SBC?

To the extent your plan has terms that are required to be described in the SBC template that cannot reasonably be described in a manner consistent with the template and instructions, you must accurately describe the relevant plan terms while using your best efforts to do so in a manner that is still consistent with the instructions and template format as reasonably possible.

235. What if we have carved out a certain benefit, such as carving out the pharmacy benefit to a pharmacy benefit manager (“PBM”)?

If you use two or more insurance products provided by separate insurers, or use a combination of insured and self-funded coverage (e.g. insured medical and self-funded Rx), you are responsible for providing complete SBCs that integrate both coverage types. However, you may contract with one of your issuers (or other service providers) to perform that function or you must synthesize the information into a single SBC or provide multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements.

The DOL says that you can contract with another party (e.g., the PBM) to assume responsibility to:

1. Complete the SBC,

2. Provide the required information to you so you can complete a portion of the SBC, or

3. Deliver an SBC in accordance with the final regulations.

If you contract this responsibility to the vendor, the following conditions must also be satisfied:
1. You monitor the vendor’s performance under the contract;

2. If you learn of a violation of the final regulations and have the information to correct it, you correct the violation as soon as practicable; and

3. If you have knowledge of a violation of the final regulations and you don’t have the information to correct it, you must communicate with participants and beneficiaries regarding the lapse and begin taking significant steps as soon as practicable to avoid future violations.

236. Do we have to provide an SBC for our dental or vision coverage?

You will not have to provide an SBC for your dental or vision coverage if they are limited scope HIPAA excepted benefits. Excepted benefits are those dental and vision benefits that are either provided under a separate policy or contract of insurance or are not an integral part of the group health plan (i.e. employees can waive the dental or vision).

237. Are we required to provide SBCs to individuals who are COBRA qualified beneficiaries?

Yes. While a qualifying event will not usually trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a current employee. There are also limited situations in which a COBRA qualified beneficiary may need to be offered coverage that is different than the coverage he or she was receiving before the qualifying event and this may also trigger the right to an SBC.

238. Where possible, we provide our plan communications to employees using electronic media (e.g. internet posting, email). Can the SBC be distributed electronically?

Yes. The SBC can be provided in paper format or it can be provided electronically. To provide it electronically to participants already covered under the plan, the disclosure must comply with the DOL’s ERISA regulations for electronic disclosures.

With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if:

1. The format is readily accessible;

2. The SBC is provided in paper form free of charge upon request; and

3. In a case in which the electronic form is an Internet posting, you timely notify the individual in paper form (such as a postcard) or email that the SBC documents are available on the Internet, you provide the Internet address, and you notify the individual that the documents are available in paper form upon request.
239. Can the SBC be provided electronically through our online enrollment system?

Yes. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online.

In either case, the individual must have the option to receive a paper copy upon request.

240. Our plan is a governmental plan that is not subject to ERISA. Do we still have to comply with the ERISA electronic disclosure regulations?

Governmental plans can provide the SBC electronically if either the substance of the provisions of the DOL electronic disclosure rules are met, or if the provisions governing electronic disclosure in the individual health insurance market in your state are met.

241. If we make mid-year changes to our plan that require us to change the information in the SBC, do we have to send out a new SBC?

No. However, if you make a mid-year material modification in any of the terms of the plan or coverage that is not reflected in the most recently provided SBC, you must provide notice of the modification to enrollees not later than 60 days prior to the date on which such modification will become effective. Of course, providing an updated SBC reflecting the modification no later than 60 days prior to the effective date of the change will also satisfy your obligation.

You are required to comply with this 60-day advance notice requirement for any mid-year changes you make after the SBC requirement is effective for your group health plan.

Like the SBC, the 60-day advance notice can be provided in paper format or electronically if the disclosure complies with the DOL’s regulations for electronic disclosures.

242. Will we also have to send a Summary of Material Modification (SMM) to the plan participants if we have sent out the SBC advance notice?

No. If you provide the advance notice of a material modification in a timely manner, the notice will also satisfy your obligation to provide a Summary of Material Modification (SMM) as required under ERISA.

243. Are there model notice/templates we can use to fulfill the SBC obligation?

Yes. There are sample templates and documents that can be used to comply with the requirement. Updated materials are issued periodically.

You can view or download the following templates and documents that are currently applicable and the templates and document that are applicable for open enrollments starting on or after April 1, 2017 on the DOL website:
244. **We have several employees who are fluent only in a non-English language. Do we have to provide a translated version of the SBC to them?**

Under some circumstances, you (or the insurer) will be required to provide a “culturally and linguistically appropriate” notice to individuals who are only fluent in a non-English language. To satisfy this requirement, certain support services such as a telephone customer service hotline that can answer questions in the non-English language must be made available if notices are being sent to a participant or beneficiary in a county where the U.S. Census Bureau has determined that 10% or more of the population in that county is literate only in a non-English language.

In addition, SBCs sent to those counties must include a statement, prominently displayed, in the applicable non-English language clearly indicating how to access the language services provide by the plan or insurer. Sample language for this statement is available on the model notice of adverse benefit determination at: [http://www.dol.gov/ebsa/IABDModelNotice2.doc](http://www.dol.gov/ebsa/IABDModelNotice2.doc).

A translated SBC in the applicable non-English language must be provided upon request. To help plan sponsors meet the language requirements for open enrollments and plan years starting before April 1, 2017, HHS has provided written translations of the SBC template, sample language, and uniform glossary in Spanish, Tagalog, Chinese, and Navajo at: [http://cciio.cms.gov/resources/other/index.html#sbcug](http://cciio.cms.gov/resources/other/index.html#sbcug).


245. **We currently have a 180-day waiting period before coverage is effective. When will that have to be changed?**

For plan years starting on or after January 1, 2014, your waiting period cannot be longer than 90 days.
246. Can we change our waiting period to three months instead of 90 days?

No. Because three consecutive months in some cases may result in a waiting period that is more than 90 days, using three months instead of 90 days is not permitted. All calendar days are counted toward the 90-day limit beginning on the employee’s start date, including weekends and holidays.

247. Our plan currently has a 90 day waiting period and then coverage is effective on the first day of the month following 90 days. Will that satisfy the requirement?

No. Except for a limited exception for certain “variable hour” employees (see below), you are not permitted to delay the effective date of coverage to the first day of the month following 90 days.

248. We currently have a 6-month waiting period and our plan year will not start until March 1, 2014. Can we apply the full 6-month waiting period to an employee hired in late 2013 or before March 1 of 2014?

No. For individuals who are in their waiting period before March 1st (the effective date of the 90-day limit for your plan), then beginning on March 1, 2014, your 6-month waiting period can no longer apply because the waiting period would exceed 90 days.

Example: Prior to March 1, 2014, your plan provides that full-time employees are eligible for coverage after a 6-month waiting period and employee Adam begins work as a full-time employee on November 1, 2013.

Conclusion: The first day of Adam’s waiting period is November 1, 2013. Beginning March 1, 2014, your plan may not apply a waiting period that exceeds 90 days. Accordingly, Adam must be given the opportunity to elect coverage that begins no later than March 1, 2014 (which is only 121 days after Adam’s start date) because otherwise, on March 1, 2014, the plan would be applying a waiting period that exceeds 90 days. Note: your plan would not be required to make coverage effective for Adam before March 1, 2014.

249. We currently require new employees to complete an orientation period before becoming permanent employees and eligible for coverage. Are we required to include the orientation period as part of the waiting period?

You are permitted to condition eligibility on among other things, satisfying a reasonable and bona fide employment-based orientation period of no more than one month during which you and the employee would evaluate whether the employment situation was satisfactory for each party, and standard orientation and training processes would begin. If you condition eligibility on an employee’s having completed a reasonable and bona fide employment-based orientation period of one month or less, the maximum 90-day waiting period could then begin on the first day after the orientation period.

For purposes of the length of the orientation period, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee’s start date in a position that is otherwise eligible for coverage. For example, if an employee’s start date in an otherwise eligible position is May 3, the
last permitted day of the orientation period is June 2. Similarly, if an employee’s start
date in an otherwise eligible position is October 1, the last permitted day of the
orientation period is October 31. If there is not a corresponding date in the next
calendar month upon adding a calendar month, the last permitted day of the
orientation period is the last day of the next calendar month. For example, if the
employee’s start date is January 30, the last permitted day of the orientation period
is February 28 (or February 29 in a leap year). Similarly, if the employee’s start date
is August 31, the last permitted day of the orientation period is September 30.

250. If we require new full-time employees to complete a one-month orientation
period plus satisfy our 90-day waiting period, are we automatically exempt from
having to pay an employer mandate penalty for that 120-day period?

No. The final regulations clarify that compliance with the 90-day waiting
period/orientation period final regulations does not ensure compliance with the
employer mandate rules. Those rules state that you will not be subject to a penalty
for the first three full months of employment if you provide affordable, minimum value
coverage to newly-hired full-time employees by the first day of the fourth full calendar
month of employment. Therefore, if you have a one-month orientation period, you
may comply with both the 90-day waiting period/orientation period rules and the
employer mandate by offering coverage no later than the first day of the fourth full
calendar month of employment. However, you may not be able to impose the full
one-month orientation period and the full 90-day waiting period without potentially
becoming subject to an assessable payment under the employer mandate. For
example, if an employee is hired as a full-time employee on January 6, and you offer
coverage May 1st (the first day of the fourth month after the start date), you comply
with both provisions and would not be subject to an assessable payment under the
employer mandate. However, if you start coverage May 6th, which is 121 days after
the date of hire, you may be subject to an assessable payment under the employer
mandate.

251. What happens if our new employee is in their waiting period but has not yet
reached 90 days when the new plan year begins on March 1, 2014?

You could continue the waiting period until that employee’s waiting period has
reached 90 days.

Example: Prior to March 1, 2014, your plan provides that full-time employees are
eligible for coverage after a 6-month waiting period and employee Shawn starts work
as a full-time employee on February 15, 2014.

Conclusion: The first day of Shawn’s waiting period is February 15, 2014. Beginning
March 1, 2014, your plan may not apply a waiting period that exceeds 90 days.
Accordingly, Shawn must be given the opportunity to elect coverage that begins no
later than May 16, 2014 (which is only 91 days after Shawn’s start date) because
otherwise, the plan would be applying a waiting period that exceeds 90 days after
March 1, 2014.
252. Part-time employees are not eligible for our plan but there are situations where a part-time employee is promoted to full-time status. Assuming an employee worked as a part-time employee for more than 90 days, would we have to allow him to enroll immediately?

No. A waiting period is defined as the period that must pass before coverage becomes effective for an employee who is otherwise eligible to enroll. Because the employee was not eligible to enroll as a part-time employee, a 90-day waiting period can be applied commencing on the date the individual becomes a full-time employee.

253. If we implement a 90-day waiting period but an employee fails to complete the enrollment forms in a timely fashion and coverage is delayed a month, will that violate the law?

No. As long as your employee had the opportunity to elect coverage that would begin on a date that does not exceed the 90-day limit, you will not be in violation of the law merely because the employee took additional time to elect coverage.

254. Only full-time employees working 30 or more hours per week are eligible for our plan. Sometimes we have new hires with variable work schedules where it cannot be immediately determined if they will regularly work 30 hours per week. How can we handle those situations without violating the waiting period rules?

You may take a reasonable period of time to determine whether the employee works enough hours to meets the plan’s eligibility criteria, which may include a look-back measurement period that is no more than 12 months long. If in reviewing the measurement period, you determine the employee has worked the requisite hours to be eligible for coverage, then up to a 90-day waiting period can be applied but in no case can the coverage start later than 13 months plus a fraction of a month from the employee’s start date.

**Example:** Under your group health plan, only employees who work full time (defined under the plan as regularly working 30 hours per week) are eligible for coverage. Jerry begins working on November 26, 2014. Jerry’s hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability. Therefore, you cannot determine at Jerry’s start date that he is reasonably expected to work full time. Under the terms of the plan, variable hour employees such as Jerry are eligible to enroll in the plan if you determine they are full time after a look-back measurement period of 6 months. You then make coverage effective no later than the first day of the first calendar month after a 90-day waiting period, if the applicable enrollment forms are received. Jerry’s 6-month measurement period ends May 25, 2015. Jerry is determined to be full time and you notify him of his plan eligibility. If Jerry then elects coverage by completing his enrollment form on August 28, 2015, his first day of coverage will be September 1, 2015.

**Conclusion:** In this Example, because Jerry’s coverage becomes effective no later than 13 months from his start date, plus the time remaining until the first day of the next calendar month, the plan is in compliance with the requirement. The measurement period is 12 months or less (and is, therefore, permissible) because you may use a reasonable period of time to determine whether Jerry is full time and
the waiting period you apply after the end of the measurement period is 90 days or less (and is, therefore, permissible).

Jerry:

255. In addition to covering full-time employees working 30 or more hours per week, part-time employees also become eligible for coverage when they have completed a cumulative 1,200 hours of service. Will this have to be changed to comply with the 90-day rule?

No. A cumulative hours of service condition with respect to part-time employees is permitted as long as the amount of cumulative hours worked required for eligibility is less than or equal to 1,200 hours. Accordingly, coverage for part-timers under your plan must begin no later than the 91st day after a part-time employee has worked 1,200 hours. In addition, the cumulative hour requirement can only be applied one time. Re-application of the requirement to the same individual each year is prohibited.

256. We have employees covered by a multiemployer plan operating under a collective bargaining agreement that allows employees to earn eligibility for coverage by working hours for multiple contributing employers over a quarter. Is that allowed?

If the employee earns eligibility by aggregating hours worked in a quarter across multiple contributing employers, and then retains coverage through the next full quarter, regardless of whether the employee has terminated employment, it would be considered to be a design that accommodates a unique operating structure and not designed to avoid compliance with the 90-day waiting period limit.

Clinical Trials

257. Our plan is not grandfathered so what will we have to do to comply with the clinical trial mandate starting in 2014?

Under the clinical trial mandate, if your plan is providing coverage to “qualified individuals”, then starting with any plan year that begins on or after January 1, 2014, the plan:
1. May not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;

2. May not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

3. May not discriminate against the individual on the basis of the individual's participation in the trial.

258. How is a “qualified individual” defined?

A “qualified individual” is defined as a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either:

1. The referring health care professional is a provider participating in the trial and has concluded that the individual's participation in such trial would be appropriate; or

2. The participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

259. Will we have to provide coverage for the investigational item, device or service?

No. Your plan is only required to cover the patient's routine costs. Routine patient costs would include any items and services consistent with the coverage provided under your plan that is typically covered for individuals who are not enrolled in a clinical trial. Your plan would NOT have to cover:

1. The investigational item, device, or service, itself;

2. Any items or services that are not used in the direct clinical management of the patient but rather, are provided in connection with data collection and analysis needs; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

260. How will we know if a trial is an approved trial?

An approved clinical trial is defined as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is any of the following:

1. The study or investigation is federally approved or funded by certain governmental entities or departments;

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The health care provider participating in the trial should be able to verify that it’s an approved trial.

261. Can we require employees or dependents that are qualified individuals to use our HMO’s in-network providers?

You can require the employee to use an in-network provider only if the in-network provider is participating in the trial and will accept the individual as a participant in the trial.

If the employee or dependent is participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides (and therefore is outside the network), then the plan would have to cover the routine medical costs associated with the trial if the plan otherwise covers routine out-of-network services.

262. Are there examples of the types of services we would have to cover?

Yes. If your plan generally covers chemotherapy to treat cancer, the plan cannot limit coverage of chemotherapy for an individual due to the fact that it is provided in connection with the individual’s participation in an approved clinical trial for a new anti-nausea medication. In addition, if your plan typically covers items and services to diagnose or treat certain complications or adverse events, the plan cannot deny coverage of those items and services when provided to diagnose or treat complications or adverse events (e.g., side effects) in connection with an individual’s participation in an approved clinical trial.

263. We only offer health insurance to our executives. Will we be able to continue this plan?

Yes, if the plan is a fully insured “grandfathered” plan. For insured plans that have lost grandfather status, a new nondiscrimination rule applies.

264. Our insured plan is not grandfathered. Will we have to comply with the new nondiscrimination rule?

Yes. PPACA’s nondiscrimination rule for insured plans that have lost grandfather status prohibits discrimination in favor of highly compensated individuals using rules similar to those in Code Section 105(h) that apply to self-funded group health plans.

265. When will we have to comply with this rule?

The rule was supposed to apply for plan years beginning on or after September 23, 2010. However, on December 22, 2010, the IRS and Departments of Labor and Health and Human Services announced that compliance with the new nondiscrimination provision will not be required (and thus, any sanctions for failure
to comply will not apply) until after regulations or other administrative guidance has been issued. In order to provide insured group health plan sponsors time to implement any changes required as a result of any regulations or other guidance, the Departments anticipate that the future guidance will not apply until plan years beginning a specified period after issuance of the regulations.

266. What are the nondiscrimination rules under Code §105(h) that will apply to our insured plans if they lose grandfathered status?

Under the current Code §105(h) rules, self funded plans must not discriminate in favor of highly compensated employees (HCEs). Until we have regulations on this new provision, it is not clear how the nondiscrimination rules will apply to insured plans. At this time we only know that the rules will be "similar" to the current rules under Code §105(h). Under 105(h), a plan is considered nondiscriminatory only if it satisfies both the eligibility and benefit tests summarized below:

Eligibility Test

Satisfy at least one of the following nondiscriminatory participation requirements:

- At least 70% of all nonexcludable (see below) employees must actually participate in the plan; or
- If at least 70% of all nonexcludable employees are eligible to participate, then 80% or more of the eligible employees actually participate in the plan; or
- The plan must benefit a classification of employees that the IRS has determined does not discriminate in favor of HCEs using standards that are applied under Code §410(b)

There are certain employees who can be excluded from consideration when determining if the plan passes the eligibility tests described above, if they are not eligible for coverage and:

- Have not completed at least 3 years of service at the beginning of the plan year.
- Have not attained age 25 at the beginning of the plan year.
- Are part-time or seasonal employees.
- Are covered under a collective bargaining agreement if the benefits are subject to good faith bargaining.
- Are nonresident aliens who receive no income from sources within the US.

Benefits Test

Under the subjective nondiscriminatory benefits test, the types and amounts of benefits provided to highly compensated individuals must be provided to all participants. The rule also implies that contributions must be the same for each participating employee. In addition:

- Maximum benefit levels cannot vary based on age, years of service, or compensation.
• Waiting periods cannot be shorter for HCEs.
• Benefits cannot discriminate in actual operation (e.g. making exceptions for just HCEs or their family members).

267. How do we know which of our employees are considered highly compensated employees?

A “highly compensated employee” is defined as any employee who is any of the following:
• One of the five highest paid officers; or
• A shareholder who owns more than 10% in value of the employer’s stock; or
• Among the highest paid 25% of all employees (other than excludable employees (described above) who are not participants, and not including retired participants).

268. What are the penalties if we violate the nondiscrimination rule for insured, nongrandfathered plans?

An insured group health plan failing to comply with the nondiscrimination requirements is subject to an excise tax of $100 per day per individual discriminated against for each day the plan does not comply with the requirement.

269. Will there be any changes to my healthcare flexible spending accounts (health FSAs)?

Yes. Healthcare FSAs will no longer be permitted to reimburse employees for expenses incurred on or after January 1, 2011, for over-the-counter medications (except insulin) unless the individual obtains a prescription for the drug or medicine.

Effective immediately, reimbursements will be permitted for the health care expenses of the employee’s children until the end of the year in which the child turns age 26 on a tax-favored basis regardless of whether the child qualifies as the employee’s tax dependent. The child no longer has to meet certain requirements including student status, financial support, or other dependency requirements.

Starting in 2013, the maximum contribution to a healthcare FSA will be capped at $2,500 per plan year. That amount will be indexed annually as follows:
• Plan years starting in 2014 - $2,500
• Plan years starting in 2015 - $2,550
• Plan years starting in 2016 - $2,550

270. Our FSA plan year does not start on January 1, 2011. Will my employees be able to change their election amounts mid-plan year in anticipation of the limitations for OTC reimbursements coming on January 1, 2011?

No. Mid-plan year election changes will not be allowed due to the change in the reimbursements for over-the-counter medications. Employees will still be entitled to
reimbursement with a prescription. Otherwise, employees can use those election amounts for reimbursement on other qualified expenses.

271. **What would qualify as a prescription for over-the-counter medications?**

A written or electronic order that meets the legal requirements of the state in which the medication is purchased is sufficient if its written by any individual who is legally authorized in that state to issue a prescription.

272. **Can an FSA (or HRA or HSA) still be used to reimburse employees for over-the-counter items that are not drugs or medicines?**

Yes. Items that are not drugs or medicines such as crutches, bandages, blood sugar tests, or contact solutions are still reimbursable if they qualify as medical care.

273. **Our FSA plan uses an electronic debit card. Can that still be used to purchase over-the-counter drugs or medications that have a prescription?**

Yes, but only if certain criteria are met. The IRS has indicated that it will not challenge the use of debit cards for purchasing over-the-counter drugs or medications purchased through January 15, 2011. After January 15, 2011, debit cards may continue to be used to purchase over-the-counter medicines if prior to the purchase:

1. The prescription for the over-the-counter medicine or drug is presented (in any format) to the pharmacist;

2. The over-the-counter medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations pertaining to the practice of pharmacy;

3. An Rx number is assigned;

4. The pharmacy or other vendor retains a record of the Rx number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase in a manner that meets IRS recordkeeping requirements;

5. All of these records are available to the employer or its agent upon request; and

6. The debit card system has been programmed so that it will not accept a charge for an over-the-counter medicine or drug unless an Rx number has been assigned.

If these requirements are met, the debit card transaction will be considered fully substantiated at the time and point-of-sale.

You should contact your TPA or debit card vendor for specific guidance on how these purchases will be handled.
274. **Our health care FSA plan year is not on a calendar year basis. It starts on July 1. How do we implement the new FSA limit for non-calendar year plans?**

The limit on health FSA salary reduction contributions is effective for plan years beginning after December 31, 2012. Thus, the rule for your plan is effective for the plan year beginning on July 1, 2013.

275. **Because our FSA plan is not on a calendar year basis, will we have to track employee contributions over two plan years to determine if the employee exceeds the maximum in a calendar year?**

No. The limit will apply on a plan year basis, not a calendar year basis. Therefore, you just have to ensure that employee’s health FSA elections do not exceed the limit for the plan year.

276. **We have several married couples where both spouses work for us. Can they each elect health FSA coverage up to the maximum?**

Yes. The limit on salary reduction contributions to a health FSA applies on an employee-by-employee basis. If each spouse is eligible to elect salary reduction contributions under your plan, then each spouse may elect to make salary reduction contributions up to the maximum limit to his or her health FSA.

277. **We use a flex credit system where we contribute flex credits to each employee’s health FSA. Will those credits count towards the $2,500 maximum?**

It depends. The limit applies only to an employee’s salary reduction contributions and not to employer non-elective contributions. So if you contribute non-cashable flex credits to your employee’s health FSA, each employee may still elect to make salary reduction contributions of up to $2,500 (indexed annually) for that plan year. However, if the employee may elect to receive those flex credits as cash or as a taxable benefit, the flex credits are counted toward the maximum limit.

278. **If we adopted the $500 health FSA carryover provision, will that change the amount our employees can elect to contribute to their FSAs?**

No. Employees with carryover amounts from the previous plan year would still be able to elect up to $2,500 (indexed annually) in health FSA salary reductions for the current plan year.

279. **We are considering changing our FSA plan year from a January 1 basis to a fiscal year basis beginning July 1 and may have to run a short plan year. Do we have to adjust the maximum amount for the short plan year?**

Yes. If you run a short plan year for a valid business purpose that begins after 2012, the $2,500 limit (indexed annually) must be prorated based on the number of months in that short plan year. However, if a principal purpose of changing from a calendar year to a fiscal year is to delay the application of the $2,500 limit, the plan year change does not satisfy the valid business purpose requirement and the plan year remains the plan year that was in effect prior to the attempted change.
280. Our health FSA has a 2.5 month grace period. If an employee carries unused contributions into the FSA grace period, do those amounts count towards the new plan year’s election limit?

No. Unused salary reduction contributions that are carried over into the grace period do not count against the $2,500 limit (indexed annually) applicable for the subsequent plan year.

281. If we have to reduce our health FSA maximum, do we need to amend our plan document to reflect the change?

Yes. Your cafeteria plan must be amended to reflect the new maximum limit. The amendment to conform your cafeteria plan to the new limit must be adopted on or before December 31, 2014, and may be made effective retroactively if necessary, provided that your cafeteria plan operates in accordance with the IRS rules for plan years beginning after December 31, 2012.

282. Can we continue to offer our FSA plan to our part-time employees who are not eligible for our health plan?

No. Because your FSA is not a HIPAA “excepted benefit” for the part-time employees, it would be subject to PPACA’s health insurance reforms and would fail to meet the preventive services requirement. In order to be an “excepted benefit”, your health FSA must meet two conditions:

1. Other group health plan coverage (e.g. major medical coverage), not limited to dental or vision only coverage, must be made available for the year to the class of health FSA participants by reason of their employment; and

2. The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater than two times, cannot exceed $500 plus the amount of the participant's salary reduction election).

Because your part-time employees are not eligible for your health plan, it would fail to meet #1 above.

283. Can we offer our FSA plan to union employees that are not offered our major medical plan but are offered coverage under their union plan?

The answer is not clear. Because the union employees are not eligible for your major medical plan, it appears your health FSA would fail to be a HIPAA excepted benefit. But if you make required contributions to the union plan on behalf of your union employees as a result of collective bargaining, it’s possible that arrangement could qualify as an offer of coverage by you by reason of the union member’s employment. While not answering the question directly, in an informal discussion with IRS representatives, they did point out that under the employer mandate regulations, coverage under a union plan can satisfy the employer’s requirement to offer coverage if the employer is making contributions to a union plan under a collective bargaining agreement.
Until further guidance is issued, you may want to discuss your situation with your legal counsel.

284. Will there be any changes to my Health Reimbursement Arrangement (“HRA”)?

Employer and employee contributions to Health Reimbursement Arrangements (HRAs) will be included in the calculation of health plan costs for purposes of the "Cadillac Plan Tax" when it goes into effect for fiscal years beginning January 1, 2018.

HRAs will no longer be permitted to reimburse employees for expenses incurred on or after January 1, 2011 for over-the-counter medications (except insulin) unless the individual obtains a prescription for the drug or medicine.

Effective immediately, reimbursements from an HRA will be permitted for the health care expenses of the employee’s children until the end of the year in which the child turns age 26 on a tax-favored basis regardless of whether the child qualifies as the employee’s tax dependent. The child no longer has to meet certain requirements including student status, financial support, or other dependency requirements.

285. If we offer our current employees an HRA that allows them to purchase coverage on the individual market, will the HRA be considered integrated with that individual market coverage and therefore satisfy the annual limit or preventive care requirements?

No. An employer-sponsored HRA plan cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore the HRA would violate the prohibition on annual dollar limits and the requirement to provide certain preventive services at 100%.

286. Can we integrate an HRA that reimburses the medical expenses of an employee’s spouse and/or dependents (a family HRA) with self-only coverage under our major medical plan?

No. An HRA is integrated with your major medical plan only for the individuals who are enrolled in both the HRA and the major medical plan. If the spouse and/or dependents are not enrolled in your major medical plan, the coverage of these individuals under the HRA is not integrated, and the HRA coverage generally would fail to meet the ACA’s group market reforms.

However, it appears that HRA coverage for those family members not covered under your major medical plan could be integrated with another employer’s plan (e.g., the spouse) if the employee attests that they are covered by the other employer’s non-HRA group major medical plan.

To facilitate transition to compliance with the group market reforms through the use of integrated HRAs, an HRA available for the expenses of family members not enrolled in the employer’s other group health plan will not be treated as failing to be integrated for plan years beginning before January 1, 2017 solely because the HRA covers expenses of one or more of an employee’s family members even if those
family members are not also enrolled in the employer’s other group health plan or in another employer’s group health plan.

287. We are a small employer that is not subject to the ACA’s employer mandate. Can we allow our employees to use an HRA to pay for individual health insurance?

Yes. Starting on January 1, 2017, small employers can provide a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) that reimburses employees for the medical care expenses of the employee, the employee’s spouse and the employee’s dependent children, including individual health insurance policies purchased on the individual market. To offer a QSEHRA, you must meet certain criteria including:

1. You cannot be offering any other group health plan coverage to any employee.

2. The maximum annual reimbursement for a QSEHRA cannot exceed $4,950 in a year for self-only HRA coverage, or $10,000 if the HRA covers the employee’s family. These amounts will be indexed annually. Also, the maximum annual dollar limits must be prorated for individuals that are not covered by the HRA for an entire year, based on the number of months the individual is covered by the HRA.

3. The HRA must be funded solely by the employer.

4. The HRA must be provided on the same terms to all eligible employees (with a few permissible exceptions).

5. You will be required to provide an annual notice to eligible employees at least 90 days before the beginning of the plan year. The notice must include:

   - The dollar amount of eligible benefits available under the HRA;

   - A statement that the employee should provide information about the HRA permitted benefit to any Marketplace through which the employee applies for a subsidy; and

   - A statement that if the employee does not have minimum essential coverage (MEC) for any month, he or she may be subject to a tax penalty under the ACA’s individual mandate and reimbursements from the HRA may be includible in gross income if MEC is not maintained for any month.

6. You must report the employee’s total permitted HRA coverage for the year in a new data box on the employee’s W-2.
288. Will we be allowed to replace our current retiree coverage with an HRA that allows our retirees to purchase coverage on the individual market or at a Marketplace?

Yes. If you offer the HRA on a stand-alone, retiree-only basis, then it is not subject to PPACA’s health insurance reforms and can be used to help retirees purchase individual or Marketplace coverage.

However, because the stand-alone HRA is considered an employer-sponsored plan, and would constitute minimum essential coverage under the individual mandate, any early retirees who are not eligible for Medicare that elect the HRA would not be eligible for premium tax credits at a Marketplace for any month in which funds are retained in the early retiree’s HRA (including amounts retained in the HRA during periods of time after you as the employer has ceased making contributions).

289. Can we provide an HRA that reimburses only the cost of individual dental or individual vision (but not medical) policies?

Yes. An HRA that reimburses (or pays directly for) premiums for individual dental or vision coverage is not required to comply with the ACA’s annual dollar limit prohibition or the preventive services requirement.

290. We have a location in San Francisco where we offer a stand-alone HRA to our employees to satisfy the San Francisco Health Care Security Ordinance. Will we be able to continue that arrangement?

As of January 1, 2014, the answer appears to be no. Your HRA would violate the prohibition on annual dollar limits after that date.

291. Some of our employees have HRAs that have accrued significant balances. Will those amounts have to be forfeited?

Not necessarily. Unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with the plan terms without causing the HRA to fail to comply with the annual dollar limit prohibition. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

292. Will there be any changes to our Health Savings Accounts (“HSA”)?

Employer and employee contributions to Health Savings Accounts (HSAs) will be included in the calculation of health plan costs for purposes of the "Cadillac Plan Tax" when it goes into effect for fiscal years beginning January 1, 2018.

Also, the tax on distributions from a health savings account that are not used for qualified medical expenses increased to 20% (from 10%) of the disbursed amount effective for taxable years beginning January 1, 2011.
HSAs are no longer permitted to reimburse employees for expenses incurred on or after January 1, 2011 for over-the-counter medications (except insulin) unless the individual obtains a prescription for the drug or medicine.

However, the rules for distributions from an HSA remain subject to the current rules. To treat a distribution as nontaxable, the child must be a tax dependent of the employee.

293. Insurers are required to follow new minimum medical loss ratio (MLR) guidelines. Will this affect our plan?

Insurers are required to track and report to HHS their MLR, which is the proportion of premium revenues spent on medical claims and quality improvement. Insurers in the large group market must have a medical loss ratio of at least 85%. The medical loss ratio for insurers in the small group market must be at least 80%. If the insurer fails to meet these standards, the insurance companies will be required to provide a rebate to their policyholders.

Insurers must provide the rebates to the group policyholder (usually the employer) through lower premiums or in other ways that benefit the participants.

294. If our insurer has to pay a rebate, when will we receive it?

The MLR percentage is calculated on a calendar year basis. If a rebate is payable, it must be paid by August of the following year. The first insurer rebates must be paid by August 1, 2012 for the 2011 calendar year.

For rebates payable for the 2014 calendar year and later, the rebate must be paid no later than September 30 of the following year.

295. If we receive a rebate, are there guidelines or limits on how we can spend the money?

If you receive a rebate, how you can use it will vary by your plan type:

- **ERISA Plans** - To the extent that distributions, such as premium rebates, are considered to be plan assets, they become subject to the requirements of Title I of ERISA. Therefore, plan sponsors will have to determine if the rebate is a plan asset and to what extent the rebate is attributable to participant contributions. The DOL has issued Technical Release 2011-04 that gives specific instructions to plan sponsors of ERISA plans regarding their responsibilities under ERISA concerning rebates.

- **Nonfederal Governmental Plans** - The employer must use the amount of the rebate that is proportionate to the total amount of premium paid by all participants under the policy (1) to reduce subscribers’ portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan; (2) to reduce subscribers’ portion of the annual premium for the subsequent policy
year for only those subscribers covered by the group health policy on which the rebate was based; or (3) to provide a cash refund only to subscribers that were covered by the group health policy on which the rebate is based. The reduction in premium or cash rebate may, at the option of the policyholder, be: 1) divided evenly among the participants; 2) divided based on each participant’s actual contribution to premiums; or 3) apportioned in a manner that reasonably reflects each participant’s contributions.

- **Church Plans** - Rebates may only be paid to the employer if the insurer receives written assurance from the employer that the amount of the rebate that is proportionate to the total amount of premium paid by all participants under the policy will be used for the benefit of current participants under the policy. Otherwise, the issuer must distribute the rebate directly to the participants of the group health plan.

There are special rules for rebates paid in the case of a terminated plan.

296. **The rebate we received for our ERISA plan is less than the amount we paid out of our general assets towards the cost of coverage. Are we allowed to keep the whole amount?**

You could keep the whole amount of the rebate only if it is less than the total amount you paid for the year AND your plan document was drafted to provide that insurer refunds or rebates will be used first to offset your contributions.

297. **What if our ERISA plan document is silent as to premium rebates or refunds?**

If there are no provisions in your plan document or other written instruments governing your plan, then you must determine what portion of the refund are plan assets under ERISA’s general standards of fiduciary conduct. Once the amount of the rebate that is plan assets is determined, you have a fair amount of leverage in determining both how that money will be used and exactly which individuals will receive the rebate, *provided that the money is used for the exclusive benefit of participants and beneficiaries*. This includes returning the rebate to participants in cash, using it to offset future employee contributions, or to make enhancements to future benefits.

298. **We use a Veba trust to fund our plan where both the employer and employee contributions are deposited into the trust. Can we get our portion of the rebate back?**

No. For insured plans that are funded solely by trust assets, the whole amount of the rebate is plan assets and must be returned to the trust or to plan participants.

299. **Are former employees who were covered under our ERISA plan last year entitled to a share of an MLR rebate?**

Maybe. If you decide that part of the rebate is plan assets that must be returned to participants, then that should also include former participants. However, under DOL guidelines, you don’t have to share the rebate with former participants if you find that
the cost of tracking down and distributing the rebate to them approximately equals or exceeds the proceeds that would be paid to them.

If you choose to issue a rebate directly to participants, you should weigh the costs of whether to include former participants in the distribution to determine if those costs approximate or exceed the cost of the proceeds.

300. Are our COBRA participants entitled to a share of an MLR rebate?

The statutory and regulatory language on MLR rebates refers to “enrollees,” “participants” and “subscribers,” which generally includes COBRA qualified beneficiaries. Therefore, it is likely that, COBRA qualified beneficiaries should receive the same share of any MLR distribution that is provided to similarly-situated active employees. Also, because a plan should include only the net cost of the active rate (insurance rate less experience rebates) in determining the applicable COBRA premium, an MLR rebate should reduce the COBRA applicable premium for your insured group health plan.

301. If we receive a rebate for our PPO option but not our HMO option, would we have to apply the portion of the rebate that is plan assets to the PPO plan only (since that’s where the rebate came from) or could the enhancement be applied to the HMO plan?

The rebate should only be used for the plan option that created the rebate.

302. As a governmental plan, are we required to track down former participants and return their portion of the rebate to them?

No. For governmental and church plans, the rebate amount attributable to employee contributions must be returned to the participants that are in the plan at the time the rebate is received.

303. Is there a timeframe under which our ERISA plan must use MLR refunds?

Yes. ERISA fiduciary duty rules, including the trust requirements for plan assets, govern the treatment of MLR rebates from insurers. However, the DOL will not enforce ERISA’s trust requirement under certain circumstances, including if the portion of the rebate that is plan assets is used within three months of its receipt.

In addition, directing the insurer to hold and apply the rebate to future benefit enhancements you have adopted would also avoid the need for a trust.

Conversely, if you receive the rebate and the portion that is plan assets is not used up within three months, the money will be subject to ERISA trust requirements.

304. Must our ERISA plan issue refunds or provide premium reductions to participants in proportion to whatever each individual employee actually paid (for example, based on employee-only versus family coverage or salary-dependent employee contributions)?

Not necessarily. Absent plan document terms that specifically describe the disposition of the rebate, the DOL has indicated that acceptable methods may include:
- Dividing the rebate evenly among participants,
- Dividing the rebate based on each participant’s actual contribution to premium, or
- Apportioning the rebate in a manner that reasonably reflects each participant’s contribution to premium (e.g. single vs. family coverage).

It is up to you to decide which of these options is the most “reasonable, fair and objective” in consideration of the plan’s contribution structure and other circumstances.

305. If we have to return a portion of the refund to participants will it be taxable to them?

For cash refunds, if your employees pay their contribution on a pretax basis, then the rebate payment will be taxable income for the employee. If the employee contributions were initially paid with after-tax dollars, the refund will not be subject to federal taxes unless the participant deducted the premium payments on their individual Form 1040.

If you use the refund for a contribution holiday or contribution reduction for your plan participants, to the extent that a premium refund will result in less contributions for an employee to pay for benefits and more money paid as taxable take-home pay, that increased income is taxable. For example, if an employee makes $500 per week and the pre-tax contribution is $50, the employee is only taxed on $450. However, if the employer receives a rebate and determines that it must return $50 to employee as a premium holiday for that week, then the employee’s taxable income for that week is $500, not $450. In other words, the $50 the employer paid gets taxed only because it was not salary-reduced on a pretax basis from the employee’s pay.

The IRS has issued a comprehensive set of FAQs addressing the federal tax consequences to employees when a MLR rebate stems from a group health insurance policy. The FAQs can be accessed at the IRS website here: http://www.irs.gov/newsroom/article/0,,id=256167,00.html.

306. If the plan asset portion of the MLR rebate can be classified as de minimis, does that mean the employer can use the money for purposes other than specified under the plan document, MLR rules or ERISA’s fiduciary rules?

No. If you determine that the administrative cost of reducing the employee contributions or paying cash to participants would be equal to or greater than the cost of the rebate amount itself, then you would still have to use the money for another allowable purpose such as enhancing the benefits for the plan participants.

307. What types of things would be considered benefit enhancements?

Examples of benefit enhancements include lowering the plan deductible, increasing the plan cost-sharing payment, reducing office visit copays, increasing a benefit limit, etc. Generally this would entail using the portion of the rebate that is plan assets to pay the increased premium associated with the benefit enhancement. For example, if the amount to be returned to participants is $10,000, and the insurer indicates that for $10,000 they would reduce the deductible for all participants in the plan option
that generated the rebate from $500 to $250, then that may be an appropriate use of the rebate.

308. **Instead of returning money back to participants, can we instead use the rebate to fund a wellness program for our employees?**

Providing wellness incentives is not explicitly allowed or prohibited as a "benefit enhancement" under the MLR rules. If you determine that distributing payments to participants is not cost-effective (e.g. the payments are of de minimis value or give rise to tax consequences to the participants) then there is a possibility that paying for biometric screenings or other wellness screenings for plan participants may be prudent and appropriate.

## Wellness Programs

309. **We have a wellness program that provides a reward of 20% of the cost of coverage for employees that meet certain wellness standards. Will we be able to keep that program?**

Yes, you are still allowed to provide wellness incentives (or surcharge) such as premium discounts and additional benefits to individuals who participate in a "health-contingent" wellness program that requires your employees to satisfy a standard related to a health factor. In fact, effective with plan years starting on or after January 1, 2014, the Act increases the maximum reward to 30% (up from 20%) of the cost of coverage for employees who participate in a health-contingent wellness program.

In addition, effective with plan years starting on or after January 1, 2014, the maximum reward or surcharge for a health-contingent wellness program designed to prevent or reduce tobacco use is increased to 50% of the cost of coverage.

**Note:** The EEOC has issued proposed wellness program regulations under the ADA whereby the incentive cannot be more than 30% of the cost of employee-only coverage, even if the spouse participates in the wellness program. Further, they would prohibit the application of the 50% tobacco cessation surcharge unless the wellness program does not include biometric screenings or other medical tests that actually test for the presence of tobacco or nicotine.

310. **Can we combine a health-contingent wellness program incentive that is 30% of the cost of coverage for meeting a non-tobacco based standard with another 50% incentive for meeting a tobacco-based standard?**

No. The total combined maximum incentive cannot exceed 30% of the cost of coverage if the plan does not have a tobacco-based standard and 50% of the cost of coverage if the wellness program includes a tobacco-based incentive.

311. **Is it true we can get a grant to help us pay for a wellness program?**

It depends. The Act includes grants for up to five years for small employers (less than 100 employees who work 25 or more hours per week) that establish new wellness programs. Small employers with existing wellness programs as of March 23, 2010 are not eligible for grants under this provision.
Guidance on the availability of these grants and how to obtain them has not yet been published.

312. Is it true that we have to automatically enroll our newly-hired full-time employees?

The requirement for employers with more than 200 full-time employees that offer health coverage to employees to automatically enroll new full-time employees was repealed before it went into effect upon passage of the Bipartisan Budget Act of 2015 on November 2, 2015.

313. If we want to offer coverage to same-sex spouses, does our insurer have to offer that coverage?

Yes. PPACA requires health insurers offering non-grandfathered coverage in the group market (including qualified health plans offered through the Marketplace) to guarantee the availability of coverage, and cannot employ marketing practices or benefit designs that discriminate on the basis of certain specified factors, including an individual’s sexual orientation. So if an insurer offers a plan that provides coverage to opposite-sex spouses, it must, at the employer’s request, also offer that same coverage to same-sex spouses if the marriage was entered into in a jurisdiction that authorizes same-sex marriage.

IRS REPORTING

314. Will we have to report anything to the government regarding our plan’s coverage or contributions?

Yes. You will be required to report the aggregate cost of your employer-sponsored health coverage on your employee’s W-2.

There are also two new IRS and employee reporting requirements that apply for coverage provided starting in 2015 with the first filings due in 2016 (these reporting requirements were delayed for one year from their original effective date in 2014/2015). The first reporting requirement under Code § 6055 applies to any entity that provides “minimum essential coverage” (MEC) to an individual. Minimum essential coverage includes any employer-sponsored group health plan sponsored by an employer except for coverage that is limited to HIPAA excepted dental or vision benefits. The information you report to the IRS will, in part, allow the IRS to determine which individuals had MEC that satisfies the individual coverage mandate.

The second reporting requirement under Code §6056 applies to applicable large employers (i.e. those with 50 or more full-time employees (including full-time equivalents)). The §6056 reporting is needed by the IRS for the administration of the penalties under the employer mandate as well as the administration of the premium tax credit program that helps individuals and families afford health insurance coverage purchased through a Marketplace Exchange.
315. Is it true we will have to make changes to what we report on our employee’s W-2?

Yes. You will be required to report the aggregate cost of employer sponsored health coverage on your employees’ W-2. The amount to be reported on the W-2 is NOT included in the employee’s gross income.

Originally, the effective date of this change was taxable year 2011. However, the IRS issued guidance on October 12, 2010 delaying the effective date of the reporting requirement to taxable year 2012 (i.e. W-2s issued in 2013 covering the 2012 taxable year). The guidance made the reporting requirement optional for benefits provided in tax year 2011.

On March 29, 2011 and January 2, 2012, the IRS issued further guidance that includes a delay in the W-2 reporting requirement until further guidance is issued for the following employers:

1. Employers filing fewer than 250 W-2s for the previous calendar year (for example, employers filing fewer than 250 W-2s for taxable year 2011 will not be required to report the cost of coverage on the 2012 W-2);

2. Employers sponsoring self-funded plans that are not subject to federal COBRA continuation coverage such as self-funded church plans; and

3. Federally recognized Indian tribal governments and tribally chartered corporations that are wholly owned by a Federally recognized Indian tribal government.

The Form W-2 includes code DD that should be used to report the aggregate cost of employer sponsored health coverage in Box 12 on your employees’ Form W-2.

316. What coverages are included in the amount that we must report on the W-2?

The aggregate cost of your health coverage is the total cost of coverage provided to the employee under all employer-sponsored coverage including:

- Medical coverage
- Dental and vision, unless HIPAA excepted stand-alone plans (i.e., coverage offered under a separate policy, certificate or contract of insurance or coverage employees may waive separately)
- Prescription drug coverage
- Executive physical benefits
- On-site clinics*
- EAPs that provide medical care*
- Wellness programs that provide medical care*
- Medicare supplemental policies
- Health Care FSA – employer contributions only (e.g., “seed” or match)
- Hospital or other fixed indemnity insurance or specified illness insurance if the employer makes any contribution towards the cost of the fixed indemnity or specified illness insurance or allows employees to purchase the coverage on a pre-tax basis under a §125 plan

*See below for more details and exceptions

317. **Our EAP and wellness programs are considered group health plans but the cost is so little we don’t charge a premium to COBRA qualified beneficiaries to access them. Do we still have to include their cost in the aggregate reportable cost?**

No. The cost of coverage provided under an EAP, wellness program, or on-site medical clinic that qualifies as a group health plan subject to COBRA does not have to be included in the aggregate reportable cost if you do not charge COBRA qualified beneficiaries to access those benefits. However, if you charge a COBRA premium for such coverage, then it must be included in the aggregate reportable cost on the W-2.

318. **We offer an EAP to our employees that our long-term disability insurer provides for no additional cost as an add-on to the LTD benefits. Do we still have to include it in the aggregate reportable cost?**

No. Group health plan coverage provided as an add-on or value-added program does not have to be reported if the EAP portion of the program providing the health benefits is only incidental in comparison to the portion of the program providing the disability benefits.

319. **We are a church plan and our medical plan is self-funded and our dental and vision are excepted benefits so we are not required to report them. Do we still have to report the cost of our EAP or wellness program?**

No. Because your plan is not subject to COBRA or any other federal continuation coverage requirement you do not have to report the cost of coverage provided under an EAP, wellness program, or on-site medical clinic, even if they qualify as group health plans.

320. **We are a controlled group of corporations comprised of a number of member employers. Do we have to aggregate all the W-2 we filed for all of our member employers to determine if we filed less than 250 W-2s in the preceding year?**

No. The exemption for employers that filed fewer than 250 W-2s applies separately to each member employer of your controlled group.

321. **Is there coverage we don’t have to include in the reporting?**

Yes. Your reporting should not include:

- Long Term Care, accident, or disability income benefits
- Health reimbursement arrangements (delayed until further notice)
- Specific disease, indemnity, etc. coverage if not excludable from employee’s gross income
• Specified illness or disease policies such as cancer policies where the full premium is paid by the employee on an after-tax basis
• Hospital (or other) Indemnity insurance policies where the full premium is paid by the employee on an after-tax basis
• Archer MSA or HSA contributions of the employee or the employee’s spouse
• Employee salary reduction contributions to a Health FSA
• Referral-only EAP

322. **What value should we use for the costs that must be reported?**

If your plan is insured, you can use the premium charged by the insurer as the reportable amount. If your plan is self-funded, you may calculate the reportable cost using the COBRA applicable premium (minus the 2% admin fee).

323. **Our insurer charges us a composite rate for all covered employees. Do we report the same amount for every employee?**

Yes. Where the insurer is charging a single composite rate for all employees, you can use that composite rate to calculate the reportable cost.

324. **We are an S corporation and our 2% or greater shareholder-employees are required to include the value of group health plan premium payments we make on their behalf in their income. Would we still have to also report this cost in Box 12 of their W-2?**

No. Payments or reimbursements of health insurance premiums for a 2% or greater shareholder-employee of an S corporation do not have to be reported in Box 12 on the W-2 if the individual is required to include the premium payments in gross income.

325. **What do we do when an employee terminates employment in the middle of the year?**

You may apply any reasonable method of reporting the cost of coverage for an employee who terminated employment during the calendar year, provided that the method is used consistently for all employees receiving coverage who terminate employment during the year. For example, calculating the total cost per month and then multiplying it by the number of covered months (including COBRA months) is a reasonable method. Or, as an alternative, it would be a reasonable method to do the calculation without including the COBRA months.

Under the transition rules that apply until future guidance, if the terminated employee requests a W-2 before the end of the calendar year, the employer is not required to report any amount of health benefits on that W-2.

326. **What amount do we report if there is a cost or coverage change in the middle of the year?**

The reportable cost must reflect the increase or decrease in cost for the periods to which the increase or decrease applies.
If an employee changes coverage during the year (e.g. terminates coverage, changes plan options, adds or drops dependents) the reportable cost must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods the employee had coverage.

If the change in coverage in the middle of a month where costs are determined on a monthly basis, an employer may use any reasonable method to determine the reportable cost for such period, such as using the reportable cost at the beginning of the period or at the end of the period, or averaging or prorating the reportable costs, provided that the same method is used for all employees with coverage under that plan.

327. **What happens if the employee notifies us of a coverage change that may have an effect on the aggregate reportable cost for the previous year?** For example, if one of our employees notifies us of a divorce in January that occurred in the preceding year and would reduce the cost of the employee’s coverage for that year?

The aggregate reportable cost for a calendar year reported on Form W-2 may be based on the information available to you as of December 31 of the calendar year. Therefore, if an employee notifies you of a coverage change in the subsequent calendar year that has a retroactive effect on his or her coverage for the prior year, you are not required to include it in the calculation of the aggregate reportable cost for that prior year. In addition, you are not required to furnish a Form W-2c if a Form W-2 has already been provided for a calendar year, before this type of notification (for example, if a Form W-2 is provided to employees on January 15, and an employee notifies you of a retroactive change on January 20).

328. **We contribute to a multiemployer plan for our union employees. Do we have to report that contribution or the value of the multiemployer plan coverage on the union employee’s W-2?**

No. Neither the amount you contribute nor the cost of the coverage provided to an employee under a multiemployer plan must be included when determining the aggregate reportable cost that must be reported on the W-2.

329. **Do we have to provide a W-2 that includes the aggregate cost of our health plan coverage to retirees covered by our plan that don’t receive any other compensation from us?**

No. You are not required to issue a Form W-2 to an individual to whom you are not otherwise required to issue a Form W-2.
330. If our plan is insured, do we still have to file the §6055 return?

No. Your insurer is responsible for filing the §6055 return.

331. If we provide minimum essential coverage to our employees under a self-funded plan, who is responsible for the §6055 reporting?

The plan sponsor that establishes and maintains the plan must file the §6055 report. So if minimum essential coverage is provided under your self-funded plan, you must file a §6055 annual return with the IRS for every primary insured employee covered under the plan.

332. What information will we have to include on the Code §6055 return for our self-funded plan?

Your §6055 return must include the following information:

- The name, address, and EIN of the employer sponsoring the plan;
- The name, address, and taxpayer ID number (generally the social security number(“SSN”)) of the employee or former employee;
- The name and SSN of each other covered individual;
- The months during which each individual was enrolled in coverage during the calendar year for at least one day.

333. What if we are not able to get the spouse’s or children’s social security number (SSN)?

You can provide the dates of birth in lieu of SSNs but only if you are informed that an individual does not have an SSN or you are unable to obtain an SSN after making reasonable efforts to obtain it.

To demonstrate reasonable efforts, you are required to request the SSNs from covered individuals at the time their relationship with the individual begins – for employers, this means on the date the employer receives a substantially complete application for new coverage or to add an individual to existing coverage or, if already enrolled on September 17, 2015, the next open enrollment period. If the covered individual does not provide the SSN, you must make the first annual solicitation at any reasonable time after the individual’s substantially complete initial application for coverage (e.g., within 75 days). If the covered individual fails to provide the SSN at that time, then you must make a second annual request by December 31 of the following year. If the covered individual fails or refuses, you can then use the individual’s date of birth without making any additional efforts to obtain the SSN. You should document your efforts to obtain missing SSNs.

For example, if you make an unsuccessful initial solicitation for an SSN on June 1, 2016 when the employee first enrolls in coverage, you must make the first annual solicitation no later than 75 days (or at any reasonable time) after June 1, 2016. The second annual solicitation must be made by December 31, 2017, to have acted in a
responsible manner. Assuming that request is also unsuccessful, you would not be penalized if your §6055 reporting submitted in early 2018 reported a date of birth in place of the SSN for the individual in question.

334. **We are a parent of a controlled group of corporations comprised of a number of member employers and our plan covers employees of all the member employers. Do we have to file the §6055 return on behalf of the other employer members?**

No. Your plan is treated as being sponsored by more than one employer and each member employer is responsible for filing the return for its own employees.

However, one member of your controlled group may assist you and/or the other members by filing returns and furnishing the employee statements on behalf of all the employer members of the controlled group.

335. **What forms should we use to file the §6055 return?**

If you are a large employer, you can use Form 1095-C, along with transmittal Form 1094-C. Employers that are not applicable large employers (e.g., small self-funded employers) can use Form 1095-B, along with transmittal Form 1094-B. If you are both a large employer and have a self-funded plan, Form 1095-C can be used to satisfy both the §6055 and §6056 reporting requirements (see the Section below on the §6056 reporting requirements).

The IRS has released final versions of the 2016 §6055 forms and instructions, which are available [HERE](https://www.irs.gov/). 

336. **What is the deadline for filing the §6055 return?**

The return must be filed on or before February 28th of the year following the calendar year in which you provided minimum essential coverage, regardless of your plan year. The return can be filed electronically and high-volume filers (those that file 250 or more §6055 returns during the calendar year) must file electronically. If filing electronically, you have an additional month until March 31st to file the report.

For 2015 filings only, the deadlines were extended as follows:

- May 31, 2016, if not filing electronically, and
- June 30, 2016 if filing electronically.


337. **Can our TPA file the §6055 report on our behalf?**

Generally, yes, but the regulations do not allow you to transfer the liability for reporting failures to your TPA or any other third party.

However, governmental employers that maintain self-funded health plans may enter into a written agreement with another governmental unit, or an agency or
instrumentality of a governmental unit, designating the other governmental unit, agency, or instrumentality as the person responsible for the §6055 return with the IRS and for providing the statement to the employees.

The designated agency must be part of the same governmental unit as the government employer. For example, a state health department may designate the state personnel agency to file the required return and statements. The designated agency must accept the designation, and the agreement must be in writing. In the absence of such a designation, the government employer that maintains the self-insured group health plan will remain the responsible party under §6055.

338. Do we have to provide reporting on HSAs, HRAs or FSAs?

HSAs are not minimum essential coverage so reporting is not required. Reporting is not required for FSAs that supplement group health plans that are providing minimum essential coverage. HRAs are considered self-insured minimum essential coverage though reporting is generally not required for HRAs that supplement group health plans that are providing minimum essential coverage. If however, the HRA covers individuals that are not covered under the major medical plan (e.g. employee has self-only coverage and family HRA), then reporting is required showing the months the family members that are not covered under the major medical plan had coverage under the HRA.

In addition, you do not have to file a §6055 report for the following:

- On-site medical clinic;
- Wellness programs that offer reduced premiums or cost-sharing under a group health plan;
- Coverage that supplements your primary health plan; or
- Coverage that supplements government provided coverage such as Medicare.

339. Do we file a §6055 return for employees that are offered our coverage but waive it?

No.

340. If my §6055 filing is incorrect due to retroactive enrollment of a baby or some other circumstance that occurs at the end of the year, will I be required to file a corrected return with the IRS?

Yes, when information on the form filed with the IRS becomes incomplete or incorrect, you are required to file a corrected return.

341. Do we have to provide a copy of the §6055 return to our employees?

Yes. You will have to provide a copy of the form filed with the IRS or a substitute statement that includes the information that was included on the return and a phone number of the person that has been designated as your contact person to each employee named in your §6055 return. You do not need to provide a copy to those employees who were not eligible for the coverage or waived the coverage.
342. **Is the deadline for employee reporting the same as the IRS reporting deadline?**

No. The statement to your employees must be furnished to them on or before January 31 of the year following the calendar year in which you provide them with minimum essential coverage, regardless of your plan year. The IRS return is due on or before February 28th (March 31st if filing electronically) of the year following the calendar year in which minimum essential coverage was provided.

For 2015 only, the deadline to provide statements to employees was extended to March 31, 2016.

For 2016 only, the due date for furnishing the statements is extended from January 31, 2017, to March 2, 2017.

343. **Do we have to mail the form to the employee or can we provide it electronically?**

Either method is allowed. You can satisfy your obligation by sending the statement by first class mail to the primary insured employee’s last known permanent address, or, if no permanent address is known, to the individual’s temporary address.

You can send the statement electronically if the employee has specifically consented to receiving the statement electronically in a manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished. Prior to, or at the time of consenting, you must provide a conspicuous disclosure to the employee that includes all of the following:

1. The statement will be furnished on paper if the employee does not consent to receive it electronically;
2. The consent applies to each statement required to be furnished after the consent is given until it is withdrawn or only to the first statement required to be furnished following the date of the consent;
3. The employee can request a paper copy of the statement and the procedure for obtaining a paper copy of their statement after giving the consent and whether a request for a paper statement will be treated as a withdrawal of consent;
4. The employee may withdraw a consent by writing (electronically or on paper) to the person or department whose name, mailing address, telephone number, and email address is provided in the disclosure statement;
5. There may be conditions under which you will cease furnishing statements electronically to the employee and what those condition are (e.g. if the employee terminates employment);
6. The employee must update their contact information and the procedures for updating that information; and
7. A description of the hardware and software required to access, print, and retain the statement, and if applicable, the date when the statement will no longer be available on your web site. You must also advise the employee that the
If you change the hardware or software required to access the statement that creates a material risk that the employee will not be able to access a statement, you must, prior to changing the hardware or software, notify the employee. The notice must describe the revised hardware and software required to access the statement and inform the employee that a new consent to receive the statement in the revised electronic format must be provided. After implementing the revised hardware or software, you must then obtain the new consent from the employee to receive the statement electronically.

344. If one of our employees dies during the year, do we still have to provide the statement for that employee?

Yes. Statements must be provided to deceased individuals if they had any months of coverage during the prior year because the individual’s estate may be liable for penalties if the estate is not able to establish coverage under the individual mandate.

345. Are we subject to penalties if we fail to file the required information in a timely manner?

If you fail to timely file complete and accurate returns under §6055 with the IRS, or fail to timely furnish a correct statement to responsible individuals, then you could be subject to a penalty of $260 per return with a maximum of $3,193,000 for a calendar year. However, penalties may be reduced if corrective action is taken within 30 days and may even be waived if the failure to file timely or accurately is due to reasonable cause and not due to willful neglect.

Relief from these penalties is available in 2016 and 2017 for returns filed and statements furnished for coverage in 2015 and 2016 if you can show that you have made good faith efforts to comply. No relief will be provided if you cannot show a good faith effort to comply with the requirements or you fail to timely file the return or furnish a statement by the appropriate deadline.

346. We are a large employer so we will also have to file the Code §6056 return. What information will we have to include on the Code §6056 return?

If you employ an average of at least 50 full time employees (including full-time equivalents), you are considered a large employer and must file a §6056 annual return with the IRS for every full-time employee. Your return must show:

- Your employer’s name, the date, and the employer’s EIN and the calendar year for which the information is reported;
- The name and telephone number of your contact person;
- A certification as to whether you offered your full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under your plan by calendar month;
The number of full-time employees for each calendar month during the calendar year, by calendar month;

For each full-time employee, the months during the calendar year for which minimum essential coverage under the plan was available;

For each full-time employee, the employee’s share of the lowest cost monthly premium for self-only coverage providing minimum value offered to that full-time employee under your plan, by calendar month; and

The name, address, and taxpayer identification number (SSN) of each full-time employee during the calendar year and the months, if any, during which the employee was covered under your plan.

The return will also include indicator codes (rather than having you provide specific or detailed information) for you to report the following information:

Whether the coverage offered to your full-time employees and their dependents provides minimum value and whether the employee had the opportunity to enroll his or her spouse in the coverage;

The total number of employees, by calendar month;

Whether an employee’s effective date of coverage was affected by a permissible waiting period;

Whether you had no employees during a particular month;

Whether you are part of a controlled group, and, if applicable, the name and EIN of each employer member of the controlled group;

If an appropriately designated person is reporting on your behalf that is a governmental unit for purposes of §6056, the name, address, and identification number of the appropriately designated person;

If you are a contributing employer to a multiemployer plan, whether you are subject to an employer mandate penalty due to your contributions to the multiemployer plan; and

If a third party is reporting on behalf of your aggregated employer group, the name, address, and identification number of the third party.

347. If we are subject to both the §6055 and §6056 reporting because we are a large employer with a self-funded plan, can we combine the filings to streamline the process?

Yes. The IRS will be providing a single combined form for reporting the information required under both §6055 and §6056.

348. We offer coverage to all of our full-time employees. Is there an easier way to satisfy the §6056 reporting requirement?

Yes. The final rule provides for several alternatives to the general method that you can use under certain circumstances. First, you can report simplified §6056 information and use a simplified statement for your employees as long as you made a “qualifying offer” of health insurance to a full-time employee for all months during the year in which the employee was a full-time employee. A qualifying offer of insurance is one that provides minimum value at a cost of 9.5% or less of the federal poverty level for employee-only coverage, and also offered minimum essential
coverage to the employee’s spouse and dependents. Once the IRS issues the return forms, it is expected that you will be able to use a code indicating that you have made a qualifying offer to some or all of your full-time employees.

A second alternative, which will be available only for 2015, applies if you made a qualifying offer of coverage to 95% of your full-time employees and their spouses and dependents. It allows you to provide your employees with a simplified statement informing the employee of the coverage provided and that the employee was not be eligible for premium tax credit for any months in which the qualifying offer was made.

Lastly, if you offer coverage to at least 98% of your employees – including full-time and part-time employees - you will not be required to determine for §6056 reporting purposes whether your employees are full-time or part-time employees and will not be required to provide a total count of your full-time employees. To qualify for this alternative method, you must certify that you have offered coverage to at least 98% of your employees included in the report and that the coverage offered is both affordable and provides minimum value.

349. **We are a parent of a controlled group of corporations comprised of a number of member employers and our plan covers employees of all the member employers. Do we have to file the §6056 return on behalf of the other employer members?**

No. Each employer member with full-time employees that is the common-law employer of the employee is responsible for the filing with respect to its full-time employees even though the determination of whether you are a large employer is made at the aggregated group level.

However, employer members of your controlled group without any full-time employees are not required to file the §6056 report.

350. **We contribute to a multiemployer plan on behalf of our union employees. Are we required to file returns under §6056?**

Yes, however, the multiemployer plan may file the return with respect to the employees that it covers and assist you in providing the statements to those employees. For any employees you provide coverage to under your own plan, you will be responsible for the reporting and for providing a statement to the covered employees.

351. **Does §6056 apply to nonprofit and/or governmental employers?**

Yes, §6056 applies to all applicable large employer regard to whether the employer is tax-exempt or a governmental employer (including the United States, states and their subdivisions, and Indian tribal governments).

352. **Can our TPA file the §6056 report on our behalf?**

Generally, yes, but the regulations do not allow you to transfer the liability for reporting failures to your TPA or any other third party.
However, a large employer that is a governmental unit or any agency or instrumentality may appropriately designate another person that is part of, or related to, the same governmental unit as the large employer to report on its behalf.

The designation must be in writing, must be signed by both the large employer member and the designated person, and must include the name, address, and employer identification number of the designated person. The designation must contain information identifying the category of full-time employees (which may be full-time employees eligible for a specified health plan, or in a particular job category, as long as the specific employees covered by the designation can be identified) for which the designated person is responsible for reporting under §6056 on behalf of the large employer. If the designated person is responsible for reporting under §6056 for all full-time employees of a large employer, the designation must indicate that is the case. The designation must contain language that the designated person agrees and certifies that it is the appropriately designated person under §6056(e), and an acknowledgement that the designated person is responsible for reporting under §6056 on behalf of the large employer and subject to the requirements of §6056. The designation must also include the name and employer identification number of the large employer.

For example, a political subdivision of a state may designate the state, another political subdivision of the state, or an agency or instrumentality of the state as the designated person for purposes of § 6056 reporting. The person designated might be the governmental unit that operates the relevant health plan or the governmental unit that does other information reporting on behalf of the designating governmental unit. If the written designation is accepted by the designee and is made before the filing deadline, the designated governmental unit is the designated entity responsible for §6056 reporting.

353. What forms should we use to file the §6056 return?

The filing may be made on IRS Form 1095-C for every full-time employee. The return will be filed with a single transmittal form, Form 1094-C. Form 1095-C can be used to satisfy both the §6055 and §6056 reporting requirements. If you are a large employer that provides insured coverage, you are required to complete only the section of Form 1095-C that reports the information required under Section 6056.

The IRS has released final versions of the combined 2016 §6055/6056 forms and instructions, which are available HERE.

354. What is the deadline for filing the §6056 return with the IRS?

The return must be filed with the IRS on or before February 28th of the year following the calendar year to which the reporting relates regardless of your plan year (e.g., the return must be filed by the last day of February, 2016 for the 2015 calendar year). The return can be filed electronically and high-volume filers (those that file 250 or more §6056 returns) must file electronically. If filing electronically, you have an additional month until March 31st to file the §6056 report.

For 2015 filings only, the deadlines were extended as follows:

- May 31, 2016, if not filing electronically, and
June 30, 2016 if filing electronically.

Information on filing the returns electronically can be found at the ACA Information Returns (AIR) website here:


355. Do we file a §6056 return for full-time employees that are offered our coverage but waive it?

Yes.

356. Do we file a §6056 return for full-time employees that are not offered our coverage?

Yes.

357. If I am a large employer but all my employees are part-time employees, will I be required to report pursuant to §6056?

No. Applicable large employers without any full-time employees are not subject to the Section 6056 reporting requirements.

358. How do we report on a full-time employee that works for more than one employer member of our controlled group?

In cases where a full-time employee works for more than one member of your controlled group, the full-time employee is treated as the employee of the employer member for whom the employee had the greatest number of hours of service for the calendar month. If the full-time employee works an equal number of hours for two or more members of your controlled group, the employer members have discretion to designate who the employee worked for during the calendar month.

359. Do we have to provide a copy of the §6056 return to our full-time employees?

Yes. You will have to provide a written statement only to each full-time-employee named in your §6056 return that includes the name, address and contact information of the entity that filed the return and the information in the return pertaining to that individual. You can either provide a copy of the return filed with the IRS or a substitute statement that includes the information that was included on the return.

360. What is the deadline to provide the reporting to my employees?

The statement to your full-time employees must be furnished to them on or before January 31 of the year following the calendar year in which you provide them with minimum essential coverage.

For 2015 only, the deadline to provide statements to employees was extended to March 31, 2016.

For 2016 only, the due date for furnishing the statements is extended from January 31, 2017, to March 2, 2017.
361. Do we have to mail the form to the employee or can we provide it electronically?

Either method is allowed. You are permitted to mail it separately to the employee to the employee's last known permanent address or, if no permanent address is known, to the employee's temporary address. Alternately, it can be included in the same mailing with one or more of the other required information returns such as the combined §6055 and §6056 employee statement and the Form W-2.

You can send the statement electronically if the employee has specifically consented to receiving the statement electronically in a manner that reasonably demonstrates that the recipient can access the statement in the electronic format in which it will be furnished. Prior to, or at the time of consenting, you must provide a conspicuous disclosure to the employee that includes all of the following:

1. The statement will be furnished on paper if the employee does not consent to receive it electronically;

2. The consent applies to each statement required to be furnished after the consent is given until it is withdrawn or only to the first statement required to be furnished following the date of the consent;

3. The employee can request a paper copy of the statement and the procedure for obtaining a paper copy of their statement after giving the consent and whether a request for a paper statement will be treated as a withdrawal of consent;

4. The employee may withdraw a consent by writing (electronically or on paper) to the person or department whose name, mailing address, telephone number, and email address is provided in the disclosure statement;

5. There may be conditions under which you will cease furnishing statements electronically to the employee and what those condition are (e.g. if the employee terminates employment);

6. The employee must update their contact information and the procedures for updating that information; and

7. A description of the hardware and software required to access, print, and retain the statement, and if applicable, the date when the statement will no longer be available on your web site. You must also advise the employee that the statement may be required to be printed and attached to a Federal, State, or local income tax return.

If you change the hardware or software required to access the statement that creates a material risk that the employee will not be able to access a statement, you must, prior to changing the hardware or software, notify the employee. The notice must describe the revised hardware and software required to access the statement and inform the employee that a new consent to receive the statement in the revised electronic format must be provided. After implementing the revised hardware or software, you must then obtain the new consent from the employee to receive the statement electronically.
362. Are we subject to penalties if we fail to file the required §6056 information in a timely manner?

If you fail to timely file complete and accurate returns under §6056 with the IRS, or fail to timely furnish a correct statement to responsible individuals, then you could be subject to a penalty of $260 per return with a maximum of $3,193,000 for a calendar year. However, penalties may be reduced if corrective action is taken within 30 days and may even be waived if the failure to file timely or accurately is due to reasonable cause and not due to willful neglect.

Relief from these penalties is available in 2016 and 2017 for returns filed and statements furnished for coverage in 2015 or 2016 if you can show that you have made good faith efforts to comply. No relief will be provided if you cannot show a good faith effort to comply with the requirements or you fail to timely file the return or furnish a statement by the appropriate deadline.

INDIVIDUAL RESPONSIBILITY

363. Won’t my employees be required to obtain their own health insurance coverage?

All individuals will be required to have health insurance starting in 2014, with exception for individuals who are incarcerated, not legally present in the United States or who maintain religious exemptions. Employees and their dependents covered under your group health plan will satisfy the individual mandate. If your plan year renews at a time other than January 1, your eligible employees and their dependents cannot be penalized if they don’t have coverage for the period in 2014 prior to the start of your 2014 plan year. If you don’t offer group health plan coverage to your employees and they wish to avoid penalties, they will be required to buy the coverage themselves, either through a Marketplace or in the individual market unless they have other coverage (e.g. a spouse’s plan or Medicare or Medicaid).

Individuals who are required to have health insurance and do not have health insurance will be required to pay a penalty, which will vary based on income levels and will be phased in over three years from 2014 through 2016. In 2016, the minimum penalty will be $695, and the maximum penalty will be $2,085.

If you offer group health plan coverage to your employees but it does not provide a required level of coverage or the cost of the coverage you offer is determined to be unaffordable, they may be able to purchase subsidized insurance through the exchanges.

364. What types of coverage will allow our employees to satisfy the individual mandate?

Individuals must have coverage that is deemed to be “minimum essential coverage”. That includes any of the following:

- Employer-sponsored health coverage including COBRA coverage and retiree coverage (does not include dental-only or vision-only coverage).
• Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace (also known as an Affordable Insurance Exchange).

• Medicare Part A coverage and Medicare Advantage plans.

• Most Medicaid coverage.

• Children's Health Insurance Program (CHIP) coverage.

• Certain types of veterans health coverage administered by the Veterans Administration.

• TRICARE.

• Coverage provided to Peace Corps volunteers.

• Coverage under the Nonappropriated Fund Health Benefit Program.

• Refugee Medical Assistance supported by the Administration for Children and Families.

• Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage).

• State high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage).

• Foreign coverage.

• Other health coverage recognized by HHS as minimum essential coverage.

In addition, for 2014 only, the following limited coverages will count as minimum essential coverage:

• Family planning services Medicaid.

• Tuberculosis-related services Medicaid.

• Pregnancy-related Medicaid.

• Emergency medical conditions Medicaid.

• Section 1115 demonstration projects.

• Coverage for medically needy individuals.

• “Space available care” in a facility of the uniformed services.

• “Line-of-duty care” for individuals not on active uniformed services duty.

365. Are our foreign employees working in the United States subject to the individual mandate?

It will depend on the circumstances. The individual mandate applies to all foreign nationals who are in the United States long enough during a calendar year to qualify as resident aliens for tax purposes. Foreign nationals who live in the United States for a short enough period that they do not become resident aliens for federal income tax purposes are not subject to the individual shared responsibility payment even though they may have to file a U.S. income tax return.
The IRS has more information available on when a foreign national becomes a resident alien for federal income tax purposes on their website here: http://www.irs.gov/taxtopics/tc851.html

366. Does the individual mandate apply to our employees who are U.S. citizens working in other countries?

Yes. However, U.S. citizens who live abroad for a calendar year (or at least 330 days within a 12 month period) are treated as having minimum essential coverage for the year (or period). These are individuals who qualify for the foreign earned income exclusion under Internal Revenue Code §911. If they qualify, they need take no further action to comply with the individual mandate. See IRS Publication 54 for further information on the §911 exclusion.

In addition, all bona fide residents of the United States territories (Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, and the Northern Mariana Islands) are treated by law as having minimum essential coverage. They are not required to take any action to comply with the individual shared responsibility provision.

367. What happens if one of our employees has a gap in coverage during the year?

Individuals who have a short gap in coverage for less than a continuous three-month period will not be penalized during the gap in coverage. However, this exemption may only be used once per year. If an individual has a continuous period gap that is three or more months, none of the months in the period will be exempt from the penalty.

368. If our plan year starts on July 1, 2014, will our employees be penalized for the period of no coverage between January 1st and July 1st because they didn’t enroll in our plan for the plan year starting on July 1, 2013?

No. An employee who is eligible to enroll in your non-calendar year plan with a plan year beginning in 2013 and ending in 2014 (the 2013-2014 plan year) will not be liable for a penalty for the months beginning in January 2014 and continuing through the month in which the 2013-2014 plan year ends.

369. We have several Medicare eligible employees. How will these bills affect their Medicare coverage?

The Act makes several improvements to Medicare including:

- Provides a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010);
- Phases down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020;
- For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013);
- For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011);
Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage.

On the other hand, changes to the provider reimbursement levels and Medicare Advantage programs could reduce access to providers or coverage options for Medicare beneficiaries.

TAXES AND SUBSIDIES

Cadillac Plans

370. Okay, I've been hearing all about these “Cadillac plans”. What are they?

A “Cadillac Plan” is determined based on the cost of the coverage provided. The annual cost of a plan for single coverage, or family coverage that exceeds specified dollar thresholds, will be considered a “Cadillac Plan”. When PPACA was enacted, the tax was due to go into effect beginning in 2018 with dollar thresholds for self-only coverage that exceed $10,200 annually, or family coverage that exceeds $27,500 annually in 2018. But with the passage of the Consolidated Appropriations Act for 2016, the Cadillac Tax was delayed for two years and is not scheduled to go into effect until 2020. The dollar thresholds for 2020 and later will be the indexed amounts that would have resulted had the tax been applicable in 2018.

When effective, coverage with a cost that exceeds the specified cost threshold amounts will be subject to a 40% excise tax on the value of coverage that exceeds the threshold dollar amounts. The tax is imposed on insurers for insured plans.

The threshold amounts are increased by $1,650 for individual coverage and $3,450 for family coverage for retired individuals age 55 and older who are not eligible for Medicare and for plans where the majority of employees covered by the plan are engaged in a high-risk profession or are employed to repair or install electrical or telecommunications lines. Employers may reduce the cost of coverage when applying the tax if the employer’s age and gender demographics are not representative of the age and gender demographics of a national risk pool.

371. What professions would be classified as high-risk professions under the Cadillac tax?

High-risk professions include:

- law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968),
- employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938),
- individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders),
- individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288 (b)), determined without regard to paragraph (2) thereof), and
- individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries.

This also includes employees who are retired from a high-risk profession if the employees were in one of the above high-risk professions for at least 20 years during the employee’s employment.

372. Do I pay the excise tax or does the insurance carrier/TPA pay it? How do they know the amount?

The tax would apply to your fully insured and self-funded group health plans, but not to any plans sold in the individual market, except for coverage eligible for the deduction for self-employed individuals. Although the issuer of the fully-insured plan is required to pay the tax, it is the employer’s responsibility to calculate the amount of benefits that are subject to the tax and calculate the tax. For multi-employer plans, the plan sponsor is required to calculate the tax. If your plan is self-funded, you (as either the plan administrator or employer) would be responsible to both calculate and pay the tax.

373. What coverages should we be including when we are determining the aggregate cost of group health plan coverage for our employees?

The group health plan costs that should be considered in the calculation include:
- Medical and prescription drug;
- Dental and vision unless provided under a separate policy, certificate or insurance contract;
- Employee and employer contributions to a health FSA;
- Employer contributions to an HRA;
- Employer contributions to an HSA, including employee contributions made on a salary-reduction basis under your §125 plan;
- Hospital indemnity or specified illness policies purchased by employees on a pre-tax basis; or
- On-site clinic (unless limited to treating employees with minor illnesses or injuries or rendering first-aid in cases of accidents occurring during work hours).

374. How do we calculate the cost of our plan?

The cost of the coverage will be determined using your plan’s COBRA rate. For the account-based plans, it will be the amounts contributed to the accounts.

375. If the tax is based on the cost of individual and family coverage but we use a composite rate for our COBRA rates, how should we determine the cost of coverage?

You will have to calculate separate individual and family COBRA premiums for purposes of the Cadillac tax, even if for actual COBRA purposes, you use a composite COBRA rate.
376. Do the cost thresholds remain the same or are they adjusted each year for changes in the cost-of-living?

For each calendar year, the self-only and family dollar amounts will be increased under a cost-of-living adjustment.

377. Does the Cadillac tax apply to collectively-bargained multiemployer plans?

Yes, but any coverage provided under a multiemployer plan (as defined in Code §414(f)) is treated as family coverage. Thus, the dollar threshold for an employee with either self-only or family coverage under a multiemployer plan would be the dollar threshold for family coverage.

378. When would I have to start paying the excise tax on these so-called “Cadillac plans”?

This new tax will be effective for taxable years beginning January 1, 2020.

379. As a small employer with only 21 employees, will we be eligible for any assistance to help us provide coverage to our employees?

It depends. Effective January 1, 2010, premium subsidies are available for small employers with fewer than 25 full-time equivalent employees and average annual wages of $50,000 or less that purchase coverage for employees and pay at least 50% of the cost. Additional premium subsidies are available for employers with 10 or less full time equivalent employees and average annual wage of $25,000 or less. These dollar amounts are indexed for inflation as follows:

- For 2014, the average annual wage thresholds increased to $25,400 and $50,800.
- For 2015, the average annual wage thresholds increased to $25,800 and $51,600.
- For 2016, the average annual wage thresholds increased to $25,900 and $51,800.

The IRS has more information about the credit, including tax tips, guides and answers to frequently asked questions available on their website at: [http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers](http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers).

380. How much is the tax credit?

For 2010 through 2013, the tax credit is 35% of the employer’s contribution towards health premiums. Starting in 2014, the maximum credit will increase to 50% of premiums paid, but the credit will only be available if you purchase coverage through a SHOP Marketplace.
The tax credits are reduced if the number of your full time employees exceeds 10 or if average annual wages exceed $25,000.

381. **Does it include dental or vision?**

Yes. The credit can also apply to dental or vision; long-term care, nursing home care, home health care, or community-based care; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental health insurance.

382. **Can premiums we paid in 2010, but before the new health reform legislation was enacted, be counted in calculating the credit?**

Yes. In computing the credit for a tax year beginning in 2010, you may count all premiums paid in 2010.

383. **We are a tax-exempt organization. Can we qualify for the tax credit?**

Yes. The tax credit is available to you if you’re an organization described in Code section 501(c) that is exempt from tax under Code section 501(a). The tax credit is 25% of your contribution towards health premiums. However, the amount of the credit cannot exceed the total amount of income and Medicare (i.e., hospital insurance) tax you are required to withhold from your employees’ wages for the year and your share of Medicare tax on your employees’ wages.

Starting in 2014, the maximum credit will increase to 35% of premiums paid, but the credit will only be available if you purchase coverage through a SHOP Marketplace.

384. **Can we claim the credit if we had no taxable income for the year?**

Yes. For a tax-exempt employer, the credit is a refundable credit so even if you have no taxable income, you may receive a refund.

385. **How do we claim the tax credit?**

The credit is claimed on your company’s annual income tax return with an attached Form 8941, Credit for Small Employer Health Insurance Premiums, showing the calculation of the credit.

A tax-exempt small business claims the credit by filing the Form 990-T, Exempt Organization Business Income Tax Return, with an attached Form 8941 showing the calculation of the claimed credit. Filing Form 990-T with an attached Form 8941 is required for a tax-exempt eligible small business to claim the credit, even if it is not otherwise required to file Form 990-T.

386. **Is there a limit on the amount of years a small business can claim the tax credit?**

Yes. Starting in 2014, the credit will be available to eligible small employers for two consecutive taxable years.
387. How do we determine how many full time equivalent employees (FTE) we have for purposes of the tax credit?

The number of FTEs is determined by dividing the total hours for which you paid wages to your employees during the year (but not more than 2,080 hours for any employee) by 2,080. The result, if not a whole number, is then rounded to the next lowest whole number.

**Example:** For the 2010 tax year, an employer pays 5 employees wages for 2,080 hours each, 3 employees wages for 1,040 hours each, and 1 employee wages for 2,300 hours.

The employer’s FTEs would be calculated as follows:

Total hours not exceeding 2,080 per employee is the sum of:

a. 10,400 hours for the 5 employees paid for 2,080 hours each (5 x 2,080)

b. 3,120 hours for the 3 employees paid for 1,040 hours each (3 x 1,040)

c. 2,080 hours for the 1 employee paid for 2,300 hours (lesser of 2,300 and 2,080)

This adds up to 15,600 hours.

15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number = 7.

388. How do we determine the amount of our average annual wages?

The amount of your average annual wages is determined by first dividing (1) the total wages paid by the employer to employees during your tax year; by (2) the number of your full time equivalent employees for the year. The result is then rounded down to the nearest $1,000 (if not otherwise a multiple of $1,000). For this purpose, wages means wages as defined for FICA purposes (without regard to the wage base limitation).

**Example:** For the 2010 tax year, an employer pays $224,000 in wages and has 10 FTEs. The employer’s average annual wages would be: $22,000 ($224,000 divided by 10 = $22,400, rounded down to the nearest $1,000).

389. Do we have to count our seasonal employees when determining the number of full time equivalent employees we have or the amount of our average annual wages?

No. Seasonal employees (i.e. workers who perform labor or services for no more than 120 days during the taxable year and retail workers employed exclusively during holiday seasons) are excluded when determining if you have less than 25 full time equivalent employees for purposes of the small business premium tax credit and from the calculation of the employer’s annual wage level for purposes of the credit.
390. **What is the Patient-Centered Outcomes Research (PCORI or CER) fee?**

PPACA established the Patient-Centered Outcomes Research Institute. Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will assist patients, clinicians, purchasers and policy-makers in making informed health decisions through the dissemination of comparative clinical effectiveness research findings.

The trust fund will be funded in part by fees paid by health insurers and plan sponsors. The fee is imposed for each plan year ending on or after October 1, 2012, and before October 1, 2019.

391. **How much is the fee?**

For plan years ending before October 1, 2013, the fee is $1 multiplied by the average number of lives covered under the plan for the plan year. For plan years that end on or after October 1, 2013 but before October 1, 2014, the fee is $2 multiplied by the average number of lives covered under the plan for the plan year. The fee amount will be indexed annually starting in 2014 as described below:

- $2.08 per covered life for policy years and plan years ending on or after October 1, 2014, and before October 1, 2015.
- $2.17 per covered life for policy years and plan years ending on or after October 1, 2015, and before October 1, 2016.
- $2.26 per covered life for policy years and plan years ending on or after October 1, 2016, and before October 1, 2017.

392. **If our medical plan is insured, is there anything we have to do?**

For insured plans, the insurer will be responsible for all the PCORI fee requirements including reporting on and paying the fee.

393. **We sponsor a self-funded health plan. How will we pay the fee?**

You must pay and report the fee on IRS Form 720, “Quarterly Federal Excise Tax Return”. The Form 720 can be filed and paid electronically or submitted on-line using an approved transmitter software. The fee is due once a year (not quarterly), which will be due by July 31 of each year. Your payment and return will cover the plan year that ended during the preceding calendar year. For example, for applicable plan years that end in 2012, the first due date for filing Form 720 is July 31, 2013.

Information on paying the fee electronically through the Electronic Federal Tax Payment System (EFTPS) can be found here: [https://www.eftps.gov/eftps/](https://www.eftps.gov/eftps/)
394. Our plan is not subject to ERISA. Do we still have to pay the PCORI fee?

Yes. The fee applies to church and governmental plans that are not subject to ERISA on the same basis it applies to ERISA plans.

395. We sponsor a single self-funded plan that covers employees of three other employer members of our controlled group. Is each employer member responsible for their own fee?

No. The fee is imposed on the plan sponsor of the plan, not each participating employer member.

396. If we have two plan options, one is a self-funded PPO option and the other is an insured HMO option. Will there be two fees for our arrangement?

Yes. For the insured plan option, the insurer will report and pay the fee. For the self-funded plan option, you will have to report and pay the fee.

397. Can we hire our TPA to file the return on behalf of our self-funded plan?

No. There is no way for a third party to file Form 720 on behalf of the plan sponsor. The IRS indicated that the costs of establishing such a third-party payer program would outweigh the benefits given the limited period over which the fee will apply.

398. Can we use plan assets from our plan trust or employee contributions to pay the PCORI fee?

No. The fee is imposed on the plan sponsor, not the plan. As such, paying the PCORI fee generally is not a permissible expense of the plan for purposes of ERISA.

399. Our self-funded plan includes prescription drug benefits managed by a pharmacy benefit manager. We will have to pay two separate fees?

No. A single self-funded plan that provides two or more separate health benefits will only be assessed a single fee. Even if the prescription drug benefits are provided under a separate plan, you will still only pay a single fee as long as each plan operates on the same plan year basis.

400. We also sponsor a health care FSA and provide dental and vision benefits. Will we have to pay a separate fee for them?

The fee does not apply to HIPAA-excepted health FSAs and according to the final regulations, it does not apply to limited-scope dental or vision benefits that are offered separately from the medical benefits. An example from the regulations illustrates this point:

**Example 1**: Plan Sponsor D sponsors and maintains three separate plans to provide certain benefits to its employees – Plan 501, Plan 502, and Plan 503. Plan 501 is a calendar year plan that provides accident and health benefits on a self-funded basis to employees of Plan Sponsor D. Plan 502 is a calendar year HRA that can be used to pay for qualified accident and medical expenses for employees of Plan Sponsor D and their eligible dependents. Plan 503 provides dental and vision benefits for employees of Plan Sponsor D and eligible dependents on a self-funded basis.
Conclusion: Because Plan 501 and Plan 502 provide accident and health coverage and are maintained by Plan Sponsor D for the benefit of its employees, Plans 501 and 502 are applicable self-funded health plans that are subject to the fee. Because dental and vision benefits are excepted benefits, Plan 503 is not an applicable self-funded health plan subject to the fee.

401. We offer a health reimbursement arrangement (HRA) that is integrated with a high deductible health plan. Do we have to pay separate fees for each plan?

An HRA is not subject to a separate fee if the HRA is integrated with another self-funded plan that provides major medical coverage as long as you are the plan sponsor for both plans and they both have the same plan year.

However, if the HRA is integrated with an insured major medical plan, then the insurer will pay the fee for the major medical plan and you will be responsible for reporting and paying the fee for the HRA. You may treat each employee’s HRA as covering a single covered life. You are not required to include in your count of covered lives any spouse, dependent, or other beneficiary of the employee.

402. We don’t offer a major medical plan but we offer a stand-alone HRA to help our employees pay for their health care expenses. Will we have to pay the fee for the HRA?

Yes. If you only sponsor a stand-alone HRA or FSA, you will have to pay the fee for that HRA or FSA. However, you may treat each employee’s health HRA or FSA as covering a single covered life. You are not required to include in your count of covered lives any spouse, dependent, or other beneficiary of the employee.

403. Will the fee apply to our EAP or wellness program if they provide limited medical benefits?

Even though they may be considered group health plans, the fee will not apply for an EAP, disease management program, or wellness program if the program does not provide significant benefits for medical care or treatment.

404. We have employees working and living overseas that are covered under a separate expatriate plan. Does this fee apply to that coverage?

No. The fee does not apply to any group insurance policy or self-funded plan if the facts and circumstances show that the policy or plan is designed specifically to cover primarily employees who are working and residing outside of the United States.

Individuals (and their dependents) would be deemed to be living outside the United States if the address you have on file for the primary insured person is outside the United States.

405. For our self-funded plan, how do we determine the average number of lives covered under our plan for the plan year?

For any plan year that begins before July 11, 2012 and ends on or after October 1, 2012, you can use any reasonable method for determining the average number of covered lives for the plan year.
For subsequent plan years, you can choose one of three alternative methods to determine the average number of lives covered under the plan for the plan year:

- **Actual Count Method** – add the total number of lives covered for each day of the plan year and divide that total by the number of days in the plan year.

- **Snapshot Method** – add the total number of lives covered on one date in each quarter, or more dates if an equal number of dates are used for each quarter, and divide that total by the number of dates on which the count was made. For this purpose, the date or dates for each quarter must be the same (for example, the first day of the quarter, the last day of the quarter, the first day of each month, etc.) or, each date used for the second, third, and fourth quarters must be within three days of the date in that quarter that corresponds to the date used for the first quarter, and all dates used must fall within the same policy year or plan year. There are two methods you can use under the snapshot method for counting the number of covered lives:
  - **Snapshot Factor Method** – The sum of the number of participants with employee-only coverage on the designated date, plus the product of the number of participants with coverage other than employee-only coverage on the date multiplied by 2.35; or
  - **Snapshot Count Method** – The actual number of lives covered on the designated date.

- **5500 Method** – add together the number of participants (i.e. employees or former employees) covered at the beginning of the plan year and the number of participants covered at the end of the plan year, as reported on the Form 5500 filed for the applicable self-funded health plan for that plan year. If your plan only offers employee-only coverage, then you would add the number of participants covered at the beginning of the plan year to the number of participants covered at the end of the plan year and then divide by two.

You must use the same method of calculating the average number of lives covered under the plan consistently for the duration of the plan year. However, you may use a different method from one plan year to the next.

**406. Do we include COBRA qualified beneficiaries in our count?**

Yes. The fee applies to individuals covered as COBRA qualified beneficiaries.

**407. Do we have to count covered retirees and their dependents when calculating the fee?**

Yes. The fee applies to retiree coverage whether provided under an active employee plan or a stand-alone, retiree-only plan.
408. **What is the transitional individual market reinsurance fee?**

A transitional reinsurance program will be established in each State to help stabilize premiums for coverage in the individual market during the benefit years 2014 through 2016. Under this provision, all health insurers and self-funded group health plans providing *minimum value (MV)* major medical benefits must make contributions for each individual covered by your plan to support reinsurance payments to individual market insurers that cover high-cost individuals. HHS and the Department of the Treasury have developed an MV calculator for insured large group or self-funded plans to use to determine whether a plan provides the minimum 60% value. You can access the calculator and methodology at: http://cciio.cms.gov/resources/regulations/index.html.

Insurers will report and pay the fee for insured plans and self-funded plans will report and pay the fee on an annual basis beginning in 2014.

409. **How much is the reinsurance fee?**

For 2014, the first year of the program, the fee was $5.25/month or $63/year per covered life. The fee for 2015 was $44, and for 2016 the fee is $27.

In addition, States are permitted to assess additional fees on insurers (but not self-funded ERISA plans) if they need to collect additional contributions to pay for the cost of the program.

410. **So for our insured plan option, the insurer will pay the fee?**

Yes. Health insurers will be responsible for calculating the fee and remitting it to HHS. However, the insurer is not prohibited from passing the cost of the fee on to their policyholders through higher premiums or assessments.

411. **If our plan is self-funded, will the TPA be responsible for the cost of the fee?**

No. As plan sponsor, you are liable for the cost of the fee. Your TPA can however assist you with determining the number of covered lives your plan has or can accept the responsibility to file and pay the fee on your behalf. Otherwise, you will pay the fee directly to HHS. By November 15th of each year of the program starting in 2014 (delayed until December 5th for 2014 only), you will have to report to HHS the number of covered lives subject to the fee. HHS will then notify you of your contribution amount. You would then pay your reinsurance contributions in two installments to HHS. The first of the two installments each year must be paid by January 15th of the following year and would include the reinsurance contribution amounts ($52.50 for 2014) allocated to reinsurance payments and administrative expenses. The second installment ($10.50 for 2014) would cover the portion of the reinsurance contribution amount allocated to the payments for the U.S. Treasury and would have to be paid at by November 15th of the following calendar year. For 2015,
the fee could be paid in installments of $33 and $11. For 2016, the fee is $27 that may be paid in installments of $21.60 and $5.40.

If your TPA is willing to report and transfer your contributions to HHS, you should work with your TPA to determine the timing of the collection of the fee and revise your TPA administrative services agreement to include the rights and obligations of each party to pay and remit the assessment.

If your plan is self-funded and self-administered (i.e. your plan does not use a TPA for core administrative functions such as claim processing (including the adjudication of appeals) or plan enrollment functions, it is exempt from the requirement to pay the fee for 2015 and 2016 (but not 2014).

412. How will we pay the fee for our self-funded plan?

HHS will implement a streamlined process for the collection of reinsurance contributions. You, or your TPA on behalf of your plan, can complete all required steps for the reinsurance contributions process on the website Pay.gov including registration, submission of the annual enrollment count, attaching supporting documentation (if applicable), and scheduling the remittance of your contributions. The website is only accepting payments via an electronic Automated Clearing House (ACH) financial transaction.

After registering and creating a user profile, you, or your TPA on your behalf, will be required to complete a form called the “ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form”. The form requires you to provide basic company and contact information. You will then select the type of payment based on how you prefer to make your contribution. Next, you will add your plan’s annual enrollment count. The form will auto-calculate the contribution amounts. For 2014, you were required to then upload your supporting documentation in .CSV format for the applicable benefit (calendar) year. For 2015 and 2016, if you are reporting for fewer than four entities (e.g., a single employer filing for their self-insured plan), you won’t have to upload a supporting documentation .CSV file. To complete the submission, you will also submit payment information and schedule the two payment dates for remittance of the contributions.

The 2016 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form is available on pay.gov.

CMS has also released several tools for 2016 to assist you in completing the process including:

- Transitional Reinsurance Form Quick Start Guide
- 2016 Reinsurance Contributions Annual Enrollment and Contributions Submission Form Manual
- 2016 Reinsurance Contributions Form Completion and Submission Interactive Web-Based Training
- 2016 Reinsurance Contributions Glossary
413. What if we are already registered on Pay.gov for another purpose?

If you are already registered on Pay.gov, you do not need to create a new account. You can use your existing account to carry out the reinsurance process. However, you may have to update your password if you have not logged into Pay.gov for an extended period.

414. If the pay.gov account was created in 2014 or 2015 by a former employee who left the organization and her login credentials were not saved, what should we do for 2016?

The person making the payment for 2016 should go to Pay.gov and click the Register button on the top right corner of the home page and register as a new user.

415. What type of supporting documentation will we have to provide?

For 2014, you were required to upload supporting documentation for the enrollment count you provided. Starting in 2015, supporting documentation must be uploaded only if you are filing for four or more Contributing Entities (plans). The supporting documentation must be a .CSV format and must not exceed 2MB.

CMS has released the following materials for 2016 to assist you in completing the supporting documentation if you are filing for four or more entities:

- 2016 Benefit Year - Supporting Documentation: Job Aid and Job Aid Manual
- 2016 Benefit Year - Supporting Documentation: File Layout Requirements

416. Do we need to include company-level information in the Supporting Documentation file?

The Supporting Documentation requires you to include company-level information that identifies each Contributing Entity and its Annual Enrollment Count among other data. Information on each covered life should NOT be submitted. The Supporting Documentation contains one (1) row for each Contributing Entity. Therefore, for 2015, if you are a Contributing Entity submitting Annual Enrollment Counts for at least four entities, you should have one (1) row of data within the Supporting Documentation for each entity.

417. Is the Automated Clearing House (ACH) process at Pay.gov the only way to pay the reinsurance contributions payment?

Yes. HHS has created a streamlined approach to complete the contributions process through Pay.gov. The Automated Clearing House (ACH) process via Pay.gov is the only method being accepted for reinsurance contributions payment.

418. Will we be able to pay the full amount in one payment rather than two installments?

Yes, as long as the full payment is made by the January 15th deadline.
419. Can we use plan assets from our plan trust or employee contributions to pay the reinsurance fee?

Yes. The Department of Labor has advised that paying reinsurance contributions would constitute a permissible expense of the plan for purposes of ERISA because the payment is required by the plan, not the plan sponsor.

420. Our plan is not subject to ERISA. Do we still have to pay the reinsurance fee?

Yes. The fee applies to church and governmental plans that are not subject to ERISA on the same basis it applies to ERISA plans.

421. We sponsor a single self-funded plan that covers employees of three other employer members of our controlled group. Is each employer member responsible for their own fee?

No. The fee is imposed on the plan, not each participating employer member. However, if each employer member maintained their own separate group health plan, then each employer member’s plan would be responsible for paying the fee.

422. Does the fee apply to just medical or does it also apply to our health FSA, dental and/or vision coverage?

The fee does not apply to health FSAs, dental, or vision coverage because they do not provide major medical benefits.

423. We offer a health reimbursement arrangement (HRA) that is integrated with a high deductible plan. Does the fee apply separately to our HRAs?

No. An HRA that is integrated with a group health plan is excluded from reinsurance contributions because it is integrated with major medical coverage though the reinsurance contributions generally will be required for the high deductible plan.

424. We offer a stand-alone, retiree-only HRA that allows our retirees to purchase their own individual coverage. We will have to pay the fee for this plan?

No. A retiree-only HRA that reimburses expenses only until the account balance is exhausted is not considered to provide major medical coverage. Therefore, it is exempt from making reinsurance contributions.

425. Will the fee apply to our EAP or wellness programs if they provide only limited medical benefits?

No. An employee assistance plan, disease management program, or wellness program that does not provide comprehensive major medical coverage is not subject to the fee.

The fee also does not apply to coverage that is limited in scope such as hospital indemnity or specified illness policies.
426. **We have employees working and living overseas that are covered under a separate expatriate major medical insurance policy. Does the individual market reinsurance fee apply to that coverage?**

No. The reinsurance fee does not apply to insured expatriate health coverage as long as it’s limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents.

427. **Does this fee apply to plans sponsored by Indian Tribal Governments?**

In most cases, yes. A plan offered by a Tribe to employees (or retirees or dependents) because of a current or former employment relationship is subject to the fee.

Conversely, plans (whether fully insured or self-insured) offered by a Tribe to Tribal members and their spouses and dependents (and other persons of Indian descent closely affiliated with the Tribe) in their capacity as Tribal members (and not in their capacity as current or former employees of the Tribe or their dependents) would not be subject to the fee.

428. **For our self-funded plan, how will the average number of covered lives be determined?**

To determine the number of covered lives under a self-funded group health plan for purposes of the reinsurance fee, a plan must use one of the following methods:

- **Actual Count Method** - Add the total number of lives covered for each day of the first nine months of the calendar year and divide that total by the number of days in the first nine months; or

- **Snapshot Count Method** - Add the total number of lives covered on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the calendar year, and divide that total by the number of dates on which a count was made. For this purpose, the same months must be used for each quarter (for example January, April and July) and the date used for the second and third quarter must fall within the same week of the quarter as the corresponding date used for the first quarter; or

- **Snapshot Factor Method** - Add the total number of lives covered on any date (or more dates, if an equal number of dates are used for each quarter) during the same corresponding month in each of the first three quarters of the calendar year (provided that the date used for the second and third quarters must fall within the same week of the quarter as the corresponding date used for the first quarter), and divide that total by the number of dates on which a count was made, except that the number of lives covered on a date is calculated by adding the number of participants with self-only coverage on the date to the product of the number of participants with coverage other than self-only coverage on the date and a factor of 2.35. For this purpose, the same months must be used for each quarter (for example, January, April, and July); or
• **Form 5500 Method** - Use the number of lives covered for the benefit year calculated based upon the “Annual Return/Report of Employee Benefit Plan” filed with the Department of Labor (Form 5500) for the last applicable time period. If your plan covers more than self-only coverage, then the number of covered lives equals the sum of the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500. If your plan offers only self-only coverage, then the number of covered lives equals the sum of the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, divided by 2.

If the outcome of any of the counting methods is a fraction, you must round to the nearest hundredths (two decimal points).

429. **We have a 7/1 plan year. In 2014, we moved from a fully insured plan (7/1/2013 - 6/30/2014) to a self-funded plan effective 7/1/2014. Since the transitional reinsurance fee is a calendar year fee – who is responsible for payment and how do we calculate and pay the fee for 2014?**

Both you and the insurer would be responsible for paying a portion of the fee based on the portion of the year your covered lives were enrolled in the self-funded and fully-insured plans. The counting methods (except for the Form 5500 method) calculate covered lives based on enrollment in the first nine months of the calendar year and account automatically for partial years. So you will have to separately pay pro-rated fees based on the portion of the nine-month measurement period that your plan is self-funded using one of the approved methods. The insurer will also have to pay a pro-rated share of the fee for the portion of the year your plan was insured.

For example, if your self-funded plan had 500 covered lives on the first day of its new plan year of 7/1/14, and uses the snapshot count method on the first day of each quarter for the first three quarters of the year, you would use 0 lives for the count on 1/1 and 4/1, and 500 for 7/1 and then divide by three. Thus, you will pay approximately 33% of the cost of the fee for the year (assuming the covered lives count was relatively steady for the year). Meanwhile the insurer, if using the same method, would have covered lives counts on 1/1 and 4/1 while the plan was insured but would count 0 lives on 7/1 and divide by three. Therefore, they would pay approximately 66% of the fee for the year.

430. **We switched our plan from insured to self-funded in the middle of the third quarter of 2014. Can we use either of the Snapshot” counting methods in our situation?**

Yes, but you can’t pick count dates in that quarter where you could report zero covered lives. For example, if you switched to self-funded on September 1st (that is, 62 days into the third quarter), you would not be permitted to use a date of July 1st or August 1st as the count date for the third quarter because this would not properly reflect the number of covered lives under the self-funded plan in the third quarter. However, you would be entitled to reduce your count of covered lives for the third quarter by 62/92, the proportion of the quarter during which your self-funded plan had no enrollment.
431. If there is a reduction in the number of covered lives in the fourth quarter of the year, can we exclude those lives from our annual enrollment count?

No. You must submit an annual enrollment count no later than November 15th of 2014, 2015, and 2016, as applicable. The permitted counting methods calculate covered lives based on enrollment only in the first 9 months of a calendar year.

432. Do we count our employees or retirees that are covered by both our group health plan and Medicare?

You count them only if your group health coverage is the primary payer of medical expenses (and Medicare is the individual’s secondary payer). For example, a working 68-year-old employee enrolled in your group health plan would be counted for purposes of reinsurance contributions if your plan is the primary payer to Medicare. However, a 68-year-old retiree enrolled in your group health plan for whom Medicare is the primary payer would not be counted.

If a covered individual is eligible for Medicare due to end-stage renal disease or disability, then a reinsurance contribution would be required only if your plan is the primary payer to Medicare for that individual.

433. Do we include COBRA qualified beneficiaries in our count?

Yes. The fee applies to individuals covered as COBRA qualified beneficiaries.

434. Our self-funded plan includes a self-funded prescription drug benefit managed by a pharmacy benefit manager. Will we have to pay two separate fees?

No. Two or more self-funded group health plans that collectively provide major medical coverage for the same covered lives are treated as a single self-funded group health plan.

435. Our major medical plan is insured but our prescription drug coverage is carved-out on a self-funded basis. Will we have to pay two fees?

No. Where the major medical coverage is the insured coverage, the insurer is liable for the fee.

436. We have two plan options. One is a self-funded PPO option and the other is an insured HMO option. Who will pay the fees for each option?

For your HMO option that is insured, the insurer will be responsible for the reinsurance contribution associated with that coverage option. For the self-funded PPO, you will be responsible for the reinsurance contribution associated with that coverage option.

437. What do we need to do if we discover that the Form we submitted is wrong after the payment date has passed and the contribution was paid?

If you discover that data entered on the Form is incorrect after remitting payment, you will need to contact CMS at reinsurancelcontributions@cms.hhs.gov to provide a disclosure of this error. You should include the following in the email: Pay.gov tracking ID, Taxpayer Identification Number, and Gross Annual Enrollment Count.
When submitting this information, use the subject line of 'Discrepancy Disclosure' to ensure it is routed properly.

438. **Will the 2016 timing of the reinsurance contribution submission process be similar to 2015 and 2014?**

Yes. The contribution submission schedule for the 2016 benefit year will be similar to the schedule for the 2014 and 2015 benefit years.

439. **Can we deduct the cost of the reinsurance fee as a business expense?**

Yes. Sponsors of self-funded health plans that pay Reinsurance Program fees may treat the fees as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code.

### Health Insurer Fee

440. **Are there any other taxes or fees we need to be aware of?**

Yes. Beginning in 2014, a fee is imposed on insurers providing health insurance for any U.S. health risk during the calendar year in which the fee is due. Each year, the fee will be apportioned to the insurers based on each insurer’s relative market share of net health insurance premiums written for the prior year. The insurer must pay the fee no later than September 30 of each calendar year based on their prior year’s collected premium. They have indicated that the cost of the fee will be assessed to each policyholder.

Insurance coverage for long term care, disability, accidents, specified illnesses, hospital indemnity or other fixed indemnity insurance, benefits for medical care that are secondary or incidental to other insurance benefits, and Medicare supplemental health insurance are excluded.

**Note:** The Consolidated Appropriations Act for 2016 included a one-year moratorium on the collection of the fee for 2017.

441. **Is our self-funded health plan subject to this fee?**

No. Employers that sponsor self-funded health plans are not subject to the fee.

442. **Will this fee apply to our insured dental and vision coverage?**

Yes. Dental and vision insurance coverage is subject to the fee, even if they are limited in scope and HIPAA excepted benefits.

443. **If we have an EAP or wellness program that provides limited medical services, will the fee apply to those benefits?**

Coverage provided under an EAP, a disease management plan, or a wellness plan will not be considered health insurance, and therefore will not be subject to the fee, if they do not provide "significant benefits in the nature of medical care or treatment".
444. Does the fee apply to our insured retiree coverage?

Yes. There are no exceptions for coverage provided on an insured basis to retired employees.

445. We purchase travel insurance for employees that are travelling overseas. Will the fee apply to this coverage?

Travel insurance coverage that provides benefits for sickness or accidents occurring during travel is not subject to the fee provided that the medical benefits are not offered on a stand-alone basis and are incidental to the other benefits provided under the policy such as cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, etc.

Coverage which provides comprehensive major medical protection for travelers with trips lasting 6 months or longer is subject to the fee.

446. Will I still be allowed to deduct the Medicare Part D retiree drug subsidies I receive from the federal government? Will the subsidies still even be available?

The Act does not change the subsidy program, so the Medicare Part D retiree drug subsidies will still be available to you. However, the Act will eliminate the tax deduction starting in 2013 if you receive Part D drug subsidy payments. This will only affect employers subject to corporate taxes. Public entities, not-for-profit and religious entities are not affected by this change.

Even though the deduction is not eliminated until 2013, it will likely require immediate changes to your financial statements.

447. Will my employees see any other tax increases?

Yes. Starting in 2013, employees with income in excess of $200,000 and couples filing jointly with incomes in excess of $250,000 will see an increase of 0.9% in their Medicare tax. However, you will only be required to withhold the additional FICA taxes on amounts exceeding these thresholds for employees to whom you pay in excess of $200,000. There is no employer match when you are withholding the additional Medicare Tax. More information on the Medicare tax increase can be found on the IRS website here:


Starting in 2013, the Medicare tax (a total of 3.8%) will also be applied to net investment income for individuals or couples meeting the above income thresholds. The tax is not withheld from wages by employers but employees may request that additional income tax be withheld from their wages. For individuals, the tax will be
reported on, and paid with, the Form 1040. For estates and trusts, the tax will be reported on, and paid with, the Form 1041.

Also effective January 1, 2013, the threshold floor for deductibility of medical expenses on individual income tax returns is increased from 7.5% of Adjusted Gross Income (AGI) to 10%. The AGI floor for those 65 and older (and their spouses) remains at 7.5% through 2016.

MISCELLANEOUS

448. Will reform reduce my health insurance costs?

This is the $64,000 question. Some economists believe there may be small reduction to health insurance costs due to competition from the exchanges. Insurance company analysts and lobbyists believe costs will go up because the individual mandate will not drive enough new insureds into the system to offset the added costs related to guaranteed issuance of policies and elimination of preexisting condition exclusions.

449. Are there any other requirements that I should know about that aren't getting as much media attention?

New Voluntary Long Term Care Program: The Community Living Assistance Services and Supports (CLASS) program was intended to create a new, national, voluntary long-term care benefit that would provide a cash benefit to participants if they became unable to perform at least two activities of daily life.

The program was scheduled to be effective January 1, 2011 but on October 14, 2011, HHS Secretary Kathleen Sebelius notified Congress that there was no "viable path forward for CLASS implementation" to ensure solvency of the program. She also indicated that it would be suspended indefinitely.

New Nutritional Labeling Guidelines: The Act requires chain restaurants with 20 or more locations and food sold from vending machines to display the nutritional content of each standard item on the menu or menu board, (including drive-through menu boards), or in close proximity to the vending machine selection buttons. The information should include the number of calories and percentage of daily diet requirements. Daily specials and temporary menu items (less than 60 days per year) are excluded from this requirement.

Tax on Indoor Tanning Services: The Act imposes a tax on indoor tanning services of 10% effective for services performed July 1, 2010 and thereafter.

Reasonable Break Time For Nursing Mothers: The Act amends the Fair Labor Standards Act to require you to provide a reasonable break time for an employee to express breast milk for a nursing child for 1 year after the child’s birth, as well as a place, other than a bathroom, that is shielded from view and free from intrusion by coworkers and the public for such purpose. If you have less than 50 employees, the requirements will not apply if you can show they would impose an undue hardship.
The DOL’s Wage and Hour division has a website dedicated to providing information on PPACA’s break time requirement for nursing mothers here: http://www.dol.gov/whd/nursingmothers/

**Adoption Assistance:** The Act increases the adoption tax credit and adoption assistance exclusion by $1,000, makes the credit refundable, and extends the credit through 2011. The enhancements are effective for tax years beginning after December 31, 2009.

**450. Is COBRA coverage extended now beyond 18 months for my terminating employees?**

No, COBRA coverage is not expanded beyond the already existing 18-, 29- and 36-month COBRA qualifying events. One of the proposed pieces of legislation did include an extension of COBRA until the date at which the exchanges opened in 2014, but that was not included in the final bill that was passed.

**451. I’ve heard that several state attorneys general have filed a lawsuit against the federal government claiming that it is unconstitutional to force individuals to buy health insurance. Is it?**

No. On June 28, 2012, the U.S. Supreme Court upheld the constitutionality of the individual mandate under Congress’ taxing authority. As a result, plan sponsors should continue their efforts to implement all the applicable provisions, including their long-term "Play or Pay" strategy.