ADLER POLLOCK & SHEEHAN P.C.

THE AFFORDABLE CARE ACT

UNDERSTANDING THE EMPLOYER MANDATE

An Overview

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I. Introduction

The Patient Protection and Affordable Care Act (the "Affordable Care Act") was enacted by Congress and signed by President Obama on March 23, 2010. The Affordable Care Act is a 2,409 page statute regulating virtually every aspect of the nation's healthcare system. The law is divided into ten "titles," each addressing a different part of the healthcare system.

Title I of the Affordable Care Act is 374 pages and addresses "quality affordable healthcare for all Americans." Title I of the Affordable Care Act deals with health insurance and addresses the Employer Mandate; it is a very complex body of law.

II. Overview of What the Law Requires

The Affordable Care Act requires that most U.S. citizens and legal U.S. residents either have minimum healthcare insurance coverage or pay a penalty. It creates State-Based American Health Benefit Exchanges and Small Business Health Option Program ("SHOP") Exchanges, through which individuals and small businesses with up to 100 employees can purchase qualified coverage, with premium and cost-sharing credits available, to individuals and families with incomes between 133 and 400% of the federal poverty level.

Beginning January 1, 2015, large employers with 100 or more employees must provide their full-time employees, and their dependents, the opportunity to enroll in a healthcare plan that is both affordable and provides essential minimum coverage. Under final regulations issued on February 12, 2014, large employers with 50 to 99 full-time equivalents have been given until January 1, 2016 to comply with the law's coverage mandate. The law defines large employers to include those with 50 or more full-time equivalent employees. A full-time employee is one who works 30 or more hours a week, or provides 130 hours of service a month.

The law requires employers to pay penalties for employees who receive tax credits for health insurance through an exchange, with exceptions for small employers. The Affordable Care Act also imposes new regulations on the health plans in the exchanges and in the individual and small group markets.

Small employers are able to participate in the exchanges beginning January 1, 2014. States have the option to define small employers as either being up to 50 or up to 100 employees through the end of 2015, and increasing to up to 100 employees beginning in 2016. Exchanges may also choose to offer coverage to larger businesses beginning in 2017.

Beginning January 1, 2014, non-exempted individuals must either maintain "minimum essential health coverage" for themselves and their dependents or pay a "shared responsibility payment," a penalty calculated on a per month basis. The rules apply to individuals of all ages, including senior citizens and children. Every child must have

minimum essential coverage or qualify for an exemption for each month of the year. The person who claims the child as a dependent for federal income tax purposes is responsible for paying for the insurance if the dependent does not have coverage or qualify for an exemption.

There are several exemptions from the requirement to maintain minimum health coverage recognized under the Affordable Care Act including those for members of recognized religious sects, members of healthcare sharing ministries, persons who are not U.S. citizens or U.S. nationals, and incarcerated individuals.

Other persons are subject to the requirement to maintain minimum essential coverage, but are exempt from the penalty for noncompliance. These persons will be treated as having minimum essential coverage. Such persons include individuals unable to afford coverage because the health insurance premiums exceed eight (8%) percent of their household income, tax payers with household income below the income tax filing threshold ($10,000 single or $20,000 for married), and hardship cases where the individual can show a hardship makes obtaining minimum essential coverage impossible. Native Americans are also exempt from the penalty provisions.

III. Minimum Coverage Requirements – the Essential Health Benefits Package

Effective as of January 1, 2014, health insurance companies must provide health insurance policies which offer certain health benefits. The health benefits which must be offered in the health insurance policies are:

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

In addition to the benefits that insurance companies must provide, the law also imposes a series of Coverage Mandates that define the coverage limits for these policies. These Coverage Mandates include the following:

- Elimination of life-time limits;
- Elimination of annual limits;
- Restriction of policy rescissions to cases involving fraud or intentional misrepresentation prohibited by the terms of the plan or coverage;
- First-dollar coverage for certain preventative health services;
- Extension of dependent coverage until age 26;

- Elimination of pre-existing condition exclusions;
- Restriction of waiting periods to no more than 90 days;
- Guaranteed enrollment and guaranteed renewal;
- Limits on deductibles to $2,000 for single coverage and $4,000 for family coverage;
- Medical underwriting is prohibited;
- Restriction on premiums differences based on age and tobacco use is limited to ratios of no more than 3 and 1.5, respectively; and
- Elimination of any other such differences, except differences based on single or family coverage or geography

Minimum essential coverage does not include "specialized coverage" such as vision or dental care. Minimum essential coverage does include eligible employer-sponsored plans, including group health plans, governmental plans, church plans and grandfathered plans and grandfathered group health plans.

Fully-insured plans provided to employees pursuant to collective bargaining agreements ("CBA") are grandfathered until the last expiration date of the CBA related to that coverage. Grandfathered status may be maintained upon the CBA expiration date if no changes have been made since March 23, 2010, or if changes are made to the coverage that would have otherwise caused the plan to lose its grandfathered status.

Individuals without employer coverage who are not eligible to purchase coverage on the open market must pay for the lowest cost plan available from an Exchange. An individual ineligible for coverage under an eligible employer-sponsored plan must pay the premium for the lowest cost plan available in the individual market through the exchange serving the rating area in which the individual resides, as well as pay for coverage for the individual's family members who are not themselves eligible for coverage under an eligible employer-sponsored plan.

A refundable tax credit called the "Premium Assistance Credit" is available to help subsidize the purchase of health insurance. The credit is available to a taxpayer for any month that one or more members of the taxpayer's family are enrolled in qualified health insurance through an exchange and not eligible for minimum essential health coverage from another source, such as from an employer or through government coverage. The credit is not available when minimum essential coverage is available from an employer or government. An employer-sponsored plan is not considered "minimum essential coverage" if the required employee's contribution for the coverage exceeds 9.5% of the employee's household income, or the plan fails to meet the minimum value of the lowest-rated plan offered in the employer's location.

Those persons without health plan coverage must pay a tax penalty to be included in the 2014 tax return if they do not have appropriate coverage in 2014. The amount of the penalty is equal to the ***greater*** of $695 per year and up to a maximum of three times that amount ($2,085) per family, or 2.5% of the excess of the employee's, or the employee's family's, household income over their tax return filing threshold amount

($10,00 for single or $20,000 for married). The $695 penalty amount is phased in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee amount. The 2.5% penalty amount is phased in according to the following schedule: 1% for 2014, 2% for 2015 and 2.5% for 2016. After 2016, the penalty amount will be increased annually by a cost of living adjustment.

Exemptions from imposition of the penalty are available based on financial hardship. Persons for whom the lowest health plan option exceeds 8% of their household income are exempt, as are persons with income below the tax return filing threshold for their filing status for the applicable tax year.

IV. The Employer Mandate

A, Employer Obligations

Effective as of January 1, 2015, the Affordable Care Act requires that all large employers with 100 or more full-time equivalents provide their employees, and their dependents the opportunity to enroll in a healthcare plan. Under final regulations issued on February 12, 2014, large employers with 50 to 99 full-time equivalents have been given until January 1, 2016 to comply with the law's coverage mandate. An employer subject to the Affordable Care Act is only required to provide its full-time employees with the opportunity to *enroll* in a healthcare program; part-time employees, although counted when determining large employer status, are not required to be provided with health care coverage.

To be considered a large employer, a business must employ, at a minimum, 50 full-time equivalent employees. A full-time employee is one who works 30 or more hours a week, or provides 130 hours of service a month (including vacation, holiday, illness, incapacity including disability, layoff, jury duty, military duty or leave of absence).

After all the full-time employees have been counted, an employer must then take the total hours worked by its part-time employees and divide that number by 120. This number is then rounded down to the nearest full number. This calculation is used to convert the employer's part-time workers to full-time equivalents for purposes of applying the large employer test.

Example: A business has 25 employees who work 80 hours a month and 30 employees who work full-time. The employer must first calculate the total amount of part-time hours on a monthly basis (25 x 80 = 2,000) and then divide that total by 120 to get the number of full-time equivalents (2,000 ÷ 120 = 16.67 or 16 full-time equivalents).

30 full-time employees
+ 16 full-time equivalents

46 total full-time employees and full-time equivalents

Thus, although there are a total of 55 employees on the employer's payroll, this employer will not be considered a large employer under the Affordable Care Act for the following year.

IRS Notice 2012-58 describes safe harbor methods that an employer may use to determine which employees are considered full-time employees for purposes of administering the Affordable Care Act employer penalty provisions. The safe harbor methods include a measurement, or look back, that allows an employer to measure how many hours an employee averaged per week during a defined period of not less than 3 and not more than 12 consecutive months in a year.

Businesses that employ a large number of seasonal employees (retail, farm, resorts, etc.) have an exception that they may use. If an employer's workforce exceeds 50 full-time employees, including equivalents, for 120 days or less during the calendar year, the employees causing the employer to cross over to large employer status during the 120-day period are considered seasonal employees and the employer will not be considered to be a large employer. Full-time seasonal employees who work less than 120 days during the year are excluded from the calculation of large employer status.

B. Determining Large Employer Status

As noted above, an employer with 50 full-time equivalent employees is considered a large employer subject to the requirements of the Affordable Care Act. This includes counting all employees in a controlled group of companies. A group of companies under "common control" will be treated as a single employer for Affordable Care Act compliance purposes. This rule prohibits a company from splitting itself into two divisions to get the employee count below 50 employees.

The Affordable Care Act includes a provision that adopts the definition of common control as set forth in ERISA and the control group concept set forth in IRS Code Section 414. Like ERISA, the Affordable Care Act provides that any group of companies under "common control" is to be treated as a single employer. "Common Control" is defined in Section 414 as the same five or fewer persons or entities owning at least 80% of a group of companies. Under the concepts described in IRS Code Section 414, certain controlled groups of companies will be considered to be large employers if the controlled group of companies employs more than 50 full-time equivalent employees. IRS Code Section 414 and the accompanying regulations create various classes of controlled groups:

- A *parent subsidiary* relationship is created whenever a parent organization owns 80% or more of the equity of a subsidiary organization or any two of the five owners in a controlled group of companies owns more than 50% of the equity in the parent and subsidiary organizations. The subsidiary organization may be another corporation, a group of corporations, a partnership(s) or an LLC(s).

- A *brother/sister* common controlled group exists where the same five or fewer persons (counting individuals, estates and trusts as "persons") collectively own 80% or more of the equity in two separate businesses.

- Groups consisting of three or more corporations, partnerships or LLCs that are a combination of parent-subsidiary and brother/sister groups.

- Trades or businesses (whether or not incorporated) that are under common control.

- An affiliated service group, such as law firms, accounting firms, civic organizations, temporary staffing companies and third-party administrators when separate organizations are linked by at least 10% common ownership and the organizations are closely allied in the services they provide.

In any of these circumstances, the combination of companies or organizations will be considered to be a single employer for the purposes of applying the large employer status definition under the Affordable Care Act.

In addition to providing that all employers in a controlled group will be considered a large employer, these rules also prevent the group from discriminating between groups of lower and highly-compensated employees by favoring highly-compensated employees over lower-compensated employees in the benefits provided under a health insurance plan. Thus, a group of employees in a controlled group consisting of highly paid executives in a parent corporation and rank-in-file employees in a subsidiary must all be provided with the same level of benefits.

C. Is the Health Insurance Affordable? Does it Provide Essential Minimum Coverage?

If an employer is considered to be a large employer, it must provide its employees, and their dependents, the opportunity to enroll in a healthcare plan and that healthcare plan must be both affordable and provide essential minimum coverage. Affordability and essential minimum coverage are both defined under the Affordable Care Act. Employers who offer health insurance coverage that is inadequate or unaffordable will *not* be treated as meeting the Employer Mandate if at least one full-time employee declines the employee's healthcare coverage and obtains a premium credit in an exchange plan.

In order for the healthcare plan to be considered affordable, the cost of single coverage to the employee cannot exceed 9.5% of the employee's household adjusted gross income for the taxable year. The determination of affordability is based on the affordability of single coverage. Although large employers may provide coverage to dependents, it is only the coverage provided to individuals that is used to determine the

affordability of the healthcare plan. Coverage provided to dependents need not meet the 9.5% affordability requirement.

A major concern for large employers is knowing the adjusted gross income for the employee's household. The household's adjusted gross income not only includes the employee and the employee's significant other, but will include all dependents that are required to file a tax return. There are, however, three safe harbors that large employers can rely on when determining the coverage provided is affordable.

The first of these safe harbors is the W-2 safe harbor. If the cost of the coverage does not exceed 9.5% of the income listed in box 1 of the employee's W-2, the coverage will be considered to be affordable. Large employers should be careful in applying the W-2 safe harbor, however, since the income listed in box 1 will routinely exclude some income, such as an employee's contributions to a traditional 401(k) plan.

The second safe harbor is known as the rate of pay safe harbor. This safe harbor will apply if the employee's out-of-pocket cost per month does not exceed 9.5% of the employee's monthly income. For salaried employees, this is a simple equation. For hourly employees, a large employer must take the employee's hourly rate and multiple it by 130 to project the employee's monthly income.

The third safe harbor is the federal poverty line safe harbor. Here, a large employer uses the federal poverty line for an employee with single coverage in determining what is affordable for that employee.

To be considered essential minimum coverage, the large employer's healthcare plan must cover 60% of the essential health benefits covered in the lowest plan provided by the exchange in the employer's locality. Otherwise known as "bronze level" coverage, the essential minimum benefits include those noted above, including emergency services, ambulatory services, hospitalization, lab services, prescription drug coverage and maternity and newborn care, among others. Vision, dental, disability and long-term care are not included in essential minimum benefits.

D. The Penalty for Failing to Offer Health Care, or Offering Insufficient Healthcare Benefits.

Large employers not offering coverage or offering coverage to less than 95% of its full-time employees must pay $2,000 multiplied by its total number of full-time employees minus 30. This penalty only applies if at least one full-time employee receives subsidies in the exchange. Beginning in 2015, the $2,000 penalty also applies to employers that do not offer coverage to the children (under age 26) of full-time employees, regardless of whether or not the coverage offered to children is affordable.

Large employers offering coverage to at least 95% of its full-time employees pay the lesser of $3,000 multiplied by the number of full-time employees receiving subsidies, and $2,000 multiplied by the total number of full-time employees minus 30. This penalty

may occur because an employer did not offer coverage to a full-time employee or because the coverage offered was unaffordable or did not provide minimum value.

A large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to a penalty if at least one of its full-time employees has certified to the employer as having enrolled in health insurance coverage purchased through a State Exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.

Example: In 2014, an employer fails to offer minimum essential coverage for 150 full-time employees, one of which receives a tax credit for enrolling in a State Exchange offered plan. The employer will be assessed a $240,000 annual penalty, payable monthly ($2,000 per employee x 120, the number of employees over 30).

E. Large Employers With Collectively-Bargained Health Plans.

The grandfathering rules applicable to large employer health plans in effect on March 23, 2010 (*see* discussion in Section I of *A Summary of the Patient Protection Affordable Care Act*) are applicable to large employers with collectively bargained health plans and such employers are subject to the same requirements as employers with non-collectively bargained plans and are not provided with a delayed effective date for compliance with the reform provisions with which other non-grandfathered health plans must comply. In other words, all of the coverage mandates that apply to grandfathered non-collectively bargained plans (like the mandate to cover dependent children to age 26 or the prohibitions on annual or life-time limits) apply at the same time and in the same way to all collectively bargained plans.

There are, however, two special rules that apply to a large employer's collectively-bargained plan. Under the first rule, even if changes are made to an insured's collectively-bargained healthcare plan that would otherwise cause a grandfathered plan to lose its grandfathered status, the insured's collectively-bargained healthcare plan will not lose its grandfathered status until expiration of the last CBA in effect on March 23, 2010 that is related to the insured's healthcare plan. At that time, the insured collectively-bargained plan either retains or loses its grandfathered status, which is determined by comparing the plan's terms on the date of termination to the plan's terms as they existed on March 23, 2010.

Under the second rule, a change in insurers during the period of the CBA will not by itself cause a loss of grandfather status upon expiration of the CBA in effect on March 23, 2010.

There is no delay in the effective date, however, for changes to collectively-bargained health plans necessary to implement the Employer Mandate.

Practically speaking, because the Employer Mandates were postponed to January 1, 2015, it is unlikely that there will actually be health insurance plans under CBAs that were in effect on March 23, 2010, when the Employer Mandate becomes law.

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