THE REGULATORY UPDATE BELOW WAS ISSUED ON JULY 10, 2013, AND UPDATES THE INFORMATION IN THE GUIDE THAT FOLLOWS, WHICH WAS ORIGINALLY ISSUED ON JUNE 13, 2013

HealthPlans
A HARVARD PILGRIM COMPANY

TO: Our Valued Clients and Brokers

FROM: Health Plans, Inc.

RE: Postponement of ACA employer mandate provisions until 2015 and transition relief on the individual mandate

The IRS has recently made two significant changes to the provisions of the ACA relating to the shared responsibility provisions. These changes are summarized below.

Postponement of ACA employer mandate provisions

On July 2, the Treasury Department posted a blog indicating that there will be a one year delay before the employer shared responsibility payments and mandatory employer reporting requirements under the ACA will take effect. Last night, the IRS issued Notice 2013-45 which confirmed the information contained in the blog: The shared responsibility payments (aka the "play or pay" penalties) which were scheduled to take effect starting January 1, 2014 will now be postponed until January 1, 2015. The employer reporting requirements which the IRS will use to facilitate administration of the employer play or pay penalties are also delayed until 2015 with reports due early 2016.

At this time, all other ACA provisions scheduled to take effect for plan years beginning on and after January 1, 2014 are still in force, such as the benefit mandates, the 90-day limit on waiting periods, and federal fees. Please also note that the Individual Mandate for 2014 remains in effect.

According to Notice 2013-45, "Proposed rules for the information reporting provisions are expected to be published this summer….This transition relief will provide additional time for dialogue with stakeholders in an effort to simplify the reporting requirements consistent with effective implementation of the law."

This language suggests that there may be further changes to the reporting requirements after the proposed rules have been issued and analyzed/tested by employers, TPAs, insurers and other stakeholders. Presumably, at that point final rules upon which all stakeholders can rely will be issued.

Transition relief on the individual mandate

Under the individual mandate of the ACA, individuals are generally required to have minimum essential coverage beginning January 1, 2014. Those who are not covered for more than three months each year may potentially be subject to a penalty. The IRS had earlier issued guidance indicating that employers with non-calendar year plans would be allowed to amend their Section 125 plans to permit individuals eligible for coverage to make a special election to enroll as of January 1, 2014. However, on June 26 the IRS issued Notice 2013-42 which provides a transition rule for 2014 that eliminates the need for the special election and Section 125 plan amendment.

Under the transition rule, if an eligible employee is not enrolled in his/her employer's non-calendar year plan and does not obtain coverage elsewhere such as in an Exchange, the individual mandate penalty will not apply for the period between January 1, 2014 and the date the non-calendar plan year begins in 2014. For example, if the plan year begins on July 1, 2014, no penalty would apply to an eligible, but not enrolled employee for the period January 1 through June 30, 2014, or to that employee's tax dependents. In addition, these individuals would be permitted to have up to three months without coverage *after* the plan year begins before a penalty would be assessed. In other words, the individual mandate for employees and dependents eligible for non-calendar year group health plans will be effective on the date the plan year begins in 2014.

We will update our Compliance Guide to reflect this change.

Health Plans will continue to keep you apprised of developments in these rules as regulations and guidance are issued by the Departments of Treasury, Labor and Health and Human Services. We will also update our Compliance Guide to incorporate the changes as they are announced.

If you have questions about these matters, please contact your **Health Plans** Account Manager.

Federal Health Care Reform

Compliance Guide

Changes for 2014

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This *Guide* reflects **Health Plans, Inc.'s** current understanding of the following provisions of the Affordable Care Act (ACA), most of which start taking effect January 1, 2014:

Shared responsibility provisions

- The **individual mandate**
- The **employer mandate** (aka the "**play or pay**" provisions)
- The employer notice and reporting requirements

Benefits and eligibility mandates

Federal fee assessments applicable to health plans

As additional guidance and implementing regulations are issued on any of these provisions, we will update this material.

This *Guide* will also be posted on our web site at www.HealthPlansInc.com in the Health Care Reform section.

Key terms appear in **bold** throughout the Guide and are defined in the Glossary.

Inside:

Shared Responsibility Overview

Under the general heading of "shared responsibility," the ACA imposes requirements on both individuals and employers.

For individuals, the requirements center on obtaining health coverage or facing a possible penalty each year. This is known as the **individual mandate**.

For **applicable large employers**, the requirements include the need to provide medical coverage to **full-time employees** or face potential penalties. These are known as the **employer mandate** or **play or pay** rules. In addition, virtually all employers are also subject to a variety of notice and reporting requirements.

The chart below provides a high level overview of how the **individual** and **employer mandates** interact and potentially trigger financial penalties.

Individual mandate – *applies to virtually all individuals, subject to income guidelines and limited exemptions which may waive the requirement*	**Employer mandate –** *applies only to certain "large" employers with 50 or more* ***full-time employees*** *and* ***full-time equivalents***
Individuals must obtain • ***Affordable*** • ***Minimum essential coverage*** under a health plan beginning in 2014, or face a possible tax penalty	Unless a large employer offers **full-time employees** and their eligible children • ***Affordable*** • ***Minimum value coverage*** the employer may face potential penalties if any **full-time employee** obtains subsidized coverage through an Exchange[1]

[1] The federal government uses the terms Insurance Exchange (or "Exchange") and Insurance Marketplace (or "Marketplace") interchangeably to mean the entities through which individuals in each state will be able to purchase insurance coverage that satisfies the for coverage under the ACA. For clarity, we will use the term "Exchange" throughout this *Guide*.

Special rule for non-calendar year plans

The individual mandate takes effect on January 1, 2014. However, the employer mandate will not take effect until the first day of the plan year that begins in 2014 ***if*** the eligibility criteria for participating in the plan as of January 1, 2014 are no more restrictive than they were on December 27, 2012 (the date the shared responsibility regulations were issued).

Example
Assume that as of December 27, 2012, a plan that begins its plan year on July 1st defined full-time as being scheduled to work 35 hours per week.

If on January 1, 2014, the eligibility is still based on 35 hours per week, the plan will not be assessed a penalty if an employee averaging 32 hours per week obtains a subsidy between January and June 2014.

The following sections describe the **individual** and **employer mandates** as well as other aspects of the shared responsibility provisions.

Individual Responsibility

The Individual Mandate

Basic rule

Beginning January 1, 2014, most individuals in the United States are required to participate in a health plan that provides **minimum essential coverage**, unless the plan is not **affordable**, or unless the individual qualifies for a waiver based on a handful of statutory exemptions.

If an individual is without **minimum essential coverage** for more than three consecutive months during the calendar year, a penalty tax will be calculated and is payable when the individual's tax return is filed. The **minimum essential coverage** requirement also applies to joint filers and to dependents listed on each taxpayer's return.

> Appendix 1 – Individual Mandate, includes additional detail about how the individual mandate works, the exemptions from the mandate, and the penalties individuals may face if they do not obtain minimum essential coverage.

Linking subsidized individual coverage to employer penalties

If an individual is covered by a policy issued through an Exchange, the individual will avoid any penalty. However, if an employee of an **applicable large employer** obtains subsidized coverage through an Exchange, that employer may be subject to a penalty under the **employer mandate** described in the next section.

> The threshold requirement for triggering an employer penalty is that at least one **full-time employee** (as defined by the ACA) obtains subsidized coverage through an Exchange.
>
> If no **full-time employee** obtains subsidized coverage, no employer penalty can be triggered.

Under the ACA, subsidized coverage is ***not*** available to any employee who:

- Is already enrolled in an employer-sponsored health plan
- Declined **affordable**, **minimum value coverage** under an employer-sponsored health plan
- Is eligible for other coverage such as Medicare Part A, Medicaid, CHIP or Tricare.
- Has household income that exceeds four times the federal poverty level (about $46,000 for individuals/$94,000 for a family of four)
- Is not a citizen or legal resident

When an employee receives subsidized coverage through an Exchange, the Exchange will provide a Certification to the employer as notice that the employer may be subject to a penalty. The Certification is the first step in assessing any penalty against an employer, and will also include instructions for the employer about how to appeal a penalty. Further guidance on this process should be forthcoming from the IRS.

Employer Responsibilities

The ACA includes numerous obligations for employers in terms of plan design, fees and reporting. However, the "employer responsibility" or "employer shared responsibility" provisions refer specifically to the:

- ***Employer mandate***, aka the "**play or pay**" provisions
- ***Notice requirements*** regarding the availability of Exchanges
- ***Reporting requirements*** regarding the status of the coverage offered by the employer

Employer mandate – the "play or pay" provisions

This part of the law refers to the requirement that **applicable large employers** offer **full-time employees**[2] a medical plan that meets certain cost and coverage standards (play) or face possible penalties (pay).

Basic rule

Applicable large employers may be subject to penalties if one or more **full-time employees** enroll for subsidized coverage through an Exchange ***unless:***

A. The employer has offered **minimum essential coverage** to **substantially all full-time employees** and their eligible children, and
B. The plan offered is **affordable** and provides **minimum value coverage**

Employer penalties

Under the basic rule above, one of two penalties may be levied against employers. These penalties are called the **Part A** and **Part B penalties** throughout this *Guide*, following their subsection designations under the law.

Part A penalty (no offer penalty) **–** if an **applicable large employer** fails to offer **minimum essential coverage** to **substantially all full-time employees** and their eligible children, and one or more employees obtain subsidized Exchange coverage, an employer could pay a penalty equal to:

(Total # of full-time employees – 30) x $2,000

[2] For the purposes of the employer responsibility provisions, "employee" means common law employee under the standards used by the IRS. It does not include leased employees, sole proprietors, partners in partnerships or 2% S corporation shareholders. It also does not include employees who work outside the United States.

Example:

Part A Penalty

Assumptions

- 500 **full-time employees**
- 400 or 80% are offered **minimum essential coverage**
- 1 **full-time employee** receives subsidized health coverage through an Exchange

[(500 – 30) x $2,000] = (470 x $2,000) = $940,000

Part B penalty (cost and coverage penalty) **–** if the coverage offered fails to provide **affordable, minimum value coverage,** the **Part B penalty** would be equal to the ***lesser of*** the **Part A penalty** above, or:

(Total # of full-time employees who receive subsidized coverage through an Exchange) x $3,000

Example:

Part B Penalty

Assumptions

- 500 **full-time employees**
- 500 are offered **minimum essential coverage**
- 1 **full-time employee** receives subsidized health coverage through an Exchange
- The plan is either **unaffordable** or does not provide **minimum value coverage**

1 x $3,000 = $3,000

The $2,000 Part A penalty is multiplied by the number of **all** full-time employees in excess of 30.

The $3,000 Part B penalty is multiplied only by the number of employees who **actually obtain subsidized coverage** through an Exchange

While each penalty is expressed as an annual amount, they are prorated based on the actual number of months during which a full-time employee had subsidized Exchange coverage.

The Essential Questions

To determine whether it would be at risk for a penalty under the rule, an employer will need to answer the questions below.

Question 1. Are we an applicable large employer?

Question 2. Who are our full-time employees?

Question 3. Have we offered minimum essential coverage to substantially all full-time employees?

Question 4. Does the plan provide minimum value coverage and is it affordable?

This section of the *Guide* provides an overview of how to answer these questions. In the Appendices at the end of the *Guide*, there is additional detail about the information that is required to answer the questions based on each employer's workforce and the plans offered to their employees.

QUESTION 1. ARE WE AN APPLICABLE LARGE EMPLOYER?

An employer will be subject to the **employer mandate** part of the ACA only if it is an **applicable large employer** as defined by the regulations. This determination must be made for each year, beginning 2014, based on the workforce composition during the previous calendar year.
In general, an organization is an **applicable large employer** if:

- The number of **full-time employees** and **full-time equivalents (FTEs)**
- Averaged 50 or more
- On business days during the previous calendar year

Special transition rule for the first year

To establish status as an **applicable large employer** for 2014, employers may compute the average number of **full-time employees** and **full-time equivalents** over any consecutive six-month period in 2013 instead of over the entire calendar year.

Defining the terms

- **Full-time employee** means:
  - An employee who averaged 30 **hours of service** per week or 130 **hours of service** per month during the previous calendar year (or, under special transition rule for the first year, during the six-month period chosen by the employer)
  - **A new employee**, other than a seasonal employee, who is reasonably expected to average 30 **hours of service** per week or 130 **hours of service** per month going forward
- **Full-time equivalents (FTE)** means the combined **hours of service** of all **non-full-time employees** for each month (capped at 120 per person), divided by 120
- **Hours of service** means each hour for which an employee is paid or is entitled to payment, such as vacation time, sick time, disability, jury duty, military duty or leave of absence.

The answer to Question 1 is easy for most employers. Either they always have more than 50 **full-time employees** and **full-time equivalents**, or the combination of **full-time employees** and **full-time equivalents** never approaches 50.

But for employers whose workforces fluctuate above and below 50, or include commissioned employees, **seasonal employees** or employees on variable, part-time or non-traditional schedules, or which are members of a larger controlled group of corporations or are new businesses just starting up, the answer may require a multi-step analysis and calculation. More information about how to make this determination is available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

Not an applicable large employer?

Employers which are not **applicable large employers** based on the number of **full-time employees** during the previous calendar year will not be subject to the **employer mandate** in the current year.

But most other provisions of the ACA do apply to all employers. Please see the other sections of this *Guide*, including *Employer Notice and Reporting Responsibilities*, *Benefits and Eligibility Changes*, and *ACA Action Plan*.

QUESTION 2. WHO ARE OUR FULL-TIME EMPLOYEES?

Employers will need to classify all employees as either **full-time** or **non-full-time** for several reasons:

1. **Applicable large employers** must offer **full-time employees** coverage under the employer's medical plan, or the employer risks a penalty

> **Full-time employee** means an employee who averages 30 **hours of service** per week or 130 **hours of service** per month. [3]

   To determine whether **new employees** need to be treated as **full-time employees** and offered coverage, each needs to be categorized upon hire as:

   - **Non-variable hour employee** (initially eligible for coverage)
   - **Variable hour employee** (initially ineligible for coverage)
   - **Seasonal employee** (initially ineligible for coverage)

   (These terms are defined in the Glossary and explained on pages 38-40.)

2. All employees need to be reevaluated at specified times to see if, based on actual hours, their status has changed, thereby either gaining or losing eligibility for coverage under the plan
3. **Applicable large employers** will be required to report to the IRS the number of **full-time employees** they had each month of the calendar year starting 2014
4. All employers will need to be able to document their findings regarding their status as an **applicable large employer** each year and regarding the status of any employee who receives a subsidy through an Exchange

Determining who is a **full-time employee** is the most challenging part of the **employer mandate**. Here's why:

The ACA was originally drafted to require that **full-time** status be determined on a month-by-month basis. This approach was quickly determined to be impractical for most employers, if not impossible, for the following reasons:

[3] During the first year of implementation, for plans subject to collective bargaining agreements (CBAs), it is **Health Plans**' understanding that employers may use the definition of full-time included in the CBA if full-time status requires more than 30 hours per week. However, the waiting period can be no more than 90 days, regardless of the waiting period provision in the CBA. For example, if the CBA defines full-time as 40 hours per week, those scheduled to work 40 hours per week would be offered coverage after 90 days; those scheduled to work less than 40 hours per week would be treated as **non-full-time employees** during the first year of implementation.

- Employers cannot offer coverage in advance for a given month because they cannot know with certainty what the employee's **hours of service** would be until the month is over.
- If eligibility is determined retroactively, and an employer hadn't offered coverage to a **full-time employee** who received subsidized coverage for that month, there would be no opportunity for the employer to take corrective action, offer coverage for the period in question, and avoid a penalty.
- The administrative costs of evaluating eligibility and then either starting or stopping coverage for each employee every month could be prohibitive.

The IRS addressed these issues by creating a safe harbor method for determining employee status that uses look-back periods to determine eligibility and locking in that status for a specified period going forward.

Overview of safe harbor method for identifying full-time employees
The safe harbor method of identifying **full-time employees** uses a three-phase approach:

1. ***Measurement period***
   Each employee's **hours of service** are tracked over this specified look-back period that may be 3-12 months long based on the employer's choice.
2. ***Administrative period***
   During the optional **administrative period**, which may be up to 3 months long, the employer evaluates the data collected, determines each employee's status as either **full-time** or **non-full-time** based on **hours of service** during the **measurement period,** and then either offers coverage to **full-time employees** or notifies **non-full-time employees** of termination of coverage, as applicable.
3. ***Stability period***
   This is the fixed period of time during which an employee's status as **full-time** or **non-full-time** is locked in, in most cases without regard to whether the employee's **hours of service** during that period actually change. The length of the **stability period** depends on the length of the **measurement period.**
   - If a **full-time employee's** hours drop below an average of 30 per week/130 per month during the **stability period**, the employee is still eligible for coverage until the end of the **stability period.**
   - If a **non-full-time employee's** hours increase to an average of 30 per week/130 per month during a **stability period**, the employee remains ineligible to participate in the plan until such time that the employee's hours over a **standard measurement period** have averaged at least 30 per week or 130 per month.

More information on the rules

***Appendix 2 – Tracking hours and classifying employees*,** provides additional information on the process of determining each employee's eligibility for coverage, including:

- Identifying every employee as either **ongoing** or **new**
- Distinguishing between different types of **new employees**
- Applying the rules to establish **measurement**, **administrative** and **stability periods** under the safe harbor rule for the first year of implementation, as well as for subsequent years
- Defining and counting **hours of service** for different categories of employees
- Using the hours data to classify all employees as either **full-time** (eligible for coverage) or **non-full-time** (and ineligible for coverage)

The ***Summary of Rules*** chart on page 41 outlines the specific regulatory requirements for establishing **measurement, administrative** and **stability periods**, including the special transition rule for the first year of implementation.

Examples of establishing **measurement**, **administrative** and **stability periods** begin on page 42.

Employer action required

To establish **measurement**, **administrative** and **stability periods** to take effect as of the date the plan year begins in 2014, employers will need to take the following steps as soon as possible in 2013:

1. Decide the length of the **measurement**, **administrative** and **stability periods** for **ongoing** and **new employees**, and determine whether to use the special transition rule for the first year of implementation
2. Determine when the **measurement period** must begin in 2013 to establish the **stability period** for the plan year that begins in 2014; for many employers data from July 1, 2013 going forward may be required

The decisions regarding the length of **measurement**, **administrative** and **stability periods** will necessarily be made by each individual employer based on the unique nature of each employer's business needs and workforce composition.

QUESTION 3. HAVE WE OFFERED MINIMUM ESSENTIAL COVERAGE TO SUBSTANTIALLY ALL FULL-TIME EMPLOYEES?

This question determines whether an employer is at risk for a **Part A penalty** if any employee obtains subsidized coverage.

Here is a recap of the **Part A penalty** formula: [4]

(Total # of full-time employees – 30) x $2,000

Analysis:

This section provides information about:

A. What it means to *offer* coverage
B. The definition of **minimum essential coverage**
C. The meaning of **substantially all**

A. What it means to *offer* coverage

Offering coverage means notifying **full-time employees** of their eligibility and giving them the opportunity to enroll in a plan. The timing of the offer depends on whether the **full-time employee** is an **ongoing** or **new employee**.

Defining the terms

Ongoing employee – an employee who has been employed for at least one compete standard **measurement period**[5] (see *Appendix 2* for more about **standard measurement periods**)

New employee – everyone else

The different types of **measurement periods** are explained in detail in Appendix 2.

- **Ongoing full-time employees** must be offered the opportunity to enroll in the plan for themselves and their eligible children at least once a year. (The ACA does not require that coverage be offered to spouses.) Most employers already follow this rule by having annual open enrollment periods. **Applicable large employers** who currently don't allow employees to enroll in their plans after their initial eligibility periods[6] will want to consider whether to incorporate annual open enrollment periods going forward to help avoid being subject to a **Part A penalty**.

[4] See pages 7-8 for a detailed explanation and example of the **Part A penalty**.
[5] For the initial implementation of these rules, an **ongoing employee** is any employee on the payroll on the date that the first **measurement period** begins
[6] Except under the HIPAA Special Enrollment rules

- **New employees** who, upon hire, are not **seasonal employees**, and who are reasonably expected to work 30 or more hours per week or 130 or more hours per month, i.e., are reasonably expected to work **full-time**, must also be offered coverage and be permitted to begin coverage by their 91st day of work.

  To satisfy this rule, employers who routinely begin coverage on the first of the month after the waiting period would need a waiting period that ends on the first of the month coinciding with or following completion of 60 days of employment.

- **New employees** who are either **seasonal** or who are not reasonably expected to average 30 hours per week or 130 hours per month (i.e., **variable hour employees**) do not need to be offered coverage. Instead, employers should begin the **initial measurement period** to track **hours of service** for these employees to determine their status for the following **stability period**.

- **New employees** whose status changes from **variable hour** or **seasonal** to **full-time** during their **initial measurement periods** must be offered coverage by:
  - The first day of the fourth month following the change in employment status
  - Or, if earlier, the first day of the first month following the end of the **initial measurement** and **administrative periods** if the employee had averaged 30 hours per week or 130 hours per month or more during the **initial measurement period**

  See chart: *Summary of Rules Applicable to Establishing Measurement, Administrative and Stability Periods* on page 41 for details about how employers are required to establish the length of these periods.

B. The definition of minimum essential coverage

Minimum essential coverage is coverage that incorporates the benefits and eligibility provisions of the ACA. Plans deemed to provide **minimum essential coverage** include the following:

- Most employer-sponsored medical plans (including COBRA and retiree coverage) that satisfy the benefits and eligibility mandates of the ACA
- Coverage purchased in the individual market
- Medicare coverage
- Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of Veterans coverage
- TRICARE

But not including:

- Specialized coverage, such as dental-only or vision-only plans
- Disease-specific plans, such as those for cancer
- Disability policies
- Workers' compensation

Health Plans works with clients to help ensure that their plan designs are compliant with the benefits and eligibility provisions of the ACA and provide **minimum essential coverage**.

C. The meaning of substantially all

Under the current ACA safe harbor rule, **substantially all** means 95% of **full-time employees**. Thus, if employers correctly identify and offer coverage to 95% of their **full-time employees** at the proper times, they would not be subject to a **Part A penalty**.

QUESTION 4. DOES THE PLAN PROVIDE MINIMUM VALUE COVERAGE AND IS IT AFFORDABLE?

This question encompasses a two-part test to see if an employee obtaining subsidized coverage might trigger a **Part B penalty** for an employer.

Here's a recap of the **Part B penalty**: [7]

Total # of full-time employees who receive subsidized coverage through an Exchange x $3,000

> **Important** – Employers only need to offer one plan design that satisfies the tests for **minimum value** and **affordability** at the employee-only level of coverage. Any additional plan designs would not be subject to these requirements.

A. Does the plan provide minimum value coverage?

Minimum value coverage means that the plan covers at least 60 percent of the cost of the plan's covered services. This level of coverage is based on the coverage available under a Bronze level plan through an Exchange, and represents the lowest level of coverage that satisfies the **individual mandate**.

Minimum value coverage can be determined in one of three ways:

1. Using the Minimum Value Calculator provided by Health and Human Services (available at http://cciio.cms.gov/resources/regulations/index.html)
2. Comparing the plan design against a checklist issued by the Internal Revenue Service in a notice of proposed rule making issued on May 3, 2013[8], or
3. Obtaining a certification of value from a member of the American Academy of Actuaries

Health Plans will work with our clients to help ensure that their plan designs are compliant with the **minimum value** standard.

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[7] See page 8 for a detailed explanation and examples of the Part B penalty.

[8] The three choices in the proposed checklists are: (1) A plan with a $3,500 integrated medical and drug deductible, 80 percent plan cost-sharing, and a $6,000 maximum out-of-pocket limit for employee cost-sharing; (2) a plan with a $4,500 integrated medical and drug deductible, 70 percent plan cost-sharing, a $6,400 maximum out-of-pocket limit, and a $500 employer contribution to an HSA; and (3) a plan with a $3,500 medical deductible, $0 drug deductible, 60 percent plan medical expense cost-sharing, 75 percent plan drug cost-sharing, a $6,400 maximum out-of-pocket limit, and drug co-pays of $10/$20/$50 for the first, second and third prescription drug tiers, with 75 percent coinsurance for specialty drugs.

B. Is the plan affordable?

A **Part B penalty** may be triggered if an employee obtains subsidized coverage and the employer's plan is not **affordable** as defined by the ACA.

For employers who want to avoid a **Part B penalty**, this means figuring out an employee contribution policy that both satisfies the ACA's affordability rule and also generates sufficient amounts to meet the employer's health care benefits budget.

Basic rule
For the purposes of the **employer mandate**, coverage is defined as **affordable** if the employee contribution does not exceed 9.5% of the employee's household income for self-only coverage under the lowest cost plan that provides **minimum value**.

Safe Harbor rule
Because an employer normally wouldn't know what an employee's total household income is, the implementing regulations provide a choice of three optional safe harbor methods for determining affordability.

Safe Harbor Options to Determine Affordability

9.5% of W-2 earnings in Box 1

The earnings reported in Box 1 reflect actual earnings, not rate of pay, and also do not include the employee's pre-tax contributions for coverage, flex plans, 401(k), etc., so this approach could result in a different amount for every employee.

9.5% of monthly rate of pay as of the first day of the plan year

For hourly workers the rate of pay is multiplied by 130 hours to establish monthly pay on which the premium would be based. If wages go up, employers are not permitted to increase employee contributions. But if wages go down, the employee's contributions would need to be reduced.

9.5% of the federal poverty guideline in effect for an individual as of the first day of the plan year.

For 2013, the federal poverty guideline for an individual is $11,490 – this results in a monthly contribution of about $91 for single coverage. The rate for 2014 has not yet been published.

Employers may use different safe harbor methods for different categories of employee, provided the method chosen is applied on a uniform and consistent basis for all employees in a category.

The permissible categories are:

- Collectively bargained/non-collectively bargained;
- Employees covered by different collective bargaining agreements;
- Salaried/hourly employees;
- Employees with primary places of employment in different states

Employers will want to work with their benefits/legal counsel and payroll vendors to determine the best method for setting and administering employee contribution rates.

Ultimately the decision regarding how to set employee contribution rates will be unique to each employer, driven by the composition of their workforces and their overall business plan.

Please see *Appendix 2* for more information about the process required to track hours and determine employee eligibility for coverage.

Employer Notice and Reporting Responsibilities

Under the ACA, employers have multiple new notice and reporting responsibilities. This section outlines the requirements as of the publication of this *Guide*. In some instances, as noted below, guidance regarding the requirements has not yet been issued by the implementing agencies, the Departments of Labor, Health and Human Services and Treasury ("the Departments").

Notice Requirements

Summaries of Benefits and Coverage

The Summaries of Benefits and Coverage ("SBCs") that plans are required to provide to participants with respect to coverage that begins on or after January 1, 2014 must include statements aboutwhether the plan provides:

- **Minimum essential coverage**, and
- **Minimum value coverage**

A plan provides **minimum essential coverage** if it is compliant with the benefits and eligibility mandates of the ACA. **Health Plans** works with our clients to help ensure that their plan designs are compliant with the ACA. This means that our clients can answer yes to the first question.

As outlined on page 17, **minimum value coverage** means that the plan covers at least 60 percent of the cost of the plan's covered services. For 2014, **Health Plans** anticipates working with clients to make this determination. We will advise our clients when the process for making determinations has been finalized.

Health Plans will make these mandated changes to the SBC template and will incorporate the new messages for all SBCs issued for coverage that begins in 2014.

The guidance issued on April 23, 2013, by the Department of Labor (DOL) extended all the other content and enforcement standards that were in effect for the first year of SBC implementation through the end of 2014. **Health Plans** will keep clients advised of any changes to these standards for 2015.

Notice Regarding New Health Insurance Exchange Coverage Options

The ACA modified the Fair Labor Standards Act (FLSA) to require that all employers subject to the FLSA[9], regardless of size, provide a notice to employees about the available of insurance Exchanges and the possibility that an employee may qualify for subsidized coverage through an Exchange.

[9] If an employer wants to confirm whether it is subject to the FLSA, the Department of Labor has an internet compliance assistance tool to determine applicability of the FLSA. *See* www.dol.gov/elaws/esa/flsa/scope/screen24.asp.

These notices must be supplied to:

- All current employees, regardless of eligibility for the employer's health plan, by October 1, 2013
- All **new employees** within 2 weeks of starting work, beginning October 1, 2013

Mandated content
The DOL provided model notices to be used by employers for this purpose. The variable employer- and plan-specific information that must be included is:

- Employer name, address, EIN and phone number
- Employer contact name, phone number and email address
- Eligibility criteria for coverage under the plan, including dependent eligibility criteria
- A statement regarding whether the plan meets the minimum value standard

Optional employee-specific content
Employers may, but are not required to personalize the notices to provide the following employee-specific information:

- Whether the employee is or will be eligible for coverage during the next three months
- The cost of employee-only coverage
- The frequency of premium payments
- Changes in availability of coverage or cost for the next plan year

The model notices are available at www.dol.gov/ebsa/pdf/FLSAwithplans.pdf.

Revised COBRA Election Notice
Beginning October 1, 2013, the COBRA election notice distributed to employees eligible for COBRA must provide information about the availability of health Exchanges.

Mandated content
The DOL has provided new model language for COBRA election notices add to the current election forms. **Health Plans** will incorporate the new language into the election forms for the plans for which we provide COBRA administration services beginning October 1, 2013.

Annual §6055 Notices to the IRS and Employees from All Employers Offering Coverage
In January every year, beginning in 2015, all employers offering coverage will be required to send:

- An annual information return to the IRS showing which employees were covered under the plan and over what period
- Notices to all individuals covered under the plan for any part of the prior tax year showing the duration of coverage

The §6055 information returns and individual notices will be used to enable the IRS to administer the individual mandate. The content requirements are similar to the current Massachusetts notices to the state and 1099-HC forms to Massachusetts residents regarding the duration of coverage during the prior calendar year.

Annual §6056 Report to IRS from Applicable Large Employers

A separate report required by the IRS applies only to **applicable large employers**. In addition to the information mandated for the §6055 notices, the §6056 report also includes:

- The terms and conditions of coverage for **full-time employees**, which may include showing the cost of coverage for employees
- Data showing which employees received coverage and when

The IRS has indicated that the §6055 and §6056 requirements may be combined in some way. Future guidance should be forthcoming from the IRS which should address content and format requirements and options for these notices.

Benefits and Eligibility Mandates Beginning in 2014

There are a number of mandates and one optional change for plan years that begin in 2014. Most of these changes were announced in 2010, when the ACA was passed. Each is outlined in the chart below, with additional details following.

Provision	Mandated?	Applicable to	
		GF Plans	NGF Plans
Cover children to age 26, no exceptions	✓	✓	✓
Restrict waiting period to maximum of 90 days	✓	✓	✓
Remove all pre-existing condition limitations	✓	✓	✓
Remove annual maximum coverage on essential health benefits	✓	✓	✓
Cover costs of routine services provided during clinical trials	✓		✓
Restrict out-of-pocket maximums to HDHP limits ($6350/$12,700 in 2014) • Count medical copays, coinsurance, deductibles toward out-of-pocket maximum • Beginning 2015, count Rx copays and integrated dental coverage toward out-of-pocket maximum	✓		✓
Permit one-time opt-in/opt-out election for participants in non-calendar year plans	Optional, but if chosen must amend medical and cafeteria plans	✓	✓

Coverage to age 26, no exceptions
Grandfathered plans that cover dependent children will have to extend coverage to age 26, regardless of whether the child has coverage available through another, non-parent, source. This provision has been in effect for non-grandfathered plans since 2010.

Restrict waiting period to maximum of 90 days
This new requirement applies to both grandfathered and non-grandfathered plans. To be compliant, plans must permit eligible employees to begin coverage by their 91st day of employment. This means that plans using a 90-day waiting period which had typically begun coverage on the first of the month following satisfaction of the waiting period will need to either offer coverage on the first of the month following 60 days of employment, or on the day following completion of the waiting period.

Remove overall annual dollar maximums on essential health benefits
Health plans must remove any overall annual dollar limits on essential health benefits listed below:

- Ambulatory patient services
- Hospitalization
- Emergency services
- Maternity and newborn care
- Mental health and substance abuse disorders, 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 pediatric oral and vision care

The move toward unlimited coverage began with the elimination of lifetime limits for plan years that began on and after September 23, 2010. For the following three years, plans were temporarily permitted to replace the lifetime limits with annual limits as follows:

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

The annual dollar limits on essential health benefits will be phased out altogether by the end of 2014.

Cover routine services during clinical trials
This change applies only to non-grandfathered plans. Under this rule, routine services received during approved clinical trials must be covered at the same level as the same services provided outside clinical trials. This includes services such as hospital visits, imaging, and laboratory tests for patients involved in

clinical trials, but not the cost of the investigational item, device or service or of items and services provided solely to satisfy data collection and analysis needs.

Approved clinical trials are defined in the ACA as:

- Federally funded or approved trials
- Clinical trials conducted under an FDA investigational new drug application
- Drug trials that are exempt from the requirements of an FDA investigational new drug application

Restrict out-of-pocket maximums to HSA-qualified HDHP limits
The ACA mandates that:

- Out-of-pocket maximums under medical plans be limited to the statutory out-of-pocket maximums which apply to HSA-qualified HDHPs. For 2014, those amounts are $6,350 for individuals; $12,700 for families.
- All patient out-of-pocket costs – deductibles, coinsurance and copayments, including copayments for office visits, hospital admissions and prescription drugs – must count toward each member's out-of-pocket maximum.

  Out-of-pocket maximum safe harbor for 2014 only
  Plans often use separate service providers, such as a third-party administrator (TPA) for administering major medical claims and a prescription benefit manager (PBM) for retail and mail order prescriptions. Recognizing that sharing information on out-of-pocket accumulators to ensure that all service providers would know when a member reached the out-of-pocket limit "...may require new regular communications between service providers", the regulators created a safe harbor rule which is available for 2014. Under the safe harbor, the rule on accumulating out-of-pocket maximums will be satisfied if:

  - The major medical coverage complies with the HSA-eligible HDHP out-of-pocket limit on medical expenses, and
  - To the extent that the plan consists of coverage in addition to major medical coverage, any out-of-pocket limit on the additional expenses (such as prescription drugs) is no more than the limit for major medical expenses.

This rule represents a change for all plans except those currently operating as HSA-qualified HDHPs. **Health Plans** will adjust its claims processing system to count all medical copayments toward the out-of-pocket maximums for plan years beginning in 2014, and will be working with prescription drug managers and other service providers to help plans meet the more stringent requirements applicable in 2015.

Permit one-time opt-in/opt-out election

The **individual mandate** requires that most individuals have **minimum essential coverage** beginning January 1, 2014, or face a potential penalty. Coverage offered through the Exchanges and by most employers satisfies this requirement. Recognizing that some eligible employees in non-calendar year plans would not have the opportunity to secure coverage by January 1, 2014, the regulators permit employers to allow their employees to change their current benefits election to opt in to the employer coverage or opt out of the employer coverage (presumably to enroll through an Exchange) once during the plan year that began in 2013.

Important

- This provision applies only to non-calendar year plans.
- Employers are not required to incorporate these options, but if they do, both medical and cafeteria plans must be amended since these election changes must be compliant with the Section 125 rules, which otherwise would not permit a mid-year change in election.
- This is a one-time option – it is not available after the end of the plan year that began in 2013.

ACA Benefits and Eligibility Action Plan

ACA Action Plan for Employers

Employer Actions Required	When	Next Steps
Determine status as applicable large employer *See pages 9-10*	By December 31, 2013	• Determine minimum six-month consecutive period during which measurement will be made • Work with payroll vendor to track and evaluate hours
Classify current employees as either full-time or non-full-time for 2014 plan year Establish rules for classifying new employees as either full-time or non-full-time *See pages 11-13; 37-52*	By beginning of open enrollment period for plan year that begins in 2014 – May need to use hours data attributable to periods beginning no later than July 1, 2013	• Decide length of initial and standard measurement, administrative and stability periods • Decide whether to have different periods for different categories of employees • Work with payroll vendor to track and evaluate hours • Establish internal systems for generating reports and taking appropriate actions to enroll full-time employees
Offer coverage to full-time employees *See pages 14-16* Terminate coverage of non-full-time employees *See page 12* Distribute updated SBC to employees *See page 20*	Before the plan year that begins in 2014	• Reduce waiting period for new full-time employees to maximum of 90 days • Hold open enrollment in advance of plan year that begins in 2014 • Include updated SBC with open enrollment materials • Provide at least 95% of full-time employees opportunity to enroll for 2014 plan year if want to avoid Part A penalty • Determine cost for at least one employee-only coverage options that is affordable and provides minimum value if want to avoid Part B penalty • Notify COBRA administrator of employees who become ineligible for coverage

Employer Actions Required	When	Next Steps
Distribute Exchange Notices to all employees *See pages 20-21* Distribute updated COBRA election notice to COBRA-eligible employees *See page 21*	By October 1, 2013 On and after October 1, 2013	• In September 2013, **Health Plans** will distribute model notices for employers to complete and distribute to their employees Model notices are also available at http://www.dol.gov/ebsa/healthreform/ • **Health Plans** will modify the COBRA election notice for clients for whom we administer COBRA; other clients should contact their COBRA administrators
For non-calendar year plan years only – one time transition rule Determine whether to allow eligible employees to either enroll for coverage or drop coverage before 2014 open enrollment period begins *See page 26*	By November 2013	If not permitting change, no action required If permitting change: • Request medical plan amendment from **Health Plans** Account Manager • Amend cafeteria plan to permit one-time election change during plan year that began in 2013
Submit data to IRS and notices to employees applicable to IRS §6055 and §6056 *See pages 21-22*	Track data on plan membership on and after January 1, 2014 Submit data and distribute employee notices beginning January 2015	• TBD – awaiting further guidance from the IRS on these requirements; **Health Plans** will notify clients when guidance has been issued

ACA Action Plan for Health Plans

Health Plans **Actions Required**	**When**	**Next Steps**
Confirm minimum value coverage for Exchange notice distribution *See page 17* Update minimum value assessment with any plan changes	By early September 2013 As clients provide Health Plans with plan changes	• Begin analyzing plan designs • Update SBCs to incorporate updated minimum value statement
Draft updated SBCs for 2014 plan year *See pages 23-25*	For open enrollment periods occurring in 2013 and 2014	Incorporate: • Mandated benefit changes (see below) • Client-initiated benefit changes • New minimum essential coverage and minimum value coverage statements
Amend plans for mandated and optional changes for 2014 plan year *See pages 23-26*	As each client notifies **Health Plans** of the coverage they are requesting for the 2014 plan year	Include the following, as applicable, for all plans: • Extend coverage to age 26, with no exceptions • Restrict waiting period to 90 days maximum • Remove all pre-existing condition limitations • Remove overall annual maximum on essential health benefits • Permit employees in non-calendar year plans to drop or enroll in coverage once during 2014 (only if requested by client) Include the following as applicable for non-grandfathered plans • Add coverage for costs of routine services provided during clinical trials • Restrict out-of-pocket maximums for non-HDHP plans to HDHP maximum • Count all out-of-pocket costs toward out-of-pocket maximum

Federal Fee Assessments

PCORI Fees

Health Plans initially advised clients of this fee in our August 2012 Compliance Bulletin. We are again including this information because the first payments are due on July 31, 2013 for plan years ending between October 1, 2012 and December 31, 2012.

To recap:
The ACA created the Patient-Centered Outcomes Research Institute (PCORI). PCORI is charged with promoting research to evaluate and compare health outcomes and clinical effectiveness related to medical treatments, services, procedures and drugs in order to help patients, clinicians, purchasers and policymakers make informed health care decisions.

PCORI will be funded in part by fees assessed on sponsors of self-funded group health plans and on insurers, hence the PCORI fee. The fee will be assessed annually for a seven year period, based on the average number of covered individuals — employees and dependents ("covered lives") — in a plan for each plan year ***ending*** on or after October 1, 2012 and before October 1, 2019.

Important
Unlike other assessments that **Health Plans** collects and pays on behalf of plan sponsors, this fee must be filed on a plan sponsor's tax form and must be paid directly to the IRS by the plan sponsor.

Clients will want to work with their tax advisors to calculate and pay this assessment.

The chart on the next page outlines how the PCORI fee will work for self-funded group health plans.

PCORI Fee Summary Chart

Topic	Regulatory Details
Applicable plans	Medical plans covering employees and/or retirees, including HRAs that are not integrated into the medical plan, without regard to whether the plan is grandfathered *But not* excepted benefits, such as limited scope dental and vision plans and most flexible spending accounts; or expatriate plans and stop loss coverage
Applicable plan years	Each plan year ending on or after October 1, 2012, and before October 1, 2019.
Fee due date	By July 31 of the calendar year immediately following the last day of the plan year, for example: · If plan year ends between 10/1/12 and 12/31/12 – first fee due by July 31, 2013 · If plan year ends between 1/1/13 and 12/31/13 – first fee due by July, 31, 2014
Fee amount	Plan years ending between 10/1/12 and 9/30/13: $1 times average number of covered lives Plan years ending between 10/1/13 and 9/30/14: $2 times average number of covered lives Plan years ending between 10/1/14 and 9/30/19: Prior year amount + adjustment indexed to national health expenditures
Reporting method	Annually by plan sponsors on federal excise tax Form 720
Defining "average covered lives" ***Special Transition Rule*** *– for the first year, plans with plan years starting before July 11, 2012* *and ending on or after October 1, 2012 may determine the average number of covered* *lives using any reasonable method*	Employers may choose from three methods of counting covered lives: Actual Count Method Add all covered lives for each day of plan year, then divide by number of days in plan year (usually 365) Snapshot Method Add covered lives on one day from each quarter and divide by 4 *Note:* At your request, ***Health Plans*** *can provide you with a quarterly census report to use with this method* Form 5500 Method For plans that provide coverage to employees and dependents, the sum of number of participants on Form 5500 at beginning and at end of plan year For plans that provide employee only coverage, the sum of number of participants on Form 5500 at beginning and at end of plan year, divided by 2

Transitional Reinsurance Fee

The transitional reinsurance program was established under the ACA to help stabilize premiums in the individual health insurance market from 2014 to 2016. The statute specifies that the program will be funded by contributions from insurers in the individual, small group and large group markets, as well as by self-insured group health plans. Health and Human Services (HHS) has set an annual per capita rate of $63 for 2014. The fee applies to all participants – subscribers and dependents – in group health plans that provide major medical coverage.

The ACA requires that specific amounts be collected on a national basis to pay reinsurance payments to insurers in the individual market. "Contributing entities" are required to provide the data necessary to calculate the fee and to pay the associated HHS invoices within 30 days of the date the invoices are issued. For self-funded plans, the contributing entity is the plan sponsor, although the TPA may make the payment on behalf of the plan sponsor. As outlined below, **Health Plans** will undertake this process for our clients. The chart on the follow page outlines how the fees will be assessed and collected.

Transitional Reinsurance Fee Summary Chart

Topic	Regulatory Details
Applicable plans	• Medical plans covering current and former employees and/or retirees not yet eligible for Medicare • *But not* stand-alone HRAs or excepted benefits, such as limited scope dental and vision plans and most flexible spending accounts; or stop loss coverage
Applicable reporting years	Calendar years 2014, 2015 and 2016
Target assessments	For the reinsurance pool: $10 billion in 2014, $6 billion in 2015 and $4 billion in 2016 For the general funds of the U.S. Treasury: $2 billion in 2014, 2015; $1 billion in 2016
Fee amount	$63 per average covered life for 2014; TBD for 2015 and 2016
Reporting method	By November 15 of the applicable reporting year, **Health Plans** will send HHS the average covered lives for each client, based on plan membership between January 1 and September 30
HHS assessment process	No later than December 15, HHS will issue invoices to the **Health Plans** based on average covered lives reported and the annual assessment target
Health Plans assessment process	Each client's share of the total assessment, based on the covered lives count, will be reflected on the client's funding request report
Fee due to HHS	**Health Plans** must forward the total due within 30 days of receiving HHS invoice

Topic	Regulatory Details
Defining "average covered lives"	Actual Count Method Add all covered lives for each day of calendar year through September 30, then divide by number of days in from January 1 through September 30 (usually 273) Snapshot Method Add covered lives on one or more days from each quarter (using the same number of days for each quarter) and divide by the number of days used Form 5500 Method For plans that provide coverage to employees and dependents, the sum of number of participants on Form 5500 at beginning and at end of plan year For plans that provide employee only coverage, the sum of number of participants on Form 5500 at beginning and at end of plan year, divided by 2 **Note: Health Plans** will use the Snapshot Method to calculate average covered lives.

Please see *Appendix 1 and 2*, for additional information about the individual and employer mandate provisions of the ACA. The *Glossary* of terms applicable to those provisions is at the end of the *Guide*.

Please contact your **Health Plans** Account Manager with any questions about the material in this *Guide*.

Appendix 1 – Individual Mandate

Under the **individual mandate**, most individuals are required to obtain **minimum essential coverage**, unless it is not **affordable**.

For the purposes of the **individual mandate**, these terms are defined as follows:

> **Affordable** means that premiums for coverage are not more than eight percent (8%) of household income
>
> **Minimum essential coverage** means coverage that is compliant with the ACA benefits and eligibility mandates, and includes the following types of coverage:
>
> - Most employer-sponsored medical coverage (including COBRA and retiree coverage) that satisfies the benefits and eligibility mandates of the ACA
> - Coverage purchased in the individual market
> - Medicare coverage
> - Medicaid coverage
> - Children's Health Insurance Program (CHIP) coverage
> - Certain types of Veterans coverage
> - TRICARE
>
> But not including:
>
> - Specialized coverage, such as dental-only or vision-only plans
> - Disease-specific plans, such as those for cancer
> - Disability policies
> - Workers' compensation

Exemptions from the individual mandate

There are limited exemptions from the **individual mandate** which are granted to individuals who:

- Have household income below the minimum threshold for filing a tax return
- Have been certified by an Exchange as having a hardship which makes the individual unable to obtain coverage
- Belong to religious sects recognized under federal rules as conscientiously opposed to accepting any insurance benefits
- Belong to a recognized health care sharing ministry
- Are members of a federally recognized Indian tribe
- Are incarcerated
- Are not lawfully in the United States

Individual penalties

Individuals who are not exempt from the **individual mandate** will be subject to a penalty tax calculated as shown in the chart below if they:

- Have **affordable**, **minimum essential coverage** available
- But are **not** enrolled in a plan

Individual Mandate Penalty Tax

Year	Annual penalty is greater of	
2014	1% of income	$95 x uncovered individuals in family, capped at $285
2015	2% of income	$325 x uncovered individuals in family, capped at $975
2016 and thereafter	2.5% of income	$695 x uncovered individuals in family, capped at $2,085

More about the individual penalty

- No penalty is assessed if a coverage gap is less than 3 consecutive months in any calendar year; this exception is available only once a year, so a second coverage gap would result in a penalty.
- Although expressed as an annual amount, the penalty will be prorated to apply only to those months the individual had no **minimum essential coverage**.
- The penalty for individuals under age 19 is 50% of the adult penalty shown in the chart above.

Appendix 2 – Tracking hours and classifying employees

Whether an employee is a **full-time employee**[*] or a **non-full-time employee** governs whether the employee must be offered coverage in order for the employer to avoid a **Part A** or **Part B** penalty. (See pages 7-8 for an explanation of the employer penalties).

Making the **full-time** vs. **non-full-time** determination requires that employers do the following:

1.	Identify every employee as either an **ongoing** or **new employee**
2.	Identify whether **new employees** are full-time/**non-variable hour**, **variable hour** or **seasonal employees**
3.	Establish a. **Standard measurement**, **administrative** and **stability periods** for **ongoing employees** for the first year of implementation if using the special transition rule for the first year b. **Standard measurement**, **administrative** and **stability periods** for **ongoing employees** for plan years beginning on and after October 1, 2014, and for plan years beginning between January 1 and September 30, 2014 if not using the special transition rule **c.** **Initial measurement**, **first administrative** and **first stability periods** for **new employees**

Decide whether to have different **measurement**, **administrative** and **stability periods** based on the categories below:

a. Union vs. non-union employees
b. Employees subject to different collective bargaining agreements
c. Hourly vs. salaried
d. Employees at work sites in different states

[*] All terms in **bold** are defined in the Glossary at the end of this *Guide*.

4. Count **hours of service** accumulated during the **measurement period** using the rules applicable to**:**

a. Hourly employees
b. Salaried employees
c. Employees paid under other arrangements (such as commissions)
d. Employees who work non-traditional schedules

Factor in unpaid breaks in service and leaves of absence as applicable, applying the:

i. Default break in service rule or rule of parity
ii. Rule applicable to protected FMLA, USERRA and jury duty leaves
iii. Rule applicable to educational institutions

5. Classify all employees as either **full-time** or **non-full-time** for the following **stability period** based on the results of the **measurement period** under 4 above

a. Apply the exception for status changes during a **new employee's initial measurement period** as applicable

1. Identify every employee as either an **ongoing** or **new employee**

An **ongoing employee** is an employee who has been employed for at least one entire **standard measurement period.** (See **Step 3** for information about the **standard measurement periods**.)

Everyone else is a **new employee** who will fall into one of the three sub-categories described in Step 2.

How it works for the first year
In the first year of implementation, those who were employed as of the first day of the first **measurement period** will be considered **ongoing employees**. Their status as of the first plan year that begins on or after January 1, 2014 will be based on the results of their first **measurement period**. Anyone hired after the first **measurement period** has begun will be treated as a **new employee**, and classified into one of the subcategories described under 2, which follows**.**

2. Identify whether **new employees** are **full-time/non-variable hour**, **variable hour** or **seasonal employees**

The rules for determining **full-time status** for **new employees** depend on whether they are hired as **seasonal employees** or, if not seasonal, on how many hours they are expected to work when first hired.

How it works for the first year
As described in 3, to implement these rules, employers will determine when the first **measurement period** begins. Anyone hired after that date would be a **new employee**, subject to the rules below.

Categories of new employees

Category	Description
Non-variable hour employee	As of first day of work, the employee is not a **seasonal employee** and is reasonably expected to be paid for an average of at least 30 hours per week or 130 hours per month. Even if the employee's hours are expected to vary, as long as they are expected to average at least 30 per week or 130 per month, the employee is a **non-variable hour employee** who must be treated as a **full-time employee** and offered coverage under the plan within 90 days
Variable-hour employee	As of first day of work, the employee is reasonably expected to be paid for an average of less than 30 hours per week or 130 hours per month, and is not a **seasonal employee**. Even if the employee's hours don't vary, as long they are reasonably expected to average less than 30 per week or 130 per month, the employee is a **variable-hour employee**.
Seasonal employee	As of first day of work, the employee is: o Employed to do agricultural work that is performed exclusively at certain seasons or periods of the year, and which, from its nature, cannot be continuous or carried on throughout the year, or o Employed as a retail worker exclusively through holiday periods; or o Employed as a worker not specifically defined as **seasonal** (e.g., summer camp counselors, seasonal resort workers), to whom the employer has applied a good faith interpretation of the rule for agricultural employees If an employee is classified as a **seasonal employee**, it doesn't matter how many hours the employee is expected to be paid.

Special rule for variable hour and seasonal employee status changes

If a new **variable hour** or **seasonal employee** changes to being a **non-variable employee** – i.e., becomes reasonably expected to average 30 or more hours per week, or 130 hours or more per month during the **initial measurement period** (described in the following section), the employee must be treated as a **non-variable hour** (i.e., **full-time**) employee by the earlier of the following:

- The first day of the fourth month following the change in employment status, or
- If the employee actually averaged at 30 hours per week during the **initial measurement period**, the first day of the month following the end of the **initial measurement period** and associated **administrative period**

3. Establish **measurement**, **administrative** and **stability periods** for **ongoing** and **new employees**

Here is a high-level summary of how the **measurement**, **administrative** and **stability periods** work. The specific rules that govern the length of each type of period are summarized in the chart on page 41.

- **Measurement period** = **look back period** during which employee hours are tracked – may be 3-12 months long; there are three types of **measurement periods**:
  - **Standard measurement period (SMP)** for all **ongoing employees** that starts on the same days each year
  - **Transition measurement period (TMP)** an optional **measurement period** for **ongoing employees** that applies only for the first year of tracking employee hours
  - **Initial measurement period (IMP)** for new **variable hour** and **seasonal employees** that begins between the date of hire and the first of the following month, as determined by the employer
- **Administrative period** = **evaluation period** during which data collected during **measurement period** is assessed and employees are offered coverage or notified of termination of coverage – may be up to 3 months long
- **Stability period = lock in period** during which the status established during the **measurement period** generally cannot change – length is driven by length of **measurement period**

Employers must use the same periods for all employees in a specific category, but may vary the periods among the categories listed below:

- Union vs. non-union employees
- Employees subject to different collective bargaining agreements
- Hourly vs. salaried employees
- Employees at work sites in different states

The decision about whether to measure and lock in status on different schedules for different categories of employees would be made by each employer based on the unique nature of each employer's workforce and business needs.

The chart on the next page summarizes the rules that apply to determining the length of the **measurement**, **administrative** and **stability periods**. Examples begin after the chart.

Summary of Rules Applicable to Establishing Measurement, Administrative and Stability Periods

Type of employee	Type of measurement period	Administrative Period (AP)	Stability Period (SP) for full-time employees	Stability period (SP) for non-full-time employees
Ongoing employee* **Special transition rule for the first year** *Available only for plan years that begin between January 1, 2014 and September 30, 2014 if the employer is implementing 12-month stability periods*	**Transition measurement period (TMP):** • May be as few as 6 months • Must begin by July 1, 2013 • Must end no earlier than 90 days before first day of plan year that begins in 2014	• May be up to 3 months long • Must end before stability period begins	Must be 12 months	Must be no longer than SP for full-time employees
Ongoing employee Applicable to plan years beginning on and after 10/1/14 or plan years beginning 1/1/14 for plans implementing stability periods less than 12 months long	**Standard measurement period (SMP)** May be 3-12 months long	• May be up to 3 months long • Must end before stability period begins	Must be longer of: • 6 months • Length of SMP If the SMP is less than 6 months, then the FT SP = 6 months If the SMP is 6 months or longer, then the FT SP = IMP	Must be no longer than SMP
New **full-time/non-variable hour employee** Upon hire is not seasonal and is reasonably expected to work an average of at least 30 hrs/wk or 130 hrs/mo	N/A - (new full-time/non-variable hour employees are treated as FT employees from date of hire; offer coverage and enroll by 91st day of employment)	N/A	Same length as **SP** for ongoing full-time employees	N/A
New variable hour or **seasonal employee**** Upon hire is a seasonal employee or is reasonably expected to work less than 30 hrs/wk or 130 hrs/mo	**Initial measurement period (IMP):** • May be 3- 12 months long • Must start by 1st of month after date of hire • IMP and corresponding AP must end by the last day of 1st calendar month beginning after the employee's 1st anniversary	• May be up to 3 months long • Must end before SP begins • Must end no later than last day of 1st calendar month that begins after the employee's one year anniversary of employment	Longer of 6 months or length of IMP	No longer than • 1 month longer than IMP or • The end of the SMP and corresponding AP for ongoing employees in which IMP ends

*Note that when the first **measurement period** is implemented, an **ongoing employee** is anyone working on the date the **measurement period** begins.

See page 39 for the special rule governing a change in status from **variable hour or **seasonal** to **non-variable hour employee**.

Examples of measurement, administrative and stability periods

The examples on the following pages illustrate how 12-month and 6-month **stability periods** would play out over several years.

Key:

TMP = **transition measurement period** (optional for first year of implementation)
SMP = **standard measurement period** (for all **ongoing employees**)
IMP = **initial measurement period** (for new **variable hour** or **seasonal employees**)
AP = **administrative period**
SP = **stability period**

Example 1: 12-month stability periods for new and ongoing full-time employees

- **Transition rule for ongoing employees**
- **Standard rules for ongoing employees**
- **Initial rules for new employees**

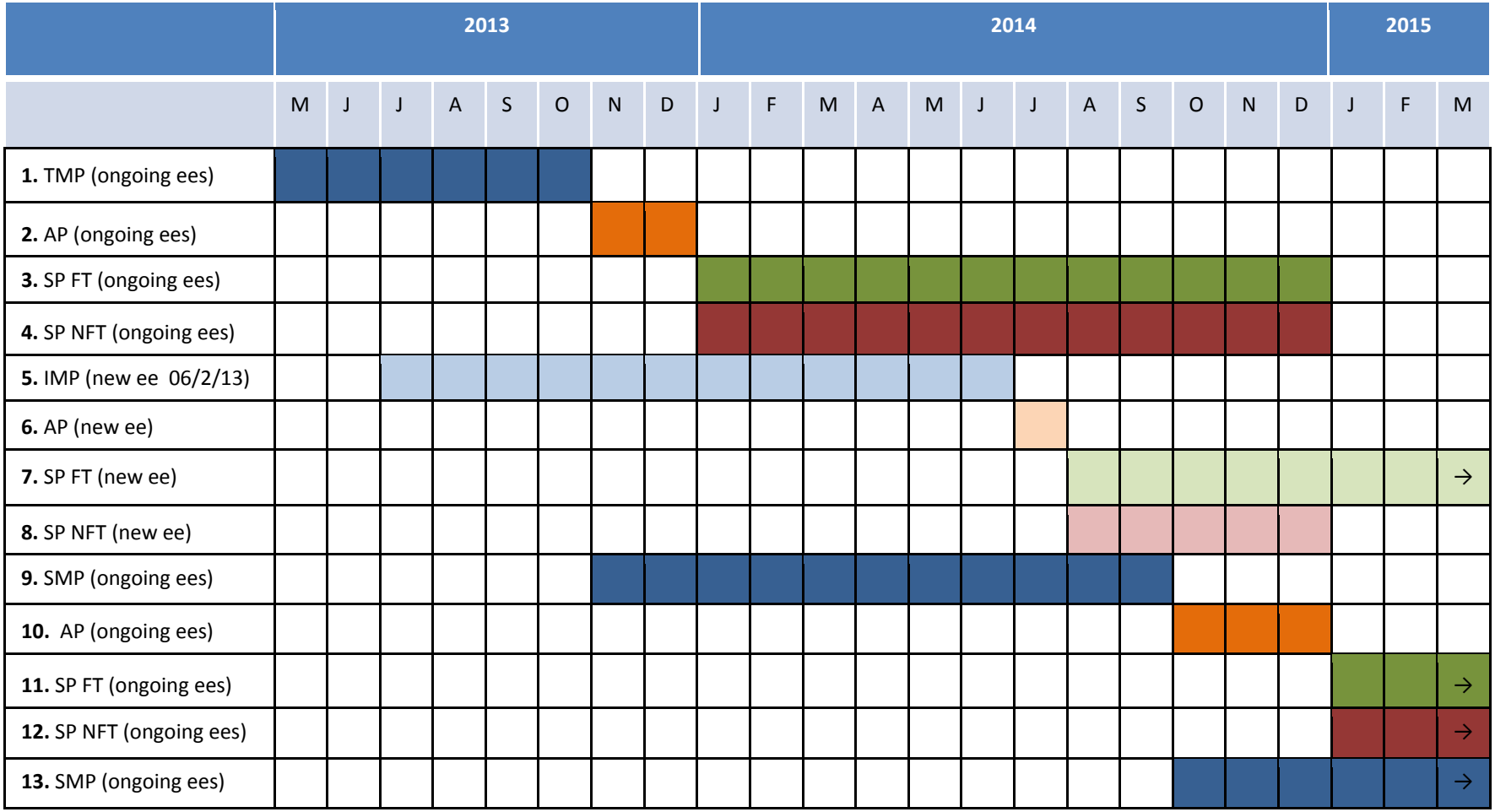
The transition rule permits employers to establish 12-month **stability periods** in the first year of implementation by using shorter **measurement periods**. The transition rule differs from the standard rule because it does not require that the 12-month stability period be linked to the length of the **initial measurement period**.

To use the special transition rule, the **transition measurement period** (TMP) must:

- Be at least six consecutive months
- Begin no later than July 1, 2013
- End no sooner than 90 days before the first plan year that begins in 2014

Assumptions:

- Plan year begins on January 1
- Employer wants a 12-month **stability period** beginning with the first day of the plan year.
- Employer wants a 2-month **administrative period** the first year and 3-month **administrative periods** the following years



To satisfy the transition rule, for all employees who are employed on May 1, 2013 (i.e., **ongoing employees**):

Row	Explanation
1	The transition measurement period during which employee hours are tracked runs from May 1 through October 31, 2013. The period satisfies the transition rule because the transition measurement period: • Is at least six consecutive months long • Began by July 1, 2013 • Will end no more than 90 days before the first plan year in 2014 begins on 1/1/14
2.	The administrative period during which average employee hours are calculated, employees are notified of status and enrollment is conducted runs from November 1 through December 31, 2013. The period satisfies the transition rule because: • The administrative period Is no more than 3 months long
3. 4.	The stability periods during which both full-time and non-full-time ongoing employee status is locked in runs from January 1 through December 31, 2014. The period satisfies the rule because: • The stability period is 12 months long as required to use the transition measurement period
9.	The standard measurement period for ongoing employees to establish eligibility for the 2015 plan year runs from October 1, 2013 through September 30, 2014. The period satisfies the rule after the first year of implementation because: • The standard measurement period is between 3 and 12 months long
10.	The administrative period associated with (9) runs from November 1 through December 31, 2015
11.	The stability period for full-time employees runs from January 1 through December 31, 2016 • The stability period for full time employees is the longer of 6 months or the standard measurement period
12.	The stability period for non-full-time employees runs from January 1 through December 31, 2016 • The stability period for non-full-time employees is no longer than the standard measurement period

To apply the **initial measurement** and **stability periods** to **new employees** (assumes an employee hired on June 15, 2013)

Row	Explanation
5.	The initial measurement period (IMP) for a new seasonal or variable hour employee hired during June 2013 begins on July 1, 2013, and runs for 12 months • Because the stability period for new employees who are found to be full-time during the measurement period is the longer of the IMP or 6 months, and because the employer wants a 12-month stability period for full-time employees, the IMP must also be 12 months long
6.	The administrative period is limited to one month so that the combined initial measurement period (5) and administrative period (6) are over no later than the last day of the month following the month of the employee's anniversary of employment (July 31, 2014)
7.	The stability period for new variable hour and seasonal employees hired in June 2013 and found to be full-time after the initial measurement period begins August 1, 2014 and continues through July 31, 2015 – again, the stability period must be the longer of 6 months or the initial measurement period
8.	The stability period for new variable hour and seasonal employees hired in June 2013 and found to be non-full-time during the initial measurement period begins August 1, 2014 and ends on December 31, 2014, the earlier of one month longer than the length of the initial measurement period (5) or the end of the standard measurement and associated stability periods (9 and 10) during which the initial measurements period (5) ends

Example 2: Six-month stability periods for new and ongoing full-time employees

Assumptions:

- Plan year begins on April 1
- 6 month **initial** and **standard measurement periods** for **new** and **ongoing employees**
- 6 month **stability period** (SP) for **ongoing full-time** and **non-full-time employees**
- **Stability period** for **new employees** is 1 month longer than the IMP, but must end no later than the end of the SMP and corresponding **administrative period**
- 3 month **administrative period** for **ongoing employees**
- 2 month **administrative period** for **new employees**

	2013			2014												2015		
Dark shades = ongoing ee Light shades = new ee	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
1. SMP (began 7/1/13 for anyone employed on that date	←																	
2. AP (ongoing ee)																		
3. SP FT (ongoing ee)																		
4. SP NFT (ongoing ee)																		
5. IMP (ee hired 10/2013)																		
6. 1st AP (new ee)																		
7. 1st SP FT (new ee)																		
8. 1st SP NFT (new ee)																		
9. SMP (ongoing ee)																		
10. AP (ongoing ee)																		
11. SP FT (ongoing ee																		
12. SP NFT (ongoing ee)																		
13. SMP (ongoing ee)																		

Row	Explanation
1	The standard measurement period began on July 1, 2013 because: • The employer wanted a six-month stability period for ongoing employees • The employer wanted a three-month administrative period for ongoing employees • The plan year begins on April 1
2	The three-month administrative period during which hours were totaled and open enrollment held began on January 1 and ran through March 31
3	The stability period for full-time employees began on April 1, and must be the longer of six months or the length of the SMP – which in this case is six months
4	The stability period for ongoing non-full-time employees also begins on April 1 and cannot be any longer than the stability period for full-time employees
5	The initial measurement period for new variable hour and seasonal employee hired during October 2013 • Must begin by November 1, no later than the 1st of the month following the first day of work • Needs to be six months long, ending on April 30, 2014, if the employer wants the first stability period to be six months long for those who turn out to be full-time
6	The administrative period is, as the employer specified, two months long for new variable hour and seasonal employees
7	The first stability period following the initial measurement period for full-time employees is the longer of six months or the initial measurement period
8	The first stability period following the initial measurement period for non-full-time employees may be no longer than: • One month longer than the initial measurement period, or • The end of the standard measurement period (row 9) and corresponding administrative period (row 10) in which the initial measurement period (row 5) ends
9	This is the standard measurement period for ongoing employees that determine status for the stability period that begins on October 1, 2014
10-13	These rows illustrate how the standard measurement, administrative and stability periods play out over time

4. Count **hours of service** accumulated during each measurement period.

An employee's status as either **full-time** or **non-full-time** is based solely on the **hours of service** that employee averages during the applicable **measurement period**.

An **hour of service** is any hour for which an employee is paid, including, but not limited to, work time, vacation, sick pay and jury duty.

Below are the different options under the regulations for how to count **hours of service** depending on the employee's classification**.**

Hourly employees – Count all hours for which the employee was paid, whether it was for actual work or for paid time off such as vacation, sick time or jury duty

Salaried employees – Use any method below:

a) Count all hours for which the employee was paid, whether it was for actual work or for paid time off such as vacation, sick time or jury duty (same as hourly, above)
b) Use a days-worked equivalency method and count 8 hours for each day for which the employee is entitled to pay for worked or non-worked time
c) Use a weeks-worked equivalency method and count 40 **hours of service** for each week worked for which the employee is entitled to pay for worked or non-worked time

IMPORTANT: Employers may not use either b) or c) above if the result substantially understates an employee's **hours of service** (e.g., a weeks worked equivalency would apply to a firefighter or nurse who works three 10-hour days, not a days worked equivalency which would understate the hours of service if only 8 hours per day was counted).

Other employees whose hours either may be subject to regulatory limits or are not tracked (e.g., airline pilots, truck drivers, commissioned employees, adjunct faculty) – The IRS guidance instructs employers to use a "reasonable method", pending additional guidance.

IMPORTANT: As examples of unreasonable methods, the IRS specifically stated that it would be unreasonable to fail to consider either travel time for a traveling salesman paid on commission or class preparation time for an adjunct faculty member.

Unpaid Breaks in Service and Leaves of Absence

An employee generally retains the same status as **full-time or non-full-time** during an entire **stability period** as long the employee continues to be employed.

However, a rehire's or returnee's status can change to "**new employee**" under the break-in-service rules below. Employers may use either break-in-service rule, but should be consistent for all employees in the same category.

> ***Break of 26 or more consecutive weeks –***Employees who resume employment after at least 26 weeks without having an hour of service may be treated as **new employees**.
>
> ***Break of fewer than 26 weeks (Rule of Parity) –*** Returning employees can be treated as **new employees** if:
>
> 1. The break in service is at least four weeks long
> 2. The period of prior service is shorter than the break
>
> Under the second rule, employees who are not paid for less than 4 weeks would resume the status in effect when they left.

Special Rules for Protected Leaves and for Employees of Educational Organizations

To avoid penalizing employees for protected absences and to recognize that the calendars for educational institutions frequently include extended periods when classes are not in session and employees perform no **hours of service**, the regulations include the special provisions below.

Protected Leaves – FMLA, USERRA, jury duty

If an employee returns from an unpaid **protected leave**, the employer may choose one of the following methods to average the absence into the applicable **measurement period**:

A. Disregard the period of leave for the purpose of the **measurement period** during which the employee returns to work (i.e., reduce the **measurement period** for that individual by the duration of the unpaid absence), or
B. Impute the average hours from the period before the leave to the period of leave

Educational Organizations

The same averaging rules that apply to protected leaves also applies the employees of educational organizations who experience "employment break periods" of at least four weeks during which the employee of the educational organization is not credited with an hour of service. Such breaks in service may occur over summer breaks or extended holiday periods.

However, an educational organization is not required to take into account more than 501 **hours of service** for all employment break periods that occurring in a single calendar year. For example, if an employee worked an average of 32 hours per week before the employment break period, the employer would only have to credit 15.7 weeks of the absence at 32 hours per week (501 hours ÷ 32 hours). Any remaining unpaid absence during that calendar year would be averaged in at 0 hours per week.

5. Classify all employees as either **full-time** or **non-full-time** for the following **stability period** based on their **hours of service**

Based on the **hours of service** each employee accumulates during the **measurement periods**, employers will use the **administrative period** to classify them as:

Full-time – averaged 30 or more hours per week or 130 or more hours per month during the previous **measurement period**

Full-time employees retain that status for the duration of the following **stability period**, and remain eligible to participate in the medical plan.

During the **administrative period**, they should be notified of their eligibility for coverage and permitted to enroll or continue their participation in the medical plan effective the first day of the following **stability period**.

Non-full-time – average less than 30 hours per week or 130 hours per month during the previous **measurement period**

Non-full-time employees retain that status for the duration of the following **stability period**, and remain ineligible to participate in the medical plan.

During the **administrative period**, those employees who were participating in the plan during the **measurement period** and have lost **full-time status** should be notified of their change in status and offered COBRA effective the first day of the following **stability period**.

Special rule for variable hour and seasonal employee status changes

If a **new variable hour** or **seasonal employee** changes to being a **non-variable employee** – i.e., becomes reasonably expected to average 30 or more hours per week, or 130 hours or more per month – during

the **initial measurement period**, the employee must be treated as a **non-variable hour** (i.e., **full-time**) employee by the earlier of the following:

- The first day of the fourth month following the change in employment status, or
- If the employee actually averaged at 30 hours per week during the **initial measurement period**, the first day of the month following the end of the **initial measurement period** and associated **administrative period**

This special rule applies only to **new employees**.

The status for **ongoing employees** is based only on their average **hours of service** during the **standard measurement periods**.

Glossary

Term	Definition/Explanation
Administrative period	The time permitted for an employer to compile the data collected during the measurement period, make determinations, provide enrollment materials as applicable and enroll newly eligible employees. For ongoing employees, this period will usually include the open enrollment period. Administrative periods: • May be up to 90 days long • Must be completed by the end of the prior stability period to avoid a gap in coverage going forward (see chart on page 41) Different length administrative periods may apply for new and ongoing employees.
Affordable – employer mandate	The employee's monthly contribution for coverage is no more than: 9.5% of household income 9.5% of the employee's W-2 earnings for the prior calendar year 9.5% of the employee's regular monthly wages (for hourly employees, the hourly rate × 130; for salaried employees, the monthly salary) 9.5% of the federal poverty guideline for an individual in effect as of the first day of the plan year, divided by 12
Affordable – individual mandate	The employee's contribution for coverage is no more than 8% of household income

Term	Definition/Explanation
Applicable large employer	An employer who: o Employed an average of 50 full-time employees + full time equivalents on business days during the prior calendar year, or o Is a member of a controlled group of employers that collectively employed an average of 50 full-time employees + full time equivalents on business days during the previous calendar year
Employer mandate	A label to identify the rule that subjects employers to penalties if one of their full-time employees obtains subsidized coverage through an Exchange and the employer either: o Failed to offer at least 95% of employees participation in a plan that provides minimum essential coverage, or o Offered a plan that was not affordable and/or failed to provide minimum value coverage
Full-time employee	An employee who: o Upon hire is reasonably expected to average at least 30 hours of service per week or 130 hours of service per month, or o After completion of a measurement period has been determined to have averaged at least 30 hours of service per week or 130 hours of service per month
Full-time equivalents	The sum of all hours of service of non-full-time employees, up to a maximum of 120 for any individual in a month, divided by 120
Hours of service	All hours for which an employee is paid, including work time, vacation time, sick pay, jury duty, etc.
Individual mandate	The requirement that essentially all individuals in the United States be covered under a health plan that provides minimum essential coverage or face a potential tax penalty
Initial measurement period	The first period of time during which a non-full-time employee's hours of service are measured to determine eligibility for coverage

Term	Definition/Explanation
Measurement period	*See separate listings for:* Initial measurement period Standard measurement period Transition measurement period
Minimum essential coverage	Coverage that is deemed by the ACA as providing sufficient coverage, including the following: • Most employer-sponsored medical coverage (including COBRA and retiree coverage) that satisfies the coverage mandates of the ACA • Coverage purchased in the individual market • Medicare coverage • Medicaid coverage • Children's Health Insurance Program (CHIP) coverage • Certain types of Veterans coverage • TRICARE But not including: • Specialized coverage, such as dental-only or vision-only plans • Disease-specific plans, such as those for cancer • Disability policies • Workers' compensation
Minimum value coverage	A health plan with benefits that cover 60% of the cost of covered services
New employee	An employee who has not completed an entire standard measurement period
Non-full-time employee	Any employee who is not designated as a full-time employee after the most recent measurement period
Non-variable hour employee	A new employee who, upon hire, is reasonably expected to average at least 30 hours of service per week or 130 hours of service per month
Ongoing employee	An employee who has completed a standard measurement period

Term	Definition/Explanation
Part A penalty	The penalty applied when a full-time employee obtains subsidized coverage through an Exchange and the applicable large employer has not offered a plan with minimum essential coverage to substantially all full-time employees; the penalty equals: (Total employees – 30) x $2,000
Part B penalty	The penalty applied when a full-time employee obtains subsidized coverage through an Exchange and the plan offered to substantially all full-time employees by an applicable large employer is not affordable and/or fails to provide minimum value coverage; the penalty equals: (Number of employees with subsidized coverage) x $3,000
Play or pay provisions	Another term for employer mandate
Protected leave	Leaves of absence under the FMLA, USERRA, and jury duty
Seasonal employee	An employee covered under 29 CFR500.20(s)(1) (generally agricultural workers) and retail workers employed exclusively through holiday periods. Employers may also use a good faith interpretation of these rules for workers not specifically defined.
Stability period	The period of time during which an employee's status as full-time or non-full-time, and as eligible or ineligible to participate in the medical plan, is locked in
Standard measurement period	The period of time during which an ongoing employee's hours of service are measured to determine whether the employee will be considered to be full-time or non-full-time for the subsequent stability period
Substantially all	95% of full-time employees

Term	Definition/Explanation
Transition measurement period	A special, one-time measurement period to permit plans to use a 12-month stability period for the first stability period for ongoing employees that begins in 2014. Under the transition rule, the transition measurement period can be no less than six consecutive months and must begin no later than July 1, 2013, and end no more than 90 days before the beginning of the first plan year that begins on or after January 1, 2014. See page 43 for a chart that illustrates when the transition measurement periods must start and end, depending on the length of the corresponding administrative period.
Variable hour employee	A non-full-time, non-seasonal employee, including employees whose hours do not actually vary, but whose hours of service average less than 30 per week or 130 per month