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SUMMARY OF HEALTH REFORM'S "PLAY OR PAY" AND "PLAY AND PAY" EMPLOYER MANDATE RULES

[Note that the following is only a very general summary of these very complex rules, some aspects of which are awaiting regulatory clarification. In addition, note that the following discusses certain open issues caused by the recently announced one year delay in the employer mandate rules. Naturally, the following should not be viewed as legal advice for any particular situation, but instead should be viewed only as a starting point for additional discussion, and employers should monitor carefully developments in this area (especially concerning the recently announced one year delay).]

1. Overview. Despite the extraordinary amount of confusion, misinformation and sometimes hysteria in the media, the general rule of thumb is that the requirements of the employer mandate rules of the Affordable Care Act are relatively easy to meet for most employers. (Of course, as with all rules, there are exceptions to this one.) Naturally, the devil is in the many details of the rules, and employers should be cautioned that even relatively innocent violations of some of these details can result in very significant penalties.

In very general terms, an employer need not worry about the employer mandate rules, which become effective on January 1, 2015, if it can "check three boxes:"

(a) The employer offers (doesn't necessarily pay for or subsidize) "Minimum Essential Coverage" ("MEC") to at least 95% of its 30 hour employees and their dependent children;

(b) The MEC provides at least "60% Minimum Actuarial Value;" and

(c) The plan's least expensive self-only coverage is "affordable" under a 9.5% test.

2. Covered Employers – The rules apply to covered for-profit, non-profit and governmental employers that employed, on average, at least 50 FTEs during the preceding calendar year. Until the recent extension of the employer mandate effective date, for purposes of determining whether an employer was to be a covered employer in the 2014 calendar year, employers were permitted to use a shorter "look-back" period of six consecutive calendar months in 2013 instead of the entire 2013 calendar year. It is unclear whether this transition rule will be extended. Employers average their number of employees across the months in the year to determine whether they meet the large employer threshold.

For this purpose, FTE is defined as an employee who provides, on average, at least 30 hours of service per week (or 130 hours of service in a calendar month). The FTE count also includes a number of full–time employee equivalents "determined by dividing the aggregate number of hours of service of employees who are not FTEs for the month by 120." (Example: In addition to its 40 employees who work at least 30 hours of service per week, Employer has 20 PTEs who each work 24 hours per week. In the aggregate, the PTEs work 480 hours per week or 1920 hours per month. 1920 divided by 120 is 16, so

Employer's 20 PTEs are counted as 16 FTEs which, when added to the 40 employees working over 30 hours per week, result in Employer being subject to the rules.) Note that this the conversion of part-timers to FTEs is used only to determine if the employer meets the 50 employee coverage threshold, but these less than 30 hour employees need not be provided coverage under the play or pay and play and pay rules discussed below. For purposes of determining working hours, all hours for which an employee actually performs duties, as well as all hours for which the employee is paid but does not actually perform duties (e.g., vacation, disability, leaves of absence, etc.) are counted.

An employer must generally take into account only work performed in the United States. Therefore, employees working overseas generally will not have hours of service, and will not qualify as full-time employees for purposes of determining an employer's status as a covered employer and calculating any potential penalty.

An employer is not subject to these rules if the employer's workforce exceeds 50 FTEs for a limited period during the measuring calendar year (either 120 days or four calendar months or less) and all of the employees in excess of 50 who were employed during that period of no more than 120 days or four calendar months were seasonal workers. For this purpose, a seasonal worker is defined as a worker who performs services on a seasonal basis (as defined by the Secretary of Labor), including retail workers employed exclusively during the holiday season.

The determination of an employer's status as a covered or non-covered employer is made on a controlled group basis under the aggregation rules of Code section 414(b), (c), (m) and (o). However, each individual company is considered separately for purposes of the actual penalty assessment.

If an employer was not in existence during the preceding calendar year, the determination of whether the employer is a covered employer is based on the average number of employees that the employer is reasonably expected to employ in the current calendar year.

3. How Does an Employer "Play" in Order to Avoid the "Play or Pay" Penalty?

To avoid the Play or Pay penalty, an employer must offer "substantially all" of its 30 hour employees, and their dependent children (as defined in Code Section 152(f)(1)), the opportunity to enroll in "minimum essential coverage" ("MEC") under an employer sponsored health plan. Under IRS proposed regulations, an employer will satisfy this requirement if it offers MEC to all but 5% (or if greater, five) of its 30 hour employees and their children under age 26. Note that spouse coverage is not required.

(Until the recent extension of the employer mandate effective date, an employer was not to be liable for a failure to offer dependent coverage in 2014 if it took steps during the 2014 plan year to offer coverage to 30 hour employees' children up to age 26. It is unclear whether this transition relief will be extended.)

The law designates certain types of coverage as MEC including coverage under government sponsored programs (including Medicare, Medicaid, CHIP, TRICARE, veteran's health care and health care for Peace Corps volunteers), certain employer-sponsored plans (including a self-insured group health plan), certain plans in the individual market within a State, certain grandfathered health plans, self-funded student health insurance plans, foreign health coverage, refugee medical assistance supported by the Administration for Children and families, Medicare advantage plans and AmeriCorps coverage, and certain other coverage such as a State health benefit risk pool. The regulators have acknowledged that there could be other plans that

provide health coverage comparable to the mandated MEC and proposed a process for plan sponsors to take to have their plan's coverage be recognized as meeting the MEC requirement.

Unfortunately, the biggest single gap in guidance under the ACA is the definition of MEC (although the regulators have promised "additional guidance" on this point). All we know at this point is that fully insured health plans satisfying the essential health benefits requirements applicable to insurers under the ACA will constitute MEC, that "excepted benefits" under section 2791 of the Public Health Services Act (e.g. accident or disability income insurance, on-site medical clinics, limited scope dental or vision benefits if provided under a separate policy, long-term care insurance and hospital indemnity insurance) will not constitute MEC, and that MEC need not satisfy the 60% actuarial value test discussed below.

Therefore, self-funded employers only know at this point that, for them, MEC is something between excepted benefits and 60% actuarial value. "Creative" promoters have suggested that various very limited self-funded designs constitute MEC, although it seems unlikely that the regulators (or the courts) ultimately will determine that those very limited designs were what the Congress had in mind when it used the words "minimum essential" before the word "coverage." Naturally, self-funded employers should monitor developments on this point carefully (and fully insured employers may want to have their carriers certify that their products are MEC under the law).

4. What is the "Play or Pay" Penalty that Becomes Effective on January 1, 2015?

Sometimes referred to as the "No Coverage Penalty," this penalty is imposed if a covered employer fails to offer substantially all (at least 95%) of its 30 hour employees and their dependent children the opportunity to enroll in minimum essential coverage, and at least one of its 30 hour employees enrolls in health coverage purchased through a State exchange with respect to which a premium tax credit or cost sharing reduction is allowed or paid to the employee. (As a general rule, employees qualify for a premium subsidy or reduced cost sharing if they meet certain income requirements for assistance (generally, they must have household income of no more than 400 percent of the federal poverty line (the subsidy is phased out for household income between 100-400 percent of the federal poverty line)).

The employer is assessed a penalty calculated by multiplying the number of 30 hour employees employed during the applicable month (minus the first thirty 30 hour employees) by $1/12^{th}$ of $2,000. If an employer is aggregated under the controlled group rules for purposes of determining covered employer status, the thirty employee reduction for purposes of calculation of the penalty is allocated ratably among the group based on the number of each employer's 30 hour employees.

Because the potential employer penalty is determined based on the number of the employer's 30 hour employees in any given month, and that number is subject to constant change, IRS proposed regulations provide for an optional safe harbor determination method as an alternative to the month-to-month calculation of 30 hour employee status. This complex safe harbor allows employers to use all or part of a calendar look-back "measurement period" for counting hours of service and using that determination prospectively in a corresponding "stability period." Under proposed regulations, the safe harbor requirements differ based on whether employees are new employees or ongoing employee, and in the case of new employees, whether the employees are expected to work full-time or are variable or seasonal employees. In addition, proposed regulations provide that an employer may apply different measurement and stability periods for different pre-approved categories of employees (e.g., collectively bargained and non-collectively bargained employees, employees located in different states, etc.).

5. What is the "Play and Pay" Penalty that Becomes Effective on January 1, 2015?

Sometimes referred to as the “Unaffordable Coverage Penalty,” this penalty applies if the employer offers to at least 95% of its 30 hour employees and their dependent children the opportunity to enroll in minimum essential coverage under an eligible employer sponsored plan, and at least one 30 hour employee enrolls in health coverage purchased through a State exchange with respect to which a premium tax credit or cost sharing reduction is allowed or paid to the employee because the employer’s coverage is either (a) “unaffordable,” or (b) does not provide “minimum value" to the employee.

Employer provided coverage is “unaffordable” if an employee’s contribution for the lowest cost, self-only coverage exceeds 9.5% (subject to adjustment) of the employee’s household income. Because it will be difficult for employers to determine their employee’s household incomes, employers can take advantage of one three affordability safe harbors to determine whether the plan they offer is affordable. Under the Form W-2 safe harbor, the employer can avoid the penalty if the employee’s contribution for the lowest cost, self-only coverage does not exceed 9.5% of the wages the employer pays the employee for the calendar year, as reported in Box 1 of Form W-2. Alternatively, employers may choose to use a safe harbor based on 9.5% of the rate of pay for employees, or a safe harbor based on 9.5% of the federal poverty level for a single individual.

Amounts newly made available for the year under an HRA that is integrated with the employer's plan are taken into account in determining affordability under the 9.5% test if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost sharing. Affordability under the 9.5% test is determined by assuming that each employee fails to satisfy the requirements of a wellness program, except the requirements of a nondiscriminatory wellness program related to tobacco use.

The statute provides that, in order to provide “minimum value” to the employee, "the plan's share of the total allowed costs of benefits provided under the plan must be at least 60% of such costs." If this sounds like meaningless gibberish, it is only because it is. Fortunately, the regulators have translated this to "60% of the percentage of health care costs, on average, that the plan is expected to cover." (An HHS report found that 98% of individuals covered by employer plans already enjoy this level of coverage.) We also know that "allowed costs" for this purpose are based on the "essential health benefits" as defined under the ACA rather than on the scope of covered services under the plan in question. Self-insured plans and fully insured plans in the large group market are not required to offer essential health benefits so the minimum value test allows adjustments if the plan in question does not offer essential health benefits (although excluding some essential health benefits from a plan's design may negatively impact the plan’s ability to satisfy the 60% minimum actuarial value rule, and theoretically could affect the plan's MEC status, depending on what future guidance provides).

Employers may choose between three methodologies to determine minimum value: (a) a safe harbor design checklist; (b) an independent actuarial certification; or (c) a minimum value "calculator."

The safe harbor design checklist may be used by plans that cover costs in the following four categories: physician and mid-level practitioner, hospital and emergency room, pharmacy, and lab and imaging, and that meet certain specified cost sharing requirements. This approach requires no actuarial calculations. In very general terms, the plans that satisfy the design based safe harbors are plans that cover costs in all four categories and include one or more of the following features (or features more generous than

the following):

-A $3500 deductible, 80% coinsurance, and a $6000 OOP;

-A $4500 deductible, 70% coinsurance, a $6400 OOP, and a $500 employer contribution to an HSA; and

-A $3500 medical deductible, a $0 Rx deductible, 60% medical coinsurance, 75% Rx coinsurance, a $6400 OOP, and Rx co-pays of $10/$20/$50 for the first, second and third prescription drug tiers with 75% coinsurance for specialty drugs.

Plans that do not qualify under the safe harbor design checklist and that have features that cannot be accommodated under the calculator discussed below may acquire an independent actuarial certification that the plan design meets the 60% minimum actuarial value standard, employing "prescribed continuance tables, recognized actuarial standards, and specified assumptions and methodologies."

However, it is expected that most self-funded plans will prove compliance with the 60% minimum actuarial value test by utilizing the minimum value calculator. The calculator allows employers to enter information about their plan's benefits and cost sharing terms into an on-line calculator to determine whether the plan provides minimum value. The on-line actuarial value calculator is similar to the HHS actuarial value calculator that must be used by health plans in the State exchanges, although the calculator for employer plans is based on tables reflecting claims data for self-insured plans. The calculator is found at http://cciio.cms.gov/resources/regulations/index.html.

Employer contributions for a year to an HSA are taken into account in the minimum actuarial value calculation. Amounts newly available for a year under an HRA that is integrated with the employer's plan also are taken into account if the amounts may be used only for cost sharing and not to pay insurance premiums. Reduced cost sharing available under a wellness program is not taken into account, except with respect to tobacco use wellness programs in which case minimum value is calculated assuming that every eligible individual satisfies the terms of the tobacco use program.

The play and pay penalty is a monthly penalty calculated by multiplying number of 30 hour employees who receive a premium tax credit or cost sharing reduction for health coverage purchased through an exchange by $1/12^{th}$ of $3,000. (This penalty in any month is capped at an amount equal to $1/12^{th}$ of $2,000 multiplied by the number of 30 hour employees of the employer (less thirty).)

6. Transition Relief for Fiscal Year Plans.

Until the recent extension of the effective date for the employer mandate, a transition rule provided that if an employer maintained a fiscal year plan as of December 27, 2012, the employer would not be subject to the Play or Pay/Play and Pay penalties until the first day of the fiscal plan year starting in 2014 (instead of on January 1, 2014) with respect to any employee who is eligible to participate in the plan as of December 27, 2012, provided that the employee is offered affordable, minimum value coverage not later than the first day of the 201 plan year. Additional transition relief was provided for employers that had a significant percentage of their employees already eligible for (33% or more) or covered under (25% or more) a fiscal year plan as of December 27, 2012. It is unclear whether this transition relief will be extended.