Pay or Play Guide

A Guide to the Affordable Care Act's "Employer Shared Responsibility" Rules Under Code Section 4980H

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Table of Contents

Page

Pay or Play Guide

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Overview

The health care reform law from 2010 (the Patient Protection and Affordable Care Act, now called the "ACA" by regulators)[1] requires certain large employers to provide health plan coverage or pay a penalty tax to the federal government. There are several requirements that must be satisfied in order to ensure that the penalty tax is avoided. We sometimes refer to this requirement as the "Pay or Play Rule", although it is sometimes called the "Employer Shared Responsibility" rule (or is referred to by its Internal Revenue Code section, Section 4980H).

This Guide outlines which entities are subject to the penalty tax, how the tax is calculated and how the tax can be avoided. For ease of understanding, the Guide sometimes discusses how hypothetical companies could avoid (or be subject to) the Pay or Play Rule and the related tax penalty. The Guide makes the Pay or Play Rule easier to understand by using a step-by-step explanation.[2]

[1] The ACA has been modified several times in its brief history, including by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)), as amended by the Medicare and Medicaid Extenders Act of 2010, Public Law 111-309 (124 Stat. 3285 (2010)), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Public Law 112-9 (125 Stat. 36 (2011)), the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10 (125 Stat. 38 (2011)), and the 3% Withholding Repeal and Job Creation Act, Public Law 112-56 (125 Stat. 711 (2011)).

[2] John Barlament would like to thank Sarah Fowles and Alyssa Dowse for their contributions to the Guide.

Step 1

Step 1: Understand General Pay or Play Rule

The Pay or Play Rule applies to an employer with at least 50 full-time (and/or full-time equivalent ("FTE")) employees. The penalty under the Pay or Play Rule depends on whether an employer offers "minimum essential coverage" to all full-time employees and dependents (with a few exceptions). If an employer does not offer minimum essential coverage to all full-time employees (and their dependents)[3] the employer must pay an annual tax of $2,000 for each full-time employee (less the first 30), if at least one full-time employee obtains federally-subsidized coverage through an "Exchange."[4] We call this the "Subsection A Penalty."

If an employer does offer minimum essential coverage to all full-time employees (and their dependents) but at least one full-time employee obtains federally-subsidized coverage through an Exchange, the employer must pay an annual tax of the lesser of: (1) $3,000 per subsidized full-time employee; or (2) $2,000 for each full-time employee (less the first 30 full-time employees). We call this the "Subsection B Penalty".[5] These rules are illustrated in a flowchart in Exhibit A, at the end of this Guide.

Note that the Pay or Play Rule includes an "inflation adjustment" for the $2,000 and $3,000 penalty amounts. This adjustment is calculated by multiplying the applicable dollar amount (i.e., $2,000 or $3,000) by a "premium adjustment percentage" that HHS will set each year.[6] This means that, beginning in calendar years after 2014, these dollar amounts (and an employer's potential liability) will increase from year to year. The premium adjustment percentage for 2015 is 4.213431463%,[7] resulting in increased penalties of $2,080 (instead of $2,000) and $3,120 (instead of $3,000) for 2015.[8] For ease of explanation and examples, this Guide will use the $2,000 and $3,000 dollar amounts when explaining the Pay or Play Rule.

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[3] A "dependent" means a "child" (as defined in Internal Revenue Code ("Code") Section 152(f)(1)) of an employee who has not attained age 26. 26 CFR 54.4980H-1(a)(12). A "dependent" does not include a stepchild or eligible foster child (as defined in Code Section 152(f)(1)(C)), or any individual who is excluded from the definition of dependent under Code Section 152 by operation of Code Section 152(b)(3) (certain citizens or nationals of other countries). A "dependent" also does not include a spouse or, presumably, a domestic partner. An employer can rely on an employee's representation about that employee's children and their ages, unless the employer has knowledge to the contrary. 26 CFR 54.4980H-1(a)(12).

[4] According to the federal agencies that enforce the ACA, Exchanges "will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors" and will "enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses." U.S. Department of Health and Human Services ("HHS"), Proposed Regulations, Establishment of Exchanges and Qualified Health Plans (July 2011).

[5] The terms "Subsection A Penalty" and "Subsection B Penalty" are our terms, not Internal Revenue Service ("IRS") terms. The IRS refers to the former as "4980H(a) liability" and the latter as "4980H(b) liability". IRS Notice 2011-36, I. Note that a few other exceptions exist to some of these penalty calculations, such as New, Full-Time Employees who have not yet completed about three months of service. In addition, the IRS has provided transition relief for some of these penalty calculations, such as the ability to subtract the first 80 employees (instead of the first 30 employees) for an employer's 2015 plan year. See Step 1(a) with respect to transition relief.

[6] Code Section 4980H(c)(5). The "premium adjustment percentage" will be set by the HHS no later than October 1 of the preceding calendar year and will be "the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds such average per capita premium for 2013." ACA Section 1302(c)(4). HHS will publish the premium adjustment percentage each year in its annual "notice of benefits and payment parameters." 45 CFR 156.130(e).

[7] On March 11, 2014, HHS released a final rule stating that it will base the premium adjustment percentage on the per enrollee employer-sponsored health insurance premiums from the National Health Expenditure Accounts data (calculated by the Centers for Medicare and Medicaid's Office of the Actuary). Based on that data, HHS has stated that the premium adjustment percentage for 2015 will be 4.213431463%. HHS Final Rule, Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744, 13802 (March 11, 2014).

[8] The amount of any annual increase is rounded down to the next lowest multiple of $10. Code Section 4980H(c)(5)(B).

In addition, note that both penalties are determined on a month-by-month basis. So, an employer may owe a lesser amount if a penalty applies for only a portion of a year (e.g., the penalty would be one-half of the above amounts if the employer failed the Pay or Play Rule for only six months, not twelve months). The tax generally is not deductible.[9]

These general rules are subject to several exceptions as further described in this Guide.

Step 1(a): When is the Pay or Play Rule Effective?

The Pay or Play Rule was originally to be effective for calendar months beginning January 2014.[10] However, in July 2013, the Obama administration announced that the Pay or Play Rule will be delayed for one year.[11] With the delay, the Pay or Play Rule will generally now be effective in 2015. The IRS issued final regulations regarding the Pay or Play Rule on February 12, 2014.[12]

Note that the delay of the Pay or Play Rule does not affect most other ACA requirements that come into effect in 2014, such as the new limits on waiting periods.

The Pay or Play Rule final regulation contained a delayed effective date for some non-calendar year health plans (e.g., those that operate on a basis other than January 1 - December 31)[13] and for certain other purposes, such as when a dependent must be offered coverage. The final regulation also included various transition rules for calculating the Subsection A Penalty and the Subsection B Penalty. These transition rules are summarized in the following chart. Note that certain other transitional relief which was relevant prior to 2015 is not summarized below.[14]

Type of Transition Relief	Description of Relief	Comments	Example
Subsection A Penalty Relief: 70% of Full-Time Employees (and Dependents) Must be Offered Coverage	The final regulations require that large employers offer coverage to at least 95% of their full-time employees (and dependents) to avoid a Subsection A Penalty under the Pay or Play Rule. The IRS reduced this requirement to 70% for 2015 and any calendar months during the 2015	This transition rule applies to an employer with a non-calendar year plan year only if the employer did not modify the plan year of its plan after February 9, 2014 to begin on a later calendar date. Beginning in 2016, an employer subject to the Pay or Play Rules must offer coverage to at least	

[9] Code Section 4980H(c)(7).
[10] See, e.g., 78 Fed. Reg. 218, 239 (stating that "Section 4980H is effective for months after December 31, 2013.").
[11] The White House and the Treasury Department originally announced the delay of the Pay or Play Rule in separate blog posts on July 2, 2013. The IRS officially delayed the Pay or Play Rule on July 9, 2013 when it issued Notice 2013-45.
[12] IRS Final Regulations, Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8544 (February 12, 2014).
[13] A calendar year plan year is "a period of twelve consecutive months beginning on January 1 and ending on December 31 of the same calendar year." 26 CFR 54.4980H-1(a)(35).
[14] For an explanation of this prior relief, see our January 28, 2013 and August 1, 2013 versions of this Guide.

Type of Transition Relief	Description of Relief	Comments	Example
	plan year that fall in 2016. Accordingly, an employer will not be subject to the Subsection A Penalty for the 2015 plan year if the employer offers coverage to at least 70% of its full-time employees (and dependents, unless the transition relief for dependent coverage applies as discussed below).[15]	95% of its full-time employees (and dependents) to avoid the Subsection A Penalty. This transition relief does not provide relief from the Subsection B Penalty.[16]	
Subsection A Penalty Relief: Reduction of 80 Full-Time Employees Used in Calculation	For the 2015 plan year, the Subsection A Penalty will be equal to $2,000 for each full-time employee (less the first ***80*** full-time employees). This transition relief applies only to employers with 100 or more full-time or full-time equivalent employees on business days during 2014 (or applicable large employer members that are part of such large employer).[17]	This transition rule applies to an employer with a non-calendar year plan year only if the employer did not modify the plan year of its plan after February 9, 2014 to begin on a later calendar date. Beginning in 2016, employers will calculate the Subsection A Penalty with a 30 full-time employee reduction (instead of 80). This transition relief may indirectly reduce an employer's 2015 Subsection B Penalty, which is capped at the amount of the Subsection A Penalty.[18]	
Pay or Play Rule Delayed until 2016 for Certain	The final regulations provide that certain mid-size employers (those with	This transition relief does not apply to employers with 100 or more full-time	As of February 9, 2014, Employer A sponsors a calendar year plan under

[15] 79 Fed. Reg. at 8575.
[16] 79 Fed. Reg. at 8575-76.
[17] 79 Fed. Reg. at 8575-76.
[18] 79 Fed. Reg. at 8575-76.

Type of Transition Relief	Description of Relief	Comments	Example
Mid-Size Employers	between 50 and 99 full-time and full-time equivalent employees during 2014) will not be subject to the Pay or Play Rule during 2015 and, for employers with non-calendar plan years, during the portion of the 2015 plan year that falls in 2016. This transition relief applies to a mid-size employer who certifies on an IRS form that the employer (1) employs on average between 50 and 99 full-time and full-time equivalent employees on business days during 2014, (2) does not reduce the size of its workforce or overall hours of workforce between February 9, 2014 and December 31, 2014 in order to meet the 50-99 employee requirement, and (3) during the "coverage maintenance period," does not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014. The "coverage maintenance period" is the period from February 9, 2014 to December 31, 2015 for an employer with a calendar year plan, and is the period from	employees. Such employers must comply with the Pay or Play Rule beginning in 2015. Employers who are eligible for this transition relief must comply with the Pay or Play Rule beginning in 2016. An employer that first comes into existence in 2015 may take advantage of this transition relief if it expects to employ fewer than 100 full-time and full-time equivalent employees during 2015 and meets similar workforce, maintenance and certification requirements. It appears that mid-size employers who qualify for this transition relief must still comply with certain related reporting requirements under the Affordable Care Act. It appears that employers qualifying for this transition relief will make the required certification as part of those reporting requirements. The transition relief is not available to an employer that changes its plan year after February 9, 2014 to begin on a later date.[20]	which 40 of its full-time employees are offered coverage with an employer contribution of $300 per month for employee-only coverage. The coverage is affordable with respect to some, but not all, full-time employees. In 2014, 2 of Employer A's employees voluntarily terminate employment and Employer A terminates 3 employees due to nonrenewal of a customer contract but does not otherwise reduce the size of its workforce or reduce any employee's hours of service. Had those 5 employees continued employment throughout 2014, Employer A would have had an average of 100 full-time employees (including FTEs) on business days in 2014. As a result of the terminations, it had an average of 97 full-time employees (including FTEs) for business days in 2014. From February 9, 2014, through December 31, 2015, Employer A does not change the eligibility requirements for the plan (including existing dependent

[20] 79 Fed. Reg. at 8574-75.

Type of Transition Relief	Description of Relief	Comments	Example
	February 9, 2014 to the last day of the 2015 plan year for an employer with a non-calendar year plan. An employer may reduce its workforce or the overall hours of service due to a business activity (e.g., sale of division) if the change is unrelated to this transition relief. In addition, the IRS will not treat an employer as eliminating or materially reducing health coverage if the employer meets certain requirements in the final regulations.[19]		health coverage) and continues to make a contribution of $300 per month toward the cost of employee-only coverage that provides minimum value. Employer A certifies in a timely manner as to its eligibility for the transition relief. In this case, no Pay or Play penalty would be due for 2015.[21]
Non-calendar year plans: "Eligibility Transition Guidance"	The first transition rule for non-calendar year plans provides that if an employer maintained a non-calendar year plan as of December 27, 2012, and did not modify the plan year after December 27, 2012 to begin at a later calendar date, no Pay or Play penalty will apply to employees who would be eligible for coverage beginning on the first day of the 2015 plan year under the eligibility terms of the plan as in effect on February 9, 2014. All transition rules for non-	If an employer maintains a calendar year plan as of February 9, 2014 in addition to the non-calendar year plan, this relief does not apply to those employees who are eligible for the calendar year plan. If an employee terminates employment before the beginning of the 2015 plan year but would otherwise be eligible for coverage beginning on the first day of the 2015 plan year under the eligibility terms of the plan as in effect on February 9, 2014, this	Employer Z has 600 employees, all of whom are full-time employees within the meaning of the final regulations, and Employer Z maintained a plan with an April 1 plan year as of December 27, 2012 (and did not later change the plan year). All of Employer Z's employees are eligible for coverage under the plan under the eligibility terms as in effect on February 9, 2014, but the coverage is not affordable. All of Employer Z's employees are offered affordable

[19] 79 Fed. Reg. at 8574-75.
[21] 79 Fed. Reg. at 8575.

Type of Transition Relief	Description of Relief	Comments	Example
	calendar year plans require that the plan year was not modified after December 27, 2012 to begin at a later calendar date. This could limit the transition relief available to employers that changed their plan year during 2013 to take advantage of "early renewal" opportunities or who changed their plan year during 2013 to delay implementation of certain aspects of health care reform.[22]	relief will still apply to that employee.[23]	coverage that provides minimum value no later than April 1, 2015. In this case, no Pay or Play penalty will be due for any employee of Employer Z before April 1, 2015.[24]
Non-calendar year plans: "Significant Percentage Guidance (All Employees)"	The second transitional rule for non-calendar year plans seems to be designed to allow a non-calendar year plan additional time to expand its eligibility provisions and offer coverage to those who were not previously eligible for coverage. Like the first transitional rule for non-calendar year plans, this rule only applies to an employer that maintained a non-calendar year plan as of December 27, 2012, and did not modify the plan year after December 27, 2012 to begin at a later calendar date.	This relief applies only if the employer offers minimum essential coverage to a sufficient percentage of its full-time employees (95% or, if the relief below applies, 70%) as of the first day of the 2015 plan year. If an employer maintains a calendar year plan as of February 9, 2014 in addition to the non-calendar year plan, this relief does not apply to those employees who are eligible for the calendar year plan. If an employer maintains two or more non-calendar year plans, this transitional	Employer Y has 1,100 employees. 1,000 of Employer Y's employees are full-time employees and 100 of Employer Y's employees are not full-time employees. Employer Y maintained a plan with a July 1 plan year as of December 27, 2012 (and did not later change the plan year). Employer Y chooses December 1, 2013 to measure the number of employees it covered. On December 1, 2013, Employer Y covered 23% of its employees under the plan and so does not meet the 1/4 rule. During the open

[22] 79 Fed. Reg. at 8570.
[23] 79 Fed. Reg. at 8570.
[24] 79 Fed. Reg. at 8570-71.

Type of Transition Relief	Description of Relief	Comments	Example
	The second transitional rule will apply if the plan either (1) had, as of any date between February 10, 2013 and February 9, 2014, at least 1/4 of its employees[25] covered under the non-calendar year plan, or (2) offered coverage under the non-calendar year plan to 1/3 or more of its employees during the open enrollment period that ended most recently before February 9, 2014. If one of these rules is met, no Pay or Play penalty will apply for any month prior to the first day of the 2015 plan year with respect to employees who are offered affordable coverage that provides minimum value no later than the first day of the 2015 plan year.[26]	rule only applies to that employer if all non-calendar year plans had the same plan year as of December 27, 2012.[27]	enrollment period that ended most recently before February 9, 2014, Employer Y offered coverage under the plan to 45% of its employees and so meets the 1/3 rule. Employer Y offers affordable coverage that provides minimum value to all full-time employees as of the first day of the 2015 plan year. Employer Y will not be subject to any Pay or Play penalty for the period before July 1, 2015.[28]
Non-calendar year plans: "Significant Percentage Guidance (Full-Time Employees)"	The third transitional rule for non-calendar year plans is designed for employers that cannot satisfy the second transition rule for non-calendar year plans due to large numbers of seasonal or part-time employees. Like the first transitional	This relief applies only if the employer offers minimum essential coverage to a sufficient percentage of its full-time employees (95% or, if the relief below applies, 70%) as of the first day of the 2015 plan year. If an employer maintains a	Employer W has 2,000 employees, of whom 500 are full-time employees and 1,500 are not full-time employees. Employer W maintained a plan with a July 1 plan year as of December 27, 2012 (and did not later change the plan year).

[25] It is not completely clear if the term "employees" refers to <u>all</u> employees of an employer or if certain groups of employees (e.g., foreign employees) could be excluded.
[26] 79 Fed. Reg. at 8571.
[27] 79 Fed. Reg. at 8571.
[28] 79 Fed. Reg. at 8571.

Type of Transition Relief	Description of Relief	Comments	Example
	rule for non-calendar year plans, this rule only applies to an employer that maintained a non-calendar year plan as of December 27, 2012, and did not modify the plan year after December 27, 2012 to begin at a later calendar date. The third transitional rule will apply if the plan either (1) had, as of any date between February 10, 2013 and February 9, 2014, at least 1/3 of its full-time employees covered under the non-calendar year plan, or (2) offered coverage under the non-calendar year plan to 1/2 or more of its full-time employees during the open enrollment period that ended most recently before February 9, 2014. If one of these rules is met, no Pay or Play penalty will apply for any month prior to the first day of the 2015 plan year with respect to employees who are offered affordable coverage that provides minimum value no later than the first day of the 2015 plan year.[29]	calendar year plan as of February 9, 2014 in addition to the non-calendar year plan, this relief does not apply to those employees who are eligible for the calendar year plan. If an employer maintains two or more non-calendar year plans, this transitional rule only applies to that employer if all non-calendar year plans had the same plan year as of December 27, 2012.[30] The term "full-time employee" for purposes of the 1/3 and 1/2 rules under this transitional rule means an employee who is employed on average at least 30 hours of service per week under Code Section 4980H. The final regulations do not state whether an employer could count an employee's hours using the Look-Back Measurement Method (which would "look back" to hours in 2012). The more conservative approach is likely to determine whether an employee is full time based on whether the employee works at least 30 hours per week (130	Employer W chooses December 1, 2013 to measure the number of employees it covered. On December 1, 2013, Employer W covered 20% of its full-time employees under the plan and so does not meet the 1/3 rule. During the open enrollment period that ended most recently before February 9, 2014, Employer W offered coverage under the plan to 60% of its full-time employees and so meets the 1/2 rule. Employer W offers affordable coverage that provides minimum value to all full-time employees as of the first day of the 2015 plan year. Employer W will not be subject to any Pay or Play penalty for the period before July 1, 2015.[31]

[29] 79 Fed. Reg. at 8571.
[30] 79 Fed. Reg. at 8571-72.
[31] 79 Fed. Reg. at 8572.

Type of Transition Relief	Description of Relief	Comments	Example
		hours per month) as of the applicable dates used for this transitional rule.	
Offers of Coverage for January 2015	This transition rule is designed for employers who will offer coverage to full-time employees on a day other than the first day of January 1, 2015. This transition rule provides that if an employer offers coverage to a full-time employee no later than the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.[32]	This transition rule applies only for January 2015.[33]	Employer V has never offered health plan coverage to employees. Employer V will begin offering coverage to its full-time employees effective the first payroll period of January 1, 2015, which begins January 12, 2015. Those full-time employees offered coverage beginning January 12, 2015 will be treated as having been offered coverage for the entire month of January 2015.
Short Measurement Period, Long Stability Period	The final regulations recognize that employers who wish to adopt a 12-month measurement period and a 12-month stability period under the look-back measurement method will have time constraints due to the final regulation being published in February 2014. The transition rule allows an employer to adopt a shorter measurement period (such as six months) but keep the longer stability period (such as 12 months). To rely on this transition rule,	The effect of this rule is surprisingly difficult to succinctly summarize due to the varying length of the administrative period an employer could select (0 - 90 days) and the varying length of the measurement period the employer could select (apparently, 6 months to 11 months, although 11 months is reduced in some situations). An employer with a plan year beginning on July 1 must use a measurement period that is longer than	An employer with a calendar year plan may use a transition measurement period from April 15, 2014 through October 14, 2014 (six months), followed by an administrative period ending on December 31, 2014. In addition, an employer with a July 1, 2014 plan year may use a 10-month transition measurement period from June 15, 2014 through April 14, 2015, followed by an

[32] 79 Fed. Reg. at 8573.
[33] 79 Fed. Reg. at 8573.

Type of Transition Relief	Description of Relief	Comments	Example
	the transition measurement period must be at least six months long, must begin no later than July 1, 2014 and must end no earlier than 90 days before the first day of the plan year beginning on or after January 1, 2015. If an employer hires an employee during or after the transition measurement period described above, the general Pay or Play Rules for new employees under the look-back measurement method would apply.[34]	6 months to comply with the requirement that the measurement period begin no later than July 1, 2014 and end no earlier than 90 days before the stability period. Measurement periods beginning after July 1, 2014 cannot rely on this transitional relief and must follow the typical rule that the measurement period is equal in length to the stability period. In addition, mid-size employers who are not subject to the Pay or Play Rules in 2015 (as described above) cannot rely on this transition rule in 2016. Accordingly, such mid-size employers must adopt a 12-month measurement period in 2015 if they would like to adopt a 12-month stability period that begins in 2016.	administrative period from April 15, 2015 through June 30, 2015.[35]
Determination of Large Employer Status	Some employers will be close to 50 full-time (and full-time equivalent) employees. These employers may need extra time to determine if they are subject to the Pay or Play Rule. A transition rule allows an employer the option to determine its "large employer" status	This rule will be helpful for such employers who otherwise would have needed to verify their size as of December 31, 2014 (and then offered, or not offered, coverage as of January 1, 2015 -- an administratively difficult task). However, whether an	Employer U, which does not use seasonal workers, counts its full-time and full-time equivalent employees from January 1, 2014 through June 30, 2014. Employer U employs an average of 48 full-time and full-time equivalent employees during those

[34] 79 Fed. Reg. at 8572.
[35] 79 Fed. Reg. at 8572.

Type of Transition Relief	Description of Relief	Comments	Example
	with respect to a period of at least six consecutive calendar months in the 2014 calendar year (rather than the entire 2014 calendar year). This transition rule can be used for purposes of the new transitional rule for employers with 50-99 full-time (and full-time equivalent) employees described above.[36]	employer meets the requirements of the seasonal worker exception for purposes of determining large employer status for 2015 is based on the entire 2014 calendar year.[37]	six consecutive months. Employer U is not a large employer for 2015 and is not subject to the Pay or Play Rule for 2015. Employer U must re-determine during 2015 whether it is a large employer for 2016, and will have to make that determination based on the entire 2015 calendar year.
"Dependents" who Must be Offered Coverage	In order to avoid a Pay or Play Rule penalty, an employer must offer coverage to full-time employees and their "dependents." The Pay or Play final regulation requires that coverage be offered to an employee's children (but not the employee's stepchildren or foster children) who have not yet attained age 26. "Dependent" does not include a spouse or, presumably, a domestic partner. Under a special transitional rule, an employer does not need to offer dependent coverage in 2015, as long as it "takes steps" in 2014 or 2015 (or both) to provide such coverage.[38]	This relief applies to employers for the 2015 plan year with respect to plans under which (1) dependent coverage is not offered, (2) dependent coverage that does not constitute minimum essential coverage is offered, or (3) dependent coverage is offered for some, but not all, dependents. This relief is not available to the extent the employer offered dependent coverage during the 2013 or 2014 plan years. If coverage was offered to some, but not all, dependents during the 2013 or 2014 plan year, the relief applies only with respect to dependents who were not offered	Employer T offers no coverage to employees' dependents during the 2013 or 2014 plan years. However, during the 2014 and 2015 plan years, Employer T takes steps to extend coverage to employees' dependents, such as working with its TPA or insurer to obtain cost estimates and to select plan designs for dependent coverage. Assuming these are sufficient steps, it appears Employer T is not required to offer dependent coverage during 2015 to comply with the Pay or Play Rule (though of course it must comply with other requirements of the Pay

[36] 79 Fed. Reg. at 8573.
[37] 79 Fed. Reg. at 8573.
[38] 79 Fed. Reg. at 8573-74.

Type of Transition Relief	Description of Relief	Comments	Example
		coverage at any time during the 2013 or 2014 plan year.[39]	or Play Rule).
Multiemployer Plan Coverage	An applicable large employer member is not subject to a Pay or Play Rule penalty with respect to a full-time employee who satisfies the eligibility requirements of a multiemployer plan if: (1) the employer is required to contribute to a multiemployer plan pursuant to a collective bargaining agreement or an appropriate related participation agreement; (2) coverage under the multiemployer plan is offered to the full-time employee (and the employee's dependents); and (3) the coverage offered to the full-time employee is affordable and provides minimum value.[40]	Employers can rely on this transition rule until the IRS issues additional guidance regarding multiemployer plan arrangements under the Pay or Play Rule. Any future guidance would apply prospectively. Note that, if a Pay or Play Rule penalty is due with respect to an employee (e.g., if the coverage is not affordable or does not provide minimum value), then the applicable large employer member is responsible for the penalty.[41] Employers who contribute to a multiemployer plan should likely contact the plan and obtain satisfactory proof that all three of the requirements from the column to the left are, in fact, satisfied. Note that some items (such as whether the coverage is affordable) seem ambiguous.	

[39] 79 Fed. Reg. at 8573.
[40] 79 Fed. Reg. at 8576. The IRS intended for this transition rule to be a continuation of the multiemployer plan guidance originally set forth in the proposed regulations. See IRS Proposed Regulations, Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 218, 238 (January 2, 2013); see also IRS Correction to Proposed Regulations, Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 16445 (March 15, 2013).
[41] 79 Fed. Reg. at 8576.

Step 2

Step 2: Determine if You are a "Large Employer"

The Pay or Play Rule applies to an "applicable large employer."[42] An "employer" is the entity that is the employer of an "employee" as determined under a common-law test.[43]

An "employer" includes all types of common law employers, including private employers, public employers, churches and non-profit employers.[44]

A "large" employer is an employer who employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year.[45] If an employer does not have at least 50 full-time employees, it still can be subject to the Pay or Play Rule if:

* The employer is part of a "controlled group"[46] and the total full-time employees (including full-time equivalent ("FTE")) employees)[47] of the controlled group at least equals 50 (see Step 2(a) in Appendix I). As discussed further in Step 2(a), each employer in a controlled group is generally called an "applicable large employer member."[48] The Pay or Play Rule penalty generally applies separately with respect to each applicable large employer member;[49]
* The employer is a new employer and it expects to employ an average of at least 50 full-time employees in the current calendar year (see Step 2(b) in Appendix I);
* The employer is deemed to be "large" due to a predecessor employer (see Step 2(c) in Appendix I) [50]; or
* The employer has enough FTE employees to cause the employer to be treated as a large employer (see Step 2(d) in Appendix I).

Many employers will know (prior to examining Steps 2(a)-2(d)) that they are a "large" employer. <u>If you know that you are a "large" employer subject to the Pay or Play Rule, you can proceed to Step 3 below. If you are not certain, proceed to Appendix I for the remainder of Step 2 (i.e., Steps 2(a)-2(d)).</u>

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[42] Code Section 4980H.
[43] 26 CFR 54.4980H-1(a)(16). For additional information on the common-law standard see 26 CFR 31.3121(d)-1(c).
[44] 78 Fed. Reg. at 221. It also includes an employer that is an organization described in Code Section 501(c) which is exempt from federal income tax pursuant to Code Section 501(a).
[45] Code Section 4980H(c)(2). See also 26 CFR 4980H-1(a)(4. Remember that, under the transitional relief described in Step 1(a), certain mid-size employers (i.e., employers with between 50 and 99 full-time and full-time equivalent employees during 2014) will not be subject to the Pay or Play Rule during 2015. An employer should use the rules in this Step 2 to determine if it would be an "applicable large employer" under the Pay or Play Rule and, if so, if the transitional relief for mid-size employers applies. If the transitional relief applies, the employer should keep records proving that it is eligible for the relief in 2015.
[46] 26 CFR 54.4980H-1(a)(16).
[47] The term "full-time equivalent employee" or "FTE" is defined at 26 CFR 54.4980H-1(a)(22).
[48] 26 CFR 54.4980H-1(a)(5).
[49] This seems to be fairly clear with respect to the Subsection A Penalty, based on 26 CFR 54.4980H-4(d), and the Subsection B Penalty, based on 26 CFR 54.4980H-5(d). See the further discussion of this rule in Step 2(a).
[50] The IRS has not yet defined the term "predecessor employer." See 26 CFR 54.4980H-1(a)(36).

Step 3

Step 3: Will Any of Your Employees Receive Federally Subsidized Exchange Coverage?

Generally, beginning in 2014, individuals will be able to obtain health insurance through an "Exchange." Exchanges were expected to be state-created marketplaces where insurance products can be easily compared. If a state does not create an Exchange the federal government can establish and operate an Exchange in that state.[51] Only 16 states and the District of Columbia will create Exchanges. In the states that have not created an Exchange, the federal government will establish and operate an Exchange in that state, or will operate the Exchange in partnership with the state.[52]

Some individuals who obtain Exchange coverage will be eligible for federal subsidies to help pay for health insurance premiums, or to help reduce certain health plan costs.[53] For purposes of the Pay or Play Rule, beginning in 2015, an employer can face a penalty if an employee obtains either federal Exchange subsidy: the premium assistance subsidy or the cost-reduction subsidy.[54] We refer to both of these subsidies as "federal Exchange subsidies" throughout this Guide. An employer should receive notice from the U.S. Department of Health and Human Services that an employee has received such an Exchange subsidy.[55] The subsidies will be available in an Exchange established by a state and most likely will be available in a Federally-run exchange.[56]

If the subsidies are not available in a Federally-run exchange, this would be significant. If no subsidy is available in a particular state, a large employer in that state could not face a penalty under the Pay or Play Rule. As will be explained below in more detail (and as is illustrated in Exhibit A), an employer can face a Pay or Play Rule penalty only if an employee receives subsidized Exchange coverage.[57]

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[51] ACA Section 1321(c).

[52] See Kaiser Family Foundation, "State Decisions for Creating Health Insurance Exchanges, 2014" (available at http://kff.org/health-reform/state-indicator/health-insurance-exchanges/ (as visited February 24, 2014).

[53] The subsidies for premiums are found in Code Section 36B, as added by ACA Section 1401. The cost-sharing provisions are found in ACA Section 1402.

[54] Code Sections 4980H(a)(2), 4980H(b)(1)(B).

[55] See 78 Fed. Reg. at 231 (discussing general concepts of notifying employers and introducing the concept of a "Section 1411 certification", which is the notice an employer will receive if a full-time employee receives an Exchange subsidy which potentially triggers a Pay or Play Rule penalty). See also 26 CFR 54.4980H-1(a)(35) (defining "Section 1411 certification").

[56] Final regulations interpreting the premium subsidies under Code Section 36B contain a definition of "Exchange" that includes federally-operated Exchanges, indicating that the premium tax credit is available through both types of Exchanges (state-operated and federally-operated). 26 CFR 1.36B-1(k). Federal court cases have been brought in the District of Columbia, Indiana, Oklahoma, and Virginia challenging the legality of these final regulations. See *Halbig v. Sebelius*, Case No. 13-0623 (D.C.); *State of Indiana v. Internal Revenue Service*, Case No. 1:13-cv-1612 (S.D. Ind.); *Pruitt v. Sebelius et. al.*, Case No. 6:11-cv-00030 (E.D. Okla.); and *King v. Sebelius*, Case No. 3:13-cv-630 (E.D. Va.). As of February 24, 2014, the D.C. and Virginia cases were dismissed and the dismissals appealed by the plaintiffs. The Oklahoma and Indiana cases are pending. Thus, this remains an open question.

[57] Under the statute, both the Subsection A Penalty and the Subsection B Penalty are triggered when an "employee" (rather than a dependent) has been certified as receiving subsidized exchange coverage. Code Sections 4980H(a)(2), 4980H(b)(1)(B). However, a prior portion of the same statute seems to require an offer of coverage to both employees and dependents. See Code Sections 4980H(a)(1) (Subsection A Penalty) and 4980H(b)(1)(A) (Subsection B Penalty). It is unclear whether a violation of this prior portion would trigger the Pay or Play Rule penalty. It is possible that an employer violating this prior portion (i.e., not offering coverage to dependents) would not face any penalty. Some groups have made this argument to the federal government. See, e.g., The ERISA Industry Committee letter to Jeanne M. Lambrew, Deputy Assistant to the President for Health Policy (August 27, 2012) (available at http://www.eric.org/uploads/doc/health/ERIC_Letter_SharedResponsibilityDependentCoverage_082712.PDF) (as visited August 29, 2012). In the final Pay or Play Rule regulation the IRS indicates that an employer must cover "dependents" in order to avoid all Pay or Play Rule penalties. 79 Fed. Reg. at 8567, 8573. However, the regulation does not seem to address how a Pay or Play Rule penalty could be triggered if an employee (but not a dependent) is offered affordable, minimum value coverage which constitutes minimum essential coverage under an eligible employer - sponsored plan -- as noted above, the statute does not seem to support a penalty.

Unfortunately, it may be very difficult for an employer to know, in advance, whether an employee is eligible for subsidized Exchange coverage. This is because an employer usually would not know the employee's income or eligibility for other coverage (e.g., Medicaid).[58]

Avoid Pay or Play Rule Penalty Through Plan Design

Steps 4 through 6 will discuss when an employer could be subject to the Pay or Play Rule penalty. As will be discussed, it is possible for an employer to design its health plan so that it never pays a Pay or Play Rule penalty. However, this may require that an employer modify its current health plan design. Also, in some situations it may be financially better (i.e., cheaper) for the employer to pay the penalty, rather than provide the coverage.

What must an employer do to ensure it never pays a Pay or Play Rule penalty? In general, an employer must:

* Offer "Minimum Essential Coverage" under an "eligible employer-sponsored plan" to nearly all its "full-time" employees (and, dependents of those employees) who are eligible for federal Exchange subsidies (which will often be individuals with household income between 100% and 400% of the federal poverty level, although this range can vary from state-to-state);[59]
* Ensure that the employer's plan provides "Minimum Value"; and
* Ensure that the employee's share of the premium for self-only coverage for the employer's lowest-cost, Minimum Value coverage is "Affordable".

Employers who wish to avoid all possible Pay or Play Rule penalties must ensure they satisfy these three requirements. Steps 4 through 6 discuss each of these requirements.

[58] A prior version of this Guide illustrated how Medicaid expansion could affect an employer's Pay or Play rule risk. For more details on Medicaid expansion, see *"Current Status of State Medicaid Expansion Decisions, 2014," Kaiser Family Foundation* (http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/) (last visited February 27, 2014). The prior version of the Guide is available upon request.

[59] Theoretically, an employer could avoid the Pay or Play Rule penalty by offering coverage only to those employees eligible for a federal Exchange subsidy (or by offering coverage to those employees as a separate coverage category under its health plan). This option seems impractical because of the complexities involved in calculating household income and determining applicable Medicaid coverage, as discussed previously in Sections 3(a) and 3(b).

Step 4: Verify Whether You Offer Minimum Essential Coverage Under an Employer Plan

Most employers with major medical coverage will "offer" "minimum essential coverage" under an "eligible employer-sponsored plan", as explained in Steps 4(a) and 4(b). An employer will "offer" health plan coverage if it provides an "effective opportunity" to (a) elect to enroll at least once during the plan year, and (b) elect to decline to enroll if the coverage does not provide minimum value or requires an employee contribution for any month of more than 9.5% of 1/12 of the federal poverty level for a single individual.[60] Whether there is an "effective opportunity" is a facts-and-circumstances test.[61] Note that the coverage which is offered generally must apply to every day of every month. That is, if an employee is not offered coverage for even a single day in a month, the employer generally is treated as not "offering" coverage for that month.[62]

There are certain situations where an employer may "offer" coverage on behalf of another employer, but there remain some unresolved questions raised by the definition of "offer." Consider the following scenarios.

Employers Within a Controlled Group. Holding Company Inc. has two subsidiaries, Subsidiary A and Subsidiary B. All three companies are applicable large employer members. Subsidiary A offers minimum essential coverage to its full-time employees. Subsidiary A's offer of coverage to its employees is treated as an offer of coverage by Holding Company and Subsidiary B.[63]

Multiemployer and Multiple Employer Plans. A unionized employer contributes to a multiemployer plan. An offer of coverage under the multiemployer plan made to an employee on behalf of the employer generally is treated as being made by the employer.[64] This rule also applies to single employer Taft-Hartley plans and multiple employer welfare arrangements (MEWAs).[65]

Staffing Firms. Packaging Inc. utilizes the services of temporary employees acquired through Staffing Firm. Staffing Firm is not the common law employer of the temporary employees.[66] Staffing Firm makes an offer of coverage under a plan that Staffing Firm has established and maintains. Staffing Firm's offer of coverage will be treated as being made by Packaging Inc. *only if* Packaging Inc. pays Staffing Firm additional fees with respect to employees actually enrolled in Staffing Firm's coverage.[67]

Employee Negotiates Higher Wages. Hospital Inc. hires Nancy, a nurse, on February 1, 2015. Nancy will be a full-time employee. Nancy has health plan coverage through her husband. Nancy asks Hospital Inc. to pay her higher wages in lieu of health plan benefits. Nancy and Hospital Inc. intend for the arrangement to last the entire period of Nancy's employment (it is not just for a single year). Will Hospital Inc. face a Pay or Play Rule penalty because it has failed to "offer" Nancy coverage? If the answer is "no" because there was a "waiver" by Nancy, must Nancy "waive" the offer of health plan

[60] 26 CFR 54.4980H-4(b)(1).
[61] 26 CFR 54.4980H-4(b)(1).
[62] 26 CFR 54.4980H-4(c). Note that there are some exceptions to this rule, as discussed in Step 7.
[63] 26 CFR 54.4980H-4(b)(2).
[64] 26 CFR 54.4980H-4(b)(2). See Step 1 for a further discussion of this rule, along with important restrictions.
[65] 26 CFR 54.4980H-4(b)(2).
[66] Note that some employers using temporary workers assume that staffing firms or professional employer organizations (PEOs) are the common law employer of the temporary workers. However, in the preamble to the final regulation, the IRS indicates that in a "typical case," a PEO or staffing firm is not the common law employer of the worker. 79 Fed. Reg. 8566.
[67] 26 CFR 54.4980H-4(b)(2). Note that this "additional fees" requirement may cause issues if the current arrangement is not structured this way.

coverage every year?

The arrangement seems risky in light of the IRS regulation. As noted above, the regulation generally requires that an employee have an opportunity to enroll (or decline to enroll if the coverage does not meet minimum value and cost standards) at least once each plan year.[68] Hospital Inc. should reconsider the arrangement in light of the IRS regulation.

No "Offer" Per Collective Bargaining Agreement. An employer has a workforce which is partially unionized. The union employees are full-time. The employer and the union representatives had -- prior to 2015 -- agreed that the employer would not offer health plan coverage to the union employees. Instead, the union negotiated higher wages and other benefits. Will the employer have a Pay or Play Rule risk because it does not, as of January 1, 2015, offer health plan coverage to these employees?

Likely yes. In the preamble to the final regulation, the IRS addressed this question. The IRS stated that the bargaining-away of the coverage would not be viewed as an offer of coverage.[69]

Step 4(a): Verify You Provide Minimum Essential Coverage

"Minimum essential coverage" means coverage under any of the following:

(i) Certain government programs (such as Medicare Part A or Medicaid);
(ii) Coverage under an employer-sponsored plan;
(iii) Plans in the individual market within a State;
(iv) Grandfathered health plan coverage; or
(v) Other coverage recognized by HHS.[70]

Minimum essential coverage does not include coverage under certain excepted benefits.[71] Thus, if the only coverage offered by an employer consists of these excepted benefits, the employer could face a Subsection A Penalty under the Pay or Play Rule. These excepted benefits include:

(i) Coverage only for accident, or disability income insurance, or any combination thereof;
(ii) Coverage issued as a supplement to liability insurance;
(iii) Liability insurance, including general liability insurance and automobile liability insurance;
(iv) Workers' compensation or similar insurance;
(v) Automobile medical payment insurance;
(vi) Credit-only insurance;
(vii) Coverage for on-site medical clinics; and
(viii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

[68] 26 CFR 54.4980H-4(b)(1).
[69] 79 Fed. Reg at 8566.
[70] Code Section 5000A(f)(1).
[71] Code Sections 4980H(a)(1), (b)(1) and 5000A(f)(3).

In addition, an employer does not provide minimum essential coverage if the only coverage offered by the employer consists of one or more of these benefits, where the benefits are provided under a separate policy, certificate or contract of insurance:

(i) Limited scope dental or vision benefits;
(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
(iii) Such other similar, limited benefits as are specified in regulations;
(iv) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act);
(v) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and
(vi) Similar supplemental coverage provided to coverage under a group health plan.[72]

The following benefits also are not minimum essential coverage, but apparently only if they are offered as independent, noncoordinated benefits:[73]

(A) Coverage only for a specified disease or illness; and
(B) Hospital indemnity or other fixed indemnity insurance.

The above list includes many types of health plans which are not traditional, major medical plan coverage. For example, a typical, fully-insured dental or vision plan (which is separate from a major medical plan) is an "excepted benefit" and will not constitute "minimum essential coverage." So, if an employer provides only a typical, fully-insured dental or vision plan (without providing any major medical plan) the employer is not offering minimum essential coverage and could face a penalty under the Pay or Play Rule. However, as noted in the following text box, the list seems to fail to include some plans which might be surprising.

[72] Code Section 5000A(f)(3)(A), (B). Note that there is some slight confusion caused by the statute's language. Code Section 5000A(f)(3)(B) refers to a "separate policy, certificate, or contract of insurance" and also refers to PHSA Sections 2791(c)(2) and (4). However, PHSA Section 2791(c)(3) refers to benefits "offered separately", without mentioning a policy, certificate or contract of insurance. It is unclear if Congress was attempting to distinguish between insured and self-funded benefits in its reference to PHSA Section 2791(c)(2). In addition, PHSA Section 2791(c)(4) only refers to a "separate insurance policy", without listing a "certificate" or "contract of insurance". It is unclear if Congress was attempting to distinguish among different types of insurance policies or contracts in its reference to PHSA Section 2791(c)(4). Further complicating the statute, IRS regulations appear to incorporate the descriptions of excepted benefits under PHSA Sections 2791(c)(2) and (4), without requiring that such excepted benefits be offered under a separate policy, certificate or contract of insurance. 26 CFR 1.5000A-2(g).

[73] Code Section 5000A(f)(3)(B). See IRS Proposed Regulations, Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 Fed. Reg. 7314, 7317 (Feb. 1, 2013). Note that Code Section 5000A(f)(3) references PHSA Section 2791(c)(3) and provides that benefits described in that section are not "minimum essential coverage" if they are provided under a separate policy, certificate or contract of insurance. However, PHSA Section 2791(c)(3) also requires that these benefits be offered as "independent, noncoordinated benefits." Although the statute does not clearly incorporate these additional requirements of PHSA Section 2791(c)(3), the preamble to certain IRS proposed regulations provides that the benefits referenced in PHSA Section 2791(c)(3) are excepted benefit s "only if offered under a policy, certificate, or contract of insurance ***separate from, and not coordinated with***, any group or individual health plan maintained for the same plan sponsor." (emphasis added.) Accordingly, it appears that these benefits must meet the additional requirements in PHSA Section 2791(c)(3) in order to constitute excepted benefits under Code Section 5000A(f)(3).

Can Our Self-Insured Dental or Vision Plan Constitute "Minimum Essential Coverage"? Perhaps, but this seems unlikely. The above definition of "minimum essential coverage" excludes many typical, fully-insured dental or vision plans. These plans are usually provided under a "separate policy, certificate or contract of insurance" and satisfy this requirement of the exception. However, a self-insured dental or vision plan is not provided under a "separate policy, certificate or contract of insurance". It appears that a self-insured dental or vision plan could be an "eligible employer-sponsored plan" (as discussed in Step 4(b), below). Thus, it appears that a self-insured dental or vision plan could be "minimum essential coverage." This suggests that an employer could avoid the Pay or Play Rule penalty simply by providing a self-insured dental or vision plan. Note, though, that a self-insured dental or vision plan which is not an "excepted benefit" may need to comply with the full scope of the ACA, such as no dollar limits on essential health benefits and free preventive care. Also, it is somewhat doubtful whether such a plan would provide "Minimum Value" (as discussed in Step 5). Further IRS guidance would be helpful.

Step 4(b): Verify You Provide Such Coverage Under an Eligible Employer-Sponsored Plan

An "eligible employer-sponsored plan" includes:

* A governmental plan;
* Any other plan or coverage offered in the small or large group market within a State;
* A grandfathered health plan offered in a group market; or
* A self-insured group health plan under which covered is offered by, or on behalf of, and employer to the employee.[74]

The term "group health plan" means an employee welfare benefit plan as defined under the Employee Retirement Income Security Act ("ERISA") to the extent that the plan provides medical care to employees or their dependents.[75] Most health benefits offered by employers meet the requirements necessary to be considered employee welfare benefit plans under ERISA.

Bottom Line: The definitions described in Steps 4(a) and 4(b) are likely to be satisfied by most employers who provide major medical health plans to employees. Thus, we expect that most employers offering major medical health benefits to employees will be providing an "eligible employer-sponsored plan" and that these employers will satisfy Step 4.

[74] Code Section 5000A(f)(2); 26 CFR 1.5000A-2(c)(1).
[75] 26 CFR 1.5000A-1(d)(7); PHSA Section 2791(b)(2).

Step 5

Step 5: Ensure That Your Plan Provides "Minimum Value"

An employee could potentially receive an Exchange subsidy if the employer's health plan does not provide "minimum value."[76] The statute states that a plan does not provide "minimum value" if the "plan's share of the total allowed cost of benefits provided under the plan is less than 60 percent of such costs."[77]

Note that most employer-sponsored plans are expected to satisfy the minimum value requirement. A report issued by HHS found that approximately 98% of individuals covered by employer-sponsored plans are enrolled in plans that have an actuarial value of at least 60% using methods and assumptions similar to those the agencies have provided for determining minimum value.[78]

The IRS has issued proposed regulations that provide four options for determining whether an employer's plan provides minimum value. Note that the proposed regulations seem to require that all small, fully-insured plans be tested in the same manner, regardless of whether they are grandfathered or not.[79]

The proposed options are summarized in the table below.

Method	Overview	Comments
Minimum Value Calculator	The federal government has posted an online "calculator" in which terms of the health plan can be described. The website then determines whether the plan provides minimum value.[80]	This option is probably the easiest method for an employer to use. However, some plans with non-standard features cannot use the calculator and would need to select a different option.

[76] Code Section 36B(c)(2)(C)(ii).

[77] Code Section 36B(c)(2)(C)(ii). Note that, unlike the rules for determining the "actuarial value" of a plan, the 60% standard for minimum value does not include a de minimis variation of 2 percentage points. See IRS Notice 2012-31, IV; HHS Final Regulations, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12852 (Feb. 25, 2013) ("whereas the statute allows for de minimis range with actuarial value there is no similar provision in section 36B of the Code with regard to [minimum value]").

[78] See IRS Notice 2012-31, II.

[79] See IRS Proposed Regulations, Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25910 (May 3, 2013), stating that a plan can use the following method to determine if the plan provides minimum value: "For plans in the small group market, conformance with the requirements for a level of metal coverage defined at 45 CFR 156.140(b) (bronze, silver, gold, or platinum."); see also IRS Notice 2012-31, V ("For employer-sponsored plans in the small group market, minimum value must be determined using a method that is consistent with actuarial value rules under Section 1302(d) of the Affordable Care Act and HHS guidance provided under that provision."). However, somewhat confusingly, other guidance could be read as stating that only non-grandfathered, small, fully-insured plans are subject to this test (while grandfathered plans are subject to some other test, apparently). See Center for Medicare and Medicaid Services ("CMS"), Actuarial Value and Cost-Sharing Reductions Bulletin, I (Feb. 2012) available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/Av-csr-bulletin.pdf.

[80] See 26 CFR 1.36B-6(d)(1). The minimum value calculator can be found at http://cciio.cms.gov/resources/regulations/index.html#hmr.

Method	Overview	Comments
Small, Fully-Insured Plan	Certain small, fully-insured health plans will satisfy a metal coverage tier (such as a bronze silver, gold or platinum) and will automatically be deemed to provide minimum value.[81]	Presumably an employer would rely on an insurer's statement that the plan satisfies a particular coverage tier.
Actuarial Certification	An employer (or perhaps an insurer on behalf of an employer) can hire an actuary to certify that the plan provides minimum value if the plan has nonstandard features that are not compatible with the minimum value calculator described above.[82]	Will probably be the last resort for employers (if employer must hire the actuary) due to extra cost.
Safe Harbor Plan Design	The proposed regulations describes certain plan designs, which are likely to automatically provide minimum value.[83]	The proposed safe harbor plan designs are not final and could change. We expect more guidance on this option. Current proposed safe harbor offers three options: 1. A plan with a $3,500 integrated medical and drug deductible, 80% 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% plan cost-sharing, a $6,400 maximum out-of-pocket limit and a $500 employer contribution to a HSA. 3. A plan with a $3,500 medical deductible, $0 drug deductible, 60% plan medical expense cost-sharing, 75% plan drug cost-sharing, a $6,400 maximum out-of-pocket limit and drug

[81] See 26 CFR 1.36B-6(d)(4).
[82] 26 CFR 1.36B-6(d)((3).
[83] See 26 CFR 1.36B-6(d)(2); 78 Fed. Reg. at 25912.

Method	Overview	Comments
		co-pays of $10 / $20 / $50 for the first, second and third prescription drug tiers, with 75% coinsurance for specialty drugs.

Wellness Plan Rewards and Minimum Value.

The proposed regulations also address the minimum value calculation for an employer that offers its employees a reward-based wellness plan where the reward is a reduction in the deductible or out-of-pocket maximum. In such a case, the employer can take into account the wellness plan reward only to the extent it relates to tobacco use.[84] As noted in the three examples below, this can sometimes be easy to apply, and other times difficult and unclear.

Wellness Program Example #1 (simple). Sample Co. offers a self-funded health plan. The plan has a $2,000 deductible but, if an employee participates in the wellness program, the deductible is decreased by $300 (to $1,700). The wellness program focuses only on tobacco use. Sam, the Benefits Director for Sample Co., wants to know if the plan provides minimum value. Sam logs into the website, which contains the minimum value calculator. The calculator asks Sam to include the plan's deductible. Sam is uncertain on how to answer the question: Is it $2,000 (the general deductible) or $1,700 (the deductible for individuals who do not use tobacco or who complete a tobacco cessation course)?

It appears that, under the proposed regulations, Sam would list the deductible as $1,700. This is true because the wellness program provides a discount which is based on not using tobacco. Note that Sam will list $1,700 even if some (or many) employees do not qualify for the discount and are subject to the full $2,000 deductible. Sample Co. is pleased to list the deductible as $1,700 (rather than $2,000) because it makes the plan look more valuable and results in the plan being more likely to provide minimum value.

Note that there would be a different result if the $300 deductible decrease related to a health factor other than tobacco use (such as acceptable blood glucose or cholesterol levels). In that case, the possible $300 discount is ignored, and Sam would list $2,000 (not $1,700) as the plan's deductible for minimum value purposes.

Wellness Program Example #2 (moderate difficulty). What if tobacco use is just one factor that can help an employee earn the $300 reward? For example, suppose Sample Co.'s wellness plan gives the $300 deductible discount to any employee who earns 100 wellness points. There are four ways to earn the 100 points (acceptable glucose levels are worth 25 points; acceptable cholesterol levels are worth 25 points; physical activity is worth 25 points; and not using tobacco is worth 25 points). Thus, everyone who earns the wellness reward will not use tobacco. Could the company apply 25% of the $300 (i.e.,

[84] 26 CFR 1.36B-6(c)(2). Note that the preamble to the proposed regulations provides transition relief from the Pay or Play Rule for plan years beginning before January 1, 2015 with respect to reward-based wellness plans. 78 Fed. Reg. at 25911. Several requirements must be satisfied to qualify for the transition relief, including that the applicable wellness program must have been in effect on May 3, 2013.

$75) reward when it inputs information on minimum value?

Perhaps -- it seems to be supported by the proposed regulation. The regulation states that the wellness program incentive is earned "to the extent" the incentive relates to tobacco use.[85] This seems to mean that to the extent the wellness discount is not tobacco-related, it is ignored. If so, here $225 (that is, $300 - $75 = $225) would be ignored as the "non-tobacco discount," and $75 could apparently be "counted" as the "tobacco discount." While this seems logical, no examples or other language in the regulation supports the conclusion. So, this remains a bit unclear.

Wellness Program Example #3 (difficult). Suppose Sample Co. offers a wellness plan in which an employee earns a $300 deductible discount by earning five points. Sample Co. offers seven ways (similar to the ways noted in the prior example — for example, no tobacco use, exercise and cholesterol levels) to earn the five points. Each of the seven ways is worth one point. So, some employees who earn the $300 deductible discount will qualify, in part, because of not using tobacco. But, other employees will earn the $300 deductible discount even though they do use tobacco. Sample Co. does not know in advance (and may not know at all, because Sample Co.'s wellness vendor may not share the information with Sample Co.) how many employees qualified for the discount because of not using tobacco. When Sample Co. lists its deductible in the minimum value calculator, can Sample Co. include some portion of the $300 deductible discount?

This is very unclear. Unless Sample Co. has some data to support the amount it lists, it would seem to be risky to list any discount. Unfortunately, we will probably not know the answer to this question until the IRS issues further guidance.

HRAs, HSAs and Minimum Value.

An employer's contributions to a health reimbursement arrangement ("HRA") or health savings account ("HSA") can help the employer to demonstrate that its plan provides minimum value. For an HRA, an employer considers amounts which are newly made available with respect to an HRA that is integrated with the employer's health plan, if the new amounts may be used only to reduce cost-sharing for covered medical expenses.[86] For an HSA, the full amount an employer contributes is considered. However, for both amounts, it appears that the most that can be taken into account is the amount of expected spending for health care costs in a benefit year.[87] It is not clear how an employer would determine this amount.

HRA Example. As noted in the prior examples, Sample Co. has a health plan. Sample Co. also offers an HRA and contributes $1,200 to the HRA for each individual who participates in the health plan. The HRA can only be used to reduce cost-sharing for covered medical expenses. Sam, the benefits director for Sample Co., sees that the minimum value calculator requests that Sam input the HRA Employer Contribution. Sam would like to include the full $1,200 HRA contribution, because it would make the health plan more likely to provide minimum value. Can Sam include the full $1,200 contribution?

It appears that Sam can include the entire $1,200. The HRA (presumably its plan document and summary plan description) limit eligible expenses to reducing cost-sharing for covered medical expenses. This is good — that is the first hurdle Sam must clear under the new regulations. Next, Sam would need to confirm that the HRA is integrated with the health plan. This is likely true here, assuming

[85] 26 CFR 1.36B-2(c)(3)(v)(A)(4).
[86] 45 CFR 156.145(d); 26 CFR 1.36B-6(c)(4).
[87] 26 CFR 1.36B-6(c)(3).

that all employees who receive an HRA contribution also are in the health plan (and that all employees in the health plan also receive an HRA contribution).

Finally, the regulations state that the amount of the HRA contribution that is taken into account is the amount of expected spending for health care costs in a benefit year.[88] Suppose Sample Co. knows that, on average, HRA participants spend 70% of Sample Co.'s contribution each year (the remaining 30% rolls over to the following year). Would Sam put into the minimum value calculator 70% of $1,200 (i.e., $840)? Or does the calculator expect Sam to include the full $1,200 — and then the calculator will adjust this amount downward? The regulations are not clear on this point. However, other minimum value calculator guidance seems to indicate that Sam would include the full $1,200 amount.[89]

[88] 26 CFR 1.36B-6(c)(5).

[89] See Department of Health and Human Services, "Minimum Value Calculator Methodology," (stating that an employer will include, in the case of HSAs, an annual amount contributed by the employer or, in the case of HRAs, the amount first made available) (available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-methodology.pdf) (last visited March 3, 2014).

Step 6: Verify the Coverage is Affordable for Employee

Generally, an employee will be able to receive an Exchange subsidy only if the plan does not provide "minimum value" (as discussed in Step 5) or if the employee's required health plan premium contribution under an employer's plan is not "affordable" -- that is, the contribution exceeds 9.5% of the employee's household income.[90] Hidden within this general rule, however, are some subtle nuances, such as how "household income" is calculated, what level of coverage is used in the calculation (e.g., the lowest cost plan offered by the employer versus the highest-cost plan offered by the employer) and what type of coverage is used in the calculation (e.g., employee-only versus family coverage). We discuss these nuances in this Step 6. Note that some items remain unaddressed by the IRS. For example, it is not clear in all instances if the 9.5% is based on the maximum an employee could pay or what the employee actually does pay (this amount could be lower due to the avoidance of a spousal surcharge).

Step 6(a): What is "Household Income"?

In general, "household income" is the modified adjusted gross income of the employee and any members of the employee's family (including any spouse and dependents) who are required to file an income tax return.[91] "Modified adjusted gross income" means adjusted gross income (within the meaning of Code Section 62) increased by amounts excluded from gross income under Code Section 911, by the amount of any tax-exempt interest a taxpayer receives or accrues during the taxable year, and by the portion of the taxpayer's social security benefits not included in the taxpayer's gross income (under Code Section 86) for the taxable year.[92]

This definition of "household income" poses a problem for employers. Employers may know the income (or much of the income) of employees. However, employers usually do not know the income of an employee's spouse and dependents. Thus, an employer would have "practical difficulties" (in the words of the IRS) determining whether a health plan is "affordable" to an employee.[93]

Step 6(b): Applying Household Income to Cost of Plan

Because of this practical difficulty, the IRS allows an employer to determine that its health plan coverage is "affordable" by using one of three safe harbors, as noted in the following chart. Note that all the safe harbors focus on the cost of self-only coverage, not some other level of coverage (e.g., family coverage). This means an employer could charge more than 9.5% (e.g., 10% or 15%) for self-plus-one or family coverage yet still avoid Pay or Play Rule penalty.[94]

Note that, if an employer's health plan coverage is affordable for the employee based on the cost of self-only coverage, the employee's family members generally will not be eligible to receive an Exchange subsidy.[95] This is the case even if the employee's cost of self-plus-one or

[90] Code Section 36B(c)(2)(C)(i)(II).
[91] IRS Notice 2011-73, II, citing Code Section 36B(d)(2)(A).
[92] Code Section 36B(d)(2)(B).
[93] IRS Notice 2011-73, II.
[94] See 26 CFR 1.36B-2(c)(3)(v)(A)(2) ("an eligible employer-sponsored plan is affordable for a related individual if the portion of the annual premium the employee must pay for self-only coverage does not exceed [9.5%]").
[95] 26 CFR 1.36-2(c)(3)(v)(A)(2).

family coverage under the employer's health plan is prohibitively expensive. Employers should keep in mind that, by charging high premiums for self-plus-one or family coverage, an employer might inadvertently cause its employee to be unable to afford family coverage under its health plan ***and*** cause the employee's spouse and dependents to be unable to obtain subsidized coverage through an Exchange.

Name of Safe Harbor	Description	Comments
Rate of Pay Safe Harbor	Coverage will be affordable for a calendar month if employee's required contribution for month for lowest cost, self-only coverage that provides minimum value does not exceed 9.5% of a Rate of Pay Safe Harbor Amount. This Rate of Pay Safe Harbor Amount equals 130 hours multiplied by employee's hourly rate of pay as of the first day of the coverage period (generally first day of plan year) or the employee's lowest hourly rate of pay during the calendar month.[96] For salaried employees, monthly salary is used instead of hourly rate of pay. Employer can use any reasonable method to convert payroll periods to monthly salary.[97] The IRS notes that as a "practical matter," the Rate of Pay Safe Harbor cannot be used for tipped employees or for employees who are compensated solely on the basis of commissions.[98] The IRS notes that employers can use the two other affordability safe harbors for employees whose compensation is not based on a rate of pay.[99]	Rate of Pay Safe Harbor available only to extent employer does not reduce monthly wages of salaried employees during calendar year (including transfers of employment to another applicable large employer member).[100] The Rate of Pay Safe Harbor is available if an employer reduces the hourly rate of pay of an hourly employee, provided that the rate of pay is applied separately to each calendar month, rather than to the entire year and the employee's required contribution may be treated as affordable if it is affordable based on the lowest rate of pay for the calendar month multiplied by 130 hours.[101] For example, assume Employer W employs Employee D from January 1, 2015 - December 31, 2015. Employee D's contribution for self-only coverage is $85 per month. D is paid at a rate of $7.25 per hour. W can assume D earns $942.50 per calendar month (130 x $7.25). The maximum "affordable" premium is 9.5% of $942.50 = $89.53. Because D is only charged $85 (less than $89.53), D's coverage is affordable.[102]

[96] 26 CFR 54.4980H-5(e)(2)(iii).
[97] 26 CFR 54.4980H-5(e)(2)(iii).
[98] 79 FR at 8564.
[99] 79 FR at 8564-65.
[100] 26 CFR 54.4980H-5(e)(2)(iii).
[101] 26 CFR 54.4980H-5(e)(2)(iii).
[102] This example comes from 26 CFR 54.4980H-5(e)(v), Ex. 4.

Name of Safe Harbor	Description	Comments
Federal Poverty Line Safe Harbor	Coverage will be affordable for a calendar month if employee's required contribution for lowest-cost self-only coverage that provides minimum value under the plan does not exceed 9.5% of a Federal Poverty Line Safe Harbor. The Federal Poverty Line Safe Harbor is determined by calculating Federal poverty line for single individual (where individual is employed) for applicable calendar year, divided by 12.[103] The Federal poverty line is the federal poverty line that is in effect within six months before the first day of the plan year for the state in which the employee is employed.[104]	For example, the general federal poverty line for 2014 for a single person is $11,670, and 9.5% of $11,170 is $1,108.65. One-twelfth of $1,108.65 is approximately $92.39. Coverage would be affordable if employee's monthly contribution amount for self-only premium of the employer's lowest cost coverage that provides minimum value is equal to or less than $92.39. This is true even if employee's wages vary somewhat in a particular month (e.g., because of low hours in a month, an hourly employee may end up paying a larger "percentage" of wages in a particular month).[105]
Form W-2 Safe Harbor	Verify whether employee's required contribution for the calendar year for the employer's lowest cost self-only coverage that provides minimum value during the entire calendar year does not exceed 9.5% of that employee's Form W-2 wages from the employer for the calendar year.[106] The cost of COBRA or other continuation coverage is ignored if the employee terminates employment. This is good for an employer because COBRA is usually expensive for the employee, since an employer usually does not subsidize its cost. Thus, if the cost was considered in the test, the former employee's coverage would likely be unaffordable. Note that the opposite rule applies for an employee who reduces hours and elects COBRA. The cost of COBRA (again, usually unsubsidized) does count for purposes of the W-2 Safe Harbor.[107]	W-2 wages are used, which provides some level of employer control. However, employers may not always precisely know wages in the middle of the year due to bonuses or other variable compensation.

[103] 26 CFR 54.4980H-5(e)(2)(iv).
[104] 26 CFR 54.4980H-5(e)(2)(iv).
[105] This example is from 26 CFR 54.4980H-5(e)(v), Ex. 6.
[106] 26 CFR 54.4980H-5(e)(2)(ii)(A).
[107] 26 CFR 54.4980H-5(e)(2)(ii)(A).

Additional Detail on Form W-2 Safe Harbor. The Form W-2 Safe Harbor has a few additional details to note. First, the IRS expects that the affordability determination under the Form W-2 Safe Harbor will be made after the end of the calendar year.[108] For example, an employer would determine whether it met this affordability test for 2015 for an employee by looking at that employee's W-2 wages for 2015 and comparing 9.5% of that amount to the employee's 2015 employee contribution.[109] An employer is not permitted to, under the W-2 Safe Harbor, make discretionary adjustments to the employee's required contribution in order to satisfy the W-2 Safe Harbor.[110] Rather, the employee's required contribution must remain a "consistent amount or percentage" of all Form W-2 wages for the year.[111]

The IRS regulation also provides an adjustment if an employee did not work the entire year. In essence, an employee's Form W-2 wages are adjusted downward, by a proportionate amount, for an employee who did not work an entire year.[112]

Employee Exchange Subsidy Uses Alternative Test. It appears that these "safe harbors" for employers would not apply to an employee's eligibility for an Exchange subsidy. In other words, some individuals will be deemed to have "affordable" employer coverage for purposes of the employer penalty under the Pay or Play Rule yet have "not affordable" coverage for Exchange subsidy purposes. For these employees, the employer will not owe the penalty tax. However, those same employees may still qualify for an Exchange subsidy.[113]

Wellness Plan Rewards and Affordability. As discussed above, the affordability test is based on whether the plan charges more than 9.5% of an employee's wages for self-only coverage. Proposed IRS regulations provide that affordability for these purposes will, like minimum value (as described in Step 6(b) above), consider only tobacco-related wellness program discounts.[114] However, the final Pay or Play regulations do not adopt this guidance and appear to limit this guidance to plan years beginning prior to January 1, 2015.[115] Thus, the more cautious approach is to ignore tobacco-related wellness program discounts when calculating affordability. In any event, discounts for other wellness program activities (such as exercise or having acceptable blood sugar or cholesterol levels) will be ignored for affordability purposes.

HRAs and Affordability. Under earlier guidance, it appeared that amounts an employer newly makes available for the current plan year under an integrated HRA would be considered — and could assist the employer — for affordability purposes under the Pay or Play Rule. According to

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[108] 26 CFR 54.4980H-5(e)(2)(ii)(A).
[109] IRS Notice 2011-73, II.
[110] 26 CFR 54-4980H-5(e)(2)(ii)(A).
[111] 26 CFR 54.4980H-5(e)(2)(ii)(A).
[112] 26 CFR 54.4980H-5(e)(2)(ii)(B).
[113] IRS Notice 2011-73, II. This concept was adopted in the IRS final regulation. 26 CFR 54.4980H-5(e)(2). For example, an employee's household income may be less than W-2 wages due to adjustments to gross income for alimony paid or losses due to self-employment. Such an employee may qualify for subsidized Exchange coverage. The IRS safe harbor would not penalize the employer in this situation.
[114] See 78 Fed. Reg. at 25911. As noted in footnote 84 above, the preamble to the proposed regulations provides transition relief from the Pay or Play Rule for plan years beginning before January 1, 2015 with respect to reward-based wellness plans. Several requirements must be satisfied to qualify for the transition relief, including that the applicable wellness program must have been in effect on May 3, 2013. Based on the delayed effective date of the Pay or Play Rule, this transition rule will likely only benefit employers with non-calendar year plans.
[115] 79 Fed. Reg. at 8570, providing that the preamble to the proposed minimum value regulations provide "transition guidance" under section 4980H for determining affordability and MV as related to wellness programs for plan years of an employer's group health plan "beginning before January 1, 2015."

the IRS, this rule would apply only if the employee may use the amounts only for premiums or may choose to use the amounts for either premiums or cost-sharing.[116] However, the final Pay or Play Rule regulations do not adopt this guidance. Thus, it appears that the more cautious approach is to disregard amounts available under an HRA when calculating affordability.

[116] See 78 Fed. Reg. at 25911.

The remainder of this Guide (including Step 7, the Summary and Appendices -- a total of 50 additional pages) is available by sending an email to John Barlament at john.barlament@quarles.com

Thank you!