Health Care Reform Summary

Patient Protection and Affordable Care Act (PPACA)

Contents

The following information summarizes the PPACA's impact on employers, individuals, the health industry and plan design, and Exchanges. This information is not legal or tax advice, but is for discussion purposes only and should not be relied on solely to determine compliance with the PPACA. Many aspects of the PPACA are being developed and this information is subject to change. Readers of this information should seek advice from an independent tax advisor and/or legal counsel familiar with their particular circumstances.

Employers

1. **Anti-Abuse Rules –** The Treasury Department and the IRS are aware of various structures under which employers might attempt to manipulate and evade application of Section 4980H, also known as the Employer Mandate. Final regulations will provide further guidance. Complaints from employees will be investigated by OSHA.

2. **Controlled Groups and Affiliated Services Groups –** For the purpose of counting the number of full-time and full-time equivalent (FTE) employees for determining whether an employer is an applicable large employer (ALE), section 4980H provides that all entities treated as a single employer under section 414(b), (c), (m), or (o) are treated as a single employer for the purposes of determining if the Employer Mandate applies. Therefore, all employees of a controlled group under section 414(b) or (c), or an affiliated services group under section 414(m), are taken into account in determining whether the members of the controlled group or affiliated services group together constitute an ALE.

3. **Employer Mandate/Play or Pay/Section 4980H** – Effective 2015, an applicable large employer (ALE) as defined by the PPACA, must offer minimum essential coverage to employees and dependents or pay a penalty to the IRS. An ALE is one who employs 50 or more full-time and full-time equivalent employees during the 12 calendar months of the preceding calendar year. For example, an employer's employee population in 2015 determines whether it will be subject to the employer mandate for 2016. All employees of controlled groups and affiliated services groups must be taken into consideration regarding ALE status.

   When an employer becomes an ALE for the first time, the employer must provide minimum essential coverage (MEC) no later than April 1st to avoid the 4980H(a) penalty. This rule applies only during the first year that an employer is an ALE and would not apply if, for example, the employer falls below the 50 employee threshold for a subsequent calendar year and then increases employment and becomes an ALE again.

   Determination of whether an employer that was not in existence in the preceding calendar year is an ALE is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

   A. Determine Applicable Large Employer (ALE) Status:
   A full-time employee means, with respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week. A full-time equivalent employee (FTE) means a combination of employees, each of whom individually is not treated as a full-time employee because they are not employed on average at least 30 hours of service per week. The FTE count is calculated by adding the number of hours of service in a calendar month for all non full-time employees dividing by 120. An "hour of service" includes each hour for which the employee is paid for the performance of duties and for periods of paid time off due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, leave of absence, etc. See the ACA Company Size Calculator at FrankCrum.com and at the end of this document.

To determine the total number of full-time employees the employer must:

1) Count the number of full-time employees who were employed for 30 or more hours of service per week per calendar month. This would be any employee with 130 hours of service or more regardless of fluctuations from week to week. Perform this step for all 12 calendar months.

2) Combine the number of hours of service of all non-full-time employees for the month, up to 120 hours (disregard the hours between 120.1 and 129.9 and only use 120). Divide the aggregate number by 120. If the result is a fraction, it must be used exactly. Perform this step for all 12 calendar months.

3) Add the number of full-time employees and FTE's calculated in steps (1) and (2) for each of the 12 calendar months and include fractions exactly. Add the monthly totals, and divide by 12. Round down to the next lowest whole number.

4) If the result is 50 or more full-time and full-time equivalent employees, determine whether the seasonal worker exception applies. A seasonal worker is one who performs services on a seasonal basis, as defined by the Secretary of Labor, including but not limited to workers covered by 29 CFR 500.20(s)(1) and retail workers employed exclusively during holiday seasons. In identifying a seasonal worker, an employer may use a reasonable good faith interpretation. If the seasonal worker exception applies, for each month with 50 or more, subtract the number of seasonal workers for that calendar month. This exception applies only if there are four (4) consecutive months or less with 50 or more employees. This final result determines applicable large employer status. If the final result is 50 or more, the Employer Mandate applies.

   Sample Calculation for One Calendar Month: A company has 44 full-time (30 hours or more) employees, 21 part-time employees who each happened to have exactly 24 hours of service for a four week calendar month. The part-time employees' hours would be treated as the equivalent of 16.8 full-time equivalent employees based on the following calculation: (21 X 24 X 4) = 2,016 hours, divided by 120 = 16.8 FTEs.

B. <u>Determine Applicable Large Employer (ALE) Tax Penalty</u>:

   1) If an ALE <u>does not offer</u> minimum essential coverage or does not offer coverage to at least 95% of its full-time employees and their dependents, and with either scenario, one or more employees obtain a premium tax credit through an Exchange, the employer owes a monthly 4980H(a) penalty amount equal to the number of full-time employees (minus 30) multiplied by $1/12^{th}$ of $2,000 (as indexed). An employer is allowed to exclude 30 full-time employees from the penalty calculation. This only relates to the full-time employee count, not the full time equivalent employee count.

Sample 4980H(a) Penalty Calculation: A company with 55 full-time employees in a month minus 30 equals 25 employees to base the penalty amount on. If just one full-time employee obtains subsidized coverage through the Exchange, the employer owes (25 multiplied by $167.00 as indexed) a penalty of $4,175 for that month. This is analyzed and calculated by the IRS on a monthly basis.

2) If a large employer <u>does offer</u> minimum essential coverage to at least 95% of all full-time employees and their dependents but one or more employees obtain a premium tax credit through an Exchange because:
   - ✓ They are one of the 5% or 5, whichever is greater, that were not offered coverage, or
   - ✓ The plan does not meet minimum value (60%), or
   - ✓ The employee's cost of premium for single coverage exceeds 9.5% (as indexed) of the employee's gross wage,

   the employer owes an amount equal to the number of employees receiving the subsidy (premium tax credit) for a given month multiplied by 1/12th of $3,000 ($250/month as indexed). This 4980H(b) penalty will not exceed the penalty that would apply if the employer offered no coverage (which is the 4980H(a) penalty).

   Sample 4980H(b) Penalty Calculation: One employee who obtains subsidized coverage for three months equals a total of three penalty months. Three (3) multiplied by $250 equals a penalty of $750.

An employee is not eligible for the Federal subsidy (tax credit) if the employer meets the following conditions: (a) the employer offers a group health plan to at least 95% of full-time employees and their dependents, (b) the plan offered has a minimum value of at least 60% and includes hospitalization and physician services, and (c) the employee's paycheck deduction for single coverage is not more than 9.5% (as indexed) of the employee's gross wages.

C. <u>Determine Eligibility and Coverage</u>:
Applicable large employers who employ variable hour/seasonal employees and who offer coverage will use the following terms to determine who must be offered health coverage and when coverage must be offered. It is critical that the employer obtain written (or electronic) confirmation of the employee's choice to enroll or decline to defend against IRS penalty assessments. See the "Variable Hour Calculator for Large Employers" spreadsheet at FrankCrum.com and at the end of this document.

Applicable large employers will use the following terms to "look back" and measure eligibility (Initial and Standard Measurement Periods), notify and enroll employees (Administrative Period), and provide on-going coverage or no coverage (Stability Period). The two types of measurement periods can be pay period based as long as they equate to a 3-12 month measurement. (Example: A month measurement could be March 26 through March 25.)

1) Initial Measurement Period – The 3-12 consecutive month timeframe used for tracking (locking-in) the hours of service of a newly hired variable hour/seasonal employee. This period can begin on the date of employment or on the first day of the month following the date of employment. If the Initial Measurement Period begins on the first of the month following the date of employment, the time between the date of employment and the first of the following month must be included in the Administrative Period time limit.

2) Standard Measurement Period – The 3-12 consecutive month timeframe used for tracking (locking-in) the hours of service of an existing variable hour/seasonal employee. This date will coincide with the Plan anniversary date which can be either calendar year or fiscal year based.

3) Administrative Period – A period of time, not to exceed 90 days, immediately after the close of a measurement period to allow employers to run reports, communicate, and enroll employees as necessary in advance of the stability period. Administrative periods cannot extend or reduce the measurement or stability periods. The Initial Measurement Period and the Administrative Period combined may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date, totaling at most 13 months and a fraction of a month. (Example: A hire date of 01/07/2014 could have a maximum combined Initial Measurement Period plus an Administrative Period ending no later than 02/28/2015 with an effective date of coverage no later than 03/01/2015.)

4) Stability Period – The period of time that follows the close of a measurement period (and any subsequent administrative period) during which an employee is continuously treated as either a fulltime or a non-fulltime employee (based on the hours of service in the prior measurement period), regardless of the number of hours of service during the current stability period. Stability periods cannot be less than six (6) months or less than the length of the measurement period, whichever is greater.

Applicable large employers (ALE) will use the following terms to identify employee types.

1) New Employee: An employee who is newly hired and is expected to be employed on a generally consistent basis as either fulltime (30 or more hours of service per week) or part-time (less than 30 hours per week). The waiting period for a fulltime employee to begin coverage can be no longer than 90 calendar days. Therefore, offering coverage as of the first of the month following 90 days of employment is no longer lawful.

2) New Variable Hour/Seasonal Employee:
A variable hour employee means an employee who, based on the facts and circumstances at the start date, cannot be determined that they will be

reasonably expected to be employed on average at least 30 hours of service per week, or determined they will be part-time.

A seasonal employee means an employee in a position for which the customary annual employment is generally six months or less. The reference to customary means that by the nature of the position an employee in this position typically works for a period of six months or less and that period should begin each year in approximately the same part of the year.

To determine whether the large employer's health plan must be offered to a newly hired variable hour/seasonal employee, the employer will use the Initial Measurement Period and evaluate for hours of service to be an average of 30 or more per week of the employee's 3-12 consecutive month measurement period. For example, a large employer with a 12 month Initial Measurement Period would offer coverage after the end of the measurement period (and any subsequent Administrative Period) to any variable hour/seasonal worker who averaged 30 or more hours of service in the measurement period. A variable hour/seasonal employee not meeting the threshold of an average 30 hours of service per week is not a full-time employee and is not required to be offered coverage.

A newly hired variable hour/seasonal employee who has a change in status (increases their hours of service, possibly because of a promotion, to 30 hours or more during the Initial Measurement Period) is treated as a full-time employee as of the first day of the fourth month following the change in employment status, but not later than the first day of the first month following the end of the Initial Measurement Period. (Example: A newly hired variable hour/seasonal employee's date of employment is 11/03/2014 and changes to a position working full-time hours on 01/07/2015 (the employer maintains an Initial Measurement Period of 12 months) this employee would need to be offered coverage with an effective date no later than May 1, 2015.) The change in employment status rule only applies to newly hired variable hour/seasonal employees. A change in employment status for an ongoing employee does not change the employee's status as a full-time or non full-time employee during the Stability Period.

3) Ongoing Employee: Any employee who has been employed for at least one Standard Measurement Period.

4) Employee Rehired or Resuming Employment After an Unpaid Absence: An employee returning after 26 unpaid weeks may be treated as a new employee. Other parity rules may be permitted.

An employee determined to be a fulltime employee during a measurement period must be treated as such during the Stability Period, which would be at least the greater of six consecutive months or the length of the Standard Measurement Period.

An employee determined not to be a fulltime employee during a measurement period may be treated as a non-fulltime employee during the Stability Period, which cannot be longer than the measurement period.

Listed below are illustrations of how the measurement periods (Initial and Stability), the intermediate period of running reports and communicating to employees (Administrative Period), and the period where coverage/non-coverage remains stable (Stability Period) work together. These illustrations include the following scenarios:

1) Ongoing Employee

2) Newly Hired Variable Hour/Seasonal Employee

3) Newly Hired Variable Hour/Seasonal Employee Transition to Ongoing Employee

Illustration 1) - Ongoing Employee

Standard Measurement Period: Used for identifying ongoing variable hour employees' hours of service. 12 months in length.
Administrative Period: Used to process reports, evaluate for average weekly hours of 30 or more, and notify eligible employees. 90 days in length.
Stability Period: Coincides with Plan Year, coverage/non-coverage continues regardless of hours in this period. 12 months in length.

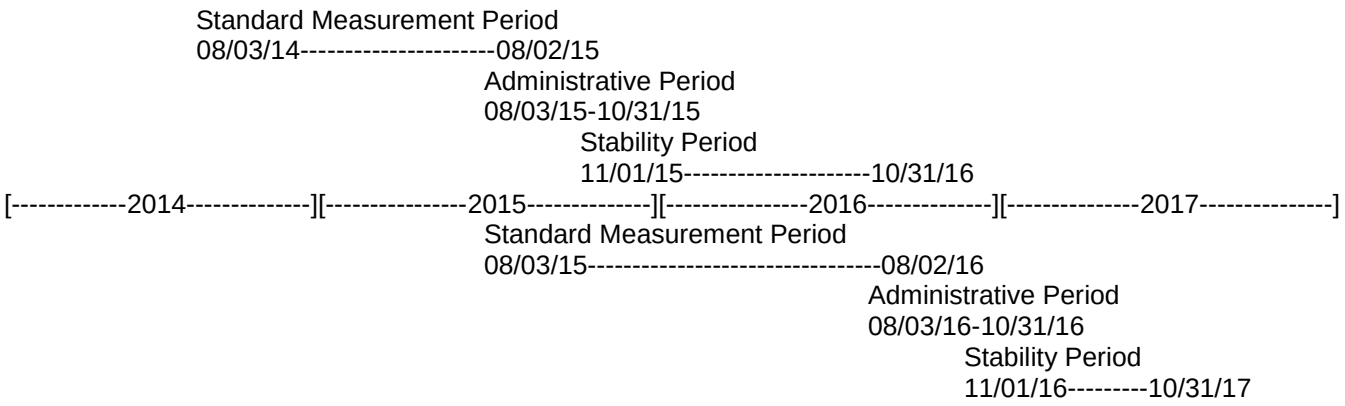


Illustration 2) – Newly Hired Variable Hour/Seasonal Employee

Initial Measurement Period: Used for tracking a new ongoing variable hour employee's hours of service beginning on their DOE. 11 months in length.
Administrative Period: Used to process reports, evaluate for average weekly hours of 30 or more, and notify the eligible employee. 2+ months in length.
Initial Stability Period: Coverage/non-coverage continues regardless of hours of service. 12 months in length.

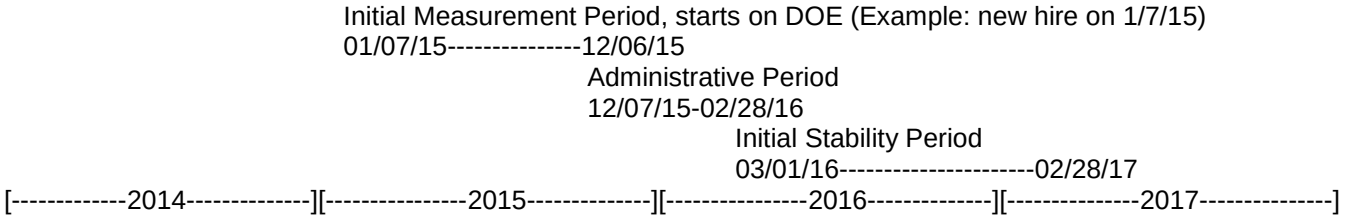
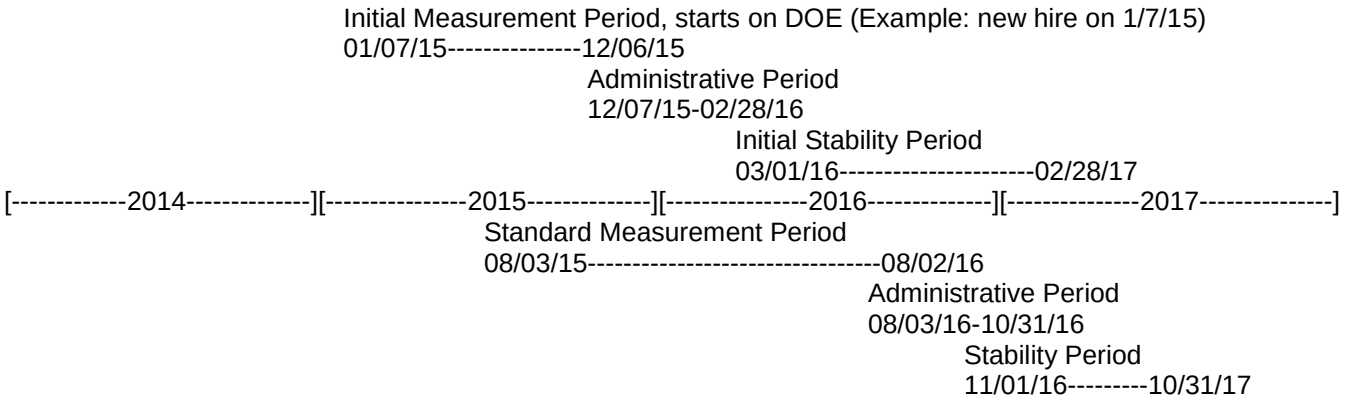


Illustration 3) – Newly Hired Variable Hour/Seasonal Employee Transition to Ongoing Employee

Initial Measurement Period: Used for tracking a new ongoing variable hour employee's hours of service and can begin on DOE. 11 months in length.

Administrative Period: Used to process reports, evaluate for average weekly hours of 30 or more, and notify the eligible employee. 2+ months in length.

Initial Stability Period: Coverage/non-coverage continues regardless of hours of service. 12 months in length.



If the employee is <u>determined to be full-time</u> in the Initial Measurement Period of 01/07/15–12/06/15 (therefore offered coverage in the Initial Stability Period of 03/01/16–02/28/17), the employee must be tested again on 08/03/16 since they were employed during the Standard Measurement Period 08/03/15-08/02/16. If the employee <u>tests as still full-time</u>, in the Standard Measurement Period, the employee must be given coverage in the Stability Period of 11/01/16-10/31/17 (automatically gaining coverage for the period 03/01/17-10/31/17). If the employee <u>tests as no longer full-time</u> on 08/03/16, the employee must be allowed to continue coverage through the end of the Initial Stability Period 2/28/17, however, coverage terminates 02/28/17 because of the loss of full-time status. The employee will be tested next on 08/3/17 for the Standard Measurement Period of 08/3/16-08/2/17.

If the employee is <u>determined to be not full-time</u> in the Initial Measurement Period of 01/07/14–12/06/14 (therefore not offered coverage in the Initial Stability Period of 03/01/15–02/28/16), the employee must be tested again on 08/03/15 since they were employed during the Standard Measurement Period 08/03/14-08/02/15. If the employee <u>tests as full-time</u>, in the Standard Measurement Period, the employee must be given coverage in the Stability Period of 11/1/15-10/31/16. If the employee <u>tests as still not full-time</u> on 08/03/15, the employee will be tested next on 8/3/16 for the Standard Measurement Period of 08/03/15-08/02/16.

D. Affordability Safe Harbors

Because employers generally will not know their employees' household incomes, employers can take advantage of one or more of the three affordability safe harbors set forth in the final regulations that are based on information the employer will have available, such as the employee's Form W-2 wages or the employee's rate of pay. If an employer meets the requirements of any of these safe harbors, the offer of coverage will be deemed affordable for purposes of the Employer Shared Responsibility provisions regardless of whether it was affordable to the employee for purposes of the premium tax credit.

The three affordability safe harbors are (1) the Form W-2 wages safe harbor, (2) the rate of pay safe harbor, and (3) the federal poverty line safe harbor. These safe harbors are all optional. An employer may use one or more of the safe harbors only if the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that provides minimum value for the self-only coverage offered to the employee. An employer may choose to use one or more of the safe harbors for all of its employees or for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost self-only option available to the employee that also meets the minimum value requirement

1) Form W-2 Safe Harbor

   Application of this safe harbor is determined after the end of the calendar year and on an employee-by-employee basis, taking into account the employee's annual W-2 wages (as reported in Box 1) and the employee contribution for the full calendar year for the employer's lowest-cost self-only coverage that provides minimum value. For example, the employer would determine whether it met the affordability safe harbor for 2015 for an employee by looking at that employee's W-2 wages for 2015 (as reported in Box 1) and comparing 9.5% (as adjusted) of that amount to the employee's required 2015 employee contribution.

2) Rate of Pay Safe Harbor

   The rate of pay safe harbor provides employers with a design-based method for satisfying affordability without having to analyze each employee's wages and hours. Unlike the W-2 safe harbor (under which income is uncertain until after the end of the year and subject to variables outside the employer's control, such as the amount of the employee's pre-tax contributions to a 401(k) plan), the rate of pay safe harbor is easy to apply prospectively and avoids the need to analyze each employee's Form W-2 after the end of the year.

   Under this safe harbor, for an hourly employee, the employer uses 130 hours per calendar month multiplied by an hourly employee's rate of pay, regardless of whether the employee actually works more than 130 hours during a calendar month. The affordability calculation under the rate of pay safe harbor is not altered by a leave of absence or reduction in hours worked. Thus, for example, if

an hourly employee treated as a full-time employee earns $10 per hour in a calendar month (and earned at least $10 per hour as of the first day of the coverage period) but has one or more calendar months in which the employee has a significant amount of unpaid leave or otherwise reduced hours, the employer may still require an employee contribution of up to 9.5% (as adjusted) of $10 multiplied by 130 hours ($123.50). The final regulations permit an employer to apply the rate of pay safe harbor to an hourly employee even if the employee's rate of pay is reduced during the year. In this situation, 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.

An offer of coverage to a non-hourly employee is treated as affordable for a calendar month if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as adjusted) of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available. If coverage is offered during at least one day during the calendar month, the entire calendar month is counted both for purposes of determining the assumed income for the calendar month and for determining the employee's share of the premium for the calendar month.

The preamble to the final regulations notes that the rate of pay safe harbor cannot be used, as a practical matter, for tipped employees or for employees who are compensated solely on the basis of commissions. In those situations, employers can use the two other affordability safe harbors, Form W-2 wages and federal poverty line, for determining affordability for employees whose compensation is not based on a rate of pay.

3) Federal Poverty Line Safe Harbor

If an employer's offer of coverage is affordable to all employees who earn more than 100% of the federal poverty line, then the affordability standard is satisfied. This safe harbor is the easiest to apply since the employer has to do just one calculation and can ignore employees' actual wages (which, depending on fluctuations in hours or rates of pay, may cause problems under the other safe harbors).

Employer-provided coverage offered to an employee is affordable if the employee's monthly cost for self-only coverage under the plan does not exceed 9.5% (as adjusted) of the federal poverty line for a single individual divided by 12 (to convert the poverty level from an annual to a monthly amount). It is irrelevant whether any employees are members of a family. Since the poverty line for single individuals is less than the poverty line for families, using the amount for single individuals will always be most favorable to employees. Employers are

permitted to use the guidelines in effect six months prior to the beginning of the plan year, to provide employers with adequate time to establish premium amounts in advance of the plan's open enrollment period.

4. **Exchange Notification** – Employers covered by the FLSA must notify all new employees within 14 days of hire regarding the Individual Mandate and Federal/state exchanges.

5. **FSA Maximum** – Effective 2013, the annual maximum an employee can have deducted from their pay for medical expense reimbursement in a Flexible Spending Account (FSA) is $2,500 (as adjusted). The employer must amend their Plan documents if the document does not indicate the maximum.

6. **Grandfather/Non-Grandfather Status** – Effective 2010, employers with existing plans determined whether they would designate their plan as having grandfathered status to take advantage of having an exemption from some aspects of the PPACA or accept non-grandfathered status. All new plans effected after 3/23/2010 are automatically non-grandfathered and all aspects of the PPACA apply. Grandfathered plans are not exempt from the employer mandate.

7. **High Cost Health Plan Tax on "Cadillac" Plans** – Effective 2018, employers will be assessed a 40% excise tax on the annual value of employer provided health coverage that exceeds $10,200 for single coverage or $27,500 for family coverage.

8. **Medicare Tax** – Effective 2013, the new .9% additional Medicare tax applies to an individual's wages, Railroad Retirement Tax Act compensation, and self-employment income which exceeds $200,000. There is no match from the employer for this tax.

9. **Non-Discrimination Testing** – This requirement was set to take effect for plan years beginning on or after September 23, 2010. However, it has been delayed indefinitely pending the issuance of regulations. The regulations will specify the new effective date. Fully insured group health plans will have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This reform does not apply to grandfathered plans.

10. **Notification Regarding Material Changes** – Effective 2012, employers must provide employees with at least 60 days advance notice of material changes.

11. **Patient Centered Outcome Research Institute (PCORI)** – Effective July, 2013, the PCORI, a private, nonprofit corporation whose purpose is to "assist, through research, patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings" begins its role in health care reform. The fees described in the final rule apply to policy and plan years ending on or after October 1, 2012, and before October 1, 2019.

12. **Reinsurance Assessment (Pre-existing Condition Fee)** – Effective 2014, the contribution rate will be $5.25 per covered life per month. A covered life is based on the total number of lives covered under the plan, not just the number of employees enrolled.

13. **Reporting Requirements** – Effective for the 2015 tax reporting year (reported in early 2016), Code Sections 6055 and 6056 of the ACA require health insurance issuers, employers, sponsors of self-insured health plans, government agencies that administer government-sponsored health insurance programs, and other entities that provide coverage to file annual returns and to provide forms to employees. Below are the various categories and applicable forms.

ALE Fully Insured

Responsible Party	IRS Form	Form Parts Required
Insurer	1094-B Transmittal form to IRS	All
Insurer	1095-B Form to employee	I, II, III, and IV
Employer	1094-C Transmittal form to IRS	I, II, III, and IV
Employer	1095-C Form to employee	I and II

ALE Self Insured

Responsible Party	IRS Form	Form Parts Required
Employer	1094-C Transmittal form to IRS	I, II, III, and IV
Employer	1095-C Form to employee	I, II, and III

Non-ALE Fully Insured

Responsible Party	IRS Form	Form Parts Required
Insurer	1094-B Transmittal form to IRS	All
Insurer	1095-B Form to employee	I, II, III, and IV

Non-ALE Self Insured

Responsible Party	IRS Form	Form Parts Required
Employer	1094-B Transmittal form to IRS	All
Employer	1095-B Form to employee	I, III, and IV

Form 1094-C: Transmittal to the IRS by the ALE
Form 1094-B: Transmittal to the IRS by the insurer
Form 1095-C: Issued to the employee by the ALE
Form 1095-B: Issued to the employee by the insurer

14. **Small Business Tax Credit** – Effective 2010 through 2013, the maximum credit is 35 percent for small business employers and 25 percent for small tax-exempt employers such as charities. Effective 2014, employers with no more than 25 fulltime equivalent employees and annual average wages of less than $50,000 can receive a tax credit of 50% for offering a health insurance plan to their employees. The tax credit will be up to 35% of the employer's contribution (up to 50% beginning in 2014).

15. **Summary of Benefits and Coverage and Uniform Glossary** – Effective 2012, health insurance issuers and group health plans must provide health plan participants and enrollees with information to better help them understand the plan's benefits and coverage. The requirement to provide a summary of benefits and coverage (SBC) and uniform glossary applies for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), these requirements apply beginning on the first day of the first plan year that begins on or after September 23, 2012. The SBC must be provided when potential enrollees are shopping for coverage, when they actually apply for coverage, at each plan year, and upon request. In addition, health insurance issuers and group health plans must also provide access to a glossary of common terms used in health insurance with easy-to-understand definitions. Enrollees and policyholders must be notified of any significant changes in coverage that will occur in the middle of the plan year at least 60 days before such changes take effect.

16. **W-2 Reporting** – Effective 2012, employers must report the total annual premium of the employer sponsored healthcare coverage on each covered employee's Form W-2.

17. **Whistleblower Protection** – Individuals who file a complaint with the Occupational Safety and Health Administration (OSHA) regarding an employer who violates the PPACA or takes other adverse action, such as termination of an employee to avoid insurance coverage, will be afforded whistleblower protection. Final regulations will be published in 2013.

Individuals

18. **Health Insurance Premium Tax Credit** – Effective 2014, subsidies (premium credit) will become available to some individuals through state and federally facilitated exchanges. The subsidy is available to individuals with income between 100% and 400% of the poverty level, who are not offered a health plan by their employer, or who are offered a health plan by their employer, but the plan does not meet minimum essential coverage, have minimum value (60%), or costs more than 9.5% (as adjusted) of the employee's compensation to obtain a plan at the employee only coverage tier.

19. **Individual Mandate** – Effective 2014, tax payers (and their spouse and dependents) must have minimum essential coverage for each calendar month, qualify for an exemption, or pay a penalty when filing their 2014 taxes in 2015. The penalty will be phased-in according to the following schedule: 2014 = $95, 2015 = $325, and 2016 = $695 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. The penalty is the greater of the flat fee or percentage of taxable income and may be increased annually by a cost-of-living adjustment. Exemptions may be granted for financial hardship, religious objections,

Indian tribes, those without coverage for up to two (2) months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 9.5% (as adjusted) of an individual's income, members of a health care sharing ministry, and those with incomes below the tax filing threshold.

20. **Medicaid Expansion** – Effective 2014, Medicaid expands to non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

Health Industry and Plan Designs

21. **90 Day Waiting Period Maximum** – Effective 2014, a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period that exceeds 90 days.

22. **Administrative Simplification Provision** – Effective 2013, section 1104 of the ACA amended certain Administrative Simplification Provisions of HIPAA. Specifically Section 1104(b)(b)(h) of the ACA requires health plans to file a certification statement with HHS no later than December 31, 2013, certifying that the data and information systems for the plan are in compliance with the standards and operating rules for health plan eligibility, electronic funds transfer (EFT), health claim status, health care payments and remittance advice transactions. This certification requirement applies to all plans, regardless of their grandfathered status.

23. **Annual Benefit Limit Restriction** – Effective 2010, group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime limits or unreasonable annual limits on the dollar value of essential health benefits. This requirement applies to all plans, although plans were allowed to request a waiver of the annual limit requirement through HHS. The annual limit waiver program closed to applications effective Sept. 22, 2011. All annual limits will also be prohibited beginning in 2014.

24. **Auto Enrollment** – This provision of the ACA was repealed on November 2, 2015.

25. **Claims and Appeals Process Enhancements** – Currently being developed, this portion of the ACA requires both group health insurance issuers and group health plans to establish internal claims and appeals and external review processes for adverse benefit determinations. Those processes require the plan and issuer to disclose evidence relied upon in making an adverse benefit determination, to disclose any new rationale for upholding an adverse benefit determination as part of an internal appeal, to provide notice of an adverse benefit determination and of a final internal adverse benefit determination, and to disclose the right to an external review. Under the temporary regulations, if a health insurance issuer satisfies the obligations to have effective

internal claims and appeals and external review processes (including these information collection requirements that are an inherent part of those processes), those obligations are satisfied not just for the issuer but also for the group health plan. For group health plans maintained by small entities, it is anticipated that the health insurance issuer will satisfy those obligations to have effective internal claims and appeals and external review processes (including these information collection requirements that are an inherent part of those processes) for both the plan and the issuer in almost all cases.

26. **Clinical Trial Coverage Cannot Be Denied** – Effective January 2014, if a qualified individual is in an approved clinical trial, the plan cannot deny coverage for related services. An approved clinical trial is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application).

27. **Dependent Coverage Through Age 26** – Effective 2010, group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage of children must make coverage available for adult children up to age 26. There is no requirement to cover the child or spouse of a dependent child. This requirement applies to grandfathered and non-grandfathered plans. However, grandfathered plans need not cover adult children who are eligible for other employer-sponsored coverage, such as coverage through their own employer, until 2014.

28. **Emergency Services Without Prior Authorization** – Plans that cover emergency services are required to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level. The regulations require that plans or issuers not seek pre-authorization or pre-certification for emergency services.

29. **Essential Health Benefits** – Effective 2014, non-grandfathered plans in the small group market (both in and outside of the Exchanges) must offer essential health benefits. Grandfathered plans, self-insured group health plans, and health insurance coverage offered in the large group market are not required to offer essential health benefits. Essential health benefits include the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitation services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. An essential health benefits package must include the 10 benefits listed above, limit cost-sharing, and provide either bronze, silver, gold, or platinum level coverage (60/70/80/90% respectively of the full actuarial benefits provided under the plan).

30. **Guarantee Issue and Renewability** – Effective 2014, requires guarantee issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual, the small group market, and the Exchange.

31. **Lifetime Limit Prohibition** - Group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime limits or unreasonable annual limits on the dollar value of essential health benefits. This requirement applies to all plans, although plans were allowed to request a waiver of the annual limit requirement through HHS. The annual limit waiver program closed to applications effective Sept. 22, 2011. All annual limits will also be prohibited beginning in 2014.

32. **Medical Loss Ratio** – Effective 2011, insurance companies are required to spend a specified percentage of premium dollars on medical care and quality improvement activities, meeting a medical loss ratio (MLR) standard. Insurance companies that were not meeting the MLR standard were required to provide rebates to their consumers beginning in 2012.

33. **Minimum Essential Coverage** – Effective 2014, the individual mandate tax penalty is assessed against any applicable individual who does not have minimum essential coverage (MEC). MEC coverage is the 63 immunization and wellness services defined by the Department of HHS, under any of the following: (1) a government-sponsored program, including coverage under Medicare Part A, Medicaid, the CHIP program, and TRICARE; (2) an eligible employer-sponsored plan; (3) a health plan offered in the individual market; (4) a grandfathered health plan; or (5) other health benefits coverage such as a state health benefits risk pool.

34. **Minimum Value** – Qualified health insurance plans must meet a 60 percent minimum actuarial value threshold which includes hospitalization and physician services. Actuarial value is the amount of expected healthcare expenses that health insurance plans must cover. Enrollees are responsible for the remaining costs in the form of deductibles, coinsurance, and co-pays.

35. **Patient Protections** – The ACA's Patient's Bill of Rights includes the following protections: Helps children with pre-existing conditions gain health insurance coverage; Stops plans from retroactively cancelling policies when patients become sick; Bans lifetime caps on coverage and restricts plans' ability to impose annual limits on; benefits; Protects consumers' choice of primary care doctor, and allows women to go directly to their OB/GYN without a referral; Helps protect people from incurring medical debt in a time of emergency by requiring insurers to meet new cost-sharing requirements for emergency services

36. **Pre-Existing Condition Prohibition Under Age 19** – Effective 2010, health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage

for children under age 19. This provision applies to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.

37. **Preventive Care Without Cost Sharing** – Health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for certain preventive care services without cost-sharing (for example, deductibles, copayments or coinsurance). Grandfathered plans are exempt from this requirement.

38. **Rescission Prohibition** – Effective 2010, health care reform prohibits rescissions, or retroactive cancellations, of coverage, except in cases of fraud or intentional misrepresentation. Also, plans and issuers must provide at least 30 days' advance notice to the enrollee before coverage may be rescinded. This provision applies to all grandfathered and non-grandfathered plans.

39. **Wellness Program Incentives** – Proposed rules effective for plan years beginning on or after January 1, 2014, codify the existing HIPAA rules allowing employee wellness programs to offer an incentive, such as a premium reduction, for achieving a health standard and increases the maximum amount of the incentive from 20%, as the current HIPAA rules allow, to 30% of the cost of employee-only coverage under the plan, and up to 50% for wellness programs designed to prevent or reduce tobacco use. The proposed rule addresses both "participatory wellness programs" such as reimbursement for gym memberships and awards to employees who attend health-related seminars, which are generally available to all employees regardless of their health status, as well as "health-contingent wellness programs," which provide rewards to employees who meet a specific health-related standard. For example, these types of wellness programs often provide rewards to employees who do not smoke or reduce their tobacco use, or who maintain a certain cholesterol level or take steps to reduce their current level.

Exchanges/Health Insurance Marketplace

40. **Consumer Operated and Oriented Plan** – This proposed rule would implement the Consumer Operated and Oriented Plan (CO-OP) program, which provides loans to foster the creation of consumer-governed, private, nonprofit health insurance issuers to offer qualified health plans in the Affordable Insurance Exchanges (Exchanges). The purpose of this program is to create a new CO-OP in every State to expand the number of health plans available in the Exchanges with a focus on integrated care and greater plan accountability. Because of the tax law changes for 2013, this may not be a viable option.

41. **Federal** – Exchanges will perform a variety of functions, including: certifying health plans as QHPs to be offered in the Exchange; operating a website to facilitate comparisons among qualified health plans for consumers; operating a toll-free hotline for consumer support, providing grant funding to entities called "Navigators" for consumer assistance, and conducting outreach and education to consumers regarding Exchanges; determining eligibility of consumers for enrollment in qualified health plans

and for insurance affordability programs (premium tax credits, Medicaid, CHIP and the Basic Health Plan); and facilitating enrollment of consumers in qualified health plans.

The final rule allows Exchanges to work with health insurers on structuring QHP choices. This could mean that the Exchange allows any health plan meeting the standards to participate or that the Exchange creates a competitive process for health plans to gain access to customers on the Exchange.

Exchanges will use an integrated enrollment system to allow individuals to enroll in health coverage. The final rule outlines the enrollment process, which will incorporate websites and toll-free call centers, along with other consumer tools. Exchanges may also decide whether to use the single application that will be made available or design one on their own that is comparable. The final rule imposes high standards for the privacy and security of personal information during the eligibility and enrollment processes.

42. **Private** – Private companies may offer a solution to very large employers where the employer sends their employees to using a web-based platform to choose their health benefits from certain previously selected insurers. This does not include the range of providers a Federal or State Exchange will, nor is their any tax subsidy option.

43. **Small Business Health Options Program** – The Affordable Care Act directs each state that chooses to operate an Exchange to establish insurance options for small businesses through a Small Business Health Options Program (SHOP). States that choose to operate an Exchange may merge the SHOP with the individual market Exchange. The SHOP will allow employers to choose the level of coverage they will offer and offer the employees choices of all QHPs within that level of coverage. SHOP Exchanges can also allow employers to select a single plan to offer its employees, like is typically done today. The final rule allows minimum participation rules to be met through coverage in any SHOP plan, not a single one. Exchanges will decide how a SHOP is structured. Specifically, the final rule provides flexibility with regard to the size of small businesses that can participate in SHOP. States can set the size of the small group market at either 1 to 50 or 1 to 100 employees until 2016. In 2016, employers with between 1 and 100 employees can participate in a SHOP and starting in 2017, states have the option to let businesses with more than 100 employees buy large group coverage through the SHOP.

44. **State** – Effective 2014, state insurance Exchanges are required to be in place, permitting individuals and certain "small employers" to obtain coverage through the purchase of a qualified health plan. However, depending upon each state's rules, a "small employer" may be limited to employers with either less than 50 or less than 100 employees. Note that access to coverage through an Exchange is limited to U.S. citizens and legal immigrants. If a state does not establish its own exchange, a Federally-facilitated exchange will be available. The final rule allows states that set up their own Exchanges to have flexibility in a number of areas. For example, states will be able to decide whether their Exchange should be operated by a non-profit organization

or a public agency, how to select plans to participate and whether to collaborate with HHS with respect to certain functions. In addition, a state can choose to operate its Exchange in partnership with other states through a regional Exchange or it can operate multiple Exchanges that cover distinct areas within the state.

Funding Mechanisms to Cover the Cost of the PPACA

45. **Employer Shared Responsibility** – Effective 2015, ACA defined large employers will either provide coverage or pay a penalty in 2016 as described in Section 1.

46. **Excise Tax on Cadillac Plans** – Effective 2020, employers will be assessed a 40% excise tax on the annual value of employer provided health coverage that exceeds $10,200 for single coverage or $27,500 for family coverage.

47. **Executive Compensation Deduction Limit** – This provision limits the deductibility of executive compensation for insurance providers if at least 25 percent of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

48. **FSA Limit** – Effective 2013, the annual maximum an employee can have deducted from their pay for medical expense reimbursement in a Flexible Spending Account (FSA) is $2,500. The employer must amend their Plan documents if the document does not indicate this maximum.

49. **Health Insurer Fee** – Effective 2014, a new tax on fully insured health insurance products will begin. Although the tax is levied on health insurance providers, it will be passed on to businesses and the self-employed in the fully insured market in the form of increased premiums.

50. **HSA/MSA Non-Medical Distribution Tax Increase** – Distributions can only be used for qualified medical expenses and a nonqualified distribution is subject to a penalty. The penalty for making nonqualified distributions from increased from 10% to 20%.

51. **Individual Mandate** – Effective 2014, individuals will either buy coverage from their employer, buy coverage through and Exchange, or pay a penalty as described in Section 16.

52. **Itemized Medical Deduction Increase** – The PPACA increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent.

53. **Medical Device Excise Tax** – Effective 2013, a new 2.3-percent medical device excise tax is effective for manufacturers and importers to pay on their sales of certain medical

devices. The new tax does not apply to sales of eyeglasses, contact lenses, and hearing aids. The new tax also does not apply to the sale of any other devices that are of a type generally purchased by the general public at retail for individual use.

54. **Medicare Part D Retiree Tax Deduction Elimination** – Effective 2013, employers who receive subsidies from the federal government for providing prescription drug coverage to retired former employees eligible for Medicare Part D will only be eligible to deduct costs in excess of the subsidy.

55. **Medicare Tax .9%** - Effective 2013, the new .9% additional Medicare tax applies to an individual's wages, Railroad Retirement Tax Act compensation, and self-employment income which exceeds $200,000. There is no match from the employer for this tax.

56. **Net Investment Income Tax 3.8%** - Effective 2013. The 3.8 percent Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above certain threshold amounts. The IRS and the Treasury Department have issued proposed regulations on the Net Investment Income Tax.

57. **Over-The-Counter Drugs Excluded From FSA** – This change reduces the types of items that individuals were previously allowed to exempt from Federal and FICA tax through a Flexible Spending Account.

58. **Patient Centered Outcome Research Institute/Comparative Effectiveness Research Fee** - This Trust finances an "Institute" tasked with advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. The fee is payable by the employer sponsoring self-insured plans and by the insurer of fully insured plans beginning in 2013.

59. **Pharmaceutical Manufacturing Sector Tax** – The Affordable Care Act created an annual fee payable beginning in 2011 by certain manufacturers and importers of brand name pharmaceuticals.

60. **Reinsurance Assessment (pre-existing condition fee)** - Section 1341 of the ACA is known as the "Transitional Reinsurance Program." Part (b)(1)(A) states "health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3 year period beginning January 1, 2014." The annual contribution rate will be $63 per covered life, or $5.25 per covered life, per month in 2014. A covered life is based on the total number of lives covered under the plan, not just the number of employees.

61. **Tanning Tax** – Effective 2010, a 10% excise tax on indoor UV tanning services began.

Implementation Time Table

2010

- A temporary small business tax credit became available for six years for certain small businesses that provide qualified health coverage. The rules include:
    - Only firms with 10 or fewer employees receive the full credit. For firms with 11 to 25 employees, the credit is reduced. Firms with more than 25 employees are ineligible for the credit.
    - Only firms that pay their workers an average wage of $25,000 or less are eligible for the full credit. The credit is reduced as the average wage goes up, phasing out at $50,000.
    - Only firms covering 50 percent or more of insurance costs will be eligible. Beginning in 2014, if firms qualify for the tax credit, insurance coverage must be purchased in a Small Business Health Options Program (SHOP) exchange.
- On July 1, a 10 percent excise tax was imposed on certain indoor tanning services.
- In June, early insurance reforms began. Temporary high-risk pools were created for uninsured adults with pre-existing conditions. For plans that began in late September, there were prohibitions on lifetime and annual benefit spending limits, non-group plans were not allowed to cancel coverage, plans cover most preventive care, and dependents were allowed to remain on their parents' policies until age 26.

2011

- Manufacturers and importers of brand-name drugs began paying a $2.5 billion tax.
- The prohibition of purchases of over-the-counter medications from consumer-driven accounts began.
- The penalty for using Health Savings Accounts (HSAs) for non-qualified purchases doubled to 20 percent.

2012

- Businesses would have been required to send additional Form 1099s for every business-to-business transaction of $600 or more, but this provision was repealed in 2011. Previous Form 1099 reporting requirements still exist.
- Manufacturers and importers of brand-name drugs tax rose to $2.8 billion.
- Employers were required to provide a Summary of Benefits and Coverage (SBC) to employees during open enrollment season. Health insurance plans (in the case of fully insured products) and health insurance plan sponsors (in the case of self-insured products) designed the summaries, but employers were required to distribute the summaries to employees.

2013

- Medicare payroll tax on wages and self-employment income in excess of $200,000 ($250,000 joint) will increase by 0.9 percent.
- Medicare investment tax imposes a new 3.8 percent tax on investment income for higher-income taxpayers.
- Flexible Spending Accounts (FSAs) will be limited to a maximum of $2,500 annual contribution.

- Employers will be required to report the cost of employee health benefits on W-2s for tax year 2012 (both employer and employee contribution). Until the IRS issues additional regulations, employers that file less than 250 Form W-2s may not be required to report this information.
- The threshold at which medical expenses, as a percentage of income, are deductible increases to 10 percent, from 7.5 percent.
- An annual 2.3 percent excise tax on medical devices begins.

2014

- Employers must determine size, whether they will be considered "large" or "small," for the requirements of the employer mandate. A large employer is defined as an employer who employed an average of at least 50 fulltime and fulltime equivalent (FTE) employees on business days during the preceding calendar year.
- An $8 billion small business health insurance tax will fall on the fully insured market, where the majority of small businesses purchase insurance.
- Health insurance exchanges open to individuals
    - The federal government begins subsidizing the purchase of health insurance for individuals with incomes up to 400 percent of the federal poverty level.
    - Individual mandate tax begins. Most individuals without minimum essential coverage are subject to a tax. Individual mandate tax penalty begins at $95 or 1 percent of household income, whichever is greater.
- Insurance reforms take effect, and insurers cannot impose coverage restrictions based on pre-existing conditions. Modified community rating standards go into effect for individual or family coverage based on geography, age and smoking status. Insurers must offer coverage to anyone. The law also limits out-of-pocket cost-sharing, and small group and individual market insurance plans must include government defined essential health benefits and multiple coverage levels.

2015

- Employer mandate begins, requiring companies to provide insurance or pay penalties. The penalties are based on the number of full-time employees during the preceding calendar year; whether the company offers coverage to full-time employees; whether coverage is "affordable" and meets "minimum value;" and whether one or more full-time employees qualify for a government subsidy. A fulltime employee qualifies for a subsidy if his or her household income is between 138 and 400 percent of the federal poverty level and the employee's share of the self-only portion of the premium exceeds 9.5 percent of their income. Here are some scenarios:
    - More than 50 FTE employees and the business does not offer insurance to the full-time employees, with one or more full-time employees receiving premium subsidies because their income falls between 138 percent and 400 percent of the federal poverty level. The penalty is $2,000 per full-time employee (minus the first 30 full-time employees).
    - More than 50 FTE employees and the business offers insurance with one or more full-time employees receiving premium subsidies because their share of the self-only portion of the premium exceeds 9.56 percent of their income. The

penalty is the lesser of $3,000 per subsidized full-time employee or $2,000 per full-time employee (minus the first 30 full-time employees).
    - More than 50 FTE employees and the business offers insurance, with no full-time employees receiving premium subsidies. There is no penalty on the employer. All non-grandfathered and exchange health plans are required to meet federally mandated levels of coverage.
    - Fewer than 50 FTE employees: No penalty or requirement to offer insurance. Those who qualify for the small employer tax credit must purchase a plan from the SHOP exchange. If an employer chooses to offer health insurance, it must cover the essential health benefits package.
- Small business health insurance tax rises to $11.3 billion.
- Individual mandate tax penalty increases to $325 or 2 percent of income, whichever is greater.

2016

- Small business health insurance tax remains $11.3 billion.
- Individual mandate tax penalty increases to $695 or 2.5 percent of income, whichever is greater.
- Small business (SHOP) health insurance exchanges must open up to businesses with up to 100 employees.

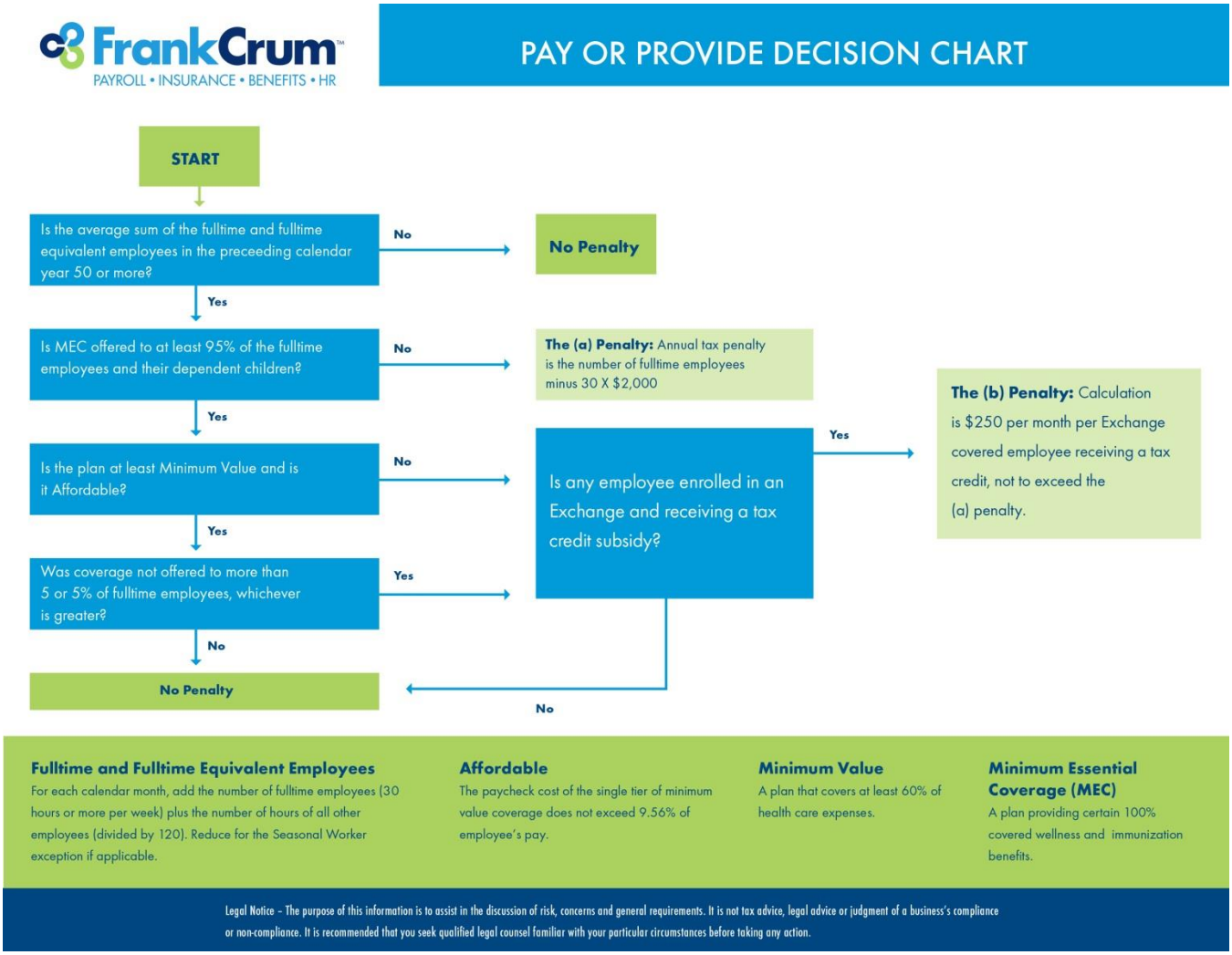
2017

- Brand-name drug tax rises to $3.5 billion.
- Small business health insurance tax increases to $13.9 billion.
- Individual mandate tax penalty is based on 2016 levels and will rise according to a cost-of-living adjustment.
- States may allow large employers to enter the exchange.

2018

- Cadillac tax begins on high-cost health insurance plans with an aggregate value that exceeds threshold amounts of $10,200 for individual coverage and $27,500 for family coverage.
- Brand-name drug tax rises to $4.2 billion.
- Small business health insurance tax rises to $14.3 billion.
- Individual mandate tax penalty is based on 2016 levels and will rise according to a cost-of-living adjustment.

Employer Pay or Provide Decision Chart



2015 Department of Health and Human Services Poverty Guidelines

Link: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/

ACA Company Size Calculator

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Full-time Employees: Employees 30 hrs or more per week on average.	0	0	0	0	0	0	0	0	0	0	0	0	The cell below adds the subtotal row, keeps any fractions and divides by 12.
Full-time Equivalents: All other employees' hours (but not more than 120 hrs per employee) in the calendar month divided by 120.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Subtotal Before Seasonal Worker Exception	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Number of Fulltime and Fulltime Equivalent Employees (rounded down) Before Seasonal Worker Exception =													0.0
Including applicable controlled and affiliated services groups, does this calculation result in ACA large employer status before the Seasonal Worker exception?													**No. See Comments!**
Seasonal Worker Exception: If four or less of the above calendar months have a subtotal of 50 or more, enter the number of Seasonal Workers, if any, for those months. If more than four months are 50 or more, this exception cannot be used; see Final Employee Count and Comments.	0	0	0	0	0	0	0	0	0	0	0	0	The cell below adds the subtotal row, keeps any fractions and divides by 12.
Subtotal After Applicable Seasonal Worker Exception	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Final Employee Count =													**0.0**
Including applicable controlled and affiliated services groups, does this calculation result in ACA large employer status after the Seasonal Worker exception?													**No. See Comments!**

Comments

1. Large employers with 50-99 employees must offer coverage in 2016 or pay a tax penalty.
2. Large employers with 100 or more employees must offer coverage in 2015 or pay a tax penalty.
3. Controlled and affiliated services groups must be taken into consideration such that all entities treated as a single employer under section 414(b), (c), (m) or (o) are treated as one employer for purposes of section 4980H.
4. Seasonal Worker - Workers covered by 29 CFR 500.20(s)(1) and retail workers employed exclusively during holiday seasons. Employers may apply a reasonbable good faith interpretation of the term seasonal worker and a reasonable good faith interpretation of 29 CFR 500.20(s)(1) including as applied by analogy to workers and employment positions not otherwise covered by 29 CFR 500.20(s)(1).

FrankCrum is not providing legal counsel or tax advice and this is not a determination of compliance with 4980H. The employer, as defined by the ACA, is responsible for compliance and penalties. If an employer determines they are not a large employer as defined by the ACA, it is recommended they seek legal guidance to ensure they have made the proper determination. Serious tax penalties can result.

Variable Hour Calculator for Large Employers

Employee Name	Employed Entire Measurement Period?	Hours of Service for Measurement Period	Average Hours Per Week	Hours of Service Average 30 or More Hours Per Week?
Employee 1		2080	40.00	Yes
Employee 2		2000	38.46	Yes
Employee 3		1800	34.62	Yes
Employee 4		1560	30.00	Yes
Employee 5		1500	28.85	No
Employee 6		1400	26.92	No
Employee 7		1000	19.23	No

*Employees not employed prior to the beginning of the Measurement Period may be disregarded as not eligible since they were not employed the entire period.

*An employer is permitted to treat, as a measurement period, a period that ends on the last day of the payroll period preceding the payroll period that includes the date that would otherwise be the last day of the measurement period, provided that the measurement period begins on the first day of the payroll period that includes the date that would otherwise be the first day of the measurement period.

*FrankCrum does not provide legal or tax advice and this is not a determination of compliance with 4980H. Employers should seek legal and/or tax advice to ensure they have made the proper determination; serious penalties can result. The employer, as defined by the ACA, is responsible for compliance and potential penalties.

Contact Information

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Important Notice:

This information is not legal counsel or tax advice, but is for discussion purposes only and should not be relied on solely to determine compliance with the PPACA. Many aspects of the PPACA are being developed and this information is subject to change. Readers of this information should seek advice from an independent tax advisor and/or legal counsel familiar with their particular circumstances.