# AFFORDABLE CARE ACT

## SUMMARY GUIDE

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## About the Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 signed into law respectively on March 23 and March 30, 2010, led to important health care delivery changes impacting employers nationwide. It is crucial for all employers to understand how their businesses may need to respond. The following highlights some key provisions that affect employers and employer-sponsored health plans, along with important reporting requirements and health plan changes.

## About This Guide

This guide is intended to provide the reader with an overview of the PPACA and includes links to more information. Guidance from regulatory agencies can impact the information in this guide, so it is important to check back with APS for updates. This guide does not constitute legal advice to any current, past, or prospective client of the author or customer or prospective customer of Automatic Payroll Systems, Inc. on any particular issue. Any action taken or contemplated in connection with any benefits tracking or employer legislative requirements issue should be discussed in advance with legal counsel of your choosing.

## Regulations Are Not Final

On January 2, 2013, the IRS published a proposed rule on the Federal Register[1] outlining regulations and providing guidance under section 4980H of the IRS Code in regards to the Shared Responsibility for Employers Regarding Health Coverage. This proposed rule is open for comments until March 18, 2013. APS will continue to monitor this proposed ruling and will update our blog when more information is available.

## *Important Provisions:*

**INDIVIDUAL MANDATE.** This mandate is now referred to as the Individual Shared Responsibility Provision[2]. Starting in 2014, individuals may be subject to a penalty[3] if they do not have "minimum essential coverage"[4] (i.e. being covered by an employer-sponsored health plan, an individual health plan, etc.). The penalty starts to phase in gradually in 2014, phases in completely in 2016, and then is adjusted for cost of living changes for 2017 and beyond.

Penalty Amounts[5]:

- 2014 - The greater of $95 or 1% of taxable income
- 2015 - The greater of $325 or 2% of taxable income
- 2016 - The greater of $695 or 2.5% of taxable income
- 2017 and beyond – based on the cost-of-living adjustment each year

For any dependent under the age 18, the penalty is 1/2 of the individual amount. Individuals may be exempt from the mandate[6] if they fall into one of these categories:

- Low income individuals who cannot afford health insurance
- Undocumented immigrants
- Religious objectors
- Incarcerated individuals

There are also certain cases where individuals would not be subject to the penalty[7] if the mandate is not satisfied, these include:

- American Indian tribes
- Individuals receiving financial hardship waivers
- Individuals whose income falls below the tax filing threshold
- Individuals who lacked insurance for less than three months during a given year

*Share of Cost Assistance:* Premium assistance in cost-sharing and tax credits will be available for certain low-income individuals receiving qualified health coverage through a state-established Health Insurance Exchange[8].

**EMPLOYER MANDATE.** This mandate is now referred to as Shared Responsibility for Employers Regarding Health Coverage[9]. Starting in 2014, large employers[10], defined as having at least 50 full-time equivalent employees[11] (FTEs) are subject to this mandate and may be subject to penalties (Shared Responsibility Assessment) for not providing any employee health coverage or for providing coverage not considered affordable or not meeting the requirements of minimum essential coverage. For situations where there is more than one entity with common ownership[12], the aggregate will be used in determining the total number of FTEs. In other words, if the combined total meets the threshold, then each separate company is subject to the mandate.

## Paid Hours

Consistent with existing DOL regulations and other guidance under the Affordable Care Act (for example, Notice 2010-44[13] (2010-22 IRB 717)), and with IRS Notice 2011-36[14], the proposed regulations provide that an employee's hours of service include the following: (1) Each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and (2) each hour for which an employee is paid, or entitled to payment by the employer on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (29 CFR 2530.200b-2(a))[15].

## Tracking Hours for Hourly and Non-Hourly Employees

In addition to tracking and reporting hours of service[16] for hourly employees, employers are required to track and report hours of service for non-hourly employees. For employees not paid on an hourly basis, employers are permitted to calculate the number of hours of service under any of the following three methods:

1. Counting actual hours of service (as is the case of employees paid on an hourly basis) from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence;
2. Using a days-worked equivalency method or
3. Using a weeks-worked equivalency

Employers may apply different methods for different classifications of non-hourly employees, so long as the classifications are reasonable and consistently applied. In addition, an employer may change the method of calculating non-hourly employees' hours of service for each calendar year.

Refer to the Shared Responsibility for Employers Regarding Health Coverage[17] for more information on different types of employees and how to calculate their hours of service.

For more information about the reporting requirements of tracked hours of service, see the Annual Reports section under Reporting Requirements.

## Look-Back Period

***Ongoing Employees.*** The look-back measurement method[18] for ongoing employees is no less than three months and no more than 12 months. It is at the discretion of large employers to determine what timeframe to use and apply that timeframe as the standard look-back measurement.

***New Variable Hour and Seasonal Employees.*** For new variable hour and seasonal employees[19], employers may utilize the look-back measurement they have chosen as the standard, as well as an administrative period of up to 90 days. However, 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).

Refer to the Shared Responsibility for Employers Regarding Health Coverage[20] for more information on additional employee classifications and how to determine the look-back period.

## Pay or Play Scenarios

**#1** - An employer meets the 50 full-time employees threshold and offers affordable coverage that meets the requirements of minimum essential coverage

- Companies that fall into this scenario will not be subject to pay a penalty. The IRS states that as long as the employer is providing affordable health coverage that provides a minimum level of coverage to its full-time employees, employers are not subject to pay a penalty.

**#2** - An employer meets the 50 full-time employees threshold and does not offer health coverage

- Companies that fall into this scenario will be subject to pay a penalty per full-time employee for not offering any health coverage whatsoever. The applicable penalty amount for a calendar month will be 1/12$^{th}$ of $2,000 per full-time employee after the first 30 employees.

**#3** - An employer meets the 50 full-time employees threshold but offers health coverage deemed as unaffordable or that does not meet the minimum essential coverage requirements and has at least one full-time employee receiving coverage through an Exchange

- Companies who fall into this scenario will be subject to pay a penalty only for each full-time employee receiving coverage through an Exchange. The applicable penalty amount for a calendar month will be the lesser of 1/12$^{th}$ of $3,000 per full-time employee who goes to an Exchange or 1/12$^{th}$ of $2,000 per calendar month for each full-time employee, excluding the first 30 full-time employees. Stay tuned to the APS blog for updates on federal and state Exchanges.

## Affordability

IRS Notice 2011-73[21] continues the process of developing regulatory guidance in regards to Health Coverage Affordability Safe Harbor for Employers. In order to avoid a potential assessable payment under section 4980H(b), the coverage offered must be affordable, generally meaning that the employee portion of the self-only premium for the employer's lowest cost coverage that provides minimum value not exceed 9.5 percent of the employee's household income. Recognizing the inability of employers to ascertain their employees' total household incomes, Notice 2011-73 described a potential safe harbor under which coverage offered by an employer to an employee would be treated as affordable for section 4980H liability purposes if the employee's required contribution for that coverage was no more than 9.5 percent of the employee's wages from the employer reported in Box 1 of the Form W-2 (Form W-2 wages) instead of household income.

This potential affordability safe harbor would apply in determining whether an employer is subject to the assessable payment under section 4980H(b), but would not affect an employee's eligibility for a premium tax credit under section 36B.

## Minimum Essential Coverage

According to the IRS, employers will need tools available to determine if the coverage it offers provides minimum value[22]. A minimum value calculator will be made available by the IRS and the Department of Health and Human Services. Employers will be able to input certain information about the plan, such as deductibles and co-pays, to get a determination as to whether the plan meets the minimum value requirements by covering at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.

**SMALL BUSINESS HEALTH CARE TAX CREDIT.** As of January 1, 2010, employers (with 25 or fewer full-time employees averaging $50,000 or less in wages) may be generally eligible for a tax credit[23] of up to 35% for small business employers and 25% for small tax-exempt employers (such as charities) of the employer's premium costs of providing employee health coverage as long as the employer contribution is at least 50% of the employee-only premium cost. Effective January 1, 2014, the maximum tax credit increases to 50% and 35%, respectively.

> ***Credit Example:*** If an employer pays $50,000 a year toward their employees' health care premiums - and qualifies for a 15% credit - the employer will save $7,500. Add that up for tax years 2010 through 2013 and the employer is looking at a total savings of $30,000. With the increase occurring in 2014, if the credit increases for an employer to 20%, the credit would increase from $7,500 to $12,000.

While these numbers sound great, according to a 2012 study conducted by the Government Accountability Office[24], only 170,300 small business actually claimed it on their 2010 taxes. It was estimated that between 1.4 million and 4 million small businesses were eligible to claim the tax credit for 2010. The low number has been attributed to the simple fact that most small businesses do not offer health coverage and therefore couldn't claim the tax credit.

Furthermore, according to employer representatives, tax preparers, and insurance brokers that GAO met with, the credit was not large enough to employers to begin offering insurance.

It is important to review the eligibility requirements of this tax credit and even consult a tax expert to determine if the credit is enough to justify offering health insurance for employees.

**MEDICAL LOSS RATIO.** Insurers are required to report their Medical Loss Ratios (MLRs)[25] and meet a target of spending at least 85% of the premium on claims for large plans and 80% of for small plans. If the minimum MLR target is not met, the insurer must issue a rebate check to the policyholder. Rebate checks started going out as of August 2012. Rebate checks issued are dependent upon information reported for the previous calendar year. Therefore, check issued in 2012 were dependent upon 2011 reported data. Please see our FAQ section for more information on how to handle MLR rebate checks.

**NOTICE OF EXCHANGES AND SUBSIDIES.** According to the original Health Care Reform Acts, effective March 1, 2013 employers of all sizes were required to provide each newly hired employee with a written notice of the existence of health insurance exchanges and potential subsidies available. As of January 24, 2013, the Department of Labor (DOL)[26] announced that it has delayed the compliance date.

The DOL expects that the timing for distribution of notices will be late summer or fall of 2013, coinciding with the open enrollment period for Exchanges. Once a compliance date has been set, employers will be required to notify newly-hired and current employees in writing about:

- Existence of and service provided by the State's Health Care Exchange
- How to contact the Exchange to request assistance
- The employee's potential eligibility for a premium tax credit if the employer's plan does not provide "minimum essential coverage" or is unaffordable
- The consequences of purchasing a health plan through the exchange (i.e. the loss of the employer contribution)

The Department of Labor is considering providing model, generic language that could be used by employers to satisfy this requirement. If a model is provided, APS will make it available on our blog.

**AUTOMATIC ENROLLMENT.** Effective January 1, 2014, employers (with more than 200 full-time employees) offering health plans must automatically enroll new full-time employees[27] and allow them to opt out.

**"CADILLAC PLAN" TAX.** Effective January 1, 2018, insurers of fully insured plans and plan administrators of self-insured plans will be subject to a non-deductible excise tax on high-cost health plans[28].

**BREAK TIME FOR NURSING MOTHERS.** A provision amends the Fair Labor Standards Act (FLSA) requiring an employer to provide an employee (up to one year after the birth of her child) reasonable break time[29] and private location when the employee has a need to express breast milk for her nursing child. If able to demonstrate undue hardship, an employer with fewer than 50 employees may not be subject to these requirements.

## *Reporting Requirements:*

**COST OF EMPLOYER-SPONSORED HEALTH COVERAGE.** Effective as of the 2012 tax year, an employer must report the aggregate value of medical, dental, vision, and supplemental insurance benefits coverage on the Form W-2. The IRS[30] has provided transitional relief, so this requirement only applies to employers who file 250 or more W-2s for the 2012 tax year. In future tax years, small employers will be required to comply with this provision.

**ANNUAL REPORTS.** Effective for 2014, employers (with 50 or more full-time employees) must file an information return[31] in a form to be established by the Secretary of the Treasury containing:

- Employer's name and employer identification number
- Attestation whether or not the employer allows full-time employees (and their dependents) to enroll in minimum essential coverage under an eligible employer-sponsored plan
- Number of full-time employees for each month during the calendar year
- Name, address, tax identification number, and the months of health plan coverage for each full-time employee during the calendar year

> **NOTE:** The employer must provide employees a written report including the name and contact information for the person filing the return and the information required to be shown on the return.

**SUMMARY OF BENEFITS AND COVERAGE.** Beginning on the first day of the first plan year that begins on or after September 23, 2012, group health plans and self-insured health plans sponsors must provide participants a uniform summary of benefits and coverage[32]. In four pages, the uniform summary must describe in a "culturally and linguistically appropriate manner" the health plan benefits offered, coverage limitations, share of cost provisions, and any restrictions on continuation of coverage. The DOL has created a document that may be used by employers who do not have an existing form in place.

## *Health Plan Changes:*

**DEPENDENT COVERAGE EXTENSION.** Group health insurance plans and self-insured plans offering dependent coverage[33] must allow such coverage to continue for an adult child up to age 26 (or to the end of the plan year during which the child turns age 26).

**LIFETIME OR ANNUAL LIMITS.** Effective for plan years beginning on or after September 23, 2010, a group health plan or self-insured plan may not impose a lifetime dollar limit[34] on "essential health benefits" (e.g. emergency services, hospitalization, maternity and newborn care, etc.) and must phase out any annual limits on such coverage by 2014.

**PRE-EXISTING EXCLUSIONS.** Effective for plan years beginning on or after September 23, 2010, a group health plan or self-insured health plan may not impose pre-existing condition exclusions[35] for children under 19 and must completely eliminate such exclusions for participants of any age by January 1, 2014.

**PROHIBITED RESCISSIONS.** Effective for plan years beginning on or after September 23, 2010, a group health plan or self-insured plan may not rescind or cancel health coverage once the individual has become a covered participant.

**OVER-THE-COUNTER MEDICATIONS REIMBURSEMENT.** Effective January 1, 2011, no over-the-counter medication reimbursement[36] from health savings, flexible spending, or health reimbursement accounts may be made.

**HEALTH FSAS LIMITS.** As of January 1, 2013, annual salary reduction contributions to health flexible spending accounts will be limited to $2,500, indexed for inflation.

**LIMITED WAITING PERIODS.** Effective January 1, 2014, a group health plan or self-insured plan waiting period[37] must not exceed 90 days.

Employers should review their current health plans, identify any necessary changes, and develop action plans to ensure compliance. Stay tuned the APS blog for upcoming health care reform articles that will cover many different issues and questions surrounding the Affordable Care Act.

Q1: **What is the intent of the Health Care Reform acts signed into law?**

A1: The main intent is to expand coverage, control healthcare costs, and improve healthcare delivery within the existing employer-based health system over the years of 2010-2018.

Q2: **Should we undertake an immediate review of our company health care plan to determine if it meets the requirements of the new law?**

A2: Employer penalties for not providing "minimum essential coverage" under their health care plans (or for not providing health care at all) do not go into effect until 2014. Your health insurance provider is likely to contact you long before then with any proposed changes that would be needed to avoid sanctions. If you do not offer insurance now and continue not to after 2013 and have 50 or more FTEs you will be subject to penalties.

Q3: **What does the Pay or Play provision mean?**

A3: Employers with 50 or more FTEs will be required to make available a minimum level of coverage or pay a per-employee fee.

Q4: **We just received a medical loss ratio rebate check from our health insurance carrier. In what ways are we permitted to use it? If we opt to distribute the rebate through cash refunds to participants, how should these refunds be taxed?**

A4: Basically, the guidance allows an employer to use the rebate in one of three ways. The employer may elect to:

1. Reduce the participants' portion of the annual premium for the next plan year for all plan participants covered;
2. Reduce the participants' portion of the annual premium for the next plan year for only those participants covered by the group health plan in the previous calendar year; or
3. Provide a cash refund only to employees who were covered by the group health plan in the previous calendar year.

Should the employer opt to cut refund checks (option 3 above), the employers only have to distribute rebates to current employees who participated in the plan during the previous calendar year under most circumstances. Employers are not required to track down former employees and attempt to provide them with a rebate if the employer finds that the cost of doing so equals or exceeds the amount of the former employee's share of the rebate. Therefore, as long as the company's rebate amount is not a substantial amount of money per participant, it is not required to track down previous employees.

If the cost of health insurance is shared among the employee and the employer, the rebate must be split according to the contribution formula and may only be provided to employees who participated in the plan in previous calendar year. The employer may choose the method of distribution, as long as the method is reasonable and consistent. For example, the employer may opt to divide the rebate evenly among employees who contributed to the plan in the previous calendar year, or may choose to allocate the refund based on contribution amounts. So, it is up to the employer whether it would like to make distinctions as to types of coverage (i.e. single or family coverage) and the refund amount. It is also up to the employer whether the company prorates the rebates based on the length of time each employee spent in the plan in the previous calendar year. It is simply important to remain consistent among employees in this regard.

With respect to taxes, if the employee's premiums were taken on a pre-tax basis, then the rebate is treated as taxable wages, subject to income and employment taxes. The same does not hold true if the premiums were taken on an after tax basis.

Q5: **I only have 35 employees and currently do not provide insurance but want to know if I would need to offer health insurance in the future to my employees.**

A5: The new law will not require you to provide insurance. However, if you choose to provide insurance to your employees, available tax credits are designed to both support those small businesses that provide coverage today as well as those that newly offer such coverage.

Currently, a small business health care tax credit is in effect that provides a 35% tax credit on health premiums, with the credit increasing to 50% in 2014.

Q6: **I have been hearing about the new W-2 reporting requirements under the Health Care Reform Act and have a few questions. (1) Are employers now required to report the value of employee benefits on each employee's W-2 form? (2) Does the value of benefits become taxable income to the employee? (3) What amount should the employer report on the Form W-2 for health coverage - the amount the employer paid, the amount the employee paid, or both?**

A6: Yes, many employers were required to meet this reporting requirement for 2012 W-2s. However, the IRS provided transitional relief from the requirement for small employers for the 2012 tax year. For 2012 W-2s, an employer was not subject to the reporting requirement if the employer was required to file fewer than 250 W-2s for the 2011 calendar tax year.

No, the reporting requirement in no way changes the tax treatment of employee benefits. The reporting requirements were simply put into place to provide each employee with an idea of the value of his/her benefits package, so the employee may take it into consideration when considering life changing decisions that affect benefits, such as changing jobs, transferring to part time status, etc. The IRS has stated that "the purpose of the reporting is to provide useful and comparable consumer information to employees on the cost of their health care coverage."

For most plans, the amount reported on the W-2 should include both the portion the employee contributed and the portion the employer contributed to the plan. It is important to consult with your accounting professional regarding exceptions to this general rule.

Q7: **Who pays the "Cadillac tax"?**

A7: The Cadillac tax is divided pro rata among insurance coverage providers. In fully-insured plans, the cost is divided among the various insurers. For plans that are entirely self-insured, the employer is responsible for the tax. Most expect the insurers to ultimately pass on the costs to employers and individuals through increased premiums, however.

Q8: **What is the small business tax credit and how do I know if I am eligible?**

A8: Effective January 1, 2010, tax credits became available to qualifying small businesses that offer health insurance to their employees. So if your business qualifies for a tax credit, you are eligible right now.

The tax credit is worth up to 35% of the premiums your business pays to cover its workers and 25% for nonprofit firms. In 2014, the value of the credit will increase to 50% and 35% for nonprofits.

Your business qualifies for the credit if you cover at least 50 percent of the employee-only cost of health care coverage for your workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. The full credit is available to firms with average wages below $25,000 and less than 10 FTEs. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Q9: **Can a tax-exempt organization be a qualified employer?**

A9: Yes. The same definition of qualified employer applies to an organization described in IRS Code section 501(c) that is exempt from tax under IRS Code section 501(a). However, special rules apply in calculating the credit for a tax-exempt qualified employer.

Q10: **Can an employer with 25 or more employees qualify for the credit if some of its employees are part-time?**

A10: Yes. Because the limitation on the number of employees is based on full-time equivalent (FTE) employees, an employer with 25 or more employees could qualify for the credit if some of its employees work part-time. For example, an employer with 46 half-time employees (meaning they are paid wages for 1,040 hours) has 23 FTEs and therefore may qualify for the credit.

Q11: **Are seasonal workers counted in determining the number of FTEs and the amount of average annual wages?**

A11: Generally, no. Seasonal workers are disregarded in determining FTEs and average annual wages unless the seasonal worker works for the employer on more than 120 days during the tax year.

Q12: **If an owner of a business also provides services to it, does the owner count as an employee for the purposes of the tax credit calculation?**

A12: Generally, no. A sole proprietor, a partner in a partnership, a shareholder owning more than 2% of an S corporation, and any owner of more than 5% of other businesses are not considered employees for purposes of the credit. Thus, the wages or hours of these business owners and partners are not counted in determining either the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit.

Q13: **Do family members of a business owner who work for the business count as employees?**

A13: Generally, no. A family member of any of the business owners or partners, or a member of such a business owner's or partner's household, is not considered an employee for purposes of the credit. Thus, neither their wages nor their hours are counted in determining the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit. For this purpose, a family member is defined as a child (or descendant of a child); a sibling or step-sibling; a parent (or ancestor of a parent); a step-parent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter- in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

Q14: **How is the credit reduced if the number of FTEs exceeds 10 or average annual wages exceed $25,000?**

A14: If the number of FTEs exceeds 10 or if average annual wages exceed $25,000, the amount of the credit is reduced as follows (but not below zero).

If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceed $25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed $25,000 and the denominator of which is $25,000. In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding $25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than $50,000.

> ***Example:*** For the 2010 tax year, a qualified employer has 12 FTEs and average annual wages of $30,000. The employer pays $96,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit.

The credit is calculated as follows:

1. Initial amount of credit determined before any reduction: (35% x $96,000) = $33,600
2. Credit reduction for FTEs in excess of 10: ($33,600 x 2/15) = $4,480
3. Credit reduction for average annual wages in excess of $25,000: ($33,600 x $5,000/$25,000) = $6,720
4. Total credit reduction: ($4,480 + $6,720) = $11,200
5. Total 2012 tax credit: ($33,600 – $11,200) = $22,400.

Q15: **Does taking the credit affect an employer's deduction for health insurance premiums?**

A15: Yes. In determining the employer's deduction for health insurance premiums, the amount of premiums that can be deducted is reduced by the amount of the credit.

Q16: **What is the average premium for the small group market in a State (or an area within the State)?**

A16: The average premium for the small group market in a State (or an area within the State) will be determined by the Department of Health and Human Services (HHS) and published by the IRS. Publication of the average premium for the small group market on a State-by-State basis is available on the IRS website[38].

Q17: **With whom should I consult if I have more detailed questions regarding the tax credit calculations?**

A17: You should speak with your accounting professional.

Q18: **Can I join a pool now to lower my costs?**

A18: Beginning in 2014, reform will create state-based health insurance exchanges that pool small businesses and their employees to help give the kind of purchasing power that big businesses enjoy today. Increased purchasing power and competition is intended to make premiums more affordable. The exchange will also reduce administrative costs for your businesses and your employees, enabling them to compare the prices, benefits, and quality of health plans.

Q19: **Will I be required to purchase health insurance for myself and my employees in the Exchange?**

A19: No, the Exchange is a place where individuals who do not have Medicare, Medicaid or an employer-provided health care plan can go to purchase health insurance. If you provide or plan to provide group health coverage, you will have no reason to use the Exchange.

Q20: **Will I be required to drop my current coverage?**

A20: No. Group health plans in effect as of March 23, 2010, are grandfathered under the law and will be considered "qualified coverage" that meets the mandate to have health insurance that begins January 2014. Employees and dependents can be added to the policy without losing grandfathered status.

Q21: **If my plan is grandfathered, does that mean I do not have to comply with any of the new requirements?**

A21: It depends. A grandfathered health plan is any group plan or individual coverage that was in effect on the date of a new law's enactment. There are some provisions in the Affordable Care Act that do apply to grandfathered plans and some that do not. For a list of these provisions, please refer to the SHRM article on grandfathered plans[39].

Q22: **What will cause my plan to lose grandfathered status?**

A22: Plans will lose their "grandfathered" status if there are significant changes to the plans such as a cut in benefits or an increase out-of-pocket spending for consumers. While there are some other ways that a plan may lose its grandfathered status, grandfathered plans may enroll new employees or add dependents without losing grandfathered status.

Q23: **If two or more companies have a common owner or are otherwise related, are they combined for purposes of determining whether they employ enough employees to be subject to the Employer Shared Responsibility provisions?**

A23: Yes. Consistent with longstanding standards that apply for other tax and employee benefit purposes, companies that have a common owner or are otherwise related generally are combined together for purposes of determining whether or not they employ at least 50 full-time employees (or an equivalent combination of full-time and part-time employees). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions[40], even those companies that individually do not employ enough employees to meet the threshold. (The rules for combining related employers do not apply for purposes of determining whether an employer owes an Employer Shared Responsibility payment or the amount of any payment). The proposed regulations provide information on the rules for determining whether companies are related and how they are applied for purposes of the Employer Shared Responsibility provisions. For more information on these provisions, see the proposed regulations[41] in their entirety.

Q24: **What benefits are affected by the ban on annual and lifetime limits?**

A24: Reform prohibits lifetime and annual limits on only a limited set of "essential benefits" including:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care; and
- Any additional benefits that the Secretary later deems "essential."

Q25: **How will COBRA be affected?**

A25: In the short term, there should be no effect on COBRA. Individual coverage through the exchange is not available until 2014, so employees who experience a COBRA qualifying event will still rely on COBRA continuation coverage. It remains to be seen how COBRA will operate once the exchanges are established. Presumably, individuals will be able to obtain coverage at a more affordable rate through the exchange than through COBRA continuation coverage; so, it may become a less attractive option.

Q26: **Does an adult child dependent need to maintain student status to obtain coverage through their parents' employment-based plan? Do they need to be IRS dependents?**

A26: There is no requirement that an adult child maintain full-time student status to be eligible for coverage up to age 26. Also, while Reform extends the exclusion from gross income to adult children, it does not require that those adult children maintain dependency status. Even if the adult child is married, he/she may remain on the parent's plan.

Q27: **What are the new elements of the simplified cafeteria plan?**

A27: Beginning in 2011, small employers (those employing no more than 100 full time employees on the average in either of the two prior years, including all employers under common control) were permitted to offer a simplified cafeteria plan.

No discrimination testing is required if the employer makes a non-elective contribution of either 2% of compensation to all eligible employees, or the lesser of 6% of pay or twice the employee deferral amount. Such plans may require one year of service and attainment of age 21 to be eligible. Collectively bargained employees may be excluded. Once a plan is established, it can continue until after the year in which the employer has an average of 200 employees.

Q28: **What are the required break times for nursing mothers?**

A28: A health care reform provision amends the federal Fair Labor Standards Act (FLSA) such that an employer must provide breastfeeding employees with "reasonable break time" and a private, non-bathroom place to express breast milk during the workday, up until the child's first birthday. Employers are not required to pay for time spent expressing milk.

All employers are covered but those with less than 50 workers do not have to comply if they show that complying with the law would cause "an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business."

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