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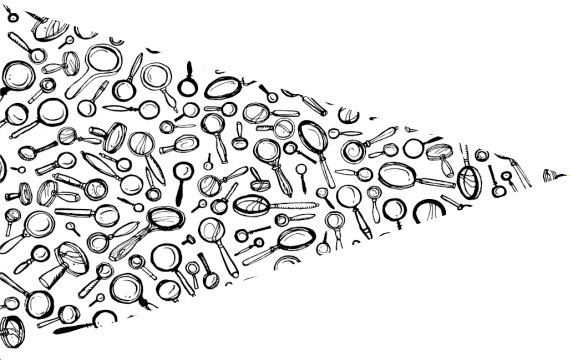

Employer coverage requirements and taxes under the Affordable Care Act

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In June 2012, the US Supreme Court upheld the major coverage provisions of the Affordable Care Act (the ACA) as constitutional, prompting companies to pay closer attention and spurring action within their organizations to prepare for the employer requirements under the law. Although some uncertainties remain regarding the law and possible changes to it that may result from the 2012 presidential and congressional elections, looming deadlines are driving companies to step up their compliance efforts now to mitigate the potential for unforeseen tax liabilities under the ACA.

This article provides:

- A summary of the major employer coverage requirements under the ACA, including key definitions that are being addressed in the federal regulatory process
- A timeline of compliance deadlines and summary of new reporting requirements
- Analysis of considerations related to employer-sponsored coverage for part-time workers and employers' communication with employees
- Analysis of how new employer coverage requirements under the ACA will translate to the assessment of taxes under the law

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Major coverage requirements under the ACA

One of the primary goals of the ACA is to expand health insurance coverage to millions of previously uninsured Americans. Initial insurance market reforms went into effect for plan years beginning after September 23, 2010, including provisions that require employer-sponsored plans to cover dependents up to age 26 and prohibit plans from limiting coverage of pre-existing conditions or applying annual and lifetime limits on certain benefits. The major coverage requirements and expansion provisions under the law become effective on January 1, 2014, including:

- **Individual mandate.** The law mandates that all Americans, with some exceptions, maintain minimum essential coverage[1] or face a tax.
- **Insurance Exchanges.** The law establishes new state-based insurance Exchanges through which individuals and small employers can shop for health insurance. Federal premium tax credits and subsidies will be made available to low- and moderate-income individuals who do not have access to affordable employer-sponsored insurance to purchase private insurance coverage through an Exchange.
- **Medicaid expansion.** The law allows states to expand the Medicaid program to allow individuals up to 133% of the federal poverty level (FPL) to be eligible for the program.
- **Employer mandate.** The law builds upon the existing employer-based health insurance system but mandates, for the first time, that employers with 50 or more full-time equivalents provide affordable coverage of at least minimum value to full-time employees and their dependents or pay tax penalties if a full-time employee obtains Exchange coverage and a federal premium tax credit.

The ACA's new standards of affordability and minimum value are driving employers to digest the law's requirements in relation to their structure, workforce demographics and current health care benefit packages. Understanding the linkage between the coverage an employer must offer, an employee's ability to obtain tax credits for Exchange coverage, and the role of the states and the federal agencies in making these determinations are all critical in order to fully assess an employer's potential tax liability under the ACA.

In addition, the employer community has reacted with concern to the Supreme Court's ruling on the ACA's Medicaid provisions, allowing states to decide whether to comply with the Medicaid expansion provisions without risk of losing existing federal funding for their current Medicaid programs. In states that do not expand Medicaid, employers could face greater exposure to taxes for lower-wage employees who otherwise would have been eligible for Medicaid and may now be entitled to tax credits for Exchange coverage if their employer coverage is not affordable.

In October 2013, employers must be prepared as open enrollment begins in the state-based insurance Exchanges, and their plans must be in compliance for months beginning January 1, 2014. Further, the Administration is working on federal regulations that will shape companies' efforts to adhere to the law's requirements. Major regulations on the employer requirements of the ACA are expected to be released before the end of this year, which will have a significant impact on companies' ability to assess their benefit designs, their coverage and compliance costs, and their associated risk for taxes.

1. The ACA defines minimum essential coverage as employer-sponsored plans, government-sponsored coverage (e.g., Medicare, Medicaid); plans in the individual market, grandfathered health plans, or other coverage recognized by the Secretary of Health and Human Services in conjunction with the Treasury Secretary (guidance forthcoming). Notably, the ACA excludes excepted benefit plans (e.g., indemnity plans) from the definition of minimum essential coverage.

Definition of a large employer

As employers move ahead with ACA compliance efforts, it will be imperative as a first step that they understand the definition of "large employer" to determine whether their company is subject to the employer mandate and thus need to undertake an accurate assessment of their potential liability for taxes.

Large employer. Under the ACA, an employer with "50 or more full-time equivalents" is considered a large employer. To calculate the number of full-time equivalent employees, the Department of the Treasury has indicated in guidance that for each calendar month of the preceding calendar year, employers must:

1. Count the number of full-time employees (including seasonal employees) who work on average 30 hours per week per month.
2. Calculate the number of full-time equivalent employees by aggregating the number of hours worked by non-full-time employees (including seasonal employees) and dividing by 120.
3. Add the number of full-time employees and full-time equivalents calculated in steps (1) and (2) for each of the 12 months in the preceding calendar year.
4. Add the monthly totals and divide by 12. If the average exceeds 50 full-time equivalents, determine whether the seasonal employee exception applies.

Seasonal employee exception. The law creates special rules for employers whose workforce exceeds 50 full-time employees for 120 consecutive days or fewer during a calendar year if the employees in excess of 50 who were employed during that period of no more than 120 days (four calendar months, for this purpose only) were seasonal employees. If an employer meets this set of circumstances, the employer would not be an applicable large employer and would not be subject to the employer mandate for the current calendar year.

If the seasonal exception does not apply, the employer is an applicable large employer for the current calendar year and is subject to the employer mandate.

For purposes of the ACA's employer tax penalties, the Department of the Treasury in Notice 2012-58 in August 2012 requested comments on the definition of seasonal employee and has stated that through at least 2014 employers are permitted to use a "reasonable, good faith interpretation of the term 'seasonable employee.'" The ACA cites the definition of seasonal employee as someone who works less than 120 days under existing Department of Labor regulations.

Controlled group rules. An additional important factor to consider is that an employer's size is measured on a controlled group basis as defined by Internal Revenue Code (IRC) §§414 (b), (c), (m), and (o). For the purpose of determining size, an employer must aggregate the total number of employees of all corporations that are under common control and are members of that employer's particular controlled group. This includes, for example, employees of a controlled group of corporations, partnerships or proprietorships under common control, affiliated service groups or others to be prescribed by Treasury.

The law and guidance from the Department of the Treasury indicate that employers will determine on an annual basis whether they are large employers. For employers who expand their workforces and cross the threshold to be considered large employers, it remains unclear how long these employers will have to begin offering health coverage to full-time employees without facing potential tax penalties. The law requires large employers to report to the Internal Revenue Service (IRS) by January 31 the number of full-time employees an employer had each month in the preceding calendar year.

Determination of full-time employee status

Like the definition of "large employer," the determination of "full-time employee" status under the law is critically important to companies. Large employers will be subject to a tax if any full-time employee receives a premium tax credit because the employer-sponsored health care plan does not meet the law's affordability (page 6) or minimum value standards (page 8). Consequently, employers will need to know which employees will be considered full-time.

The ACA defines a full-time employee as an employee who is employed on average 30 hours of service per week in any month. This is a significant adjustment for many employers who currently do not define full-time status at 30 hours. Many employers are re-examining their workforce, benefit offerings, and their payroll and administrative systems to comply with the 30-hour standard. In addition, because full-time status is determined on a monthly calculation, it has created uncertainty and administrative issues for employers with employees whose hours fluctuate, such as part-time, seasonal and temporary employees. In situations where an employee is hired for or promoted to a position that the employer classifies as or reasonably expects to be full time, the employee must be eligible for the employer's health plan after the employer's applicable wait period. However, for variable hour employees whose status is not known due to fluctuating hours or uncertain duration of employment, the Administration has proposed safe harbor methods for measuring full-time employee status.

Measurement/stability period safe harbor. The Department of Treasury in Notice 2012-58 (issued on August 31, 2012) announced that employers at least through the end of 2014, could use a "measurement/stability period" safe harbor, which allows a look-back measurement period to determine whether a certain category of employee should be considered full time based on employees' hours of service. Per the Notice, "a new employee is a variable hour employee if, based on the facts and circumstances at the start date, it cannot be determined that an employee is reasonably expected to work on average at least 30 hours per week." The Administration requested comments on the types of safe harbor rules that could apply to short-term assignment employees, temporary employees, and employees hired into high-turnover positions.

Under the Notice, employers can choose a standard measurement period of 3 to 12 months for ongoing employees, after which employees determined to be full time would be eligible for coverage during a associated stability period equal to or greater than the look-back period (but not less than six months) during which coverage must be offered. Importantly, the Notice states that employers may use measurement periods and stability periods that differ either in length or in their starting and ending dates for the following categories of employees:

- Collectively bargained employees and non-collectively bargained employees
- Salaried employees and hourly employees
- Employees of different entities
- Employees located in different states

Employers can use an initial measurement period to determine the status of newly hired variable hour or seasonal employees. The associated stability period for newly hired variable hour or seasonal employees must be the same length as the stability period for ongoing employees.

To transition from the rules for new employees to the rules for ongoing employees, the Notice states that once an employee who has been employed for an initial measurement period also has been employed for an entire standard measurement period, the employee must be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees.

Optional administrative period. The Notice also provides for an optional administrative period not to exceed 90 days for ongoing employees between the standard measurement period and the associated stability period to determine which ongoing employees are eligible for coverage, and notify and enroll them. The Notice states that the administrative period for ongoing employees must overlap with the previous stability period so as not to result in gaps in coverage.

For newly hired variable hour or seasonal employees, the notice also provides for an optional administrative period not to exceed 90 days. However, the Notice limits the combined length of the initial measurement period and administrative period to effectively no more than 13 months (plus the fraction of a month to the first day of the next calendar month).

Limitation on waiting periods. The law's limitation on waiting periods before coverage is offered and its interaction with the determination of employees' full-time status is of importance to employers because of the associated taxes. The ACA's prohibition on waiting periods of more than 90 days applies to employer-sponsored group health plans.

The Administration in Notice 2012-59 (issued on August 31, 2012) clarified that the calculation of the 90-day waiting period begins upon the date that an employee becomes eligible to participate in the plan. The Administration also has stated that for newly hired variable hour or seasonal employees, an employer who uses the measurement stability period safe harbor will be considered in compliance with the limitation so long as coverage for an eligible employee is effective within 13 months of the employee's start date (plus the fraction of a month to the first day of the next calendar month). Failure to comply with this provision may result in an excise tax equal to $100 per day during the non-compliance period multiplied by the number of affected employees.

Potential liability for increased taxes

The Congressional Budget Office (CBO) in July 2012 projected that taxes under the ACA's employer mandate would total $117 billion from FY2012 to FY2022, underscoring the stakes for employers of compliance with the law.

Although the ACA does not require an employer to offer coverage to its employees, a large employer may be subject to a non-deductible excise tax if at least one full-time employee receives a premium tax credit for Exchange coverage and the employer:

- Fails to offer coverage to full-time employees (and their dependents) in accordance with IRC §4980H(a)

Or

- Offers coverage to full-time employees that does not meet the law's affordability or minimum value standards in accordance with IRC §4980H(b)

An employer's exposure to increased taxes is directly linked to an employees receipt of federal tax credits to purchase health care coverage on an Exchange. Individuals with household income between 100% and 400% of the federal poverty level (FPL) are generally eligible for tax credits for Exchange coverage unless they are eligible for other types of coverage, including affordable employer-sponsored coverage. This provision of the law was designed specifically for those who do not have access to affordable employer-sponsored coverage.

Calculating taxes. Under IRC §4980H(a), large employers who do not offer coverage to their full-time employees and their dependents will be subject to an annual tax of $2,000 times the total number of full-time employees if at least one full-time employee receives a premium assistance tax credit for Exchange coverage. The ACA permits employers to subtract the first 30 employees when calculating their taxes for not offering coverage.

Under IRC §4980H(b), if a large employer offers coverage to its full-time employees and their dependents but the coverage is unaffordable to employees with household incomes between 100-400% of FPL or does not provide minimum value, employers face an annual tax of $3,000 times the number of full-time employees eligible for and receiving tax credits for Exchange coverage. Taxes for offering coverage that does not meet the affordability or minimum value standards are capped at an employer's potential taxes for not offering coverage.

As employers evaluate their potential liability for tax penalties, they also must take into consideration the ACA's expansion of nondiscrimination rules (under IRC §105(h)) that generally prohibit employers with self-insured group health plans from discriminating in favor of more highly compensated employees. The ACA extended these provisions to apply to fully insured, as well as self-funded health coverage. This change has raised new issues for executive health plans, insured employers with tiered health benefits and others. In 2011, the IRS issued guidance deferring enforcement of the provision for insured plans until further guidance is issued.

Special considerations for employees' eligibility for tax credits, employer potential liability for increased taxes. The law and subsequent guidance issued by the Administration provide for specific instances in which employees are eligible for "minimum essential coverage," as defined in the law, and therefore will not be considered eligible for tax credits for Exchange coverage, as well as instances in which employers will not be liable for taxes for employees who receive tax credits for Exchange coverage.

If an employee is enrolled in an eligible employer-sponsored plan, regardless of the cost or value of the plan, that employee will be considered ineligible for a premium tax credit.

In addition, Medicaid-eligible employees will not be eligible for tax credits. Therefore, employers will not face tax penalties for those employees. States can expand Medicaid eligibility to 133% of FPL, with Medicaid eligibility effectively being 138% of the FPL because of a 5% income disregard in the ACA for determining Medicaid eligibility. In states that do not expand Medicaid, employers could face greater exposure to increased taxes because lower-wage employees who would have been eligible for Medicaid under an expansion may be entitled to the premium tax credit for Exchange coverage.

An employee or related individual is not considered eligible for minimum essential coverage under an employer plan during any period when coverage is not required to be offered, such as any waiting or measurement period prior to when coverage takes effect. Employees may be eligible for a premium tax credit through an Exchange during such periods. However, employers will not be liable for taxes under IRC §4980H provided that they comply with the standards for the waiting, measurement, administrative and stability periods as described on page 4.

Affordability standard and safe harbor estimates

Under the law, a large employer who offers coverage must confirm that it meets two tests in order to avoid tax penalties: the coverage must be both *affordable* to full-time employees of certain income and of *minimum value*.

The affordability test states that employees with household income between 100% and 400% of the FPL may be eligible for a premium tax credit to purchase Exchange coverage if the employee's share of the self-only premium for the employer's lowest-cost plan that provides minimum value exceeds 9.5% of household income. The Department of Treasury has reiterated in guidance that although an employer must offer coverage to employees and their dependents, the affordability test is based on an employee's contribution to self-only coverage.

Further, in recognizing that employers do not have access to information about employees' household incomes, and are prohibited from accessing taxpayer return information, the Department of the Treasury has proposed a safe harbor that would shield employers from tax penalties if the employee's share of the self-only premium for the employer's lowest-cost, minimum value plan does not exceed 9.5% of the employee's current W-2 wages. While this is generally a stricter test than household income, basing the calculation on current wages provides a more predictable and workable method for employers to confirm that they are offering affordable coverage to employees. Because employers know the wages they pay to employees, they can set their premium contribution levels accordingly.

The Exchanges will still make eligibility determinations based on whether an employee's premium share exceeds 9.5% of household income. Thus, some employees may be eligible for Exchange credits based on household income, but employers will not be liable for tax penalties for these employees if employers utilize the safe harbor. Employers unable to utilize the safe harbor will still be able to utilize the general rule, which determines affordability by applying the 9.5% standard to an employee's household income. Treasury has stated that employers can rely on this guidance at least through the end of 2014.

The table on the following page summarizes general estimates based on 2012 FPL data for a single individual at various income levels and the associated employee monthly premium contribution share for self-only coverage to meet the affordability test.

In states that expand Medicaid, the table illustrates that employers could face tax penalties for full-time employees who work an average of 30 hours per week with hourly wages between $9.52 and $28.64 (and if the employees' premium contribution exceed the limits and they subsequently seek Exchange coverage and receive premium tax credits). In states that do not expand Medicaid, employers could face greater exposure to taxes because minimum wage employees who would have been eligible for Medicaid may be entitled to the premium tax credit for Exchange coverage.

It is important to note that employers need to analyze their current workforce demographics, including full-time status now based on 30 hours per week and the premium contribution they make to employees of certain wages. In addition, employers are beginning to analyze what their benefit packages must look like under the minimum value test and other benefit requirements such as the coverage of preventive care with no cost-sharing and the lifting of annual and lifetime limits on certain benefits (see subsequent discussion on pages 8-9). All of this must be taken into account for an employer to determine not only if they are able to offer coverage that is affordable to the employee, but also to the employer in setting their own premium contribution level to the coverage they must offer.

Affordability safe harbor estimates

Estimates for individual eligibility for Medicaid or tax credits and affordability safe harbor[1]					
Scenario	Percent of FPL	Annual income	Hourly wage[4]	Affordability test safe harbor (9.5% of current wages – annual contribution)	Estimated employee monthly premium share for self-only coverage for affordability test safe harbor[5]
In states that expand Medicaid under the ACA to 133% of FPL:					
Minimum wage worker[2] eligible for Medicaid	~101%	$11,310	$7.25	Medicaid eligible	n/a
Statutory upper limit for Medicaid eligibility	133%	$14,856	$9.52	$1,411	$118
Effective upper limit for Medicaid eligibility[3]	138%	$15,415	$9.88	$1,464	$122
Upper limit for eligibility for tax credits	400%	$44,680	$28.64	$4,245	$354
In states that do not expand Medicaid under the ACA:					
Minimum wage worker eligible for Exchange credits if employer coverage is not offered, or does not meet standards for affordability or minimum value	~101%	$11,310	$7.25	$1,074	$90
Upper limit for eligibility for tax credits	400%	$44,680	$28.64	$4,245	$354

1. This is based on 2012 HHS Federal Poverty Guidelines for one person ($11,170).
2. Federal minimum wage is $7.25 per hour. Note: As of January 1, 2012, minimum wage rates are higher than the federal minimum wage in the District of Columbia and 18 states (Alaska, Arizona, California, Colorado, Connecticut, Florida, Illinois, Massachusetts, Maine, Michigan, Montana, Nevada, New Mexico, Ohio, Oregon, Rhode Island, Vermont and Washington).
3. ACA §2002 requires states to apply an "income disregard" of 5% of the FPL in meeting the income test, resulting in an effective income threshold of 138% of FPL for Medicaid eligibility.
4. This is based on the ACA threshold for classification as a full-time employee (average 30 hours per week) multiplied by 52 weeks.
5. This is 9.5% of current wages divided by 12 months

Minimum value standard

Under the ACA, employers are required to provide coverage to their full-time employees that is both affordable and of at least minimum value or face taxes for full-time employees that qualify for premium tax credits from the Exchange. The law states that a plan shall not meet the minimum value determination if "the plan's share of the total allowed costs of benefits provided under that plan is less than 60% of such costs." How minimum value is determined will have a tremendous impact on the affordability and administration of employee benefit plans and is intricately intertwined with the other employer provisions. The Administration expects that most large employers' health care plans already meet or exceed this 60% threshold, but it will be important for employers to review the upcoming regulations on the minimum value standard and how they must certify compliance.

Generally, minimum value is understood to be a 60% actuarial value test, meaning that a plan would pay for at least 60% of medical expenses on average (for a standard population and for allowable charges) and employee cost-sharing requirements would be set accordingly. However, the Secretary is authorized to issue regulations further defining the minimum value standard. In April, the Departments of Treasury and Health and Human Services (HHS) issued a request for comments on several approaches to determining whether an employer plan provides minimum value. Key concepts addressed in the request for comments are highlighted below.

Standard population. Minimum value for employer-sponsored self-insured plans and insured large group plans will be measured against a standard population rather than the population covered by the employer's own plan. Treasury and HHS have proposed to develop a "standard population" from a large set of commercial claims data purchased by HHS that reflects typical self-insured employer plans. HHS plans to make publicly available detailed "continuance tables" based on this standard population data set as soon as fall 2012.

Covered benefits. Although large employers are not required to offer the 10 essential health benefits or any other particular category of benefits (see page 9), minimum value will be determined in comparison to a standard population and claims data set of large employer health plans. The Administration has stated that the value of large employer health plans is primarily driven by spending on the provision of four core categories of benefits:

- Hospitalization and emergency room services
- Physician and mid-level practitioner care
- Pharmacy benefits
- Laboratory and imaging services

Employers have expressed concerns that proposed methods to measure minimum value might create de facto benefit requirements or otherwise limit flexibility in designing a plan that meets employees' needs.

Employer contributions to HSAs and HRAs. Treasury and HHS have proposed to credit only an "appropriate portion" of the amounts contributed by an employer to an health savings account (HSA) or made available to an employee under a health care reimbursement account (HRA) in the calculation of minimum value. This "appropriate amount" would be adjusted so that the employer only receives the same credit for HSA or HRA contributions as it would receive for the same amount of first dollar coverage.

Employers have spoken out strongly against this proposal and called for regulations to expressly confirm that the employer's full contribution to an HSA or an HRA be factored into determining whether plans have met minimum value. Employers say that counting only a portion of employer contributions to HSAs or HRAs will likely cause a dampening effect on employer contributions to these plans.

Minimum value standard (cont'd.)

Proposed methods for determining Minimum Value. Treasury and HHS have proposed three distinct options (summarized in the table below) for determining minimum value on a pass/fail basis: a Minimum Value (MV) Calculator, a Safe Harbor Checklist, and an Actuarial Certification. All three options are linked by the standard population claims data set. Employers are concerned that the more "nonstandard" a plan is, the more likely it is that an employer will default to the actuarial certification option.

Essential health benefits. The requirement to cover the essential health benefits (EHB) package applies to products sold in the individual and small group markets, both inside and outside state insurance Exchanges. The "small group market" is defined in the ACA as the health insurance market through which "small employers" can purchase group health insurance coverage. For plan years that start in 2016 or later, a "small employer" is defined as an employer with 100 or fewer employees. For plan years that start prior to 2016, states may choose to define the small group market as small employers with no more than 50 employees. As a result, some employers who are defined as "large" for purposes of determining employer tax penalties may be considered "small" for purposes of purchasing group health insurance and will therefore have less control over their benefit design.

Although large group and self-insured plans are not required to offer the essential health benefits package, these plans are prohibited from imposing lifetime or annual limits on any essential health benefits that they do offer. The 10 EHB categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive services and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Treasury-HHS proposed methods for determining minimum value	
Minimum value (MV) calculator	The MV calculator allows an employer to input in-network cost-sharing features (i.e., deductibles, co-payments, coinsurance, out-of-pocket limits) of their health plan for different categories of benefits into an online calculator. Employers would not be able to use the MV calculator if they have "non-standard" features on any of the four core categories of benefits, such as atypical quantitative or cost-sharing limits.
Safe-harbor checklist	The checklist allows an employer to perform an "eyeball test" and see if their plan design features meet one of several design-based safe harbors, such as a high-deductible health plan with an employer-provided HSA. In order to utilize this option, an employer would be required to cover all four core categories of benefits and services and could not have nonstandard features. Each safe harbor checklist would describe the cost-sharing attributes of a plan that apply to the four core categories.
Actuarial certification	The certification option allows an employer that sponsors a plan with nonstandard features to use a certified actuary to determine whether a plan meets minimum value. Plans with nonstandard features, such as atypical quantitative limits on the four core benefits, will need to use this method for determining MV.

Part-time employees

Although the employer coverage requirements apply only to full-time employees (those who average 30 hours of service per week on any month), large employers are engaging with the Administration to evaluate their options for offering coverage to part-time employees. Below are a few considerations for employers with a part-time workforce.

Importantly, hours worked by part-time employees are included in the calculation for full-time equivalent employees used to determine whether an employer is a large employer and therefore subject to the employer mandate (see page 3).

In general, large employers are not required to offer coverage to part-time workers and will not face penalties if a part-time worker receives a tax credit for Exchange coverage. As such, if an employer offers coverage to part-time employees, the coverage does not have to meet the affordability and minimum value standards that apply to plans that large employers offer to full-time employees. If the employer coverage offered to a part-time employee does not meet the affordability or minimum value standards, an otherwise eligible employee can receive tax credits for Exchange coverage without triggering additional taxes for the employer.

Plan requirements. Employer plans offered to part-time employees will be subject to certain insurance market reforms, such as preventive care without cost sharing, and no annual and lifetime limits on EHBs. Part-time employees who enroll in employer plans would satisfy the individual mandate's requirement to maintain minimum essential coverage so long as (1) the employer plan is offered in the small or large group market within a state or (2) the employer plan is a grandfathered plan.

Waiting periods. The application of the 90-day waiting period limitation prior to coverage applies for coverage offered to part-time employees. The Administration in August 2012 clarified that the calculation of the 90-day waiting period begins upon the date that an employee becomes eligible to participate in the plan and does not preclude other conditions for plan eligibility such as an hours-of-service requirement that part-time employees must fulfill to participate in the plan provided that the eligibility condition is not intended to avoid compliance with the 90-day limitation on waiting periods. Employers can rely on this guidance at least through the end of 2014.

Employer communication with employees

Employers are considering options for communicating with employees about employer-sponsored coverage within the context of the new employer reporting requirements. In part to mitigate any potential liability for increased tax liabilities, employers have a vested interest in ensuring that employees are aware of their options for employer-sponsored coverage.

Fair Labor Standards Act. The ACA amended the Fair Labor Standards Act (FLSA) to require employers to inform employees "of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance." In addition, the amendment to the FLSA requires employers to inform employees that they might be eligible for premium assistance tax credits and cost-sharing subsidies for Exchange coverage "if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60% of such costs." The notice also must inform employees that if they purchase Exchange coverage, they "may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes."

The ACA states that "in accordance with regulations" issued by the Department of Labor, employers will be required to provide this notice to current employees on March 1, 2013, and to new employees on the date of hire thereafter. To date, the Department of Labor has not issued regulations on the amended FLSA requirements.

Although the ACA requires employers to provide this notice to employees only once, some employers are considering it as a basis for ongoing communication with employees about employer coverage options.

Employer reporting to IRS/Treasury. Similarly, employers are exploring how best to develop communication materials about their plans by building upon IRC §6056's new requirement to provide statements to individuals including information about the monthly premium for the lowest-cost option under the employer's plan and the employer's share of the total allowed cost of benefits under the plan (see page 14). This statement could provide an important opportunity for employers to communicate with employees about the health coverage employers offer, and whether that coverage meets the law's affordability and minimum value standards.

Employee application for tax credits

Because employers may receive requests for information from employees who apply for tax credits for Exchange coverage, it will be helpful for employers to be familiar with the workings of the Exchanges and the ACA's requirements for individuals to maintain minimum essential coverage. Individuals will not be subject to taxes under the individual mandate if an individual's required contribution for coverage exceeds 8% of household income or if the individual's income is below the threshold for filing a federal income tax return.

An overview of the application process for individuals and the open enrollment periods for Exchange coverage is provided below and provides context for the employer reporting requirements to the IRS.

Exchange application process. For employed individuals who seek credits or subsidies for Exchange coverage because they are not eligible for employer-sponsored coverage or assert that employer-sponsored coverage is unaffordable or is not of minimum value, the employee must provide the following employer-related information to the Exchange (in addition to other information):

- The name, address and employer identification number (if available) of the employer
- Whether the enrollee or individual is a full-time employee and whether the employer provides minimum essential coverage
- If the employer provides minimum essential coverage, the lowest-cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution under the employer-sponsored plan.

If an enrollee claims an employer's minimum essential coverage is unaffordable, the employee also must provide:

- Their taxpayer identification number
- Their tax filing status
- The number of individuals for whom a personal exemption deduction is allowed under, including the taxpayer and the taxpayer's spouse
- The modified gross income of the taxpayer and of all individuals for whom a deduction is allowed under IRC §151 who are required to file a tax return
- Other information to be prescribed by the Secretary in regulation to determine whether the taxpayer is eligible for a credit or subsidy
- The taxable year to which the above information relates, or (if applicable) the fact that such information is not available

The ACA requires Exchanges to notify employers whenever an employee is determined to be eligible for a tax credit for Exchange coverage because the employer does not offer minimum essential coverage or because the employer coverage is unaffordable. Exchanges also will notify employers that they might be liable for tax penalties.

In a March 2012 regulation, HHS established that the inaugural open enrollment in state-based Exchanges will run from October 1, 2013, through March 31, 2014. In subsequent years, open enrollment will run from October 15 through December 7. The ACA also requires Exchanges to provide special enrollment periods to facilitate enrollment for special circumstances including at any point when a qualified individual loses access to minimum essential coverage through their employer.

Employer reporting requirements

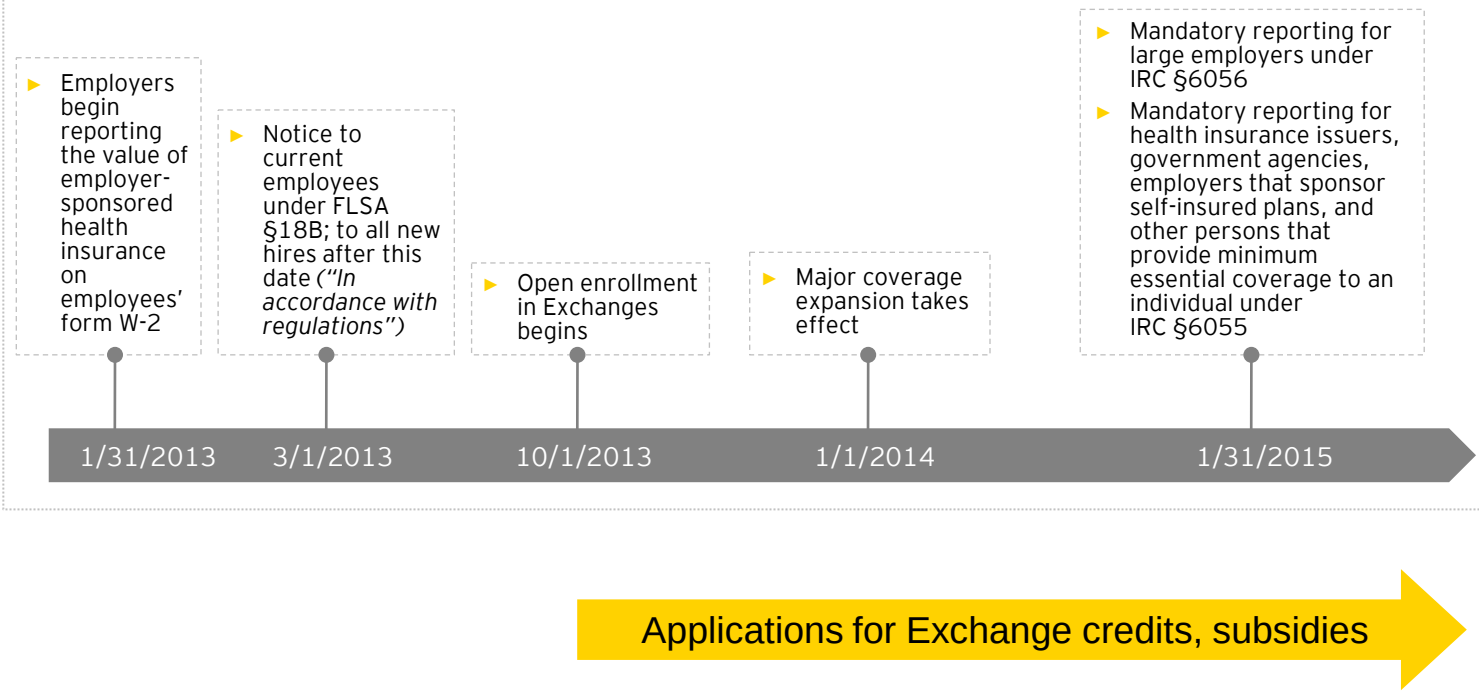
Employers will face a host of new reporting requirements in order to demonstrate the value of coverage offered to employees, communicate to employees their coverage options, and certify compliance with the employer coverage provisions. Employers who issue more than 250 forms W-2 annually are already working to comply with the requirement to report the cost of certain group health coverage on employees' forms W-2 issued after January 1, 2013.

Beginning in tax year 2014, large employers will be required to report to the IRS information about the coverage that they offer to full-time employees. Self-insured employers beginning in tax year 2014 also will be required to provide to the IRS information about employees' enrollment in health insurance coverage; health insurers will report this information to the IRS for employers who offer fully insured plans. Information reported to the IRS about the coverage that is offered to full-time employees and employees' enrollment in coverage also must be provided to individual employees enrolled in the employer's plan.

Employers are examining a variety of options to streamline the reporting process, including a prospective reporting process that would use general plan and wage data to show that at least one plan of minimum value is affordable to their full-time employees (see pages 15-16). Exchanges would like to be able to access this information from the IRS to determine individuals' eligibility for tax credits. Employers also have proposed that the Administration consider waiving the retrospective reporting requirements for employers who voluntarily and prospectively report affordability and minimum value information to the IRS and simply require employers to provide additional information for individuals whom the IRS verifies to be eligible for tax credits. This approach could help avoid the IRS being overwhelmed by an influx of unnecessary data on the 156 million individuals that the CBO projects will be covered by employer-sponsored plans in 2014. These proposals are being raised by employers, but the Administration has not issued guidance on the employer reporting requirements.

The timeline below illustrates upcoming compliance deadlines for the employer reporting requirements, and the table on the following page summarizes the employer reporting requirements to the IRS.

Key compliance dates for employer reporting process



Applications for Exchange credits, subsidies

Employer reporting requirements (cont'd.)

Summary of annual employer reporting requirements to Treasury/IRS			
ACA Provision	9002 (amends IRC §6051)	1502 (IRC §6055)	1514 (IRC §6056)
Applies to:	Employers who issue at least 250 W-2 forms annually	Health insurance issuers, government agencies, employers that sponsor self-insured plans and other persons that provide minimum essential coverage to an individual	Large employers who are subject to IRC §4980
Due by:	January 31, 2013 (first due date, January 31, each year thereafter)	January 31, 2015 (first due date, January 31 each year thereafter)	January 31, 2015 (first due date, January 31 each year thereafter)
Data elements:	► The aggregate cost of applicable employer-sponsored coverage, except for— ► Contributions to Archer Medical Savings Accounts or health savings accounts ► Contributions to a flexible spending arrangement.	► Name, address, tax ID number of insured and all others covered under the policy ► Dates of coverage during the calendar year ► Whether coverage is a qualified health plan (QHP) offered through an Exchange ► For QHPs offered through an Exchange, the amount of cost-sharing subsidies or premium assistance tax credits received ► **For employer-sponsored coverage:** ► Name, address and employer ID number of the employer maintaining the plan ► The portion of the premium paid by the employer ► If the coverage is a QHP in the small group market offered through an Exchange ► **Statements to individuals:** ► Name and address of the person required to submit the return, including phone number of the information contact ► Information included in return with respect to the individual ► **Notification of non-enrollment:** Not later than June 30 of each year, the Secretary of the Treasury, acting through the IRS and in consultation with the Secretary of HHS, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage. Such notification shall contain information on the services available through the Exchange operating in the state in which such individual resides.	► Name, date and employer ID number of the employer ► Certification as to whether the employer offers full-time employees and their dependents the opportunity to enroll in minimum essential coverage offered under an eligible employer-sponsored plan ► Length of any waiting period ► Months during the year for which coverage was available ► Monthly premium for the lowest-cost option under the plan ► Applicable large employer's share of total allowed cost of benefits under the plan ► The number of full-time employees for each month during the calendar year ► The name, address and taxpayer identification number of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans, and ► Such other information as the Secretary of the Treasury may require ► **Statements to individuals:** ► Name and address of the person required to submit the return, including phone number of the information contact ► Information included in return with respect to the individual

Efforts to streamline reporting

One of the greatest challenges under the law is confirming that state-based Exchanges have accurate information about whether an individual has been offered affordable employer coverage in order to make the initial determination of the individual eligibility for tax credits for Exchange coverage. Employers have voiced concerns about the states' role in making this eligibility determination and have raised questions about how the Exchanges and the IRS will coordinate information sharing prior to the IRS assessing a tax on an employer. Employers are concerned that taxes could be assessed before there is a meaningful opportunity to determine the facts (e.g., whether an individual who received Exchange coverage with a tax credit was actually a full-time employee or whether they were offered affordable employer coverage). To address this concern, employers have spoken out strongly in favor of a system in which the IRS would not assess any tax against an employer before (1) individuals' eligibility for tax credits is verified against the individuals' annual tax filings for the period (i.e., after the year in question); and (2) employers have had the opportunity for a meaningful appeal in which an employer may challenge whether individuals were full-time employees or offered affordable, minimum value coverage.

These employer concerns would be mitigated and the process should operate more efficiently if an effective system of information sharing and verification among the Exchanges, the IRS, and employers is established. Developing a streamlined process requires working through complicated statutory rules and tax administration questions, which are further complicated by the confidentiality of individuals' tax return information under IRC §6103 and preclude IRS disclosure except in specific circumstances. In an effort to establish a more streamlined and efficient process, some employers have proposed a prospective reporting process that would use general plan and wage data to show that at least one plan of minimum value is affordable to full-time employees. The prospective reporting system builds upon concepts that the Department of the Treasury has outlined in notices addressing the affordability safe harbor for employers based on the wages that an employer pays and reporting requirements under IRC §6056. Employers have suggested that Treasury and the IRS establish reporting structures under IRC §6056 that allow employers to prospectively report to the IRS:

- The length of any wait period (if applicable)
- Monthly employee premium for the lowest-cost plan options and general employee wage levels
- The employer's share of the total allowed cost of benefits under the plan
- The length of look-back period to determine full-time employee status (if applicable)

Allowing employers to report prospectively this information to the IRS would provide the federal agencies and the state-based insurance Exchanges information regarding employer coverage that they could access in real time via the IRS database to assist in the initial determination of individual eligibility for tax credits.

Efforts to streamline reporting (cont'd)

While the Exchanges will still make eligibility determinations based on whether an employee's premium share exceeds 9.5% of household income, the affordability safe harbor provides a vehicle for employers to prospectively report general employee premium contribution and wage information to demonstrate that the employee premium contribution for self-only coverage does not exceed 9.5% of current wages. This is generally a stricter test than household income, but basing the calculation on current wages provides a more predictable and workable method for employers to indicate that they are offering affordable coverage to employees.

The table below illustrates how general wage bands alongside employee contribution levels could be reported prospectively via IRC §6056 to determine whether the employee premium contribution for self-only coverage exceeds 9.5% of the projected annual wages for a full-time employee. In addition, the table illustrates how prospective reporting can be focused specifically on employees whose current wages indicate that they might be eligible for premium tax credits. While this would not replace the need for Exchanges to make determinations based on household income or for the IRS to verify eligibility for premium tax credits, this information prospectively filed by employers by January 31 would provide a benchmark of basic data about employer plans.

Potential affordability safe harbor reporting via IRC §6056 by an employer with four contribution levels

General employee hourly wage levels	Employee monthly premium contribution for self-only coverage[1]
$9.88[2]-$14.99	$122
$15.00-$19.99	$185
$20.00-$24.99	$247
$25.00-$28.64[3]	$308

1. Employee premium share is 9.5% of the lower wage level (annualized) for each employee contribution level. This is based on the ACA threshold for classification as a full-time employee (average 30 hours per week) multiplied by 52 weeks.
2. The 2012 HHS Federal Poverty Guidelines for one person set at 100% of the FPL at $11,170. In 2012, $9.88 is the hourly wage that corresponds with the effective upper limit for Medicaid eligibility (138% of FPL or $15,415 in 2012).
3. Based on 2012 HHS Federal Poverty Guidelines for one person, $28.64 is the hourly wage in 2012 that corresponds with the upper limit for eligibility for tax credits (400% of FPL or $44,680 in 2012).

Efforts to streamline reporting (cont'd.)

Employers see the proposed prospective reporting approach as a complement to other annual reporting requirements. For example, the law requires that employers report by January 31 to the IRS:

- The number of full-time employees for each month during the calendar year
- The name, address and tax identification number of each full-time employee during the calendar year and the months (if any) during which the employee (and dependents) were covered under a health plan offered by the employer

The tally of full-time employees in this report would include employees determined by the employer to be full time based in the initial and standard measurement periods of the look-back/stability period safe harbor. End-of-year reporting by employers on their full-time employees combined with IRS verification of household income based on individual tax filings will allow for more accurate assessment of employer taxes.

Employers have urged the Administration to consider waiving the retrospective reporting requirements for employers who voluntarily and prospectively report affordability and minimum value information to the IRS and simply require employers to provide additional information for individuals when the IRS is seeking to verify an individual's eligibility for tax credits. This approach could be tested in 2014 and 2015 to help avoid the IRS being overwhelmed by an influx of unnecessary data on the 156 million individuals that the Congressional Budget Office projects will be covered by employer-sponsored plans in 2014. Alternatively, employers have urged the Administration to consider delaying the retrospective reporting requirements to allow employers sufficient time to develop new reporting systems or make changes to existing systems.

In addition, employers continue to explore alternative reporting processes that might be less onerous. Employers are asking IRS to consider options such as an exception-based reporting process that would substantially ease reporting requirements for employers who can demonstrate over time that only a minimal percentage of their employees go to Exchanges and are determined to be eligible for tax credits.

Employers also have asked the Administration to consider potential modifications of the January 31 deadline for employers with varying plan year start dates to avoid a situation in which employers and other health insurance issuers would have to include data from two different plan years in their reports to IRS and statements to individuals. Employers have made the case that reporting processes may need to be set up that allow for rolling reporting deadlines for employer plan level information to utilize the affordability safe harbor, rather than one calendar year report in January for these employers.

The diagram below combines the major employer requirements with employers' recommendations for flow of information and timing of the reporting process.

Employer prospective reporting to IRS	Exchange functions	Employer interaction with IRS
► The length of any wait period ► Affordability safe harbor: monthly employee premium for the lowest-cost plan options and general employee wage levels ► The employer's share of the total allowed cost of benefits under the plan ► The length of any look-back period used to determine employee status	► Exchange determination of individual eligibility based on employee information and employer reporting under IRC §6056 ► Exchange notifies federal agencies of employees receiving Exchange coverage	► Year-end employer reporting per IRC §6056, (including employees determined to be full time based on a measurement period) ► IRS verification of individual eligibility for tax credits based on annual individual tax filings ► Employer appeals and total assessment of taxes under IRC §4980H on annual employer tax filings

Assessment of employer taxes

Even among employers who for decades have voluntarily offered health benefits to their employees, a driving force in ACA compliance efforts is the avoidance of unanticipated tax liabilities and controlling administrative costs. As such, employers must take a holistic view of the law's various requirements and how they interact with each other in order to assess and valuate their risk for increased tax liabilities under the law.

As discussed in this article, employers must first calculate whether they are considered large employers under the ACA (50 or more full-time equivalents) and subject to the law's coverage requirements. Employers that meet this threshold then must determine who of their employees are full time (work on average 30 hours per week per month) and must be offered health insurance that meets the law's affordability and minimum value standards in order to avoid increased taxes.

Employer reporting to the IRS is primarily focused on enforcement of these requirements and underscores the agency's central role in the administration of the law. Employers are engaging with the IRS in the regulatory process to help develop a process that allows for practical and workable administration of employer benefits and provides predictability of potential taxes for employers, including how and when an employer will be notified of its total liability for taxes for a given year.

Employers are seeking to distinguish the determination of individual eligibility for premium insurance tax credits or cost-sharing subsidies by state insurance Exchanges from the subsequent verification of individual household income and determination of employer tax assessments by Treasury and the IRS. Employers feel that this is necessary because the Exchanges will make eligibility determinations in real time based in part on employee self-reporting of their household income and employment status. Reporting of household income may often be incomplete. Even if an attempt is made to verify household income with the IRS during the coverage year, it likely will be based on prior year tax returns and might not accurately capture current household income. Treasury and IRS will not be able to verify accurately employees' household income until their annual individual taxes are filed, which may occur after the coverage year. Furthermore, multistate employers are very concerned about the potential of having to interact with numerous state insurance Exchanges and potentially federally facilitated Exchanges through HHS for states that do not establish Exchanges or are not prepared in 2014.

Employers believe it is critical that the IRS verify individual eligibility for a premium tax credit based on household income once the individual's tax return has been filed for the previous year. Verification by the IRS is necessary because this is the standard by which employers will be held liable for tax penalties and is information that cannot be known to an employer and often may not be truly verifiable in real time by Exchanges. Employers also have urged Treasury to coordinate any assessment of taxes under IRC §4980H that captures total liability for an employer on a given year with an employer's annual corporate tax filing and have asked that it be made clear that IRS traditional appeals processes are available to employers to engage with the IRS to confirm the accuracy and appropriateness of any assessments.

Other tax issues under the ACA. In addition to the law's taxes related to employee coverage, other provisions of the ACA will affect employers' financial liabilities and payroll functions. For example, beginning in 2012, the law imposes an annual tax of $1 (increasing to $2 after the first year) multiplied by the average number of covered lives in a health plan to fund comparative effectiveness research. The tax will be assessed on health insurers and sponsors of self-insured plans.

Insurers and third-party administrators on behalf of self-insured plans also will be required to contribute to a new transitional reinsurance program in 2014, 2015 and 2016 as part of an effort to reduce the uncertainty of insurance risk and stabilize premiums in the individual market during the first three years of the operation of the state-based Exchanges. The ACA requires contributions over the three-year period to total $25 billion. HHS' final regulations on the transitional reinsurance program state that the contribution will be determined on a per capita basis, but the agency has not yet announced the per capita contribution amount.

Beginning in tax year 2013, the employee portion of the Medicare hospital insurance payroll tax will increase by 0.9% on wages in excess of $250,000 for joint returns, $125,000 for married filing separately, and $200,000 for all others. Although the law does not affect the employer portion of the Medicare Hospital Insurance tax, employers will be required to withhold an additional 0.9% Medicare tax but only as to amounts over $200,000.

Conclusion

As companies develop a better understanding of the ACA's requirements, many are undertaking a more thorough analysis of how the law will affect their enterprise and their potential for increased tax liabilities. Understanding the linkage between the coverage an employer must offer, an employee's ability to obtain tax credits for Exchange coverage, and the role of the states and the federal agencies in making these determinations are all critical in order to fully assess an employer's potential tax liability under the ACA. In addition, the law's new reporting requirements for employers are pressing all large companies to determine whether their IT systems are configured to comply with new payroll and reporting requirements.

Because a comprehensive set of federal regulations on the employer requirements has not yet been released, companies are increasingly concerned that they will not be able to make changes needed to meet the compliance deadlines for the major employer provisions of the law that take effect in 2013 and 2014. Companies have said that they need as much as 18 months lead time to budget, plan and implement some changes needed to comply with the law.

In the months ahead, it is critical for companies to watch for upcoming regulations defining key requirements for employers and move ahead with compliance activities in order to minimize risk for increased tax liabilities. Many companies are undertaking compliance reviews and exploring other options to have their health plan offerings and associated administrative processes audited and certified to mitigate the potential risk for unforeseen taxes.

More information

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