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ACA Outlook: What Will 2015 Hold for the Affordable Care Act and Employers?

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For many employers, the effective date of the Affordable Care Act's "play-or-pay" mandate is only weeks away. The impending deadline comes amid questions about the future—and perhaps viability—of the law itself. Entering 2015, the ACA faces challenges both in a new Republican-controlled Congress and in the Supreme Court. Yet, the political and legal uncertainty surrounding the ACA should not deter employers from ensuring they are prepared for the "play-or-pay" mandate and other upcoming requirements.

Section 4980H—Employer "Play-or-Pay" Mandate

Section 4980H of the Internal Revenue Code, as added by the ACA, requires "applicable large employers" with 50 or more full-time employees (including full-time equivalent employees) to offer health coverage to full-time employees and their children or pay a penalty. Even employers that offer coverage may incur a penalty if that coverage does not provide "minimum value" to plan participants or if it is not "affordable." Although the effective date of the employer shared responsibility or play-or-pay mandate was scheduled by statute to become effective in 2014, the IRS delayed this requirement until January 1, 2015.[1] For employers with between 50 and 99 full-time employees, the mandate is delayed an additional year until 2016.

Specifically, under Section 4980H(a) and the IRS final rule,[2] "applicable large employers" must offer "minimum essential coverage" to at least 95% (70% in 2015) of their full-time employees (and their children) or pay a penalty if any full-time employee receives a federal subsidy to purchase insurance through a health exchange. The 4980H (a) penalty is $2,000 for each full-time employee in excess of 30 employees, indexed to inflation. For 2015 only, the penalty will exempt the first 80 full-time employees instead of 30. Employers will pay a penalty under Section 4980H(b) if a full-time employee receives a premium tax credit to purchase health insurance on an exchange because: (1) the employer health coverage offered did not provide "minimum value," that is the plan's share of the total allowed costs of benefits provided under the plan is not at least 60% of those costs; (2) the employer health coverage offered was "unaffordable", or (3) the employee was not among the 95% (70% in 2015) of full-time employees offered coverage. The

1 Employers with fiscal year plan years may not have to meet the requirements of 4980H until the first day of the 2015 plan year if certain requirements are met. 79 Fed. Reg 8544 (Feb. 12, 2014).

2 79 Fed. Reg. 8544. For more information on the IRS final rule, see Ilyse Schuman, *IRS Final Rule Partially Delays ACA Employer Shared Responsibility Requirement*, Littler ASAP (Feb. 24, 2014).

penalty under Section 4980H(b) is the lesser of $2,000 for each full-time employee in excess of 30 (80 in 2015) or $3,000 for each full-time employee who receives a premium tax credit to enable him or her to purchase coverage through the health insurance exchanges. Individuals must have household incomes between 100% and 400% of the federal poverty level to be potentially eligible for a federal subsidy.

Many employers spent this past year exploring options to avoid or minimize penalties, while at the same time containing health coverage costs. Because the penalty under 4980H(a) (the "A" penalty) is likely to be much greater than under 4980H(b)(the "B" penalty), some employers have been considering strategies to avoid paying the former, but still pay the latter penalty only with respect to those employees actually receiving federal subsidies because the coverage was unaffordable or did not provide minimum value. The IRS final rule allows employers to use of one of three safe harbors to determine whether the health plan they offer is affordable. A plan will be deemed affordable with respect to a full-time employee if any one of the safe harbors is satisfied. Health coverage is deemed affordable if that employee's required contribution for the calendar year for the employer's lowest cost self-only coverage that provides "minimum value" during the year does not exceed 9.5% of (1) that employee's Form W-2 wages from the employer for the calendar year; (2) an amount equal to 130 multiplied by the employee's hourly rate of pay as of the first day of the coverage period or the lowest hourly rate during the calendar month or 9.5% of the employee's monthly salary for salaried employees; or (3) the federal poverty level for a single individual. Because a plan's affordability is based on self-only coverage, some employers may have shifted costs to family coverage, while keeping employee-only coverage "affordable."

Another strategy some employers may have considered to avoid paying the "A" penalty was to offer so-called "skinny" plans to full-time employees.[3] Although such plans could still subject an employer to a "B" penalty if they failed to provide minimum value, the employer would avoid paying the "A" penalty. The viability of this strategy depends on how many employees actually elect to purchase coverage through an exchange and receive a tax credit. According to regulations issued by the Department of Health and Human Services, whether a plan provides minimum value can be determined using a minimum value calculator, a plan design safe harbor, or certification by an actuary for certain plans. The calculator developed by HHS was found to deem some plans that failed to cover in-patient hospitalization or physician services as providing minimum value. The IRS recently issued guidance to target the use of certain low-cost plans to avoid paying either an "A" or "B" penalty. IRS Notice 2014-69[4] would prohibit employers from using the minimum value calculator to make plans that fail to provide in-patient hospitalization or physician services satisfy the minimum value standard. According to the Notice, plans that fail to provide substantial coverage for in-patient hospitalization services or for physician services (or for both) do not provide the minimum value intended by the minimum value requirement, and HHS and the IRS will shortly propose regulations to this effect. Although employer-sponsored group health plans other than insured plans in the small group market are not required to offer a package of "essential health benefits," the "minimum value" component of the play-or-pay penalty is effectively being used a back door to impose similar requirements.

Because the penalty under 4980H only applies with respect to full-time employees, the determination of full-time employee status is critical to compliance with the employer play-or-pay mandate. The ACA defines a full-time employee as one working 30 or more hours a week, calculated on a monthly basis. Note that the IRS "common law" definition of employee is used for this purpose. The IRS final rule specifies that the monthly equivalency of 30 hours per week is 130 hours. 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.

The IRS final rule allows employers to use the "lookback" measurement method as an alternative to a strict monthly measurement of hours of service. Employers can use the look-back method for determining the full-time status of ongoing as well new employees as an alternative to a monthly calculation. Under the lookback approach for ongoing employees, an employer would determine each employee's full-time status by looking back at a defined measurement period of three to 12 months to determine full-time status for a subsequent "standard stability period." If an employee worked an average of 30 hours per week during the measurement period, the employer would treat the employee as full-time during the subsequent stability period, the duration of which would be at least the greater of six consecutive calendar months or the

3 These plans have also been referred to as "bare bones" or "MEC" plans, an apparent reference to a health plan that provides "minimum essential coverage" and little else. Such plans usually provide basic preventive services required by the Market Reforms of the ACA, doctor visits, and the like, but exclude hospitalization and other major medical expenses. See IRS Notice 2014-69 for a general description of such plans.

4 Notice 2014-69, available at: http://www.irs.gov/pub/irs-drop/n-14-69.pdf.

length of the measurement period. If an employee did not work an average of 30 hours per week during the standard measurement period, the employer would treat the employee as not full-time during the subsequent stability period, which may be no longer than the associated measurement period.

Employers may also use the lookback measurement method for new variable hour, part-time or seasonal workers. The effect of using the lookback method for such new employees is that the employer can wait until the beginning of the subsequent initial stability period to offer coverage to such employees who worked an average of 30 hours a week during the initial measurement period. By contrast, the lookback method is not available for new employees who are reasonably expected to work full time. New employees who are hired to work a full-time scheduled must be offered coverage by the first day of the fourth calendar month after the date of hire to avoid a potential penalty. Therefore, it is critical that employers accurately categorize new employees as full-time versus part-time, variable or seasonal.

Despite the detailed discussion of the lookback measurement and method in the final rule, a number of questions and ambiguities remain. Many employers have already devoted a great deal of time preparing to implement the lookback measurement method. Although the use of the lookback approach is complicated and administratively burdensome, it does afford more flexibility and certainty than a strict monthly calculation. Looking ahead to 2015, the questions and challenges regarding determination of full-time employee status are likely to grow. Although additional guidance from the IRS may be forthcoming, employers will enter the new year with compliance challenges ahead. As questions about implementing the play-or-pay mandate and the final rule move from theoretical to real-time, even more questions and challenges are likely to present themselves.

Recordkeeping Requirements

The ACA requires employers and/or health insurance issuers to report to the IRS information about employer-sponsored health coverage. These reporting requirements were delayed until the 2015 tax year to coincide with the delay in the employer play-or-pay mandate. Specifically, Section 6056 of the Internal Revenue Code, as added by the ACA, requires applicable large employers (ALEs), those subject to the play-or-pay mandate, to provide information to the IRS about the type of health coverage offered to their full-time employees. ALEs must also provide this information to employees. Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, is to be used to report the information required under Section 6056 with respect to each covered employee, and Form 1094-C is to be used to transmit the 1095-C return to the IRS. The IRS will use these forms to determine whether the employer owes a penalty under Section 4980H, and whether employees are eligible for premium tax credits.

Section 6055 of the ACA requires health insurance issuers and employers that sponsor self-insured health plans that provide individuals with "minimum essential coverage" to report to the IRS information concerning the type and period of coverage offered for the purposes of enforcing the ACA's individual mandate. Form 1095-B is to be used to report the information required under Section 6055, and Form 1094-B is to be used to transmit the 1095-B return to the IRS. Self-insured ALEs report the information required under both Sections 6055 and 6056 on a single combined Form 1095-C.

The draft instructions for Forms 1094-C and 1095-C provide direction on how to complete the forms. ALEs must file a Form 1095-C for each employee who was a full-time employee of the employer for any month of the calendar year. An ALE that provides health coverage through an employer-sponsored self-insured health plan must also complete Form 1095-C, Part III, for any individual (including any full-time employee, non-full-time employee, employee's family members, and others) who enrolled in the self-insured health plan. If an employer is providing health coverage in another manner, such as through an insured health plan or a multiemployer health plan, the issuer of the insurance or the sponsor of the plan providing the coverage will provide the information about their health coverage to any enrolled employees, and the employer will not complete Form 1095-C, Part III, for such employees. The Forms use a series of codes to describe whether offers of coverage were made to full-time employees and their dependents, and whether such coverage provided minimum value and was affordable.

An employer can use the "qualifying offer method" to report information on employees who received a "qualifying offer" of health coverage for all 12 months. Employers that made a Qualifying Offer for one or more months of calendar year 2015 to at least 95% of its full-time employees can use a code rather than inserting the dollar amount of the employee contribution for lowest-cost employee-only coverage

providing minimum value. If an employer certifies that it offered affordable, minimum value coverage to at least 98% of the employees on whom it reports using Form 1095-C, then the employer is not required to identify which of the employees for whom it is filing were full-time employees, and is not required to provide the full-time employee count.

An ALE must file Forms 1094-C and 1095-C by February 28 if filing on paper (or March 31 if filing electronically) of the year following the calendar year to which the return relates. An employer must furnish a Form 1095-C to each of its full-time employees by January 31 of the year following the year to which the Form 1095-C relates. The first Forms 1095-C are due to individuals by February 1, 2016. Although employers with between 50 and 100 full-time employees (including full-time equivalents) do not have to comply with the play-or-pay mandate until 2016, they are still required to submit Forms 1094-C and 1095-C for the 2015 tax year.

Although some efforts were made to simplify the reporting requirements for employers, the reporting obligations remain complex, burdensome and, in some respects, unclear. ALEs will need to ensure they have the systems in place beginning in January 2015 to track the information necessary to complete the forms. This may not be an easy task.

Employer Reimbursement for Individual Health Policies

Although employers may be tempted to reimburse employees for purchasing their own individual health insurance policies as an alternative to offering an employer plan, employers face significant excise taxes for doing so. On September 13, 2013, the Departments of Treasury, Labor and HHS published guidance on the application of the ACA market reforms to health reimbursement arrangements (HRAs), certain health flexible spending arrangements (health FSAs) and certain other employer health care arrangements. On May 13, 2014, two FAQs were made available on the IRS website addressing employer health care arrangements. This guidance explained that employer health care arrangements, such as HRAs and employer payment plans, are group health plans and, as such, subject to the ACA's prohibition on annual limits and the requirement to provide certain preventive services without cost sharing (the ACA "market reform" requirements).

This prior guidance provided that these employer health care arrangements will not violate these ACA market reform provisions when integrated with a group health plan that complies with the market reform requirements. The guidance also stated that an employer health care arrangement—such as a stand-alone HRA—cannot be integrated with individual market policies to satisfy the ACA market reforms and therefore would be subject to excise taxes under Section 4980D of the Internal Revenue Code of $100/day per applicable employee.

In FAQs released on November 6, 2014, the Departments clarified that the payment or reimbursement by the employer of individual market health policies on an after-tax basis does not cure the problem. Regardless of whether the employer treats the money on a pre-tax or post-tax basis, the arrangement is group health plan coverage subject to the ACA market reform applicable to group health plans. Employer health care arrangements cannot be integrated with individual market policies and will violate the ACA's annual limit and preventive services requirements. This prohibition appears to apply to reimbursement for individual policies purchased through an ACA exchange as well as in the individual market outside of the exchange. In effect, an employer is left with only one option if it does not want to offer a health plan to its employees, but wants to help its employees buy individual coverage. Employers can increase employees' taxable wages to help their employees purchase individual policies. However, the employer cannot condition the receipt of the addition wages on the purchase of an individual health insurance policy. The employees must remain free to use the "no strings attached" additional wages however they want.

What's Next for Health Care Reform?

During November, 2014, the future of the Affordable Care Act was cast into doubt in both the Congress and courts. With Republicans taking control of the Senate and increasing their control of the House, the law will be under assault in both chambers during the 114th Congress. With the GOP short of a 60-seat majority in the Senate next Congress, legislation to repeal the ACA will still run into a Democratic road block. However, Republicans may turn to the "reconciliation" process to pass ACA legislation with a simple majority vote. Even if legislation repealing the ACA were to pass Congress, it still faces a certain presidential veto. Opponents of the ACA have changed their messaging from "repeal" the ACA to "repeal and replace" the ACA. The contents of the replacement bill remains in flux. Piecemeal changes to the ACA are much more likely. Changing the definition of full-time employee under the ACA from 30 hours to 40 hours per week appears to be among the priorities for both employers and GOP leadership. The "Forty Hours is Full-Time" legislation passed the House, but was not considered in the Senate. This may well change next Congress.

At issue in the *King v. Burwell* case is whether the IRS has authority to expend premium tax credits to those buying their health insurance in the federal ACA exchange, also known as the "Marketplace." The viability of the ACA may hinge on how the Supreme Court answers this question. The ACA provides tax credits to help subsidize the cost of purchasing health insurance through an exchange for those with household incomes between 100% and 400% of the federal poverty level. Under the ACA, states have the right to decide whether they will establish and manage their own exchanges or have the federal government do so. In 36 states, the federal government runs the exchange.

The litigants in *King v. Burwell* challenged the ability of the IRS to issue ACA tax credits to consumers in those states declining to set up their own exchanges. The challengers contend that language in the ACA conferring subsidies for the purchase of insurance through an "exchange established by the State" precludes subsides in those 36 states that have decided not to establish their own exchange. The Fourth Circuit rejected these claims and ruled that the subsidies are available for federal as well as state exchanges. On the same day, the U.S. Court of Appeals for the District of Columbia in *Halbig v. Burwell* reached the opposite conclusion, although the decision was vacated pending review by the full panel.

The Supreme Court's decision to review the Fourth Circuit's decision in *King* sets the stage for yet another opportunity for the Court to either extend the life of the ACA or effectively kill it. If the Supreme Court rules against the Administration, the tax credits will not be available to millions of consumers in states where there is no state-established exchange and insurance may become unaffordable for consumers in these states, and unattractive for insurers to offer.[5] A decision is expected before the end of the Supreme Court's current term in July 2015.

As open enrollment on the ACA exchanges for 2015 comes to a close and the effective date of the employer play-or-pay mandate commences, many employers are wondering what's next for them in the healthcare arena. New obligations, challenges, uncertainty, and perhaps opportunities await them in the new year.

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5 Also, a decision against the ACA in *King* would mean that an employer with employees only in states that did not establish an Exchange would not be subject to the employer mandate, because none of its employees would be eligible for a Federal subsidy for Exchange coverage.