Health Care Reform "Pay or Play" Q&A

By Eleanor Evans, Esq., CAPLAW

The federal health care reform law's so-called "pay or play" rules for employers take effect January 1, 2014. These rules require "large employers" – those with an average of 50 or more full-time and full-time equivalent employees – to offer full-time employees and their dependents health insurance coverage that meets certain standards. If a large employer does not do so and one or more of its employees receives subsidized health insurance coverage through a state health care exchange, the employer will need to pay the federal government a fee.

Despite the uncertainty that surrounds implementation of this key aspect of the health care reform law, employers should be planning now for how they will comply starting in 2014. This Q&A is intended to help employers in the Community Services Block Grant network better understand how the "pay or play" rules affect them and what actions will need to be taken to ensure compliance. Ultimately, each employer should consult with a qualified professional to determine the best way for it to comply with the "pay or play" mandate.

"Large Employer" Determination

1. What is a "large employer"?

In general, a "large employer" is one that employed an average of 50 or more full-time employees (including full-time equivalents, or FTEs) on business days during the previous calendar year. For this purpose, a full-time employee is an employee who averages at least 30 hours of service per week or 130 hours of service per calendar month.[1]

An hour of service is defined as each hour for which an employee is paid or entitled to payment either for performing duties for his or her employer or for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military leave or leave of absence.[2] For hourly employees, an employer must calculate actual hours of service from records of hours worked and hours for which payment is made or due. An employer may choose from three methods of calculating hours of service for its non-hourly (i.e. salaried) employees and may apply different methods to different classifications of non-hourly employees as long as those classifications are reasonable and consistently applied.[3]

2. How will an employer know whether it is a "large employer"?

Many organizations will know that they have at least 50 full-time employees without needing to do any calculations. For example, a Community Action Agency (CAA) with 200 employees who average at least 35 hours per week would not need to perform a calculation to determine whether it is a large employer.

Organizations with around 50 employees will need to perform a calculation to determine whether they will be subject to the pay or play rules.[4] For information on how to perform this calculation, see the sidebar "Determining Whether Your Organization Is a 'Large Employer'" on page 4.

"Play" Mandate

3. What does it mean to "play"?

Starting January 1, 2014, large employers must offer all of their full-time employees and their dependents[5] the opportunity to participate in a health insurance plan that qualifies as "minimum essential coverage," provides "minimum value," and is "affordable."

4. What is "minimum essential coverage"?

For this purpose, the term "minimum essential coverage" means coverage under a fully insured or self-insured employer-sponsored group health plan other than certain limited scope coverage, such as stand-alone dental or vision coverage or a flexible spending account.[6]

5. What is the "minimum value" requirement?

A plan provides "minimum value" if it pays for at least 60 percent of the actuarially determined cost of services provided under the plan.[7] There are three ways for a large employer to determine whether a plan meets this requirement: (1) using an online calculator developed by the federal government; (2) comparing the plan's covered services with those in a series of checklists of design-based safe harbors; or (3) for plans with non-standard design features, hiring an actuary to determine and certify that the plan provides minimum value.[8] The U.S. Department of Health and Human Services estimates that the overwhelming majority of employer-sponsored plans currently meet the minimum value requirement.[9]

6. What is "affordable" coverage?

A large employer is considered to offer "affordable" coverage if an employee's required premium contribution for the lowest-cost employee-only coverage offered by the employer equals no more than

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Possible Accommodations for Those Who are Physically Disabled:

- Training employees to assist a physically disabled client in using equipment offered to other clients for use such as copiers, computers, etc.
- Assisting clients who are physically disabled with filling out any necessary forms for participation in your CAA's programs and services.

When considering what accommodations to make for individuals with disabilities, keep the following goals in mind:

- Promote non-discrimination,
- Ensure maximum integration,
- Facilitate effective communication, and
- Avoid additional costs, when possible.

Scenarios Revisited

Now that you are familiar with Section 504 legal requirements relating to accommodations for qualified individuals with disabilities, you are better equipped to resolve the issues in the scenarios from the beginning of this article.[18]

Did you come up with any of the following accommodations?

Scenario 1: A reasonable accommodation for Amanda may include providing the services of a sign language interpreter for the presentation and reserving a seat for her in the front row so she can easily see the interpreter.

Scenario 2: A reasonable accommodations for Will may include revising the CAA's policy so that staff may accompany Will to the copy machine and operate the controls for him.

Scenario 3: Several reasonable accommodations exist for Sandra. One may include having at least one computer with a screen reader and offering an electronic version of the workshop application form so Sandra could use one of the CAA's computers to fill out the form by herself. Another possibility is for a staff member to assist Sandra in filling out the form. A third option is to offer Sandra the stipend she would have received by participating in your program and register her in the identical program offered by the other organization which caters to the needs of individuals with disabilities like hers. If your CAA decides to pursue this third option, it must ensure that Sandra is willing to accept it, since the law requires CAAs to integrate qualified individuals with disabilities unless the individual agrees to participate in separate and different programs. When offering this third option to Sandra, the CAA must also make clear that it will work to accommodate Sandra in its program, if she prefers that option. A fourth option is to offer Sandra the third option as a standby until the CAA can take the necessary steps to accommodate Sandra in its program. If this fourth option is the one that is chosen, the CAA should establish a time frame within which it anticipates its ability to accommodate Sandra.

The above solutions to the various scenarios are "reasonable" in that they do not require the CAA to fundamentally alter the services that they provide. They are simply providing the qualified disabled individual with meaningful access to the CAA's benefits and programs, as required by law.

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9.5 percent of the employee's household income.[10] Because employers generally will not have access to data on their employees' household incomes, proposed regulations offer employers three possible "safe harbor" methods for determining affordability. Under these rules, coverage is affordable if a full-time employee's premium contribution does not exceed: (1) 9.5 percent of the employee's wages reported on Form W-2; (2) 9.5 percent of the employee's rate of pay at the beginning of the plan year; or (3) 9.5 percent of the federal poverty line for a single individual. An employer may choose to apply any one of these safe harbors for any reasonable category of employees, as long as it does so on a uniform and consistent basis for all employees in a particular category.[11]

7. How is an employer whose plan is not on the calendar year expected to meet the January 1, 2014 "play" mandate?

Recognizing that large employers with existing non-calendar year plans would face challenges in complying by the January 1, 2014 deadline, the Obama Administration has issued two transition rules for large employers that maintained non-calendar year plans as of December 27, 2012.[12]

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Under the first rule, an employer with a non-calendar year plan has until the first day of the 2014 plan year (rather than January 1, 2014) to offer affordable, minimum value coverage to those full-time employees who, under the terms of the plan that were in effect as of December 27, 2012, would be eligible to

participate in the plan as of the first day of the 2014 plan year. As long as the employer meets this deadline, it will not be penalized for failing to offer these employees qualifying coverage as of January 1, 2014.[13]

Under the second rule, an employer with a non-calendar year plan has additional time to expand eligibility under the plan and to offer coverage to those employees who were not eligible to participate under the plan's terms as of December 27, 2012. This rule applies if either: (1) at least one-quarter of the employer's employees (full and part-time) were covered under a non-calendar year plan on any date between October 31, 2012 and December 27, 2012 selected by the employer for making this determination; or (2) the employer offered coverage under a non-calendar year plan to one-third or more of its employees (full and part-time) during the most recent open enrollment period before December 27, 2012. If the employer offers affordable, minimum value coverage by the first day of the 2014 plan year to employees who would not have been eligible for coverage under any of the employer's group health plans in effect as of December 27, 2012, it will not be penalized for failing to offer coverage to these employees as of January 1, 2014.

"Pay" Mandate

8. What does it mean to "pay"?

If a large employer does not offer its full-time employees and their dependents the chance to enroll in a health plan that provides minimum essential coverage, it must pay a fee if at least one full-time employee enrolls in coverage through the state health insurance exchange (see Q&A 9 for an explanation of state health insurance exchanges) and receives a subsidy (i.e., a premium tax credit or a cost-sharing reduction) for that coverage. The fee, which is calculated on a monthly basis, is $2,000 per year for every full-time employee, excluding the first 30 full-time employees and not counting FTEs.[14]

If a large employer offers health insurance coverage, but the coverage is not "affordable" and/or does not provide "minimum value," the employer will be subject to a fee if at least one full-time employee enrolls in coverage through the state health insurance exchange and receives a subsidy for that coverage. In this case, the fee, which is calculated on a monthly basis, is the lesser of: (1) $3,000 a year for each full-time employee receiving an exchange subsidy, or (2) $2,000 a year for each full-time employee, excluding the first 30 full-time employees and not counting FTEs.[15] Unless a large employer only has around 30 full-time employees (not counting FTEs), the $3,000 per year penalty for full-time employees receiving subsidized exchange coverage will almost always be less than the $2,000 per year penalty for every full-time employee.

A large employer may use optional "safe harbor" methods to determine which of its employees are full-time employees who must be offered affordable, minimum value health insurance coverage for themselves and their dependents and to calculate liability for potential fees if it does not offer this coverage. These methods permit an employer to determine ahead of time, based on an employee's hours of service for an earlier period (known as a "measurement period"), whether an employee will be considered a full-time employee for a particular future period (known as a "stability period") and therefore must be offered qualifying coverage for that period. The safe harbors, which are quite complicated to apply, will be of most relevance to employers with numerous variable hour or seasonal employees.[16]

9. What are state health insurance exchanges?

The health care reform law requires the establishment, by January 1, 2014, of a health insurance exchange in each state that centralizes the purchase of individual (as opposed to group) health plans in that state. Each exchange will have a website that directs individuals to health plans, provides standardized information on available health plans, and assists individuals in determining whether they are eligible for premium tax credits or cost-sharing reductions (together referred to in this article as "exchange subsidies") when they purchase insurance through the exchange.

If a state chooses not to establish an exchange itself, the federal government will set up the exchange in that state and run it. Twenty-six states have chosen this option. Seven other states will be working with the federal government to establish and operate their exchanges. The remaining states will set up and run their exchanges themselves.[17]

10. Who is eligible for "exchange subsidies"?

To be eligible for an exchange subsidy as defined in Q&A 9 above, an individual's household income must be at least 100 percent, and no more than 400 percent, of the federal poverty line. Legal resident aliens with household incomes under 100 percent of the federal poverty line who are not eligible for Medicaid will also qualify. Individuals whose employers offer them affordable coverage that provides minimum value are not eligible for exchange subsidies, nor are individuals who are eligible for Medicaid, Medicare, CHIP, or government-sponsored insurance for veterans and members of the Armed Forces.[18]

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11. Will small businesses be able to purchase insurance through an exchange?

In addition to insurance exchanges for individuals, the health care reform law (known as the Affordable Care Act) calls for establishment of the Small Business Health Options Program (SHOP) to assist small businesses in finding qualified health plans, getting information on their cost and benefits, enrolling their employees, and consolidating billing. Starting in 2014, SHOP or a merged SHOP and individual exchange will be offered in each state. Employers with up to 100 employees will be eligible, although states can limit participation to employers with up to 50 employees until 2016.[19]

If an employee purchases insurance through an exchange and is determined to be eligible for a subsidy, the exchange will notify the IRS and the employer.

12. How will an employer know if it is required to "pay"?

If an employee purchases insurance through an exchange and is determined to be eligible for a subsidy, the exchange will notify the IRS and the employer. In the following calendar year, the IRS will determine whether the employer owes any fees and, if so, the amount of those fees. It will then notify the employer of its determination, provide a certification that one or more employees has received a subsidy, and give the employer an opportunity to contest the certification and assessment before issuing a notice and demand for payment.[20]

13. Does an employer have any obligation to report information regarding its compliance with the pay or play mandate?

Starting in 2015, large employers will be required to report to the IRS certain information on their compliance with the pay or play rules during the previous calendar year. A large employer will need to report whether it offers its full-time employees and their dependents minimum essential coverage, and if it does, describe certain terms of the plan, list the number of full-time employees for each month of the calendar year, and provide the name, address and taxpayer identification number of each full-time employee and the months (if any) during which the employee and any of his or her dependents were covered under the plan. In addition, the employer will need to provide each employee named on the IRS filing with an annual statement detailing the information reported to the IRS on that employee.[21]

Issues to Consider in Deciding Whether to Pay or Play

14. What are important issues for large employers in the CSBG network to consider when deciding to pay or play?

The following issues are important for CSBG-network employers to consider when deciding whether to pay or play:

- Whether fees for failing to offer coverage or offering coverage that does not meet the affordability or minimum value requirements will be allowable costs under the federal cost principle circulars (more on this below).
- If the employer is small enough to purchase coverage through SHOP in its state, what the quality and price of that coverage will be (more on this below).
- What the quality and price of coverage offered through the applicable individual exchange will be.
- Whether the employer's recruitment and retention of quality employees will be affected if it drops coverage altogether.
- The tax consequences for employees if the employer drops coverage and employees purchase insurance through the individual exchange. Employer-provided coverage is a tax-free benefit and employees generally pay their premiums on a pre-tax basis while premiums employees pay for exchange coverage will be paid on an after-tax basis. Depending on their household income, however, employees may receive exchange subsidies.
- Whether employees will be likely to seek higher salaries if the employer drops coverage. Note that additional compensation paid in the form of salaries will be taxable to employees, whereas employer-provided health insurance coverage is provided tax-free.

The individual exchanges and SHOP are scheduled to begin selling insurance to small employers and individuals by October 1, 2013.[22] Although the Supreme Court resolved uncertainties about the Affordable Care Act's constitutionality last summer, the legal challenges to the law delayed implementation of the individual exchanges and SHOP in some states. The fact that so many states have decided to rely on the federal government to set up and run their exchanges has also slowed this process. These delays have resulted

in uncertainty about the quality and pricing of plans that will be offered through the individual exchanges and SHOP. Due to this uncertainty, many employers considering whether to drop coverage are postponing that decision until 2014 or later, when there will be more clarity about exchange and SHOP plans.

Federal grantees considering dropping coverage may also want to delay their decision to see if guidance will be forthcoming as to whether fees a large employer pays for its failure to "play" will be allowable costs under the federal cost principle circulars. It is clear that the cost of providing health insurance to employees is an allowable cost.[23] However, no guidance specifically addresses whether fees an employer pays due to its failure to "play" will be allowable costs.

Federal grantees considering dropping coverage may also want to delay their decision to see if guidance will be forthcoming as to whether fees a large employer pays for its failure to "play" will be allowable costs under the federal cost principle circulars.

Costs of fines and penalties resulting from violations of, or failure of a federal grantee to comply with federal, state, and local laws and regulations are unallowable except when incurred as a result of compliance with specific provisions of an award or instructions in writing from the awarding agency.[24] The Affordable Care Act, however, gives large employers a choice of whether to "play" or to "pay." Only if an employer neither plays nor pays will it be violating or failing to comply with the Act. Therefore, it seems unlikely that fees paid for failing to play would be considered unallowable fines or penalties under this provision. Taxes that a federal grantee is required to pay are generally allowable, except for taxes from which an exemption is available to the grantee.[25] It is not clear, however, whether the fees for failure to play would be considered taxes that a federal grantee is required to pay. Moreover, the cost principle circulars also require that, to be allowable, a cost must be allocable to the organization's federal grant(s). According to the circulars, a cost is allocable to a particular cost objective, such as a grant, contract, project, service, or other activity, in accordance with the relative benefits received.[26] It is possible, therefore, that absent guidance specifically stating that fees paid for failure to play are allowable, funding sources could seek to disallow the fees on the grounds that they do not benefit an organization's federal grants.

(See endnotes on pages 17-18)

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End Notes

OMB Proposes Consolidation of Circulars

1. The circulars applicable to Community Action Agencies are the administrative grant requirements found at OMB Circulars A-102 (state and local governments); A-110, 2 CFR Part 215 (nonprofits) and the cost principles found at OMB Circulars A-87, 2 CFR Part 225 (state and local governments) and A-122, 2 CFR Part 230 (nonprofits).

Ensuring Equal Access to CAA Programs

1. Scenarios adapted from those included in: *ADA National Network "At Your Service: Welcoming Customers with Disabilities" Web Course,* http://www.wiawebcourse.org/.
2. 42 U.S.C. § 9918(c)(1).
3. 29 U.S.C. § 794(a).
4. 45 C.F.R. Part 84.
5. 45 C.F.R. § 84.3(l).
6. *See Southeastern Community College v. Davis*, 442 U.S. 397, 407 FN7 (1979).
7. Title II of the ADA requires that state and local governments give people with disabilities an equal opportunity to benefit from all of their programs, services, and activities. State and local governments are required to follow specific architectural standards in the new construction and alteration of their buildings. They also must relocate programs or otherwise provide access in inaccessible older buildings, and communicate effectively with people who have hearing, vision, or speech disabilities. Title III of the ADA requires places of public accommodation, including private social service center establishments (e.g., day care centers, senior citizen centers, homeless shelters, food banks, and adoption agencies), to comply with basic nondiscrimination requirements that prohibit exclusion, segregation, and unequal treatment. Places of public accommodation must also comply with specific requirements related to architectural standards for new and altered buildings; reasonable modifications to policies, practices, and procedures; effective communication with people with hearing, vision, or speech disabilities; and other access requirements. 42 U.S.C. §§ 12131-12134 (Title II) and 42 U.S.C. §§ 12181-12189.
8. 45 C.F.R. § 84.4(b)(1), (3).
9. 45 C.F.R. § 84.4(b)(4).
10. 45 C.F.R. § 84.4(b)(2).
11. *See Alexander, Governor of Tennessee, et al. v. Choate et al.*, 469 U.S. 287, 301 (1985).
12. See Id. at 300.
13. *See Southeastern Community College*, 442 U.S. at 412.
14. Information provided by *AboutTTY.com*: "What is a TYY?".

Health Care Reform "Pay or Play" Q&A

1. Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 218, 241 (2013) (to be codified at 26 C.F.R. § 54.4980H-1(a)(18)) (proposed Jan. 2, 2013).
2. 78 Fed. Reg. 218, 241 (to be codified at 26 C.F.R. § 54.4980H-1(a)(21)).
3. 78 Fed. Reg. 218, 243 (to be codified at 26 C.F.R. § 54.4980H-3(b).
4. Note that, in certain cases, if an employer is part of a so-called "controlled group," the employees of all the entities in the controlled group will be added together to determine whether any member of the group is a large employer. Thus, if an employer on its own does not meet the 50-employee threshold,

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End Notes

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if it is part of a controlled group, it will be considered a large employer if all the entities in the controlled group together have 50 or more employees and full-time equivalent employees (FTEs). 78 Fed. Reg. 218, 241 (to be codified at 26 C.F.R. § 54.4980H-1(a)(14)).

5. Note that the term "dependent" is defined to mean an employee's child who has not reached age 26. An employee's spouse is not a dependent. 78 Fed. Reg. 218, 241 (to be codified at 26 C.F.R. § 54.4980H-1(a)(11)).
6. 26 U.S.C. § 5000A(f).
7. 26 U.S.C. § 36B(c)(2)(C)(ii).
8. 45 C.F.R. 156.145(a)(1)-(3).
9. Actuarial Value and Employer-Sponsored Insurance, ASPE Research Brief, U.S. Department of Health and Human Services (November 2011) (visited May 21, 2013) http://aspe.hhs.gov/health/reports/2011/AV-ESI/rb.shtml.
10. 26 U.S.C. § 36B(c)(2)(C)(i).
11. 78 Fed. Reg. 218, 252 (to be codified at 26 C.F.R. § 54.4980H-5(e)(2).
12. 78 Fed. Reg. 218, 236.
13. Id.
14. 26 U.S.C. § 4980H(a) and 78 Fed. Reg. 218, 250 (to be codified at 26 C.F.R. § 54.4980H-4).
15. 26 U.S.C. § 4980H(b) and 78 Fed. Reg. 218, 250 (to be codified at 26 C.F.R. § 54.4980H-5).
16. 78 Fed. Reg. 218, 250 (to be codified at 26 C.F.R. § 54.4980H-1(a)(22), (39) and (40) and -3(c)-(e)).
17. 42 U.S.C. §§ 18031 and 18041. Establishing Health Insurance Marketplaces: An Overview of State Efforts (The Henry J. Kaiser Family Foundation, May 2, 2013) (visited May 21, 2013) http://kff.org/health-reform/issue-brief/establishing-health-insurance-exchanges-an-overview-of/.
18. 26 U.S.C. § 36B(a) and (c); 26 U.S.C. § 5000A(f)(1)(A)(ii); and 42 U.S.C. § 18071(b).
19. Affordable Insurance Exchanges: Choices, Competition and Clout for Small Businesses (Healthcare.gov, visited May 21, 2013) http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011c.html. 42 U.S.C. §§ 18031 and 18041.
20. See 26 U.S.C. § 4980H(d); 78 Fed. Reg. 218, 231; and Internal Revenue Service, Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act, Q&A 16 (Dec. 28, 2012) (visited May 21, 2013) http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act.
21. 26 U.S.C. §§ 6055-6056.
22. See 45 C.F.R. § 155.410(b).
23. 2 C.F.R. Part 230, App. B, ¶8.g. (OMB Circular A-122, which applies to nonprofit grantees); see similar provision in 2 C.F.R. Part 225, App. B, ¶8.d. (OMB Circular A-87, which applies to state and local governmental grantees).
24. 2 CFR Part 230, App. B, ¶16 (OMB Circular A-122, which applies to nonprofit grantees); see similar provision in 2 CFR Part 225, App. B, ¶16 (OMB A-87, which applies to state and local government grantees).
25. 2 CFR Part 230, ¶47a (OMB Circular A-122, applies to nonprofits); see also 2 CFR Part 225, App. B, ¶40 (OMB Circular A-87, applies to state and local governments).
26. 2 C.F.R. Part 230, App. A.3.; 2 C.F.R. Part 225, App. A.3.

Determining Whether Your Organization is a Large Employer

1. 78 Fed. Reg. 218, 242 (to be codified at 26 C.F.R. § 54.4980H-2(b)(1)).
2. 78 Fed. Reg. 218, 243 (to be codified at 26 C.F.R. § 54.4980H-2(c)).
3. 78 Fed. Reg. 218, 238.
4. 78 Fed. Reg. 218, 243 (to be codified at 26 C.F.R. § 54.4980H-1(a)(34) and -2(b)(2)).

Disallowance for Costs Extending Beyond Budget Period Upheld

1. 45 C.F.R. §§ 74.26(a); 74.27(a).
2. 2 C.F.R. Part 230, Appendix A, A.2.a.
3. 2 C.F.R. Part 230, Appendix A, A.4.a.
4. 2 C.F.R. Part 230, Appendix A, A.4.b.
5. 2 C.F.R. Part 230, Appendix A, A.2.g, A.4.a.
6. 45 C.F.R. § 74.28.
7. 45 C.F.R. § 74.21(b)(2), (b)(7).
8. 45 C.F.R. § 74.2

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