Employment, Labor & Benefits Advisory

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Treasury Department/IRS Request Comments on the Employer Mandates under the Patient Protection and Affordable Care Act

BY ALDEN J. BIANCHI

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (together, the "Act") overhauled much of the country's health care financing system and marked the beginning of a new era of comprehensive federal health care regulation. Where employers and employer-sponsored group health plans are concerned, compliance with the Act initially focused on reforms in the insurance markets and "grandfathered" plans. Recently issued Notice 2011-36 moves beyond the Act's insurance market reforms to focus on (and invite comments in connection with) certain of the Act's provisions that affect employers directly. These provisions include:

- ***Auto-enrollment***. Rules requiring employers with more than 200 full-time employees that offer group health plan coverage to automatically enroll employees in their group health plans.
- ***Employer shared responsibility***. An "employer shared responsibility" mandate that applies to "applicable large employers" (i.e., those with 50 or more full-time equivalent employees). These rules, which are set out in new Internal Revenue Code § 4980H, require applicable large employers to either offer coverage to their "full-time employees" or be potentially liable for an "assessable payment" if at least one full-time employee qualifies for subsidized coverage or a cost-sharing reduction (or an advance payment of such credit or reduction) through a state health insurance exchange.
- ***90-day limit on waiting periods***. A rule limiting waiting periods for group health plans and health insurance issuers offering group health insurance coverage under new § 2708 of the Public Health Service Act to 90 days.[1]

Notice 2011-36 does not provide guidance; it instead furnishes employers, their professional advisors, and other interested parties with an important opportunity to have their ideas heard at the early stages of the rulemaking process. This client advisory explains the key features of Notice 2011-36 and how it may impact the auto-enrollment, employer shared responsibility, and waiting period rules.

Background

Auto-enrollment

Under the Act's automatic enrollment requirement, employers with more than 200 full-time employees, that (1) are subject to the Fair Labor Standards Act (this includes most businesses and enterprises involved in interstate commerce and (2) offer group health coverage to their employees, must automatically enroll employees into health insurance plans offered by the employer following the

expiration of any applicable waiting period. Employees must be afforded the opportunity to decline coverage or to elect a different coverage option. This provision has no effective date, which would ordinarily mean that it is effective on enactment. But the Department of Labor has said that it will not enforce this requirement until after regulations are published.

Employer Shared Responsibility

Code § 4980H provides that an "applicable large employer" is liable for an assessable payment if any full-time employee is certified as eligible to receive an applicable premium tax credit or cost-sharing reduction and either of the following situations applies:

1. ***No-coverage prong***. The employer fails to offer to its "full-time employees" (and their dependents) the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan," or
2. ***Coverage prong***. The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that, with respect to a full-time employee who qualifies for a premium tax credit or cost-sharing reduction, either is (a) "unaffordable" or (b) does not provide "minimum value."

Only employees with household incomes between 100% and 400% of the federal poverty limit are eligible to apply for a premium tax credit or cost-sharing reduction.

Under the "no-coverage" prong, if an employer fails to make an offer of coverage to its full-time employees, an assessable payment is imposed monthly in an amount equal to $166.67 multiplied by the number of the employer's full-time employees, excluding the first 30. Under the "coverage" prong, if the employer makes an offer of coverage, the assessable payment is equal to $250 per month multiplied by the number of full-time employees who qualify for and receive a premium tax credit or cost-sharing reduction from a state health insurance exchange. The amount of the assessable payment under the coverage prong is capped at the amount that would be charged under the no-coverage prong. As a result, an employer that offers group health plan coverage can never be subject to a larger assessable payment than that imposed on a similarly situated employer that does not offer group health plan coverage.

The Act provides that a "full-time employee" with respect to any month is an employee who is employed on average at least 30 hours of service per week. An applicable large employer with respect to a calendar year is defined as an employer who employed an average of at least 50 "full-time employees" on business days during the preceding calendar year (special rules will need to be developed for new established entities). Thus, whether an employer is an applicable large employer depends on the number of full-time equivalent employees (FTEs), which includes full-time and part-time employees. Assessable payments, on the other hand, are determined on the basis of "full-time" employees.

The term "minimum essential coverage" is defined circularly (and unhelpfully) to mean coverage under an "eligible employer-sponsored plan." An "eligible employer-sponsored plan" includes "group health plans offered in the small or large group market within a state" but does not include "excepted benefits" as defined and described under the Public Health Service Act.[2]

Employer-provided health insurance coverage is deemed "unaffordable" if the premium required to be paid by the employee exceeds 9.5% of the employee's household income. To demonstrate that coverage is unaffordable, the employee must obtain an affordability waiver from a state health insurance exchange.

Coverage is deemed to provide "minimum value" if it pays for at least 60% all plan benefits, without regard to co-pays, deductibles, co-insurance and employee premium contributions.

Ninety-day limit on waiting periods

Group health plans, including self-funded group health plans, and health insurance issuers offering coverage in the group or individual markets may not impose a waiting period that exceeds 90 days. The term ''waiting period'' for this purpose is defined in the Public Health Service Act as ''the period that must pass … before the individual is eligible to be covered for benefits under the terms of the plan.''

Notice 2011-36: Proposed Approaches

Definitions of "employer," "employee," and "hours of service"

The definitions of "employer," "full-time employee," and "hours of service" are important in implementing the Act's auto-enrollment, employer shared responsibility, and waiting period requirements. Notice 2011-36 offers the following suggestions in this regard:

- ***Employer***. For purposes of Code § 4980H, as under Code provisions generally, "employer" would mean the entity that is the employer of an employee under the common-law test. All entities under common control would be aggregated and treated as a single employer for this purpose, which means that all employees of a single controlled group or affiliated service group would be taken into account in determining the employer's status as an "applicable large employer." The term "employee" would mean a worker who is an employee of the employer, also applying the common-law test. But "leased employees" (under the rules prescribed by Code § 414(n)(2)) would not be "employees" for this purpose, because the Act makes no reference to leased employees.
- ***Full-time employee***. Code § 4980H treats, with respect to a month, an employee who has an average of at least 30 hours of service per week as a full-time employee. Notice 2011-36 proposed to treat 130 hours of service in a calendar month as the monthly equivalent of at least 30 hours of service per week. This amount is set at 130 hours instead of 120 hours because the average month consists of more than four weeks (52x30/12=130).
- ***Hours of service***. The notice proposes to define "Hours of service" with reference to existing Department of Labor guidance under which an employee's hours of service include (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. For employees paid on an hourly basis, the employer would be required to calculate actual hours of service from records of hours worked and hours for which payment is made or due. For employees not paid on an hourly basis, Notice 2011-36 suggests that employers could apply "days-worked" or "weeks-worked" equivalencies.

Applicable Large Employers

Code § 4980H defines the term "applicable large employer," with respect to a calendar year, as an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year. The notice proposes to define "full-time" for this purpose to mean the sum of the employer's full-time employees and its full-time equivalent employees. Full-time employee status is determined on a monthly basis and it includes an employee (including a seasonal employee) who is employed, on average, at least 30 hours of service per week (or at least 130 hours of service in the calendar month). An employee who is not a full-time employee under this standard (including a seasonal employee) for a given month is taken into account in the full-time equivalent calculation. Each "full-time equivalent employee" is treated as one full-time employee for the year according to a series of steps suggested by the notice. Once the calculation of full-time and full-time equivalents are completed and summed, seasonal employees are subtracted. If the final total is 50 or more, the employing entity is an "applicable large employer." The term "seasonal employees" is defined in the Act with reference to existing Department of Labor rules[3] as employees who perform labor or services

on a seasonal basis, including seasonal workers and retail workers employed exclusively during holiday seasons. The Act provides that, if an employer's workforce exceeds 50 full-time employees for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal employees, the employer would not be an applicable large employer. The notice proposes that, for this purpose only, four calendar months would be treated as the equivalent of 120 days.

Determining employer shared responsibility liability

Assessable payments under Code § 4980H(a) (i.e., the "no-coverage prong") are determined by reference to the number of full-time employees employed for a given month, while liability under Code § 4980H(b) (i.e., the "coverage prong") is determined by reference to the number of full-time employees with respect to whom an applicable premium tax credit or cost-sharing reduction is allowed or paid for a given month. The Treasury Department and IRS concede in the notice that:

> [A] determination of full-time employee status on a monthly basis for purposes of calculating an employer's potential § 4980H liability may cause practical difficulties for employers, employees, and the State Exchanges. These difficulties include uncertainty and inability to predictably identify which employees are considered full-time and, consequently, inability to forecast or avoid potential § 4980H liability.

To address these concerns, the regulators propose an alternative standard under which applicable large employers could use a look-back/stability period safe harbor. Under this approach, an employer would be permitted to determine each employee's full-time status by looking back at a defined period of not less than three but not more than twelve consecutive calendar months (the measurement period), to establish whether the employee averaged at least 30 hours of service per week (or at least 130 hours of service per calendar month) during the measurement period.

If the employee is determined to be a full-time employee during the measurement period, then the employee would be treated as a full-time employee during a subsequent "stability period," regardless of the number of the employee's hours of service during the stability period, so long as he or she remained an employee. For an employee who was determined to be a full-time employee during the measurement period, the stability period would be a period of at least six consecutive calendar months and no shorter in duration than the measurement period. What is not clear is how the look-back/stability period safe harbor rules would apply in the case of employees hired during, or who move into full-time status during, the measurement period. The notice says only that safe harbor will need to be adapted and its application will be limited in some respects.

Treasury and IRS requested comments on other possible alternative methods of determining full-time employee status for purposes of calculating an applicable large employer's potential assessable payment. Comments are also invited on a series of specific questions relating to how a look-back/stabilization period might work.

Request for comments

The Notice concludes with a general request for comments under Code § 4980H. Separately, comments are requested on the manner in which the 90-day waiting period under the Public Health Service Act might be implemented, and how this requirement might coordinate with the Act's employer mandates.

Conclusion

Notice 2011-36 is important in at least two respects: First, it marks an important inflection point in the regulatory implementation of the Act. The Act's employer mandates are now front and center. Second, while the rules implementing the Act's insurance market reforms were, for the most part, issued as interim final regulations that provided for little or no input from the regulated community, the regulators are now soliciting input at the front end of the rulemaking process. This should not be seen as a change of heart on the part of the regulators. The insurance market reforms began to take effect a

mere six months after the Act's passage, leaving little time to issue guidance. The employer mandates generally have a much longer lead time, giving the regulators the luxury of time to solicit comments. One hopes that interested parties will engage in the process and provide the regulators with their views. The result might well be a set of workable rules that cause only as much disruption as is necessary to implement the Act.

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If you have any questions about this advisory, please contact the author or your Mintz Levin attorney.

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Endnotes

1 This requirement is not technically an employer mandate. It is rather one of the Act's insurance market reforms that take effect in 2014. It is included in the notice because of its close relationship to the auto-enrollment and employer shared responsibility rules.

2 "Excepted benefits" include (i) coverage only for accident, or disability income insurance, or any combination thereof, (ii) coverage issued as a supplement to liability insurance, (iii) liability insurance, including general liability insurance and automobile liability insurance, (iv) workers' compensation or similar insurance, (v) automobile medical payment insurance, (vi) credit-only insurance, (vii) coverage for on-site medical clinics, (viii) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits, and (ix) any of the following if provided under a separate policy, certificate, or contract of insurance: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; other limited benefits similar to those above, to the extent specified in regulations; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; or Medicare supplemental health insurance, coverage supplemental to TRICARE, or similar coverage supplemental to coverage under a group health plan.

3 29 C.F.R. § 500.20(s)(1).

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