Q&A from Assurex Global Webinar "Health Care Reform"	February 19 & 21, 2013
Question	**Answer**
Q: Can a 25 year old child on our plan enroll in the Exchange and get the subsidy? Domestic partner/civil union? Child of civil union? Q: If the single cost is affordable and the employee enrolls with the employer, but the family cost is expensive - may the family purchase coverage through the Exchange? Assuming that it is economical without a subsidy.	A: Any individual can purchase individual health insurance coverage through an Exchange; the determination of their qualification for subsidies depends on the household income and whether the individual is eligible for employer-sponsored "affordable" minimum value coverage. Remember that affordable employer sponsored coverage is based only on the contribution requirement for employee-only coverage. Consequently, if a dependent is eligible for the employee's plan and the coverage is affordable for the employee only, the dependent will not be
Q: Are you saying that if the employee is not eligible for premium assistance, then their family is not eligible? Q: How do penalties apply to family members if employee coverage is deemed affordable, but they cannot afford to cover the family? Q: Can family members still purchase insurance on the Exchange even if they are not eligible for subsidy? Q: What about the proposed rule related to premium assistance that says the individual mandate does not apply to family members if the employee's cost for family coverage exceeds 8% of the household income?	A: It is possible that an employee's family members may not qualify for premium tax credits (since the cost of self-only coverage is deemed to be affordable for the whole family), but they may nevertheless avoid the individual shared responsibility tax if the lowest-cost family coverage exceeds 8% of household income. Unlike eligibility for the subsidy, which is based only on the cost of single coverage, for purposes of the individual mandate tax the cost of the family coverage is considered.
Q: For a group with a 7/1/2014 plan year, the rules don't apply till then. Can an employee that qualifies for subsidized coverage elect and get the subsidy on 1/1/2014? Q: Will employees be required to have insurance coverage on January 1, 2014, or will they have a transition period and be able to elect coverage as of 4/1/14 when our new plan year begins to avoid paying a penalty?	A: An eligible individual may qualify for subsidized coverage when purchasing individual health insurance through a public Exchange, and the individual mandate rules apply beginning 1/1/2014 regardless of when the employer plan year begins.
Q: Can the employer put money in the employee's healthcare FSA to cover Exchange purchased coverage and have it a tax-free contribution to the employee?	A: No - Section 125 and ACA rules prohibit using health FSA funds to purchase individual health insurance coverage though an Exchange.
Q: What about COBRA coverage? If the COBRA premium is greater than 9.5% of household income, would that person be eligible for a subsidy?	A: If the only coverage available to the individual (including COBRA) exceeds 9.5% of their household income, the individual would be eligible for subsidized coverage assuming they meet all eligibility requirements.

Q: Can an employer use an HSA to help their employees purchase insurance on the Exchange?

A: Generally, HSA funds cannot be used to pay health premiums, whether on an Exchange or otherwise. HSA funds can only be used to pay for the following health insurance premiums:
- Continuation coverage under federal law (e.g., COBRA or USERRA coverage)
- Any health plan maintained while the individual (i.e., the HSA holder or his or her spouse or dependent) is receiving unemployment compensation
- For HSA holders age 65 or over, any deductible health insurance (e.g., retiree medical coverage) other than a Medicare supplemental policy

Q: Does an employer have to offer COBRA coverage if the terminated employee could now go to an Exchange. What is the benefit for them to stay on COBRA?

A: COBRA must be offered upon termination of employment or an employees reduction in hours. However, if the former employee voluntarily elects to drop the employer plan and take coverage through the Exchange (which may provide better coverage and/or lower premiums), COBRA would not be available.

Q: Can you further clarify the measurement period and the transition rule?

A: For employers choosing to use the optional look-back measurement period, typically, the measurement period is required to match the chosen stability period. However, for ease of administration in determining full-time status for the 2014 fiscal plan year, the employer may adopt a transition measurement period that is shorter than 12 months, but that is no less than 6 months. In addition, the transition measurement period must begin no later than July 1, 2013 and end no earlier than 90 days before the first day of the 2014 plan year.

Q: Is it true that the IRS states that to determine full time you can use any 6 month period during that year?

A: Not exactly. For determining individual full-time status for benefit eligibility, employers choosing a 6-month measurement period may choose any 6-month consecutive period prior to the plan renewal (starting on any day of the month), so long as such measurement period ends no earlier than 90 days before plan year (to comply with the requirement that the waiting/administration period be no more than 90 days).

Q: Transition Rule - the law states fiscal year plan, does this then actually mean plan year or is there a different definition?	A: The IRS uses the term "fiscal year plan" to describe any plan with a plan year other than the calendar year. The preamble to the regulations specifically states the transition relief is intended for "…plans with plan years other than the calendar year (fiscal year plans)…". The term "fiscal year plan" in this context has nothing to do with the employer's "fiscal year" for other purposes such as corporate finances or taxes.
Q: What about plan years ending 6/30/13?	A: Employers that meet (a) or (b) below qualify for transition relief for non-calendar plan years: (a) at least 1/4 of the company's employees covered under the fiscal plan years (as of the end of the most recent enrollment period or any date between October 31, 2012 and December 27, 2012), OR (b) 1/3 or more of the company's employees offered coverage under those plans during the most recent open enrollment period before December 27, 2012 If the employer satisfies either of the above criteria for transition relief for non-calendar plan years, no penalties will apply until the plan renews 7/1/14, so the employer has additional time to make any necessary changes to plans and/or coverage availability. If the employer does not satisfy the criteria, any employees working 30 hours or more must be offered coverage as of 1/1/14 to avoid potential penalties.
Q: After the transition rule measurement period, which may be no shorter than 6 months, does the measurement period and stability period have to be the same period going forward?	A: Employers will have the option to use a measurement period of between 3 - 12 months. The stability period must be at least as long as the measurement period, but can be no shorter than 6 months. Also, if an employer uses a shorter measurement period (e.g. 3 months) any employee that is determined not to be full-time during the measurement period must be "re-measured" every 3 months.
Q: Once you choose a measurement method, do you need to stick with that same method from year to year?	A: No, the measurement method may be changed going forward annually. However, it cannot be changed during a year once the standard measurement period has begun.
Q: We have bi-weekly pay periods, so can our 6 month measurement period start on any day of a month? Sure would make it easier.	A: Typically, employers are choosing to use 12-month measurement periods for ease of administration; however, whatever standard measurement period is chosen, it can be started on any day of the month. Initial measurement periods applicable to new hires may begin any time form the date of hire to the first of the month following the date of hire.

Q: Can small employers (less than 50 FTEs), use this measurement period to determine if they must offer these employees coverage?

A: Small employers with less than 50 FTEs are not subject to penalties for failing to offer coverage to employees determined to be working 30 or more hours per week, and therefore do not need to use the measurement period to determine eligibility. Rather, small employers may continue to use the eligibility requirements set forth in their current plans if desired. Keep in mind, however, small employers are subject to the maximum 90-day waiting period for all eligible employees, so some may consider implementing the measurement period system so that an initial measurement period of longer than 90 days can be applied to new "variable hour" and seasonal employees.

Q: How do you handle 12-month measurement periods for new employees hired throughout the year?

A: For new full-time employees (expected to work 30 or more hours per week), they must be offered coverage within 90 days of being hired. For new variable hour or seasonal employees, the measurement period may begin any date between the employee's hire date and the first day of the month after the hire date. Starting the initial measurement period on the first of the month would be easier administratively, because the employer would only have 12 initial measurement periods to keep track of with multiple new hires in each one; using date of hire would mean a different initial measurement period for every employee. Also keep in mind, the initial measurement period and the administrative period combined may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the start date (at most, 13 months plus a fraction of a month) for new hires. After the initial measurement period and stability period, the employee would then be subject to the same standard measurement period and stability period used for other ongoing employees.

Q: For a 1/1 renewal, how do you handle a new hire during the year? Say 5/12. How do you calculate and when does insurance become active?

A: If the new employee is a full-time employee hired 5/1/14, the employee must be offered coverage within 90 calendar days. If the new employee is a variable hour or seasonal employee and the employer is using a 12-month measurement period, the measurement period would run 5/1/14-4/30/15, with an administrative period of 1 month, and therefore the employee must be offered coverage no later than 6/1/15.

Q: How do you handle status changes if they work full time for 6 months, then change to a variable hour employee the last 6 months of the measurement period. When you look at their hours at the end of 12 months, since they worked 30 hours for a portion of the year, they will most likely have an average of 1560 hours. How do we handle these associates?

A: If they are considered variable hour employees, and the optional look-back measurement period is used, the employee's hours of service must be averaged over the entire measurement period. If the employee has 1560 or more hours of service, the employee would be eligible for benefits for the entire stability period following such measurement period for as long as they are employed by the company.

Q: Can I still require an employee to work 12 months before they are eligible for insurance?

A: New full-time employees (expected to work 30 or more hours per week) must be offered coverage within 90 days of being hired. For new variable hour or seasonal employees, the employer may use the optional look-back measurement period, which could require up to a 12-month measuring period plus the administrative period.

Q: I understand that the standalone HRA would not qualify as a health plan. Does that also mean that it CANNOT be offered and still qualify for preferable tax treatment? Let's say you have a firm of less than 50 employees, not offering insurance, and great majority of employees are over 400% of FPL (professional group). Could the employer/employees still have a standalone HRA providing them with preferential tax treatments even though the standalone HRA is not a qualified PPACA plan?

A: No - The rule that prohibits no lifetime or annual maximum applies to all HRA's regardless of the size of the employer. Consequently a stand alone HRA which imposes a maximum benefit level will not be permitted.

Q: Can you set up an HRA for employees to use for any healthcare expense - premiums or expenses if you don't offer insurance?

A: No. The DOL has issued specific guidance that an HRA is only permitted if it is integrated with a group health plan which has no lifetime or annual maximums. An HRA set up solely to fund individual health insurance policies would violate this rule.

Q: If you have a fully insured plan that includes an HRA, you pay the research fee twice...once for the plan through the carrier and once directly for the HRS?

A: Correct, but the HRA fee is only based on the number of employees eligible to participant, not any family members.

Q: Please clarify, per participate research fee for PORF, is that per employee and each covered dependent?

A: Essentially yes, the research fee is based on the total number of participants, including employees and covered dependents (other than for an HRA which is based only of the number of eligible employees).

Q: We just met with our broker and our Patient Outcomes Research Fee was included on our 4/1 renewal. Per this slide, it wouldn't be due until July 2014. The broker itemized it out in our 4/1/2013 renewal as a fee. Please verify.

A: The fee is due by July 31st in the year after the end of the plan year. Thus, the first time the fee will be due will be for plan years beginning during November and December 2011, or 1/1/2012. These plans will need to pay the fee by July 31, 2013.

Q: If you choose the 5500 method to calc the Patient Outcome Research Fee - year 1, must you use that method going forward - yr 2, etc.?	A: The method used to calculate the fee can be changed from plan year to plan year.
Q: We have a high deductible fully insured plan with an underlying HRA plan that as administered through our insurance carrier. Our understanding is that the insurance carrier would be responsible for paying the research fee. Is that accurate?	A; The insurance carrier is responsible to pay the fee for the fully insured health plan. The plan sponsor (generally the employer) is responsible to pay the fee for the HRA.
Q: Under Employer Shared Responsibility rules, what is considered "Unaffordable" coverage?	A: Coverage for an employee under an employer-sponsored plan is affordable if the employee's required contribution for employee-only coverage does not exceed 9.5% of the employee's household income for the taxable year. Household income is defined as the modified adjusted gross income of the employee and any members of the employee's family (including a spouse and dependents) who are required to file an income tax return. Modified adjusted gross income means adjusted gross income increased by (1) amounts excluded from gross income under section 911 (foreign income), (2) the amount of any tax-exempt interest a taxpayer receives or accrues during the taxable year, and (3) an amount equal to the portion of the taxpayer's social security benefits which is not included in gross income under section 86 for the taxable year.
Q: For "affordability" measurements, is this in reference to the premiums only? (Not deductibles)	A: For coverage to be deemed 'affordable', the employee's required contribution to the employee-only premium cannot exceed 9.5% of household income. It is not based on the entire plan premium for the plan or any related deductibles, cost sharing etc.
Q: How as an employer are we supposed to know the household income?	A: You won't need to, due to a special "safe harbor" rule. Employer's may choose to use one of the three following options for determining affordability as household income is often unknown to the employer: (i) based on the employee's W-2 wages (as reported in Box 1); (ii) based on employee's rate of pay; or (iii) based on federal poverty level.
Q: Just so I am clear, I cannot just take someone's hourly rate x 2080/12 to get a monthly figure, I will need to use one of the 3 safe harbor methods?	A: Correct

Q: Does the 4980H(b) penalty apply to all other FTE's or only to employees who become eligible when they enroll through the Exchange?

A: The penalty under 4980H(b) only applies to applicable large employers for full-time employees that are not offered affordable, minimum value coverage that then enroll and receive a subsidy through the Exchange. The penalty would not apply to all full-time employees (unlike penalty 4980H(a)), but instead applies only to those employees that enroll and receive a subsidy through the Exchange.

Q: Should employers use gross income of the employee from the employee's gross wages in 2012, since I won't know gross wages for 2013, until early 2014?

A: Although the determination of whether an employer actually satisfied the safe harbor would be made after the end of the calendar year, an employer could theoretically use the safe harbor prospectively, at the beginning of the year, by structuring its plan and operations to set the employee contribution at a level to ensure that the employee contribution for each employee would not exceed 9.5% of that employee's W-2 wages for that year.

Q: How frequently does the federal government update the FPL? Is it annual?

A: Yes, the FPL is updated annually. There are rates provided for the 48 contiguous states and separate rates provided for Alaska and Hawaii.

Q: What is considered minimum essential coverage?

Q: What is minimum value coverage?

A: “Minimum essential benefits”, "minimum essential coverage" and “minimum value” are three distinct concepts:

• Minimum essential benefits refers to the list of ten categories of benefits, within which the specific benefits which must be provided is determined on a state by state basis (this requirement only applies to individual coverage and small group coverage offered through an exchange);

• Minimum essential coverage has not yet been clearly defined as of this response. The IRS is expected to release minimum essential coverage rules.

• Minimum value refers to a plan which covers 60% on an individual’s health care expenses (the so-called “bronze plan”), which all applicable large employers, insured and self-funded, must offer to employees at an affordable contribution level in order to satisfy the employer shared responsibility requirements.

Q: Safe Harbor Rule Q:"As long as the ee contribution for single coverage meets a safe harbor . ERs will not be liable for penalty" How will ees be eligible for subsidy, if the test is based on EE insurance rate?

A: So long as the cost of employee-only coverage meets one of the safe harbors (and assuming the coverage provides minimum value), the employer will not be subject to a penalty on the basis of lack of affordability—even if the actual cost for coverage exceeds the 9.5% threshold.

If the employee-only coverage is not affordable, the employee and dependents may still qualify for subsidized coverage through the Exchange even though no penalty applies to the employer.

Q: Can you use the W-2 safe harbor for hourly employees who are paid above minimum wage and the federal poverty level safe harbor for employees who are paid minimum wage. In other words use different calculations for different employees in the same company?

A: §54.4980H–5(e)(2)(i) states: “Use of any of the safe harbors is optional for an applicable large employer, and an applicable large employer member may choose to apply the safe harbors for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category.”

Q: For the 4980(H)(b) W-2 Safe Harbor, do we calculate what the employee actually contributes for the plan he/she selected or what the contribution would be for the lowest value plan we offer?

Q: What if two plan options are offered and one is greater than the 9.5% of the "rate of pay" and one is less than the 9.5%? (Traditional versus HDHP, for example)

Q: If we offer a no cost employee only health plan and the employee has the option to buy up to a better plan, how does this affect the eligibility for the subsidy.

A: For purposes of calculating affordability, it is only necessary to consider the employee contribution for employee-only coverage of the lowest cost plan offered (so long as that lowest cost plan provides the required minimum value coverage). It does not matter if the employee is eligible for, or elects, more expensive coverage.

Q: How does this affect part-time employees for calculation of affordability?

A: Penalties only apply to applicable large employers for failing to offer affordable coverage to full-time employees as defined by the ACA. It is not necessary to offer affordable coverage to part-time employees.

Q: What if your company offers wellness screenings annually that allow an employee to reduce their premium depending upon certain metrics (Health)...will the starting point of employee premium still need to be below 9% at its starting point before premium reductions take place or is there leverage due to the screenings being offered?

A: Affordability is based on the required contribution for the individual. Consequently, if an employee is required to pay more to participate in the plan due to a wellness incentive or surcharge, the plan could be "unaffordable" to that employee while the same plan is "affordable" to another employee who participates in the wellness program.

Q: Can you clarify, if an employer offers discounts for wellness program participation which would bring the cost below the 9.5% and the employee does not participate, then the employer is subject to the subsidy if it is above the 9.5%?

Q: How are eligibility waiting periods impacted by ACA?

Q: Must we offer insurance coverage from date of hire, rather than after completion of 90 day probation/orientation to avoid penalties?

A: For plan years beginning on or after January 1, 2014, a group health plan may not apply a waiting period that exceeds 90 days for any employees eligible for coverage as a full-time employee. There is no requirement to offer coverage on date of hire.

Q: Is the FTE calculated on 30 hrs a wk or 40?

A: For purposes of the employer shared responsibility rules, a FTE is 30 or more hours per week (130 hours or more per month).

Q: IS THERE A MINIMUM - MAXIMUM # OF EMPLOYEES IN RE TO REQUIREMENT TO "OFFER" HEALTH INSURANCE ? & WHEN DOES THIS "RULE" GO INTO EFFECT?

A: For applicable large employers (50 or more FTEs), penalties will apply for plan years beginning on or after 1/1/14 (subject to the transition relief criteria) if employers fail to offer coverage to eligible full time employees.

Q: It seems at one point the guideline was requiring employers to contribute at least 60% of premium. Is this no longer the case even with family coverage?

A: There is no requirement that the employer contribute a certain % toward the cost of coverage. However, for "applicable large employers" if the employer contribution is too low, it can trigger a penalty under the 4980H(b) rules if the coverage is unaffordable to a particular employee (i.e. exceeds 9.5% of their household income).

Q: Define "Applicable Large Employer"

A: Section 4980H(c)(2) defines an 'applicable large employer' with respect to a calendar year as an employer that employed an average of at least 50 full-time employees (taking into account FTEs) on business days during the preceding calendar year. For purposes of counting the number of full-time and full-time equivalent employees, all entities of a controlled group under Section 414 are treated as a single employer.

Q: Need to understand control group and how to determine "large employer". Example: XYZ company is parent of 3 separate employers: A is 100% owned by XYZ. B is 80% owned by XYZ. C is 51% owned by XYZ. How do I determine "large employer"?

Q: For fully insured plans, who is responsible for the filing of IRS Form 720?

A: Determination of controlled group status is based on the rules contained in IRC §414. The §414 rules are complex and beyond the scope of what can be address in this format. In general, if A, B and C are all determined to be a part of a controlled group, all FTEs of the three companies must be aggregated to determine applicable large employer status (50 FTEs or more). If aggregated, the control group is considered an applicable large employer, than each company separately is considered an applicable large employer and therefore individually liable for the shared responsibility rules. Employers with common ownership across multiple entities must have the structure analyzed in detail by someone qualified to make a determination based on the Code §414 rules.

Q: Being part of control group doesn't get ER around the 50 FTE measure, but can an ER use it to their advantage to reduce the $2000/EE fine? So, if ER has 3 separate companies and does not provide affordable MEC to one of those companies, is the $2000/EE applied to only that company as opposed to all the companies within that control group?

A: Yes, that's correct. 4980H penalties would apply only to the individual company failing to offer coverage, as set forth in the shared responsibility rules, rather than to all companies within a control group.

Q: Do I count employees that are a part of a union and get their benefits from the union as a part of my FTE's for purposes of the employer shared responsibility rules?

A: Yes, both union and non-union employees should be considered to determined both (a) status as an applicable large employer, and (b) FTEs that should be offered coverage to avoid 4980(H) penalties.

Q: None of our part-timers go over the 30 hours per week or 1560 for the year; We pay 100% of our full-timers healthcare; We have about 30 full-timers and a LARGE group of part-timers. So to be clear, to see if we would be subject to the employer shared responsibility in 2014. I would need to count ALL of our part-timers' hours combined for 6 months and divide by 120?

A: Close - each month you need to count the total hours worked by your part-time employees and divide by 120 to determine the number of FTEs for that month. You would then average the number of FT and FTE employees determined for each month over the total months you are using to make the determination.

Q: ER Shared Responsibility - If you have different classes of employees (bargaining and non) and bargaining ees have qualified coverage but it is not offered to non bargaining ees, are the bargaining ees included in the number of ees an ER is charged for?

A: Yes, if it is an applicable large employer (50 or more FTEs), all employees working 30 or more hours per week in either class must be offered coverage to avoid penalties, and the penalty under 4980H(a) is based on the total number of full-time employees (not counting the first 30), regardless of if they are covered or not.

Q: Do we have to pay even if we are tax exempt and non-profit? What about a governmental body employer - like a municipality?

A: 4980H penalties apply to all common law employers, including an employer that is a government entity (such as Federal, State, local or Indian tribal government entities) and an employer that is an organization described in section 501(c) that is exempt from Federal income tax under section 501(a).

Q: Does FMLA count as hours of service?

A: Technically, yes. The proposed regulations contain an averaging rule to prevent periods of special unpaid leave from reducing an employee's hours of service during a measurement period. Special unpaid leave is defined as unpaid leave under the Family and Medical Leave Act of 1993, under the Uniformed Services Employment and Reemployment Rights Act of 1994, or for jury duty. The employer can neutralize the effect of special unpaid leave in either of two ways:

- the employer can determine the employee's average hours of service by excluding any periods of special unpaid leave during the measurement period and applying that average for the entire measurement period, or
- the employer can impute hours of service during the periods of special unpaid leave at a rate equal to the average weekly hours of service for weeks that are not part of a period of special unpaid leave.

Q: I have 100+ employees. I have 15 employees who work more than 30 hours but only work 10 months of the year. I do not cover them in the health plan....since I don't have to count the first 30 I should not have to pay a penalty. right?	A: Not necessarily. This would be true for penalties under 4980H(a), but the 30 employee margin of error rule does not apply to penalties under 4980H(b). Therefore, the employer may still be liable for penalties for eligible employees not offered affordable, minimum value coverage that enroll for coverage through the Exchange.
Q: 95% Rule: Offer = no penalty to employer. What will force employee to accept coverage. And what about waivers. Q: For an employee who declines coverage should we have them sign a waiver that they actually declined coverage?	A: There is no penalty to applicable large employers so long as coverage is OFFERED to eligible employees. The employees do not have to accept the coverage for the employer to avoid penalties. There is no specific ACA requirement that employees sign waivers; however, employers will need to be able to demonstrate that they offered coverage to all full-time employees and a signed waiver could be important documentation.
Q: Is the first penalty of $2,000 times EEs bases on full-time employee number or the average FTE number in the prior calendar year?	A: The penalty under 4980H(a) is based on "true" full-time employees and does not include FTEs (FTEs are relevant only for determining applicable large employer status). Employers are required to offer coverage to at least 95% of full-time employees to avoid the penalty; however, if the employer fails to do so, there is no penalty for the first 30 employees.
Q: Can you speak on temporary workforce, staffing companies? If we do not know the length of their assignment - hourly variable rule? Q: What about FT temporary staff under 6 month contracts but who can renew after 6 months for another 6. Do they need to be offered insurance, even though our temporary employees are not eligible for health benefits? Q: What about new temp employees for 90 probation period, do they have to be offered insurance immediately? Q: Employees in an Intern status, PT or FT, are not eligible for benefits or paid holidays under our current policy. To clarify, under the shared responsibility, interns who work 30+ (but temporary), should be "offered" benefits and our policies should be changed?	A: The IRS is still taking comments on final rules as they apply to “short-term hires" or temporary employees; however, for the 2014 plan year, the employer is allowed to treat an employee who is not expected to work the entire measurement period as a variable hour employee. If the employer imposes a 6-12 month new hire initial measurement period, it is unlikely any of these employees would “earn” full time status.

Q: For purposes of the Shared Responsibility Rules (Pay or Play), how should we address temps that are not hired through an agency. I doubt that we need to offer them coverage, but please clarify how this works. Would they be covered under the 95% margin of error rule (assuming that less than 5% of our total EEs are temps)?

A: If they are 1099 independent contractors, the employer does not need to consider such penalties for determining status as an applicable large employer or for eligibility for coverage; however, it they are temporary/seasonal employees of the company, it is necessary to consider them for both purposes (the employer may use up to a 12-month measuring period to determine FTE status for eligibility, often avoiding having to provide coverage for those employed for short durations).
So long as at least 95% of full-time employees are offered coverage, penalty 4980H(a) - $2000/full-time employee will be avoided; however, if any FTE is not offered coverage and enrolls and receives a subsidy for coverage through the Exchange, the employer may be subject to penalty 4980H(b).

Q: We are a large employer. We have a calendar plan year. Our Health Plan does not have an open enrollment period. Staff are eligible to enroll when they meet the eligibility requirement and after that time only if there is a qualifying event. Does the ACA require an open enrollment period each year?

A: To avoid penalties under the shared responsibility rules, coverage must be offered to all employees working 30 or more hours per week. The following definition exists for "offer of coverage" - Prop. Reg. § 54.4980H-4(b) "An applicable large employer member will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll (or decline to enroll) in the coverage no less than once during the plan year. Whether an employee has an effective opportunity is determined based on all the relevant facts and circumstances, including adequacy of notice of the availability of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer."

Q: Any news about the mandatory auto-enrollment mandate? (for employers with more than 200 FTEs)

A: The DOL has delayed the implementation of the auto-enrollment rules until after guidance is issued and has stated that guidance will not be ready in time for the rules to be in effect by 2014.