THE HEALTH CARE LAW: WHAT YOU NEED TO KNOW NOW

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IN FOCUS:
Employers with 50 or more full-time-equivalent employees
April 2013

Industry Colleagues:

It looks as though implementation of the 2010 health care law will be one of the greatest challenges restaurant operators will ever face. It’s made even more complicated by the fact that, just months from the largest pieces of the health care law going into effect, we are still awaiting important details from federal regulators.

The National Restaurant Association has been working for three years to address the challenges the restaurant industry faces in implementing this law by actively participating in regulatory progress, advocating for flexibility, and asking regulators to address the implementation of the employer requirements as a total package and not through piecemeal rulings.

We are also asking Congress to make changes to the law before employer requirements take effect Jan. 1, 2014.

We are focusing our efforts on addressing the major pieces of the law that most directly affect the restaurant industry. Our efforts to educate regulators at the Treasury, Health and Human Services and Labor Departments are squarely focused on making impact. Our work will continue.

You’ll find important information here on the current status of the law. More than 20,000 pages of regulations have been released to explain the law — so far. That’s staggering. Many of the most significant proposals for America’s employers are still in the works.

We encourage you to actively engage with this issue through the National Restaurant Association’s online Health Care Knowledge Center, Restaurant.org/Healthcare. Sign up for our e-newsletters, get as much information as possible so you can make good business decisions, and join us in advocating for change.

Sincerely,

Dawn Sweeney
President & CEO
National Restaurant Association

Phil Hickey
Chairman
National Restaurant Association

The National Restaurant Association provides the following information on the 2010 health care law and federal agencies’ evolving regulatory guidance as a service to members. This information is not intended as legal advice and is not meant to be a substitute for the reader’s seeking legal counsel. We have taken every step to ensure accuracy, but can provide no guarantees. Employers are advised to consult with legal counsel on all matters related to the law. The Association’s Health Care Knowledge Center at Restaurant.org/Healthcare offers links to relevant regulatory guidance.

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Health care law requires “applicable large employers”\(^1\) to offer coverage or face possible penalties

**Businesses have little time to get ready for 2014 requirements**

Employers with more than 50 full-time-equivalent employees face some of the health care law’s most challenging requirements. Starting in 2014, “applicable large employers” — employers with 50 or more full-time-equivalent employees — must offer “minimum essential coverage”\(^2\) to full-time employees and their dependents or face possible penalties. (Hereafter, “applicable large employers” are referred to as “large employers”)

Large employers can face two types of penalties: (a) if they fail to offer minimum essential coverage to at least 95 percent of their full-time employees (and their dependents), or (b) if they offer a plan but the plan is not “affordable” or doesn’t meet a “minimum value” standard.

Penalties for large employers are triggered if one or more full-time employees uses a federal premium tax credit\(^3\) or cost-sharing reduction\(^4\) to buy private insurance through an exchange because they don’t have access to coverage through their employer, or because the coverage they are offered is not affordable or does not provide minimum value.

Businesses don’t have much time to get ready for 2014, and critical guidance remains missing.

Employers can rely on proposed regulations that the Treasury Department/Internal Revenue Service published in the *Federal Register* Jan. 2, 2013, until further guidance is available. The regulations explain the law’s so-called “employer shared responsibility” provisions. But businesses are still waiting for explanations on many other provisions of the law, including new reporting rules that could play a central role in how the IRS calculates and assesses penalties against large employers.

The National Restaurant Association is urging Congress to make changes to the law before the employer requirements take effect Jan. 1, 2014. The Association is also urging Congress to provide some transition relief for large employers that make good-faith efforts to comply in the initial years of the law’s implementation.

Visit [Restaurant.org/Healthcare](http://Restaurant.org/Healthcare) to read more about the law and the National Restaurant Association’s efforts on behalf of the restaurant industry.

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1 “Applicable large employers” (hereafter referred to as “large employers”) are defined under the 2010 health care law as employers with 50 or more full-time-equivalent employees.

2 “Minimum essential coverage” has multiple meanings under the health care law and has not been fully defined in the context of employer-sponsored coverage. For a large employer to avoid the subsection (b) penalty (see page 8), the employer’s minimum essential coverage must be affordable and of minimum value.

3 Premium tax credits are government subsidies aimed at reducing premium costs for lower- to middle-income individuals who buy private health plans on exchanges. The credits will generally be available to people with incomes between 100 percent and 400 percent of the federal poverty level who don’t have access to affordable, minimum-value coverage through their employer, a government program or another source. If an individual is approved for a premium tax credit, the exchange will pay the credit directly to the exchange health plan in which the employee is enrolled.

4 Cost-sharing reductions are government subsidies to help limit out-of-pocket costs and other cost-sharing amounts (such as deductibles and co-payments) for people who purchase health plans on exchanges. These cost-sharing reductions are available to people with incomes up to 250 percent of the federal poverty level.
Overview

Health Care Law:
Key Dates and Deadlines

The health care law kicks into high gear in 2014, but states and the federal government are rolling out parts of the law in the lead-up to full implementation. Here’s a look at some key dates and deadlines.

2013

- **[Jan. 1]** New Medicare payroll / investment income taxes. New 3.8 percent tax on investment income and extra 0.9 percent tax on wages above a certain level hit taxpayers at income levels above $200,000 (single filers)/$250,000 (married, filing jointly).

- **[March-May]** Insurers apply for approval of plans. Insurers begin filing applications to get government approval for “qualified health plans” that can be sold to individuals and small businesses through public exchanges starting Oct. 1.

- **[April]** Application form finalized. HHS says it expects to finalize the application forms that individuals and small businesses can use to apply for health care coverage through exchanges.

- **[July]** Plans approved for sale on exchanges. HHS plans to begin announcing which qualified health plans have been approved for sale through exchanges.

- **[Late summer/fall]** Employee-notification mandate. Employers must provide notice to new and existing employees about exchanges. Notice rule was to take effect March 1 but Department of Labor delayed it because critical information was still missing. DOL says it plans to provide model notices.

- **[Oct. 1]** Exchanges begin open enrollment. Individuals and small businesses can begin enrolling in health care coverage through exchanges for 2014.

- **2014**

- **[Jan. 1]** Employer mandate. Employers with 50 or more full-time-equivalent employees must offer “minimum essential coverage” to full-time employees (those who average at least 30 hours of service a week in a given month), or face potential penalties.

- **[Jan. 1]** Individual mandate. Most individuals are required to obtain health insurance coverage — through their employers, state exchanges, Medicaid/Medicare or elsewhere — or face an annual individual mandate tax penalty. Penalty for 2014 is $95 for an individual or 1 percent of income, whichever is higher. Tax penalty climbs to $695, or 2.5 percent of income, by 2016. The penalty is indexed after that year.

- **[Jan. 1]** Exchanges officially open. Exchanges must be up and running in all states to let individuals and small employers enroll in the private health care plans sold through exchanges.

- **[Jan. 1]** 90-day maximum waiting period. Rule on maximum 90-day waiting period takes effect for all group health plans.

- **Automatic enrollment.** Employers with more than 200 full-time employees must automatically enroll full-time employees into one of the plans the employer offers after the applicable waiting period. The Department of Labor says it isn’t ready, so employers won’t be required to comply until regulations are issued. DOL says this will not be in effect before 2014.

- **Reinsurance fee starts.** Estimated fee for health insurers and plan sponsors in 2014: $63 per person in a group health plan (see Page 11).

2017

- **Exchanges may grow.** Only individuals and small group employers are eligible to purchase coverage on exchanges from 2014 through 2016, but beginning in 2017 states may elect to allow large group plans (those with 100 or more participants) to be sold on exchanges too.

2018

- **“Cadillac” plans.** Beginning in 2018, the law imposes a new 40 percent excise tax on the value of coverage that exceeds certain dollar thresholds. For 2018, the dollar thresholds for the excise tax are $10,200 for individual coverage and $27,500 for family coverage.
To Whom Must Coverage be Offered?

Large employers must make offers of coverage to full-time employees and their dependents

Understanding who is full-time isn’t so easy

To avoid penalties, large employers must offer health care coverage to full-time employees and their dependents.

• Who is full time? The health care law defines full time as an employee who averages at least 30 hours of service a week in a month, or 130 hours of service in a calendar month. Figuring that out won’t always be easy, especially in many restaurant businesses. While some employees clearly average 30 or more hours a week during a month, others move in and out of full-time status from month to month.

As an alternative to assessing employees’ status on a monthly basis, Treasury/IRS proposed regulations issued Jan. 2, 2013, give employers the option of measuring variable-hour and seasonal employees’ hours during a defined measurement or “look-back” period. Based on an employee’s full- or part-time status during the measurement period, employers can apply the same status to a subsequent “stability period,” no matter how many hours the employee works during the stability period. The look-back measurement method is complex but may provide more predictability. (See more on Page 4.)

One thing is clear: The law creates a new, bright-line distinction between part-time and full-time employment. Large employers who want to avoid monthly penalties need to track each employee’s hours of service and status to be sure eligible employees are offered the opportunity to enroll in health plans. Employers have two options for measuring full-time status:

>> Large employers can manage their workforce every month to ensure that only those employees in positions classified as full-time work full-time hours, and those who work in positions that are classified as part-time never work more than 30 hours a week, or

>> To assess the full-time status of variable-hour and seasonal employees for whom an employer cannot determine full-time status, large employers can choose the IRS’s optional look-back method to consider employees’ hours of service during a measurement period and then lock in that status for as many as 12 months moving forward.

• Who’s a dependent? The regulations define dependents as full-time employees’ children who have not reached the age of 26. Dependents don’t include spouses.

The IRS says the law could require big changes in plan design and administration for employers who currently don’t offer coverage to dependents. As transition relief, the IRS says large employers who show they are taking steps toward satisfying the requirement to offer dependent coverage won’t face tax penalties solely based on their failure to offer coverage to dependents for plan years that begin in 2014. Treasury/IRS Jan. 2, 2013, proposed regulations provide full details.

While employers are required to offer affordable coverage to their full-time employees to avoid penalties, there’s no requirement that dependent coverage meets the same affordability test. The affordability test is based on what an employee pays for single-only coverage, not what he or she pays for dependent coverage. (See Affordability, Page 6.)
Who’s full time?
Optional “look-back measurement” method could add stability

Whether new or ongoing, some employees are clearly full-time, averaging at least 30 hours of service a week during a month (which is how the health care law defines full-time employment). Under the health care law, these employees must be offered health care coverage if their large employer wants to avoid penalties. But for other employees — workers whose hours vary from month to month, or seasonal employees — full- or part-time status is not always clear.

Employers seeking more stability and predictability in knowing which employees are full time may want to check out the Treasury/IRS optional “lookback measurement” method for assessing the full-time status of certain employees. The method, as outlined in proposed Treasury/IRS regulations Jan. 2, 2013, lets employers look back at an employee's hours over a period of three to 12 months, assess their full- or part-time status over that time, and then lock in that status for the same amount of time going forward (but no less than six months).

For example, an employee who averages full-time hours during a 12-month look-back period is entitled to full-time status (and the associated benefits) for a subsequent 12-month "stability period," regardless of how many hours he or she works.

The method is complex but can give employers more certainty and let them track data over longer periods. Here’s a top-line summary of how the method works for ongoing employees and for new variable-hour and seasonal employees. Note: The Treasury/IRS regulations include detailed examples and important nuances. This explanation does not capture all the details of the method, so employers should refer to the proposed regulations when implementing these methods within their operations.

ONGOING EMPLOYEES
For an employee who has been with an employer for at least one
"standard measurement period" (the employer can choose a period of three to 12 months), the IRS's look-back measurement method lets the employer look back at the employee's hours of service in that period to assess the employee's full- or part-time status.

If the employee averaged 30 or more hours of service a week during the look-back period, they have full-time status for a subsequent "stability period," no matter how many hours they work. If they averaged fewer than 30 hours a week (130 hours of service per calendar month) during the look-back period, they're considered part-time for the stability period, regardless of their hours of service. The stability period must be at least six months or the same length as the standard measurement period, whichever is longer.

With some limitations, employers can add an administrative period of up to 90 days between the look-back and stability periods to assess an employee's status, make an offer of health care coverage if they're full-time, and enroll them in coverage. Employers must generally apply uniform measurement, administrative and stability periods for all employees, although some exceptions apply. For example, an employer can make distinctions between salaried and hourly employees. Measurement periods can be timed to coincide with calendar months or payroll periods, the IRS says.

NEW EMPLOYEES — FULL-TIME
If on their start date a new employee (who is not a seasonal employee) is reasonably expected to average 30 hours of service a week, the employee is full-time and thus eligible for an offer of health care coverage to start no later than 91 days after their start date.

NEW EMPLOYEES — PART-TIME
If an employer uses a look-back period to measure the full-time status of ongoing employees, the employer must use a similar process to determine the status of new "variable-hour" and seasonal employees. A new variable-hour employee is a person for whom it can’t be determined at the time of their start date whether they'd be reasonably expected to average 30 or more hours a week. The IRS proposal does not yet define seasonal employee, but for now, the agency said it will let employers use a "reasonable, good-faith interpretation" of which employees are seasonal employees. The employer can set an “initial measurement period” of three to 12 months to assess whether the new variable-hour or seasonal employee logs full-time or part-time hours. As with ongoing employees, the employer then applies the employee's status to a subsequent stability period that’s as long as the initial measurement period or six months, whichever is longer. The initial stability period used for new variable-hour and seasonal employees must be the same length as the standard stability period used with ongoing employees. With some limitations, the employer can add an administrative period of up to 90 days after the measurement period and before the stability period to notify the variable-hour and seasonal employees of their status and enroll them in coverage, as needed. However, the initial stability period and associated administrative period cannot be more than 13 months plus a fraction of a month, depending on the employee's start date.

NEW EMPLOYEES — VARIABLE-HOUR AND SEASONAL
If an employer uses a look-back period to measure the full-time status of ongoing employees, the employer must use a similar process to determine the status of new "variable-hour" and seasonal employees. A new variable-hour employee is a person for whom it can’t be determined at the time of their start date whether they'd be reasonably expected to average 30 or more hours a week. The IRS proposal does not yet define seasonal employee, but for now, the agency said it will let employers use a "reasonable, good-faith interpretation" of which employees are seasonal employees. The employer can set an “initial measurement period” of three to 12 months to assess whether the new variable-hour or seasonal employee logs full-time or part-time hours. As with ongoing employees, the employer then applies the employee's status to a subsequent stability period that’s as long as the initial measurement period or six months, whichever is longer. The initial stability period used for new variable-hour and seasonal employees must be the same length as the standard stability period used with ongoing employees. With some limitations, the employer can add an administrative period of up to 90 days after the measurement period and before the stability period to notify the variable-hour and seasonal employees of their status and enroll them in coverage, as needed. However, the initial stability period and associated administrative period cannot be more than 13 months plus a fraction of a month, depending on the employee's start date.
Employers must look at how they design and price their health plans for full-time employees

Employers could face penalties if coverage doesn’t provide minimum value or isn’t affordable

Large employers who choose to offer benefits need to pay close attention to how they design and price their plans for full-time employees.

Employers can face penalties if any full-time employee uses premium tax credits or cost-sharing reductions to buy private insurance through a public exchange either because their large employer did not offer coverage or because the coverage their employer offered was not affordable or of minimum value.

Does your plan provide minimum value?

Your broker or agent can help you figure out whether your plan meets the law’s minimum-value standard. To provide minimum value, an employer’s plan must pay for at least an average of 60 percent of medical expenses incurred, for allowable charges.

The federal government will give large employers several methods for determining minimum value, including a calculator on the HHS website, a “safe-harbor” checklist, or possibly permitting an actuary to certify the plan. Plans sold on exchanges meet the minimum-value standard.

The Department of Health and Human Services has not issued final regulations to define the minimum value standard, but has posted a minimum-value calculator on its website.

HHS in late February posted a Minimum Value Calculator on its website. The agency is seeking feedback on the calculator. Visit HHS.gov to search for the Minimum Value Calculator, released with other regulations on Feb. 25.

Brokers and agents can help employers design plans that provide minimum value. Insurance professionals can also work with large employers to make sure plans meet new federal insurance requirements and that plan documents are in line with the law. That includes documenting the hours-of-service requirement for coverage offers and incorporating dependent-coverage offers.

Is your plan affordable?

Employer plans generally are considered unaffordable if employees are asked to pay more than 9.5 percent of their household income for self-only coverage in the employer’s lowest-cost plan. The IRS offers a few other ways to measure affordability, based on wages. See next page.
Affordability

How do I know whether the plans I offer my full-time employees are affordable?

If a full-time employee who works for a large employer is asked to pay more than 9.5 percent of his or her household income for individual coverage under an employer’s plan, the employer’s health plan is considered unaffordable for that employee. The affordability test applies to the employer’s lowest-cost health plan, not all health plans offered.

Failing the affordability test can be costly for an employer. If the employee goes to an exchange and the exchange certifies that an employer’s plan is unaffordable for a particular employee and that the employee qualifies for a federal subsidy to help them buy insurance on an exchange, a large employer can be assessed $3,000 a year for each full-time employee who receives a subsidy.

Because employers generally won’t know their employees’ household incomes, the IRS gives employers a few other ways to test affordability. These wage-based tests can give employers more certainty about affordability so they can plan accordingly. The agency outlined three “affordability safe harbors” in its Jan. 2, 2013, proposed regulations.

1 W-2 SAFE HARBOR: Under this test, a health plan is considered affordable if a full-time employee’s share of the premium for self-only coverage during a year is less than 9.5 percent of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2. This is a retroactive test: The employer determines at the end of a calendar year, and on an employee-by-employee basis, whether coverage was affordable for each employee in the previous calendar year. For example, an employer would look at an employee’s 2014 Form W-2 (generally furnished to an employee in January 2015) to see if the employee contributed more or less than 9.5 percent of their W-2 wages to premiums in 2014. The test is retroactive but the IRS notes that an employer could also use the W-2 safe harbor prospectively, by deciding at the beginning of a year to set each employee’s premium contribution at a level not to exceed 9.5 percent of the employee’s W-2 wages for the year. For example, the employer could automatically deduct 9.5 percent, or a lower percentage, from an employee’s Form W-2 wages.

2 RATE-OF-PAY SAFE HARBOR: Under this test, a health plan is considered affordable if a full-time employee’s share of premiums for self-only coverage is less than 9.5 percent of the employee’s rate of pay. This method is to be used prospectively. Employers may choose to apply the rate-of-pay safe harbor broadly, not just on an employee-by-employee basis. For example, a large employer could set premiums for all employees based on the rate of pay for the lowest-paid employee. This would ensure premiums are affordable for all employees.

3 FEDERAL POVERTY LEVEL SAFE HARBOR: Under this test, a health plan is considered affordable if a full-time employee’s share of the premium for self-only coverage is less than 9.5 percent of the federal poverty level. Using 2013 federal poverty guidelines, this means the employee’s share of the premium for self-only coverage could not exceed $1,091.55 for the year (9.5 percent of $11,490, the federal poverty level for an individual in 2013), or not more than $90.96 per month.

WHAT WILL INSURANCE COST IN 2014?

Employers of all sizes are waiting to see what will happen to health insurance costs in 2014. Many experts predict premiums will rise because the law sets higher standards for health plans and includes new taxes and fees. The possibility of “rate shock” — at least for individuals and small employers — will become clearer by mid-summer. That’s when federal and state governments begin to announce the “qualifying health plans” that have been approved for sale through online exchanges to small businesses and individuals for 2014. Health insurers began filing proposed prices with regulators for such plans this spring; several states are close to announcing approved plans.

Costs for large employers who choose to offer coverage also will depend on how many full-time employees (and their dependents) accept an employer’s offer of coverage. That’s hard to predict. Employees could turn down coverage for any number of reasons. They might decide to pay an individual-mandate tax penalty instead of obtaining coverage. They might buy coverage on an exchange if they find better coverage or cheaper rates. They might choose coverage through a parent’s or spouse’s employer. Or they might qualify for Medicaid if their income falls below a certain level.
Large employers should run the numbers to assess the cost of offering coverage vs. their potential liability for penalties. Some employers may conclude it’s more workable to offer coverage than pay penalties. Others might find the law’s cost and administrative burdens make it easier to pay penalties.

A variety of factors will affect the decision, including the role benefits may play in recruiting and retaining employees. Tax considerations may also be important. Health benefits are tax-deductible for employers, and employees don’t pay income or payroll taxes on health benefits. Employer penalties are not tax-deductible.

Large employers face two possible penalties under the health care law starting in 2014. Both are indexed to inflation after the law’s first year.

**Coverage vs. penalties: What’s your choice?**

Collecting the right data is critical for business decisions

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Subsection (a) penalty — coverage not offered

Section 4980H(a) of the Internal Revenue Code applies a penalty to large employers that don’t offer minimum essential coverage to at least 95 percent of their full-time employees (and dependents). The penalty is triggered if any full-time employee uses a premium tax credit or cost-sharing reduction for coverage through an exchange.

**Under the subsection (a) penalty,** the employer is liable for a $2,000 annual ($166.67 monthly) penalty multiplied by the total number of full-time employees, minus the first 30 full-time employees.

**PENALTY MATH**

If a large employer does not offer coverage to at least 95 percent of full-time employees (and dependents), and any full-time employee gets a federal tax subsidy to buy a plan on a public exchange, the employer will be liable for a subsection (a) penalty:

\[
\text{Subsection (a) PENALTY} = \frac{\text{\$2K per year}}{\text{# full-time employees}} - 30 \right) = \text{Subsection (a) PENALTY}
\]

Subsection (b) penalty — coverage generally offered

Section 4980H(b) of the tax code applies a penalty to large employers that offer minimum essential coverage to at least 95 percent of their full-time employees (and dependents); the penalty is triggered when one or more full-time employees receive federal subsidies to buy coverage through an exchange because (1) the employer’s coverage wasn’t affordable, (2) the employer’s coverage didn’t provide minimum value, or (3) the employee was among the 5 percent of full-time employees who were not offered coverage.

**Under the subsection (b) penalty,** the large employer is liable for a $3,000 annual ($250 monthly) penalty for each full-time employee who receives a federal premium tax credit or cost-sharing reduction for coverage on an exchange. The penalty is computed separately for each month. The amount of the penalty for the month equals the number of full-time employees who receive a premium tax credit for the month multiplied by $250. An employer’s liability in this scenario can never exceed the total penalty that would be paid for not offering coverage at all.
Tax Subsidies Trigger Employer Penalties

Large employers face possible penalties only when one or more full-time employees gets a federal subsidy to purchase a private health plan on a public exchange. Understanding who is eligible for subsidies can help a large employer assess the law’s impact on their business, including their potential liability for penalties.

**Who Qualifies for Tax Subsidies**

**The Trigger:** Penalties for large employers are triggered when one or more full-time employees uses a federal premium tax credit or cost-sharing reduction to buy private insurance on an exchange.

**Who Qualifies:** Generally, federal premium tax credits and cost-sharing reductions will be available to people with household income between 100 percent and 400 percent of the federal poverty level (currently $11,490 to $45,960 for a single person, or $23,550 to $94,200 for a family of four).

**Medicaid-Eligible Employees Don’t Qualify for Tax Subsidies:** Employees who are eligible for Medicaid or a program such as CHIP (Children’s Health Insurance Program) are not eligible for tax subsidies to buy coverage on an exchange. Thus, no employer penalties are triggered when a full-time employee qualifies for Medicaid or CHIP.

The current Medicaid program covers certain people with incomes below 100 percent of the federal poverty level. The health care law gives states some incentives to expand Medicaid in 2014 to cover most people with incomes up to 138 percent of the federal poverty level.

- **In states that expand Medicaid in 2014,** employees may qualify for Medicaid with incomes up to $15,718 (138 percent of the federal poverty level for a single person) or $32,499 (138 percent of the federal poverty level for a family of four), based on 2013 federal poverty guidelines. As of mid-March governors in about half the states indicated that they favor expanding Medicaid.

- **In states that choose not to expand Medicaid,** large employers could face more penalties as lower-income employees without access to Medicaid (i.e., those with incomes between 100 percent and 138 percent of the federal poverty level) apply for federal subsidies to buy coverage on exchanges instead — thus triggering employer penalties. Large employers who offer health care coverage in non-Medicaid-expansion states may also find their total health care costs are higher because employers must pick up a larger share of health-plan costs to keep premiums affordable for lower-income employees.

**How Employees Get Tax Subsidies:** HHS has drafted a single application for individuals to apply for Medicaid or federal subsidies through the exchange in their state. The draft form asks employees for income data and information about whether they have access to affordable, minimum-value coverage through their employer. HHS says it expects to finalize the form in April.

**Employees Who Reject Plans Are Not Eligible for Tax Subsidies**

**Employers Won’t Be Penalized If Full-Time Employees Don’t Sign Up:** If a large employer offers a full-time employee the opportunity to enroll in affordable, minimum-value coverage and the employee turns it down, the employee does not qualify for government subsidies to buy a plan on an exchange. If a full-time employee rejects a large employer’s offer of affordable, minimum-value coverage, the employer will not be liable for penalties.
Here’s what employers can expect as implementation of the health care law moves forward.

1. Get ready to track and report new data.

To comply with the law, employers will likely need to track and report a voluminous amount of new information, often in ways that data has never been tracked or reported before. Large employers might need to ramp up systems for tracking data, including employees’ monthly hours of service, wage data to determine health-plan affordability, and which employees qualified for offers of health care coverage.

Some reporting requirements are in effect. Employers who provide benefits are required to provide data on the value of health care coverage on employees’ W-2 forms, Box 12. The IRS website offers details on the W-2 requirement, including a list of which health coverage to include. All employers who offer coverage must include the value of health care coverage on W-2s beginning in tax year 2013.

More substantial reporting requirements are coming. Starting in January 2015, new Sections 6055 and 6056 of the Internal Revenue Code will require large employers and their insurers to file annual reports with the IRS with individualized information on full-time employees and their dependents. Employers who offer health coverage must provide details on which individuals (and dependents) were offered coverage under employer health plans, premium costs, employers’ contribution to premiums, and more.

Treasury/IRS haven’t explained the new reporting rules yet. However, the employer reports are likely to play a central role in how the IRS calculates and assesses employer penalties. The IRS indicates it will cross-check employer reports against employees’ tax returns and information provided by exchanges. The law requires a massive inflow of data from all players: individuals (starting with 2014 tax returns, taxpayers must declare whether they obtained health coverage for themselves and their dependents), exchanges (who will provide data on which employees used federal tax subsidies to buy exchange coverage), health insurers, employers, and others.

2. Prepare to communicate with employees — and exchanges.

Americans face a new mandate in 2014 to either obtain health care coverage or pay tax penalties. As the mandate approaches, employers may be a first source of information in educating employees about the health care law. The law is complex and confusing. Some people assume health care coverage will be free once the law takes effect. Large employers must be prepared to communicate with their employees on a range of topics:

- Employees will want to know if you plan to offer coverage. If so, they’ll want to know to whom and at what cost.
- If you offer coverage, employees might want to compare the cost of your coverage to the cost of buying coverage on their own through an exchange.
- Employees will want information they can take to exchanges to see whether they qualify for federal subsidies to buy insurance on exchanges.
Mandatory employee-notification requirement for employers: The health care law requires nearly all employers to notify employees about how to access exchanges. The notice requirement applies to all employers covered by the federal Fair Labor Standards Act. It is expected to take effect in late summer or early fall 2013, according to the Department of Labor. The DOL said in January it hopes to provide employers with a model notice they can give to employees. The agency also might approve a voluntary notice from the Department of Health and Human Services. The HHS notice would serve as an alternative way for employers to provide employees with the FLSA-required notice and other information employees might need to apply for Medicaid or federal subsidies for coverage through exchanges.

Employer interaction with exchanges: Employers might be in for a big surprise as they learn the extent of their interaction with exchanges. On Oct. 1, 2013, millions of individuals will begin turning to online public exchanges to learn about their insurance options for 2014. They’ll go to exchanges to learn if they qualify for a government program such as Medicaid. They’ll go to exchanges to shop for plans, enroll in coverage, and see if they qualify for subsidies if they don’t have access to minimum essential coverage through their employer.

The process will be incredibly complex. One of the most challenging pieces of the puzzle: How exchanges will verify whether an employee has access to minimum essential coverage through a large employer. The process will involve determining whether the employer’s plan is affordable for a particular employee and meets minimum-value standards. The stakes are high because large employers face penalties when an exchange determines that one or more of a large employer’s full-time employees is eligible for federal subsidies to help pay for an exchange plan.

Details remain unclear and the process could vary by state. HHS in January released a controversial 21-page draft application that individuals could take to exchanges to apply for Medicaid, health plans through exchanges, and federal subsidies for exchange coverage. HHS’s form would be the starting point for all individuals to go to exchanges, whether their employer is large or small and whether the employee works full-time, part-time or on a seasonal basis.

The draft form is difficult for both employees and employers. It asks employees for information such as their average weekly hours, whether their employer offers coverage that’s affordable and of minimum value, and a contact name for their employer. In many instances, employers will need to provide information for an employee’s application.

Each time an exchange determines that an employee is eligible for federal premium tax credits or cost-sharing reductions to purchase coverage...
on an exchange, HHS has outlined a proposed process where the exchange will “ping” the employer and give employers up to 90 days to challenge the eligibility determination. The employer response is optional, not required.

The system is daunting, and the logistics are far from clear as federal and state governments inch closer to the Oct. 1 deadline to launch exchanges. The National Restaurant Association is among the employers who filed strong comments urging HHS to simplify the process.

3. Beware the auto-enrollment mandate.

The health care law includes a controversial mandate that amends the Fair Labor Standards Act to insert a new Section 18A, “Automatic Enrollment for Employees of Large Employers.” The provision requires that employers with more than 200 full-time employees automatically enroll new full-time employees in health care coverage by their 91st day of employment. The employer must provide adequate notice to employees about automatic enrollment and the opportunity to opt out. The Department of Labor’s Employee Benefits Security Administration is responsible for implementing Section 18A of the FLSA. In recognition of the significant complexities involved in implementing Section 18A, the DOL announced in 2012 that it will waive the automatic enrollment requirement until rules can be promulgated.

The National Restaurant Association is urging Congress to eliminate the requirement. The Association believes the automatic enrollment requirement is redundant and confusing, and can result in unnecessary hardship for employees who find themselves automatically enrolled in a plan in which they do not wish to participate.

4. Watch for nondiscrimination rules.

The health care law applies nondiscrimination rules to insured group health plans. However, regulations have not been issued to explain how this would work. Any employer — large or small — that offers management-only or tiered health-benefit plans should especially be on the lookout for the new nondiscrimination rules, which could be issued in 2013. Until the rules are released, it’s unclear how these types of plans may be affected by the law.

5. Check out new fees. Many businesses are likely to be affected by new taxes and fees in the health care law. Large employers that are self-insured should check out “Sticker Shock” for information on new fees. See whether your plans will be affected and how much you could owe.
NON-CALENDAR YEAR PLANS

Q: I'm a large employer who offers a non-calendar year plan that starts in 2013 and continues into 2014. At what point am I required to comply with the law’s employer mandate?

A: Employers with non-calendar year plans don’t have to comply with the law’s employer mandate until the first day of their 2014 plan year. If your fiscal plan year starts April 1, 2014, for example, you won’t be penalized for failing to comply with new rules for large employers in January, February and March. However, there are caveats to this relief! Read the IRS proposed rule as published in the Jan. 2, 2013 Federal Register, to be sure you can take advantage of this transition relief.

AFFORDABILITY

Q: Who verifies whether an employer’s plan is affordable?

A: An exchange will make this determination at first, as part of deciding whether an employee is eligible for federal subsidies to buy exchange coverage because their large employer’s coverage wasn’t affordable or didn’t provide minimum value. It’s unclear how the exchange will get all the information it needs to make the determination. HHS outlined a potential process in proposed regulations (Jan. 22, 2013), but nothing is final.

Ultimately, the IRS will determine affordability, based on (a) the household income the individual reports on his or her tax return, and (2) information that large employers and their insurers will be required to report to the IRS annually on full-time employees, health premiums and more. The reporting rules have not been explained but are to take effect in January 2015.

The IRS’s process — not the exchange’s process — will result in penalties for the employer if the IRS determines that an employer’s offer of coverage was not affordable for a full-time employee based on household income.

TIP INCOME

Q: Are employees’ tip earnings included when determining whether employees can afford employer-sponsored health coverage?

A: Yes. Tip income is considered part of an employee’s wages and household income.

DEPENDENT COVERAGE

Q: Does the coverage I offer dependents of my full-time employees need to be “affordable”?

A: While the law requires large employers to offer health care coverage to full-time employees and their dependents to avoid penalties, the law doesn’t require dependent coverage to meet an affordability test. The affordability of an employer’s lowest-cost plan is based on what the full-time employee pays for self-only coverage — not what he or she pays for dependent coverage.

EMPLOYER PREMIUM CONTRIBUTIONS

Q: Does the health care law require large employers that offer health care coverage to pay a certain percent of the premiums?

A: No, but large employers could face penalties if they require full-time employees to pay more than 9.5 percent of their household income for self-only coverage. So the affordability test (see Page 6) could dictate the percentage of the employer contribution. Also, insurers that write group health plans usually require employers to contribute a certain percentage (usually at least 50 percent) toward the premium.

SAYING NO TO COVERAGE

Q: If a full-time employee declines the health care coverage I offer, will I owe a penalty?

A: No. As long as you can show you offered that full-time employee the option of enrolling in an affordable, minimum-value health plan, you won’t face penalties if he or she declines coverage. Full-time employees may turn down employers’ coverage offers for any number of reasons, such as they don’t want to pay for health insurance, they get insurance through a parent or spouse, or they qualify for Medicaid or another federal or state program. Full-time employees who reject employers’ offers of affordable, minimum-value insurance aren’t eligible for premium tax credits or cost-sharing reductions to help pay for insurance on exchanges. Because employer penalties are triggered only when a full-time employee receives a premium tax credit or cost-sharing reduction to pay for insurance on an exchange, employers won’t face penalties in these cases.

PENALTY ASSESSMENT

Q: How will employer penalties be assessed?

A: We are waiting for regulations from the Treasury Department to know exactly how this process will work. According to information available so far, the IRS plans to evaluate large employers’ required annual reports, employees’ tax returns, and information from exchanges before it issues a “notice and demand” for an employer’s tax liability. The agency says this will include a process for employers to appeal the IRS’s determination of employer penalties.

But prior to the IRS’s involvement, employers will have some interaction with the exchanges. This will occur as exchanges approve employers’ applications to receive premium tax credits or cost-sharing reductions to help pay for health coverage on an exchange. In regulations issued in late January, the HHS outlined a proposed process whereby an exchange will notify an employer each time an employee obtained one of these subsidies, and inform the employer that this could trigger an employer penalty. Employers would not be required to respond, but would have the option of filing a response within 90 days to challenge the exchange’s determination of the employee’s eligibility for the subsidy.

EXCHANGES

Q: Can large employers buy insurance through exchanges?

A: Not yet. States will have the option in 2017 of opening up the exchanges to groups of 100 or more. However, each state will make the decision for itself.
Pressing for Action in Congress

The National Restaurant Association is urging Congress and the White House to ensure that the health care law’s mandates, taxes and penalties don’t slow job creation. The law is likely to put significant cost and administrative pressures on employers starting in 2014. As labor-intensive businesses with narrow profit margins, restaurants are likely to feel the law’s impact more than many other employers.

The Association is asking Congress to act on the following issues, which have significant implications for restaurant employers:

• **FULL-TIME EMPLOYEE DEFINITION:** The definition of full-time employee is of particular importance to restaurants because of the industry’s unique reliance on large numbers of part-time and seasonal workers with fluctuating and unpredictable work hours, as well as unpredictable lengths of service. The law’s definition of full time as 30 hours of service per week, per month on average is significantly below the standard most employers use today, based on other federal labor laws.

• **LARGE EMPLOYER DEFINITION:** The definition of a large employer under the health care law is based on a 12-month calculation to determine whether an employer has 50 or more “full-time-equivalent employees” — a definition not used in many businesses, especially those with large shift-work environments.

• **COMPLIANCE ISSUES SUCH AS AUTO-ENROLLMENT AND EMPLOYER REPORTING:** The law requires large employers to enroll full-time employees into coverage automatically if an employee does not opt out within a certain timeframe. This aspect of the law could result in unexpected payroll deductions and confusion for employees. The law also lays out significant new reporting requirements for employers with 50 or more full-time-equivalent employees. The new reporting rules have not been defined but could impose heavy administrative burdens on employers if not streamlined.

• **TIMING AND TRANSITION RELIEF:** With open enrollment in insurance exchanges set to begin in the fall of 2013, compliance time is short and employers do not have all the information they need to design their plans, establish compliance systems or communicate with employees. Using 2014 as a transition period would allow employers to make plan and systems changes and to help employees understand their options.

For more information on any of these issues or to see how your company can get involved, contact Michelle Neblett, the National Restaurant Association’s director of labor and workforce policy, at mneblett@restaurant.org.
The health care law may be one of the toughest challenges your restaurant company has ever faced.

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The National Restaurant Association is tackling operators’ health care questions head-on by bringing in restaurant-focused health care experts. Get the big picture and the details — and go home ready to take care of business.

For details, visit [Restaurant.org/Show](http://Restaurant.org/Show)