



The following Frequently Asked Questions (FAQ) are provided as a resource to NGA members as employers work to determine the impact of the Affordable Care Act on the businesses and work to implement the law. This resource has been developed in conjunction with NGA's employment, labor, and healthcare law firm, Epstein, Becker, and Green and is made possible through the generous support of NGA member companies to the Campaign to Preserve Competition, Consumer Choice, and a Democratic Workplace. *Please note: this material is for information purposes only and is not a substitute for legal advice.*

1. How can I determine if my business is required to comply with the Employer Mandate?

Only "Applicable Large Employers," defined as having 50 or more "full-time" (including full-time equivalent) employees, are subject to the Employer Mandate provision of the Patient Protection and Affordable Care Act ("PPACA"). The Employer Mandate provides that such Applicable Large Employers are subject to a penalty if any full-time employee receives a premium tax credit or cost-sharing reduction to purchase health coverage through an Affordable Health Insurance Exchange ("Exchange"). Please note, full-time equivalent employees are used only for purposes of determining whether the Employer Mandate applies to your business and not for purposes of calculating penalties.

Small businesses, however, are encouraged to provide insurance coverage to their employees through small business tax credits which are available to help offset the employer contribution toward employee premiums.

2. How do I calculate the number of employees for purposes of the Employer Mandate?

To determine whether your business has to comply with the Employer Mandate, you must determine the total number of full-time (including full-time equivalent) employees as defined by PPACA.

PPACA defines a full-time employee as any individual who works an average of 30 hours per week for any given month. In addition, in determining whether the Employer Mandate applies to your business, you must account for the number of full-time equivalent employees you employ.

Here is how to calculate the number of employees for purposes of whether the Employer Mandate applies to your business:

1. Determine the total number of employees who work an average of 30 hours per week for any given month; plus
2. Add up the total number of hours worked during the month by part-time employees who work less than 30 hours per week; divide that number by 120, which will provide you with the number of full-time equivalent employees.
3. Add together the number of full-time employees and full-time equivalent employees to determine whether your company meets the 50 FTE threshold.

Example: Company A has 40 full-time employees who work 30 or more hours per week and 15 part-time employees who all work 20 hours per week (so each employee who works 20 hours per week works 80 hours per month).

1. Company A has 40 full-time employees; plus
2. To calculate full-time equivalents: 15 employees x 80 hours per month / 120 = 1200/120 = 10 full-time equivalent employees.
3. 40 full-time employees + 10 full-time equivalents = 50 FTEs under the Employer Mandate

Based on these calculations, Company A has 50 FTEs and must comply with the Employer Mandate. However, if Company A does not offer coverage or does not provide affordable coverage that provides minimum value, Company A is only subject to a penalty based on the number of full-time employees it employs or 40.

A more detailed memorandum, titled *IRS Notice of Proposed Rulemaking on the Employee Mandate*, is available through NGA which provides a detailed discussion of the method of determining the total number of full-time employees.

3. If I have more than one store, are all stores combined together to determine the 50 full-time employees or equivalent or does each location stand alone? What if my stores have different ownership structures?

Yes, common ownership of multiple stores may result in the different stores being considered part of the same controlled group for purposes of compliance with the Employer Mandate.

If two or more stores fall under the control of one entity, and the aggregate number of full-time employees for all the stores is 50 or more, then under the Employer Mandate applies even if the separate stores do not individually have enough employees to meet the threshold.

A more detailed memorandum, titled *ACA Implementation: Determining Common Ownership for the Employer Mandate*, is available through NGA which provides a detailed discussion of the rules governing parent-subsidiary groups, brother-sister groups, combined groups, and the rules of attribution.

4. If my business is required to comply with the Employer Mandate, which of my employees must I offer coverage to?

Under PPACA, to avoid penalties, applicable large employers must offer health care coverage to their full-time employees (and their dependents). As discussed above, full-time employees are employees who work an average of 30 hours a week in any given month.

Example: In the example provided in response to Question 1, Company A would have to provide coverage to its 40 full-time employees only.

5. What is the definition of a full-time employee under the Employer Mandate? How do I calculate whether or not an employee is full or part-time? What if they change hours every few weeks?

As stated in response to Question 1, a full-time employee under the Employer Mandate is any employee who works an average of 30 or more hours a week in any given month.

In general, to account for fluctuating work weeks, employers may use a Look-Back Stability Period Safe Harbor (“Look Back Period”) for determining whether employees worked the requisite average of 30 hours per week to be considered full-time. This approach allows employers to select a period of time between three months and one year to use as a “Measurement Period” to determine if an employee worked an average of 30 hours a week over that period. If the employer determines that an employee was employed on average at least 30 hours of service per week during the “Measurement Period,” then the employer must treat the employee as a “full-time” employee during a corresponding “Stability Period,” regardless of the number of hours of service the individual works over that time period.

Example: Company B decides to use a 3-month measurement period to determine whether its employees work at least 30 hours per week during the measurement period. Employee Max works the following hours per week for the 3-month period: Week 1, 25 hours; Week 2, 25 hours; Week 3, 40 hours; Week 4, 28 hours; Week 5, 30 hours; Week 6, 32 hours; Week 7, 29 hours; Week 8, 35 hours; Week 9, 30 hours; Week 10, 25 hours; Week 11, 28 hours; and Week 12, 35 hours.

1. Calculate the total number of hours worked by Max during the 3-month period.
 - a. $25 + 25 + 40 + 28 + 30 + 32 + 29 + 35 + 30 + 25 + 28 + 35 = 362$
2. Divide that number by the number of weeks in that period.
 - a. $362 / 12 = 30.16$

Since Employee Max worked an average of 30.16 hours per week during the Measurement Period, he must be treated as a full-time employee for the duration of the Stability Period, which must be at least six consecutive months. In all cases, the Stability Period must be at least six months long and in no case shorter in duration than the applicable Measurement Period used.

A more detailed memorandum, titled *IRS Notice of Proposed Rulemaking on the Employee Mandate*, is available through NGA which provides a detailed discussion of the method of determining the total number of full-time employees.

6. What constitutes an hour of service for purposes of the Employer Mandate?

The regulations states that an hour of service includes: (1) each hour for which an employee is paid for performance of services, or entitled to payment even when no work is performed, 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, layoff, jury duty, or leave of absence. If you are unsure if a particular service or

period of time constitutes an hour of service for purposes of the Employer Mandate, we recommend you consult with your benefits professionals.

7. Must I use the same Look Back Period for all of my employees?

Generally, an employer must apply the same Look Back Period to all employees, but different periods may be used for certain categories of employees, such as hourly and salaried employees or employees in separate collective bargaining units. However, before making such distinctions we recommend you consult with your benefits professionals.

8. When must I provide insurance for a newly-hired employee? Can they sign up at any time after they qualify or only once per year?

Under the Employer Mandate, if a newly hired employee is reasonably expected to work an average 30 hours per week, an employer must offer the employee coverage within three (3) months of the employment. However, if, based on the facts and circumstance at the time of hire, it cannot be determined whether an employee is reasonably expected to average at least 30 hours per week, a Look-Back Period maybe used with an initial measurement period of between three and 12 months and an administrative period of up to 90 days. Under this approach, the initial measurement period and administrative period may not extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s start date.

9. Am I required to provide spouse or family coverage?

The Employer Mandate imposes liability on employers who do not offer their full-time employees and the employee’s dependents the opportunity to enroll in minimal essential coverage. Dependent is defined as the children of the employee (up to 26-years-old), but does not include the employee’s spouse. While employers are not required to offer family coverage, they must offer dependent coverage.

10. As an owner of a business, are my family members and I that work in the business exempt from the regulation?

Under the Employer Mandate, there are no exemptions for family members who are considered full-time employees. All full-time employees are calculated to determine a company’s liability.

11. How does PPACA impact my union contracts if I am subject to a union contract?

Plans subject to a Collective Bargaining Agreement (“CBA”) must follow the rules under PPACA. However, if the health plans under the CBA were in place prior to March 10, 2010, they are considered a grandfathered plan. Health plans subject to CBAs are generally able to maintain their grandfathered status through the end of the agreement. Many CBAs, however, have been renewed since 2010, thus, the grandfather status would be lost. Further, if the plan gets rid of some benefits, increases costs or reduces what employers pay, then the health plan would lose its grandfathered status and be subject to the health reform rules. Employers have the flexibility to keep grandfathered plans if they change plan funding from self-insured to fully-

insured, or change insurance companies if they offer the same coverage. Of significant concern, however, depending on the level of compliance for essential health benefits and coverage required by the law, costs may go up for the union plan to come into compliance with the PPACA.

Additionally, beginning in 2018 certain high-cost health plans will be subject to the Cadillac Tax. As we anticipate many union plans to be taxed the Cadillac Tax, it is likely those additional costs will be passed on to the employer through the CBA during negotiations.

12. Can you explain the purpose of the Health Insurance Exchanges?

A health insurance exchange (“Exchange”) is a set of government-regulated organizations from which individuals or small businesses may purchase health insurance. Exchanges are intended to facilitate the purchase of health insurance coverage for individuals and small businesses by standardizing the benefits offered. For larger employers, the Exchange will also determine individual eligibility for tax subsidies which trigger the penalties under the Employer Mandate.

Exchanges are not themselves insurers, so they do not bear risk. However, the Exchanges determine the insurance companies and to a certain extent the benefits packages that are allowed to be offered through them.

As established under PPACA, all exchanges must be fully certified and operational by January 1, 2014.



13. What if a qualifying employee rejects the company plan participation? What liabilities do I have?

The Employer Mandate requires that a large employer offer full-time employees coverage; however, employees are free to reject the employer’s coverage. The employee bears the liability for turning down affordable health coverage and is subject to an annual tax penalty under PPACA’s Individual Mandate Provision.

14. If a qualifying employee is fully covered on a spouse plan, do I need to provide double coverage?

The Employer Mandate requires that an employer offer its full-time employees the opportunity to enroll in coverage. In order to avoid liability, an offer of coverage should be made, even if the employer is aware the full-time employee has coverage elsewhere.

15. What specifically must I do effective January 1, 2013?

A detailed timeline of PPACA’s requirements through 2018 is attached to this document as Attachment “A”.

16. Where is there a resource for questions I have regarding this law and how it applies to my business?

The NGA has sought to provide its members with detailed memoranda summarizing PPACA’s major employer requirements. Additionally, NGA has in place an arrangement with Epstein Becker & Green (“EBG”) where EBG attorneys are available to help answer any questions NGA members may have. For copies of the NGA memos, or to submit a question to EBG please contact Greg Ferrara, Vice President Public Affairs, National Grocers Association, GFerrara@nationalgrocers.org

17. How will I obtain updates on new rules between now and January 1, 2014?

The NGA will continue to provide its members with detailed summaries of any new requirements in the law. In addition, we will periodically update this information as new rules and information become available.

18. What are the penalties if I do not provide insurance coverage?

Under the Employer Mandate, if an employer does not offer coverage or offers coverage to less than 95 percent of its full-time employees, it must pay a tax penalty if a full-time employee receives a premium tax credit to purchase coverage through the Exchange. The penalty will be calculated using the following formula:

$$[(\text{Number of full-time employees the employer employed for the year})-30] \times \$2,000$$

Example: Company C has 50 full-time employees and provides coverage to only 25 FTE.

$$\text{Penalty Calculation} = 50 - 30 = 20 \times \$2000 = \$40,000$$

An employer that offers coverage to 95 percent or more of its full-time employees must nonetheless pay the tax penalty if one or more employees receive a premium tax credit on the basis of the coverage not being “affordable” or providing “minimum value.” This penalty is calculated separately each month using the following formula:

$$(\text{Number of full-time employees who received a premium tax credit for a given month}) \times \$250$$

Example: Company D has 60 full-time employees and provides coverage to 57 of the full-time employees (95%). The three full-time employees who are not provided coverage receive a premium tax credit on the basis of the coverage not being “affordable” or providing “minimum value.”

Penalty Calculation = 3 x \$250 = \$750

19. How do I verify income levels for employees in order to test what I am requiring their contribution amount to be towards their coverage?

Even if an employer offers full-time employees the opportunity to enroll in coverage, liability may still be imposed if such coverage is either “Unaffordable” or does not provide “Minimum Value.” Coverage is affordable for the purposes of the Employer Mandate if the employee’s premium obligation for self-only coverage does not exceed 9.5 percent of the employee’s household modified adjusted gross income. If an employer offers multiple health care coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the minimum value requirement.

20. How do I determine household income?

Employers generally will not know their employees’ household incomes and in some cases household income maybe less than the wages an employer pays the employee. Therefore, the regulations provide that employers can demonstrate that their coverage meets the affordability standard by showing that the employee premium share for self-only coverage under the lowest cost plan meeting the minimum value standard falls under one of the following safe harbors:

- W-2 Safe Harbor – In general, coverage meets the affordability standard if the employee premium share does not exceed 9.5 percent of the amount reported in Box 1 of Form W-2.
- Rate of Pay Safe Harbor – In general, coverage meets the affordability standard if the employee premium share does not exceed the total of the hourly rate of pay multiplied by 130 hours per month.
- Federal Poverty Line Safe Harbor – In general, coverage meets the affordability standard if employee premium share does not exceed 9.5 percent of the federal poverty line for one person.

The calculations and determinations associated with the above safe harbors are complicated and fact specific. We therefore recommend that you check with your benefits professionals on the proper application of the safe harbors.

21. If an employee works for a year full-time and is covered with insurance and then elects to go part-time, what coverage rule applies?

In general, under the Look Back Stability Safe Harbor approach, if an employee is determined to be full-time during the “Measurement Period” that individual must be offered coverage during the corresponding “Stability Period” regardless of the hours he/she actually works.

The Employer Mandate provides for a “break-in-service” provision for those full-time employees who, for various reasons, decide to take a leave of absence. Under the break-in-

service rule, if an employee experiences period of service that exceeds 26 weeks, in which no hours of service are credited, then an employer may treat the employee as a new employee once they resume full-time employment. During the break-in-service, employees may be afforded the opportunity to continue coverage under COBRA rules.

22. Is there any method to apply for a small business hardship relief or subsidy?

Under PPACA, small employer subsidies are provided to businesses that employ fewer than 25 full-time equivalent employees with average annual wages of \$50,000 or less per employee. Additional premium subsidies are available for employers with 10 or less full time equivalent employees and average annual wage of \$25,000 or less. For tax years 2010 through 2013, the maximum credit for a for-profit business is 35 percent of the employer's cost of health insurance, if the employer provides more than 50 percent of employee premium expenses. Subsidies will increase in 2014 to 50 percent of the for-profit employer's cost of health insurance and 35 percent for the not-for-profit employers.

The IRS has more information about the credit, including tax tips, guides and answers to frequently asked questions available on the [IRS website](#).

23. Will I still be able to deduct these coverage expenses on the business tax return?

Coverage expenses are tax deductible for employers providing health coverage for full-time employees. Any tax penalties associated with the Employer Mandate are not deductible.

24. Are employers required to notify employees of healthcare coverage options in 2013?

The United States Department of Labor has postponed a rule requiring employers to notify employees about their health-care coverage options under PPACA. The notice, which was set for distribution March 1, 2013, will now be distributed in the summer or fall of 2013. Once in effect, employers must provide each employee a written notice:

1. Informing the employee of the existence of Exchanges including a description of the services provided by the Exchanges, and the manner in which the employee may contact Exchanges to request assistance;
2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through an Exchange; and
3. If the employee purchases a qualified health plan through an Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

For more information see the Department of Labor FAQ regarding the employer notification requirement: <http://www.dol.gov/ebsa/faqs/faq-aca11.html>.

ATTACHMENT “A”

EPSTEINBECKERGREEN

Highlights Of The Affordable Care Act— Timeline for Employers for Non-Grandfathered Plans (as of July 1, 2012)



Claims and Appeals Processes
Employer group health plans must have implemented new internal and external claims processes in part by July 1, 2011, and generally by January 1, 2012.
Self-insured group health plans must contract with at least two Independent Review Organizations (“IROs”) by January 1, 2012, and three IROs by July 1, 2012.



Medical Loss Ratio (“MLR”) Rebates (if any)
Employer insured group health plans will receive MLR rebates if insurer fails MLR testing.
Group health plans receiving MLR rebates must establish procedures for compliance with ERISA plan asset rules for distribution of rebates to employees and/or plan sponsors.



Preventive Health Services for Women
Employer group health plans’ requirement to provide recommended preventive health services without cost-sharing is expanded to include preventive coverage for women, including coverage for contraceptives.



Summaries of Benefits & Coverages (“SBCs”)
For plan years commencing on and after September 23, 2012, self-insured group health plans and insurers must provide SBCs in connection with annual enrollment and for new enrollees.



Form W-2 Reporting for 2012 Tax Year
Form W-2s must include the value of group health plan benefits provided to employees. This applies to employers issuing 250 or more Form W-2s.
Deadline for issuance of 2012 Form W-2s is January 31, 2013.



Flexible Spending Account (“FSA”) Annual Limit
Maximum dollar limit for an employer’s FSA plan is \$2,500 annually.
Retiree Prescription Drug Expenses
Employers cannot take a deduction for subsidized retiree prescription drug expenses.



FICA Tax Increase
FICA tax will increase by 3.8% on certain unearned income of high-income individuals above certain thresholds.
Thresholds are high-income individuals earning annually \$200,000; \$250,000 if married filing jointly; or \$125,000 if married filing separately.



Medicare Tax Increase
Medicare tax on wages will increase by 0.9% for high-income individuals.
High-income individuals are those earning annually more than \$200,000 individually (\$250,000 if married filing jointly).



Employee Notice of Exchange
Employers must provide a notice to employees of availability of State Health Insurance Exchanges.



Comparative Clinical Effectiveness Research Fees
For plan years ending on and after October 1, 2012, and before October 1, 2019, self-insured group health plans and insurers must pay fees per covered life. Initial fee is \$1 per covered life, increasing to \$2 per covered life for plan years ending on and after October 1, 2013 (and adjusted for later plan years).
First possible payments are due July 1 or July 31, 2013 (depending on method of calculation).

Highlights Of The Affordable Care Act—
Timeline for Employers for Non-Grandfathered Plans (as of July 1, 2012)



HIPAA Certification

Employer group health plans must certify requirements for HHS rules on electronic transactions between providers and health plans



Quality of Care Reporting

Employer group health plans must provide a report annually, disclosing information of plan benefits and reimbursement structures that improve health outcomes. Though deadline for issuing regulations was March 23, 2012, regulations have not yet been issued and compliance is delayed until such time.



**"Pay or Play"—
Employer Shared Responsibility**

Employers with 50 or more full-time equivalent employees must offer a minimum level of affordable health care coverage or pay tax penalties.



**"Pay or Play"—
Individual Mandate**

Most individual taxpayers must have health coverage or purchase health coverage on a State Health Insurance Exchange or pay tax penalties.



Wellness Incentives

Employer plans may increase permitted wellness incentives from 20% of average costs to 30%.



Waiting Periods

Employer group health plans may not impose waiting periods longer than 90 days.

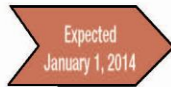
Preexisting Condition Exclusions

Employer group health plans may not impose preexisting condition exclusions.



Annual Dollar Limits

Employer group health plans may not impose annual dollar limits on essential health benefits.



Automatic Enrollment

Large employers (employers with more than 200 full-time employees) must automatically enroll new employees in employers' group health plan. Compliance is delayed until regulations are issued (expected by January 1, 2014).



Nondiscrimination Rule

Insured employer group health plans may not discriminate in favor of highly compensated employees. Compliance is delayed until regulations are issued (expected by January 1, 2014).



"Cadillac Tax"

Employers will be required to pay an excise tax if coverage under their group health plan exceeds annual cost of \$10,200 (single coverage) or \$27,500 (family coverage), to be adjusted for inflation.

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IRS Circular 230 Disclosure

To ensure compliance with certain IRS requirements, we inform you that any tax advice contained in this publication is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code.