In 2015, certain employers will be required to:

1. Offer all full-time employees (and their dependents) prescribed coverage; or
2. Potentially pay a penalty if any full-time employees "free-ride" on the system by receiving a tax credit and using it to purchase coverage in the exchange.

The answers below are meant to serve as guidelines. Please consult with your attorney or benefits manager to determine how the health reform law will specifically affect your business.

Which employers are required to offer coverage?

"Small employers" do not have to offer coverage. "Applicable large employers" are required to provide coverage to their full-time employees (and their dependents).

Am I a small employer or an applicable large employer?
A "small employer" has fewer than 50 full-time-equivalent (FTE) employees over the course of a month. An "applicable large employer" has 50 or more FTE employees over the course of a month.

How is a full-time-equivalent (FTE) employee determined?
Add the total number of hours worked by your part-time employees in a month, and then divide that number by 120. Add that number to the total number of full-time employees.

This link is a simple calculator tool that will help you determine your FTE Equivalents: http://www.uschamber.com/health-reform/calculator

How is a full-time employee defined?
A full-time employee is an employee who works at least 30 hours per week, averaged over the course of a month. Future regulations will clarify how employers may apply this to seasonal workers, new employees, and employees with varying hours month to month.

To whom must I offer health care coverage?
Generally, "applicable large employers" must offer the mandated coverage to all full-time employees (and their dependents). It is not clear what will be required with regard to offering coverage to the dependents of full-time employees.

What type of coverage do I have to offer?
The type of coverage that you must provide will depend on whether you (as an employer) will be purchasing coverage for your employees in the small group market, the large group market, or self-insuring.

The choice to self-insure or offer your employees fully-insured coverage is up to you but there are a number of additional important issues to consider as you make this decision. If you choose to offer your employees coverage through a fully-insured plan, whether you purchase coverage in the small group or the large group market will be dictated by the number of people you will be covering.

Will I purchase coverage in the small group market or the large group market?
Generally, if you have fewer than 100 employees (using the definition for full-time equivalents) you will be purchasing coverage in the small group market.

What are the different coverage requirements?
If you are purchasing coverage in the large group market or if you are self-insuring, you must offer "affordable coverage" that provides "minimum value." If you are purchasing coverage in the small group market, your coverage must (1) be "affordable" and provide "minimum value," and also (2) cover the "essential health benefits package."

How does the law define "affordable" coverage that provides "minimum value"?
Employer sponsored coverage is "affordable" if the employee's share of the premium for self-only (individual) coverage does not exceed 9.5% of the employee's household income. ***Employers may rely on the employee's W-2 statements to calculate affordability in lieu of household income, which few employers know. Future regulations will specify what is necessary as far as dependent coverage.***

A plan meets the "minimum value" requirement if it has an actuarial value of 60%, meaning that the health plan pays for 60% of the costs of services that the plan covers.

How do I know if my plan meets the 60% actuarial value requirement?
Future regulations will specify the details. In April 2012, Treasury issued a Notice outlining three possible ways for employers to determine if their plan meets the "minimum value" requirement. These options may include a calculator, a benefit

design safe-harbor checklist, or actuarial certification, but it is not clear at this point.

What deductible levels are acceptable?
Your plan cannot impose cost sharing that exceeds the high deductible health plan limits. Also deductibles for employer-sponsored health plans cannot exceed $2,000 for individual coverage or $4,000 for family coverage. These amounts will be indexed.

What is the "essential health benefits package?"
Future regulations will specify details, but under the law as it stands now, plans that have to offer the essential health benefits package must: (1) cover the essential health benefits, (2) meet the new limitations on cost sharing, and (3) satisfy the new actuarial value requirements.

What are the essential health benefits that my plan must include?
Generally, the essential health benefits include items and services contained within ten broad categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The Administration will clarify what must be covered within these ten broad categories in forthcoming regulations. For 2014 and 2015, it is likely that states will base the essential health benefits on one of four types of current plans; in 2016, a national definition will be established.

Who must offer the "essential health benefits package?"
In addition to satisfying the "affordability test" and the "minimum value" test, coverage in the small group market must cover the essential health benefits package. Plans in the large group market do not have to cover the essential health

benefits package; however, if they do cover a benefit that is defined as an essential health benefit, plans in the large group markets may not impose any annual or lifetime dollar limits on that benefit.

Are state mandate benefits covered as part of the "essential health benefits package?"

For 2014 and 2015, it will depend on which of the possible four benchmark plans a state selects. If the state chooses a benchmark plan that is subject to state mandates for plan years 2014 and 2015, those mandates will be part of the essential health benefits package for that period. If a state selects a benchmark plan that is not subject to state mandates, the state will be required to cover the costs of its mandates outside the essential health benefit benchmark package.

If my state passes new benefit mandates now, will they go into effect for 2014 and 2015?

No. The state-mandated benefits must be enacted by December 31, 2011, and covered by the selected benchmark plan to be incorporated into the essential health benefits package for 2014 or 2015.

What happens if I fail to meet the reform law requirements?

Simply failing to offer the mandated coverage to full-time employees (and their dependents) does not necessarily mean an employer will have to pay a penalty. Whether you will be penalized and at what cost will depend on:

1. Whether you are an "applicable large employer;"
2. Whether you offer minimum essential coverage to all full-time employees (and their dependents); and
3. How many full-time employees receive a premium tax credit and use it to purchase coverage in the exchange.

Which employees are eligible for a premium tax credit?

In order to be eligible for a premium tax credit, a full-time employee must have a household income between 100-400% of federal poverty level (FPL), depending on family status. If all full-time employees have household incomes above 400% of federal poverty line, an employer will not be penalized, regardless of whether coverage is offered or not.

How will I be assessed the penalty and how do I pay it?

Future regulations will specify penalty assessments. Beyond the employer

mandate penalty, additional reporting requirements as to the coverage that is offered will also increase the costs and administrative burdens on employers.

When do these penalties go into effect?

Pending changes to the law, the penalties will go into effect January 1, 2015.