

# The Affordable Care Act:

## What Nonprofit Employers Need to Know

National  
Policy  
Matters



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# Introduction

The comprehensive reforms contained in the *Affordable Care Act (ACA)\**, are already benefitting Americans with disabilities by transforming our health care system to prohibit discrimination and to improve access to care. While some reforms are currently in place, many will begin in 2014. The health insurance landscape will dramatically change as reforms to health insurance practices will mean that companies cannot deny coverage or charge more to provide insurance coverage to people with health conditions. New health insurance coverage options will be available as states decide whether to expand Medicaid to 133% of poverty and private health insurance marketplaces (formerly known as exchanges) begin operating.

While the ACA will bring about these and other complex changes in our health care system, it is important to note that the law largely builds on the existing employer-sponsored health insurance system. It does so through shared responsibility of both employers and individuals.

## Employer shared responsibility

The ACA recognized that most Americans under age 65 receive health insurance coverage from employers. The ACA is designed to provide insurance to people without access to employer sponsored insurance through the Medicaid expansion, reforms in the private individual market, creation of health insurance marketplaces, and tax credits to help low income families pay premiums for coverage.

However, Congress did not want the improved access to drive employers away from providing health insurance. Instead, it wanted to build upon the current system. It does this through creating health insurance marketplaces to help

small employers, instituting shared responsibility for employers and individuals, and allowing employers to mostly continue to provide their current health insurance plans. **As explained later, full implementation of the shared responsibility provisions is delayed one year, as announced by the Obama Administration in early July 2013.**

## Health Insurance Marketplaces (Exchanges)

This fall, a central part of the ACA will begin. Health insurance marketplaces will be established to sell private health insurance to **individuals and small employers**. The health insurance plans sold in the marketplaces must meet certain requirements for costs and essential health benefits. As of May, 2013:

### Marketplace Timeline

October 1, 2013
Enrollment begins
January 1, 2014
Coverage begins
March 31, 2014
Initial open enrollment ends

- **27 states will have a federally run marketplaces.**
- **17 states will run their own marketplaces.**
- **7 will run their marketplaces in partnership with the federal government.**

States can decide what size employers can use the Small Business Health Options Program (SHOP) marketplace. For 2014 and 2015, states can decide to include employers with 100 or fewer employees or the state can limit it to employers with 50 or fewer employees. However, in 2016, all employers with 100 or fewer employees must be able to purchase insurance through the SHOP marketplace.

This issue of National Policy Matters (NPM) is an update of the July 2010 publication by The Arc and UCP and provides an overview of the provisions affecting employers. It does not provide legal advice or human resources advice. Federal guidance and regulations are still being developed and finalized, so the information in this NPM may be subject to change. If you have additional questions about how these provisions apply to your organization, please contact an employer benefits attorney, insurance broker, or other trusted advisor.

In the states where the federal government is running the marketplaces, SHOPs will initially only allow employers to select a single plan from the multiple plans that will be available in the

The Kaiser Family Foundation is keeping an updated and interactive map with the status of the marketplaces in each state.



## Marketplaces for individual health insurance

Significant subsidies will be available to help individuals who make less than 400% of the federal poverty level (FPL) pay for health insurance coverage. In 2013, 400% of the FPL for an individual is \$45,960. For more information on this topic, [visit The Arc's website](#).

Many low and moderate income individuals will qualify for the premium tax credit. To determine when an individual qualifies for this assistance, use the [Subsidy Calculator](#) (below) found on the Kaiser Family Foundation website.

## What happens if qualified individuals do not purchase insurance through the marketplace?

Individuals who do not have qualifying health insurance (from their employers, public programs like Medicaid or Medicare, or through the new marketplace) may be subject to tax penalties if they do not purchase insurance. For more information, refer to [The Arc's Public Policy web page](#). A previous issue of National Policy Matters, [The Affordable Care Act: What Disability Advocates Need to Know](#), provides more information about the major provisions of the law and how it affects people with disabilities.

### Subsidy Calculator

#### Enter Information About Your Household

1. Enter income as

2. Enter annual income (dollars)

3. Is employer coverage available?

4. Number of Adults (21 and older)

5. Number of Children (20 and younger)

Clear

Submit

## The Obama Administration announces delay

On July 2, 2013, Administration officials announced that they will be delaying for one year aspects of the employer shared responsibility provisions, which are described in the following section. Before this announcement, large businesses with more than 50 full-time workers were required to provide affordable and adequate health insurance beginning in 2014, or face a financial penalty per employee. Now, large employers will not face penalties if they do not provide affordable and adequate health insurance in 2014.

The decision is intended give employers more time to comply with the rules and to set up the communication infrastructure needed to comply with the law and properly assess penalties. The Administration must also write the regulations that will implement the reporting provisions that employers must comply with in 2015. At the same time, the Administration indicates that this delay will not affect other provisions of the law including the new health insurance exchanges, or marketplaces, or the ability of eligible people to receive premium tax credits.

The information that follows describing the employer shared responsibility provisions is based on regulations and guidance in place as of July 2013 and may be subject to change as the Administration develops and finalizes regulations.

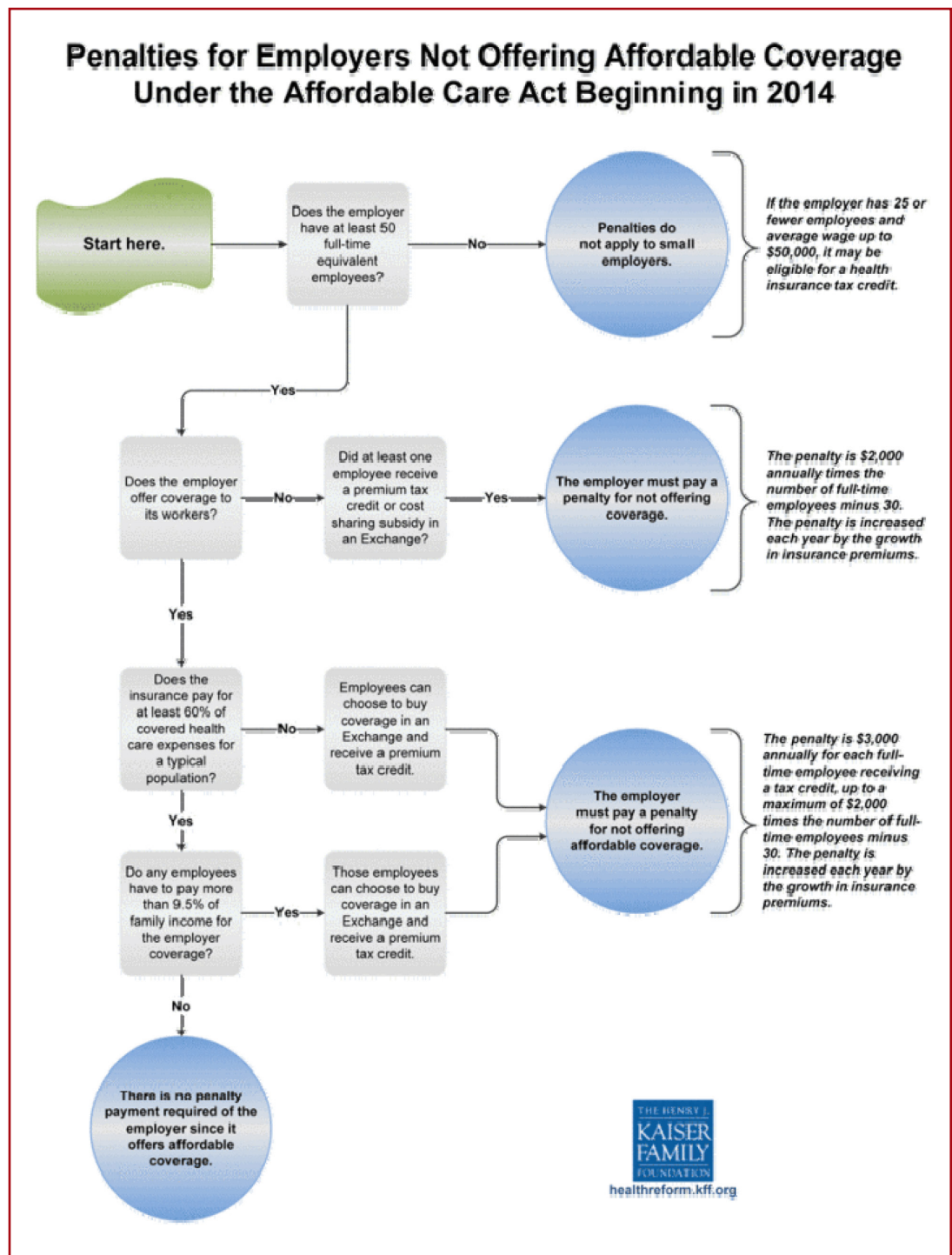
# What Does the ACA require of employers?

## Will all employers have to provide health insurance for their employees?

No, the law does not require employers to provide health insurance to their employees. However, *large* employers that do not provide any health insurance or do not provide *affordable* health insurance to their *full-time employees* and their dependents may face penalties in 2015. Refer to the [Kaiser Family Foundation diagram](#) at right:

### Are small employers subject to penalties?

No, small employers are not subject to penalties for not providing any health insurance or affordable health insurance for their employees. A small employer is less than 50 full-time employees.





## Do employers have to provide health insurance to part-time employees?

No employer (regardless of size) has to provide health insurance to their part-time employees (those who work less than an average of 30/ hours week). There are also no penalties for employers if their part-time employees obtain insurance through the health insurance marketplace.

## Will employers be penalized if they hire Medicaid beneficiaries?

No, employing a Medicaid beneficiary will not trigger penalties for non-coverage or non-affordability. However when an employer calculates the full-time equivalents (FTEs) they must include all employees receiving Medicaid.

## Who is an employee?

Various federal laws have different definitions of "employee." The ACA uses a broad definition – an employment relationship exists when the employer has the right to control and direct the details, means, and results of the work performed

by the employee. Some factors that help to determine whether an individual is an employee include whether:

- the individual is required to comply with the employer's instructions about when and where to work;
- the individual is trained by the employer;
- there is a continuing relationship between the individual and the employer; and
- there are set hours of work for the employee.

## How do I determine if I am a large employer?

A large employer has 50 or more full-time employees, taking into account full-time equivalents (FTEs) during the previous year. Full-time is 30 or more hours per week. This includes hours during which the employee is paid but no work is performed (vacation, holiday, leave, etc). The employer does not need to include full-time employees who are employed for three months or less in its calculation.

**Full time = 30 hours per week**

## How do I calculate my full-time employees?

The formula to calculate full-time employees involves adding together the number of full-time employees and full-time equivalents for each month in the previous calendar year. Full-time equivalents are calculated by dividing the total number of monthly working hours of your part-time employees by 120. This is added to the number of full-time employees (working more than 30 hours) to determine total number of full-time equivalents. Disregard all fractions. See examples of the employer size formula below.

### Example:

*49.7 full-time employees rounds down to 49 full-time employees.*

### Employer A – NOT A Large Employer

	Number of Employees	x	Average Hours per Month	=	Total # of Monthly Hours	/	120	=	Full-time Equivalents
Full-time	30		--		--		--		30
Part-time	12	x	80	=	960	/	120	=	8
									Total FTEs = 38

### Employer B – A Large Employer

	Number of Employees	x	Average Hours per Month	=	Total # of Monthly Hours	/	120	=	Full-time Equivalents
Full-time	30		--		--		--		30
Part-time	40	x	100	=	4000	/	120	=	33.3
									Total FTEs = 63

**Does this calculation happen every month?**

Yes, this is a monthly calculation.

**Is there a simpler way to do this?**

Recognizing that it may be burdensome on employers to do this every month, the regulations allow a look-back/stability period safe harbor. The regulations use the term safe harbor to give employers easier methods for complying with the law. This means that an employer can look back over a designated period to determine whether an ongoing employee is a full-time employee.

**What is the measurement period?**

Under the safe harbor method, an employer would determine an ongoing employee’s full-time status by looking back at a period of three (3) to twelve (12) consecutive months, i.e., the standard measurement period. The employer reviews the employee’s hours over time to see if the hours averaged 30 or more per week. If the employer determines an employee averaged at least 30 hours per week (or at least 130 hours per month) during the standard measurement period, then the employee must be treated as a full-time employee during the subsequent stability period.

**What is the stability period?**

For an ongoing employee determined to be a full-time employee, the stability period is a period of at least six (6) consecutive months that follows the measurement period, but not shorter than the measurement period. If the employee did not work full-time during the measurement period, then the employer does not need to treat

the employee as a full-time employee during the stability period. If the employee did work full-time then the employer has an opportunity to offer health insurance coverage.

Measurement Period	Stability Period
Three (3)- Twelve (12) months	At least six (6) months, but not less than measurement period

**What if I have new employees that may not work the same hours every week?**

The safe harbor also applies to newly hired variable hour employees. Under the safe harbor, an employer would determine whether a newly hired variable hour employee is to be treated as a full-time employee using an “initial measurement period” and associated stability period. The initial measurement period must be between three (3) and twelve (12) months, and may begin on the employee’s start date or the first day of the next month. The employer measures the number of hours completed by the new employee during the initial measurement period and determines whether the employee completed an average of 30 hours per week. If the newly hired employee is determined to be a full-time employee during the initial measurement period, then the employer must treat the employee as a full-time employee during the subsequent stability period. If the employee is determined not to be a full-time employee during the initial measurement period, then the employer may treat the employee as not a full-time employee during the subsequent stability period, which must be the same length as the stability period for ongoing employees.



# What penalties are imposed on large employers?

## Large Employer Penalties

There are two types of penalties large employers might face in 2015:

1. For **not** offering health insurance coverage to the employee and his or her dependents; or
2. For offering **unaffordable** or inadequate coverage to the employee and his or her dependents.

If an employee receives a premium tax credit in the health insurance marketplace, then this may trigger a penalty. Premium tax credits are available to individuals and families with income up to 400% of the FPL. In 2013, 400% of the FPL for an individual is \$45,960.

While part-time employees are included in the calculation for determining if an employer is a large employer, they are not counted when determining penalties.

## How are dependents defined?

Dependents are limited to an employee's children who are under the age of 26. Spouses are not considered dependents under the ACA; however, some states may require that spouses be covered.

Dependents include:

- Children by birth or adoption;
- Stepchildren; and
- Foster children.

## What is the penalty for NON-coverage?

Large employers must pay a penalty for every full-time employee who receives a premium tax credit/subsidy in the health insurance marketplace.

**Penalty for NON coverage.** If at least one full-time employee is receiving a premium tax credit, then the penalty equals \$2,000 annually times the total number of full-time employees minus 30. The first 30 employees are not counted in the penalty calculation.

It is important to note that uninsured individuals have a strong incentive to obtain a premium tax credit if they qualify, since the law also contains individual penalties for non-coverage. Employers will not be penalized if their part-time employees receive a premium tax credit in the exchange.

**Example:** *You have 60 full-time employees and one (1) of your full-time employees receives a premium tax credit.*

$$(60 - 30) \times \$2,000 = \$60,000 \text{ (annually)}$$

$$\begin{aligned} \$60,000 / 12 \text{ months} = \\ \$5,000 \text{ monthly penalty} \end{aligned}$$

## Is there any flexibility?

The regulations allow some flexibility if an employer intended to cover all employees but inadvertently someone was not covered. The regulations allow a 5% gap or 5 people, whichever is greater, as shown below.

Employer A	Employer B
300 employees	60 employees
5% = 15	5% = 3
15 is greater than 5	5 is greater than 3
Employer A is allowed a gap of up to 15 people.	Employer B is allowed a gap of up to 5 people.

## What is the penalty for UNAFFORDABLE coverage?

Large employers must pay a penalty for employees who receive a premium tax credit for the health insurance marketplace.

**Penalty for “UNAFFORDABLE” coverage.** The penalty is \$3,000 multiplied by the number of full-time employees receiving a premium tax credit.

The penalty cannot be greater than the penalty the employer would have faced for not offering insurance (\$2,000 multiplied by the total number of full time employees minus 30).

**Example:** *You have 60 full-time employees and three (3) receive a premium tax credit for the marketplace:*

$$3 \times \$3,000 = \$9,000 \text{ (annually)} \quad \$9,000 / 12 \text{ months} = \text{\$750 monthly}$$

**OR**

$$\$2,000 \times 30 \text{ (60 - 30)} = \$60,000 \text{ annually} \\ \text{\$9,000 monthly}$$

**You pay \$750 monthly**, the lesser of the two (2) amounts

## How is unaffordable or inadequate coverage defined?

Health insurance is unaffordable or inadequate if:

- The employee’s required contribution for self-only coverage exceeds 9.5% of the employee’s household income; **OR**
- The plan offered by the employer to provide minimum essential coverage pays for less than 60% of covered expenses. If that happens, the plan does not meet the minimum value standard. The Department of Health and Human Services has created a [minimum value calculator](#) to help employers determine if the employer’s plan pays for less than 60% of covered expenses.

## Is there an easier way to determine if a plan meets minimum value (MV)?

The IRS is proposing that plan designs covering all benefits included in the MV calculator (see above) and meeting any of the following three (3) examples will be considered meeting the minimum value requirement:

Plan	Integrated medical and drug deductible	Cost Sharing	Maximum out of pocket limit	Other
1	\$3,500	80%	\$6,000	
2	\$4,500	70%	\$6,400	\$500 employer health savings account
3	\$3,500 medical, \$0 drug	60% medical 75% drug	\$6,400	\$10, \$20, \$50 prescription drug tiers, with 75% coinsurance for specialty drugs

## What if the coverage for dependents is unaffordable?

The affordability test applies only to the lowest cost self-only coverage plan. Employers do not need to determine if family coverage is affordable for their employees and will not face penalties for unaffordable family coverage.

## Are there other ways to determine if a health plan is affordable?

Since household income is not known by the employer, there are three (3) safe harbor provisions for determining affordability based on information available to the employer. These provisions help employers design benefits to meet the affordability test without requiring monthly calculations of every employee's wages and hours.

These safe harbor provisions are only useable if the employer offers minimum essential coverage that meets minimum value (i.e., plans covers at least 60% of covered expenses).

The safe harbors do not affect an employee's eligibility for premium tax credits.

The three (3) safe harbors measures include:

### 1) The W-2 Safe Harbor

This test determines affordability based on whether an employee's premium contribution for the lowest-cost, self-only coverage that provides minimum value exceeds 9.5% of the employee's wages as reported on Form W-2 Box 1 for the calendar year. In order to qualify for this safe harbor, the employer must:

- offer the employee and his or her dependents the opportunity to enroll in an employer's plan that meets minimum value; and
- ensure that the employee's contribution toward the self-only premium for the employer's lowest cost coverage does not exceed 9.5% of the employee's Form W-2 wages for that specific employer.

If these conditions are met, the employer will not be required to pay a penalty even if an employee receives a premium tax credit.

### W-2 Safe Harbor Example

*Employee A is employed by a large employer from May 15 to December 31, 2013. The employer offers coverage to Employee A from August 1 through December 31, 2013. Employee A's contribution for self-only coverage is \$100 per month or \$500 for Employee A's period of employment. For 2013, Employee A's Form W-2 Box 1 wages are \$15,000.*

*To apply the affordability safe harbor, the Form W-2 Box 1 wages are multiplied by 5/8 (Five (5) calendar months of coverage offered over eight (8) months of employment during the calendar year). Affordability is determined by comparing the adjusted W-2 wages (\$9,375, or \$15,000 x 5/8) to the employee contribution for the period for which coverage was offered (\$500). Because \$500 is less than 9.5% of \$9,375, the coverage is affordable for 2013 (\$500 is 5.33% of \$9,375).*

Employee Contribution per Month		# of Months		Total Employee Contribution	Annual Wages (Form W-2 Box 1)
\$100	x	5	=	\$500	\$15,000
Adjusted W-2 Wages				% of Annual Contribution (Must be less than 9.5%)	
\$9,375 (\$15,000 X 5/8)				5.33% (\$500/\$9,375)	

## 2) Rate of Pay Safe Harbor

It may be difficult for an employer to analyze every employee's wages and hours to determine whether coverage is affordable. Under this safe harbor, an employer can take the hourly rate of pay for each hourly employee who is eligible to participate in the health plan and multiply that rate by 130 hours per month (the requirement to be considered a full-time employee) to determine whether coverage is affordable. For a salaried employee, the monthly salary would be used in the calculation.

If the employee's contribution is equal to or lower than 9.5% of this result, then the coverage is affordable. To qualify for this safe harbor, the employer must offer minimum value coverage to the employee and his/her dependents and cannot reduce the hourly wages of the hourly employees during the year.

**Rate of Pay Safe Harbor Example:** *Employee B is employed for the 2013 calendar year with an employer that provides minimum value. The employee contribution for self-only coverage is \$85 per month. Employee B is paid \$7.25 per hour and earns \$942.50 per month (130 hours of service times \$7.25 per hour). Under this scenario, the coverage is affordable because Employee B's contribution of \$85 per month is less than 9.5% of Employee B's assumed income (\$85 is 9.01% of \$942.50).*

## 3) Federal Poverty Line Safe Harbor

Some employees are not allowed to receive a premium tax credit because their income is below 100% of the Federal Poverty Line (FPL) and the ACA assumed they would be covered by

Medicaid (which may or not be the case depending on whether or not the state in which they live decided to expand Medicaid). Under this safe harbor, an employer may use the federal poverty line for a single individual to determine if coverage is affordable. Coverage is affordable if the employee's required contribution for the lowest-cost self-only coverage that provides minimum value does not exceed 9.5% of the FPL. Thus, the employer sets the annual employee contribution for employee self-only coverage for each month in the year as an amount equal to 9.5% of the Federal Poverty Level.

### **Federal Poverty Line Safe Harbor Example:**

*The FPL for 2013 is \$11,490. 9.5% multiplied by \$11,490 is \$1,091.55, then divide by 12 for a monthly premium of \$90.96. The employer will offer affordable coverage if the monthly premium is set at or below \$90.96 (i.e., equal to 9.5% of the FPL per month).*

## **How will an employer know if an employee receives a premium tax credit?**

The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. Contact for a given calendar year will occur:

- After employees' individual tax returns have been filed for that year claiming premium tax credits; and
- After large employers (50 full-time employee including full-time equivalents) have filed returns identifying their full-time employees and describing the coverage that was offered (if any).

# Can employers keep their current health insurance?

Yes, the purpose of the ACA is to build upon our current system of employer based health insurance coverage. The ACA does try to provide incentives and penalties to encourage more employers to offer coverage and/or to maintain current coverage.

Plans in existence on March 23, 2010 are “grandfathered,” meaning that employers can continue to provide their current health care coverage. To be considered grandfathered, a plan must have continuously covered at least one person since March 23, 2010. Grandfathered plans will **NOT** need to meet **all** of the **consumer protections** in the law, such as:

- **covering prevention services with no cost sharing;**
- **ensuring that an employee can see a pediatrician or OB/GYN;**
- **having guaranteed availability of coverage** – This means that each health insurance issuer must accept every employer and individual in the state that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events (i.e., birth, death, job changes of spouse etc.); and
- **having guaranteed renewability of coverage** – This means that insurers cannot use health status, utilization of health services, or any other related factor when deciding about renewals.

## What are the requirements for grandfathered plans?

There are a few requirements that all plans must meet. All plans (grandfathered or not) must adhere to the following consumer protection requirements of the law:

- no lifetime cap on benefits;
- no rescissions of coverage;
- extension of parents’ coverage to young adults (age 26);

- no coverage exclusion for children (age 18 and under) with pre-existing conditions (2014 extended to adults); and
- no “restricted” annual limits.

[The Department of Labor provides additional information about the requirements for grandfathered plans.](#)

## What changes will be allowed for grandfathered plans?

Many employers may want to keep their grandfathered status in order to avoid some of the other requirements of the law. For that reason, it is believed that most health insurance through large employers will not see major changes to their coverage. The following routine changes will be allowed.

- Keeping pace with medical inflation;
- Adding new benefits;
- Modest adjustments to existing benefits; and
- Voluntarily providing new consumer protections.

## What changes would cause an employer to lose its plan’s grandfathered status?

Employers may change health insurance companies if the benefits and cost remain nearly the same or they will lose their grandfathered status. Employers will need to document the specifics of their health insurance coverage on March 23, 2010. This will be the standard to make sure that any proposed changes do not *significantly*:

- raise co-insurance, co-payments, or deductibles;
- cut benefits; or
- reduce employers’ contributions.



## Are employers required to tell employees if the plan is a grandfathered plan?

Yes, employers must include a statement in any plan materials describing the health coverage and stating the belief that the plan is a grandfathered plan and provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

*This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to*

*other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and non-federal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]*

## Can nonprofits apply for tax credits?

### Who is eligible for the Small Business Tax Credit?

Employers are eligible if they have 25 or fewer full-time equivalent employees AND average wages are less than \$50,000 AND premium sharing meets certain standards (generally 50% of the health plan cost for employees). Refer to the [IRS step by step guide to calculating eligibility for the credit](#) for more information on this topic.

### Are non-profits eligible?

Yes, non-profits may receive a small business tax credit against payroll taxes up to 25% of the tax-exempt employer's payment for employee health care for 2010-2013, and up to 35% for 2014-2015. The credit will be applied against payroll taxes but special rules do apply. For non-profits the amount of credit cannot exceed the total

amount of income and Medicare (i.e., hospital insurance) tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages. To claim the credit, use [IRS Form 990T](#).

### What should I do if I think I may be eligible for the credit?

The credit is available beginning in tax year 2010. The IRS has developed specific guidance on calculating the credit, determining full time equivalents and average wages, qualifying arrangements, and other specifics. If a chapter thinks it may be eligible, it should carefully review the IRS guidance on the issues:

[Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance](#)



# What additional provisions apply?

## Changes to health flexible spending accounts

Effective for plan years on or after January 1, 2013, contributions to a health flexible spending account will be limited to \$2,500 per person per year, indexed in accordance with changes in the Consumer Price Index.

## Reporting on W-2 forms

Employers must report the value of health coverage on the W-2 form for all employees in 2012, including part-time employees. However, employers that file fewer than 250 Form W-2s are currently exempted. The IRS is planning to develop regulations implementing this provision. The reporting on the W-2 does not mean that the value will be taxed. The reporting is only meant to show the value of health insurance coverage.

## Reporting health insurance information to IRS

Beginning in 2015, large employers must report the following information to the IRS:

- Identification of full-time employees for each month;
- Whether full-time employees and their dependents are offered minimum essential coverage;

- The monthly premium for the lowest cost option;
- The length of the waiting period; and
- The employer's share of the total allowed costs.

This applies to coverage in effect January 2014. Proposed rules implementing this provision have not yet been published.

## 90 day waiting period

Health insurance plans can no longer apply a waiting period longer than 90 days. The waiting period means the time between when an employee is eligible for coverage and coverage begins. The 90 day period can be coordinated with the measurement period and stability period for new variable rate employees so these individuals may see longer waiting periods. Additional regulation is expected in this area, but the guidance is in effect until the end of 2014.

## Auto enrolling new employees

For employers with more than 200 employees who offer health insurance coverage, they must auto enroll new employees and give notice that the employee can opt out. This requirement could go into effect as soon as the Secretary of the Department of Health and Human Services issues regulations.

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## Helpful Resources

**IRS:** [Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance](#)

**IRS:** Toll free line to help businesses: 1-800-829-4933

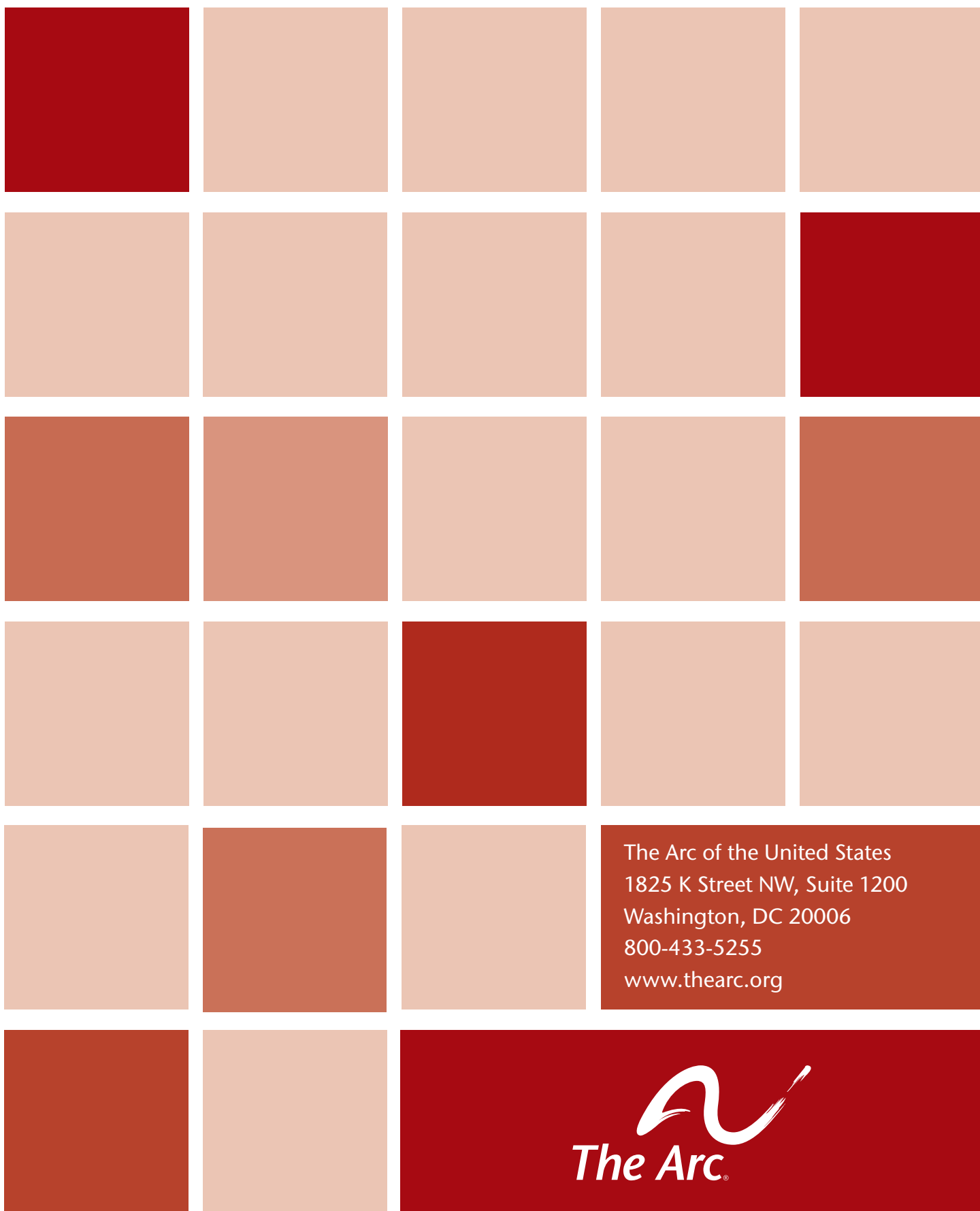
Hours of Operation: Monday – Friday, 7:00 a.m. – 7:00 p.m. your local time

**IRS:** Link to proposed rule <https://www.federalregister.gov/articles/2013/01/02/2012-31269/shared-responsibility-for-employers-regarding-health-coverage>

Minimum Value Calculator: <http://cciio.cms.gov/resources/files/mv-calculator-final-4-11-2013.xlsm>

Kaiser Subsidy Calculator: <http://kff.org/interactive/subsidy-calculator/> \*

\*The Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).



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