

ACA OVERVIEW

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What If the Employer Mandate Is Repealed?

The Affordable Care Act (ACA) requires applicable large employers (ALEs) to offer affordable, minimum value health coverage to their full-time employees in order to avoid possible penalties. Because this employer mandate has been criticized as burdensome for employers and an impediment to business growth, it seems likely that its repeal will be part of any Republican plan to repeal and replace the ACA.

If the employer mandate is repealed, many ALEs will likely want to modify their plan designs to go back to pre-ACA eligibility rules (for example, requiring employees to have a 40-hour per week work schedule to be eligible for benefits). Employers may also consider increasing the amount that employees are required to contribute for group health plan coverage.

When making plan design changes, employers should review their compliance obligations under the Employee Retirement Income Security Act (ERISA) and the ACA mandates that may remain intact.

LINKS AND RESOURCES

- [Understanding Your Fiduciary Obligations Under a Group Health Plan](#) (Department of Labor (DOL) resource for health plan sponsors)
- The DOL's [Reporting and Disclosure Guide for Employee Benefit Plans](#)

This ACA Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

HIGHLIGHTS

ERISA RULES

- As a general rule, employers can make changes to their health plans at any time.
- Employers with insured plans should check with their carriers before making mid-year changes.
- Any plan changes must be communicated to participants.

ACA REFORMS

Even if the ACA's employer mandate is repealed, the following ACA reforms will likely continue to impact plan eligibility rules:

- Restrictions on waiting periods;
- Dependent coverage to age 26; and
- Prohibition on rescissions of coverage.



EMPLOYER MANDATE RULES

Under the ACA’s employer mandate provisions, ALEs that do not offer affordable, minimum value health coverage to their full-time employees may be subject to penalties if any full-time employee receives a subsidy for health coverage through an Exchange. These employer mandate provisions, which are also known as the “employer shared responsibility” or “pay or play” rules, only apply to ALEs, which are employers with, on average, at least 50 full-time employees, including full-time equivalent employees (FTEs), during the preceding calendar year.

The employer mandate rules took effect for most ALEs beginning on **Jan. 1, 2015**. However, medium-sized ALEs (those with fewer than 100 full-time and FTE employees in 2014) generally had an additional year, **until 2016**, to comply with the employer mandate rules, if they satisfied specific criteria to qualify for this delay.

For purposes of the ACA’s employer mandate, a full-time employee means an employee who works an average of **30 or more hours per week**.

The Internal Revenue Service (IRS) provided ALEs with two methods to determine whether employees are full time under the employer shared responsibility rules—the monthly measurement method and the look-back measurement method.

Monthly Measurement Method	Under this method, an employee’s full-time status for a calendar month is determined based on hours of service for that month.
Look-back Measurement Method	<p>The look-back measurement method involves:</p> <ul style="list-style-type: none">• A measurement period for counting hours of service;• An optional administrative period that allows time for enrollment and disenrollment; and• A stability period during which coverage is provided if the employee averages full-time hours during the prior measurement period. <p>If an employee had, on average, at least 30 hours of service per week during the measurement period, the ALE must treat the employee as a full-time employee for the stability period. This rule applies regardless of the employee’s number of hours of service during the stability period, as long as he or she remains an employee, unless a special rule applies.</p>

To comply with the ACA’s employer mandate, many ALEs were required to expand their health plan’s eligibility criteria to include employees who work 30 or more hours per week. ALEs that use the look-back measurement method have also implemented complex systems for tracking and measuring employee hours in order to identify the employees who must be offered coverage. In addition, to satisfy

the ACA's affordability requirement (9.5 percent, as adjusted from year-to-year), ALEs have analyzed their employees' premium contribution rates and made adjustments when necessary.

CURRENT STATUS OF EMPLOYER MANDATE

At this time, the ACA, including its employer mandate rules, remains intact as a federal law. Proposed legislation to repeal and replace the ACA is currently making its way through the federal legislative process. The current bill that is being considered by Congress, which is referred to as the American Health Care Act (AHCA), **would reduce the penalties for failing to comply with the ACA's employer mandate to zero beginning in 2016**. This change would effectively repeal the ACA's employer mandate (although it would technically still exist).

ACA Reporting: The AHCA would not repeal the ACA's employer reporting requirements under Internal Revenue Code (Code) Sections 6055 and 6056. Under these tax provisions, ALEs are required to report on full-time employee offers of coverage and employers with self-insured health plans must report on minimum essential coverage. Under the AHCA, employers would still be obligated to report and subject to penalties for failing to report until the proposed AHCA tax credit system is effective in 2020. Starting in 2020, employers would report offers of coverage on employees' Forms W-2.

The AHCA's future is still uncertain. The bill has been amended several times and will likely be subject to additional revisions in the near future. **Since the bill has not been signed into law, the ACA's employer mandate, and its penalty provisions, remain intact.** However, because the employer mandate has been criticized as burdensome for employers and an impediment to business growth, it seems likely that its repeal will be part of any Republican plan to repeal and replace the ACA.

REPEAL'S IMPACT ON EMPLOYERS

If the ACA's employer mandate is repealed, ALEs will no longer be required to provide affordable, minimum value coverage to their full-time employees in order to avoid possible penalties. Many ALEs will likely want to modify their plan designs to go back to pre-ACA eligibility rules. Possible modifications that ALEs may consider include:

- ✓ Changing health plan eligibility rules so that only employees who have a full-time work schedule (for example, 40 hours per week) are eligible for coverage;
- ✓ Eliminating health plan coverage for employees who are part time, seasonal or temporary;
- ✓ No longer using the monthly or look-back measurement method to track employee hours and make eligibility determinations; and
- ✓ Increasing the amount that employees who elect group health plan coverage are required to contribute.

Effective Date of AHCA Repeal: The AHCA would effectively nullify the employer mandate by eliminating potential penalties effective Jan. 1, 2016. Because the employer mandate took effect for some employers in 2015, penalties could technically still apply for the 2015 calendar year, although it is unclear whether the IRS would pursue these penalties under the Trump administration. Also, an [audit report](#) released by Treasury Inspector General for Tax Administration (TIGTA) reveals that, due to system and operational problems, the IRS has been unable to identify the employers that are potentially subject to an employer mandate penalty or to assess any penalties.

It is difficult to predict whether federal agencies, such as the IRS and DOL, will issue guidance in the event the ACA's employer mandate is repealed in order to help ALEs work through the changes. Even if federal agencies plan on issuing implementation guidance, it may take a while before it is available. In the meantime, ALEs will likely want to make changes to their health plans. In general, ALEs that are considering changes to their health plan's design and administration should consider their compliance obligations under ERISA and the ACA mandates that may remain intact.

ERISA Rules

Making Plan Changes

In general, under ERISA, **employers may amend, or make changes to, their health plans at any time, provided those changes do not violate other federal laws.** An employer's decisions about plan design, including who is eligible for coverage, are generally viewed as "settlor" functions that are not subject to ERISA's rules that require fiduciaries to act solely in the interests of plan participants or beneficiaries. Thus, employers may make decisions about plan design based on their business interests, even if those decisions negatively impact plan participants or beneficiaries.

Although most employers implement plan design changes at the start of the plan year, an employer may change the terms of its health plan during the plan year. Employers with insured plans should review their insurance documents and consult with their carriers, if necessary, before making mid-year plan design changes. The following are two types of mid-plan year design changes that an ALE may consider making if the employer mandate is repealed:

- ✓ **Change the plan's eligibility rules to raise the number of hours needed to be a full-time employee who is eligible for plan coverage.** Changing the plan's eligibility rules is not a "qualifying event" for COBRA purposes, so individuals who would lose coverage because they are no longer eligible are not entitled to elect federal COBRA continuation coverage. These individuals would, however, be eligible for a special enrollment period under an ACA Exchange or another employer's group health plan.

- ✓ **Increase the amount that employees are required to pay for coverage.** If employees pay their health insurance premiums on a pre-tax basis, the Code Section 125 rules limit when they can change their elections during the plan year. Certain mid-year changes are permissible (for example, automatic increases or decreases to employees' contributions for insignificant cost changes). Also, if the cost increases significantly during a plan year, the plan may allow participants to make an election change, including dropping coverage in certain situations.

Compliance Concern—Vested Benefits: Unlike retirement plan benefits, welfare benefits (for example, group health plans) are not subject to ERISA's vesting requirements. Because welfare benefits are not vested under ERISA, they can be amended or changed at any time, as a general rule. However, there are some circumstances when group health plan benefits may vest under the terms of the plan documents. The case law on this issue generally provides that, once a participant satisfies all of the plan's conditions for receiving a benefit, those benefits cannot be reduced or eliminated for that participant. The application of this rule depends on the specific facts of each situation, including the terms of the plan document. Employers that are making changes to their eligibility rules, particularly mid-year changes, may want to consult with their legal counsel regarding any vested benefit concerns.

Communicating Changes to Participants

Any changes that are made to plan design must be formally adopted by the plan sponsor as part of the health plan's documentation. These changes also must be communicated to participants through either an updated summary plan description (SPD) or a summary of material modifications (SMM).

ERISA provides generous deadlines for communicating plan design changes to participants—the deadline is 210 days following the close of the plan year in which the amendment was adopted, except that notice of material reductions in benefits and services generally must be given no later than **60 days** after the date of the adoption of the modification. However, to help avoid benefits disputes and possible litigation, employers should communicate changes to their health plans' eligibility rules **as soon as possible, and before the changes take effect**, as a best practice.

In addition, federal courts have addressed what information an employer is required to provide to plan participants when it is **considering whether to make a plan amendment**. These cases often arise in the context of retirement plan benefits, but the same ERISA fiduciary principles would also apply to welfare plan benefits, such as group health plan coverage. In general, most courts have ruled that ERISA plan fiduciaries (that is, plan sponsors) have a duty to provide truthful information about potential plan amendments when participants ask about the possibility of plan changes.

Other ACA Reforms

When considering plan design changes, employers should remember that many ACA reforms will likely remain in place even if the employer mandate is repealed, including the following ACA reforms that impact plan eligibility.

ACA Reform	Description
Waiting Period Limits	The ACA prohibits group health plans from applying any waiting period that exceeds 90 days . A “waiting period” is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll in the plan becomes effective. This waiting period limit does not require an employer to offer coverage to any particular employee or class of employees, including part-time employees. It only prevents an otherwise eligible employee (or dependent) from having to wait more than 90 days before coverage under a group health plan becomes effective.
Dependent Coverage to Age 26	The ACA requires group health plans and health insurance issuers that provide dependent coverage to children on their parents’ plans to make coverage available until the adult child reaches age 26. This provision does not require plans and issuers to offer dependent coverage at all. It only requires plans that otherwise offer dependent coverage to make that coverage available until the adult child reaches age 26.
Prohibition on Rescissions	The ACA prohibits group health plans and health insurance issuers from rescinding coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A “rescission” is a cancellation or discontinuance of coverage that has a retroactive effect (such as one that treats a policy as void from the time of enrollment). Thus, as a general rule, changes to a health plan’s eligibility rules should be effective on a prospective basis only.