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The Affordable Care Act's Employer Mandate: Part 1

Determining Applicable Large Employer Status

This article is Part 1 in a series intended to provide an overview of the Employer Shared Responsibility provisions (also known as the "employer mandate") under the Affordable Care Act (ACA). The employer mandate generally requires certain employers – known as applicable large employers – to offer medical coverage to full-time employees in order to avoid certain potential penalties.

This article will explain if and when the employer mandate applies. Future articles will address how to determine who is a full-time employee, offers of coverage, and how to report this information to the IRS.

What's in a Name?

In 2015, the employer mandate changed the landscape of employer-provided group health plans for insurance carriers and employers alike. The employer mandate is filled with many defined terms, including:

- **Full-time employee (FTE)** – An employee who is expected to work at least 30 hours per week on average and/or who does average at least 30 hours of service per week over the course of a measurement period.
- **Applicable large employer (ALE)** – An ALE is an employer who employs 50 or more FTEs (including full-time employee equivalents) on average during the prior calendar year. ALE status is also determined in the aggregate for certain groups of related legal entities identified under the Internal Revenue Code, and each member employer of an aggregated ALE group is known as an applicable large employer member (ALEM).
- **Dependent** – An FTE's natural or adopted child (or a child placed for adoption) who has not reached age 26. For employer mandate purposes, "dependent" does not include a spouse or any other child including a stepchild or foster child.[1]
- **Minimum essential coverage** – This is broadly defined to include most traditional job-based health plans (including retiree and COBRA coverage).
- **Minimum value** – Minimum value means the plan covers at least 60% of the total allowed cost of covered services expected to be incurred by a standard population and must include coverage for hospital and physician services. In layman's terms, it's a bronze-level plan.

1. By contrast, stepchildren and foster children do count as dependents for other ACA provisions such as the ACA's dependent coverage to age 26 mandate.

- **Affordable** – Affordable coverage means the employee's share of self-only coverage in the lowest-cost available plan providing minimum value doesn't exceed an indexed percentage (9.86% in 2019) under any of three employer safe harbors: (1) Federal Poverty Limit, (2) Rate of Pay, and (3) Form W-2. These safe harbors will be addressed in a later article in this series.
- **Section 4980H(a) Penalty** – This penalty is triggered when an ALE/ALEM fails to offer minimum essential coverage to at least 95% of its FTEs and at least one FTE qualifies for a subsidy in the public health insurance exchange. This penalty amount is indexed and pro-rated monthly ($208.33/month or $2,500/year in 2019) and is multiplied by all of the ALE/ALEM's FTEs. An ALE may exclude 30 FTEs from this penalty calculation. This 30 FTE exclusion limit applies at the aggregated ALE group level, and an ALEM is limited to excluding its proportional share of the 30 FTEs. We will also refer to this as the "no offer" penalty in this article.
- **Section 4980H(b) Penalty** – This penalty is triggered when an ALE/ALEM offers minimum essential coverage to at least 95% of its FTEs but fails to offer affordable, minimum value coverage to an FTE who qualifies for a subsidy in the public health insurance exchange. This penalty is also indexed and pro-rated monthly ($312.50/month or $3,750/year in 2019) but is limited to those FTEs who actually qualify for subsidies. We will also refer to this as the "inadequate offer" penalty in this article.

This article focuses on how to determine ALE/ALEM status. The other terms and their employer mandate definitions will be covered in greater detail in later articles in this series.

Defining an ALE (or ALEM)

As indicated earlier, an ALE is an employer who employs 50 or more FTEs (including full-time employee equivalents) on average during the *prior* calendar year. With this definition fresh in mind, it's clear that the first step is to determine if the employer has 50 or more FTEs in "Year 1" making it an ALE for "Year 2." Sounds simple, right?

How to Determine ALE Status

STEPS	MONTHLY COUNT
1	Count the number of known FTEs for the month
2	Count the hours of service by all other employees for the month (do not count more than 120 hours of service for any single employee)
3	Divide #2 by 120
4	Add #1 and #3 together
5	Perform calculation for each month

Step 5 in Action

Steps	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
1	16	18	20	24	24	23	22	23	14	11	8	7
2	2,000	2,100	2,100	2,500	4,000	4,700	4,700	4,800	2,500	1,800	1,000	800
3	17	18	18	21	33	39	39	40	21	15	8	7
4	33	36	38	45	57	62	61	63	35	26	16	14

i An existing employer is an ALE/ALEM for **Year 2** if the average employee count for **Year 1** is 50 or more.

A new employer is an ALE/ALEM for the **current year** if the average employee count for the **current year** is reasonably expected to be 50 or more.

Remember that ALEM status is based upon the entire aggregated ALE group.

→ Add the Row 4 totals for all months and divide by 12

→ **486/12 = 40.5 rounded up to 41**

This is a small employer and not subject to the employer mandate for Year 2.

Remember to pro-rate for partial years by dividing by the actual number of months of operation. For example, an employer who began operations in August would divide by 5 instead of 12.

What about First-Timers? Transitional Relief is Available.

Both ALE status determinations and the employer mandate apply on a calendar year basis without regard to an employer's actual plan year. Employers who are on the brink of becoming ALEs need to continuously monitor their employee count. If an employer grows during the year or has employees logging extra hours, it may cross the 50 FTE threshold in that year (Year 1) and face the employer mandate the following year (Year 2). This can pose a particular problem for an employer with a non-calendar year plan that could be left scrambling to comply with the employer mandate in the middle of its plan year. Remember, the employer mandate imposes monthly penalties for non-compliance beginning January 1st of Year 2.

Luckily the final regulations contain some relief for first-time ALEs. The regulations give "first-timers" three months (January through March of Year 2) to:

1. Do the math for Year 1 to determine if it is an ALE for Year 2;
2. Find a broker;
3. Negotiate a plan;
4. Put together open enrollment materials;
5. Have open enrollment; and
6. Make coverage effective by April 1st of Year 2.

If the new ALE does not offer coverage to its FTEs (and dependents) by April 1st, the employer may be subject to the subsection (a) "no offer" penalty for those months (January-March) in addition to any subsequent calendar month for which coverage is not offered.

The first-time ALE also gets a break from the subsection (b) penalty if the coverage offered by April 1st provides minimum value and is affordable. If the employer does offer coverage by April 1st but the coverage is "inadequate," the employer may be subject to the subsection (b) penalty for January, February and March in addition to any subsequent calendar month for which the penalty may apply.

So, Should You Care?

If you're an employer who reaches the magic number of 50 or is over 50 FTEs, then you should care a lot – and prepare. The transitional relief is only available for the first year in which an employer is an ALE, even if the employer goes back and forth between ALE and non-ALE status. Neglecting or not being prepared for the employer mandate and the responsibilities it entails could be very costly. We will cover how to determine FTE status and the offer of coverage in Part 2 of this series.

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Agencies Release 2020 Adjusted Limits

Now that the U.S. Department of Health & Human Services (HHS) has released its final rules, and the IRS has released Rev. Proc. 2019-25, we know the 2020 cost-of-living adjustments for non-grandfathered plans subject to the Affordable Care Act (ACA), high-deductible health plans (HDHPs), and health savings accounts (HSAs). For comparison purposes, the limits for 2019 and 2020 are below:

ACA Limit	2019	2020
Out-of-Pocket Maximum Limit[2]	Self-only: $7,900 Family: $15,800	Self-only: $8,150 Family: $16,300
HDHP Minimum Deductible	Self-only: $1,350 Family: $2,700	Self-only: $1,400 Family: $2,800
HDHP Maximum Out-of-Pocket	Self-only: $6,750 Family: $13,500	Self-only: $6,900 Family: $13,800
HSA Annual Contribution Maximum	Self-only: $3,500 Family: $7,000	Self-only: $3,550 Family: $7,100
HSA Catch-up Contribution Limit (age 55 and older)	$1,000	$1,000

2. This limit does not apply to plans that remain grandfathered under the ACA.

Also in HHS' Final Rules – New Prescription Drug Guidance

Consumers and group health plans alike have struggled with the rising cost of prescription drugs, and there have been numerous high-profile cases involving dramatic price increases for prescription medication. It may seem impossible to effectively reign it in, even with existing manufacturer coupons, discount cards, and other drug-rebating programs. HHS has debated several prescription drug policy changes directed at lowering prices and has adopted a new approach. Beginning in 2020, fully insured and self-insured plans will be able to exclude the value of drug manufacturer coupons used to buy brand-name medications if a medically-appropriate generic-equivalent is available. This change is intended to shift costs from employers to consumers encouraging them to choose equally effective, lower-cost FDA-approved generic medication. This approach is purely optional. Plans do not have to disregard manufacturer coupons and may be able to include those amounts when calculating the participant's annual out-of-pocket maximum. Keep in mind that some states may prohibit fully insured plans from doing this.

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Tax Consequences of Gym Membership Reimbursement

All Good Deeds Get Taxed…

In order to encourage employees to exercise, some employers and insurance carriers reimburse or subsidize employees for the cost of a gym membership. Cash or cash equivalent rewards (i.e., gift cards) are always taxable income to the employee. Employers frequently offer non-cash rewards to employees in the belief that such things as t-shirts, water bottles, Fitbits, and gym memberships are not taxable to the employee, but each type of reward needs to be evaluated to determine whether or not it can be provided on a tax free basis.

Unless, it's of Little Value

Under the Internal Revenue Code (the "Code"), certain fringe benefits may qualify for tax free treatment if they are of little value and provided infrequently, making it hard to reasonably account for their cost. These are known as *de minimis* fringe benefits and can include company-branded water bottles, towels, T-shirts, and gym bags. By contrast, a gym membership reimbursement for multiple months will rarely qualify as a *de minimis* fringe benefit due to the dollar value, and the amounts are both known and easily accounted for. The reimbursement will also be viewed as a cash or cash equivalent, which is always taxable income to the recipient.

Off-Site Versus On-Site Gyms

While exercise has obvious health benefits, the value for an "off-site" (or third party gym open to the public) gym membership generally cannot be provided as a tax-free medical benefit because it does not meet the Code's exception for "medical care." Medical care is defined as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting a structure or function of the body. Expenses for items or services that provide only general health benefits are considered taxable, and the IRS feels that gym memberships rarely qualify as tax-free medical care.[3]

The IRS makes a limited exception to the broad "general health" exclusion. If an individual can prove that he or she was diagnosed with a specific illness, is using the gym as treatment, and has only incurred the gym membership fees because of the illness under the direction of his or her health care provider, the membership fees may be excluded from the individual's taxable income.[4] This will almost certainly require a supporting physician's statement.

Note: This limited exception will only apply to the employee who can demonstrate this and will not broadly apply to all employees receiving a reimbursement or subsidy.

Also, the IRS **does** make exceptions for "on-site" gyms and employer-owned athletic facilities. To qualify, the gym or facility needs to be:

1. Located on property owned or leased by the employer;
2. Staffed by employees or a third-party hired by the employer for its operation; and
3. Closed to the public.

The most common example would be an employer who has an on-site gym as an employee perk, along with a cafeteria, and other amenities.

3. The IRS has addressed this on several occasions, most recently in IRS Memorandum 201622031 (April 14, 2016).

4. IRS Memorandum 201622031 (April 14, 2016).

Does it Matter Who Pays?

No, it doesn't matter. Sometimes, insurance carriers contribute to the cost of participant gym memberships. While the employer is not the one paying for the gym memberships, the employer most likely should be the one addressing the tax issues. This is because, but for the employer sponsored medical plan in which the employee participates, the carrier wouldn't be paying the incentive. Since the reward is a cash or cash equivalent incentive, it's taxable income. It's becoming more common for insurance carriers to address the tax consequences of this approach with employers.

How Do We Account for the Value of the Off-Site Gym Benefit?

Since the off-site gym membership reimbursement is considered a fringe benefit and is unlikely to fit within the medical care exception, the value of the reimbursement will be added as income to employee's IRS Form W-2. The employer will add the amount to Box 1, under Wages, Tips and Other Compensation, and might detail the amount in Box 15 or on a separate statement.[5]

Summing it up

Employers need to evaluate each incentive and benefit offered to employees and determine its tax status. The reimbursement of off-site gym membership fees is generally taxable to employees and must be reported in Box 1 of Form W-2.

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5. The U.S. Department of Labor recently proposed rules that would exclude the value of gym memberships (even if offsite) from being considered as regular compensation for the purposes of determining overtime under the Fair Labor Standards Act.