Risky Business:
Managing Risk in Today's Medical Practice
WCMS Fall Conference - 2014

ACO Basics and ACA Update

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ACOs

- Mission Health Partners, Inc.
  - Network of clinicians and hospitals
  - Purpose is to improve patient care, decrease cost, demonstrate value
  - Governance by a board composed of 60% physician representatives; 40% representatives of Mission Health System (some will also be physicians)

ACOs

- Mission Health Partners, Inc.
  - Membership comprised of independent, contracted and employed physicians - Begin with primary care and add specialists
    - Affiliate Staff of Mission
    - EHR
    - Comply with evidence-based practices and clinical protocols
    - Share clinical data
    - Participate with Medicare and Medicaid
    - Meaningful participation in care initiatives
    - Ability to report 33 ACO measures, as applicable
    - Primary care – PCMH
    - Work with care managers
    - Maintain performance standards
    - Provide medical services

ACOs

- Mission Health Partners, Inc. provides
  - Care management services
    - Identify those eligible for wellness or preventative services, chronic disease management
  - Data collection
    - Providers access to their performance data
  - Systems to track and monitor progress toward quality and cost goals
  - Training for developing quality projects
  - Evidence-based protocols
  - Compensation models that are aligned with quality improvement activities

ACOs

- Agreements:
  - Participation Agreement between Mission Health Partners, Inc. and a Participant
    - Operates a network of health care providers
      - Purpose operate a program that will evaluate and modify practice patterns and create interdependence and cooperation among the network providers = Clinical Integration Program
    - Participant and Providers
      - Participate in payor contracts
        - » MSSP
      - Provide services to persons under a payor contract
      - Participate in clinical protocols, care management
      - Share data with Mission Health Partners, Inc.

ACOs

- Agreements:
  - Medicare Shared Savings Program (MSSP)
    - Payor contract under the Participation Agreement between an Accountable Care Organization operated by Mission Health Partners, Inc. and CMS
    - Participant will be listed as an ACO Participant
      - Comply with the MSSP and be accountable for the care of Medicare fee-for-service beneficiaries assigned to the ACO
  - ACO Provider Agreement
    - Agreement between Participant and Provider for the purpose of ensuring that the Provider will participate in the MSSP and comply with the requirements of the MSSP

ACOs- Medicare Shared Savings Program

- **Accountable Care Act (ACA) required HHS to establish a Medicare Shared Savings Program (MSSP)**
  - Eligible providers, hospitals, and suppliers that participate in the MSSP by creating or joining accountable care organizations (ACOs) can continue to receive traditional Medicare fee-for-service payments under Medicare Parts A and B and also be eligible for additional payments based upon specified quality and savings requirements
  - The ACO is responsible for controlling overall Medicare costs, including the costs of physicians and service providers who may or may not be a part of the ACO, of all Medicare beneficiaries assigned to the ACO, regardless of how those costs are generated

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ACOs- Medicare Shared Savings Program

- **Structure and Organization**
  - The ACO must be a separate legal entity under applicable state law comprised of "eligible" providers and suppliers
    - Participants will bill Medicare for items and services provided to Medicare fee-for-service beneficiaries under Medicare billing numbers assigned to their respective TINs
    - ACO will collect and distribute the Shared Savings Payments
    - Primary care practitioners who bill under a group number may participate in more than one ACO. The group may not. Therefore, sole practitioners who bill under their personal TINs cannot provide services to more than one ACO

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ACOs- Medicare Shared Savings Program

- **Structure and Organization**
  - 75% of the governing body must come from participants in the ACO, and there must be at least one Medicare beneficiary serviced by the ACO on the governing body
  - Medical director must be a participant, board-certified physician, who is physically present on a regular basis at any participating location

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ACOs- Medicare Shared Savings Program

- **Assignment of beneficiaries**
  - **Step 1:** Beneficiary is assigned to an ACO if he has received at least one primary care service from a physician in the ACO. If the beneficiary has received multiple services from multiple physicians in one or more ACOs, then he is assigned to the ACO that provided the greatest amount of primary care services. No assignment if a greater amount of services was received from a primary care physician outside the ACO
  - **Step 2:** If beneficiary has not received any primary care services, then assignment is made if he received a primary care service from any physician (including specialists) in the ACO
  - Beneficiaries will be assigned prospectively followed by a reconciliation at the end of the year
  - Minimum of 5000 lives is required

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ACOs- Medicare Shared Savings Program

- **Shared Savings**
  - In order to qualify for a shared savings payment, the ACO's average per capita Medicare expenditures for the performance year must be below the benchmark (42 CFR §425.602) by the minimum saving rate, and it must meet the minimum quality performance standards
  - **One-Sided Model**
    - No liability for any loss during the initial 3 year term
      - ACO can continue to participate even if it incurred losses following the 3 year term
    - Savings threshold between 3.9 (5000 lives) and 2% (50,000 lives) once exceeded, ACO begins sharing up to 50% of the first dollar of any savings
    - 10% maximum savings threshold
    - Contract will switch to a two-sided after the initial 3 year term

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ACOs- Medicare Shared Savings Program

- **Shared Savings**
  - **Two-Sided Model**
    - Sharing savings and losses
    - Savings threshold of 2% once exceeded, ACO begins sharing up to 60% of the first dollar of any savings
    - 15% maximum savings threshold
    - An ACO will pay the inverse of its savings rate (i.e. 40%) of any increase in costs back to Medicare, up to a specified loss recoupment limit (5% in year one, 7.5% in year two, 10% in year three)
    - No withhold but must provide assurance of repayment, such as a letter of credit

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ACOs- Medicare Shared Savings Program

- **Quality Performance**
  - There are 33 quality measures across four domains:
    - Patient/care giver experience
    - Care coordination/Patient safety
    - Preventative health
    - At-risk population
  - 1st performance year: quality standard is met if ACO accurately reports for all quality measures
  - Subsequent performance years: ACO will be assessed on performance based on the minimum attainment level of certain measures

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ACOs- Medicare Shared Savings Program

- **Beneficiary Issues**
  - ACOs may not provide gifts or other remuneration to beneficiaries as inducements for receiving items or services from or remaining with an ACO
    - Except an ACO may provide in-kind items or services to beneficiaries so long as there is a reasonable connection between the items and/or services and the medical care that the beneficiary is receiving, and the items or services are either preventative care items or services, or advance a clinical goal of the beneficiary such as a treatment regime, adherence to a drug regime, or management of a chronic disease
      - Example: Blood pressure monitors to patients with hypertension
  - Cherry picking patients could result in:
    - Termination of the ACO agreement with CMS or a corrective action plan

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ACOs- Medicare Shared Savings Program

- **Beneficiary Issues**
  - A guiding principal underlying the MSSP is that a Medicare beneficiary has freedom of choice of provider
    - The MSSP prohibits limiting or restricting referrals to those participating in an ACO
    - The exception is for referrals made by employees or contractors who are operating within the scope of their employment to the employer so long as the patient does not express a desire to go elsewhere; the patient's insurer determines the provider; or such referral is not in the patient's best interest

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ACOs- Medicare Shared Savings Program

- **Notification of Beneficiaries**

- Notify beneficiaries at the point of care that their ACO providers are participating in the Shared Savings Program.
- Post signs in their facilities to notify beneficiaries that their ACO providers are participating in the Shared Savings Program.
- Make available standardized written notices regarding participation in an ACO and, if applicable, data opt-out. Such written notices must be provided by the ACO participants in settings in which beneficiaries receive primary care services.
- ACOs have the option of notifying beneficiaries on the preliminary prospective assignment list and quarterly assignment list provided to the ACO. The ACO must provide the beneficiary the opportunity to decline data sharing at the next face-to-face visit

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ACOs- Medicare Shared Savings Program

- **CMS Waivers**
  - ACO Pre-Participation Waiver
  - ACO Participation Waiver
  - Shared Savings Distribution Waiver
  - Compliance with the Stark Law Waiver for the AKS and Gainsharing CMP
  - Waiver for Patient Incentives
    - Reasonable connection between incentive and medical care
- **Antitrust Safety Zone**
  - The total share for each common service is less than or equal to 30% in each participant's primary service area (PSA)
    - PSA is defined as the lowest number of postal zip codes from which the ACO participant draws at least 75% of its patients separately for all physicians, inpatient or outpatient services.
    - Hospitals and ASCs must be non-exclusive
    - Single provider with PSA share of more than 50% must be non-exclusive and ACO must be non-exclusive

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ACOs- Medicare Shared Savings Program

- **Shared Savings Distribution Waiver**
- The ACO has entered into a participation agreement and remains in good standing under its participation agreement;
- The shared savings are earned by the ACO pursuant to the Shared Savings Program;
- The shared savings are earned by the ACO during the term of its participation agreement, even if the actual distribution or use of the shared savings occurs after the expiration of that agreement.
- The shared savings are—a. Distributed to or among the ACO's ACO participants, its ACO providers/suppliers, or individuals and entities that were its ACO participants or its ACO providers/suppliers during the year in which the shared savings were earned by the ACO; or b. Used for activities that are reasonably related to the purposes of the Shared Savings Program.
- With respect to the waiver of sections 1128A(b)(1) and (2) of the Act (relating to the Gainsharing CMP),payments of shared savings distributions made directly or indirectly from a hospital to a physician are not made knowingly to induce the physician to reduce or limit *medically necessary* items or services to patients under the direct care of the physician.

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ACOs- Medicare Shared Savings Program

- Assessment of an ACO
  - CMS will collect and evaluate cost, utilization, and quality metrics related to an ACO's performance in the MSSP to determine if the ACO has improved quality and reduced costs to Medicare
  - If an ACO that negotiates with private payors, DOJ and FTC will afford the rule of reason treatment if it meets CMS's eligibility requirements and participates in the MSSP

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Building an ACO

Building an ACO

- Building an ACO
- Antitrust Concerns:
  - Price-Fixing
    - Competitors agreeing on price or other terms without "meaningful integration" of the activities of the members
  - Monopolization
    - Integrated group that exhibits substantial market power and participates in conduct that is anticompetitive in order to achieve or maintain its market power

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Building an ACO

- Building an ACO
- Antitrust Concerns:
  - Rule of Reason
    - If competing providers achieve financial or clinical integration in a manner that produces significant efficiencies that would benefit consumers, and any pricing or other agreements among those providers that would otherwise be per se illegal are reasonably necessary to realize the efficiencies, those agreement will be analyzed under the rule of reason.
    - A rule-of-reason analysis determines first if a joint venture may have substantial anticompetitive effect and if so, whether the potential effect is outweighed by procompetitive efficiencies.

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Building an ACO

- Hypothetical WNC PHO:
  - Participants
    - Regional Hospital
    - Physicians who hold medical staff appointment or clinical privileges at the Regional Hospital

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Building an ACO

- WNC PHO
- First Question
  - Why are you considering clinical integrations?
- Second Question
  - Is it to improve quality and efficiency in the delivery of services for your patients?
- Third Question
  - Is it to develop bargain power by coming together with your competitors in order to force higher reimbursement?

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Building an ACO

- WNC PHO
  - Goal is to form a multi-provider network joint venture that will create a "clinically integrated" network and engage in joint contracting with third-party payers on behalf of its participating physicians and hospital
  - Horizontal pricing agreements will be only for the provision of physician services
  - Geographic area: Buncombe, Haywood, Jackson, Macon, Transylvania, McDowell, Henderson, Mitchell, Yancey, Avery
  - Operates as a non-exclusive network
    - Insurers and employers can negotiate with individual participating providers or other networks in which they participate

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Building an ACO

- WNC PHO:
  - Background
    - WNC PHO founded in 1997 as a PHO that facilitates the "messenger model" contracting between providers and payors
    - Generates revenue for day-to-day operations:
      - Members fees and dues
      - Percentage withholds from reimbursements paid to participating physicians by payors that contract with the network
      - Monthly access fees from direct employer agreements
  - Desire to replace messenger model with a clinically integrated program in which the providers collectively offer a network of coordinated services

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Building an ACO

- WNC PHO Infrastructure
  - Structure designed to ensure:
    - Physicians work collaboratively to establish clinical practice guidelines
    - Create a high degree of transparency and visibility with respect to their practice patterns
    - Provide mechanisms for monitoring and enforcing compliance with the PHO's clinical practice guidelines
  - Committees
    - Advisory Committee: Develops and updates clinical practice guidelines
    - Oversight Committee: Oversee globally quality improvement planning
    - Quality Assurance Committee

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Building an ACO

- WNC PHO Infrastructure
  - Quality Assurance Committee
    - Includes participating physicians and a Quality Assurance Director
      - Responsible for establishing the measures for individual and group performance benchmarking
      - Monitoring individual and group compliance with the network's standards
      - Administering corrective actions as necessary

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Building an ACO

- WNC PHO Infrastructure
  - Quality Assurance Committee
    - Develop measures to:
      - Identify high-cost providers
      - Inappropriate use of resources
      - Failures to comply with clinical practice guidelines
    - Audit Medical records, generate reports that will include:
      - Individual physician compliance rates under applicable measures
      - Comparisons of the physician's compliance rates against their previous performance and with peer physician
      - Cumulative compliance rates for all physicians for whom particular measures are applicable
    - Reports shared with participating physicians (individually and group), payors to promote transparency, compliance and accountability

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Building an ACO

- WNC PHO Infrastructure
  - Quality Assurance Committee
    - Make recommendations for improving individual and aggregate compliance performance and assist with risk management
  - Implement and oversee corrective actions
    - Mentoring, counseling and educational activities
    - Financial withholds
    - Expulsion from the network

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Building an ACO

- Professional liability exposure
  - Attack on protocols
  - Attack on deviations from protocols
  - Attack on poor metrics
- State peer review protection
  - North Carolina General Statute Section §90-21.22A

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Building an ACO

- State peer review protection
  - North Carolina General Statute Section §90-21.22A
  - Create a formal peer review structure
    - Determine who should be on the committee
    - Analyze and define the flow of information
    - Establish security measures
    - Rigorously adhere to and enforce the policy

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Building an ACO

- WNC PHO Infrastructure
  - New Administrative Positions
    - Medical Director
    - Medical Informatics Officer – specializes in the management and processing of data, information, and knowledge
  - Clinical Practice Guidelines
    - Participating physicians develop their own evidence-based clinical practice guidelines for disease-specific conditions
    - Periodically review, reassess and update these guidelines

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Building an ACO

- WNC PHO Infrastructure
  - Electronic Tools
    - Facilitate physicians' use of quality measure parameters in evaluating and treating patients
    - Facilitate physician-to-physician communication
    - Measure and evaluate physician performance
  - Electronic Tools Requirements for Physicians
    - Physicians must maintain the necessary computer equipment, software, rights or licenses
    - Make available practice data and medical records for the network's use in connection with developing, reviewing and enforcing clinical practice guidelines

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Building an ACO

- WNC PHO Infrastructure
  - **Physician Investment and Commitment**
    - Satisfy credentialing and medical staff appointment requirements
    - Pay a membership fee
    - Comply with a Participating Practitioner Agreement
    - Commit to the network's clinical integration program
    - Comply with electronic infrastructure requirements
    - Serve as a member of one or more committees
    - Provide continuing financial contributions, in the form of withholds from reimbursements made to the physicians by payors that contract with WNC PHO, to support clinical integration activities

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Building an ACO

- WNC PHO Infrastructure
  - **Payor Contracting**
    - WNC PHO states that it will secure payor contracts only to the extent that it is able to demonstrate the value of the program to the payors
      - Market will decide
    - WNC PHO will require all participating physicians to participate in any contract between it and a payor
      - » Allows a stable and identifiable roster of physicians
      - » Facilitates in-network referrals
      - » Increases patient volume
      - » Maximizes providers' use of protocols
      - » Reduces transaction cost to physicians and payors

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Building an ACO

- WNC PHO Infrastructure
  - Projected Benefits
    - **Patients**: improved outcomes; better adherence to preventive screenings and services; reduced medical errors; better infection control rates; shorter hospital stays; lower hospital re-admission rates; earlier disease detection and better disease control procedures; more timely communication of current treatment plans; more timely scheduling of primary and specialty care appointments; and elimination of unnecessary duplication of tests and repetitive completion of registration paperwork

Building an ACO

- WNC PHO Infrastructure
  - Projected Benefits
    - **Payors:** centralized credentialing and contracting; more satisfied beneficiaries; elimination of unnecessary duplication of services; earlier disease detection; avoidance of preventable hospitalizations; reduced medial errors; improved infection control rates; decreased lengths of hospital stay and re-admittance rates; and lower costs of care
    - **Participating Providers**: reduced paperwork; greater ease of scheduling; improved patients diagnosis and treatment plans through timely receipt of diagnostic information and availability of clinical practice guidelines; seamless referrals to specialists and admission to ancillary and hospital providers; reduction of staff time required to duplicate medial records; and timely scheduling of patient care

Building an ACO

- WNC PHO Infrastructure
  - **Spillover Effects**
    - WNC PHO prices cannot set a floor for prices outside of it
    - Antitrust laws prohibit the participating providers from exercising market power including using WNC PHO prices to set a floor for prices outside of it or otherwise coordinating the terms on which the participants will contract with payors outside the network.

Building an ACO

- WNC PHO – Antitrust Analysis
  - **Clinical Integration**
    - Created mechanisms intended to monitor and control costs and utilization, while assuring quality of care
      - Advisory, Oversight and Quality Assurance
    - Investment in electronics allows transparency into physicians' practice patterns
    - Participating Practitioner Agreement – Requires physician commitment and enables corrective action
    - Physician investment – human capital, time and money
    - Selective network – providers must be dedicated to the network's collective achievement of cost, utilization and quality goals
    - Providers must be interdependent
    - Must be able to demonstrate beneficial results

Building an ACO

- WNC PHO – Antitrust Analysis
  - **Ancillarity**
    - The joint venture contracting appears to be subordinate to the network's effort to improve efficiency and quality through clinical integration.
      - Joint contracting supports establishing and maintaining a consistent physician panel – shared commitment
      - If all physicians contractually bound to participate in all WNC PHO contracts, greater incentive to contribute time and effort, support network goals
      - Single panel will facilitate marketing to patients, payors and physicians
      - Increase value of services, attract more patients, promote in-network referrals
      - Enhance network's ability to collect, analyze and respond to data
      - Therefore, the network will increase the quality of care

Building an ACO

- WNC PHO – Antitrust Analysis
  - **Ancillarity**
    - The justification for joint contracting cannot be that physicians would not be incentivized to participate in a clinical integration program absent the ability to fix prices and engage in joint negotiation with payors.
    - If the question is "How much integration is enough?" then the clinical integration and not the price is ancillary.

Building an ACO

- WNC PHO – Antitrust Analysis
- **Competition**
  - Assume initially that WNC PHO will negotiate higher reimbursement because the program will require increased utilization of physician resources in order to achieve efficiencies, improved care and ultimately, lower costs
    - Individual participating providers are free to contract on an individual basis or through other networks with payors
    - WNC PHO will not force payors to contract with it by instructing participating providers to refuse to contract individually
    - WNC PHO will make clear the non-exclusivity of the network
    - WNC does not prevent payors from directing or incentivizing patients to choose certain providers through anti-steering, anti-tiering or similar contractual provisions

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Building an ACO

- Hypothetical based on the Federal Trade Commission Advisory Opinion
  - *Norman PHO Advisory Opinion*
  - *February 13, 2013*

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ACA Update

King v. Burrell

- *King v. Burwell*
  - Supreme Court granted certiorari in *King*
  - Issue is whether federally-facilitated marketplaces can grant premium tax credit
    - Fourth Circuit in *King* upheld the IRS's rule allowing FFMs to grant premium tax credits but the District of Columbia Circuit decided that only state-operated exchanges could grant tax credits
    - Issue created by language in the ACA that authorizes premium tax credits, which refers to enrollment "in through an Exchange established by the State."

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King v. Burrell

- *King v. Burwell*
  - Courts usually consider the text of the entire statute rather than focusing on a single phrase
  - If the Court finds the statute ambiguous, it may defer to the IRS which is the agency charged by Congress to interpret the statute, which is how the Fourth Circuit addressed the issue in *King*.

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Shared Responsibility

- Pay or Play Mandate for Large Employers
  - Sec. 4989H(a) liability:
    - If an employer fails to offer minimum essential coverage to 95% or more full-time employees and their dependents (70% for 2015) and one employee receives federal assistance to purchase health coverage on the exchange, the penalty will be an amount determined by multiplying the full-time employees (less 30 (80 for 2015)) by $166.67
  - Sec. 4980H(b) liability:
    - If employer offers minimum essential coverage to full-time employees and their dependents and one employee receives federal assistance to purchase health coverage on the exchange because the coverage is either not affordable (9.5% W-2) or does not provide minimum value (60% of cost), the penalty will be an amount determined by multiplying the full-time employees receiving assistance by $250/month (up to a maximum of Sec. 4980H(a) liability)

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Shared Responsibility

- IRS published final regulations titled *Shared Responsibility for Employers Regarding Health Coverage* on 2/12/2014
- Is your company a large employer?
  - The rules determining whether an employer has 50 full-time employees, and is therefore subject to the ACA , are not the same rules that are used to determine whether an employee is considered full-time and has to be offered affordable coverage.
  - In order to determine whether your company is a large employer for calendar year 2015, take the sum of the total number of full-time employees and the total number of FTEs for each calendar month in any six consecutive calendar months in 2014 and divide by six.

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Shared Responsibility

- **Example:**
- From February through July 2014, assume Employer has 20 full-time employees each of whom average 35 hours of service per week and 40 employees each of whom averages 70 hours per calendar month. Each of the 20 employees who average 35 hours of service per week count as one full-time employee for each calendar month.
- To determine the number of FTEs for each calendar month, the total hours of service of the employees who are not full-time employees (but not more than 120 hours of service per employee) are aggregated and divided by 120. The result is that Employer has 23.33 FTEs for each calendar month (40 x 70 = 2800, and 2800 ÷ 120 = 23.33).
- Employer has a total of 43.33 full-time employees (the sum of 20 full-time employees and 23.33 FTEs) during each calendar month for the 6 month period it has chosen for the determination of whether it is a large employer. Because it is under 50 full-time employees, it will not have to provide health insurance in order to avoid penalties in calendar year 2015.

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Shared Responsibility

- Seasonal Employee Exception
  - If employer's workforce exceeds 50 full-time employees for 120 days (or 4 months) or fewer during the calendar year; and
  - The employees in excess of 50 during that period were seasonal employees; then
  - The employer is not a large employer.

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Shared Responsibility

- 2015 -Transition relief for large employers with more than 50 but less than 100 full-time employees
  - Employers will not be subject to the Employer Shared Responsibility provision for 2015 if:
    - Between 2/9/2014 and 12/31/2014, the employer does not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief unless for bona fide reasons; and
    - The employer does not eliminate or materially reduce the health coverage, if any, it offered as of 2/9/2014.

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Shared Responsibility

- Once an employer is deemed a large employer, how are the full-time employees determined?
  - If an employer reasonably expects an employee (who is not seasonal) to work full-time (defined as 130 hours per calendar month), there is no need to count hours. The employer must offer coverage on the first day of the month immediately following the conclusion of the employee's initial three full calendar months of employment.
  - The employer can use a monthly measurement method or a look-back measurement method to determine if a variable hour or seasonal employee is full-time.

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Shared Responsibility

- Once an employer is deemed a large employer, how are the full-time employees determined?
  - Look-back measurement method:
    - Under the look-back method for ongoing employees, an employer determines the status of an employee by looking back at a measurement period of at least three months and not more than 12 months to determine if the employee averaged at least 30 hours per week (consider seasonal employee when determining length).
    - If the employee is considered full-time, then he is treated as such during a stability period that must be at least six consecutive months and no shorter than the measurement period regardless of the number of hours he provides.
    - New variable hour, seasonal and part-time employees initial measurement period begins on employee's start date or any date up to and including the first day of the first calendar month following the employee's start date.
    - A part-time employee who moves to a full-time position must be enrolled no later than the first day of the fourth month after the change.

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Shared Responsibility

- Once an employer is deemed a large employer, how are the full-time employees determined?
  - Hours of service – Employer either counts actual hours or uses an equivalency based on eight hours per day or 40 hours per week.
  - Hours of services equal the hours the employee is paid (e.g., PTO, jury duty)

Shared Responsibility

- Final regulations published on 2/14/2104 for the Prohibition of Waiting Periods Exceeding 90-Days
  - Applies to group health plans, (grandfathered and non-grandfathered), whether fully insured or self-funded
  - Violations of the rule is an excise tax of $100 per day per affected worker, which employers are required to self-report on IRS Form 8928
- Generally permits:
  - Eligibility conditions based solely on the lapse of time for no more than 90 days

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Shared Responsibility

- Other conditions for eligibility, unless the condition is designed to avoid compliance with the 90-day waiting period limitation:
  - **Orientation Periods:** Permits an a maximum period of one month that satisfies a "reasonable and bona fide employment-based orientation period" prior to the 90-day waiting period
  - **Cumulative Hours of Service Requirements:** Permits plans to condition health coverage eligibility on an employee's completion of a "cumulative hours of service" requirement (not to exceed 1,200 hours)
  - **Variable Hours** : If an employer implements the optional measurement period approach to defining full time employees, the plan can take up to 12 months to determine whether the employee meets the plan's eligibility requirements

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Shared Responsibility

- **Once an employer is deemed a large employer, what is its responsibility to cover an employee's dependents?**
- An employer generally must offer coverage to its full-time employees and their dependents up to age 26. Dependents are children and adopted children.
- An employer will not be subject to a penalty for failing to offer children under age 26 coverage for plan years that begin in 2015 if the plan takes steps during its 2014 plan year to add dependent coverage (if certain conditions are met).
- An employer is not required to contribute toward the cost of dependent coverage, as coverage is "affordable" based on the cost of employee-only coverage.
- Employers are not required to offer spousal coverage, and the receipt of a premium tax credit by an employee's spouse or dependent will not result in a penalty on the employer.

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Health Care & Employment Law

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