2013

Healthcare Reform

Glossary of Terms

Disclaimer

We share this information with our clients and friends for general informational purposes only. It does not necessarily address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues and application of these rules to your plans should be addressed by your legal counsel.

Gallagher Benefit Services, Inc.

Glossary

"Administrative period" – an optional period of time not to exceed 90 days applied by the employer, beginning no later than the end of the measurement period to administratively enable employers to make available coverage as necessary in advance of the next stability period.

"**Calendar month**" - means one of the full months named in the calendar (such as January, February or March).

"Church, or a convention or association of churches" - has the same meaning as provided in § 1.170A-9(b) of this chapter. (ed. note – see also DOL Opinion Letter 93-0a).

"Collective bargaining agreement" - means an agreement determined to be a collective bargaining agreement, provided that the health benefits provided under the collective bargaining agreement are the subject of good faith bargaining between employee representatives and one or more employers, and the agreement between employee representatives and one or more employers satisfies section 7701(a)(46)[1].

"Dependent" - means a child (as defined in section 152(f)(1)) of an employee who has not attained age 26. A child attains age 26 on the 26th anniversary of the date the child was born.

"Eligible employer-sponsored plan" - has the same meaning as provided under section 5000A(f)(2) and any applicable guidance thereunder. (See end of glossary)

"**Employee**" - means a worker who is an employee under the common-law test. Leased employees are not considered an employee when determining large employer status. Also excluded from the term "employee" are sole proprietors, partners in a partnership, and two percent S-corporation shareholders are not considered employees.

"Full-time employee" - means, with respect to a *calendar month*, an employee who is employed an average of at least 30 hours of service per week with an employer. For this purpose, 130 hours of service in a *calendar month* is treated as the monthly equivalent of at least 30 hours of service per week, provided the employer applies this equivalency rule on a reasonable and consistent basis.

"Full-time equivalent employee (FTE)" - The term *full-time equivalent employee,* or *FTE,* means a combination of employees, each of whom individually is not treated as a full-time employee because he or she is not employed on average at least 30 hours of service per week with an employer, who, in combination, are counted as the equivalent of a full-time employee solely for purposes of determining whether the employer is an applicable large employer.

"Form W-2 wages" - refers to the amount of wages as defined for the applicable calendar year (required to be reported in Box 1 of the Form W-2) received from an applicable large employer.

"Hours Worked" – (Hour of service) –

- **For hourly employees**:
  - » Each hour for which the employee is paid, or entitled to payment, "for the performance of duties"; and

[1] **(46) Determination of whether there is a collective bargaining agreement.**
In determining whether there is a collective bargaining agreement between employee representatives and 1 or more employers, the term "employee representatives" shall not include any organization more than one-half of the members of which are employees who are owners, officers, or executives of the employer. An agreement shall not be treated as a collective bargaining agreement unless it is a bona fide agreement between bona fide employee representatives and 1 or more employers.

» Paid-Time Off

Each hour for which the employee is paid, or entitled to payment, for the period of time due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

- **Non-hourly employees**:
  - » Guidance provides three methods to determine hours worked:
    - **Actual Hours**
      - Count actual hours of service worked "from records", as well as other non-worked hours for which he or she is paid, or entitled to payment
    - **Days-Worked Equivalency**
      - Credit 8 hours of service per day for each day for which the employee would be credited with at least one hour of service
    - **Weeks-Worked Equivalency**
      - Credit 40 hours of service per week for each week for which the employee would be credited with at least one hour of service

"Initial measurement period" – The first measurement period, chosen by the employer, that applies to new employees. This time period may be not less than 3 consecutive *calendar months* and not more than 12 consecutive *calendar months*. Further, the stability period for new employees must be the same length as the stability period for ongoing employees.[2]

"Large employer" – (Applicable Large Employer) Determined on a control group basis. An employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. The hours of service of employees who are not full-time (average of 30 hours), and seasonal employees are taken into account – full-time equivalent employees (FTEs).

Determine total number of full-time employees for each employer of the control group. Add together the number of full-time employees for all employers within the control group. If under 50, determine the number of FTEs for each member of the control group.

FTEs are determined by:

- combining the hours worked by each part-time employee (up to 120 per employee) for the month.
- dividing the product by 120 (include fractions) = FTEs

Add together the number of FTEs for all members of the control group. If not a whole number, round the number down to the next whole number. Add that number to the number of full-time employees.

If that number is 50 or greater, the employer is a large employer.

"Measurement period" – The look-back period that is used to determine whether a variable hour employee is working a full-time schedule.

[2] Note: the stability period for new employees determined to not meet the 30-hour average, must not be more than one month longer than the initial measurement period and must not exceed the remainder of the employer's current standard measurement period (plus any associated administrative period) in which the initial measurement period ends.

Glossary

"Minimum essential coverage" - (or *MEC*) has the same meaning as provided in section 5000A(f) and any regulations or other administrative guidance thereunder. (see end of glossary)

"Minimum value" - has the same meaning as provided in section 36B(c)(2)(C)(ii) and any regulations or other administrative guidance thereunder. (36B(c)(2)(C)(ii) - Coverage must provide minimum value. Except as provided in **clause (iii)**, an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in **section 5000A(f)(2)**) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

"**Month**"- means the period from a day in one month to the prior day of the following month (such as from January 15 to February 14), other than a *calendar month*.

"**New employee**" – An employee who has not yet been employed for at least one complete "standard measurement period"

"**Ongoing employee**" – An employee who has been employed for at least one complete "standard measurement period".

"Plan year" – means a year equaling twelve consecutive months.[3], A plan year is permitted to begin on any day of a year and must end on the preceding day in the immediately following year (for example, a plan year that begins on October 15, 2014, must end on October 14, 2015). A calendar year plan year is a period of twelve consecutive months beginning on January 1 and ending on December 31 of the same calendar year. Once established, a plan year is effective for the first plan year and for all subsequent plan years, unless changed, provided that such change will only be recognized if made for a valid business purposes. A change in the plan year is not permitted if a principal purpose of the change in plan year is to circumvent the rules of section 4980H or these regulations.

"Period of employment" - means the period of time beginning on the first date for which an employee is credited with an hour of service for an applicable large employer (including any member of that applicable large employer) and ending on the last date on which the employee is credited with an hour of service for that applicable large employer, both dates inclusive. An employee may have one or more periods of employment with the same applicable large employer.

"Seasonal employee" – RESERVED

"Seasonal worker" - means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) workers covered by 29 CFR 500.20(s)(1), and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term "seasonal worker" and a reasonable good faith interpretation of 29 CFR 500.20(s)(1) (including as applied by analogy to workers and employment positions not otherwise covered under 29 CFR 500.20(s)(1)).

"Stability period" – The period of time selected by the employer, that follows, and is associated with a standard or initial measurement period. This is the period during which an employee determined to be 'full-time' during the preceding measurement period is entitled to health coverage. If an employee is determined to be NOT full-time, the period the employee need not be offered health coverage. The stability period must be at least six consecutive calendar months but no less than the standard measurement period.

[3] Unless a short plan year of less than twelve consecutive months is permitted for a valid business purpose.

Glossary

"Standard measurement period" – The measurement period, chosen by the employer, that applies to ongoing employees. This time period may be not less than three consecutive *calendar months* and not more than 12 consecutive *calendar months*. The period must be applied on a uniform and consistent basis for all employees in the "same category." Categories include:

- Collectively bargained employees and non-collectively bargained employees;
- Each group of collectively bargained employees covered by a separate collective bargaining agreement.
- Salaried employees and hourly employees; and
- Employees located in different states

"**Variable hour employee**" – An employee is a "variable hour employee" if, based on the facts and circumstances at the employee's start date, it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week. [4] A variable hour employee would include a retail worker hired at more than 30 hours per week for the holiday season who is reasonably expected to continue working after the holiday season but is not reasonably expected to work at least 30 hours per week for the portion of the initial measurement period remaining after the holiday season. (but see footnote 4).

"**Waiting period**" - the period of time an ***otherwise eligible employee*** must wait (passage of time) for coverage to become effective.

[4] Until 2015, A new employee who is expected to work initially at least 30 hours per week may be a variable hour employee if, based on the facts and circumstances at the start date, the period of employment at more than 30 hours per week is reasonably expected to be of limited duration and it cannot be determined that the employee is reasonably expected to work on average at least 30 hours per week over the initial measurement period.

Glossary

Prop Reg § 1.5000A-2. Minimum essential coverage.

(a) In general. Minimum essential coverage means coverage under a government sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or other health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and §1.5000A-1 and §§1.5000A-3 through 1.5000A-5.

(b) Government sponsored program. Government sponsored program means any of the following:

(1) The Medicare program under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections);

(2) The Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 and following sections) other than--

(i) Optional coverage of family planning services under section 1902(a)(10)(A)(ii)(XXI) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(XXI));

(ii) Optional coverage of tuberculosis-related services under section 1902(a)(10)(A)(ii)(XII) (42 U.S.C. 1396a(a)(10)(A)(ii)(XII));

(iii) Coverage of pregnancy-related services under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)); or

(iv) Coverage of medical emergency services under 8 U.S.C. 1611(b)(1)(A), as authorized by section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)).

(3) The Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (42 U.S.C 1397aa and following sections);

(4) Medical coverage under chapter 55 of title 10, U.S.C., including coverage under the TRICARE program;

(5) The following health care programs under chapter 17 or 18 of title 38, U.S.C.:

(i) The medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705;

(ii) The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; and

(iii) The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spina bifida.

6) A health plan under section 2504(e) of title 22, U.S.C. (relating to Peace Corps volunteers); and

(7) The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense authorization Act for Fiscal Year 1995 (Public Law No. 103-337; 10 U.S.C. 1587 note).

Glossary

(c) Eligible employer-sponsored plan.

(1) In general. Eligible employer-sponsored plan means, with respect to any employee, a group health plan (whether an insured group health plan or a self-insured group health plan) or group health insurance coverage offered by an employer to the employee, which is--

(i) A governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act (42 U.S.C. 300gg-91(d)(8)));

(ii) Any other plan or coverage offered in the small or large group market within a State;

(iii) A grandfathered health plan (within the meaning of paragraph (e) of this section) offered in a group market.

(2) Group health plan. Group health plan has the same meaning as in section 2791(a) of the Public Health Service Act (42 U.S.C. 300gg-91(a)(1)).

(3) Group health insurance coverage. Group health insurance coverage has the same meaning as in section 2791(b) of the Public Health Service Act (42 U.S.C. 300gg-91(b)).

4) Large and small group market. Large group market and small group market have the same meanings as in section 1304(a)(3) of the Affordable Care Act (42 U.S.C. 18024(a)(3)).

(5) Government sponsored program not treated as eligible employer-sponsored plan. A government sponsored program described in paragraph (b) of this section is not an eligible employer-sponsored plan.

(d) Plan in the individual market. Plan in the individual market means health insurance coverage offered to individuals not in connection with a group health plan, including a qualified health plan offered by an Exchange.

(e) Grandfathered health plan. Grandfathered health plan means any group health plan or group health insurance coverage to which section 1251 of the Affordable Care Act (42 U.S.C.18011) applies.

(f) Other health benefits coverage. Minimum essential coverage includes any plan or arrangement recognized by the Secretary of Health and Human Services as minimum essential coverage for purposes of section 5000A under 45 CFR 156.600 and following sections.

(g) Excepted benefits. Minimum essential coverage does not include any health insurance coverage that consists of excepted benefits that are described in section 2791(c)(1), (c)(2), (c)(3), or (c)(4) of the Public Health Service Act (42 U.S.C. 300gg-91(c)).

Glossary

PHSA 2791(a) Group Health Plan Defined

PHSA 2791(a) The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care (as defined under **Medical care** and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Medical care. The term "medical care" means amounts paid for—

1. the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
2. amounts paid for transportation primarily for and essential to medical care referred to in #1 above, and
3. amounts paid for insurance covering medical care referred to in #1 and #2.

Glossary

PUBLIC HEALTH SERVICE ACT §2791 [42 USC §300gg-91] Definitions

(a) Group health plan.

(1) **Definition.**

The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) **Medical care.**

The term "medical care" means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) **Treatment of certain plans as group health plan for notice provision.**

A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 300gg(c)(1) of this title is provided shall be treated as a group health plan for purposes of applying section 300gg(e) of this title.

(b) Definitions relating to health insurance.

(1) **Health insurance coverage.**

The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) **Health insurance issuer.**

The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974) [29 U.S.C.A. §1144(b)(2)]. Such term does not include a group health plan.

(3) **Health maintenance organization.**

The term "health maintenance organization" means—

(A) a Federally qualified health maintenance organization (as defined in section 300e(a) of this title),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) **Group health insurance coverage.**

The term "group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) **Individual health insurance coverage.**

The term "individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) Excepted benefits.

For purposes of this title, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:

(1) **Benefits not subject to requirements.**

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) **Benefits not subject to requirements if offered separately.**

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) **Benefits not subject to requirements if offered as independent, noncoordinated benefits.**

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) **Benefits not subject to requirements if offered as separate insurance policy.**

Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of this title), coverage supplemental to the coverage provided under chapter 55 of Title 10, and similar supplemental coverage provided to coverage under a group health plan.

Glossary

(d) Other definitions.

(1) **Applicable State authority.**

The term “applicable State authority” means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) **Beneficiary.**

The term "beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(8)].

(3) **Bona fide association.**

The term “bona fide association” means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) **COBRA continuation provision.**

The term “COBRA continuation provision” means any of the following:

(A) Section 4980B of Title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1161 et seq.], other than section 609 of such Act [29 U.S.C.A. §1169].

(C) Subchapter XX of this chapter.

(5) **Employee.**

The term “employee” has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(6)].

(6) **Employer.**

The term “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(5)], except that such term shall include only employers of two or more employees.

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(7) **Church plan.**

The term “church plan” has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(33)].

(8) **Governmental plan.**

(A) The term “governmental plan” has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(32)] and any Federal governmental plan.

(B) Federal governmental plan. The term “Federal governmental plan” means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) Non-Federal governmental plan. The term “non-Federal governmental plan” means a governmental plan that is not a Federal governmental plan.

(9) **Health status-related factor.**

The term “health status-related factor” means any of the factors described in section 300gg-1(a)(1) of this title.

(10) **Network plan.**

The term “network plan” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) **Participant.**

The term “participant” has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(7)].

(12) **Placed for adoption defined.**

The term “placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(13) **Plan sponsor.**

The term “plan sponsor” has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. §1002(16)(B)].

(14) **State.**

The term “State” means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) **Family member.**

The term “family member” means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) **Genetic information.**

(A) In general. The term “genetic information” means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions. The term “genetic information” shall not include information about the sex or age of any individual.

(17) **Genetic test.**

(A) In general. The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions. The term “genetic test” does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(18) **Genetic services.**

The term “genetic services” means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(19) **Underwriting purposes.**

The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(20) **Qualified health plan.**

The term "qualified health plan" has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) **Exchange.**

The term "Exchange" means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(e) Definitions relating to markets and small employers.

For purposes of this title:

(1) **Individual market.**

(A) In general. The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) Treatment of very small groups—

(i) In general. Subject to clause (ii), such terms [(1) So in original. Probably should be "term".] includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) State exception. Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) **Large employer.**

The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) **Large group market.**

The term "large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) **Small employer.**

The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.

(5) **Small group market.**

The term "small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) **Application of certain rules in determination of employer size.**

For purposes of this subsection—

(A) Application of aggregation rule for employers. all[(2) So in original. Probably should be capitalized.] persons treated as a single employer under subsection (b) , (c) , (m) , or (o) of section 414 of Title 26 shall be treated as 1 employer.

(B) Employers not in existence in preceding year. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) Predecessors. Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(July 1, 1944, c. 373, Title XXVII, Sec. 2791, as added Aug. 21, 1996, P.L. 104-191, Sec. 102(a), Title I, 110 Stat. 1972; May 21, 2008, P.L. 110-233, Sec. 102(a)(4), Title I.); Mar. 23, 2010, P.L. 111-148, Sec. 1562(b), Sec. 1562(c)(16)(A), (B)(i)-(ii) [renumbered Sec. 1563(b), (c)(16)(A), (B)(i)-(ii),], Title I, Subtitle G, Sec. 10107(b)(1), Title X.)