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Course Information

Course Title: *Health Care Reform: The Affordable Care Act Tax Provisions #2914*

Number of continuing education credit hours recommended for this course:

In accordance with the standards of the Certified Financial Planner Board of Standards, the National Registry of CPE Sponsors, and the IRS, CPE credits have been granted based on a 50-minute hour.

EA, OTRP **4** (All States) IRS: Qualified Sponsor number: *FWKKO*.
CPA: **4** (All states)
CFP®: **3** All states)
CLU, ChFC/PACE Recertification: 4

For a list of states which have approved PACE compliance as also meeting their state CE licensing requirement, contact The American College/PACE http://www.theamericancollege.edu

CFP Board Sponsor ID: 1008
National Registry of CPE Sponsors ID Number: 107615.
Sponsor numbers for states requiring sponsor registration:
Florida Division of Certified Public Accountancy: 4761 (Ethics #11467)
Hawaii Board of Public Accountancy: 14003
New York State Board of Accountancy: 002146
Ohio State Board of Accountancy: M0021
Texas State Board of Accountancy: 009349
Program Delivery Method: QAS self-Study (interactive)

Subject Codes/Field of Study

EA/OTRP: Federal Tax Law
CFP®: CPA: Taxes

Course Level and Prerequisites

Level of Complexity: CFP Board: Intermediate; NASBA/IRS: Overview.
This program is appropriate for professionals at all organizational levels.

Prerequisites: Basic familiarity with federal taxation

Advance Preparation: None

Course Description

The landmark legislation known as the Patient Protection and Affordable Care Act (PPACA), signed into law in 2010, is likely to affect virtually every person and institution in the United States in some way. It imposes healthcare-related requirements on health plans, health insurers, employers and individuals. In addition to imposing various tax increases to increase revenue, the PPACA uses a carrot and stick approach to ensure compliance with its provisions, offering tax credits for compliance and imposing tax penalties for non-compliance. This course will review the principal provisions of the law and will examine its tax impact on individuals and businesses.

It will consider the a) coverage-related provisions of the PPACA addressing plan grandfathering, the prohibition of pre-existing condition exclusions, the proscription of lifetime and annual benefit limits, the limitation of health coverage rescissions, the requirement for certain patient protections and the general requirement for universal health care coverage, b) the tax credits available to small businesses to encourage them to sponsor employee health plans, c) the shared responsibility for certain large employers to provide employee health coverage and the tax penalties imposed for noncompliance, d) the various personal income tax changes affecting taxpayers and e) the tax credits and tax penalties authorized help enforce the PPACA requirement that individuals maintain minimum essential coverage.

Course Content

Publication/Revision date: 2/1/2014.
Course book: by Paul J. Winn CLU ChFC
Exam (online): Thirty questions (multiple-choice).
This exam must be successfully passed within one year of purchase of the course. Passing grade of 70% required. The exam may be retaken at no charge if not passed on the first attempt.

Instructions for Taking the Final Exam Online:

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Learning Objectives

Upon completion of this course, you should be able to:

- Identify the rules applicable to –
  - grandfathered health plans,
  - the use of pre-existing condition exclusions, and
  - annual and lifetime benefit limits;
- List the conditions that would permit an insurer to rescind health insurance coverage and the applicable notice requirements; and
- Recognize the requirements imposed by healthcare reform legislation with respect to –
  - patient protection provisions,
  - the individual's requirement to maintain minimum essential coverage, and
  - dependent coverage to young adults.
- Identify the changes made by the PPACA related to –
  - the treatment of costs for over-the-counter drugs and medical expense FSA contributions,
  - the tax penalty for nonqualified Archer MSA and HSA distributions,
  - medical expense deductions applicable to years after 2012,
  - the additional taxation on the earnings of high-income taxpayers,
  - the additional tax on high-income taxpayers' net investment income, and
  - the additional tax on estate's and non-grantor trust's undistributed net investment income;
- Recognize the tax penalties generally applicable to individuals who fail to maintain minimum essential coverage; and
- Identify the amount of the premium assistance tax credit available to taxpayers whose household income is less than 400% of the federal poverty line.
- Identify the –

    - W-2 reporting requirements imposed on employers providing employer-sponsored health coverage, and
    - transition relief provided applicable to W-2 reporting;
- Recognize “full-time employee” and “full-time equivalent employee” for purposes of employer tax credits and penalties under the PPACA;
- Recognize the –
    - rules that apply to a small employer’s eligibility for a health insurance premium credit, and
    - nature of a “qualifying arrangement” under which an employer pays premiums for employee health insurance coverage;
- Identify the types of coverage that meet the PPACA definition of health insurance coverage for purposes of the small employer health insurance premium credit;
- Recognize the various limitations that may reduce the amount of health insurance premium credit available to an otherwise eligible small employer;
- Recognize the potential penalties applicable to large employers under the PPACA; and
- Identify the –
    - transition relief available to applicable large employers, and
    - annual return and notification requirements imposed by the PPACA on applicable large employers.

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Introduction

The landmark legislation known as the Patient Protection and Affordable Care Act (PPACA), signed into law in 2010, is likely to affect virtually every person and institution in the United States in some way. It imposes healthcare-related requirements on health plans, health insurers, employers and individuals.

In addition to imposing various tax increases to increase revenue, the PPACA uses a carrot and stick approach to ensure compliance with its provisions, offering tax credits for compliance and imposing tax penalties for non-compliance. This course will review the principal provisions of the law and will examine its tax impact on individuals and businesses.

In so doing, it will consider the:

- Coverage-related provisions of the PPACA addressing –
    - Plan grandfathering pursuant to which health coverage in force at the time of the law's passage may be continued,
    - The prohibition of pre-existing condition exclusions,
    - The proscription of lifetime and annual benefit limits,
    - The limitation of health coverage rescissions,
    - The requirement for certain patient protections,
    - The general requirement for universal health care coverage, and
    - The requirement that plans covering children extend child coverage until age 26;
- Tax credits available to small businesses to encourage them to sponsor employee health plans;
- Shared responsibility for certain large employers to provide employee health coverage and the tax penalties imposed for noncompliance;
- Various personal income tax changes affecting taxpayers; and
- Tax credits and tax penalties authorized to help enforce the PPACA requirement that individuals maintain minimum essential coverage.

Chapter 1 – Overview of PPACA Provisions

Introduction

The Patient Protection and Affordable Care Act (PPACA) represents the single most significant change in the delivery and financing of healthcare since the establishment of Medicare in 1965. Although certain health plans are exempt from some of the act's provisions, the PPACA generally prohibits the imposition of pre-existing condition exclusions, forbids a health plan to place a cap on benefits, permits a health plan to rescind coverage only for specified reasons, mandates certain patient protections, and requires that health plans covering children extend such coverage until the child reaches age 26. In an attempt to ensure that the cost of coverage issued within the act's requirements does not become prohibitively expensive, PPACA also requires that individuals maintain health insurance coverage and that large employers sponsor and participate in the cost of employee health care coverage or face a financial penalty.

This chapter will look briefly at the significant non-tax provisions of PPACA.

Chapter Learning Objectives

When you have completed this chapter, you should be able to:

- Identify the rules applicable to –
  - grandfathered health plans,
  - the use of pre-existing condition exclusions, and
  - annual and lifetime benefit limits;
- List the conditions that would permit an insurer to rescind health insurance coverage and the applicable notice requirements; and
- Recognize the requirements imposed by healthcare reform legislation with respect to –
  - patient protection provisions,
  - the individual's requirement to maintain minimum essential coverage, and
  - dependent coverage to young adults.

Grandfathered Health Plans

One of the concerns expressed from the time healthcare reform legislation was proposed relates to individuals' right to maintain their existing healthcare coverage. PPACA addresses the concern related to maintaining existing coverage by providing for the grandfathering of certain health plan coverage.

A grandfathered health plan is a health plan in force on March 23, 2010. It will remain a grandfathered plan—and continue to be exempt from certain provisions of the PPACA—for as long as it maintains grandfathered health plan status. Although grandfathered status generally exempts such plans from the requirement to comply with various provisions of the PPACA, that exemption may depend on whether the grandfathered plan is an individual health plan or a group health plan.

The provisions of the PPACA that do not apply to grandfathered health plans are the following:

- The patient protection provisions of the PPACA related to the choice of available healthcare professional and the providing of certain emergency services. These provisions do not apply to either a grandfathered individual or grandfathered group health plan;
- The provisions concerning the prohibition of pre-existing condition exclusions. These provisions are inapplicable to grandfathered individual health insurance;
- The prohibition of annual benefit limits imposed by the PPACA under grandfathered individual health insurance policies. The provisions concerning annual benefit limits are not applicable to grandfathered individual health insurance policies, although they apply to group health plans whether or not grandfathered; and

- The requirement that group plans offer dependent coverage up to age 26 before 2014 if the individual is eligible for group coverage outside of his or her parent's plan.

Losing Grandfathered Status

While the grandfathering provision of the PPACA generally facilitates the maintaining of current coverage, it also imposes specific requirements on such plans to enable them to keep their grandfathered status. Among these are certain disclosure and documentation requirements.

In addition, in order for grandfathered health plans to keep their favored status, they must avoid specified actions that would cause them to lose it. In general, the actions likely to cause a grandfathered health plan to lose its grandfathered status are actions that would tend to reduce or eliminate participant benefits or increase participants' costs.

Disclosure Requirements

A grandfathered health plan, in order to maintain its grandfathered status, is required to provide a grandfathered plan disclosure. The required disclosure must accomplish the following:

- Describe the benefits provided under the health plan or health insurance coverage;
- State that the health plan or health insurance coverage believes it is a grandfathered health plan; and
- Provide information about whom to contact to ask questions or lodge complaints about the plan.

Although no regular periodic disclosure is required, the disclosure statement must be included in all plan materials provided to plan participants or beneficiaries. While specific disclosure language is not mandated under the legislation, model language is provided in the regulations that may be used to satisfy the requirement for grandfathered health plan disclosure.

Documentation Requirements

In addition to providing the required disclosures, a grandfathered plan must also maintain certain documentation of the plan and make any such documentation available for examination if requested. For as long as a plan considers itself a grandfathered health plan, it must:

- Maintain records documenting the terms of the plan or health insurance coverage in effect on March 23, 2010, i.e. the date of passage of the PPACA, along with any other documents needed to verify, explain, or clarify its status as a grandfathered health plan; and
- Make the maintained records and documents available for examination upon request.

A grandfathered health plan's failure to maintain the required grandfathered health plan documentation or to make it available when requested would cause the plan's grandfathered status to be lost.

Actions Resulting in Loss of Grandfathered Status

Grandfathered health plan status can be lost by certain actions taken by a plan sponsor. Such actions include:

- Eliminating benefits;
- Increasing the participants' percentage cost-sharing requirement;
- Increasing a fixed-amount copayment beyond permitted limits;
- Certain reductions in employer or employee organization contribution rates;
- Prohibited changes in annual benefit limits before they are prohibited on or after 2014; and
- Violating anti-abuse rules.

Eliminating Benefits

A health plan's elimination of all or substantially all benefits for the diagnosis or treatment of a particular condition—benefits that were included in the plan on March 23, 2010—will cause a group health plan or health insurance coverage to lose its grandfathered health plan status. In addition, a plan's elimination of benefits for any necessary element to diagnose or treat a condition is considered

the elimination of all or substantially all benefits for the diagnosis or treatment of a particular condition. Accordingly, the elimination of such a necessary element would cause a health plan to cease being a grandfathered health plan.

To illustrate an action that would cause a grandfathered plan to lose its grandfathered status, suppose that a health plan provides benefits on March 23, 2010 for a mental health condition whose treatment consists of a combination of counseling and prescription drugs. If the plan subsequently eliminates coverage for the counseling component of the treatment but maintains coverage for the drugs prescribed for the condition, the plan would be treated as having eliminated all or substantially all the benefits for that condition. As a result, the plan would no longer be considered a grandfathered health plan.

Increasing Participants' Cost-Sharing Requirement

The term "cost-sharing requirements," as used in the PPACA and its regulations, refers to those costs incurred by covered individuals who *receive healthcare services.* Thus, cost-sharing requirements include the plan's coinsurance, deductibles and copayments. An increase in the cost-sharing requirements imposed by a health plan shifts the burden of healthcare costs to individuals in need of medical services, rather than to all health plan participants. The regulations deal differently with the effect of cost-sharing requirement increases depending on whether the increase affects a percentage or a fixed-dollar amount.

A health plan's increase in the percentage level of coinsurance is deemed to significantly alter the level of benefits provided. Thus, any increase in the percentage cost-sharing requirement—an increase in coinsurance from 20% to 30%, for example—will cause a health plan or health insurance coverage to cease to be a grandfathered health plan.

However, unlike percentage increases in cost-sharing requirements which will cause a health plan to lose its grandfathered status, limited increases in fixed amount cost-sharing requirements are permitted without loss of grandfathered status. The maximum fixed-dollar increase that may be imposed by a grandfathered health plan is limited to the medical inflation rate plus 15 percentage points. A grandfathered health plan that exceeds the permitted fixed-dollar cost-sharing limits will cease to be a grandfathered health plan.

Increasing a Fixed-Amount Copayment

The term "copayment" refers to the dollar amount for which a plan participant is responsible when accessing plan benefits. For example, a typical health plan may charge a $30 copayment for every visit made to a primary care provider and $40 for every visit to a physician who specializes in a particular medical field.

As in the case of fixed-dollar cost-sharing requirements, fixed amount copayments may also be increased within certain limits without negatively affecting a grandfathered health plan's status. Such fixed amount copayment increases imposed by a grandfathered health plan may not exceed the greater of a) medical inflation plus 15 percentage points, or b) $5 adjusted for medical inflation.

Reducing Sponsoring Organization Contribution Rates

Employers and other organizations that sponsor health plans for participants often pay a portion of the premium costs for participants' coverage. A reduction in the rate of a sponsoring organization's contributions towards the cost of coverage may also be deemed a major change depending on the extent of the reduction. The term "contribution rate**"** means the amount of sponsoring organization contributions compared to the total cost of coverage, expressed as a percentage.

Under the PPACA, a sponsoring organization that decreases its contribution rate for participant coverage by more than five percentage points below the contribution rate for the period that includes March 23, 2010 will cease to be a grandfathered health plan. The five percentage point limit is applied separately to each tier of coverage for any class of similarly situated individuals.

Changing Annual Benefit Limits

The PPACA prohibits the imposition of lifetime benefit limits and phases out permitted annual benefit limits on essential health benefits until they, too, are prohibited for plan years beginning on and after January 1, 2014 for all plans other than grandfathered individual plans. However, a group health plan or group health insurance coverage that, before January 1, 2014, imposes an overall annual dollar

limit on benefits where none existed on March 23, 2010 or decreases the overall annual dollar limit may lose its grandfathered health plan status.

Thus, a grandfathered health plan will lose its grandfathered status if it imposes a lifetime limit or:

- Imposes an overall annual limit on the dollar value of benefits if it imposed no annual or lifetime benefit limit on March 23, 2010;
- Imposes an overall annual limit on the dollar value of benefits that is lower than the lifetime limit on March 23, 2010; or
- Decreases the dollar value of the overall annual limit when compared to the limits imposed on March 23, 2010.

Violating Anti-Abuse Rules

In order to stop health plan sponsors from restructuring or changing plan eligibility rules to avoid compliance with the PPACA, anti-abuse rules were promulgated. Under the anti-abuse rules, a grandfathered plan that engages in the following will lose its grandfathered status:

- Restructuring its business to avoid compliance – A plan sponsor that undergoes a merger, acquisition or similar business restructuring will cease to be a grandfathered health plan if its principal purpose in restructuring is to cover new individuals under a grandfathered health plan; or
- Changing plan eligibility without a bona fide employment-based reason – A group health plan or health insurance coverage will cease to be a grandfathered health plan if all of the following apply–
    - Employees are transferred from a health plan or health insurance coverage under which they were covered on March 23, 2010 (a transferor plan) to another plan or health insurance coverage (a transferee plan);
    - Comparing the terms of the transferee plan with those of the transferor plan and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of its grandfathered status; and
    - No bona fide employment-based reason exists for transferring the employees to the transferee plan.

Pre-Existing Condition Exclusions Prohibited

Except in the case of grandfathered individual health coverage, the PPACA generally prohibits any pre-existing condition exclusion from being imposed by a group health plan or under any group or individual health insurance coverage. A pre-existing condition exclusion is defined as a limitation or exclusion of benefits based on the fact the condition existed before the date coverage is applied for. The PPACA does not require a group or individual health plan to cover all conditions.

Two Criteria Present in Pre-Existing Condition Exclusion

For an exclusion of benefits to be considered a pre-existing condition exclusion that is prohibited under most types of health plan pursuant to PPACA provisions, two criteria must be met. The excluded benefits must be benefits that are:

1. Normally included in the health plan; and
2. Excluded from an individual's coverage because he or she has a pre-existing condition.

The prohibition against pre-existing condition exclusions only assures individuals that they cannot be refused coverage—either denied enrollment or denied coverage for a specific condition—solely because of such a condition. However, if a health plan does not provide benefits for the diagnosis or treatment of a particular condition regardless of when the condition arose—whether it began before or after coverage commenced for the individual, in other words—the PPACA's prohibition of pre-existing conditions will not require that the health plan provide benefits for the condition.

Grandfathered Group Health Plans Not Exempt

A group health plan or group health insurance coverage that has grandfathered health plan status is not exempt from the PPACA's provisions prohibiting pre-existing condition exclusions. In other words, even though a group health plan or group health insurance coverage enjoys grandfathered status the PPACA's provisions prohibiting pre-existing condition exclusions apply just as they apply to any group health plan or group health insurance coverage that is not a grandfathered health plan.

Grandfathered individual health insurance coverage is not subject to the provisions of the PPACA that prohibit such exclusions. Simply stated, grandfathered individual health insurance coverage may continue to impose pre-existing condition exclusions for as long as it maintains grandfathered health plan status.

Pre-Existing Condition Exclusion Prohibition Effective Date Based on Participant Age

The PPACA's prohibition of pre-existing condition exclusions becomes effective generally in the first plan year—"policy year" in the case of individual health insurance coverage—beginning on or after January 1, 2014. The January 1, 2014 date for general implementation of the pre-existing exclusion prohibition is important because it is also the effective date of the PPACA's provision concerning the guaranteed availability of coverage and the provision prohibiting discrimination against individual participants and beneficiaries based on health status. (See **Requirement to Maintain Minimum Essential Coverage** below.)

However, the prohibition against the exclusion of pre-existing conditions for individuals younger than age 19 is effective much earlier. For individuals younger than age 19 who enroll in plans to which the ban on pre-existing conditions exclusions apply—group health plans or group or individual health insurance (other than grandfathered individual health insurance)—the effective date of the PPACA's provisions prohibiting pre-existing condition exclusions is the first plan year (policy year in the case of individual health insurance) occurring on or after September 23, 2010.

Benefit Limits Prohibited

The PPACA prohibits the imposition of limits on essential health benefits. The prohibition extends to annual benefit limits and lifetime benefit limits.

Annual benefit limits are dollar limits imposed by a health plan or insurer on the maximum amount of benefits it will pay for covered healthcare provided to any covered person during the calendar year. Lifetime benefit limits are dollar limits imposed by a health plan or insurer on the maximum amount of benefits it will pay for covered healthcare provided to any covered person over his or her lifetime.

Thus, under the PPACA, group health plans and health insurers offering group or individual health insurance coverage are prohibited from imposing:

- Annual limits on the dollar value of health benefits, although such annual limit prohibition is phased-in over the period from 2010 to 2014; or
- Lifetime limits on the dollar value of health benefits.

Benefit Limit Prohibition Applicable only to Essential Health Benefits

The prohibition against a health plan's imposition of benefit limits applies only to essential health benefits. Although guidance with respect to the specific benefits included in "essential health benefits" has not yet been provided, the PPACA[1] specifies that the definition of essential health benefits must include benefits for certain general categories.

The benefit categories that comprise essential health benefits to which the prohibition of benefit limits applies include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;

[1] Patient Protection and Affordable Care Act, §1302(b).

- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

One of the practical effects of prohibiting annual and lifetime limits only on essential health benefits is that a group health plan or health insurance issuer may impose limits—to the extent permitted by other federal or state law—on any benefits that are not included in the definition of "essential health benefits."

Annual Benefit Limit Prohibition Phased-In

The prohibition of annual benefit limits under PPACA is phased-in over a three-year period beginning in September 23, 2010 and ending on January 1, 2014. During the phase-in period a group health plan or health insurer offering group or individual health insurance coverage may establish an annual limit on the dollar amount of benefits that are deemed to be essential health benefits. The annual limits permitted during the phase-in period, however, are subject to specified dollar amounts.

The phase-in period was included to help ensure against adverse impacts on premiums or the offering of health coverage in the marketplace as affected plans transition to the no-limit environment. As previously noted, the imposition of annual benefit limits by a grandfathered health plan may cause the plan to lose its grandfathered status.

While any health plan or insurer offering group or individual health insurance coverage may establish a higher limit or impose no annual limits at all, the annual limit on essential health benefits for each of the three years may not be less than the following:

- $750,000 for a plan year (policy year in the case of individual coverage) beginning on or after September 23, 2010 but before September 23, 2011;
- $1,250,000 for a plan year (policy year in the case of individual coverage) beginning on or after September 23, 2011 but before September 23, 2012; and
- $2,000,000 for plan years (policy years in the case of individual coverage) on or after September 23, 2012 but before January 1, 2014.

Group health plans and *group* health insurance coverage must comply with the PPACA's provisions prohibiting annual limits on essential health benefits—including the restricted phase-in limits—whether or not the plans are grandfathered. In contrast to the applicability of the PPACA's provision to grandfathered group health plans, however, the PPACA's provisions prohibiting annual limits do not apply to grandfathered *individual* health insurance coverage as long as the coverage maintains its grandfathered status.

Unlike the PPACA's provisions prohibiting *annual* benefit limits the PPACA prohibits *lifetime* benefit limits entirely for plan years (policy years in the case of individual health insurance) beginning on or after September 23, 2010. All health plans—both group and individual, whether or not grandfathered—must comply with the PPACA's provision prohibiting the imposition of lifetime benefit limits with respect to essential health benefits. Similar to the rules governing annual benefit limits, however, a health plan or health insurer may impose lifetime limits applicable to benefits not considered essential health benefits.

Participants Already at Lifetime Benefit Limits

Not only do the provisions of the PPACA prohibit prospective lifetime limits, they also address the issue of what must be done for individuals who have already reached a lifetime benefit limit. For such individuals who are still eligible but no longer enrolled under the plan or coverage, the PPACA requires that they be given:

- A written notice concerning the prohibition of lifetime benefit limits under the law; and
- An opportunity to re-establish coverage.

Contract Rescission Limited

In contract law, the term "rescission" refers to the unwinding of a contract in such a way that each party is returned to his or her position before the contract was entered into. In other words, the rescission is intended to nullify the contract and treat it as though it never took place.

Health insurance policies generally contain a provision called, variously, an "Incontestable Provision" or a "Contestable Period" provision. Regardless of the name given to it, the provision generally identifies and limits the period of time following issuance of the coverage during which the insurer can contest the policy or make post-issue changes to it. When the contestable period ended, insurers typically could no longer contest the coverage.

Under the provisions of the PPACA, coverage cannot be rescinded under a group health plan or under group or individual health insurance coverage issued by an insurer except in the case of:

- Fraud; or
- An intentional misrepresentation of a material fact.

Contestable Period Ending not a Barrier to Rescission

The PPACA's provisions limiting the right of a health plan or insurer to rescind coverage are effective for plan years (policy years in the individual market) beginning on and after September 23, 2010 and apply to insured and self-insured coverage, whether or not grandfathered. Furthermore, coverage can be rescinded even though any contestable period has expired.

Patient Protections

The patient protection provisions of the PPACA impose requirements on certain health plans and health insurance providers relating to the choice of healthcare professionals and plan benefits for emergency services. The provisions of the PPACA and Regulations concerning the choice of healthcare professionals apply only with respect to plans and health insurance coverage with a network of providers, principally health maintenance organization (HMO) and point of service (POS) plans.

Networks of Healthcare Providers

The PPACA's provisions related to health plans and health insurance coverage involving networks of providers require that they provide certain patient protections. Pursuant to those patient protections, a plan involving a network of providers must permit:

- Covered individuals to choose any participating primary care provider;
- Participants to select a pediatrician as the primary care provider for covered children; and
- Female participants to obtain OB/GYN care without pre-authorization or referral.

Emergency Services

In addition to mandating certain patient protections specifically related to health plans involving networks of providers, the PPACA also requires all health plans providing benefits for emergency services to meet additional requirements. Plans covering such emergency services must not:

- Require individuals to obtain prior authorization for emergency services;
- Impose additional requirements or benefit limitations on out-of-network emergency services; or
- Impose out-of-network cost-sharing requirements that exceed certain limits.

Requirement to Maintain Minimum Essential Coverage

For years beginning in 2014, the PPACA requires non-exempt individuals to maintain health insurance whose coverage is at least equal to minimum essential coverage or pay a penalty. Individuals who meet certain criteria are exempt from the coverage requirement. In addition, non-exempt individuals whose income does not exceed a specified percentage of the federal poverty level are eligible for refundable tax credits to assist them to purchase the required coverage. Furthermore, individuals younger than age 30 may meet the PPACA requirement to maintain minimum essential coverage through the purchase of a catastrophic plan. (See **Catastrophic Plan** below.)

Concurrent with the individuals' requirement to maintain minimum essential coverage, insurers are required to accept all applicants for health coverage. Furthermore, insurers are permitted to apply rating variations based only on age and tobacco use.

Minimum Essential Coverage

The term "minimum essential coverage," as used in the PPACA is broadly defined. Under the law, minimum essential coverage means:

- A government-sponsored program, including –
    - Medicare,
    - Medicaid,
    - CHIP,
    - TRICARE for life,
    - Veterans' health care program, and
    - The Peace Corps volunteers health plan;
- An eligible employer-sponsored plan;
- Coverage under a health plan offered in the individual market within a state;
- Coverage under a grandfathered health plan; and
- Other coverage, such as coverage under a state health benefits risk pool.

Certain Individuals Not Required to Maintain Minimum Essential Coverage

Although the requirement under PPACA to maintain minimum essential health coverage generally applies to all individuals, certain individuals are excluded from the requirement. Those excluded from the requirement to maintain coverage are individuals who:

- Have a religious exemption;
- Are not lawfully present, i.e. neither U.S. citizens or nationals or aliens lawfully present in the U.S.;
- Are members of an Indian tribe; or
- Are incarcerated.

Catastrophic Plan

In addition to the individuals just discussed who are exempt from the requirement to maintain minimum essential coverage, individuals younger than age 30 may meet the PPACA requirement to maintain coverage by enrolling in a catastrophic plan offered in the individual market. The catastrophic plan—also referred to as a "high deductible health plan"—must provide the essential health benefits described earlier except that the plan provides no benefits, other than coverage for at least three primary care visits and preventive care, for any plan year until the individual has incurred covered expenses at least equal to the applicable deductible.

Adult Children Coverage

Before the passage of the PPACA, group health insurance plans and insurers offering group or individual health insurance coverage routinely removed enrolled children from coverage when they reached age 19 (age 23 if in school). With certain exceptions, the PPACA has required health plans that provide dependent coverage and insurers under family plans to extend the period of coverage for children. Such extended adult child coverage applies for plan years beginning on and after September 23, 2010.

Broad Definition of Child

A child is defined broadly to include a legally-adopted individual of the employee and an individual who is lawfully placed with the employee for legal adoption by the employee and includes an employee's:

- Son;
- Daughter;
- Stepson;

- Stepdaughter; and
- Eligible foster child.[2]

Certain Plans Required to Extend Dependent Coverage

Health plans and issuers offering dependent coverage are generally required under the PPACA to make the dependent coverage available until a child reaches the age of 26. (A child is a dependent for the entire calendar month during which he or she becomes age 26.) The requirement applies to all plans in the individual market and to non-grandfathered group health plans.

Grandfathered group plans that offer dependent coverage, however, are not required to offer such coverage to age 26 until 2014 if the child is eligible for group coverage outside his or her parent's plan. In 2014, grandfathered group plans offering dependent coverage will similarly be required to extend the availability of the coverage up to age 26. If both parents are covered under separate employer-sponsored group insurance plans that provide dependent coverage, neither plan can deny coverage to an eligible adult child.

Pursuant to a change in tax law brought about under the PPACA to implement the extending of dependent coverage to adult children, certain amounts related to such coverage are excluded from the employee's gross income. The amounts excluded from the employee's income are:

- The value of employer-provided health coverage for an employee's child; and
- Employer-provided reimbursements made directly or indirectly to the employee for the medical care of the dependent.

Although the PPACA requires that certain plans extend dependent coverage to a child's age 26, the amendments to the tax code exclude these amounts from the employee's income through the end of the taxable year in which the child becomes age 27. The tax benefit applies regardless of whether the extended dependent coverage is required by law or is voluntarily extended by the plan or the insurer.

Plans Not Required to Extend Dependent Coverage

Although plans that currently provide dependent coverage, other than grandfathered group plans before 2014 if the individual is otherwise eligible for group coverage, must extend the availability of dependent coverage to age 26, there is no requirement under PPACA that compels a plan or issuer to offer dependent coverage. Thus, a plan or issuer who does not currently offer dependent coverage is not required to offer it.

Medicare is not required to cover adult children under age 26 under the PPACA extension of dependent coverage provision.

Eligibility for Extended Dependent Coverage

The younger-than-age-26 children of an insured under an individual health insurance policy providing family coverage or of a plan participant who is covered under a group health plan providing dependent coverage can join or remain under a parent's plan. For purposes of the extended dependent coverage, the usual tests that must be met for an individual to be considered a taxpayer's dependent do not apply.

Thus, such extended dependent coverage is available under the parent's plan even if the adult child is:

- Married;
- Not living with the parent;
- Not attending school;
- Not financially dependent on the parent; or
- Eligible to enroll in their own employer's plan (except in the case of a parent covered under a grandfathered group health plan before 2014).

[2] An "eligible foster child" is defined as an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Summary

The PPACA provides that certain health plans and health insurance in force at the time of passage of the law receive "grandfathered" health plan status and are exempt from some, but not all, of the its provisions as long as they maintain their grandfathered status. In order to maintain that status, a health plan must refrain from certain changes affecting coverage, employee premium contribution rates, etc. A health plan that loses its grandfathered status must immediately comply with the PPACA provisions.

The PPACA prohibits all health plans, other than grandfathered individual health insurance plans, from excluding pre-existing conditions from coverage. Although general applicability of the prohibition against imposing pre-existing condition exclusions is delayed until 2014, the prohibition begins for enrollees younger than age 19 in the first plan year on or after September 23, 2010.

Annual and lifetime benefit limits imposed by insurers have traditionally functioned as caps on the amount of benefits an insurer may be required to pay for a particular insured's medical care over the period of a year or for an individual's entire lifetime. Except for grandfathered individual health coverage, the PPACA prohibits the imposition of such limits on essential health benefits. In order to reduce the adverse impact of the prohibition of benefit limits on insurance premiums and the willingness to offer health coverage in the marketplace, a three year phase-in period is permitted during which plans may impose restricted annual benefit limits. Lifetime benefit limits are prohibited for plan years beginning on and after September 23, 2010.

Rescission is the legal term generally applied to the unwinding of a contract such that the parties to the contract are in approximately the same position they were before entering into it. When the term is used in connection with an insurance policy, it refers to the insurer's retroactive cancellation of the policy, refunding any premiums paid and usually declaring it to be void from its inception.

The PPACA prohibits the rescission of health coverage for any reason other than fraud or the intentional misrepresentation of a material fact. However, if coverage may be otherwise rescinded, the fact that any contestable period has expired will not prevent rescission. All health plans, whether or not grandfathered, must comply with this provision, which is effective for plan years beginning on and after September 23, 2010.

The patient protection provisions of the PPACA impose requirements on certain health plans and health insurance providers relating to the choice of healthcare professional and plan benefits for emergency services. The PPACA provisions concerning the choice of healthcare professionals apply only with respect to non-grandfathered health plans and health insurance coverage with a network of providers. These provisions are applicable to plan years beginning on and after September 23, 2010.

The provisions related to health plans and health insurance coverage involving networks of providers require that they provide patient protections a) permitting covered individuals to choose any participating primary care provider, b) allowing them to select a pediatrician as the primary care provider for covered children and c) enabling females to obtain OB/GYN care without pre-authorization or referral.

In addition to mandating certain patient protections specifically related to health plans involving networks of providers, the PPACA also requires all non-grandfathered health plans providing benefits for emergency services to meet additional requirements. Plans covering such emergency services must not a) require individuals to obtain prior authorization for emergency services, b) impose additional requirements or benefit limitations on out-of-network emergency services, or c) impose out-of-network cost-sharing requirements that exceed certain limits.

Beginning in 2014, individuals are generally required to maintain minimum essential health coverage or face a penalty. At the same time, insurers are required to accept all applicants for coverage and may charge varying premiums for the same coverage based only on an applicant's age and tobacco use.

Issuers and group health plans that offer dependent coverage are required to extend their dependent coverage to the adult child's age 26. The temporary exception to that requirement applies to grandfathered group health plans before 2014 if the adult child is eligible for group coverage outside his or her parent's plan. Plans that do not offer dependent coverage are not required under the PPACA to provide it.

PPACA Coverage Provisions Timetable

Effective	Provision
2010	• Pre-existing condition exclusions prohibited for enrollees younger than age 19. (Not applicable to grandfathered individual health insurance coverage.) • Lifetime benefit limits prohibited. • Annual benefit limit three-year phase-out begins; restricted limits apply. (Not applicable to grandfathered individual health insurance coverage.) • Coverage rescission permitted only for fraud or intentional misrepresentation. • Patient protections related to plans using a network of providers begin. (Not applicable to grandfathered plans.) • Emergency services patient protections begin. (Not applicable to grandfathered plans.) • Group health plans and insurers issuing family health insurance policies providing dependent coverage are required to extend dependent coverage to age 26. (Not applicable to grandfathered group plans before 2014 if the adult child is eligible for group coverage outside his or her parent's plan.)
2011	• Annual benefit phase-out limit increased for affected plans.
2012	• Annual benefit phase-out limit increased for affected plans.
2014	• Annual benefit limits prohibited for affected plans. • Pre-existing condition exclusions prohibited for enrollees age 19 and older. (Not applicable to grandfathered individual health insurance coverage.) • Requirement to maintain minimum essential health coverage applicable to all non-exempt individuals.

Chapter Review

1. Which of the following provisions of the Patient Protection and Affordable Care Act apply to all group and individual health plans whether or not such plans are grandfathered?

   A. The patient protection provisions

   B. The provision related to rescission of health plan coverage

   C. The provisions concerning prohibition of pre-existing condition exclusions

   D. The provision concerning the prohibition of annual benefit limits

2. Arthur is enrolled in a group health plan that does not provide coverage for certain types of medical treatment. When will the plan be required under the PPACA to provide coverage for currently excluded treatments under its pre-existing condition exclusions prohibition?

   A. The first plan year on or after June 14, 2010

   B. The first plan year on or after September 23, 2010

   C. The first plan year on or after January 1, 2014

   D. Never

3. What is the maximum lifetime benefit limit an insurer may impose for plan years beginning on and after September 23, 2010 with respect to its payment of non-essential health benefits pursuant to the Patient Protection and Affordable Care Act?

   A. No lifetime benefit limits may be imposed under the Act

   B. $750,000

   C. $2 million

   D. Lifetime benefit limits on non-essential health benefits are not prohibited under the Act

4. Phil purchased an individual health insurance policy and, in order to obtain the coverage, intentionally misrepresented a material fact on his application for it. If the policy provisions specify that the contestable period is two years in duration, what is the longest period following the effective date of the policy within which the insurer may rescind the policy?

   A. No rescission may be made at any time

   B. Within one year from the effective date

   C. Within two years from the effective date

   D. Rescission may be made at any time

5. The Patient Protection and Affordable Care Act mandated certain protection for females enrolled in health plans utilizing a network of providers. Which of the following statements concerning that protection is correct?

   A. All health plans using a network of healthcare providers must offer OB/GYN care

   B. Female enrollees must designate an OB/GYN professional as a primary care provider in network plans

   C. Female enrollees in health plans using a network of healthcare providers must be permitted to access OB/GYN care without the need to obtain authorization or referral

   D. Access to OB/GYN care in a health plan using a network of healthcare providers must be available without cost-sharing

6. Which of the following will cause a grandfathered group health plan to lose its grandfathered health plan status?

   A. A 5% decrease in the sponsoring organization's contribution rate

   B. A 5% increase in the plan's cost-sharing requirement

   C. A fixed amount cost-sharing increase

   D. A fixed amount copayment increase

7. Beginning in 2014, insurers may apply rating variations on health insurance coverage based on which of the following factors?

   A. The proposed insured's age and tobacco use

   B. The proposed insured's health history

   C. The proposed insured's gender

   D. The proposed insured's occupation and recreational activities

8. Which of the following is NOT required by the PPACA with respect to emergency services?

   A. Health plans are prohibited from requiring prior authorization for emergency services

   B. Health plans cannot impose benefit limitations on out-of-network emergency services that are not imposed on in-network emergency services

   C. Health plans must provide benefits for emergency services

   D. Health plans are prohibited from imposing additional requirements on out-of-network emergency services that are not imposed on in-network emergency services

9. Audrey is age 28 and healthy. In order to reduce her cost to maintain required healthcare coverage, she has elected to be covered under a catastrophic plan with a high deductible. What benefits must be provided under the plan to which the deductible does not apply?

   A. Emergency services

   B. Three primary care visits

   C. Benefits for pre-existing conditions

   D. Laboratory services

10. Food Brokers, Inc. offers its employees substantial health insurance benefits but no health insurance benefits for dependents. When is the plan required to provide dependent coverage to employees' dependents younger than age 26?

    A. 2010

    B. 2013

    C. 2014

    D. The plan is not required to offer extended dependent child coverage

Chapter 2 – Personal Tax Changes

Introduction

The PPACA brings about an array of changes to both coverage requirements and tax liability, many of which impact individual taxpayers. This chapter will examine the personal tax changes, including changes in:

- Tax-favored health plans;
- Unreimbursed medical expense deductions; and
- Social Security tax rates.

In addition, the tax credits offered and tax penalties imposed in connection with the PPACA requirement to maintain minimum essential coverage—popularly referred to as the individual mandate—will be examined in depth.

Chapter Learning Objectives

When you have completed this chapter, you should be able to:

- Identify the changes made by the PPACA related to –
    - the treatment of costs for over-the-counter drugs and medical expense FSA contributions,
    - the tax penalty for nonqualified Archer MSA and HSA distributions,
    - medical expense deductions applicable to years after 2012,
    - the additional taxation on the earnings of high-income taxpayers,
    - the additional tax on high-income taxpayers' net investment income, and
    - the additional tax on estate's and non-grantor trust's undistributed net investment income;
- Recognize the tax penalties generally applicable to individuals who fail to maintain minimum essential coverage; and
- Calculate the amount of the premium assistance tax credit available to taxpayers whose household income is less than 400% of the federal poverty line.

Tax-Favored Health Plans

Tax favored health plans include Archer Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs) and Health Flexible Spending Arrangements (HFSAs). Archer MSAs and HSAs allow participants to deduct contributions made to these plans and then access the funds thus deposited to pay qualified medical expenses on a tax-free basis.

HRAs are employer-established benefit plans for employees. Under these plans an employer reimburses a participating employee's qualified medical expenses up to a maximum dollar amount specified in the HRA plan document for the coverage period. These reimbursements are normally not includible in the employee's income.

Health FSAs offer workers a way to reduce their out-of-pocket medical expenses. A health FSA is an employer-provided benefit under which a covered individual may contribute amounts regularly to the FSA on a before tax basis. The covered individual may then access the amounts in the FSA to cover out-of-pocket medical, dental, and vision expenses, such as co-pays and deductibles.

These plans undergo various changes pursuant to the PPACA.

The changes affect:

- The treatment of costs for over-the-counter drugs;
- Taxation of MSA and HSA distributions for other than qualified medical expenses; and
- FSA contributions for medical expenses.

Over-the-Counter Drug Costs

The PPACA adds Internal Revenue Code §106(f) and amends §223(d)(2)(A) to affect over-the-counter drug costs. These code sections, for years beginning in 2011, revise the medicine or drug expenses that may be paid or reimbursed by an employer-provided plan—including a health FSA or HRA—or that are considered qualified medical expenses under an Archer MSA or HSA.

Pursuant to IRC §106(f) and §223(d)(2)(A), such expenses qualify for reimbursement or as qualified medical expenses only if the medicine or drug:

- Requires a prescription;
- Is available without a prescription and the individual obtains a prescription; or
- Is insulin[3].

Accordingly, except for insulin, the costs of over-the-counter drugs qualify for reimbursement under health FSAs and HRAs or are deemed qualified medical expenses under an MSA or HSA only if the individual obtains a prescription for them.

Nonqualified Distributions from Archer MSAs and HSAs

Nonqualified distributions from an Archer MSA or HSA for other than payment of qualified medical expenses—nonqualified distributions, in other words—are includible in the account owner's income in the year distributed. Such nonqualified distributions are also subject to a penalty tax. The income tax and additional tax are reported on Form 8889 for an HSA distribution and on Form 8853 for an Archer MSA distribution.

The penalty tax for nonqualified distributions received prior to 2011 from an HSA was 10%; for similar nonqualified distributions from an Archer MSA before 2011, the penalty tax was 15%. For nonqualified distributions from an Archer MSA or HSA occurring in 2011 and later the penalty tax is increased to 20%.

Although a nonqualified distribution is includible in income, the penalty tax does not apply to nonqualified distributions received after the account holder:

- Becomes disabled;
- Dies; or
- Reaches the age of Medicare eligibility.

FSA Contributions Limited

As noted earlier, Health FSAs enable workers to contribute before-tax amounts to an account that may then be accessed tax-free to pay various out-of-pocket health-related expenses. Although annual caps on the amount that can be contributed to a health FSA are generally imposed by employers—usually as a way to limit their risk of pre-funding—no limit was previously imposed by the federal government. That changes in 2013 and later.

Beginning in 2013 PPACA imposes a $2,500 per year limit on the amount that may be contributed to a flexible spending account for medical expenses. That limit may be increased annually by a cost of living adjustment.

Unreimbursed Medical Expense Deduction Threshold Increased

Unreimbursed medical expenses incurred by a taxpayer who itemizes deductions are deductible. A taxpayer may claim a deduction for medical expenses incurred for the taxpayer, a spouse and any dependents who were dependents at the time the medical service was performed. (A payment made in advance for medical treatment would not be deductible until the medical treatment was actually rendered.)

Medical expenses have historically been deductible only to the extent the taxpayer's total medical expenses for the year exceed 7.5% of the taxpayer's adjusted gross income. For years beginning after

[3] Regular insulin is available in most states without a prescription. Insulin analogs, however, require a prescription.

December 31, 2012, a taxpayer who is younger than age 65 may deduct only the amount of medical expenses that exceed 10% of adjusted gross income.

Medical Expense Deduction Threshold Increased for Age 65 Taxpayers in 2017

Although the medical expense deduction threshold is increased generally beginning in 2013, the increase in the threshold is waived for taxpayers age 65 and older for tax years 2013 through 2016. Beginning in 2017, the 10% of AGI threshold on the deduction of unreimbursed medical expenses for taxpayers who itemize deductions applies to all taxpayers regardless of age.

Social Security Taxes

Social Security taxes—taxes imposed under the Federal Insurance Contributions Act—are comprised of two components: OASDI and HI taxes. OASDI stands for **O**ld **A**ge **S**urvivors **D**isability **I**nsurance and is a tax of 6.20% imposed on a worker's wages up to the applicable Social Security taxable earnings limit. That limit is $110,100 in 2013 and generally increases annually. HI, the second component of Social Security taxes, stands for **H**ospital **I**nsurance and is a tax of 1.45% imposed on all taxpayer wages. The HI component of Social Security taxes is designed to fund Medicare Part A. Social Security taxes are paid by both the employee and employer.

The PPACA changes these traditional percentages for certain taxpayers.

HI Component Increased for High Earners

Beginning in 2013 the PPACA imposes an additional HI tax of .9% on taxpayers' earnings exceeding the following amounts:

- $200,000 for single taxpayers and heads of households;
- $250,000 for married couples filing jointly (threshold applies to joint income amount) and surviving spouses; and
- $125,000 for married couples filing separately.

Thus, for taxpayers whose earnings exceed the above threshold amounts, the HI component is 2.35% on all earnings exceeding the specified amounts. The additional HI tax is imposed only on the employees' portion of Social Security taxes. The employer's Social Security tax rate is not affected by the HI tax rate increase for high earners.

The threshold amounts are not indexed for inflation; accordingly, they will remain at those levels unless changed by the passage of subsequent legislation.

3.8% Additional Tax on Net Investment Income for Higher-Income Taxpayers

Although Social Security taxes have traditionally applied only to *earned income*, the PPACA imposes a Medicare surtax on the *net investment income* of higher-income taxpayers. For years beginning after 2012, an additional tax is imposed at 3.8% on the lesser of the:

- Taxpayer's net investment income; or
- Taxpayer's modified adjusted gross income (MAGI) in excess of an applicable threshold amount.

The applicable MAGI thresholds vary, depending on the taxpayers' filing status. Similar to the increase in the HI tax for high earners, the applicable threshold amounts are:

- $200,000 for single taxpayers and heads of households;
- $250,000 for married couples filing jointly (threshold applies to joint income amount) and surviving spouses; and
- $125,000 for married couples filing separately.

A taxpayer's MAGI is the taxpayer's adjusted gross income without regard to the exclusions for income derived from certain foreign sources or sources within United States possessions, tax-exempt interest or tax-free Social Security benefits.

For example, suppose a married taxpayer filing jointly with a $280,000 MAGI has net investment income of $50,000. The amount subject to the 3.8% surtax is the lesser of:

- $50,000, i.e. the net investment income; or
- $30,000, i.e. the amount by which the taxpayer's MAGI exceeds the applicable threshold amount.

Thus, in this case the surtax would be 3.8% of $30,000, or $1,140. ($30,000 x .038 = $1,140)

The additional tax on net investment income is not deductible in computing other taxes. Because of that non-deductibility, the net investment income on which the additional 3.8% tax is levied is subject to double taxation.

Net Investment Income Subject to Additional Tax

The investment income subject to the 3.8% additional tax does not include distributions from qualified plans or IRAs. However, net investment income includes:

- Interest;
- Dividends;
- Capital gains;
- Taxable annuity income;
- Royalties; and
- Passive rental income.

Accordingly, gains realized upon the sale of a taxpayer's main home in excess of the excludible amount and the gain on the sale of second homes is included in the net investment income that may be subject to the additional Medicare tax.

Estates and Trusts

Estates and trusts, other than grantor trusts, that have net investment income in excess of certain threshold amounts are also subject to the additional 3.8% tax on net investment income. (A grantor trust is a trust under which the trust grantor, i.e. the creator of the trust, retains certain interests. As a result of that retained interest, the income received by a grantor trust is taxable to the grantor rather than to the trust.)

The additional tax to which estates and non-grantor trusts are subject is equal to 3.8% of the smaller of:

- The estate's or trust's undistributed net investment income for the tax year; or
- The excess of –
    - The estate's or trust's modified adjusted gross income for the tax year over
    - The dollar amount at which the highest tax bracket begins for the tax year.

The highest estate and trust income tax bracket begins at $11,950 for 2013. Thus the additional 3.8% tax on estate's and trust's undistributed net investment income in 2013 is payable if the undistributed net investment income exceeds $11,950.

Trusts and estates may avoid the 3.8% additional tax on net investment income by timely distributing income to beneficiaries. Such beneficiaries, depending on their MAGI and net investment income may be subject to the additional tax.

Estimated Taxes

The 3.8% additional tax on net investment income is subject to the individual estimated tax provisions and is treated as a tax for purposes of determining any penalty for estimated tax underpayment. Because of that, a taxpayer who anticipates being subject to the additional tax on net investment income must take it into account when calculating his or her estimated tax payments.

Individual Requirement to Maintain Health Coverage

As noted in the last chapter, for years beginning in 2014, the PPACA requires non-exempt individuals to maintain health insurance whose coverage is at least equal to minimum essential coverage or pay a penalty. Individuals who meet certain criteria are exempt from the coverage requirement.

In addition, individuals who are required to maintain minimum essential coverage but whose income does not exceed a specified percentage of the federal poverty level are eligible for refundable tax credits to assist them to purchase the required coverage.

Penalty for Failure to Maintain Health Coverage

Beginning in 2014, a non-exempt taxpayer who fails to maintain minimum essential coverage must pay an annual tax penalty. The maximum tax penalty gradually increases between 2014 and 2016 and, in 2016 is fully phased-in. For years after 2016, the penalties are indexed for inflation based on the Consumer Price Index. Any criminal penalty against a taxpayer for failure to pay the penalty is waived, and no liens or levies may be imposed to collect it.

(Note: the applicable dollar amount penalty assessed for failing to maintain minimum essential coverage on a child younger than age 18 is one-half the specified dollar amount applicable to older household members.)

2014

For each month during which a non-exempt taxpayer fails to maintain minimum essential coverage in 2014 the applicable penalty is equal to 1/12th of the greater of:

- $95 for each household member age 18 or older and $47.50 per child (up to 3 household members); or
- 1% of household income for the taxable year in excess of the threshold amount for filing a tax return.

Based on the PPACA provisions, the minimum tax penalty for failing to maintain minimum essential coverage in 2014 for the entire year for a three-person family whose members are all at least 18 years old is $285. ($95 x 3 = $285)

2015

For each month during which a non-exempt taxpayer fails to maintain minimum essential coverage in 2015 the applicable penalty is equal to 1/12th of the greater of:

- $325 for each household member age 18 or older and $162.50 per child (up to 3 household members); or
- 2% of household income for the taxable year in excess of the threshold amount for filing a tax return.

In 2015, the minimum tax penalty for failing to maintain minimum essential coverage for the entire year for a three-person family whose members are all at least 18 years old is $975. ($325 x 3 = $975)

2016

For each month during which a non-exempt taxpayer fails to maintain minimum essential coverage in 2016 the applicable penalty is equal to 1/12th of the greater of:

- $695 for each household member age 18 or older and $347.50 per child (up to 3 household members); or
- 2.5% of household income for the taxable year in excess of the threshold amount for filing a tax return.

In 2016, the minimum tax penalty for failing to maintain minimum essential coverage for the entire year for a three-person family whose members are all at least 18 years old is $2,085. ($695 x 3 = $2,085)

Exemptions to Penalty for Failure to Maintain Health Coverage

Individuals who are required to maintain minimum essential coverage may obtain an exemption to the penalties that would otherwise apply. Exemptions to the applicable individual penalty for failure to maintain minimum essential coverage apply to the following individuals:

- Individuals who cannot afford coverage – An individual would be deemed unable to afford coverage if the required contribution for the month would exceed 8% of household income for the taxable year. Such an individual would be exempt from the penalties imposed by the PPACA for a failure to maintain minimum essential coverage;
- Taxpayers with income below the income tax filing threshold, i.e. the income that requires a person to file a tax return;

- Individuals who are without coverage for less than 3 months; and
- Individuals who are determined by the Secretary of Health and Human Services to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

Refundable Tax Credits to Assist in Purchase of Qualified Health Plan

Beginning in 2014, individuals who meet specified income, coverage and other criteria are eligible to receive refundable tax credits to enable them to purchase a qualified health plan. Since the tax credit is a *refundable* tax credit, the taxpayer may receive the credit even though he or she has no income tax liability.

The material that follows examines the tax credit eligibility rules, the amount of any credits, and the special rules that apply to them.

Eligibility for Credit

Taxpayers are eligible to receive refundable tax credits for purchase of one or more qualified health plans provided they meet all of the following criteria:

- The taxpayer's household income is between 100% and 400% of the federal poverty level;
- The covered individuals are enrolled in a qualified health plan through an Affordable Insurance Exchange;
- Covered individuals are legally present in the United States and not incarcerated; and
- Covered individuals are not eligible for other qualifying coverage, such as Medicare, Medicaid, or affordable employer-sponsored coverage.

In order to be eligible for a premium tax credit, a taxpayer who is married at the close of the taxable year must file a joint income tax return.

Federal Poverty Level

The federal government's poverty level is based on income received in a year relative to annually-published guidelines. The guidelines, which are published by the federal government each year, generally increase annually to account for the higher prices for goods and services that result from inflation.

The 2013 federal poverty guidelines are as shown in the chart below:

2013 HHS Poverty Guidelines			
Persons in family/household	**48 Contiguous States and D.C.**	**Alaska**	**Hawaii**
1	$11,490	$14,350	$13,230
2	15,510	19,380	17,850
3	19,530	24,410	22,470
4	23,550	29,440	27,090
5	27,570	34,470	31,710
6	31,590	39,500	36,330
7	35,610	44,530	40,950
8	39,630	49,560	45,570
For each additional person add	4,020	5,030	4,620

Assuming the poverty guidelines for any subsequent year are as shown above (they typically would not be the same because of inflation), a taxpayer living in the contiguous 48 states, whose household is comprised of three persons and whose income is between $19,530 (see highlighted number in the chart) and $78,120 would have a household income that would make the taxpayer eligible for the credit. ($19,530 x 4 = $78,120)

Qualified Health Plan

In order to be eligible for the tax credit, covered individuals must be enrolled in a qualified health plan through an insurance exchange. As contained in the PPACA[4], the term "qualified health plan" means a health plan that—

A) Has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c)[5] issued or recognized by each Exchange through which such plan is offered;
B) Provides the essential health benefits package described in section 1302(a); and
C) Is offered by a health insurance issuer that—
    (i) Is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;
    (ii) Agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;
    (iii) Agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and
    (iv) Complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

Amount of the Credit

The amount of the tax credit for an eligible taxpayer is generally equal to the difference between the premium for the benchmark plan and the taxpayer's expected contribution. The amount of the credit is capped at the premium for the plan chosen. Thus, the tax credit will never be larger than the amount the taxpayer actually pays for their plan.

Tax Credit = Benchmark Plan Premium - Taxpayer's Expected Contribution

Benchmark Plan

The "benchmark plan," as the term is used in connection with the insurance premium tax credit, is the second-lowest-cost plan that would cover the family at the silver level of coverage. The PPACA defines[6] such a silver level plan as one "designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan."

Taxpayer's Expected Contribution

The taxpayer's expected contribution, as the term is used with respect to the tax credit, is a specified percentage of the taxpayer's household income. The applicable percentage of the taxpayer's household income increases—from 2% of income for families at 100% of the federal poverty level to 9.5% of income for families at 400% of the federal poverty level—as the taxpayer's income increases.

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[4] Affordable Care Act §1301(a).

[5] In order for a qualified health plan to be certified under the PPACA it must:

- Meet marketing requirements and not employ marketing practices or benefit designs that discourage enrollment by individuals with significant health needs;
- Ensure a sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;
- Include within plan networks essential community providers that serve predominately low-income, medically-underserved individuals;
- Be accredited with respect to local performance on certain specified clinical quality measures or receive such accreditation within a period, applicable to all qualified health plans, established by an exchange;
- Implement a quality improvement program strategy;
- Utilize a uniform enrollment form;
- Utilize the standard format for presenting health benefit plan options; and
- Provide information to enrollees and prospective enrollees and to the exchange on any quality measures for health plan performance.

[6] Affordable Care Act §1302(d)(1)(B).

The amount a family actually pays for coverage will be less than the expected contribution if the family chooses a plan that is less expensive than the benchmark plan.

The income percentages, based on the taxpayer's household income as a percentage of the federal poverty level, are as shown in the table below:

Household Income Percentage of Federal Poverty Line	Initial Percentage	Final Percentage
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but less than 400%	9.5	9.5

Household Income

Since a taxpayer's expected contribution is a specified percentage of household income, a clear understanding of how the PPACA and the final regulations implementing it define the term is important. Under the final regulations, "household income" means the sum of:

- The taxpayer's modified adjusted gross income; plus
- The aggregate modified adjusted gross incomes of all other individuals who are –
    - Included in the taxpayer's family, i.e. the individuals for whom a taxpayer properly claims a deduction for a personal exemption for the taxable year (whether or not the individuals are subject to a penalty for failing to maintain minimum essential coverage), and
    - Required to file a tax return (other than solely to report tax imposed for such items as an early distribution penalty imposed under §72(q))

Modified Adjusted Gross Income

In order to determine a taxpayer's household income, it is necessary to add together the taxpayer's modified adjusted gross income (MAGI) to the MAGI of all others that comprise the taxpayer's family. The term "modified adjusted gross income," for purposes of calculating household income, means adjusted gross income (AGI) increased by:

- Amounts excluded from gross income under section 911 (e.g. foreign earned income);
- Tax-exempt interest received or accrued during the taxable year; and
- Social Security benefits not included in the recipient's gross income.

Calculating the Credit

The tax credit available for premium assistance for a coverage month is equal to the lesser of:

1. The premiums for the month for one or more qualified health plans in which a taxpayer or member of the taxpayer's family enrolls; or
2. The excess of the adjusted monthly premium (see **Adjusted Monthly Premium** below) for the benchmark plan over 1/12th of the product of a taxpayer's household income and the applicable percentage for the taxable year.

Although the language of the regulations makes the calculation of the second part of the tax credit appear complicated, the calculation is fairly simple and is more readily understood by considering an equation. Thus, in the form of an equation, the calculation of the second component of the tax credit is as follows:

$$\text{Tax credit (component 2)} = \text{Adjusted monthly premium for the benchmark plan} - \frac{\text{Taxpayer's household income x applicable \%age}}{12}$$

We can illustrate how component 2 is determined by looking at an example. For purposes of the example, assume the following:

Adjusted monthly premium: $1,000
Taxpayer's household income: $53,700
Members of taxpayer's family: 3
Applicable poverty level guideline: $19,530

The only value that we need to calculate before substituting the values into the equation is the applicable percentage that is multiplied by the taxpayer's household income.

The following steps will produce the correct applicable percentage for the equation:

1. Divide the taxpayer's household income ($53,700) by the applicable poverty level guideline for a three-person household ($19,530); by doing so, we can see that the taxpayer's household income is 275% of the poverty level. ($53,700 ÷ $19,530 = 2.75 = 275%)
2. Consult the household income percentage chart to determine the initial and final percentages; by doing so, we see that the initial percentage for a taxpayer whose household income is between 250% and 300% of the federal poverty level is 8.05%; the final percentage is 9.5%.
3. Determine the excess of the taxpayer's federal poverty line percentage over the initial household income percentage in the taxpayer's range, which is 25. (275% - 250% = 25)
4. Determine the difference between the initial household income percentage and the final household income percentage in the taxpayer's range, which is 50. (300% - 250% = 50)
5. Divide the result in step 3 by the result in step 4; the answer is .50. (25 ÷ 50 = .50)
6. Subtract the initial percentage (8.05%) from the final percentage (9.5%) in the taxpayer's range; the amount is 1.45. (9.5 – 8.05 = 1.45)
7. Multiply the result obtained in step 6 by the result obtained in step 5; the result is .725. (1.45 x .50 = .725)
8. Add the result obtained in step 7 (.725) to the initial premium percentage in the taxpayer's range to calculate the applicable percentage; the result is 8.78. (8.05% + .725% = 8.775% = 8.78%)

Now that we have the applicable percentage value, we can substitute the amounts into the equation to determine component 2 of the tax credit calculation as follows:

$$\$607.09 = \$1{,}000 - \frac{\$53{,}700 \times .0878}{12}$$

By solving the equation, we see that component 2 of the tax credit calculation for any month is $607.09. Since $607.09 is less than the $1,000 monthly premium (component 1), it is the tax credit available as a premium assistance amount. The balance of the monthly premium—$392.91 in this case—is the taxpayer's contribution. The tax credit for the entire year would be $7,285.08. ($607.09 x 12 = $7,285.08) (Note: The CBO estimates that, when the PPACA is completely phased in, individuals receiving premium tax credits will receive an average subsidy of more than $5,000 annually.)

Adjusted Monthly Premium

The term used for the monthly premium in the final regulations implementing the PPACA when calculating the tax credit is *adjusted monthly premium* rather than simply *monthly premium*. The "adjusted monthly premium" used in the calculation of the credit is the premium an issuer would charge for the applicable benchmark plan to cover all members of the taxpayer's coverage family, *adjusted only for the age of each member*.

The adjusted monthly premium for purposes of the credit:

- Is determined without regard to any premium discount or rebate under a wellness program. Thus, participation in such a program could reduce the taxpayer's actual premium without reducing the credit to which the taxpayer is entitled under the PPACA; and
- Does not include any adjustments for tobacco use. Accordingly, although tobacco use could increase a taxpayer's premium, any increased premium would not increase the taxpayer's credit.

Special Rules Applicable to the Tax Credit

Although tax credits are normally determined at the conclusion of the taxable year, the premium tax credit may be advanced. Such advance payments are made directly to the insurer on the taxpayer's behalf. When the taxpayer's federal income tax return is filed, the advance payments are reconciled

against the amount of the taxpayer's actual premium tax credit. Any repayment due from the taxpayer may be subject to a cap. (See **Reconciling Advance Premium Tax Credits** below.)

Tax credits are available to qualified individuals who are offered, but not enrolled in, employer-sponsored insurance. Such tax credits are available if:

- The self-only premium payable by the taxpayer exceeds 9.5% of household income; or
- The employer-sponsored insurance does not provide a minimum value, i.e. it covers less than 60% of total allowed costs.

Reconciling Advance Premium Tax Credits

If advance premium tax credits are provided for a taxpayer, such credits must be reconciled at the time the individual's federal income tax return is filed. The tax credit is computed on the taxpayer's return using the taxpayer's family size and household income for the taxable year. Since a taxpayer's actual modified adjusted gross income for the year may be larger or smaller than expected, the advance premium tax credits may be more or less than the amount for which a taxpayer is eligible.

A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's advance credit payments may receive the excess credit as an income tax refund, regardless of whether the taxpayer has any federal income tax liability. A taxpayer whose advance credit payments for the taxable year exceed the taxpayer's premium tax credit owes the excess as an additional income tax liability, subject to any possible limitation.

Additional Tax Limitation

In general, if the reconciliation of the premium tax credit with advance credit payments made on behalf of the taxpayer shows an excess payment that excess is owed by the taxpayer as an additional income tax liability. In certain cases, however, the amount of any additional income tax liability resulting from such excess payment may be limited.

The additional tax imposed on a taxpayer because of excess advance credit payments is limited to the amounts in the additional tax limitation table if the taxpayer's household income is less than 400% of the federal poverty line. The dollar limit on the additional tax depends upon the taxpayer's filing status and his or her household income percentage of the federal poverty line.

The limits are as shown in the additional tax limitation table below:

Additional Tax Limitation Table*

Household Income Percentage of Federal Poverty Line	Limitation Amount for Unmarried Individuals (other than surviving spouses or heads of households)	Limitation Amount for All Other Taxpayers
Less than 200%	$300	$600
At least 200% but less than 300%	750	1,500
At least 300% but less than 400%	1,250	2,500

*For taxable years beginning after December 31, 2014, the limitation amounts may be adjusted to reflect changes in the Consumer Price Index.

Summary

The PPACA affects the tax treatment of individuals in a variety of ways. The costs of over-the-counter drugs qualify for reimbursement under health FSAs and HRAs or are deemed qualified medical expenses under an MSA or HSA only if the individual obtains a prescription for them.

For nonqualified distributions from an Archer MSA or HSA occurring in 2011 and later the penalty tax is increased to 20%. Although a nonqualified distribution is includible in income, the penalty tax does not apply to nonqualified distributions received after the account holder becomes disabled, dies or reaches the age of Medicare eligibility.

Beginning in 2013 PPACA imposes a $2,500 per year limit on the amount that may be contributed to a flexible spending account for medical expenses. That limit may be increased annually by a cost of living adjustment.

Medical expense deductions have been affected. For years beginning after December 31, 2012, a taxpayer may deduct only the amount of medical expenses that exceed 10% of adjusted gross income. Although the medical expense deduction threshold is increased generally beginning in 2013, the increase in the threshold is waived for taxpayers age 65 and older for tax years 2013 through 2016. Beginning in 2017, the 10% of AGI threshold on the deduction of unreimbursed medical expenses for taxpayers who itemize deductions applies to all taxpayers regardless of age.

Beginning in 2013 the PPACA imposes an additional tax of .9% on taxpayers' earnings exceeding $200,000 for single taxpayers and heads of households, $250,000 for married couples filing jointly (and surviving spouses) and $125,000 for married couples filing separately.

For years beginning after 2012, an additional tax is imposed at 3.8% on the lesser of the taxpayer's net investment income or the taxpayer's modified adjusted gross income (MAGI) in excess of an applicable threshold amount. The applicable MAGI thresholds vary, depending on the taxpayers' filing status. Similar to the increase in the HI tax for high earners, the applicable threshold amounts are $200,000 for single taxpayers and heads of households, $250,000 for married couples filing jointly and surviving spouses and $125,000 for married couples filing separately.

Estates and non-grantor trusts are also subject to the additional tax on undistributed net investment income. The additional tax is equal to 3.8% of the smaller of:

- The estate's or trust's undistributed net investment income for the tax year; or
- The excess of –
    - The estate's or trust's modified adjusted gross income for the tax year over
    - The dollar amount at which the highest tax bracket begins for the tax year ($11,950 in 2013).

The 3.8% additional tax on net investment income is subject to the individual estimated tax provisions and is treated as a tax for purposes of determining any penalty for estimated tax underpayment. Because of that, a taxpayer who anticipates being subject to the additional tax on net investment income must take it into account when calculating his or her estimated tax payments.

The PPACA requires that individuals maintain health coverage. Beginning in 2014, a non-exempt taxpayer who fails to maintain minimum essential coverage must pay an annual tax penalty. The maximum tax penalty gradually increases between 2014 and 2016 and, in 2016 is fully phased-in. For years after 2016, the penalties are indexed for inflation based on the Consumer Price Index.

Also beginning in 2014, individuals whose household income is between 100% and 400% of the federal poverty line and who meet coverage and other criteria are eligible to receive refundable tax credits to enable them to purchase a qualified health plan. Since the tax credit is a *refundable* tax credit, the taxpayer may receive the credit even though he or she has no income tax liability.

The amount of the tax credit for an eligible taxpayer is generally equal to the difference between the premium for the benchmark plan— the second-lowest-cost plan that would cover the family at the silver level of coverage—and the taxpayer's expected contribution. The taxpayer's expected contribution is a specified percentage of the taxpayer's household income based on the taxpayer's household income as a percentage of the federal poverty line.

If advance premium tax credits are provided for a taxpayer, such credits must be reconciled at the time the individual's federal income tax return is filed. A taxpayer whose premium tax credit for the taxable year exceeds the taxpayer's advance credit payments may receive the excess credit as an income tax refund, regardless of whether the taxpayer has any federal income tax liability. A taxpayer whose advance credit payments for the taxable year exceed the taxpayer's premium tax credit owes the excess as an additional income tax liability, subject to a dollar limitation for taxpayers whose household income is less than 400% of the federal poverty line.

PPACA Individual Tax Provisions Timetable

Effective	Provision
2011	• Medicine and drug costs reimbursable or considered qualified medical expenses if they a) require a prescription, b) are available without a prescription and the individual obtains a prescription, or b) are for insulin. • Tax penalty for nonqualified distributions from an Archer MSA or HSA is increased to 20%.
2013	• FSA contributions for medical expenses limited to $2,500 per year. • Unreimbursed medical expenses deductible for individuals younger than age 65 only to the extent they exceed 10% of adjusted gross income. • Additional HI tax of .9% imposed on taxpayers' earned incomes exceeding $200,000 for single taxpayers and heads of households, $250,000 for married couples filing jointly (threshold applies to joint income amount) and surviving spouses, and $125,000 for married couples filing separately. • Medicare surtax of 3.8% imposed on the lesser of the taxpayer's net investment income or the taxpayer's modified adjusted gross income (MAGI) in excess of $200,000 for single taxpayers and heads of households, $250,000 for married couples filing jointly (threshold applies to joint income amount) and surviving spouses, and $125,000 for married couples filing separately. The additional tax applies also to undistributed estate and non-grantor trust net investment income. A taxpayer who anticipates being subject to the additional tax on net investment income must take it into account when calculating his or her estimated tax payments.
2014	• Tax penalty imposed for each month taxpayer fails to maintain minimum essential coverage equal to 1/12th of the greater of a) $95 for each household member age 18 or older (up to 3), or b) 1% of household income for the taxable year in excess of the threshold amount for filing a tax return. • Refundable tax credits available to individuals who meet specified income, coverage and other criteria to enable them to purchase a qualified health plan.
2015	• Tax penalty imposed for each month taxpayer fails to maintain minimum essential coverage equal to 1/12th of the greater of a) $325 for each household member age 18 or older (up to 3), or b) 2% of household income for the taxable year in excess of the threshold amount for filing a tax return.
2016	• Tax penalty imposed for each month taxpayer fails to maintain minimum essential coverage equal to 1/12th of the greater of a) $695 for each household member age 18 or older (up to 3), or b) 2.5% of household income for the taxable year in excess of the threshold amount for filing a tax return.
2017	• Unreimbursed medical expenses deductible for all individuals only to the extent they exceed 10% of adjusted gross income.

Chapter Review

1. Hilary, a Medicare beneficiary, withdrew $5,000 from her Archer MSA to finance a 2013 European vacation. For what penalty tax, if any, is she liable?

   A. $750

   B. $500

   C. $0

   D. $1,000

2. Phil's daughter is covered under his group health insurance plan. If she requires regular medical treatments whose annual costs exceed his group health insurance benefits by $10,000, what is the maximum amount Phil may contribute to his employer's flexible spending account for medical expenses in 2013?

   A. $10,000

   B. $2,500

   C. $5,000

   D. No dollar limit applies to flexible spending account contributions for medical expenses.

3. Arthur and his wife file a joint federal income tax return and each has an earned income of $150,000. For what additional HI tax, if any, are they liable beginning in 2013?

   A. $0

   B. $2,700

   C. $7,050

   D. $450

4. Helen is a single physician whose 2013 modified adjusted gross income is $210,000. For what Medicare surtax is she liable on her net investment income if her net investment income is $50,000?

   A. $380

   B. $1,900

   C. $7,980

   D. $0

5. Bob and Phyllis are married, and their household includes their 20 year-old daughter. Although they are not exempt from the federal requirement to maintain minimum essential healthcare coverage, they have chosen not to purchase it and have remained uncovered for the entire year. What is the *minimum penalty* for which they would be liable in 2014?

   A. $0

   B. $285

   C. $975

   D. $2,085

6. Arthur, age 45, itemizes deductions on his federal income tax return. What would his medical expense deduction be in 2013 if his adjusted gross income was $100,000 and his total medical expenses were $11,000?

   A. $3,500

   B. $1,000

   C. $11,000

   D. $0

7. Audrey is single and has a modified adjusted gross income of $250,000. If she received $10,000 in capital gains, $2,000 in interest earnings, $5,000 in royalties and took a $6,000 traditional IRA distribution in 2013, what is the additional tax imposed under the PPACA on her net investment income?

   A. $456

   B. $646

   C. $874

   D. $1,900

8. If a taxpayer's household income of $30,000 places the taxpayer at 100% of the federal poverty level, what is the taxpayer's normal expected contribution when calculating the refundable tax credit for which the taxpayer may be eligible under the PPACA to purchase a qualified health plan?

   A. $0

   B. $300

   C. $600

   D. $1,200

9. John's non-grantor trust has undistributed net investment income in 2013. The 3.8% net investment income tax is payable only if the undistributed net investment income in 2013 exceeds what amount?

   A. The additional tax on a non-grantor trust's net investment income applies regardless of the amount of income that is undistributed

   B. $250,000

   C. $200,000

   D. $11,950

Chapter 3 – Employer Tax Changes

Introduction

The PPACA provides nonrefundable tax credits to small employers and may impose tax penalties on large employers designed to motivate them to provide health insurance benefits to employees and their dependents. Small employers are employers with fewer than 25 full-time employees. Large employers are employers with 50 or more full-time employees. Employers with 25 full-time employees but fewer than 50 full-time employees are unaffected.

It also generally requires that employers providing health coverage report the cost of the benefits on their employees' Form W-2 but also provides transition relief from the reporting requirement. Although the cost of health benefits must generally be reported, such cost continues to be excluded from the employees' income for tax purposes.

In this chapter we will examine the employer tax changes—tax credits and penalties—as well as the reporting and notification requirements brought about by the PPACA. In making that examination we will consider the:

- Form W-2 reporting of the cost of employer-provided health coverage;
- Definition of a full-time employee and full-time equivalent employee;
- Eligibility rules applicable to health insurance premium credits for small employers;
- Nature of a qualifying arrangement under which small employers contribute to employees' health insurance premiums;
- Types of benefits provided under coverage that meets the definition of health insurance coverage for purposes of the small employer credit;
- Limitations affecting the amount of health insurance premium credit available to an eligible small employer;
- Penalties applicable to large employers who do not offer full-time employees health insurance coverage and whose employees obtain health insurance a health insurance exchange and receive a credit or subsidy;
- Penalties applicable to large employers who offer full-time employees health insurance coverage but have at least one employee receiving a tax credit;
- Transition relief provided to large employers; and
- Annual return and notification requirements imposed on applicable large employers.

Chapter Learning Objectives

When you have completed this chapter, you should be able to:

- Identify the –
  - W-2 reporting requirements imposed on employers providing employer-sponsored health coverage, and
  - transition relief provided applicable to W-2 reporting;
- Understand "full-time employee" and "full-time equivalent employee" for purposes of employer tax credits and penalties under the PPACA;
- Recognize the –
  - rules that apply to a small employer's eligibility for a health insurance premium credit, and
  - nature of a "qualifying arrangement" under which an employer pays premiums for employee health insurance coverage;
- Identify the types of coverage that meet the PPACA definition of health insurance coverage for purposes of the small employer health insurance premium credit;
- Understand the various limitations that may reduce the amount of health insurance premium credit available to an otherwise eligible small employer;
- Calculate the potential penalties applicable to large employers under the PPACA; and
- Identify the –

- transition relief available to applicable large employers, and
- annual return and notification requirements imposed by the PPACA on applicable large employers.

Form W-2 Reporting of Employer-Sponsored Health Coverage

All employers that provide employer-sponsored health coverage are required to report the cost of the employee's health benefits on their Form W-2.

Although the requirement for W-2 reporting of the cost of health benefits applies to most employers that provide applicable employer-sponsored coverage under a group health plan, certain exceptions apply. Federally-recognized Indian tribal governments are exempt from the reporting requirement, and, until further notice, employers that are tribally chartered corporations wholly owned by federally recognized Indian tribal governments are also exempt.

Effective Date for W-2 Reporting

The requirement to report the cost of an employee's health benefits on his or her Form W-2 is effective beginning with the 2012 W-2 forms, i.e. the W-2 forms provided to employees in January 2013. However, transition relief is available for certain employers and with respect to some types of coverage, as explained below. Reporting for the employers covered by the transition relief is not required until future guidance is provided. (See **Transition Relief** below.)

Cost of Coverage Transition Relief

The requirement to report the cost of coverage is inapplicable with respect to the 2012 Forms W-2 (normally provided to employees in January 2013) for certain employers and with respect to certain types of coverage under IRS-provided transition relief. In addition, such reporting does not apply for subsequent calendar years until the IRS publishes guidance giving at least six months of advance notice of any change to the transition relief.

The transition relief applies to:

- Employers filing fewer than 250 Forms W-2 for the previous calendar year. For purposes of this relief, the number of W-2 forms the employer files is deemed to include the forms it files itself and any filed on its behalf by an agent under §3504, but the aggregation rules do not apply;
- Multi-employer plans, if the only applicable employer-sponsored health coverage provided is provided under a multi-employer plan;
- Health reimbursement arrangements (HRAs);
- Dental and vision plans that –
  - Are not integrated into another group health plan, or
  - Give participants the choice of declining the coverage or electing it and paying an additional premium;
- Self-insured plans of employers not subject to COBRA continuation coverage or similar requirements;
- Employee assistance programs (EAPs), on-site medical clinics, or wellness programs for which the employer does not charge a premium under COBRA continuation coverage or similar requirements; and
- Employers furnishing Forms W-2 to employees who terminate before the end of a calendar year and require a Form W-2 before the end of that year.

Additional transition relief from the information reporting provisions was provided for years 2013 and 2014. The information reporting provisions will become effective for 2015.

Reporting on the Form W-2

The amount to be reported on an employee's Form W-2 should include the portion paid by the employer **and** the portion paid by the employee. It should be reported in Box 12 of the Form W-2 with Code DD to identify the amount.

The coverage whose cost is to be included on the Form W-2 includes:

- Major medical coverage;
- Health flexible spending arrangement (FSA) amount for the plan year in excess of the employee's cafeteria plan salary reductions for all qualified benefits;
- Hospital indemnity or specified illness (insured or self-funded), paid through pre-tax salary reduction or by the employer;
- Employee assistance plan (EAP) providing applicable employer-sponsored healthcare coverage if employer charges a COBRA premium;
- On-site medical clinics providing applicable employer-sponsored healthcare coverage if employer charges a COBRA premium;
- Wellness programs providing applicable employer-sponsored healthcare coverage if employer charges a COBRA premium; and
- Domestic partner coverage included in gross income.

Cost of Health Coverage Excluded from Income

The requirement to report the cost of health benefits is designed to provide employees useful and comparable consumer information concerning the cost of their health care coverage. However, such cost is excluded from the employee's income and is not taxable.

Certain Types of Coverage Not Reportable

Although some items may need to be reported elsewhere—certain HSA contributions are reported in Box 12, Code W, for example—the following items should not be reported in Box 12 with Code DD:

- Health flexible spending arrangement (FSA) contributions funded solely by salary-reduction amounts;
- Health savings arrangement (HSA) contributions made by an employer or employee;
- Archer medical savings account (MSA) contributions made by an employer or employee;
- Hospital indemnity or specified illness (insured or self-funded) paid on an after-tax basis;
- Governmental plans providing coverage primarily for members of the military and their families;
- Accident or disability income;
- Long term care insurance;
- Supplemental liability insurance;
- Workers' compensation;
- Automobile medical payment insurance;
- Credit-only insurance;
- Excess reimbursement to highly compensated individuals included in gross income; or
- Payment/reimbursement of health insurance premiums for 2% shareholder-employees included in gross income.

Small Employer Health Insurance Premium Credit

Small employers may be eligible to receive a nonrefundable tax credit for premiums paid for employee health insurance coverage. The credit may be carried back one year (but not to any year before 2010) and forward 20 years.

The available credit is subject to limitations based on:

- The number of employees; and
- The average annual wages paid to employees.

The maximum small employer health insurance premium credit available to eligible small employers for tax years 2010 through 2013 is 35% of workers' healthcare premiums paid by small employers and 25% of such premiums paid by small tax-exempt employers, such as charities. In 2014, the maximum tax credit increases to 50% and 35%, respectively.

If an employer receives a tax credit for premiums paid, its tax deduction for the cost of providing health insurance coverage is reduced by the amount of such credit.

Eligibility Requirements

Not all small employers are likely to be eligible to receive the small employer health insurance premium credit. The credit is available if the employer meets the following three requirements:

1. The employer paid premiums for employee health insurance coverage under a qualifying arrangement;
2. The employer had fewer than 25 full-time equivalent employees for the tax year; and
3. The employer paid average annual wages for the tax year of less than $50,000 per full-time equivalent employee.

Let's consider each of these eligibility requirements more closely.

Qualifying Arrangements Generally

As noted above, in order for an employer to be eligible to receive the small employer health insurance premium credit, the employer must pay employee health insurance premiums *under a qualifying arrangement*. Although certain variations may be qualifying arrangements under the PPACA, a "qualifying arrangement" is generally one under which the employer is required to pay a uniform percentage—at least 50%—of the premium for the employee enrolled in health insurance coverage.

Qualifying Arrangement Variations

Despite the language that requires an employer to pay at least 50% of the self-only premium for each employee, some variations to that requirement may be deemed qualifying arrangements. Those variations include arrangements with composite billing or list billing, provided they meet certain requirements.

Arrangements with Composite Billing

A composite billing arrangement will be considered a qualifying arrangement even if it requires the employer to pay a uniform percentage that is less than 50% of the premium cost for employees that are not enrolled in self-only coverage. Such an arrangement will qualify if it:

- Provides for different tiers of coverage, e.g. self-only, self plus one and family coverage, and the arrangement requires the employer to pay a uniform percentage (not less than 50%) for each tier of coverage offered; or
- Requires the employer to pay a uniform percentage that is less than 50% of the premium cost for *some* employees under –
    - An arrangement with composite billing that requires the employer to pay a uniform premium percentage (not less than 50%) for each employee enrolled in self-only coverage, or
    - An arrangement with composite billing that requires the employer to pay a uniform amount that is not less than the amount the employer would have paid towards self-only coverage for each employee enrolled in a) self plus one coverage, b) family coverage, or c) any other tier of coverage.

Arrangements with List Billing

An arrangement that requires the employer to pay a separate premium for each employee based on age or other factors—a list billing arrangement, in other words—can be a qualifying arrangement even if the arrangement requires the employer to pay a uniform percentage that is *less than 50%* of the premium cost for some employees. Such list billing may involve insurance that provides self-only coverage or provides additional tiers of coverage. The requirements for such arrangements to be deemed qualifying arrangements vary.

In both list-bill variations discussed below, an arrangement may be a qualifying arrangement if an employer pays a uniform percentage (not less than 50%) of the *employer-computed composite rate*. The "employer-computed composite rate" for a tier of coverage is defined as the average rate determined by following the two steps below:

1. Add the premiums for that tier of coverage for all employees eligible to participate in the health insurance plan, regardless of whether they actually received coverage under the plan or under that tier of coverage; and

2. Divide the sum of the premiums computed in step 1 by the total number of such eligible employees.

The result of following the two steps is the employer-computed composite rate.

List Billed Insurance Policies Providing Self-Only Coverage

An arrangement involving list billing under which the insurance provides only self-only coverage will be a qualifying arrangement—even if requires the employer to pay less than 50% of the premium cost for some employees—if it requires the employer to pay a uniform percentage (not less than 50%) of:

- The premium charged for each employee enrolled in the self-only coverage; or
- The employer-computed composite rate for self-only coverage for each employee enrolled in the self-only coverage.

List Billed Insurance Policies Providing Other Tiers of Coverage

Similarly, an arrangement involving list billing under which the insurance provides other tiers of coverage may be a qualifying arrangement even if requires the employer to pay less than 50% of the premium cost for some employees if it meets certain requirements. Such an arrangement will be considered a qualifying arrangement, assuming self-only coverage is the least expensive tier of coverage, if it requires the employer to pay the following amounts:

- A uniform percentage (not less than 50%) for each employee enrolled in self-only coverage;
- A uniform amount, for each employee enrolled in self plus one coverage, that is equal to –
    - The amount the employer would have paid towards self-only coverage,
    - A uniform percentage (not less than 50%) of the premium charged, or
    - A uniform percentage (not less than 50%) of the employer-computed composite rate for the employer's self plus one coverage;
- A uniform amount, for each employee enrolled in family coverage, that is equal to –
    - The amount the employer would have paid towards self-only coverage,
    - A uniform percentage (not less than 50%) of the premium charged, or
    - A uniform percentage (not less than 50%) of the employer-computed composite rate for the employer's family coverage; or
- A uniform amount, for each employee enrolled in any other tier of coverage, that is equal to –
    - The amount the employer would have paid towards self-only coverage,
    - A uniform percentage (not less than 50%) of the premium charged, or
    - A uniform percentage (not less than 50%) of the employer-computed composite rate for any other tier of coverage.

Health Insurance Coverage Defined

The term "health insurance coverage," for purposes of the small employer health insurance premium credit, means benefits consisting of medical care under any:

- Hospital or medical service policy or certificate;
- Hospital or medical service plan contract; or
- Health maintenance organization (HMO) contract offered by a health insurance provider.

In addition, health insurance coverage, as the term is used in connection with the credit, includes coverage under the following plans:

- Limited scope dental or vision plans;
- Long-term care plans;
- Nursing home care plans;
- Church welfare benefit plans;
- Home health care plans;
- Community-based care plans; and
- Multi-employer health and welfare plans that provide coverage through a health insurance provider.

The term also includes:

- Coverage only for a specified disease or illness (e.g. coverage that provides benefits only for the treatment of cancer or other dread disease);
- Hospital indemnity or other fixed indemnity insurance (e.g. coverage that provides a benefit of $50 per day the insured is in the hospital);
- Medicare supplemental health insurance; and
- Certain other supplemental coverage.

Some Benefits Don't Qualify as Health Insurance Coverage

For purposes of the small employer health insurance premium credit, certain benefits are *not* considered health insurance coverage. Thus, an employer's providing such benefits will not enable it to qualify for the credit.

The benefits not constituting health insurance coverage for purposes of the credit are:

- Coverage only for accident or disability income insurance;
- Workers' compensation or similar insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Coverage issued as a supplement to liability insurance;
- Automobile medical payment insurance;
- Liability insurance; or
- Other similar insurance coverage.

In addition, since coverage must be offered by a health insurance provider, the term "health insurance coverage," as used in connection with the credit does not include benefits provided by any of the following:

- Health reimbursement arrangements (HRAs);
- Flexible spending arrangements (health FSAs);
- Coverage under other self-insured plans; or
- Health savings accounts (HSAs).

Employees of the Employer

In order to be eligible for the insurance premium credit, an employer must also have employed fewer than 25 full-time equivalent employees (FTEs) for the tax year. (Note: The credit for which an otherwise eligible employer would qualify is reduced if the employer had more than 10 FTEs for the tax year and is eliminated for employers who had 25 or more FTEs for the tax year.)

In general, all employees who perform services for the employer during the tax year are taken into account in determining the employer's FTEs, average annual wages and premiums paid. However, certain rules apply to:

- Employees having an ownership interest in the employer and their family members;
- Leased employees;
- Seasonal employees;
- Household and other non-business employees; and
- Ministers.

In the case of employers who are part of a controlled group, the entire group is considered a single employer for purposes of determining the number of employees. (See **Controlled Group** below.)

Employees Possessing Ownership Interests

Employees possessing certain ownership interests in a small employer as well as their family and household members are not considered employees of the employer for purposes of the small employer health insurance premium credit. Accordingly, the hours worked, wages received and premiums paid for them are not counted when figuring the credit. The following employees are not considered:

- The owner of a sole proprietorship;
- A partner in a partnership;
- A shareholder who owns more than 2% of an S corporation;
- A shareholder who owns more than 5% of the outstanding stock or stock possessing more than 5% of the total voting power of all stock of a non-S corporation;
- A person who owns more than 5% of the capital or profit interest in any other unincorporated business; and
- Family members or non-family members of the household who qualify as dependents on the individual income tax return of an excluded owner.

Leased Employees

A leased employee who is a common law employee[7] of the employer is an employee for purposes of the small employer health insurance premium credit. A leased employee who is *not* a common law employee is, nonetheless, considered an employee of the employer for credit purposes if he or she does all the following:

- Provides services to the employer under an agreement between the employer and a leasing organization;
- Has performed services for the employer substantially full time for at least one year; and
- Performs services under the employer's primary direction or control.

Although such a leased employee would be considered an employee of the employer for credit purposes, the employer cannot:

- Use the premiums paid by the leasing organization to figure the employer's credit; or
- Use the hours, wages or premiums paid with respect to the initial year of service on which leased employee status is based.

Seasonal Employees

Seasonal employees who work for the employer 120 days or less during the tax year—including retail workers employed exclusively during holiday seasons—have a mixed impact on a small employer's health insurance premium credit. Although they are not considered employees in the determination of FTEs and average annual wages, any premiums paid on their behalf are counted in determining the amount of the credit.

Household and Other Nonbusiness Employees

Household employees and other employees who are *not* performing services in the employer's trade or business are considered employees if they otherwise qualify. A sole proprietor must include both business and nonbusiness employees to determine FTEs, average annual wages and premiums paid.

Ministers

A minister performing services in the exercise of his or her ministry is considered self-employed for Social Security and Medicare purposes. However, for purposes of the health insurance premium credit, a minister's status as an employee is determined under the common law test. Accordingly, a minister is considered an employee insofar as the employer has the right to control and direct his or her work with respect to the result, the details and the means by which it is accomplished. A minister who is self-employed is not considered an employee for purposes of the credit.

Controlled Group

As noted earlier, for purposes of determining the number of employees employed by an employer, the entire group is considered a single employer for purposes of determining the number of employees. Accordingly, the following must be treated as a single employer to figure the credit:

- Employers who are corporations in a controlled group of corporations;
- Employers who are members of an affiliated service group; and
- Employers who are partnerships, proprietorships, etc., under common control.

Limitations Affect Health Insurance Premium Credit

Various limitations may apply that have the effect of reducing any health insurance premium credit to which a small employer may be entitled. Those limitations are the:

- Full-time equivalent employee (FTE) limitation;
- Average annual wage limitation;
- State average premium limitation; and
- State premium subsidy and tax credit limitation.

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[7] An employee, under common law, is an individual who performs services for another person who has the right to control and direct the individual's work with respect to the result to be accomplished as well as the details and means by which the result is accomplished.

Full-Time Equivalent Employee (FTE) Limitation

A small employer's health insurance premium credit will be reduced if the employer had more than 10 FTEs for the tax year. If the employer had 25 or more FTEs for the tax year, the credit is reduced to zero. A small employer will have 1 FTE for each 2,080 hours worked by an individual considered an employee.

The following steps should be followed in order to figure the number of FTEs an employer had for the tax year:

1. Figure the total hours of service for the tax year of all individuals considered employees of the employer; and
2. Divide the total hours of service determined in step 1 by 2,080.

If the result is not a whole number—not a 1, 2, 5 or other whole number, for example—round the result down to the next lowest number. For example, suppose the total determined in step 1 was 18,200. By dividing that number by 2,080, the result is 8.75. (18,200 ÷ 2,080 = 8.75) In such a case, the number of FTEs would be 8. However, if the result of the calculation is less than 1, round up to 1.

An employee's hours of service for a year include the following:

- Each hour for which the employee is paid, or entitled to payment, for the performance of duties for the employer during the employer's tax year; and
- Each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during the employer's tax year during which no duties are performed due to –
    - Vacation,
    - Holiday,
    - Illness,
    - Incapacity (including disability),
    - Layoff,
    - Jury duty,
    - Military duty, or
    - Leave of absence.

No more than 160 hours of service are required to be counted for an employee on account of any single continuous period during which the employee performs no duties.

Average Annual Wage Limitation

A small employer’s health insurance premium credit will also be reduced if the employer paid average annual wages of more than $25,000 for the tax year and is eliminated if the employer paid average annual wages of $50,000 or more for the tax year. For purposes of the health insurance premium credit, the term “wages” means wages subject to Social Security and Medicare tax withholding determined without considering any wage base limit. For purposes of this limitation, wages paid to a seasonal employee who worked 120 or fewer days during the tax year should not be included.

In order to figure the average annual wages an employer paid for the tax year, follow the steps below:

1. Figure the total wages paid for the tax year to all individuals considered employees; and
2. Divide the total wages paid by the employer by the number of FTEs the employer had for the tax year.

If the result of the following the steps above is not a multiple of $1,000—$1,000, $10,000 or $20,000, for example—the result should be rounded down to the next lowest multiple of $1,000. For example, if the result is $25,750, it should be rounded down to $25,000.

State Average Premium Limitation

A small employer’s credit is reduced if the employer premiums paid are more than the employer premiums that would have been paid if individuals who are considered employees enrolled in a plan with a premium equal to the average premium for the small group market in the state in which the employee works.

The average premium for the small group market in the state in which the employee works is determined by referring to the current table of state average premiums for small group markets which

is contained in the IRS Form 8941 instructions for the applicable tax year. A representative table listing the average premiums for small group markets by state is shown below:

State Average Premiums for Small Group Markets

State	Single (Employee-Only) Coverage	Family Coverage	State	Single (Employee-Only) Coverage	Family Coverage
Alabama	$5,363	$13,185	Montana	5,433	11,739
Alaska	7,961	16,808	Nebraska	5,463	13,270
Arizona	4,946	12,006	Nevada	5,417	12,125
Arkansas	4,546	10,575	New Hampshire	6,153	15,367
California	5,345	12,809	New Jersey	6,250	15,225
Colorado	5,445	13,937	New Mexico	5,639	13,121
Connecticut	6,307	16,011	New York	6,242	15,478
Delaware	6,555	15,144	North Carolina	5,510	12,541
District of Columbia	6,133	16,079	North Dakota	5,073	12,343
Florida	5,602	13,261	Ohio	5,174	12,710
Georgia	5,605	12,369	Oklahoma	5,142	11,995
Hawaii	5,246	12,782	Oregon	5,413	12,811
Idaho	4,901	10,738	Pennsylvania	5,618	13,753
Illinois	6,017	14,453	Rhode Island	6,345	15,363
Indiana	5,710	13,029	South Carolina	5,351	12,473
Iowa	4,963	12,071	South Dakota	5,364	12,750
Kansas	5,164	12,322	Tennessee	5,251	11,663
Kentucky	4,936	11,981	Texas	5,327	13,313
Louisiana	5,390	12,691	Utah	4,951	12,619
Maine	5,590	13,064	Vermont	5,800	13,409
Maryland	5,610	13,965	Virginia	5,449	13,241
Massachusetts	6,323	16,502	Washington	5,292	12,196
Michigan	5,569	13,256	West Virginia	5,947	13,734
Minnesota	5,588	14,077	Wisconsin	5,786	14,623
Mississippi	5,042	11,964	Wyoming	5,948	14,314
Missouri	5,268	12,366			

To illustrate how the state average premium limitation works, suppose a small employer whose employee works in Virginia pays 50% of the premium for employee-only coverage. Further suppose that the actual premium for employee-only coverage is $120 per week ($6,240 annually). Although the employer would have actually paid $3,120 as its share of the employee-only premium ($6,240 x 50% = $3,120), the employer is considered to have paid $2,725 as its share of the premium for employee-only coverage since the average premium in Virginia is $5,449. ($5,449 x 50% = $2,725)

State Premium Subsidy and Tax Credit Limitation

A small employer's premium tax credit may be reduced if the employer is entitled to a state tax credit or a state premium subsidy for the cost of health insurance coverage it provides under a qualifying arrangement to individuals considered employees. Even though a state tax credit or premium subsidy does not reduce the amount of the employer premiums paid, the amount of an employer's credit cannot be greater than its net premium payments.

(Net premium payments are employer premiums paid less the amount of any state tax credits the employee or received or will receive and any state premium subsidies paid.)

Calculating the Credit

IRS Form 8941, **Credit for Small Employer Health Insurance Premiums**, is used to calculate the credit and is attached to the small employer's tax return. The important lines of the form are shown below, and Form 8941 is reproduced in its entirety in Appendix A. Several worksheets are used to assist preparers in figuring the amounts to report on various lines of the form, and those worksheets are also shown below.

Line 1a on Form 8941 requires that the number of individuals employed during the tax year be entered. The number to enter is the total number of individuals listed on Worksheet 1, column (a).

1a	Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (see instructions)	1a	

Worksheet 1, partially reproduced below, should be completed to figure the number of employees and also provide information to complete Worksheets 2 and 3.

Worksheet 1

(a) Individuals Considered Employees	*(b) Employee Hours of Service*	*(c) Employee Wages Paid*
1.		
2.		
5.		
6.		
18.		
19.		
24.		
25.		
Totals: Show this amount on line 1a	Show this amount on Worksheet 2	Show this amount on Worksheet 3

On Worksheet 1 column (a), enter the name of each individual considered an employee for purposes of the credit. As discussed earlier, certain individuals employed by the employer who have an ownership interest in the employer and their family or household members are excluded. Do not list them. The total number of listed individuals in column (a) should be shown on Form 8941, line 1a.

On Worksheet 1 column (b), enter the total hours of service for the tax year for each listed employee. Do not enter more than 2,080 hours for any listed employee. For seasonal employees listed on the form—those who worked for the employer 120 days or less during the tax year—enter -0-. The information in column (b) is used to figure the employer's number of full-time equivalent employees (FTEs) on Worksheet 2.

> Tip! Preparer should complete Worksheet 2 before completing Worksheet 1 column (c). Don't complete Worksheet 1 column (c) if Worksheet 2, line 3 (FTEs), is 25 or more.

On Worksheet 1 column (c), enter the total wages paid by the employer for the tax year for each listed employee. For seasonal employees enter -0-. The information in column (c) is used to figure the employer's average annual wages on Worksheet 3.

Line 2 on Form 8941 requires that the number of full-time equivalent employees (FTEs) the employer had for the tax year be entered. The number to enter is the number of FTEs shown on Worksheet 2, line 3.

2	Enter the number of full-time equivalent employees you had for the tax year (see instructions). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12.	2

Worksheet 2, reproduced below, should be completed to figure the number of full-time employees (FTEs) to be shown on Form 8941, line 2.

Worksheet 2

1. Enter the total employee hours of service from Worksheet 1, column (b) . . . . . 1. _____
2. Hours of service per FTE 2. 2,080
3. **Full-time equivalent employees.** Divide line 1 by line 2. If the result is not a whole number (0, 1, 2, etc.), generally round the result down to the next lowest whole number. However, if the result is less than one, enter 1. Report this amount on Form 8941, line 2 . . . . . 3. _____

Enter on Worksheet 2, line 1 the total number of employee hours of service shown on Worksheet 1, column (b). Divide the number shown on Worksheet 2, line 1 by the number (2,080) on line 2, and enter the result on Worksheet 2, line 3.

For example, suppose the total employee hours of service figured on Worksheet 1 (and entered on Worksheet 2, line 1) were 41,000. By dividing the number on line 1 by 2,080, we determine that the result is 19.71. (41,000 ÷ 2,080 = 19.71) Since we must round the result down to the next lowest whole number, the number to be entered on Worksheet 2, line 3 and on Form 8941, line 2 would be 19.

Line 3 on Form 8941 requires that the average annual wages paid by the employer for the tax year be entered. The number to enter is the average annual wages shown on Worksheet 3, line 3.

3	Average annual wages you paid for the tax year (see instructions). If you entered $50,000 or more, skip lines 4 through 11 and enter -0- on line 12.	3	

Worksheet 3, reproduced below, should be completed to figure the average annual wages to be shown on Form 8941, line 3.

Worksheet 3

1. Enter the total employee wages paid from Worksheet 1, column (c) . . . . . 1. _____
2. Enter FTEs from Worksheet 2, line 3 . . . 2. _____
3. **Average annual wages.** Divide line 1 by line 2. If the result is not a multiple of $1,000 ($1,000, $2,000, $3,000, etc.), round the result down to the next lowest multiple of $1,000. Report this amount on Form 8941, line 3 . . . . . 3. _____

The total wages paid by the employer shown on Worksheet 1, column (c) should be entered on Worksheet 3, line 1. On Worksheet 3, line 2, enter the number of FTEs figured on Worksheet 2, line 3. To figure the number to enter on Worksheet 3, line 3, simply divide the number on line 1 by the number on line 2.

For example, suppose the total employee wages paid by the employer (from Worksheet 1, column (c)) were $510,000 and the total FTEs (from Worksheet 2, line 3) was 19, the result of the division would

be $26,842. ($510,000 ÷ 19 = $26,842) Because the amount must be rounded down to the next lowest multiple of $1,000, the number to be shown on Worksheet 3, line 3 and on Form 8941, line 3 is $26,000.

Line 4 on Form 8941 requires that the total premiums paid by the employer during the tax year for the employees included on line 1 of Form 8941 be entered.

4	Premiums you paid during the tax year for employees included on line 1a for health insurance coverage under a qualifying arrangement (see instructions)	4	

The number to enter on Form 8941, line 4 is the total shown in column (b) of Worksheet 4, partially reproduced below.

Worksheet 4

(a) Enrolled Individuals Considered Employees	(b) Employer Premiums Paid	(c) Employer State Average Premiums	(d) Enrolled Employee Hours of Service
1.			
2.			
15.			
16.			
20.			
21.			
24.			
25.			
Totals: Enter total # of employees who were covered for health insurance	Enter this amount on Form 8941, line 4		

Enter the name in column (a) of Worksheet 4 of each individual listed in column (a) of Worksheet 1 who was enrolled in health insurance coverage provided by the employer during the tax year.

In column (b) of Worksheet 4, only list the premiums paid by the employer for health insurance coverage offered by a health insurance provider for individuals considered employees. (Note: The health insurance premiums listed must be only for health insurance coverage that meets the definition of health insurance under the PPACA. Do not include premiums paid for excluded benefits.) The total amount for column (b) should be entered on Form 8941, line 4.

Line 5 on Form 8941 requires that the total premiums the employer *would have paid* during the tax year for the employees included on line 1 of Form 8941 if the total premium for each employee equaled the average premium for the small group market be entered.

5	Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which you offered health insurance coverage (see instructions)	5	

The number to enter on Form 8941, line 5 is the total shown in column (c) of Worksheet 4, partially reproduced below.

Worksheet 4

(a) Enrolled Individuals Considered Employees	(b) Employer Premiums Paid	(c) Employer State Average Premiums	(d) Enrolled Employee Hours of Service
1.			
2.			
15.			
16.			
20.			
21.			
24.			
25.			
Totals: Enter total # of employees who were covered for health insurance		Enter this amount on Form 8941, line 5	

In column (c) of Worksheet 4 enter the premiums the employer would have paid if the employees had enrolled in a plan with a total premium equal to the average premium for the small group market in the state in which the employee works. (To determine the premium to enter for each employee, consult the table listing the state average premiums shown in the instructions for Form 8941. The appropriate premium for each employee is the average premium *in the state in which the employee works.*) Enter the total for Worksheet 4, column (c) on Form 8941, line 5.

Line 6 on Form 8941 requires that the smaller of the premiums actually paid (line 4) or the premiums that would have been paid if the employees had enrolled in a plan with a total premium equal to the average premium in the state (line 5) be entered. Thus, simply enter the smaller of lines 4 and 5 on line 6.

Line 7 on Form 8941 requires that the product of the amount shown on line 6 and the appropriate credit percentage be entered. Accordingly, for tax years before 2014 multiply the amount on line 6 by .25 (for a tax-exempt small employer) or by .35 (for all other small employers) and enter the result on line 7. For tax years beginning in 2014, multiply the amount on line 6 by .35 (for a tax-exempt small employer) or by .50 (for all other small employers) and enter the result on line 7.

Line 8 on Form 8941 applies the full-time equivalent employee (FTE) limitation. If the number of full-time equivalent employees entered on Form 8941, line 2 is 10 or less, the amount on Form 8941, line 7 should be entered on line 8. However, if the number of full-time equivalent employees entered is more than 10, Worksheet 5 must be used.

8 If line 2 is 10 or less, enter the amount from line 7. Otherwise, see instructions	8		

If the number of full-time equivalent employees shown on line 2 is more than 10, the number to enter on Form 8941, line 8 is the amount shown on line 6 of Worksheet 5, reproduced below.

Worksheet 5

1. Enter the amount from Form 8941, line 7 . . . . 1. _____
2. Enter the amount from Form 8941, line 2 . . . . . .2. _____
3. Subtract 10 from line 2 . . . . . .3. _____
4. Divide line 3 by 15. Enter the result as a decimal (rounded to at least 3 places). . . . . .4. _____
5. Multiply line 1 by line 4 . . . . . .5. _____
6. Subtract line 5 from line 1. Report this amount on Form 8941, line 8. . . . . .6. _____

To complete Worksheet 5, enter the potential maximum credit shown on Form 8941, line 7 on line 1 of the worksheet. Enter the number of FTEs shown on Form 8941, line 2 on line 2 of the worksheet. Subtract 10 from the amount entered on line 2 and enter that amount on line 3. Divide the number entered on line 3 by 15 and enter the result, rounded to at least 3 places, on worksheet line 4. Multiply the amount on line 1 of the worksheet by the amount on line 4 and enter the result on worksheet line 5. Subtract the amount on Worksheet 5, line 5 from the amount on Worksheet 5, line 1, and enter the result on Worksheet 5, line 6 and on Form 8941, line 8.

Line 9 on Form 8941 applies the average annual wage limitation. If the average annual wages reported on Form 8941, line 3 are $25,000 or less, the amount on Form 8941, line 8 should be entered on line 9. However, if the number on Form 8941, line 3 is more than $25,000, Worksheet 6 must be used.

9	If line 3 is $25,000 or less, enter the amount from line 8. Otherwise, see instructions	9	

If the average annual wages shown on line 3 are more than $25,000, the number to enter on Form 8941, line 9 is the amount shown on line 7 of Worksheet 6, reproduced below.

Worksheet 6

1.	Enter the amount from Form 8941, line 8	1. _____
2.	Enter the amount from Form 8941, line 7	2. _____
3.	Enter the amount from Form 8941, line 3.	3. _____
4.	Subtract $25,000 from line 3	4. _____
5.	Divide line 4 by $25,000. Enter the result as a decimal (rounded to at least 3 places).	5. _____
6.	Multiply line 2 by line 5	6. _____
7.	Subtract line 6 from line 1. Report this amount on Form 8941, line 9.	7. _____

To complete Worksheet 6, enter the credit shown on Form 8941, line 8 on line 1 of the worksheet. Enter the amount from Form 8941, line 7 on line 2 of the worksheet. Enter the amount from Form 8941, line 3 (the average annual wages) on line 3 of the worksheet. Subtract $25,000 from the amount on worksheet line 3 (to determine the amount by which the average annual wages exceed $25,000) and enter that amount on line 4 of the worksheet.

Divide the amount on line 4 of the worksheet by $25,000 (to determine the percentage by which the average earnings exceed $25,000) and enter that decimal (rounded to at least 3 places) on line 5 of the worksheet. Multiply the amount on line 2 of the worksheet by the decimal in line 5 of the worksheet (to determine the reduction in the credit resulting from the average annual wage limitation) and enter that amount on line 6 of the worksheet. Subtract line 6 from line 1 and enter the result on line 7 of the worksheet and on Form 8941, line 9.

Lines 10 through 12 of Form 8941 reflect the state premium subsidy and tax credit limitation which ensures that the amount of the insurance premium credit will not be more than the employer's net premium payments. It requires that the total amount of any state premium subsidies paid and state tax credits available to the employer for health insurance premiums included on Form 8941, line 4 be entered on line 10. If neither premium subsidies nor tax credits were available, enter -0-, otherwise enter the amount of state tax credit or premium subsidy to which the employer is entitled.

On Form 8941, line 11, enter the amount by which the amount entered on Form 8941, line 4 exceeds the amount entered on Form 8941, line 10. Then, enter the smaller of line 9 or line 11 on Form 8941, line 12.

10	Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions)	10	
11	Subtract line 10 from line 4. If zero or less, enter -0-	11	
12	Enter the **smaller** of line 9 or line 11	12	

If line 12 is greater than zero, Line 13 of Form 8941 requires that the total number of enrolled individuals considered employees be entered.

13	If line 12 is zero, skip lines 13 and 14 and go to line 15. Otherwise, enter the number of employees included on line 1a for whom you paid premiums during the tax year for health insurance coverage under a qualifying arrangement (see instructions)	13	

The number of enrolled individuals can be found on Worksheet 4, column (a), shown below.

Worksheet 4

(a) Enrolled Individuals Considered Employees	(b) Employer Premiums Paid	(c) Employer State Average Premium	(d) Enrolled Employee Hours of Service
1.			
2.			
15.			
16.			
20.			
21.			
24.			
25.			
Totals: Enter total # of employees who were covered for health insurance here and on Form 8941, line 13			Enter total enrolled employee hours of service here and on Worksheet 7, line 1

Line 14 of Form 8941 requires that the number of full-time equivalent employees (FTEs) for whom the employer paid premiums for health insurance coverage during the tax year be entered.

14	Enter the number of full-time equivalent employees you would have entered on line 2 if you only included employees included on line 13	14	

Use worksheet 7, shown below, to figure the amount of FTEs enrolled in coverage.

Worksheet 7

1. Enter the total enrolled employee hours of service from Worksheet 4, column (d). . . . . 1. _____
2. Hours of service per FTE. 2. 2,080
3. Divide line 1 by line 2. If the result is not a whole number (0, 1, 2, etc.), generally round the result down to the next lowest whole number. However, if the result is less than one, enter 1. Report this amount on Form 8941, line 14 . . . . . 3. _____

To complete Worksheet 7, enter the total enrolled employee hours of service from Worksheet 4, column (d) on line 1 of the worksheet. Then divide the number of enrolled employee hours by 2,080

and enter the result, rounded down to the next lowest whole number, on Worksheet 7, line 3 and on Form 8941, line 14.

On line 15 of Form 8941, enter any credit for small employer health insurance premiums from:

- Schedule K-1 (Form 1065), box 15 (code P);
- Schedule K-1 (Form 1120S), box 13 (code P);
- Schedule K-1 (Form 1041), box 13 (code G); and
- Any notice of credit allocation the employer received from a cooperative.

15	Credit for small employer health insurance premiums from partnerships, S corporations, cooperatives, estates, and trusts (see instructions)	15	

On line 16 of Form 8941, enter the amount resulting from adding Form 8941, line 12 to Form 8941, line 15.

16	Add lines 12 and 15. Cooperatives, estates, and trusts, go to line 17. Tax-exempt small employers, skip lines 17 and 18 and go to line 19. Partnerships and S corporations, stop here and report this amount on Schedule K. All others, stop here and report this amount on Form 3800, line 4h	16	

For other than cooperatives, estates, trusts and tax-exempt small employers, the amount on Form 8941, line 16 is the credit for small employer health insurance premiums. Partnerships and S corporations should report this amount on Schedule K. All others should report the line 16 amount on IRS Form 3800, **General Business Credit**, Part III, line 4h (Small employer health insurance premiums).

On line 17 of Form 8941, cooperatives, estates and trust must enter the amount of the credit they have allocated to patrons of the cooperative or beneficiaries of the estate or trust. The amount of the credit allocated to others is then subtracted from the credit to which they are entitled, and that amount is entered on Form 8941, line 18.

The amount entered on line 18 is the credit for cooperatives, estates and trusts and should be reported on IRS Form 3800, **General Business Credit**, Part III, line 4h (Small employer health insurance premiums).

17	Amount allocated to patrons of the cooperative or beneficiaries of the estate or trust (see instructions)	17	
18	Cooperatives, estates, and trusts, subtract line 17 from line 16. Stop here and report this amount on Form 3800, line 4h	18	

On Form 8941, line 19, enter the amount the tax-exempt small employer paid in taxes considered payroll taxes for purposes of the credit. Since the credit is limited to no more than the taxes paid, enter the smaller of the credit (line 16) or the taxes paid (line 19) on Form 8941, line 20.

19	Enter the amount you paid in 20xx for taxes considered payroll taxes for purposes of this credit (see instructions)	19	
20	Tax-exempt small employers, enter the **smaller** of line 16 or line 19 here and on Form 990-T, line 44f	20	

Payroll taxes, for purposes of the credit—and which are totaled for line 19—means:

- Federal income taxes the tax-exempt employer was required to withhold from employees' wages during the calendar year;
- Medicare taxes the tax-exempt employer was required to withhold from employees' wages during the calendar year; and
- Medicare taxes the tax-exempt employer was required to pay during the calendar year.

Large Employer Shared Responsibility Regarding Health Coverage

Pursuant to the law's provisions, an applicable large employer is required to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan or be subject to a possible penalty. Full-time employees must generally be asked to pay no more than 9.5% of their household income for coverage. (The law

provides a safe harbor with respect to an employee's household income. Pursuant to the affordability safe harbor, an employer can avoid a payment if the cost of the coverage to the employee would not exceed 9.5% of the wages the employer pays the employee that year.)

The law does not mandate that a large employer provide health coverage or, if the employer does provide such coverage, to pay 100% of the premiums for it. Instead, it requires only that the employer who does not offer employees and dependents an opportunity to participate in coverage meeting the minimum essential coverage requirement or requires a full-time employee to pay more than 9.5% of income for such coverage to be subject to a possible tax penalty. A new employee expected to work full-time must be offered the opportunity to enroll in the employer's health insurance coverage and cannot be required to wait more than 90 days to be enrolled in it.

Implementation of the statutory requirement that certain large employers offer at least 95% of their employees and their dependents health insurance or potentially pay a penalty—usually referred to as the "employer mandate"—was to begin in 2014; that implementation timeline has been changed. In July 2013, the requirement that large employers offer their full-time employees and dependents affordable health insurance coverage and make contributions towards its premiums or face the possibility of a penalty under PPACA §4980H (a) was delayed until 2015.

In February 2014, with publication of the final regulations[8] relating to the shared responsibility for employers regarding health coverage, the implementation requirements of the employer mandate were further changed. The implementation changes provide transition relief during 2015 as follows:

- An applicable large employer that, during 2015, offers coverage to at least 70% (temporarily reduced from 95%) of its full-time employees will not be subject to a penalty;
- An applicable large employer that did not offer dependent coverage in either the 2013 or 2014 plan year that takes steps during its plan year beginning in 2015 toward satisfying the requirement related to providing coverage to full-time employees' dependents will not be subject to a penalty solely on account of its failure to offer such dependent coverage during that plan year; and
- An employer that employs at least 50 full-time employees (including FTEs) but fewer than 100 full-time employees (including FTEs) in 2015 will not be subject to a penalty for failure to offer health insurance to full-time employees and their dependents in 2015 provided –
    - The employer does not reduce the size of its workforce or the overall hours of service of its employees in order to satisfy the workforce size limit during the period from February 9, 2014 through December 31, 2014, and
    - The employer does not eliminate or materially reduce the health coverage offered as of February 9, 2014.

Large Employer Defined

A large employer is defined under the law[9] as "… an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year." Accordingly, employers who employed fewer than 50 full-time employees are not considered large employers subject to the shared responsibility requirements of the PPACA.

In general, an employer is not deemed to have employed more than 50 full-time employees if:

(a) The employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year; and
(b) The employees in excess of 50 employed during such 120 day period were seasonal employees.

A seasonal worker is generally defined as a worker who performs labor or services on a seasonal basis and who is paid wages by a seasonal employer for work performed only during the normal seasonal work period. Retail workers employed exclusively during holiday season are considered seasonal employees for purposes of the PPACA's shared responsibility requirement.

[8] Final regulations concerning large employers' shared responsibility may be found at http://www.ofr.gov/OFRUpload/OFRData/2014-03082_PI.pdf
[9] IRC §4980H(c)(2)(A).

Aggregation Rules Apply

The aggregation rules discussed earlier in connection with the small employer tax credit also apply to large employers. Thus, all employees of a controlled group or an affiliated service group are taken into account in determining whether the members of the controlled group or affiliate service group taken together constitute an applicable large employer. In other words, for purposes of counting the number of full-time and full-time equivalent employees for determining whether an employer is an applicable large employer, the PPACA and associated rules provide that all entities treated as a single employer under section 414(b), (c), m or (o), i.e. the aggregation rules, are treated as a single employer.

Consistent with the standards that generally apply for other tax and employee benefit purposes, employers having a common owner or which are otherwise related are combined together for purposes of determining whether or not they employ at least 50 full-time employees or an equivalent combination of full-time and part-time employees. If the combined total meets the threshold, then each separate company is subject to the employer shared responsibility provisions, **even those companies that individually do not employ enough employees to meet the threshold**.

Full-Time Employee

A full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours per week or 130 hours per month. A safe harbor method[10] is available for determining whether or not an employee should be considered a full-time employee.

Pursuant to IRS notice 2012-58, the safe harbor may be used by a large employer with respect to:

- New employees; and
- Ongoing employees.

Safe Harbor Method for New Employees

Although a new employee who is expected to work full-time for a large employer cannot be required to wait more than 90 days to be given the opportunity to enroll in the employer's coverage, the 90-day time limit does not apply to a new employee who is not expected to work full-time. Such a part-time or seasonal employee can be employed without health insurance for an initial measurement period during which his or her hours are tracked. This tracking period—generally referred to as an initial measurement period—maybe from 3 to 12 months, as determined by the employer.

At the conclusion of the initial measurement period, the employer may take up to 90 days as an administrative period during which it can determine the employee's eligibility for health coverage. (Note, however, that the combined length of the period before the start of the initial measurement period ***and*** the period that begins immediately after the end of the initial measurement period and ends at the beginning of the stability period cannot exceed 90 days.) If the employer determines that the new employee has worked an average of at least 30 hours per week during the initial measurement period, it must then offer health insurance to the employee for a period of time known as a "stability period."

The stability period, during which the employer is required to provide health insurance coverage to such an employee, must be a period at least as long as the longer of:

- 6 months; or
- The length of the initial measurement period.

Thus, if the initial measurement period was four months in duration, the minimum stability period would be six months in length. However, if the initial measurement period was 12 months in duration, the stability period during which health insurance coverage must be offered would be 12 months.

If the employee worked an average of less than 30 hours per week, the employer is permitted to treat the employee as a part-time employee to which the shared responsibility mandate does not apply.

[10] See IRS Notice 2012-58 "Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage."

Safe Harbor Method for Ongoing Employees

Employees who are ongoing employees of the employer may also be subject to measurement and stability periods if they work variable hours. The periods apply to such ongoing employees in the same way they apply to new employees.

If an ongoing employee is found to be a part-time employee during a measurement period, the employer may deny health insurance coverage for the next stability period without being subject to a penalty. However, if the employee is found to be a full-time employee during the measurement period—he or she worked an average of at least 30 hours weekly, in other words—the employer is required to make health insurance coverage available or risk becoming liable for a tax penalty.

Penalty for Non-Compliance

The penalties imposed on a large employer for failing to comply with the PPACA requirement vary, depending upon the nature of its noncompliance. Thus, liability for a penalty may arise as a result of:

- The employer's not offering coverage under IRC §4980H(a); or
- An employer's offering coverage whose employee received a premium tax credit under IRC §4980H(b).

For the purpose of determining the applicability or amount of any penalty for a failure to comply with the PPACA requirement—a penalty that may vary depending on the number of full-time employees—the rules for combining related employers do not apply.

Employers Not Offering Coverage

A large employer who does not offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan may be liable for a penalty[11]. Such an employer is subject to a penalty under the PPACA if one or more of its full-time employees is certified to the employer as being enrolled in health insurance coverage obtained through a state exchange and having received a premium tax credit or cost-sharing reduction. This subsidy—the premium tax credit or cost-sharing reduction, in other words—is not available to individuals eligible for other coverage, such as Medicare or Medicaid.

The penalty for which such an employer who fails to offer coverage to its full-time employees is liable for any month is an amount equal to the number of its full-time employees in excess of 30 multiplied by 1/12th of $2,000, regardless of the number of employees who are enrolled in health insurance coverage obtained through a state exchange and receiving a tax credit or cost-sharing reduction.

For example, suppose only one employee of a large employer who does not offer health insurance coverage enrolled in health insurance coverage through a state exchange and received a premium tax credit. If the employer employed 70 full-time employees, the penalty for which the employer would be liable is equal to:

$$(70 - 30) \quad X \quad \frac{\$2,000}{12} \quad = \quad \$6,667$$

If the employer provided no coverage for the entire year and its full-time employees remained at 70 throughout the year, the penalty for which the employer would be liable is $80,004. ($6,667 x 12 = $80,004)

Employer Not Offering Coverage May Not be Liable for Penalties

Since the liability imposed on a large employer for a failure to offer health insurance coverage to its full-time employees is triggered by an employee's obtaining health insurance coverage through a state exchange and receiving a tax credit or subsidy to assist in its purchase, an employer failing to offer such coverage may, nonetheless, avoid a penalty. Specifically, an employer who has no full-time employee whose income would qualify him or her for a subsidy when purchasing health insurance coverage through an exchange, the employer will not be liable for the penalty.

[11] IRC §4980H(a).

Employers Offering Coverage

In some cases, employers who offer health insurance coverage to their full-time employees may, nonetheless, be subject to a penalty. If a large employer offers coverage to its full-time employees but at least one full-time employee receives a premium tax credit or cost-sharing reduction, the employer is subject to a penalty. Thus, even if an applicable large employer offers coverage to the required percentage of its full-time employees (70% or 95%) and their dependents, it may be subject to a penalty if one or more of the full-time employees obtain a premium tax credit because the coverage fails to provide minimum value or its premium exceeds 9.5% of the individual's income[12].

Unlike the penalty to which an employer who fails to offer health insurance coverage to its full-time employees may be subject—whose penalty is based on the total number of full-time employees in excess of 30—the penalty applicable to an employer who offers coverage is based solely on the number of full-time employees who purchase health insurance through a state exchange and receive a premium tax credit or cost-sharing reduction. For each full-time employee receiving a credit or subsidy through a state exchange, the penalty for any month is equal to 1/12th of $3,000, i.e. $250. ($3,000 ÷ 12 = $250) Thus, if 25 employees of such large employer receive a credit or subsidy, the applicable employer penalty for that month would be $6,250. ($250 x 25 = $6,250)

The penalty to which a large employer offering coverage to its full-time employees would be subject is limited to no more than an amount equal to the number of full-time employees in excess of 30 during the month, irrespective of how many employees are receiving a credit or subsidy, multiplied by 1/12th of $2,000. Accordingly, if the large employer employed 50 full-time employees, and 25 of those employees received a credit or subsidy, the applicable penalty limit would be $5,000. ((50 – 30) x $250 = $5,000)

Medicaid Expansion Option may affect Employer Penalties

As noted earlier, a large employer may be subject to a tax penalty for its failure to provide affordable health coverage providing minimum essential benefits if an employee obtains health insurance through an exchange and **receives a subsidy**. However, a subsidy is unavailable to individuals who are eligible for other coverage such as Medicare or Medicaid and cannot be made to individuals with income below 100% of the federal poverty level.

Pursuant to the PPACA, as passed by Congress and signed into law, the eligibility for Medicaid coverage is expanded to include persons with income levels that are at or below 133% of the federal poverty level. That level was effectively increased to 138% of the federal poverty level because of the standard 5% income disregard that applies to most individuals.

The constitutionality of the healthcare reform law was subsequently challenged, and the Supreme Court upheld the law but made states' Medicaid expansion optional. Thus, each state is given the option under the PPACA to expand its Medicaid program, and some states may choose not to expand it. States that opt out of Medicaid expansion put large employers in their states at increased risk for penalties since employees who might be eligible for Medicaid in states that have chosen not to expand their program may be then eligible to purchase health insurance through an exchange and receive a subsidy to pay for it. In such a case, a large employer would be subject to the applicable tax penalties.

Transition Relief

In January 2013, proposed regulations affecting applicable large employers were issued. Among the proposed regulation's provisions are those providing transition relief for large employers offering certain types of plans. Principal among the transition relief provisions are those providing relief for:

- Fiscal year plans; and
- Cafeteria plans having fiscal years.

[12] IRC §4980H(b).

Fiscal Year Plans

The large employer shared responsibility[13] requirements effective on and after January 1, 2015 present some concerns for large employers who sponsor plans other than calendar year plans since such plans have terms and conditions that are difficult to change in the middle of a plan year.

Responding to employer concerns, transition relief has been provided for 2014 for applicable large employers with fiscal year plans. Under the proposed regulations, if an employee employed by an employer sponsoring a fiscal year plan is offered affordable, minimum value coverage no later than the first day of the 2015 plan year, no assessable payment will be due with respect to that employee for the period prior to the first day of the plan year.

Cafeteria Plan Elections

Fiscal year cafeteria plans also create concerns for employers and participants. Some background may offer additional clarity.

A cafeteria plan sponsored by an employer enables a plan participant to choose among two or more benefits consisting of cash and qualified benefits. Accordingly, such plans permit an employee to receive cash in lieu of an offered qualified benefit or elect, instead, to enroll in the benefit and pay any required employee contributions with before-tax income. The plan participant's election under the plan must be made before the beginning of the cafeteria plan's plan year and cannot normally be changed during the plan year except for certain specified reasons, which include:

- Judgments, decrees or orders resulting from a divorce, legal separation, annulment or change in legal custody that require health coverage for an employee's child or dependent foster child; and
- Certain changes in an employee's status, such as a change related to –
    - The employee's legal marital status,
    - An employee's number of dependents,
    - The employment status of an employee, spouse or dependent,
    - A dependent's eligibility for coverage under the plan,
    - A change of an employee's, spouse's or dependent's residence, or
    - The commencement or termination of an adoption proceeding (for purposes of adoption assistance provided through a cafeteria plan).

Since the requirement under the PPACA that an individual maintain health coverage (or pay a penalty) and the availability of coverage through an exchange are effective as of January 1, 2015, the irrevocability of a participant's election under a fiscal year cafeteria plan whose plan year may not end until well beyond January 1, 2015 can clearly cause difficulty for participating employees and their employers. Without relief, employees would not be permitted to change their salary reduction elections under the cafeteria plan and cease salary reductions in order to purchase coverage through an exchange. Conversely, employees who had not previously authorized a salary reduction to purchase health coverage would not be able to do so until the beginning of the next plan year at the earliest.

In order to overcome these concerns relative to employer-provided fiscal year cafeteria plans, the proposed regulations provide transition relief. Pursuant to such relief, an applicable large employer may amend one or more of its written cafeteria plans to permit either or both of the following salary reduction election changes:

1. An employee who elected to reduce salary through the cafeteria plan for health plan coverage with a fiscal plan year is allowed to prospectively revoke or change his or her election with respect to the health plan once, during the plan year, without regard to whether the employee experienced a change in status event; and
2. An employee who failed to make a salary reduction election through his or her employer's cafeteria plan for health plan coverage with a fiscal plan year before the deadline for making elections for the cafeteria plan year is allowed to make a prospective salary reduction election for health plan coverage on or after the first day of the plan year of the cafeteria plan, without regard to whether the employee experienced a change in status event.

[13] Proposed regulations may be found at http://federalregister.gov/a/2012-31269.

An applicable large employer that wants to permit the change in election rules under the transition relief for fiscal plan years must incorporate these rules in its written cafeteria plan. Despite the general rule that amendments to cafeteria plans may only be effective prospectively from the date of the plan amendment, a cafeteria plan may be amended retroactively to implement these transition rules.

Large Employer Reporting Requirements

In addition to the Form W-2 reporting requirement previously discussed that is generally applicable to employers providing employer-sponsored health benefits, large employers must meet additional reporting requirements. Every large employer that must meet the shared employer responsibility requirements of the PPACA during a calendar year must also file an annual return that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the year[14]. Transition relief has been provided relieving applicable large employers from the requirement to report the following information for years before 2015. Such reporting requirements will become effective for 2015.

The return must:

- Include the name and EIN of the large employer;
- Include the date the return is filed;
- Certify whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and, if so, to certify –
    - The duration of any waiting period with respect to the provided coverage,
    - The months during the calendar year when coverage under the plan was available,
    - The monthly premium for the lowest-cost option in each enrollment category under the plan, and
    - The employer's share of the total allowed costs of benefits provided under the plan;
- Report the number of full-time employees for each month of the calendar year;
- Report, for each full-time employee, the name, address and taxpayer identification number (TIM) of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan; and
- Include other information that may be required by the Secretary of the Treasury.

Large Employer Notification Requirements

In addition, an applicable large employer must also furnish to each full-time employee whose information is required to be reported, no later than January 31st following the calendar year, a written statement that includes:

- The employer's name and address;
- The employer's contact information, including a contact telephone number; and
- The information relating to coverage provided to that employee and his or her dependents that is required to be reported on the employer's return.

Summary

The PPACA encourages employers with fewer than 25 full-time employees to provide health insurance coverage for their employees by offering small employers a tax credit. Accordingly, small employers may be eligible to receive a nonrefundable tax credit for premiums paid for employee health insurance coverage that may be carried back one year and forward 20 years. Through 2013, the maximum small employer health insurance premium credit available is 35% of premiums paid by small employers and 25% of premiums paid by small tax-exempt employers. In 2014, the maximum tax credit increases to 50% and 35%, respectively.

The small employer tax credit is available if the employer a) paid premiums for employee health insurance coverage under a qualifying arrangement, b) had fewer than 25 full-time equivalent employees (FTEs) for the tax year, and c) paid average annual wages for the tax year of less than $50,000 per full-time equivalent employee.

[14] Internal Revenue Notice 2012-33.

Under a qualifying arrangement, the small employer is required to pay a uniform percentage of not less than 50% of the premium for the employee enrolled in health insurance coverage. Health insurance coverage that would be eligible for the credit is coverage that provides benefits under a hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance provider.

Health insurance coverage, for this purpose, also includes coverage under dental or vision plans, long-term care plans, nursing home care plans, church welfare benefit plans, home health care plans, community-based care plans and multi-employer health and welfare plans that provide coverage through a health insurance provider and various other types of coverage. Since coverage must be offered by a health insurance provider, health insurance coverage qualifying for the credit does not include benefits provided by a) health reimbursement arrangements (HRAs), b) flexible spending arrangements (health FSAs), c) coverage under other self-insured plans, or d) health savings accounts (HSAs).

Although all employees are taken into account in determining the employer's FTEs, average annual wages and premiums paid for purposes of the credit, special rules apply to business owners (and family members), leased employees, seasonal employees, household and other non-business employees and ministers.

Certain limitations may apply that have the effect of reducing any health insurance premium credit to which a small employer may be entitled. The limitations that may reduce the credit for which a small employer may otherwise be eligible are the:

- Full-time equivalent employee (FTE) limitation, under which a small employer's health insurance premium credit is reduced if the employer had more than 10 FTEs for the tax year and eliminated if the employer had 25 or more FTEs for the tax year;
- Average annual wage limitation, under which a small employer's health insurance premium credit is reduced if the employer paid average annual wages of more than $25,000 for the tax year and is eliminated if the employer paid average annual wages of $50,000 or more for the tax year;
- State average premium limitation, under which a small employer's credit is reduced if the employer premiums paid are more than the employer premiums that would have been paid if employees were enrolled in a plan with a premium equal to the average premium for the small group market in the state in which the employee works; and
- State premium subsidy and tax credit limitation that would reduce an employer's credit so that the amount of the credit does not exceed the employer's premium payments less subsidies.

Except for federally-recognized Indian tribal governments and tribally chartered corporations wholly owned by federally recognized Indian tribal governments, all employers that provide employer-sponsored health coverage are required to report the cost of the employee's health benefits on their Form W-2. Such reporting does not apply for 2012 W-2 forms and will not apply for future calendar years until the IRS publishes guidance giving at least six months of advance notice of any change to the transition relief. Transition relief with respect to Forms W-2 generally applies to a) employers filing fewer than 250 Forms W-2 for the previous calendar year, b) multi-employer plans, if the only applicable employer-sponsored health coverage provided is provided under a multi-employer plan, c) health reimbursement arrangements (HRAs), d) certain dental and vision plans, e) self-insured plans of employers not subject to COBRA continuation coverage or similar requirements, f) employee assistance programs (EAPs), on-site medical clinics, or wellness programs for which the employer does not charge a premium under COBRA continuation coverage or similar requirements, and g) employers furnishing Forms W-2 to employees who terminate before the end of a calendar year and require a Form W-2 before the end of that year.

The coverage whose cost is to be included on the Form W-2 includes a) major medical coverage, b) certain health FSA amounts for the plan year, c) hospital indemnity or specified illness coverage paid through pre-tax salary reduction or by the employer, d) employee assistance plans, on-site medical clinics and wellness programs for which the employer charges a COBRA premium, and e) domestic partner coverage included in gross income.

The requirement to report the cost of health benefits is designed to provide employees useful and comparable consumer information concerning the cost of their health care coverage. However, such

cost is excluded from the employee's income and is not taxable. Because of transition relief provided, reporting requirements will be effective for 2015 and later.

For purposes of determining the number of employees employed by an employer, for both the small-employer premium tax credit and the shared responsibility requirements, the entire group is considered a single employer for purposes of determining the number of employees. Accordingly, employers who are corporations in a controlled group of corporations, employers who are members of an affiliated service group, and employers who are partnerships, proprietorships and other employers under common control must be treated as a single employer.

The law does not mandate that a large employer provide health coverage or, if the employer does provide such coverage, to pay 100% of the premiums for it. Instead, it requires only that the employer who does not offer employees and dependents an opportunity to participate in coverage meeting the minimum essential coverage requirement or requires a full-time employee to pay more than 9.5% of income for such coverage to be subject to a possible tax penalty.

Under the PPACA, employers who employed an average of at least 50 full-time employees on business days during the preceding calendar year are required to offer at least 95% of their full-time employees health insurance and make contributions towards its premiums or pay a penalty. A full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours per week or 130 hours per month.

A large employer who does not offer at least 95% of its full-time employees and their dependents the opportunity to enroll in qualifying health insurance coverage under an employer-sponsored plan may be liable for a penalty if one or more of its full-time employees is enrolled in health insurance coverage obtained through a state exchange and is receiving a premium tax credit or cost-sharing reduction. The penalty for which such an employer who fails to offer coverage to its full-time employees is liable for any month is an amount equal to the number of its full-time employees in excess of 30 multiplied by $1/12^{th}$ of $2,000, regardless of the number of employees who are enrolled in health insurance coverage obtained through a state exchange.

Large employers who offer health insurance coverage to their full-time employees may also be subject to a penalty if at least one full-time employee receives a premium tax credit or cost-sharing reduction. The penalty for which such an employer may be liable is based on the number of full-time employees who purchase health insurance through a state exchange and receive a premium tax credit or cost-sharing reduction. For each full-time employee receiving a credit or subsidy through a state exchange, the penalty for any month is equal to $1/12^{th}$ of $3,000, i.e. $250. ($3,000 ÷ 12 = $250) Thus, if 25 employees of such large employer receive a credit or subsidy, the applicable employer penalty for that month would be $6,250. ($250 x 25 = $6,250) The penalty to which a large employer offering coverage to its full-time employees would be subject is limited to no more than an amount equal to its number of full-time employees in excess of 30 during the month, irrespective of how many employees are receiving a credit or subsidy, multiplied by $1/12^{th}$ of $2,000.

Transition relief has been provided under which a) large employers will avoid a penalty for failure to offer full-time employees and their dependents affordable health insurance coverage until 2015, b) a large employer that offers coverage to at least 70% of its full-time employees in 2015 will not be subject to a penalty, c) large employers that do not offer dependent coverage in 2015 but take steps toward satisfying the requirement will not be subject to a penalty for their failure to provide such coverage in 2015, and d) employers that employ at least 50 but fewer than 100 full-time employees will not be assessed a penalty for failure to offer full-time employees and their dependents health insurance in 2015.

Transition relief applicable to large employers provides relief for fiscal year plans and cafeteria plans having fiscal years. In addition, the relief provided with respect to cafeteria plans offered on a fiscal year basis permits employers to amend the plans to allow participants to make certain salary reduction changes in the plan year without the requirement for a change in status.

Every large employer that must meet the shared employer responsibility requirements of the PPACA during a calendar year must also file an annual return that reports the terms and conditions of the health care coverage provided to the employer's full-time employees for the year as well as various other items with respect to the coverage and covered employees. The information reporting provisions of the law become effective for 2015.

The large employer must also furnish to each full-time employee whose information is required to be reported, no later than January 31st following the calendar year, a written statement that includes a) the employer's name and address, b) the employer's contact information, including a contact telephone number, and c) the information relating to coverage provided to that employee and his or her dependents that is required to be reported on the employer's return.

PPACA Employer Tax Provisions Timetable

Effective	Provision
2010	• Small employers become eligible to receive a nonrefundable tax credits for premiums paid for employee health insurance coverage.
2015	• Large employer shared-responsibility provision requires large employers employing 100 or more full-time employees to offer their full-time employees affordable health insurance coverage and make contributions towards its premiums or potentially pay a penalty.
2016	• Large employer shared-responsibility provision requires large employers employing at least but less than100 full-time employees to offer such employees affordable health insurance coverage and make contributions towards its premiums or potentially pay a penalty.

Chapter Review

1. Food Brokers, Inc., a for-profit organization, employed 17 full-time employees in 2013. What is the maximum health insurance premium credit for which it could be eligible?

   A. 0%

   B. 25%

   C. 35%

   D. 50%

2. Burger Barn is eligible for a small employer health insurance premium credit. If the company employs 10 full-time employees and its monthly group insurance premium rates are $500 for employee-only coverage and $1,200 for family coverage, what is the minimum monthly premium contribution Burger Barn must make in order to qualify for the credit?

   A. $2,500

   B. $5,000

   C. $6,000

   D. $12,000

3. Arthur works 3,120 hours each year as the sole proprietor of a small employer. How many full-time equivalent employees does the business have if, in addition to Arthur, 4 employees each work 2,080 hours each year and 10 other employees each work 1,040 hours during the year?

   A. 4

   B. 9

   C. 5

   D. 10

4. Big Brokers, Inc, a large employer, hired a new employee it expected would work part-time. It imposes an initial measurement period of 12 months during which it tracks the hours of such employees to determine if they qualify for health insurance coverage. The company determined that the new employee worked an average of 30 hours weekly during the measurement period. What is the minimum stability period it may impose during which it provides health insurance coverage for the new employee?

A. 3 months

B. 6 months

C. 9 months

D. 12 months

5. MegaRetail, a large employer, does not offer its 70 full-time employees employer-sponsored health insurance coverage. In 2016, three of its full-time employees enrolled in health insurance through a state exchange and received a premium tax credit. For what monthly tax penalty, if any, is the company liable under the PPACA?

   A. $0

   B. $500

   C. $6,667

   D. $11,667

6. Food Brokers, Inc. employs 40 employees and provides no health coverage for them. If 10 of the employees enrolled in health insurance through an Affordable Insurance Exchange in 2015 and received a cost-sharing reduction, for what monthly penalty would Food Brokers be liable?

   A. $0

   B. $1,667

   C. $2,000

   D. $10,000

7. Agnes runs a charity that provides shelter for the homeless. The organization has a total of 10 full-time equivalent employees earning a $25,000 average annual income for whom the shelter pays the entire employee health insurance premium of $5,000 monthly in 2013. For what health insurance premium credit, if any, would the charity be eligible in 2013 under the PPACA?

   A. $60,000

   B. $21,000

   C. $15,000

   D. $0

8. An employer that employs 100 full time equivalent employees sponsors health insurance providing minimum essential coverage for which the monthly employee premium is $1,000. What is the maximum monthly premium an employee whose monthly household income is $4,000 can be required to pay for the coverage?

   A. $0

   B. $380

   C. $500

   D. $780

9. Under the transition relief provided for employers of a certain size, only an employer filing fewer than ____ Forms W-2 is relieved from the requirement to report the cost of coverage on employees' W-2 forms.

   A. 50

   B. 250

   C. 500

   D. 1,000

10. How frequently must an applicable large employer furnish a written statement to its full-time employees concerning the coverage provided to the employee under the employer's health plan?

    A. Annually

    B. Every 5 years

    C. Whenever requested by a participating employee

    D. Upon initial participation and whenever the health plan coverage is changed

Glossary

Annual benefit limit	**Annual benefit limits** are dollar limits imposed by a health plan or insurer on the maximum amount of benefits it will pay for covered healthcare provided to any covered person during the year**.**
Anti-abuse rules	**Anti-abuse rules** are rules created to stop health plan sponsors from employing certain methods designed solely to enable them to avoid compliance with the Act and Regulations.
Archer Medical Savings Account (MSA)	An **Archer Medical Savings Account** is a trust to which an account holder may make tax-deductible contributions for the purpose of paying qualified medical expenses.
Benchmark plan	The **benchmark plan**, as the term is used in connection with the insurance premium tax credit, is the second-lowest-cost plan that would cover the family at the silver level of coverage.
Coinsurance	When used in connection with health insurance coverage, **coinsurance** refers to the percentage of a healthcare provider's charges (after the deductible) for which the insured is responsible.
Contribution rate	The term **contribution rate**, for purposes of this provision, means the amount of sponsoring organization contributions compared to the total cost of coverage, expressed as a percentage.
Copayment	**Copayment** refers to the dollar amount for which a plan participant is responsible when accessing plan benefits. A typical health plan may charge a $30 copayment for every visit made to a primary care provider and $40 for every visit to a physician who specializes in a particular medical field.
Cost-sharing requirements	**Cost-sharing requirements** refer to those costs incurred by covered individuals who receive healthcare and include coinsurance, deductibles and copayments.
Emergency services	The term **emergency services** includes evaluation and stabilization and means, with respect to an emergency medical condition (defined below): • A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and • Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

Essential health benefits	**Essential health benefits** are benefits provided for services included within the following categories: (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.
Federal poverty level	The **federal poverty level** is the income level, which varies by size of the family, used to determine who is living in poverty and upon which many federal assistance programs are based.
Full-time employee	A **full-time employee** means, with respect to any month, an employee who is employed on average at least 30 hours per week or 130 hours per month.
Grandfathered health plan	A **grandfathered health plan** is a health plan in force on March 23, 2010. It will remain a grandfathered plan for as long as it maintains that status under the rules of the Act and Regulations.
Health Flexible Spending Arrangement (HFSA)	A **Health Flexible Spending Arrangement** is a program under which an employee may allocate before-tax earnings to an account from which unreimbursed medical expenses may be paid on a tax-free basis.
Health maintenance organization (HMO)	A traditional **health maintenance organization** is a health plan that provides an array of healthcare services—including preventive and routine healthcare services—to participants through a network of specified providers and coordinated by a primary care provider.
Health Reimbursement Arrangement (HRA)	A **Health Reimbursement Arrangement** is an employer-funded arrangement pursuant to which an employer reimburses employees for medical care expenses.
Health Savings Account (HSA)	A **Health Savings Account** is a trust to which an account holder may make tax-deductible contributions for the purpose of paying qualified medical expenses.
Large employer	A **large employer** is defined under the law as an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.
Lifetime benefit limit	**Lifetime benefit limits** are dollar limits imposed by a health plan or insurer on the maximum amount of benefits it will pay for covered healthcare provided to any covered person over his or her lifetime.

Medical inflation	**Medical inflation,** for purposes of the Regulations, means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).
Nonqualified distributions (MSA/HSA)	A **nonqualified distribution** from an Archer MSA or Health Savings Account is a distribution made from the tax-favored plan for any purpose other than the payment of qualified medical expenses.
Pre-existing condition exclusion	A **pre-existing condition exclusion** is a limitation or exclusion of benefits based on the fact the condition existed before the date of coverage.
Primary care provider (PCP)	A **primary care provider** (PCP) in an HMO or POS plan is the healthcare professional primarily responsible for participants' healthcare. In general, all participant care is either provided directly by or coordinated by the PCP who acts as the "gatekeeper." As the gatekeeper, the PCP is normally the individual from whom referrals must be obtained in order for the participant to receive covered healthcare from a participating specialist in the network.
Qualifying arrangement (small employer health insurance premium credit)	A **qualifying arrangement** is generally one under which the employer is required to pay a uniform percentage—at least 50%—of the premium for the employee enrolled in health insurance coverage.
Refundable tax credit	A **refundable tax credit** is a credit the taxpayer may receive even though he or she has no income tax liability.
Rescission	**Rescission** is the legal term generally applied to the unwinding of a contract such that the parties to the contract are in approximately the same position they were before entering into it.
Restricted annual benefit limit	**Restricted annual limits** may be imposed by a health plan during a three-year phase-in period—September 23, 2010 to January 1, 2014—on the dollar amount of benefits that are deemed to be essential health benefits of not less than specified amounts.
Small employer	A **small employer** is an employer who had fewer than 25 full-time equivalent employees for the tax year.
Small employer health insurance premium credit	The **small employer health insurance premium credit** is a nonrefundable tax credit for premiums paid for employee health insurance coverage.

Answers to Chapter Reviews

Chapter 1

Question #1 Answer

A. Your answer is incorrect. Pursuant to the provisions of the PPACA related to the patient protection provisions which address the choice of available healthcare professionals and the providing of certain emergency services do not apply to a grandfathered individual or group health plan. Please try again.

B. Your answer is correct. Certain provisions of the PPACA, including the prohibition of lifetime benefit limits and the provisions related to the rescission of health plan coverage apply to all group and individual health plans whether or not they are grandfathered.

C. Your answer is incorrect. Although the provisions concerning prohibition of pre-existing condition exclusions of the PPACA apply to group health plans, whether or not grandfathered, such provisions do not apply to grandfathered individual health insurance. Please try again.

D. Your answer is incorrect. Although the provisions of the PPACA related to lifetime benefit limits for essential health benefits apply to all coverage, whether or not grandfathered, the prohibition of annual benefit limits does not apply to grandfathered individual health insurance. Please try again.

Question #2 Answer

A. Your answer is incorrect. June 14, 2010 is the date of promulgation of the interim final regulations and has no relevance with respect to pre-existing condition exclusions. Please try again.

B. Your answer is incorrect. Certain provisions of the PPACA become effective for enrollees under age 19 in the first plan year on or after September 23, 2010. However, health plans are not required to provide coverage for medical treatment not generally provided under the plan at that time. Please try again.

C. Your answer is incorrect. In the first plan year on or after January 1, 2014 many of the important provisions of the PPACA become generally effective, including the provisions concerning pre-existing condition exclusions. However, coverage for medical treatment not generally provided under the plan will not be required at that time. Please try again.

D. Your answer is correct. A pre-existing condition exclusion means a limitation or exclusion of benefits based on the fact that the condition was present before the effective date of coverage. However, a health plan's exclusion of benefits for the diagnosis or treatment of a particular condition is not, in itself, a pre-existing condition exclusion. For an exclusion of benefits to be considered a pre-existing condition exclusion that would be prohibited under the PPACA, such benefits must meet two criteria: they must be benefits that are normally included in the plan and excluded from an individual's coverage because of a pre-existing condition. Although the PPACA provisions concerning pre-existing condition exclusions prohibit a health plan from imposing them, they do not require a plan to include benefits it chooses not to offer.

Question #3 Answer

A. Your answer is incorrect. The PPACA differentiates between benefits considered to be "essential health benefits" to which the proscription against the imposition of lifetime benefit limits applies and other benefits not considered essential. Please try again.

B. Your answer is incorrect. The $750,000 limit is an annual, rather than a lifetime, limit on benefits that health plans could implement on a transitional basis for plan years beginning on or after September 23, 2010 and before September 23, 2011. Please try again.

C. Your answer is incorrect. The $2 million limit is an annual, rather than a lifetime, limit on benefits that health plans may implement on a transitional basis for plan years beginning on or after September 23, 2012 and before January 1, 2014. Please try again.

D. Your answer is correct. The proscription of benefit limits applies only to those benefits considered *essential* under the law. One of the practical effects of prohibiting annual and lifetime limits only on essential health benefits is that a group health plan or health insurance issuer may generally impose such benefit limits—to the extent permitted by other federal or state law—on any benefits that are not included in the definition of "essential health benefits."

Question #4 Answer

A. Your answer is incorrect. Although the PPACA addresses the issue of health care coverage rescissions, it does not prohibit them. Please try again.

B. Your answer is incorrect. The PPACA, even though limiting the right to rescind health coverage does not require that rescissions occur only during the first year following the effective date of coverage. Please try again.

C. Your answer is incorrect. Even though the two-year contestable period generally limits the ability of an insurer to change or terminate issued health coverage to a period of not more than two years following the effective date of the policy, the provision is not applicable to permitted rescissions. Please try again.

D. Your answer is correct. Intentional misrepresentation is grounds for rescission of an individual health insurance policy at any time. Pursuant to the PPACA, coverage may be rescinded under a group health plan or under group or individual health insurance for fraud or intentional misrepresentation of a material fact even though any contestability period has expired. Accordingly, an insurer may rescind a health insurance policy at any time in the case of fraud or the intentional misrepresentation of a material fact contained in the application for coverage.

Question #5 Answer

A. Your answer is incorrect. Although the patient protection provision of the PPACA aimed specifically at females clearly relates to OB/GYN care, the law does not require every health plan using a network of healthcare providers to offer OB/GYN care. Please try again.

B. Your answer is incorrect. Certain of the patient protection provisions of the PPACA address the right of enrollees to designate a primary care provider. The PPACA, however, does not require a female enrollee to designate an OB/GYN professional as a primary care provider. Please try again.

C. Your answer is correct. The intent of the PPACA relative to OB/GYN care provided under a network plan is to ensure that such care may be accessed without the need for a specific referral. A health plan or insurer may not require authorization or referral for a female participant, beneficiary or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology.

D. Your answer is incorrect. The PPACA does not address cost-sharing arrangements in connection with the provision of OB/GYN care in health plans using a network of healthcare providers. Please try again.

Question #6 feedback

A. Your answer is incorrect. Only if a sponsoring organization decreases its contribution rate for participant coverage by *more than* five percentage points below the contribution rate for the period that includes March 23, 2010 will it cease to be a grandfathered health plan. However, it may decrease its contribution rate by 5 or fewer percentage points without jeopardizing its grandfathered status. Please try again.

B. Your answer is correct. A health plan's increase in the percentage level of coinsurance is deemed to significantly alter the level of benefits provided. Thus, any increase in the percentage cost-sharing requirement—an increase in coinsurance from 20% to 30%, for example—will cause a health plan or health insurance coverage to cease to be a grandfathered health plan.

C. Your answer is incorrect. Unlike certain other types of increases in cost-sharing requirements which will cause a health plan to lose its grandfathered status, limited increases in fixed amount cost-sharing requirements are permitted without loss of grandfathered status. Please try again.
D. Your answer is incorrect. Fixed amount copayments may be increased within certain limits without negatively affecting a grandfathered health plan's status. Please try again.

Question #7 feedback

A. Your answer is correct. For years beginning in 2014, insurers are required to accept all applicants for health coverage and are permitted to apply rating variations based only on age and tobacco use.
B. Your answer is incorrect. Although insurers have traditionally relied principally on a proposed insured's health history in determining insurability and premium levels, the PPACA prohibits consideration of those factors in underwriting the coverage beginning in 2014. Please try again.
C. Your answer is incorrect. Even though there is evidence of gender differences in both mortality and morbidity, the PPACA does not permit gender to be a factor considered in applying premium rate variations. Please try again.
D. Your answer is incorrect. Although occupation and hazardous recreational activities have traditionally been considered in underwriting health insurance, the PPACA prohibits their use in establishing premium costs. Please try again.

Question #8 feedback

A. Your answer is incorrect. That *is* required under the PPACA. The PPACA prohibits all health plans providing benefits for emergency services from requiring plan participants to obtain prior authorization for such services. Please try again.
B. Your answer is incorrect. Plans that involve a network of providers typically discourage participants from obtaining healthcare services from an out-of-network provider because of the additional costs involved in such out-of-network services by imposing additional limits on the benefits provided. However, such additional limitations may not apply to out-of-network emergency services. The PPACA prohibits all health plans providing benefits for emergency services from imposing benefit limitations on out-of-network emergency services that are not imposed on in-network emergency services. Please try again.
C. Your answer is correct. The PPACA requires all health plans providing benefits for emergency services to meet certain requirements. Plans covering such emergency services a) must not require individuals to obtain prior authorization for emergency services, b) must not impose additional requirements or benefit limitations on out-of-network emergency services and c) must not impose out-of-network cost-sharing requirements that exceed certain limits.
D. Your answer is incorrect. That *is* required under the PPACA. The PPACA prohibits all health plans providing benefits for emergency services from imposing additional requirements on out-of-network emergency services that are not imposed on in-network emergency services. Please try again.

Question #9 Answer

A. Your answer is incorrect. Although emergency services are considered essential health benefits under PPACA and must be included in coverage, they need not be provided on a first-dollar basis. Please try again.

B. Your answer is correct. Individuals younger than age 30 may meet the PPACA requirement to maintain minimum essential coverage through the purchase of a catastrophic plan. The catastrophic plan—also referred to as a "high deductible health plan"—must provide the essential health benefits required under the PPACA. However, the plan provides no benefits, other than coverage for at least three primary care visits and preventive care, for any plan year until the individual has incurred covered expenses at least equal to the applicable deductible.

C. Your answer is incorrect. The PPACA prohibits the imposition of pre-existing condition exclusions. However, the deductible applies to benefits for such pre-existing conditions provided under a catastrophic plan. Please try again.

D. Your answer is incorrect. Even though laboratory services must be provided since they are considered essential health benefits, a catastrophic plan's deductible applies to such services. Please try again.

Question #10 Answer

A. Your answer is incorrect. Even though the extended adult child coverage provision under PPACA became effective for plan years beginning on and after September 23, 2010, this date does not apply to Food Brokers, Inc. Please try again.

B. Your answer is incorrect. The requirement to extend dependent coverage to adult children younger than age 26 became effective in 2010 only for plans that provide dependent coverage; that date does not affect plans which do not provide such coverage. Please try again.

C. Your answer is incorrect. Although grandfathered group plans that provide dependent coverage must extended the dependent coverage to adult children younger than age 26 no later than 2014, that requirement does not extend to Food Brokers, Inc. Please try again.

D. Your answer is correct. Although plans that currently provide dependent coverage generally must extend the availability of dependent coverage to age 26, there is no requirement under PPACA that compels a plan or issuer to offer dependent coverage. Thus, a plan or issuer who does not currently offer dependent coverage is not required to offer it.

Chapter 2

Question #1 Answer

A. Your answer is incorrect. Hilary's withdrawal constitutes a nonqualified distribution, and, unless an exception applies, nonqualified distributions from an Archer MSA are subject to a penalty tax. A 15% penalty tax applied to nonqualified distributions from an Archer MSA prior to 2011. The penalty tax rate changed for nonqualified distributions made after 2011. Please try again.

B. Your answer is incorrect. Unless an exception applies, nonqualified distributions from Archer MSAs or Health Savings Accounts (HSAs) are subject to a penalty tax. Although a 10% penalty tax applied to nonqualified distributions from a Health Savings Account (HSA) prior to 2011, the rate changed for nonqualified distributions made after 2011. Please try again.

C. Your answer is correct. Hilary is not liable for a penalty tax because an exception to the penalty applies. The penalty tax for nonqualified distributions received prior to 2011 from an HSA was 10%; for similar nonqualified distributions from an Archer MSA before 2011, the penalty tax was 15%. For nonqualified distributions from an Archer MSA or HSA occurring in 2011 and later the penalty tax is increased to 20%. Although a nonqualified distribution is includible in income, the penalty tax does not apply to nonqualified distributions received after the account holder becomes disabled, dies or reaches the age of Medicare eligibility.

D. Your answer is incorrect. Although a 20% penalty tax rate applies to nonqualified distributions from an Archer MSA, Hilary's distribution is an exception to the tax. Please try again.

Question #2 Answer

A. Your answer is incorrect. The maximum contribution to a flexible spending account for medical expenses is not governed by a participant's maximum medical expenses. Thus, Phil's daughter's extraordinary medical expenses have no impact on the contribution. Please try again.

B. Your answer is correct. Beginning in 2013 PPACA imposes a $2,500 per year limit on the amount that may be contributed to a flexible spending account for medical expenses. That limit may be increased annually by a cost of living adjustment.

C. Your answer is incorrect. Although an employer may impose a limit on flexible spending account contributions, a $5,000 limit does not apply to such contributions for medical expenses made in 2013. Please try again.

D. Your answer is incorrect. While no dollar limit has traditionally applied to flexible spending account contributions, a limit applies to such contributions for medical expenses beginning in 2013. Please try again.

Question #3 Answer

A. Your answer is incorrect. Although neither Arthur nor his wife has an individual earned income that exceeds the threshold at which the additional HI tax applies, the threshold applies to their joint income. Please try again.

B. Your answer is incorrect. The additional HI tax only applies to the amount of earned income that exceeds the threshold for the taxpayer's filing status; it does not apply to the taxpayer's total income. Please try again.

C. Your answer is incorrect. Although the total HI component of the Social Security tax is increased to 2.35%, such increased percentage only applies to the amount of earned income exceeding the specified threshold amount. Please try again.

D. Your answer is correct. The additional tax on the taxpayers' earned income in excess of the applicable threshold amount is $450. ($50,000 x .9% = $450) Beginning in 2013 the PPACA imposes an additional HI tax of .9% on taxpayers' earnings exceeding the following amounts:
   - $200,000 for single taxpayers and heads of households;
   - $250,000 for married couples filing jointly (threshold applies to joint income amount) and surviving spouses; and
   - $125,000 for married couples filing separately.

Question #4 Answer

A. Your answer is correct. Helen has an additional tax liability resulting from the Medicare surtax of $380. The PPACA imposes a Medicare surtax on the *net investment income* of higher-income taxpayers. For years beginning after 2012, an additional tax is imposed at 3.8% on the lesser of the:
   - Taxpayer's net investment income; or
   - The taxpayer's modified adjusted gross income (MAGI) in excess of –
     - $200,000 for single taxpayers and heads of households;
     - $250,000 for married couples filing jointly (threshold applies to joint income amount) and surviving spouses; and
     - $125,000 for married couples filing separately.

   Since Helen's income subject to the surtax is $10,000 ($210,000 - $200,000 = $10,000), her additional tax liability is $380. ($10,000 x 3.8% = $380)

B. Your answer is incorrect. The Medicare surtax is applied to the lesser of the taxpayer's net investment income or the taxpayer's MAGI in excess of the applicable threshold which, in this case, is $200,000. Please try again.

C. Your answer is incorrect. The additional tax liability resulting from the PPACA's imposition of a Medicare surtax does not apply to the taxpayer's entire income. Rather, it applies to the lesser of the taxpayer's net investment income or the taxpayer's MAGI in excess of the applicable threshold. Please try again.

D. Your answer is incorrect. Helen's MAGI and net investment income clearly make her subject to additional tax liability resulting from the Medicare surtax. Please try again.

Question #5 Answer

A. Your answer is incorrect. Since the taxpayer is not exempt from the requirement to maintain minimum essential coverage, they are subject to a tax penalty for their failure to maintain the coverage. Please try again.

B. Your answer is correct. The minimum penalty for which Bob and Phyllis would be liable is $285. For each month during which a non-exempt taxpayer fails to maintain minimum essential coverage in 2014 the applicable penalty is equal to $1/12^{th}$ of the greater of a) $95 for each household member age 18 or older (up to 3) or b) 1% of household income for the taxable year in excess of the threshold amount for filing a tax return. Based on the PPACA

provisions, the minimum tax penalty for failing to maintain minimum essential coverage in 2014 for the entire year for a three-person family whose members are all at least 18 years old is $285. ($95 x 3 = $285)

C. Your answer is incorrect. If these taxpayers refused to maintain minimum essential coverage for all of 2015, the minimum penalty that would apply is $975. However, that is not the applicable penalty in 2014. Please try again.

D. Your answer is incorrect. The penalty your choice would have imposed is the penalty applicable in 2016. Thus, if Bob and Phyllis refused to maintain minimum essential coverage for all of 2016, the minimum penalty that would apply is $2,085. However, that is not the applicable penalty in 2014. Please try again.

Question #6 feedback

A. Your answer is incorrect. Although medical expenses have previously been deductible insofar as the total of such expenses exceeds 7.5% of the taxpayer's AGI, that threshold has changed for most taxpayers beginning in 2013. Please try again.
B. Your answer is correct. Arthur's medical expense deduction would be $1,000. Medical expenses have historically been deductible only to the extent the taxpayer's total medical expenses for the year exceed 7.5% of the taxpayer's adjusted gross income. For years beginning after December 31, 2012, a taxpayer younger than age 65 may deduct only the amount of medical expenses that exceed 10% of adjusted gross income.
C. Your answer is incorrect. The medical expenses are not deductible in their entirety. Medical expenses are deductible by a taxpayer who itemizes deductions only to the extent that such expenses exceed the applicable AGI threshold. Please try again.
D. Your answer is incorrect. Even though the PPACA has raised the AGI threshold for deduction of medical expenses, some of Arthur's medical expenses will be deductible. Please try again.

Question #7 feedback

A. Your answer is incorrect. Audrey's net investment income includes interest, dividends, capital gains, taxable annuity income, royalties and passive rental income. Please try again.
B. Your answer is correct. The additional tax on Audrey's net investment income is $646, which is 3.8% of her capital gains, interest and royalties. The investment income subject to the 3.8% additional tax imposed under the PPACA on high-income taxpayers does not include distributions from qualified plans or IRAs. However, net investment income includes interest, dividends, capital gains, taxable annuity income, royalties and passive rental income.
C. Your answer is incorrect. Although the additional tax for which Audrey is liable is based on various items of investment income, it is not levied on her traditional IRA distribution. Please try again.
D. Your answer is incorrect. The 3.8% additional tax imposed on the net investment income of certain high-income taxpayers is calculated on the *lesser* of the net investment income and the amount of the taxpayer's modified adjusted gross income in excess of the threshold. Since Audrey's net investment income is less than the amount by which her MAGI exceeds the applicable threshold, the tax is based on her net investment income. Please try again.

Question #8 feedback

A. Your answer is incorrect. Although the tax credit for which a taxpayer may be eligible can reduce the amount required to purchase a qualified health plan, a taxpayer whose household income is 100% of the federal poverty level is required to make some contribution towards the cost. Please try again.
B. Your answer is incorrect. Your choice would be correct only if the law imposed a 1% expected contribution on the taxpayer. Instead, under PPACA, the applicable percentage of the taxpayer's household income increases—from 2% of income for families at 100% of the federal poverty level to 9.5% of income for families at 400% of the federal poverty level—as the taxpayer's income increases. Please try again.
C. Your answer is correct. The taxpayer's expected contribution if he or she has a household income equal to 100% of the federal poverty level is 2% of such income; thus, the taxpayer's expected contribution in this case is $600. The expected contribution increases—from 2% of

income for families at 100% of the federal poverty level to 9.5% of income for families at 400% of the federal poverty level—as the taxpayer's income increases.

D. Your answer is incorrect. The taxpayer's expected contribution, as the term is used with respect to the tax credit, is a specified percentage of the taxpayer's household income. The applicable percentage of the taxpayer's household income increases—from 2% of income for families at 100% of the federal poverty level to 9.5% of income for families at 400% of the federal poverty level—as the taxpayer's income increases. Please try again.

Question #9 Answer

A. Your answer is incorrect. The additional 3.8% tax on a non-grant trust's undistributed net investment income applies only if the undistributed amount exceeds a specific threshold. Please try again.

B. Your answer is incorrect. For years beginning after 2012, an additional tax is imposed at 3.8% on the lesser of the taxpayer's net investment income or the taxpayer's modified adjusted gross income (MAGI) in excess of an applicable threshold amount. The threshold amount for married couples filing jointly is $250,000. However, that threshold amount does not apply to a trust's undistributed net investment income. Please try again.

C. Your answer is incorrect. The threshold amount at which the net investment income tax is imposed on single taxpayers and heads of household is $200,000. However, that threshold amount does not apply to a trust's undistributed net investment income. Please try again.

D. Your answer is correct. The additional tax to which estates and non-grantor trusts are subject is equal to 3.8% of the smaller of the estate's or trust's undistributed net investment income for the tax year or the excess of a) the estate's or trust's modified adjusted gross income for the tax year over b) the dollar amount at which the highest tax bracket begins for the tax year ($11,950 for 2013). Thus the additional 3.8% tax on estate's and trust's undistributed net investment income in 2013 is payable if the undistributed net investment income exceeds $11,950.

Chapter 3

Question #1 Answer

A. Your answer is incorrect. Assuming the various limitations on the health insurance premium credit do not reduce any applicable credit to zero, Food Brokers, Inc. would be eligible, as a small employer, for a credit in 2013. Please try again.

B. Your answer is incorrect. 25% is the maximum health insurance premium credit available in 2013 to a tax-exempt small employer; Food Brokers, Inc., however, is a for-profit organization to which that percentage does not apply. Please try again.

C. Your answer is correct. As a for-profit small employer organization in 2013, Food Brokers, Inc. could be eligible for a 35% tax credit. The maximum small employer health insurance premium credit available to eligible small employers for tax years 2010 through 2013 is 35% of workers' healthcare premiums paid by small employers and 25% of such premiums paid by small tax-exempt employers, such as charities. In 2014, the maximum tax credit increases to 50% and 35%, respectively.

D. Your answer is incorrect. The maximum tax credit of 50% is not available to for-profit small employers until 2014. Please try again.

Question #2 Answer

A. Your answer is correct. Burger Barn must pay at least $2,500 each month to qualify for the credit. In order for an employer to be eligible to receive the small employer health insurance premium credit the employer must pay employee health insurance premiums *under a qualifying arrangement*. Although certain variations may be qualifying arrangements under the PPACA, a "qualifying arrangement" is generally one under which the employer is required to pay a uniform percentage—at least 50%—of the premium for the employee enrolled in health insurance coverage.

B. Your answer is incorrect. Although Burger Barn may elect to pay the entire employee monthly premium for health insurance coverage, it is not required to do so in order to qualify for the health insurance premium credit. Please try again.

C. Your answer is incorrect. You answer suggests that the employer would be required to pay part of the premium for family coverage. However, Burger Barn is not required to pay any part of the premium for dependent coverage to qualify for the credit. Please try again.

D. Your answer is incorrect. A small employer need not pay all of the premium nor any part of the premium for dependent coverage to qualify for the credit. Please try again.

Question #3 Answer

A. Your answer is incorrect. While the hours of full-time employees must be counted towards the number of full-time equivalent employees, the hours of other employees must also be counted. Please try again.

B. Your answer is correct. Arthur's business has 9 full-time equivalent employees (FTEs) for purposes of the small employer health insurance premium credit. A small employer will have 1 FTE for each 2,080 hours worked by an individual considered an employee. However, employees possessing certain ownership interests in a small employer as well as their family and household members are not considered employees of the employer for purposes of the credit. Accordingly, the hours worked, wages received and premiums paid for them are not counted when figuring the credit. In this case, the hours of the four full-time employees are combined with the hours of the 10 part-time employees to produce 18,720 hours which, divided by 2,080, results in 9 full-time equivalent employees. (18,720 ÷ 2,080 = 9)

C. Your answer is incorrect. The hours of the part-time employees are counted when computing the number of full-time equivalent employees employed by a small employer. Please try again.

D. Your answer is incorrect. Although Arthur works a substantial number of hours, his hours are not counted towards the small employer FTEs because he is the business owner. Please try again.

Question #4 Answer

A. Your answer is incorrect. The stability period, during which a large employer is required to provide health insurance coverage to a new employee, must be at least 6 months but may be longer depending on the length of the initial measurement period. Please try again.

B. Your answer is incorrect. Although the employer could impose a 6 month stability period if its initial measurement period was 6 months or less, the length of Big Brokers, Inc's initial measurement period makes that option unavailable to Big Brokers, Inc. Please try again.

C. Your answer is incorrect. The period during which a large employer is required to provide health insurance coverage to a new employee who it determines must be covered, is required to be at least 6 months in duration. However, the length of that period may be affected by the length of the initial measurement period. Please try again.

D. Your answer is correct. Big Brokers, Inc. must provide coverage for at least 12 months to the new employee or risk a penalty. The stability period, during which a large employer is required to provide health insurance coverage to a new employee, must be a period at least as long as the longer of 6 months or the length of the initial measurement period. Since the initial measurement period is 12 months, that is the minimum duration of the stability period in this case.

Question #5 Answer

A. Your answer is incorrect. MegaRetail is liable for a tax penalty for its failure to comply with the shared responsibility provisions of the PPACA. Please try again.

B. Your answer is incorrect. Although only three full-time employees of the large employer obtained health insurance through a state exchange and received a premium tax credit, the tax penalty is applied based on the total number of employees in excess of 30. Please try again.

C. Your answer is correct. The employer is liable for a monthly tax penalty of $6,667. A large employer who does not offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan is subject to a penalty under the PPACA if one or more of its full-time employees is certified to the employer as being enrolled in health insurance coverage obtained through a state exchange and having received a premium tax credit or cost-sharing reduction. The penalty for which the employer is liable for any month is an amount equal to the number of its full-time employees in excess of 30 multiplied by 1/12th of $2,000. Thus, the penalty is equal to 70 - 30 = 40; 40 x $2,000/12 = $6,667.

D. Your answer is incorrect. Your answer suggests the tax penalty in this case would be calculated on the basis of all 70 full-time employees. Instead, the tax penalty for a large employer's failure to provide health insurance coverage to full-time employees is figured based on the total number of employees in excess of 30. Please try again.

Question #6 feedback

A. Your answer is correct. Food Brokers would have no liability under the PPACA. Employers with 25 full-time employees but fewer than 50 full-time employees are unaffected by either the tax credits available to small employers for providing employee health coverage or the tax penalties to which large employers could be liable for failing to provide it.
B. Your answer is incorrect. Food Brokers would be liable for $1,667, given the facts of the question, if it was considered a large employer. However, since it has fewer than 50 full-time employees, it does not qualify as a large employer. Please try again.
C. Your answer is incorrect. Employers with fewer than 50 full-time employees are unaffected by the tax penalties to which large employers could be liable for failing to provide employee health coverage. Please try again.
D. Your answer is incorrect. Although Food Brokers, Inc. is not a small employer since it employs more than 25 employees, neither is it a large employer. Since it is not a large employer under PPACA, it would not be subject to the tax penalty for failing to provide coverage. Please try again.

Question #7 feedback

A. Your answer is incorrect. The maximum small employer health insurance premium credit available to eligible small employers for tax years 2010 through 2013 is 35% of workers' healthcare premiums paid by small employers and 25% of such premiums paid by small tax-exempt employers, such as charities. Please try again.
B. Your answer is incorrect. The employer would be eligible for a $21,000 tax credit if it was a for-profit entity. Since it is a tax-exempt organization it would not qualify for the applicable 35% credit. Please try again.
C. Your answer is correct. The charitable organization would be eligible for a tax credit of $15,000. The maximum small employer health insurance premium credit available to eligible small employers for tax years 2010 through 2013 is 35% of workers' healthcare premiums paid by small employers and 25% of such premiums paid by small tax-exempt employers, such as charities.
D. Your answer is incorrect. Based on the facts given, the employer is a small employer and would be eligible for a tax credit. Please try again.

Question #8 feedback

A. Your answer is incorrect. Although large employers are required to offer full-time employees and their dependents healthcare coverage, the employees may be required to pay some part of the premium for the coverage. Please try again.
B. Your answer is correct. An employee whose monthly household income is $4,000 is not normally required to pay more than $380 monthly for the coverage. Pursuant to the PPACA's provisions, an applicable large employer is required to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. Full-time employees must generally be asked to pay no more than 9.5% of their household income for coverage.
C. Your answer is incorrect. The PPACA requires an applicable large employer to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage

under an eligible employer-sponsored plan. Full-time employees must generally be asked to pay no more than a specified percentage of their household income for coverage. The percentage, however, is not 12.5% as your answer would suggest. Please try again.

D. Your answer is incorrect. Pursuant to the PPACA's provisions, an applicable large employer must offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. Full-time employees may be required to pay a percentage of their household income for coverage. The percentage you have chosen is higher than required. Please try again.

Question #9 Answer

A. Your answer is incorrect. Although employers filing fewer than 50 Forms W-2 are not required to report the cost of coverage, even employers filing a greater number of Forms W-2 are affected by the transition relief. Please try again.

B. Your answer is correct. The requirement to report the cost of coverage will not apply for calendar years after2012 until the IRS publishes guidance giving at least six months of advance notice of any change to the transition relief. The transition relief from reporting the cost of coverage on employees' W-2 forms applies to employers filing fewer than 250 Forms W-2 for the previous calendar year. For purposes of this relief, the number of W-2 forms the employer files is deemed to include the forms it files itself and any filed on its behalf by an agent under §3504, but the aggregation rules do not apply.

C. Your answer is incorrect. The transition relief applicable to reporting the cost of coverage does not apply to an employer that filed fewer than 500 Forms W-2. Please try again.

D. Your answer is incorrect. The transition relief applicable to reporting the cost of coverage does not apply to an employer that filed fewer than 1,000 Forms W-2. Please try again.

Question #10 Answer

A. Your answer is correct. An applicable large employer must furnish to each full-time employee whose information is required to be reported, no later than January 31st following the calendar year, a written statement that includes a) the employer's name and address, b) the employer's contact information, including a contact telephone number, and c) the information relating to coverage provided to that employee and his or her dependents that is required to be reported on the employer's return.

B. Your answer is incorrect. An applicable large employer's requirement to furnish health plan coverage information does not require notification every five years. Please try again.

C. Your answer is incorrect. Although an applicable large employer is required to furnish a health plan coverage statement periodically, it is not required to provide such a statement upon request. Please try again.

D. Your answer is incorrect. While an employer would normally provide a written statement of health plan coverage upon initial participation and when changes are made, its requirement under the PPACA requires periodic statements. Please try again.

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Appendix A

Form **8941** Department of the Treasury Internal Revenue Service	**Credit for Small Employer Health Insurance Premiums** >Attach to your tax return. >Information about Form 8941 and its separate instructions is at www.irs.gov/form8941.	20**12**

Name(s) shown on return	Identifying number

1a	Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (see instructions)	1a		
b	Enter the employer identification number (EIN) used to report employment taxes for individuals included on line 1a (see instructions)	b		
2	Enter the number of full-time equivalent employees you had for the tax year (see instructions). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12.	2		
3	Average annual wages you paid for the tax year (see instructions). If you entered $50,000 or more, skip lines 4 through 11 and enter -0- on line 12.	3		
4	Premiums you paid during the tax year for employees included on line 1a for health insurance coverage under a qualifying arrangement (see instructions)	4		
5	Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which you offered health insurance coverage (see instructions)	5		
6	Enter the **smaller** of line 4 or line 5	6		
7	Multiply line 6 by the applicable percentage: • Tax-exempt small employers, multiply line 6 by 25% (.25) • All other small employers, multiply line 6 by 35% (.35)	7		
8	If line 2 is 10 or less, enter the amount from line 7. Otherwise, see instructions	8		
9	If line 3 is $25,000 or less, enter the amount from line 8. Otherwise, see instructions	9		
10	Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions)	10		
11	Subtract line 10 from line 4. If zero or less, enter -0-	11		
12	Enter the **smaller** of line 9 or line 11	12		
13	If line 12 is zero, skip lines 13 and 14 and go to line 15. Otherwise, enter the number of employees included on line 1a for whom you paid premiums during the tax year for health insurance coverage under a qualifying arrangement (see instructions)	13		
14	Enter the number of full-time equivalent employees you would have entered on line 2 if you only included employees included on line 13	14		
15	Credit for small employer health insurance premiums from partnerships, S corporations, cooperatives, estates, and trusts (see instructions)	15		
16	Add lines 12 and 15. Cooperatives, estates, and trusts, go to line 17. Tax-exempt small employers, skip lines 17 and 18 and go to line 19. Partnerships and S corporations, stop here and report this amount on Schedule K. All others, stop here and report this amount on Form 3800, line 4h	16		
17	Amount allocated to patrons of the cooperative or beneficiaries of the estate or trust (see instructions)	17		
18	Cooperatives, estates, and trusts, subtract line 17 from line 16. Stop here and report this amount on Form 3800, line 4h	18		
19	Enter the amount you paid in 2012 for taxes considered payroll taxes for purposes of this credit (see instructions)	19		
20	Tax-exempt small employers, enter the **smaller** of line 16 or line 19 here and on Form 990-T, line 44f	20		

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