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The Healthcare Playbook

A Small Business Guide to the
Patient Protection and
Affordable Care Act (PPACA)

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**The Healthcare Playbook:
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The Patient Protection and Affordable Care Act (PPACA) Timeline

When the president signed the healthcare bill into law, the clock started to tick on a variety of changes. Whether it is new taxes or new mandated requirements on health insurance purchased in the small group and individual insurance markets, this timeline provides a quick glance at changes that can be expected in coming years.

2014

- A **temporary small business tax credit** is available for two years for certain small businesses that provide qualified health coverage. The rules include:
 - Only firms with 10 or fewer employees receive the full credit. For firms with 11 to 25 employees, the credit is reduced. Firms with more than 25 employees are ineligible for the credit.
 - Only firms that pay their workers an average wage of \$25,000 or less are eligible for the full credit. The credit is reduced as the average wage goes up, phasing out at \$50,000.
 - Only firms covering 50 percent or more of insurance costs will be eligible.
 - Health insurance coverage must be purchased in a Small Business Health Options Program (SHOP) exchange.
- **Employers must distribute the Notice of Coverage Options to new employees** within 14 days of the employees' start date. The Notice of Coverage Options document is a written notice describing an employer's health insurance offerings and/or exchange availability:
 - Informing the employee of the existence of an exchange, description of exchange services, and exchange contact information; and
 - Notifying the employee if the employer's plan is below the minimum value threshold (60 percent actuarial value).
- **Employers must determine business size**, whether they will be considered "large" or "small," for the requirements of the employer mandate. Penalties will not occur until 2015, but a large employer is defined as an employer who employed an average of at least 50 full-time equivalent (FTE) employees on business days during the preceding calendar year. For 2015, the preceding calendar year is 2014. Size is determined monthly by adding the number of full-time employees to the number of FTE employees.
- **Full-time employees** are individuals who have worked an average of 130 or more monthly hours (30 hours per week).
- **New counting requirements for part-time and seasonal employees:** Part-time and seasonal employees' hours will be converted into FTE employees for determination of employer size. Total monthly part-time and seasonal hours must be added together and divided by 120. For example, if six employees each work twenty hours per month, they will count as if the firm had one additional FTE employee.
- **Large employers must determine whether employees are full-time employees:** Once a small-business owner has determined their business is "large," they may track actual monthly hours or utilize a look-back period of 3–12 months to determine whether employees' average hours exceeded 130 hours per month (30 hours per week).
- Filing occurs for a **new 3.8 percent tax** on investment income for higher-income taxpayers for tax year 2013.
- **An \$8 billion small business health insurance tax** will begin on the fully insured market, where the majority of small businesses purchase insurance.
- **Health insurance exchanges** begin offering coverage to qualified individuals and qualified small businesses with no more than 50 employees. Open enrollment for 2014 ends on March 31, 2014. Open enrollment for 2015 will begin on November 15, 2014.
- **Premium tax credits and subsidies kick in**, and the federal government begins subsidizing the purchase of health insurance for individuals with incomes below 400 percent of the federal poverty level.
- **All individual and small group health insurance policies** must provide an Essential Health Benefits package, a comprehensive list of ten broad benefit mandates and service categories.
- **Individual mandate penalty tax begins.** Most individuals without minimum essential coverage by March 31, 2014 are subject to a penalty tax. Individual mandate penalty tax begins at \$95 or 1 percent of household income above the filing threshold, whichever is greater.

- **Remaining insurance reforms take effect**, and insurers cannot impose coverage restrictions based on pre-existing conditions. Modified community rating standards go into effect for individual or small business coverage based on geography, age, and smoking status. The law also limits out-of-pocket deductibles and cost-sharing.

2015

- **Employer mandate begins**, requiring large businesses to offer health insurance or pay penalties. The penalties are based on the number of full-time employees during the preceding calendar year; whether the firm offers coverage to full-time employees; whether coverage is “affordable” and meets “minimum value;” and whether one or more full-time employees qualify for a federal premium subsidy. A full-time employee qualifies for a subsidy if his or her household income is between 100 and 400 percent of the federal poverty level and the employee’s share of the self-only portion of the premium exceeds 9.5 percent of their taxable income. Taxable income can be found in Box 1 of an employee’s W-2 form. Here are some scenarios:
 - **More than 50 FTE employees and the business does not offer insurance to the full-time employees**, with one or more full-time employees receiving premium subsidies because their income falls between 100 percent and 400 percent of the federal poverty level. The penalty is \$2,000 per full-time employee (minus 30 full-time employees).
 - **More than 50 FTE employees and the business offers insurance**, with one or more full-time employees receiving premium subsidies because their share of the self-only portion of the premium exceeds 9.5 percent of their income. The penalty is the lesser of \$3,000 per subsidized full-time employee or \$2,000 per full-time employee (minus 30 full-time employees).
 - **More than 50 FTE employees and the business offers insurance**, with no full-time employees receiving premium subsidies. There is no penalty on the employer. All non-grandfathered and exchange health plans are required to meet federally mandated minimum value standard.
 - **Fewer than 50 FTE employees**: No penalty or requirement to offer insurance. Those who qualify for the small employer tax credit must purchase a plan from the SHOP exchanges. If an employer chooses to offer health insurance, it must cover the Essential Health Benefits package.
- **Small business health insurance tax rises to \$11.3 billion.**
- **Individual mandate tax penalty** increases to \$325 or 2 percent of income above the filing threshold, whichever is greater.
- Open enrollment for coverage **in health insurance exchanges** for 2015 ends on January 15, 2015.
- **Small business (SHOP) health insurance exchanges** must provide more employer health insurance offering opportunities including:
 - Employer choice - allowing employers to choose multiple health insurance plans from which employees may select.
 - Employee choice - allowing employers to choose a metallic coverage level from which employees may choose any plan from any insurer within the coverage level.

2016

- **Large employers must report and verify** the offer of affordable and adequate coverage to employees by January 28, 2016 and to the IRS by February 28, 2016 (March 31, 2016 if submitted electronically).
- **Small business health insurance tax remains \$11.3 billion.**
- **Individual mandate tax penalty** increases again, to \$695 or 2.5 percent of income above the filing threshold, whichever is greater.
- **Small business (SHOP) health insurance exchanges** must open up to businesses with up to 100 employees.
- **Small group market definition** increases to businesses with up to 100 employees, making more businesses subject to the Essential Health Benefits package and all other insurance market reforms.

2017

- **Brand-name drug tax** rises to \$3.5 billion.
- **Small business health insurance tax** increases to \$13.9 billion.
- **Individual mandate tax penalty** is based on 2016 levels and will rise according to a cost-of-living adjustment.

- **States and the federal government** may allow large employers with 100 or more employees to enter the SHOP exchanges.

2018

- **Cadillac tax** begins on high-cost health insurance plans with an aggregate value that exceeds threshold amounts of \$10,200 for individual coverage and \$27,500 for family coverage.
- **Brand-name drug tax** rises to \$4.2 billion.
- **Small business health insurance tax rises to \$14.3 billion.**
- **Individual mandate tax penalty** is based on 2016 levels and will rise according to a cost-of-living adjustment.

PPACA Mandates

Minimum Essential Coverage and the Individual Mandate Tax

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) requires nearly all individuals to demonstrate and maintain proof of “minimum essential coverage,” which includes: qualified employer-sponsored health insurance plans, qualified plans purchased in the individual market, government-sponsored health insurance programs (e.g., Medicare, Medicaid), and grandfathered individual and group health plans.

Failure to demonstrate and maintain minimum essential coverage by March 31, 2014 will leave an individual subject to the individual mandate tax. For an individual, the tax begins in 2014 and will be \$95 or 1 percent (whichever is greater) of household income above the filing threshold. In 2015, it rises to \$325 or 2 percent above the filing threshold. In 2016, it reaches \$695 or 2.5 percent above the filing threshold. (For families, the figure will be \$2,085 in 2016.) After 2016, the amount will rise annually by a cost-of-living adjustment.

Employer Mandate Penalties

Beginning in 2015, the healthcare law requires “large” employers—businesses with 50 or more full-time or full-time equivalent (FTE) employees—to either offer minimum essential coverage to full-time employees and their dependents or pay a penalty tax. If a “large” employer *does not* offer minimum essential coverage to full-time employees and their dependents, and one or more full-time employees claim a subsidy on the individual exchange (income between 100 and 400 percent of the federal poverty level), then the employer will be subject to a \$2,000 per full-time employee penalty (minus 30 full-time employees). Dependents are defined as children up to age 26. Spouses are not considered dependents.

If a “large” employer *does* offer minimum essential coverage to full-time employees and their dependents, but it is deemed unaffordable (self-only premiums exceed 9.5 percent of employee income) or not of minimum value (60 percent actuarial value) for certain full-time employees, then the employer will be subject to the lesser of a \$3,000 penalty for those certain full-time employees or \$2,000 per full-time employee (minus 30 full-time employees).

The employer mandate was originally scheduled to begin in 2014, but guidance from the Treasury Department delayed the reporting requirements and penalties by one year to 2015.

Full-Time Employees

PPACA defines a full-time employee as an individual who is employed an average of at least 130 hours per month (30 hours per week).

Large employers may determine current employees’ full-time status by looking back at a standard measurement period of not less than three but not more than twelve consecutive months to determine whether the employee averaged at least 130 hour of service per month (30 hours per week).

Large employers must then offer minimum essential coverage to full-time employees and their dependents for a corresponding 6-12 month stability period if an employee averages full-time hours during the look-back measurement period. If an employer chooses not to offer minimum coverage to full-time employees and their dependents, they will pay employer mandate penalties, which will be calculated monthly.

Part-time employees

Part-time employees’ hours will be converted into FTE employees for the purpose of determining whether the employer is a large employer subject to the employer mandate. Conversion is done by adding up all monthly hours worked by employees who are not full-time and dividing the total by 120. For example, if 6 part-time employees each work 20 hours per month, they will count as if the firm has one additional FTE employee, calculated monthly (6 employees x 20 hours per month= 120 monthly hours/120 = 1 FTE employee).

Large employers will not be required to offer minimum essential coverage to part-time employees, but part-time employee hours will be used to determine whether the employer is large and subject to the employer mandate.

Seasonal Employees

Seasonal worker hours will count toward an employer's FTE monthly total. An employer is not considered "large" (and thus, subject to the employer mandate) if the employer has 50 FTE employees for 120 days (or 4 calendar months) or fewer during a calendar year. This situation is known as the seasonal worker exception. The Internal Revenue Service (IRS) and Department of Labor (DOL) will provide further guidance through the regulatory process to determine who is deemed to be a seasonal worker. Through at least 2014, employers are permitted to use a "reasonable, good faith interpretation" of the term seasonal employee.

How Will the Employer Mandate Affect Your Business?

How the employer mandate affects a particular business depends on a number of factors, including:

1. The number of full-time employees (or part-time and seasonal employees counted as FTEs; see the section [Part-time Employees](#)); http://nfib.com/business-resources/healthcare/mandates#Part-time_employee_counting_requirements
2. whether the business offers minimum essential coverage to full-time employees and dependents; and
3. whether one or more employees qualify for and claim government subsidies toward the purchase of health insurance in the individual exchange. An employee qualifies for a subsidy in the individual exchange if his or her required contribution for the self-only health insurance premium exceeds 9.5 percent of taxable income or if the insurance does not meet the 60 percent minimum value threshold.

Here are some scenarios:

Large Non-Offering Firms:

- 50 or more FTE employees.
- Does not offer minimum essential coverage to full-time employees and dependents. One or more full-time employees receive premium subsidies.
- Penalty = \$2,000 per full-time employee (minus 30 full-time employees).
- For example, in 2015, Employer A has 100 full-time employees and does not offer health insurance coverage to full-time employees, 10 of whom receive a premium subsidy for the year for enrolling in an individual exchange. Employer A owes \$2,000 per full-time employee (minus 30 full-time employees), for a total penalty of \$140,000 (100 full-time employees – 30 full-time employees = 70, multiplied by \$2,000 each). This penalty is assessed on a monthly basis.

Small Non-Offering Firms:

- Fewer than 50 FTE employees.
- Does not offer minimum essential coverage to full-time employees.
- No penalty.

Large Offering Firms (coverage "unaffordable" or not meeting "minimum value"):

- 50 or more FTE employees and offers minimum essential coverage to full-time employees.
- One or more full-time employees receiving premium subsidies because premiums exceed 9.5 percent of taxable income affordability test or no health insurance policies offered meet the 60 percent minimum value test.
- Penalty equals the lesser of \$3,000 per subsidized full-time employee or \$2,000 per full-time employee (minus 30 full-time employees).
- For example, in 2015, Employer B has 100 full-time employees and offers health coverage to full-time employees, 20 of whom receive a tax credit for the year for enrolling in an individual exchange because their contribution to the self-only premiums exceed 9.5 percent of their taxable income. For each employee receiving a tax credit, the employer owes \$3,000, for a total penalty of \$60,000 (20 full-time employees x \$3,000). The maximum penalty for Employer B is capped at the penalty amount that it would have been assessed for a failure to provide minimum essential coverage to full-time employees, or \$140,000 (\$2,000 multiplied by 70 (100-30)). Since the calculated penalty of \$60,000 is less than the maximum amount, Employer B pays the lesser \$60,000 penalty. This penalty is assessed on a monthly basis.

Large Offering Firms (“affordable” coverage that meets “minimum value”):

- 50 or more FTE employees.
- Offers minimum essential coverage to full-time employees that passes both “affordability” and “minimum value” tests.
- Has no full-time employees receiving premium subsidies.
- No penalty on employer.

Other Factors Affecting “Large” Employers Subject to the Employer Mandate:

- **Auto-Enrollment:** Beginning in 2015, employers with more than 200 employees will be required to auto-enroll employees in the employer’s health insurance coverage, though the employee may opt out. Auto-enrollment was scheduled to occur in 2014, but guidance from the Department of Labor has indicated this auto-enrollment requirement will be delayed beyond 2014.
- **W-2 Reporting Requirements:** Beginning in 2013, businesses with more than 250 employees must report the aggregate cost of health insurance coverage under an employer-sponsored group health plan in Box 12 (using code DD) of an employee’s W-2 form. The amount reported should include both the portion paid by the employer and the portion paid by the employee. Businesses with fewer than 250 employees have transition relief from this increased employer reporting requirement until the IRS issues further regulations.

Factors Affecting All Employers Offering Health Insurance, Whether or Not Businesses are Subject to the Employer Mandate:

Individual and Small Group Market Changes

There are many changes being made in the individual and small group marketplaces for health insurance (both inside and outside of exchanges). The small group market is currently defined as 1–50 or 2–50 employees in every state. In 2016, the small group market will increase to businesses with up to 100 employees in every state.

These markets have historically been regulated at the state level. Currently, differences exist in how the individual market and small group market function in each state. The state rules dictate how insurers can determine their expected costs, and therefore, price your premium. The changes created by the healthcare law will adjust these differences, making the two marketplaces more similar, and will shift much of insurance regulation from state governments to the federal government.

Nondiscrimination Requirements

Employers cannot provide more generous health insurance benefits or higher employer contributions to highly-compensated employees. This prohibition was supposed to begin in 2010, but was delayed. It will not be enforced until the IRS issues further regulations.

Essential Health Benefits

Beginning in 2014, all non-grandfathered individual and small group market health insurance plans must cover a broad list of ten mandated benefit categories known as Essential Health Benefits. The Department of Health and Human Services (HHS) has mandated that states choose base-benchmark plans for transition years 2014-2015 from a limited menu of options or HHS will select the largest small group plan in the state as the default base-benchmark plan.

Section 1302 of the PPACA specifies that all plans meeting Essential Health Benefits requirement will include at least the following categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- 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
- Pediatric services, including oral and vision care

No base-benchmark plans cover all Essential Health Benefit categories. Thus, all base-benchmark plans must be supplemented with additional services to comply with the law. The more costly supplemented plans will be known as Essential Health Benefit-Benchmark Plans.

The Secretary of the HHS will be allowed to review and update the Essential Health Benefits package annually beginning in January 2016. Also in 2016, the small group market will expand to businesses with up to 100 employees, forcing more businesses to comply with the Essential Health Benefits package.

Prohibition from Offering Stand-Alone Health Reimbursement Arrangements (HRAs)

Beginning in 2014, employers can no longer offer stand-alone health reimbursement arrangements (HRAs) that allow employees tax-free funds to purchase health insurance in the individual market. The Department of Labor (DOL), Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) issued regulations requiring HRAs to be integrated with group health insurance coverage (such as a high-deductible health plan). Employers can provide employees with funds to purchase health insurance on the individual market, but it must now be considered taxable income.

Waiting Period Limitations

Beginning in 2014, there are extra penalties for businesses that have a waiting period exceeding 90 days before full-time employees are eligible for minimum essential coverage. Waiting period limitations apply to all group coverage, not just large employers.

Prohibition of Annual and Lifetime Limits

Beginning on September 23, 2010, new plans were prohibited from placing annual and lifetime limits on the dollar value of coverage. For example, some policies previously had a \$1 million dollar lifetime cap on the amount an insurance company will pay out on a policy. The prohibition on lifetime limits took full effect on January 1, 2014. The new rules on lifetime limits will apply to all plans. The rules on annual limits will apply to all plans, except for individual market plans that maintain grandfathered status.

Annual Limitations on Out-of-Pocket Spending

Beginning in 2014, there are limits on annual cost sharing for in-network services, and they are tied to current Health Savings Account (HSA) maximum out-of-pocket limits (for 2014, the limits are \$6,350 for individuals and \$12,700 for families).

Separate plan service providers may impose different levels of out-of-pocket spending maximums. For example, a major medical coverage insurer may have one maximum and a prescription drug plan may have a separate maximum.

Dependent Coverage

Beginning on September 23, 2010, all employers that offer dependent coverage were required to provide dependent coverage for children up to age 26.

Coverage of Preventive Services

Beginning on September 23, 2010, all non-grandfathered plans were required to provide 100 percent coverage (no cost-sharing – deductibles or co-pays) for:

- Items or services with an "A" or "B" rating in the [current recommendations](#) of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
- Preventive care and screening for women provided for in guidelines supported by HRSA.

Deductible Limits

Beginning in 2014, deductibles in the small group marketplace (50 or fewer employees) will be limited to \$2,000 for individuals and \$4,000 for families. Deductible limits may be exceeded if a health insurance plan cannot reasonably reach the 60 percent minimum actuarial value standard without exceeding the deductible limits.

If an employer contributes to an employee's Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), then the deductible limit may be increased by the contribution amount. For example, if an employer contributes \$1,000 to an individual's HSA, that employee's deductible may be increased to \$3,000.

Minimum Value

Beginning in 2014, all non-grandfathered health insurance plans must meet a 60 percent minimum actuarial value standard. Actuarial value is the amount of expected healthcare expenses that health insurance plans must cover. Enrollees are responsible for the remaining costs in the form of deductibles, coinsurance, and co-pays. Annual employer contributions to Health Savings Accounts (HSAs) and amounts made available under Health Reimbursement Arrangements (HRAs) for the current year will count toward the actuarial value threshold.

Insurance Rating Reforms

In 2014, all plans in the individual and small group markets (both inside and outside of exchanges) will be required to have guaranteed issue and renewability.

Premiums may only vary by:

- Age (3:1 maximum)
- Tobacco (1.5:1 maximum)
- Geographic rating area
- Individual or family coverage (family size)

PPACA Tax Information

Small Business Health Insurance Tax Credit

A temporary tax credit is available for certain small businesses that provide qualified health insurance. The maximum credit equal to 35 percent of the employer contribution was available from 2010 to 2013. Beginning in 2014, a 50 percent credit is available for an additional two years, if the small business purchases health insurance through a Small Business Health Options Program (SHOP) health insurance exchange. The business must pass a series of tests to determine if they qualify and how much credit they may receive. Businesses with 10 or fewer employees paying \$25,000 or less in average wages are potentially eligible for the full credit. Businesses with between 11 to 24 employees and average annual wages of less than \$50,000 may be eligible for some credit. Businesses with 25 or more employees and/or \$50,000 in average annual wages are not eligible for any credit. Employers must contribute at least 50 percent toward employees' health insurance premiums.

The rules and calculations to determine eligibility for the credit are complicated. The tax credit can be claimed using Form 8941.¹ There are a number of tools to help you determine if you receive a credit and how much it is worth. Also, please be sure to consult an accountant or tax professional to determine your eligibility.

- **NFIB background information on the small business health insurance tax credit**
<http://www.nfib.com/advocacy/item?cmsid=51232>
- **NFIB tax credit calculator**
<http://www.nfib.com/advocacy/healthcare/credit-calculator>
- **IRS guidance on the tax credit**
<http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>

Tanning Salon Tax

On July 1, 2010, a 10 percent tax was imposed on certain indoor tanning services. Specifically, the tax applies to the use of tanning devices utilizing ultraviolet lamps. Certain businesses, such as qualified physical fitness facilities, were exempt. The tax was collected from the purchases of tanning services and remitted quarterly to the IRS on a Form 720.²

Brand-Name Drug Tax

In 2011, the manufacturers and importers of brand-name prescription drugs began paying an annual tax based on their share of the total brand-name drug market.

Flexible Spending Account (FSA) Limitations Under Cafeteria Plans

FSAs are a qualified benefit that may be offered to employees under a cafeteria plan. Beginning in 2013, for an FSA to qualify as a benefit under a cafeteria plan, the maximum amount available for reimbursement cannot exceed \$2,500. A cafeteria plan that includes an FSA that exceeds the maximum limitation will fail to qualify as a cafeteria plan.

Increased Penalty for Non-Qualified Distributions from Health Savings Accounts (HSAs)

Distributions from an HSA can only be used for qualified medical expenses and a nonqualified distribution is subject to a penalty. The penalty for making nonqualified distributions from an HSA increased from 10 percent to 20 percent in 2011.

Cafeteria Plan Safe Harbor Rules

In 2011, the application of nondiscrimination rules did not apply to cafeteria plans established by certain small businesses. Cafeteria plans were subject to nondiscrimination rules to ensure that benefits were not disproportionately allocated to highly compensated employees. Many smaller businesses struggled to meet the nondiscrimination tests because of the employee size calculation in the test.

¹ For copies and instructions of Form 8941 visit <http://www.irs.gov/uac/Form-8941,-Credit-for-Small-Employer-Health-Insurance-Premiums>

² For IRS guidance and copies of Form 720 visit <http://www.irs.gov/businesses/small/article/0,,id=224600,00.html>

An eligible small employer is provided a safe harbor from the nondiscrimination rules if the cafeteria plan satisfies minimum eligibility and participation requirements and minimum contribution requirements. An eligible small employer is an employer who employed an average of 100 or fewer employees during either of the two preceding years. A cafeteria plan satisfies the eligibility requirements if all employees are eligible to participate and able to elect any benefit available under the cafeteria plan. The minimum contribution requirement is met if the employer provides a minimum contribution for each employee who is not highly compensated, equal to, not less than, two percent of each eligible employee's compensation for the plan year.

Medical Device Tax

Beginning in 2013, an annual 2.3 percent excise tax is imposed on manufacturers and importers of certain medical devices will face.³

Limitation of Deduction Medical Expenses

Beginning in 2013, the medical expense threshold is increased to costs exceeding 10 percent of the taxpayer's Adjusted Gross Income (AGI). Previously, an individual could deduct the cost of medical expenses exceeding 7.5 percent of the taxpayer's AGI on their individual tax return.

Limited Use of Certain Medical Accounts for the Purchase of Over-the-Counter Drugs

Beginning in 2011, the cost of over-the-counter medicine could not be reimbursed with funds from an FSA, HRA, HSA or Archer MSA, unless the over-the-counter medicine was prescribed by a physician, except for insulin.

Medicare Payroll Tax Increase

Beginning in 2013, the employee portion of the Medicare payroll tax (specifically the Hospital Insurance portion of the tax) is increased by 0.9 percent from the current 1.45 percent. The increase only applies to wages over \$250,000 for joint return filers, \$200,000 for individual filers, and \$125,000 for married individuals filing separate returns. The tax increase also applies to the Medicare portion of SECA taxes for self-employment income.

New Medicare Payroll Investment Income Tax

Beginning in 2013, a new 3.8 percent Medicare payroll tax is assessed on certain investment income. This tax imposes a 3.8 percent tax on unearned income. In other words, it imposes an additional layer of tax on passive investment income, which includes investors in pass-through businesses, such as S corporations, LLC's and partnerships. Income received in the ordinary course of a trade or business is not subject to the tax.

Calculating the tax, however, is complicated because it is imposed on the lesser of this investment income or the amount by which an individual's modified adjusted gross income exceeds \$200,000 for single filers or \$250,000 for joint filers. The tax will be assessed annually using Form 8960.⁴

Small Business Health Insurance Tax

In 2014, a new tax on fully insured health insurance products began. The small business health insurance tax will cost small businesses and their employees \$102 billion in the first 10 years. Although the tax is levied on health insurance providers, it will be passed on to small businesses and the self-employed in the fully insured market in the form of increased premiums. The tax will raise \$8 billion in 2014, rise to \$14.3 billion in 2018, and the amount will continue to increase by the rate of premium growth for subsequent years.

Check out additional information about the impact this fee will have on small business health insurance plans. <http://www.nfib.com/advocacy/item?cmsid=51231>

³ For final regulations from the IRS, visit medical device final regulation.

<https://www.federalregister.gov/articles/2012/12/07/2012-29628/taxable-medical-devices>

⁴ For copies of draft Form 8960 visit <http://www.irs.gov/pub/irs-dft/f8960--dft.pdf> and for draft instructions visit <http://www.irs.gov/pub/irs-dft/i8960--dft.pdf>

Tax on Cadillac Health Insurance Plans

Beginning in 2018, businesses providing employer-sponsored health insurance coverage that exceeds a threshold amount will be charged a 40 percent excise tax. The threshold amounts are \$10,200 for individual coverage and \$27,500 for family coverage.

PPACA Compliance

Requirement to Provide “Summary of Benefits and Coverage”

Beginning in 2012, health insurance plans (fully insured products) and health insurance sponsors (self-insured products) must create an easy-to-read, plain language summary of benefits and coverage (SBC) for each enrollee. If an employer is fully insured, the plan must create the SBC and the employer must distribute the SBC to employees. If an employer is self-insured, the business or the third-party administrator must create and distribute the SBC to employees.

W-2 Reporting Provisions

In 2013, Section 9002 of the healthcare law requires employers who file more than 250 W-2s to calculate and report the aggregate cost of employer-sponsored insurance coverage on employees' Form W-2s for their 2012 benefits. Eventually, all offering employers will be required to include this information on employees' Form W-2s. Previously, there was no requirement that the employer report the total value of employer-sponsored insurance coverage on Form W-2. *Healthcare benefits continue to be a tax-free benefit; the new reporting requirement is simply for informational purposes.*

Reportable employer-sponsored costs include:

- Medical plans
- Prescription drug plans
- Health Reimbursement Accounts (HRAs)
- On-site medical clinics
- Amounts contributed by the employer to a Health Savings Account (HSA) or Medical Savings Account (MSA)
- Medicare supplemental coverage
- Employee assistance programs
- Dental and vision plans **unless** they are stand-alone plans

Flexible spending accounts, long-term care coverage, workers' compensation insurance, coverage only for accidents, and specific disease or hospital/fixed indemnity plans are *excluded* from the reporting requirement. This requirement was scheduled to begin in 2011, but was delayed until 2013. Businesses filing fewer than 250 W-2 Forms have temporary relief from this requirement until the IRS releases further guidance or regulations.

Paperwork Reporting Requirements

In 2016, Section 6055 and 6056 of the law will require health insurers (on behalf of offering small employers) and large employers to report certain information to both the IRS and their full-time employees.

- The information required to be reported includes: (1) name, address and employer identification number of the employer; (2) certification as to 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; (3) the number of full-time employees of the employer for each month during the calendar year; (4) name, address, and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under a plan sponsored by the employer during the calendar year; and (5) other information as the government may require.
- Employers who offer the opportunity to enroll in “minimum essential coverage” must also report: (1) in the case of an applicable large employer, the length of any waiting period with respect to such coverage; (2) the months during the calendar year during which the coverage was available; (3) the monthly premium for the lowest-cost option in each of the enrollment categories under the plan; (4) the employer's share of the total allowed costs of benefits under the plan; and (5), in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under each option.
 - Employers are required to report to each full-time employee the above information required to be reported with respect to that employee, along with the name, address and contact information of the reporting employer, on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.^[1]

Notice of Coverage Options Document Requirement

Employers must provide a written Notice of Coverage Options document to newly hired employees within 14 days of the employees' start date. This notice informs employees of coverage options and must describe the availability of individual health insurance exchanges, including a description of services and methods of participation.

Employers are also required to inform employees that they may be eligible for a premium tax credit and a subsidy within an individual health insurance exchange if the plan the employer provides covers less than 60 percent of total allowed health costs. Employers must notify employees that they would lose employer contributions for health coverage if that employee chose to purchase coverage through an individual health insurance exchange.

Model language can be found on the Department of Labor's website, <http://www.dol.gov/ebsa/newsroom/tr13-02.html>.

[1] Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act"* (JCX-18-10), March 21, 2010. Page 39

Additional Resources

NFIB Healthcare Reform
www.nfib.com/healthcare

Employer Mandate Resources:

- IRS Guidance for Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage
www.irs.gov/pub/irs-drop/n-12-58.pdf
- IRS Request for Comment on Employer Mandate
www.irs.gov/pub/irs-drop/n-11-36.pdf
- IRS Request for Comment on Health Coverage Affordability Safe Harbor for Employers
www.irs.gov/pub/irs-drop/n-11-73.pdf
- IRS FAQs from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods
www.irs.gov/pub/irs-drop/n-12-17.pdf
- IRS Proposed Rule on Shared Responsibility for Employers Regarding Health Coverage
<http://www.irs.gov/pub/newsroom/reg-138006-12.pdf>
- Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions) <http://www.irs.gov/pub/irs-drop/n-13-45.pdf>
- Questions and Answers on Employer Shared Responsibility Provision Under the Affordable Care Act
<http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act>

Health Insurance Exchange Resources:

- HHS Final Rule on Health Insurance Exchanges
www.regulations.gov/#!documentDetail;D=HHS-OS-2011-0020-2420

Essential Health Benefits Resources:

- HHS Final Rule on Essential Health Benefits Package
<http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>
- HHS Proposed Rule on Essential Health Benefits Package
www.ofr.gov/OFRUpload/OFRData/2012-28362_PI.pdf
- HHS Essential Health Benefits Pre-Rule Bulletin
cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf
- HHS Essential Health Benefits FAQs
cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf

IRS PPACA Tax Provisions: <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions>

HHS Regulations and Guidance: <http://www.healthcare.gov/law/resources/regulations>

Department of Labor Health Reform Regulations: <http://www.dol.gov/ebsa/healthreform/>