AFFORDABLE CARE ACT TAX OVERVIEW

LARGE EMPLOYERS

Ongoing vigilance necessary to comply with tax-related provisions

IANNUZZI • MANETTA & COMPANY P.C.
Certified Public Accountants & Advisors

DFK INTERNATIONAL

Employers face a variety of tax-related compliance requirements under the Affordable Care Act (ACA). Perhaps the most notable is the shared-responsibility provision, commonly referred to as "play or pay," which applies to large employers. It had been scheduled to go into effect in 2014, but it has been deferred to 2015 (along with certain information-reporting requirements). In addition, some "transitional relief" will be available in 2015. For example, large employers with plan years that don't start on Jan. 1 can begin play-or-pay compliance at the start of their plan years in 2015.

Large employers should use this extra time to ensure they offer their full-time employees the coverage necessary to avoid penalties — or decide that they'd prefer to risk the penalties. (Keep in mind that health insurance premiums are deductible; the play-or-pay penalties are not.)

Here's a closer look at some key tax-related ACA provisions and IRS guidance. Additional provisions and details may apply, so consult your tax and benefits advisors to determine exactly how your organization will be affected.

Play or pay

The play-or-pay provision doesn't *require* employers to provide health care coverage. Rather, in some cases, it imposes penalties on "large" employers that don't offer "minimum essential" coverage or that offer coverage that is "unaffordable" or that doesn't provide "minimum value."

Employers that could be subject to the penalties should start reviewing their workforces and coverage offerings now to determine whether there are any changes they should make to avoid or minimize penalties.

Shared responsibility basics

The play-or-pay provision imposes a penalty on large employers if just one full-time employee receives a premium tax credit. Under the ACA, premium tax credits are available to employees who enroll in a qualified health plan through a government-run Health Insurance Marketplace (originally referred to as a "health insurance exchange") and meet certain income requirements — but only if they don't have access to minimum essential coverage from their employer or the employer coverage offered is unaffordable or doesn't provide minimum value.

Determining large employer status

Under the ACA, a large employer is one with 50 or more full-time employees. Under IRS final regulations issued in February 2014, however, qualifying employers with 50 to 99 full-time employees won't be subject to the play-or-pay provision until 2016. To qualify for this transitional relief, the employer must:

- Maintain its workforce size and aggregate hours of service,
- Maintain the health care coverage it offered as of Feb. 9, 2014, and
- Certify that it meets the requirements.

Be aware that these employers will still be subject to the ACA's large-employer information-reporting requirements in 2015.

Waiting period for coverage

One notable health care act provision that took effect on Jan. 1, 2014, is a much shorter maximum waiting period for health care coverage. That is, when a new hire opts to participate in your health plan, this individual's coverage must begin within 90 days of his or her start date. The requirement is applicable to all qualifying employees and their dependents.

The waiting period should be calculated using all calendar days, including weekends and holidays. So, let's say you hire a new full-time staff member who starts work on July 1 of this year. His or her coverage must begin by Sept. 28.

New, higher incentives kick in for employee wellness programs

Beginning on Jan. 1, 2014, employers that offer a qualifying, "health-contingent" wellness program may receive a maximum reward of 30% of the cost of its health coverage (up from 20% in 2013). And the maximum reward for the prevention and reduction of tobacco usage is 50%.

These ACA incentives are intended to encourage employers to establish formal programs to promote employee wellness. To meet the definition of "health-contingent," participants must meet specified, health-related objectives to obtain a reward, such as decreasing tobacco usage or lowering their cholesterol. Additional rules and restrictions apply.

When counting full-time employees, part-timers must be factored in by calculating full-time equivalent employees (FTEs) and adding that figure to the total number of actual full-time employees. A full-time employee generally is someone employed on average at least 30 hours per week, or 130 hours in a calendar month. Calculating FTEs for a given calendar month requires totaling the hours of service for all part-time employees and dividing that figure by 120.

For hourly employees, the hours should be calculated based on records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

For salaried employees, there are three methods of determining the hours:

1. The same method used for hourly employees,
2. A days-worked equivalency method (each worker is credited with eight hours for each day worked), or
3. A weeks-worked equivalency method (each worker is credited with 40 hours for each week worked).

You can apply different methods for different classifications of nonhourly employees, so long as the classifications are "reasonable and consistently applied."

Employers must determine annually, based on their employees' actual hours of service, whether they'll be considered a large employer for the next year.

Factoring in seasonal employees

Hiring seasonal workers may impact whether you'll be subject to the play-or-pay provision. This could be the case if you're close to the threshold of being considered a large employer. Even if you aren't otherwise close to the threshold, you could be at risk if your seasonal employees work a substantial number of hours.

Fortunately, if your company meets the full-time employee threshold for 120 days or fewer during a calendar year "solely due to seasonal workers," you won't be subject to the play-or-pay provision. Nonetheless, if your business typically hires seasonal help, you should discuss any potential risks with your financial and benefits advisors.

Complexities of controlled entities

If your company controls multiple other entities, or is controlled by another entity, you may need to delve into the "controlled group" rules under the ACA. Generally, separate entities that are part of a controlled group will be treated as a single employer for play-or-pay purposes. Controlled groups can take various forms, but here are three common categories as defined by the Internal Revenue Code:

1. Parent-subsidiary. This exists when:

- One or more chains of corporations are connected through stock ownership with a common parent corporation,
- 80% of the stock of each corporation (except the common parent) is owned by one or more corporations in the group, *and*
- The parent corporation owns at least 80% of at least one other corporation.

If one of the corporations owned at least an 80% profit interest in a partnership (or other entity type), the employees of that partnership would also be aggregated with the other controlled group corporations.

2. Brother-sister. This is a group of two or more corporations in which five or fewer common owners collectively own — directly or indirectly — a controlling interest of each group and have "effective control." (A common owner must be an individual, a trust or an estate.)

Effective control requires collective ownership of more than 50% of the stock of each corporation, but only to the extent such stock ownership is identical with respect to each corporation. For example, if a shareholder of A and B corporations owned 80% of the stock in A and 20% in B, only 20% of that shareholder's ownership in A would be counted in this test.

3. Combined. This is a group of three or more organizations in which:

- Each organization is a member of either a parent-subsidiary or a brother-sister group, *and*
- At least one corporation is the common parent of a parent-subsidiary and is also a member of a brother-sister group.

There is a procedure under Internal Revenue Code Section 414(r) that allows companies to petition the IRS to separate entities from a controlled group on the basis that they're distinct lines of business. You may, however, find this a cumbersome process because of the many restrictions.

Minimum essential coverage

Minimum essential coverage is provided by "eligible employer-sponsored plans." These include plans offered in a state's small or large group market and self-funded plans, but not certain limited-coverage plans, such as dental-only plans.

Keep in mind that, since the ACA was signed into law in 2010, various additional requirements have gone into effect for health plans, unless they're grandfathered. Here are a few examples:

- Free preventive care (including birth control services, with exceptions for certain employers),

- Coverage of children up to age 26,
- No annual limits,
- No lifetime limits, and
- No exclusion from coverage for pre-existing conditions.

A large employer that offers minimum essential health coverage could nonetheless be subject to penalties if at least one full-time employee receives a premium tax credit because the coverage offered to the employee either wasn't affordable or didn't provide minimum value.

Affordability

Generally, if an employee's share of the premium for self-only coverage would cost that employee more than 9.5% of his or her annual household income, the coverage isn't considered affordable. There are three safe harbors that employers can use to satisfy the affordability requirement. An employer will avoid a penalty if:

- The cost of the self-only coverage won't exceed 9.5% of the Form W-2 wages the employer pays the employee that year,
- The employee's monthly contribution amount for the self-only premium is equal to or lower than 9.5% of the computed monthly wages, or
- The employee's cost for self-only coverage doesn't exceed 9.5% of the federal poverty line for a single individual.

The affordability test applies to the lowest cost option available to the employee, so long as the option also meets the minimum value requirement.

Minimum value

Under the minimum value requirement, a health plan must cover at least 60% of the total allowed costs of benefits provided under the plan. The Centers for Medicare and Medicaid Services offer a minimum value calculator with which employers can enter certain plan information and obtain a determination of whether a plan provides minimum value. Go to cms.gov and search for "minimum value calculator."

Alternatively:

- For plans that provide certain benefits within specific deductible, copay and other cost-sharing limits, an employer can comply with safe harbors established by the U.S. Department of Health and Human Services and the IRS.
- For a plan with nonstandard features that are incompatible with the minimum value calculator and the safe harbors, an employer can obtain actuarial certification of minimum value.
- For a plan in the small group market, an employer can meet the requirements for any of the levels of "metal coverage" (bronze, silver, gold or platinum), which are based on the level of cost-sharing.

IRS guidance has clarified that minimum value is based on only the anticipated spending of a standard population, not the anticipated spending of a specific employer's employee group.

Calculating penalties

When one or more full-time employees receive a premium tax credit, the amount of a large employer's penalty will depend on whether it offers minimum essential health care coverage to enough of its full-time employees (and their dependents, defined as an employee's children under age 26). The final regs issued in February 2014 also offer some transitional relief here: To avoid the risk of penalty for failing to offer minimum essential coverage in 2015, large employers need to offer coverage to only 70% of full-time employees, down from 95% under earlier guidance. However, the regs call for the 95% minimum to go into effect in 2016. In addition, large employers don't have to offer coverage to dependents in 2015 as long as they're taking steps to arrange for such coverage in 2016.

If a large employer doesn't offer coverage to enough full-timers, the annual penalty is $2,000 per full-time employee in excess of 30 full-time employees. Note that there's an exception for certain employers that don't meet the 95% requirement but exclude no more than five employees.

If the large employer *does* offer enough of its full-time employees (and their dependents) minimum essential coverage *but* this coverage is deemed not to be affordable or not to provide minimum value, the penalty is the *lesser* of this same penalty or $3,000 for each full-time employee receiving a premium tax credit.

For purposes of penalty calculations, only actual full-time employees are included, not FTEs. Penalties are prorated and calculated on a monthly basis. Penalties will increase annually based on premium growth.

Moving forward

For some employers, a bare-bones health plan may be a viable option for avoiding the $2,000 penalty. Of course, if the plan fails to provide minimum value, or isn't affordable, they could still be subject to the $3,000 penalty — but only for employees who receive premium credits.

Other employers may opt to simply pay the penalties because the increased costs due to the broader scope of coverage required may be greater than the penalties. These employers could incur other costs, though, such as lost tax benefits (again, unlike health care benefits, penalties aren't deductible) and the costs to remain competitive in the labor market.

Employers close to the full-time employee threshold may consider making adjustments to their workforces in an effort to avoid being considered a large employer. But before cutting employee hours in an effort to avoid penalties, it's important to look carefully at the extent to which doing so would actually reduce your FTEs — as well as the other ways the reduction would affect your organization.

Additional Medicare tax withholding

Beginning last year, under the ACA, taxpayers with FICA wages over $200,000 per year ($250,000 for joint filers and $125,000 for married filing separately) had to pay an additional 0.9% Medicare tax on the excess earnings.

How does play-or-pay affect HSA and HRA contributions?

Many companies have turned to Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) to shift more responsibility for health care costs to employees. If your business is one of them, you may have been wondering how your contributions to these plans affect compliance with the ACA's "play-or-pay" provision. (See page 1.)

In May 2013, the IRS released guidance clarifying, among other things, how an employer's HSA and HRA contributions count toward its shared responsibility to provide affordable health care benefits of at least minimum value.

According to the guidance, an employer's total HSA contributions for the current plan year count toward the minimum value calculation. For HRA contributions, amounts made newly available for the current plan year — that can be used for only premiums or for either premiums or cost-sharing reduction — will be treated as an employee's earnings and can be considered available to him or her to increase the affordability of the employer's health care coverage.

Unlike regular Medicare taxes, the additional Medicare tax *doesn't* include a corresponding employer portion. But employers *are* obligated to withhold the additional tax to the extent that an employee's wages exceed $200,000 in a calendar year.

Remember, the $200,000 amount doesn't include the employee's income from any other sources. Nor does it take into account his or her tax filing status. One consequence: You may be required to withhold the additional Medicare tax from wages paid to employees who aren't ultimately liable for the tax. An employee can't ask his or her employer to stop withholding the tax. Instead, if an employee ultimately doesn't owe the tax, he or she can claim a credit for the withheld tax on his or her income tax return for the year.

It's also possible that *no* additional Medicare tax will be withheld from employees who *are* liable for the tax. Employees who anticipate additional Medicare tax liability can't request that you withhold additional amounts specifically for the tax. They can, however, use Form W-4 to request additional *income* tax withholding sufficient to cover their liability for the additional Medicare tax.

In November 2013, the IRS released final regulations regarding the additional Medicare tax and the employer withholding requirements. The only substantial change from the proposed regulations is that employers no longer have access to relief from payment liability for any additional Medicare tax that was required to be withheld but that they didn't withhold — unless the employer can provide evidence that the employee in question has paid the tax.

Amending FSA plans

Health care Flexible Spending Accounts (FSAs) allow employees to redirect pretax income to an employer-sponsored plan that pays, or reimburses them for, qualified medical expenses not covered by insurance. A maximum employee contribution limit of $2,500 went into effect in 2013. (Employers can set a *lower* limit, however.)

According to the IRS, the new limit applies on a plan year basis. Thus, non-calendar-year plans must comply for the plan year that started in 2013.

Employers that haven't yet done so must amend their plans and summary plan descriptions to reflect the $2,500 limit (or a lower one, if they wish) by Dec. 31, 2014, and institute measures to ensure employees don't elect contributions that exceed the limit. Note that there will continue to be *no* limit on employ*er* contributions to FSAs.

"Exchange notices" to employees

Another ACA provision employers had to begin complying with last year (as of Oct. 1, 2013) was providing all employees with "exchange notices." These communications were mandated to:

- Provide notification of the existence of the new Health Insurance Marketplace,
- Offer information explaining that employees may be eligible for a premium tax credit if they buy coverage via a Marketplace, and
- Warn employees that, if they do buy from the Marketplace, they may lose any employer contribution to any existing employer-provided health plan.

The notice is, however, required to be given only once — you don't need to provide it annually. So, assuming you complied last year, you don't need to send notices to all of your employees again this year.

But keep in mind that exchange notices are required to be provided to all *new* employees hired after Oct. 1, 2013, regardless of plan enrollment status (if applicable) or of part-time or full-time status. So if you've added staff recently, be sure to keep up with this obligation. The Department of Labor offers a sample notice on its website (dol.gov) — search for "ebsa."

You don't need to provide separate exchange notices to dependents or others who are now or may become eligible for coverage under your plan but who aren't employees. And you don't need to provide notices to individuals who are no longer employees, such as retirees or COBRA beneficiaries.