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ACA Small Business Tax and Compliance

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Special Report

HIGHLIGHTS

- Transition Relief for Reimbursement Plans Ends
- Possible Legislative Fix Stalls
- SHOP Plan Employers Can Have Up to 100 Full-Time Employees in 2016
- Contraceptive Coverage Accommodation Extended to Closely-Held Businesses
- IRS Considers Who Will Pay High-Cost Plan Tax for Self-Insured Plans
- Options for Small Business

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ACA Small Business Tax and Compliance

Overview

Perhaps the best feature of the Affordable Care Act (ACA) for small businesses is what it does not do: require them to choose between offering their full-time employees ACA-compliant coverage or making Employer Shared Responsibility payments. Only Applicable Large Employers that average over 50 full-time employees a year have to make that choice.

There are important positive benefits as well for small employers that do wish to offer coverage. First, employers with fewer than 50 full-time equivalent employees can buy health coverage for their employees through a state or federal SHOP Exchange. Insurance purchased through a SHOP Exchange should be cost-competitive, the employer can decide the amount to contribute towards coverage, and coverage is guaranteed to be ACA-compliant.

Second, small employers that employ an average of 25 or fewer full-time employee equivalents and obtain employee coverage through a SHOP Exchange may qualify for the Small Business Health Care Tax Credit if they meet certain requirements.

Third, self-employed individuals may enroll in individual Marketplace Exchange coverage, and may be eligible for a Premium Tax Credit depending on their net income and family size. Self-employed people who would normally have difficulty obtaining reasonably priced insurance, or any insurance at all, no longer have to rely on their spouse's employer coverage or cling to a job because of the benefits.

Fourth, employers that obtain group health coverage through an insurer will not be responsible for navigating the technical requirements of the Market Reforms added by ACA (such as coverage that does not exclude pre-existing conditions). It is the insurer's responsibility to design and provide coverage that meets these additional standards. Small employers are exempt from penalties attributable to the insurer's noncompliance. It is also up to the insurer to satisfy new coverage provider information reporting requirements, to report and pay "PCORI fees," and pay any applicable "Cadillac Plan" tax.

However, some small employers that offer coverage may face significant burdens under ACA. The biggest burden falls on employers that "self-insure" in that they pay for their employees' coverage directly rather than through an insurer. These employers are to a large degree treated as insurers, and they must satisfy the technical coverage and administrative requirements imposed on insurers by the Market Reforms. They must also satisfy the coverage provider information reporting requirements, pay PCORI fees, and (perhaps) pay the excise tax on high-cost coverage when it goes into effect in 2018.

A burden also falls on employers that have traditionally used simple reimbursement plans. Unfortunately, premium payment or reimbursement plans for an employee's individual coverage are no longer permitted except in limited circumstances. In addition, Health Reimbursement Arrangements must be integrated into ACA-compliant employer coverage.

A third issue for some employers is that the Market Reforms require employer group health plans to provide contraceptive coverage. There is an accommodation for religious non-profit employers, and as a result of the Supreme Court's decision in *Hobby Lobby v. Burwell*, the IRS has extended that accommodation to "closely held" for-profit religious employers.

SHOP Exchange Coverage

Qualified small employers may buy qualified health plans (QHPs)—private health insurance that has been certified as meeting certain standards—through the Small Business Health Options Program (SHOP) Marketplace. The SHOP Marketplace may be a convenient option for many employers, because everything, including employee enrollment, can be handled online.

Like other employer sponsored coverage, the employer is still able to determine the coverage that employees may enroll in, how much the employer premium contribution will be, the length of open enrollment and waiting periods.

To qualify for a SHOP plan, a business must satisfy the following requirements:

1. ***Have at least one common-law employee on payroll.*** This criteria does not include a business owner or the owner's spouse, so individuals who are self-employed with no employees cannot get coverage through the SHOP (though once the business is considered otherwise eligible for SHOP, the business owner and spouse may also sign up for coverage through the SHOP).
2. ***Offer coverage to all full-time employees.*** A full-time employee is any employee working 30 or more hours per week on average. The employer does not have to offer coverage to part-time employees.
3. ***Ensure at least 70% of those full-time employees enroll in the SHOP Marketplace plan.*** This is referred to as "minimum participation percentage." Certain states set their minimum participation percentage level at a different percentage.
4. ***Have a principal business address or an employee with a primary worksite in the coverage area.*** See *Healthcare.gov* to determine what SHOP Marketplace coverage is offered in each area.

> The SHOP Marketplace may be a convenient option for many employers, because everything, including employee enrollment, can be handled online.

5. ***Employ 50 or fewer full-time equivalent employees (FTEs), including part-time employees.*** The number goes up to 100 in 2016. Full-time equivalents can be calculated manually, or the employer can use the Full-Time Equivalent Employee Calculator, available online at *https://www.healthcare.gov/shop-calculators-fte*.

SHOP Plan Levels

Similar to the individual marketplace, SHOP Marketplace plans are available in four categories or "metal levels": Bronze, Silver, Gold, and Platinum. All plans offer similar benefits, but differ in how much the employee pays for things like deductibles and copayments and the total amount they spend out-of-pocket for the year. Generally, the lower the premium the employee pays, the higher the out-of pocket costs and vice-versa.

The four categories are:

- ***Bronze:*** The health plan covers about 60% of the total costs of care. The employee pays about 40%.
- ***Silver:*** The health plan covers about 70% of the total costs of care. The employee pays about 30%.
- ***Gold:*** The health plan covers about 80% of the total costs of care. The employee pays about 20%.
- ***Platinum:*** The health plan covers about 90% of the total costs of care. The employee pays about 10%.

Employee Choice

In all states, employers can select one plan and offer it to all employees. In certain states, employers can choose a plan category (such as Gold or Silver) and allow employees to choose any plan from any insurance company in that category. This is called Employee Choice. Currently, the Employee Choice option is available only in these states in 2015: Arkansas, Florida, Georgia, Indiana, Iowa, Missouri, Nebraska, North Dakota, Ohio, Tennessee, Texas, Virginia, Wisconsin and Wyoming.

Small Business Health Care Tax Credit

Qualified employers with less than 25 employees that purchase plans through the SHOP Marketplace may qualify for a premium subsidy in the form of a Small Business Health Care Tax Credit, worth up to 50% of employer premium costs.

To claim the credit, the employer must meet certain criteria:

- The employer has fewer than 25 Full-Time Equivalent (FTE) employees. FTE employees is not the same as all employees. In some circumstances, an employer with 25 or more employees may qualify for the credit if some of its employees work less than full-time.
- The average annual employee salary at the business is less than $50,800 in 2015 (adjusted for inflation every year). All wages paid to employees (including overtime pay) are taken into account in computing an eligible small employer's average annual wages. The average salary is calculated by adding up the total wages paid by the employer during

the taxable year to its employees, and dividing that number by the number of FTEs for the year. The result is then rounded down to the nearest $1,000. For example, if an employer pays a total of $224,000 in wages to employees and has 10 FTEs, the employer's average annual wages are $22,000 ($224,000 / 10 = $22,400, rounded down to the nearest $1,000);

- The employer contribution is at least 50% of full-time employees' premium cost;
- The employer offers coverage to all full-time employees. It is not necessary for the employer to offer coverage to part-time employees or dependents;
- The coverage is purchased through the SHOP Marketplace.

The maximum credit that can be claimed by an eligible employer is a "uniform percentage" of 50% of the employer's premium payments made on behalf of its employees under a plan offered through a SHOP Marketplace (35% for tax-exempt employers). Taking the "uniform percentage" instead of a flat 50% allows for arrangements that require employers to pay a uniform premium for each enrolled employee) and offer different tiers of coverage (for example, employee-only, dependent, and family coverage) to be qualifying arrangements even if the employers pay less than 50% of the premium cost for employees not enrolled in employee-only coverage. In addition, an arrangement that requires employers to pay a separate premium for each employee based on age or other factors can be a qualifying arrangement even if it requires employers to pay less than 50% of the premium cost for some employees.

The credit phases out for eligible small employers if the number of FTEs exceeds 10, or if the average annual wages for FTEs exceed $25,400 in 2015 (adjusted for inflation).

Market Reforms

All employers that offer health coverage for more than one employee are subject to the group health plan requirements, whether the coverage is provided through an insurer or through direct employer funding. These are minimum coverage and participation standards set out for all employers, and enforced by the IRS through a $100 per day, per affected employee excise tax.

The group health coverage rules and excise tax predate ACA, but ACA significantly expanded these rules. The ACA changes are often referred to as "Market Reforms" though they are independent of the ACA Marketplace Exchanges. Grandfathered plans are exempt from most of the Market Reforms. Grandfathered plans are plans that that were in effect on March 23, 2010, and have not been substantially modified since.

Single-employee and stand-alone retiree plans are not subject to the group plan rules, and therefore they are not affected by the Market Reforms. Plans that only provide "excepted benefits" are similarly exempt from the Market Reforms. Excepted benefits include: limited scope dental or vision plans, on-site medical clinics, coverage for a specified disease or illness, hospital indemnity, nursing home care, auto medical payment insurance, Medicare supplemental coverage, workers compensation insurance, and liability insurance.

Reimbursement Plans

Starting in 2014, employers may no longer offer premium reimbursement or payment plans because they are out of compliance with the group health plan rules, as amended by the Market Reforms. The concern is the dollar benefit from a premium plan would be limited to the dollar amount of the annual premium, violating the prohibition against lifetime or annual dollar limits on certain benefits, and that such plans would not address cost-sharing for preventive services.

In lieu of premium reimbursement or payment plans, eligible small employers can use SHOP Exchange coverage or private group insurance and pay just a portion of the cost of coverage. Such coverage may even cost employers less than reimbursing individual coverage.

Transition Relief

The IRS excused employers that are not Applicable Large Employers from complying with the Market Reforms until June 30, 2015 (Notice 2015-17).

Historically, an S corporation could reimburse or pay for the premiums for individual coverage of 2-percent shareholder-employees. The amount would be included in the 2-percent shareholder-employee's income, but could be deducted under Code Sec. 162(l) (Notice 2008-1).

The IRS is considering future guidance on these arrangements. However, unless and until the IRS changes its position (and in any case, at least through 2015), taxpayers may continue to use these arrangements without incurring an excise tax or filing Form 8928. In addition, the tax treatment of these arrangements (included in the shareholder's taxable income with a deduction for the shareholder) remains in effect for now (Notice 2015-17).

This rule applies only for employees who are also 2-percent shareholders under Code Sec. 1372(b)(2). It does not apply for S corporation employees generally.

Funding Through Compensation

Early guidance by the IRS in Notice 2013-54 suggested that after-tax premium reimbursement plans might be excepted from the Market Reforms because they are not group health plans. This approach would allow existing arrangements for self-employed individuals (including partners and S corporation 2-percent shareholders) to more or less continue unaffected, and allow employers to avoid the excise tax by reporting reimbursements as taxable compensation on their employees' W-2s. The IRS has since clarified that after-tax arrangements are not generally exempt from the Market Reforms.

To avoid the Market Reforms, an after-tax arrangement would have to consist of a raise in compensation coupled with no strings attached on what the employee did with the money. Conditioning the money on purchasing insurance, or endorsing a particular kind of insurance, would constitute a group plan subject to the Market Reforms (Notice 2015-17).

Single-Employee Plans

The Market Reforms do not apply to single-employee plans. The IRS has stated in the context of an S corporation, if there are only two employees in the plan and they are both covered under the same family coverage, the plan qualifies as a single-employer plan. A business cannot get around this rule by having multiple single-employee plans because all the plans are aggregated for these purposes (Notice 2015-17).

Possible Legislative Relief?

Bi-partisan legislation has been introduced in both the House (H.R. 2911) and the Senate (S. 1697) that would amend the excepted benefits rules to treat small employer reimbursement plans as excepted benefits. Under the proposed law, small employers would be able to use Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs). Funding would be limited to employer contributions (no salary reduction contributions). QSEHRAs would be able to reimburse both medical care expenses, and insurance premiums for eligible employees and their family members.

House bill H.R. 2911, and Senate bill S. 1697, were introduced out of committee on June 15, 2015. There might be concern on the part of the administration that this legislation would weaken the SHOP Exchanges.

Contraceptives

Coverage without any cost sharing must be provided for a long list of preventive health services including contraceptives. From the beginning religious non-profit employers could use a safe harbor under which contraceptive coverage would be provided separately by the insurer at no cost to the employee and without participation by the employer. In response to the Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.,* this accommodation is available to closely held for-profit employers.

> Self-insured plans…bear the full brunt of many ACA changes that are aimed at insurance companies.

To qualify, a business must have more than 50 percent of the value of its ownership interests owned directly or indirectly by five or fewer individuals, or must have an ownership structure that is "substantially similar." The value of the ownership interests is calculated based on all ownership interests, regardless of whether they have associated voting rights or any other privileges.

A business trying to determine if it qualifies for the accommodation can send a letter describing its ownership structure to HHS at accommodation@cms.hhs.gov. If the entity does not receive a response from HHS to a properly submitted letter describing the entity's current ownership structure within 60 calendar days, it will be considered to meet the requirements provided it retains that structure.

Self-Employed Coverage

The Premium Tax Credit (PTC) helps eligible taxpayers pay for health insurance obtained through the Marketplace. The PTC for eligible taxpayers is provided on a sliding scale depending on the size of the family and household income. A taxpayer with household income at 200% of the federal poverty line for the taxpayer's family size gets a larger credit to help cover the cost of insurance than a taxpayer with the same family size who has household income at 300% of the federal poverty line.

A complicating feature of the PTC is that all or a portion of the credit amount can be advanced at the taxpayer's election in the form of lower insurance premiums throughout the year. The advance amount is based on a prediction of the taxpayer's income and family size. Differences between the advance and the actual credit amount are reconciled on the taxpayer's annual tax return, and additional tax may be owed. The additional tax may be limited depending on the taxpayer's modified AGI.

The self-employed health insurance deduction is available for coverage for which the taxpayer qualifies for a Premium Tax Credit, but there are limits. If a self-employed taxpayer receives advance payment of the premium tax credit from the government during the year, the deduction is limited to the nonsubsidized portion of the taxpayer's premiums.

Burdens on Employer Self-Insured Plans

Employers, both large and small, may pay for their employees' medical care expenses directly rather than purchasing group health insurance. Employers sponsoring these self-insured plans must comply with many changes under ACA that generally affect insurance companies.

PCORI Fees

Self-insured employer plans must pay a fee for each plan year ending after September 30, 2012. The fee equals the product of $2 ($1 for policy years ending in fiscal 2013) multiplied by the *average number of lives* covered under the plan. For plan years ending on or after October 1, 2014, the $2

amount is adjusted for increases in health care spending. The fee ends after September 30, 2019. The plan sponsor pays the fee (Code Sec. 4376).

This fee supports the "Patient-Centered Outcomes Research Institute" through a trust fund, and is generally known as the PCORI fee. The PCORI fee is also imposed on issuers of health insurance policies.

Coverage Provider Reporting

Under Code Sec. 6055, every provider of "minimum essential coverage" must report coverage information by filing an information return with the IRS and furnishing a statement to individuals. Generally, providers are insurers, carriers, or government agencies providing coverage, but they can include any employer with a self-insured plan.

Health coverage provider reporting is done through two forms: Form 1094-B (a pure transmittal form, used to identify the reporting entity and transmit Forms 1095-B), and Form 1095-B (statements furnished to individuals with a copy sent to the IRS). This format is similar to that followed by entities filing Forms W-2 with a Form W-3 transmittal. The information is used by the IRS to administer the individual shared responsibility provisions of ACA.

"Cadillac Plan" Tax

Starting in 2018, a 40-percent excise tax is imposed on health coverage providers to the extent that the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount (Code Sec. 4980I). For insured plans, the insurer pays the tax, but for self-insured plans the the entity that "administers the plan benefits" will pay the tax.

The tax is equal to 40 percent of the excess benefit, which is the sum of the monthly excess amounts. The excess amount for a month is equal to the excess of the aggregate cost for the month over an amount equal to 1/12 of the annual amount, which is $10,200 (for 2018) for self-only coverage and $27,500 (for 2018) for coverage other than self-only coverage, both multiplied by the health care adjustment percentage, which is meant to adjust for the change in cost of health care coverage between 2010 and 2018. Employer-specific adjustments for age and gender, and adjustments for retirees not subject to Medicare and those in high-risk professions are also made (Code Sec. 4980I(b)).

The IRS is just beginning to release guidance on this tax. (Notice 2015-16; Notice 2015-52). The government is trying to decide whether to place the payment burden on the plan's third party administrator (if there is one), or on the entity that has final decision making authority on administrative matters (Notice 2015-52). There might be political support from both sides to eliminate the tax as its start date approaches since both business and labor unions are opposed.

Health Coverage Options for Small Businesses

A number of employers, both large and small, are seeking ways to accommodate and comply with ACA while maintaining their current plans or offering new health coverage to their employees. Here are a few options for health insurance coverage for employers averaging under 50 full-time employees:

1. *No employer coverage for any employee.* The owners and employees will have to obtain individual coverage to avoid individual shared responsibility payments.
2. ***SHOP Exchange coverage.*** For employers with 25 or fewer FTEs, a small business tax credit is available for SHOP coverage.
3. ***Group plan coverage with purchased insurance.*** Compliance, reporting and excise tax burden is mostly on the insurer.
4. ***Health Reimbursement Arrangements.*** An HRA integrated with employer coverage to pay deductibles and co-pays is permissible as long as it is integrated with ACA-compliant employer coverage. Otherwise, HRAs have to be limited to retirees-only, excepted benefits, or single-employee plans.
5. ***Self-insured group plan coverage.*** The employer has the compliance burden for the Market Reforms, coverage provider reporting, and paying the PCORI fees.
6. ***Reimbursement plans.*** Businesses with a plan that includes only one employee can continue to use a reimbursement plan to pay for individual coverage. S corporations can continue to use reimbursement arrangements for 2-percent plus shareholder employees, and the existing deduction rules remain the same.
7. ***Individual Marketplace coverage.*** Self-employed individuals can use the ACA Marketplace Exchange for individual coverage. They might qualify for the premium tax credit, and can deduct the unsubsidized portion of the premiums.
8. ***Retiree plans.*** Stand-alone retiree plans can still use premium reimbursement plans, and such coverage can count as minimum essential coverage for the retiree. The employer must report under the coverage provider rules.
9. ***Excepted benefit plans.*** Plans that only offer coverage for excepted benefits (such as vision-only, or dental-only plans) are relatively unaffected by ACA Market reforms.
10. ***Religious employer exemption.*** Religious employers (both non-profit and closely-held for-profit) can claim an accommodation for contraceptive coverage.

If you need assistance with any of these items contact BDO's ACA team:

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