Prepared for:

Brokers of Champion Agency, Inc.
Individual and Business Responsibilities
Under the ACA

Prepared by:

Kenneth Sapon, CLU, CLTC, LUTCF, R.Ph.
President
Champion Agency, Inc.
2155 Louisiana Blvd NE
Suite 3100
Albuquerque NM 87110

Phone: 505-265-8511 Ext. 106
Mobile: 505-250-9001
Email: ken@champion-agency.com
Website: www.champion-agency.com
September 25, 2013

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Business Responsibilities Under the ACA

The Patient Protection and Affordable Care Act (ACA) has several goals, including increasing access to health insurance coverage, expanding federal private health insurance market requirements, and requiring the creation of health insurance exchanges to provide individuals and small employers with access to qualified health insurance.

For employers, ACA includes a penalty (termed a "shared responsibility" payment) for certain "large" employers who either do not offer health insurance to all of their full-time employees, or who offer health insurance coverage that does not meet certain standards.[1] The ACA sets out two elements for determining penalties. First, which firms are considered to be "large" employers, and thus potentially subject to the penalty, and second, for which employees within a firm the penalty is applied.

Under the legislation as originally enacted, many provisions of the ACA were to be effective January 1, 2014. However, in Notice 2013-45, the IRS announced it would delay enforcing the employer "shared responsibility" payment, as well as certain information reporting requirements, until January 1, 2015.

Who is a "Large" Employer?

In general terms, the ACA defines a "large" employer as an employer who employed an average of at least 50 full-time equivalent employees (FTEs) on business days during the preceding calendar year. Both full-time and part-time employees are included in this calculation.

- **Full-time employee:** An employee who works on average at least 30 hours per week.
- **Part-time employees:** Part-time employees (less than 30 hours per week) are converted into FTEs. All hours worked by all part-time employees are added up and the total is divided by 120.

> *Example: Assume a firm has 35 full-time employees (30 or more hours per week) and 20 part-time employees, each of whom works 24 hours per week (96 hours per month). The 20 part-time employees equate to 16 full-time equivalents (FTEs), calculated as follows;*
>
> *20 employees x 96 hours = 1920 total hours* *1920 ÷ 120 = 16 **F**ull-**T**ime **E**quivalent**s***
>
> *With 35 full time employees and 16 FTEs, the employer would be considered a "large' employer because there is a total FTE count of 51.*

- **Employee:** The ACA definition of an employee (as contrasted with an "independent contractor") is based on a common law standard under which an employer-employee relationship exists if the employer controls both what and how the work is to be done.
- **Seasonal employees:** Seasonal employees are generally defined as those who work for up to 120 days a year. Full-time seasonal employees who work 120 days per year or less are excluded from the calculation to determine large employer status.
- **Control group rules:** The ACA follows the control group rules of IRC Sec. 414. Thus, if an individual or organization owns all or a substantial part of several other business (for example, a group of fast-food restaurants), all of the business are considered to be one entity. For purposes of the 50-FTE rule, the employees in each business must be aggregated to determine the total.

[1] The discussion here concerns federal law. State or local law may differ.

- **Temporary agency employees:** For purposes of determining who is a large employer, "temp" (or "leased") employees are generally counted as employees of the temporary agency.

Who is a "Full-Time" Employee?

The ACA did not specify the time period an employer must use to determine if a worker is a full-time employee. However, IRS Notice 2012-58 describes a safe-harbor method that may be used to determine which employees are considered to be full-time. The safe-harbor method includes several key time periods, which vary, depending on the type of employee.

	Measurement Period	Administrative Period	Stability Period
Description	A period of time during which an employer measures the average hours an employee worked per week.	At the employer's option, a period of time during which full-time employees are identified and enrolled in a health plan.	During the stability period, the employee is treated as full-time regardless of how many hours are worked. This is also the period in which a penalty payment may be due.
On-going employees	From three to 12 months.[1] Uses data from a preceding year.	Up to 90 days.	At least six months, but cannot be shorter in duration than the measurement period.
New employees, hired as full-time	Not applicable.	Up to 90 days to enroll.	Not applicable.
New variable hour and seasonal employees	From three to 12 months.[2]	Up to 90 days. Measurement period and administrative period cannot exceed 13 months.	Three to 12 months, but cannot be longer than the measurement period.

Minimum Essential Health Insurance

If an employer is determined to be a "large" employer, and, in order to avoid a potential penalty, the employer must offer "minimum essential health coverage" to all full-time employees. The health insurance must also be both affordable and provide adequate coverage to employees and their dependents.

- **Minimum Essential Health Coverage:** The ACA lists the types of services that must be included to be considered "minimum essential health coverage", including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including vision and oral care.

[1] For on-going employees, this is referred to as the "standard" measurement period.
[2] For new employees, this is referred to as the "initial" measurement period.

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- **Coverage must be "affordable":** Coverage under an employer-sponsored plan is "affordable" if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year.
- **Affordability "safe-harbors":** As a practical matter, most employers will not know the family's household income. To overcome this, three, alternative "safe-harbor" tests have been proposed. Under the first safe-harbor, the annualized, required contribution must not exceed 9.5% of the employee's earnings from the employer, as shown in Box1 of the employee's W-2 Tax and Wage statement. Under the second safe harbor, the 9.5% affordability test is applied to the employee's hourly rate of pay for a month, multiplied by 130. Finally, if the employee's required contribution is less than 9.5% of the federal poverty level for a single individual, the coverage is treated as affordable. A plan can meet any one of these tests to comply with the affordability requirement.
- **"Adequate" coverage:** For ACA purposes, a plan is considered to provide adequate coverage (also called "minimum value") if the plans actuarial value (i.e. share of the total allowed costs the plan is expected to cover) is at least 60%. Under the ACA, the health insurance plans offered through the health insurance exchanges will generally be available at four "levels" or price points. Each level covers a specified percentage of the actuarial value of the benefits provided by the plan. These levels are: Bronze – 60%; Silver – 70%; Gold – 80%; and Platinum – 90%.
- **Dependent:** Although employers are encouraged to offer health coverage to an employee and all dependents, under proposed regulations, the term "dependent" has a narrow meaning. For ACA purposes, a "dependent" is a child of an employee who has not yet attained age 26. The term does not include a spouse or others (such as parents) that an employee might claim as a dependent on his or her federal income tax return. Thus, in order to meet the letter of the law, an employer must offer health insurance that covers only the employee and his or her children under the age of 26.

What Triggers the Penalty?

Regardless of whether or not a "large" employer offers health coverage, it will be liable for a penalty only if at least one of its full-time employees obtains coverage through a health insurance exchange and receives a premium assistance tax credit or cost-sharing subsidy.

One part of the ACA calls for the creation of health insurance exchanges. These exchanges are intended to provide an online marketplace where individuals and small businesses can shop for qualified health insurance coverage. Individuals who purchase health insurance through a health insurance exchange may receive help in paying for the coverage in one of two ways:

- **Premium assistance tax credit:** A low-income individual[1] who purchases health insurance through a health insurance exchange may be eligible to receive a refundable "premium assistance" tax credit. The U.S. Treasury pays the premium assistance credit amount directly to the health insurance company, with the individual being responsible for paying any remaining premium.

[1] Generally, someone earning from 100% up to 400% of the federal poverty level (FPL) for the family size involved. For 2013, 100% of the FPL for a family of one is $11,490; for a family of four it is $23,550; for a family of eight it is $39,360.

- **Cost-sharing subsidy:** An individual may also qualify for a "cost-sharing" subsidy, available through the health insurance exchange. The subsidy reduces the dollar amount of "out-of-pocket" expenses (deductibles or co-payments) that the individual might otherwise pay. This subsidy is generally limited to low-income individuals[1] and is only available for those months when the individual qualifies for a premium assistance tax credit.

Calculating the Employer Penalty

Assuming that an employer is a "large" employer, and at least one full-time employee has obtained health insurance coverage through a health insurance exchange, with either a premium tax credit or a cost-sharing subsidy, the method used to calculate the employer's "shared responsibility" payment will vary:

- **Large employer not offering health insurance:** For 2014, the monthly penalty assessed to an employer who does not offer health insurance will be equal to the number of full-time[2] employees minus 30 (the penalty is waived for the first 30 employees), multiplied by one-twelfth of $2,000.[3]

Example: In 2014, Employer X fails to offer minimum essential health coverage and has 100 full-time employees, 10 of whom receive a premium assistance credit for the year. For each employee over the 30-employee threshold (100 - 30 = 70), the monthly penalty amount for Employer X is $11,667, (70 x ($2,000 ÷ 12)) or (70 x $166.67).

- **Large employers offering coverage:** Even though an employer may offer health insurance coverage, the coverage may not be "affordable" or it may not be "adequate." In this situation, for 2014, the monthly penalty assessed to an employer for each full-time employee who receives a premium tax credit or cost-sharing subsidy will be one-twelfth of $3,000.[7] However, the monthly penalty will be capped at an amount equal to the total number of full-time employees during the month (regardless of the number of employees receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of $2,000.

Example: In 2014, Employer Z offers health coverage and has 100 full-time employees, 20 of whom receive a premium tax credit or cost-sharing subsidy for the year. For these 20 employees, Employer Z employer owes a penalty of $5,000 per month (20 x ($3,000 ÷ 12)) or (20 x $250). The maximum monthly penalty for is capped at the amount that would have been assessed for a failure to provide coverage, or $11,667 ((100-30) x ($2,000 ÷12)) or (70 x $166.67). Since the calculated penalty of $5,000 for the 20 employees receiving a premium tax credit or cost-sharing subsidy is less than the maximum amount of $11,667, Employer Z will pay the $5,000 monthly penalty.

[1] Generally, those earning less than 250% of the federal poverty level (FPL), for the family size involved.
[2] Part-time employees are not included in the penalty calculations. Part-time employees are included in determining whether or not an employer is a "large" employer.
[3] The $2,000 and $3,000 amounts apply to 2014. These values are subject to adjustment for inflation in future years. Under IRS Notice 203-45, enforcement of the employer penalty provisions of the ACA has been delayed until January 1, 2015.

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Other Requirements

Several other requirements must be noted:

- **Information reporting requirements:** Beginning in 2014,[1] "large" employers subject to the employer shared-responsibility requirement must report certain health insurance coverage information to both its full-time employees and to the IRS. An employer who fails to comply with these new reporting requirements will be subject to certain penalties. Additionally, information reporting requirements apply to insurers, self-insuring employers, and certain other providers of minimum essential health coverage.
- **Automatic enrollment:** Those firms with more than 200 full-time employees must automatically enroll new full-time employees in a plan and to continue the enrollment of current employees. Such automatic enrollment plans will be required to include adequate notice and the opportunity for an employee to opt out.

Seek Professional Guidance

The foregoing is a simplified, high-level summary of a complex piece of legislation. Further, the rules and regulations issued to implement this legislation are subject to change. The guidance of knowledgeable income tax, health insurance, and other financial professionals is highly recommended.

[1] Under IRS Notice 2013-45, enforcement of these information reporting requirements has been delayed until January 1, 2015.

Individual Responsibilities Under the ACA

The Patient Protection and Affordable Care Act (ACA)[1] has several goals, including increasing access to health insurance coverage, expanding federal private health insurance market requirements, and requiring the creation of health insurance exchanges to provide individuals and small employers with access to qualified health insurance.

The ACA includes an individual mandate, generally applicable to every person - including children and senior citizens - in the United States, to either maintain "minimum essential health coverage" for themselves and certain family members[2] or make an additional payment, known as a "shared responsibility payment," with their federal income tax return. Certain classes of individuals may qualify for an exemption to the individual mandate. The requirement to maintain minimum essential health coverage is measured on a monthly basis. Generally, an individual is treated as having minimum essential health coverage if he or she is enrolled and entitled to receive benefits under a qualifying program or plan for at least one day during the month.

The individual requirement to maintain minimum essential health coverage begins January 1, 2014.

Exempt Individuals

Some individuals are exempt from the requirement to maintain minimum essential health coverage or the requirement to pay the penalty. An individual's status as exempt or non-exempt is measured on a monthly basis.

- **Members of certain recognized, religious sects:** Generally, a group that has established tenets or teachings under which the members are conscientiously opposed to accepting benefits from any private or public insurance that makes payments in the event of death, disability, old age, or retirement, or that pays for or provides medical care.
- **Members of a health care sharing ministry:** Generally, a health care sharing ministry is an organization, the members of which share a common set of ethical or religious beliefs and share medical expenses among themselves.
- **In jail or prison:** Individuals who are in jail or prison, except those whose cases are pending disposition of charges.
- **Non-citizens:** An exemption applies to an individual who is neither a citizen nor a national of the United States, nor an alien lawfully present in the United States.
- **Minimum essential coverage is not "affordable":** An individual is exempt for a month in which he or she does not have access to "affordable" health coverage. For these purposes, generally, health insurance coverage is affordable if the individual's required contribution (calculated on an annual basis) does not exceed a certain percentage (8.0% in 2014) of household income.
- **Household Income below filing threshold:** Taxpayers with gross household income below the income tax filing threshold for their filing status are exempt.

[1] The discussion here concerns federal law. State or local law may differ.
[2] Generally, a spouse and any individual that a taxpayer *may* claim as a dependent on his or her federal income tax return, whether they do so or not.

- **Hardship:** Individuals who suffer a hardship that makes it impossible to obtain the required minimum essential health coverage are exempt.
- **Member of an indian tribe:** A member of a federally recognized indian tribe is exempt.
- **Short coverage gap:** No tax is assessed for an individual who does not maintain health insurance for a continuous period of three months or less during the taxable year. If there are multiple gaps in coverage during the year, the penalty exemption applies only to the first such gap in coverage.
- **U.S. citizens living abroad:** U.S. citizens who live abroad for a calendar year (or at least 330 days within a 12 month period) are treated as having minimum essential coverage for the period, regardless of whether or not they have any type of health insurance coverage.

Taxpayers claiming an exemption based on religious conscience, hardship, being a member of an indian tribe or a health care sharing ministry, or who are incarcerated must apply for an exemption certificate (to attach to their individual income tax return) at the state health insurance exchange serving their area of residence.

Minimum Essential Health Coverage

The following items are included in the minimum essential health package:

- 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
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Health insurance programs which meet these minimum coverage standards include:

- Employer-sponsored health plans, including COBRA and retiree coverage
- Coverage purchased in the individual market through a state health insurance exchange
- Medicare coverage, including Medicare Advantage
- Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans coverage
- TRICARE

Minimum essential coverage does not include specialized coverage, such as coverage only for vision care or dental care, worker's compensation, disability policies, long-term care policies, Medicare supplemental health insurance, or coverage only for a specific disease or condition.

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Acquiring Minimum Essential Health Coverage

Many in the United States are already covered by health insurance that will count as minimum essential coverage. To comply with the new legislation, they need only continue the coverage they already have. For those who do not have health insurance coverage, or who are considering changing their coverage, several options will be available:

- **State health insurance exchange:** Beginning in 2014,[1] The ACA provides for the establishment of state health insurance exchanges through which an individual can purchase health insurance coverage. A health insurance plan offered through a state health insurance exchange must meet certain requirements, including offering the essential health benefits discussed earlier. Through the exchanges, insurance companies will compete for business on a level playing field, offering qualified consumers a choice of health plans to fit their individual needs.

    - *Premium assistance tax credit* – A low-income individual[2] who purchases a qualified health plan through a health insurance exchange may be eligible to receive a refundable "premium assistance" tax credit. The U.S. Treasury pays the premium assistance credit amount directly to the health insurance company, with the individual being responsible for any remaining premium.
    - *Cost-sharing subsidy* – An individual may also qualify for a "cost-sharing" subsidy, available through the insurance exchange. The subsidy reduces the dollar amount of "out-of-pocket" expenses (deductibles or co-payments) that the individual might otherwise pay. This subsidy is generally limited to low-income individuals[3] and is only available for those months when the individual also qualifies for a premium assistance tax credit.
    - *Benefit coverage level* – The health insurance plans offered through the health insurance exchanges will generally be available at four "levels" or price points. Each level covers a specified percentage of the actuarial value of the benefits provided by the plan:

Plan	% of Actuarial Value Covered
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

As a general rule, the higher the percentage of benefits covered, the higher the premium. ACA generally eliminated the ability of health insurers to charge higher premiums based on factors other than age, tobacco use, rating area, or family size. An individual's "required contribution" is the premium for the lowest-cost bronze plan that would cover the individual and all non-exempt members of his or her family, reduced by any premium assistance tax credit. The required contribution premium amount is also the standard in determining if a policy is "affordable" or not.

[1] The affordable health insurance exchanges are expected to be operational in October 2013.
[2] Generally, someone earning from 100% up to 400% of the federal poverty level (FPL) for the family size involved. For 2013, 100% of the FPL for a family of one in the continental U.S. is $11,490; for a family of four it is $23,550; for a family of eight it is $$39,630.
[3] Generally, those earning less than 250% of the FPL for the family size involved.

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- **Coverage under an employer-sponsored plan:** Many individuals (including individuals covered under COBRA and retirees) will acquire minimum essential health coverage through an employer-sponsored group health plan. An employee's "required contribution" is the portion of the premium for the lowest-cost bronze plan that would cover the individual and all non-exempt members of his or her family.

  An employer-sponsored plan will not meet the requirements to be considered minimum essential coverage if the plan fails either of two tests:

  - *Coverage must be "affordable"* – In general, coverage under an employer-sponsored plan is "affordable" if the employee's share of the premium for the employer-provided coverage does not exceed 9.5% of the employee's household income for the taxable year.
  - *"Adequate" coverage* **–** For ACA purposes, a plan is considered to provide adequate coverage (also called "minimum value") if the plan's actuarial value (i.e. share of the total allowed costs the plan is expected to cover) is at least 60% (i.e. equivalent to a "bronze" plan).

  If an employer-sponsored health plan fails to meet either of these requirements, the employee could decline the employer-sponsored health insurance and apply for a policy through a state health insurance exchange, possibly receiving a premium assistance tax credit or a cost-sharing subsidy.

- **Other sources of qualified health insurance coverage:** Include the following:

  - "*Grandfathered" plans* – An individual may keep an individual or group plan that was in effect on March 23, 2010. Such coverage counts as minimum essential health coverage.
  - *The "open" market* – An individual is free to purchase health coverage through the open market, outside of a state health insurance exchange or employer-sponsored health plan.

The "Penalty" for Not Having Minimum Essential Health Coverage

If a non-exempt individual does not maintain the required minimum essential health coverage, then a penalty, the "shared responsibility payment," will be due with that individual's federal income tax return for that year. The shared responsibility payment for the entire year is the lesser of:

1. The annual average cost of a bronze-level plan for the individual and any non-exempt family members purchased from a health insurance exchange ÷ 12 x the number of months without coverage, or
2. The sum of the monthly penalty amounts for months when the required coverage was not maintained.

The monthly penalty amount used in this calculation is equal to the greater of:

1. A flat dollar amount (the "applicable dollar amount") x the number of uninsured adults in the household, ÷ 12, (limited to the applicable dollar amount x 3), or
2. An amount equal to the "applicable percentage" x the amount by which the taxpayer's household income exceeds the taxpayer's income tax filing threshold.

Individual Responsibilities Under the ACA

The table below shows the annual percentages and applicable dollar amounts for calendar years 2014-2016. For years after 2016, the percentage of income value remains unchanged, but the applicable dollar amount will be subject to adjustment for inflation.

Year	Applicable Dollar Amount	% of Income
2014	$95	1.0%
2015	325	2.0%
2016	695	2.5%

The flat dollar amount for a child under the age of 18 is one-half of the adult amount.

Example: In 2014, the Smith family, the parents and three children under 18, uses the Married Filing Jointly filing status. The family's household income for the year is $120,000, with an estimated filing threshold of $20,000. They are uninsured for 10 months of the year. The annual cost of a bronze-level plan for the family is $22,500.

(A) Annual average cost for a bronze-level plan *- (($22,500 ÷ 12) x 10) =* ***$18,750.00.***

(B) Monthly flat dollar amount *– The lesser of $95 x 3.5 adults (each child counts as one-half) = $332.50; (($332.50 ÷ 12) x 10) =* ***$277.08****; or $95 x 3 = $285.00; (($285.00 ÷ 12) x 10) =* ***$237.50.***

(C) Monthly percentage of household income *– $120,000 - $20,000 = $100,000; $100,000 x 1.0% = $1,000; (($1,000 ÷ 12) x 10) =* ***$833.33****.*

The sum of the monthly penalty amounts is the greater of the flat dollar amount, limited to 3 x the applicable dollar amount, ($237.50) or the monthly percentage of household income ($833.33).

The 2014 penalty amount for the Smith family is thus $833.33, the lesser of the average cost of a bronze-level health plan ($18,750) or the sum of the monthly penalty amounts ($833.33).

Seek Professional Guidance

The foregoing is a simplified, high-level review of a complex piece of legislation. Further, the rules and regulations issued to implement this legislation are subject to change. The guidance of knowledgeable income tax, health insurance, and other financial professionals is highly recommended.