The Healthcare Playbook

A Small Business Guide to the

Patient Protection and Affordable Care Act (PPACA)

NFIB
The Voice of Small Business®

December 2012
NFIB.com/healthcareplaybook

The Healthcare Playbook

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

Table of Contents

PPACA Timeline 3

PPACA Mandates 6

PPACA Tax Information 11

PPACA Compliance 14

Additional Resources 16

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 changes to the insurance purchased in the small group and individual insurance markets, this timeline provides a quick glance at changes that have already occurred and that can be expected in coming years.

2010

- A **temporary small business tax credit** is available for six 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. Beginning in 2014, if firms qualify for the tax credit, insurance coverage must be purchased in a Small Business Health Options Program (SHOP) exchange.
- On July 1st, a **10 percent excise tax on indoor tanning** services began.
- **In June, early insurance reforms began.** Temporary high-risk pools were created for uninsured adults with pre-existing conditions. For plans that began in late September, there were prohibitions on lifetime and annual benefit spending limits, non-group plans were not allowed to cancel coverage, plans cover most preventive care and dependents were allowed to remain on parents' policies until age 26.

2011

- **Manufacturers and importers of brand-name drugs** began paying a $2.5 billion tax.
- **Consumer-driven account limits began** on over-the-counter medications. **The penalty for using HSAs** for non-qualified purchases doubled to 20 percent.

2012

- **Businesses would have been required to send additional Form 1099s** for every business-to-business transaction of $600 or more, **but this provision was repealed in 2011**.
- **Manufacturers and importers of brand-name drugs tax** rises to $2.8 billion.
- **Employers must provide a Summary of Benefits and Coverage (SBC) to employees** during open enrollment season. Health insurance plans (in the case of fully insured products) and health insurance plan sponsors (in the case of self-insured products) design the summaries, but employers must distribute the summaries to employees.

2013

- **Employers must determine size** – whether they will be considered "large" or "small" – for the requirements of the employer mandate. Penalties will not occur until 2014, 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 2014, the preceding calendar year is 2013. Size is determined monthly by adding the number of full-time employees to the number of (FTE) employees. A large business employs more than 50 (FTE) employees and a small employer employs fewer than 50 (FTE) employees during a calendar month.
  - **Full-time employees:** Full-time employees are individuals who have worked an average of 30 hours per week in a month (130 total monthly hours).
  - **New counting requirements for part-time employees:** Part-time employees' hours will be converted into FTE employees for determination of employer size and penalty liability. For

example, if six employees each work five hours per week, they will count as if the firm had one additional full-time employee.

- **Employers must determine whether employees are full-time employees**: Employers may measure monthly hours or utilize a look-back period of 3-12 months to determine whether average employee hours exceeded 30 hours per week (130 hours per month).
- **Employers must notify each employee** at the time of hiring written notice of 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 60 percent actuarial value.
- **Increased reporting information** to the Internal Revenue Service (IRS) for employers who file more than 250 Form W-2s disclosing the total cost of health insurance (both employer and employee contributions).
- **Medicare payroll tax** on wages and self-employment income in excess of $200,000 ($250,000 joint) will increase by 0.9 percent.
- **Medicare investment tax imposes a new 3.8 percent tax** on investment income for higher-income taxpayers.
- **Flexible Spending Accounts** will be limited to a maximum of $2,500 annual contribution.
- Employers will be required to report employee **health benefits on W-2s for tax year 2012.** Until the IRS issues additional regulations, employers that file less than 250 Form W-2s will not be required to report this information.
- **The threshold at which medical expenses** as a percentage of income, are deductible, increases to 10 percent, from 7.5 percent.
- An annual **2.3 percent excise tax** on **medical devices** will begin.

2014

- **The $8 billion small business health insurance tax** will fall on the fully insured market, where the majority of small businesses purchase insurance.
- **Health insurance exchanges** open to individuals and small businesses with up to 100 employees, although states may limit the small employer definition to no more than 50 employees until 2016.
- **Premium credits kick in,** and the federal government begins subsidizing the purchase of health insurance for individuals with incomes up to 400 percent of the federal poverty line.
- **All health insurance policies** must provide an essential health benefits package that will be defined by federal and state officials.
- **Individual mandate tax begins.** Most individuals without minimum essential coverage are subject to a tax. Individual mandate tax penalty begins at $95 or 1 percent of household income, whichever is greater.
- **Employer mandate begins,** requiring growing firms to provide insurance. The penalties are based on the number of FTE employees during the preceding calendar year; whether the firm offers coverage to full-time employees and whether coverage is "affordable" and meets "minimum value;" and whether one or more full-time employers qualify for a government subsidy. An employee qualifies for a subsidy if his or her household income is between 138 and 400 percent of the federal poverty line and the employee's share of the self-only portion of the premium exceeds 9.5 percent of their income. Here are some scenarios:
  - **More than 50 FTE employees and the business does not offer insurance to the full-time employee,** with one or more full-time employees receiving premium subsidies because their share of the self-only portions of the premiums exceeds 9.5 percent of their income. The penalty is $2,000 per full-time employee (minus the first 30 full-time employees).
  - **More than 50 FTE employees and the business offers insurance** with one or more full-time employees receiving premium subsidies. The penalty is the lesser of $3,000 per subsidized full-time employee or $2,000 per full-time employee (minus the first 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 levels of coverage.
- **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 exchange. If an employer chooses to offer health insurance, it must cover the essential health benefits package.

- **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 family coverage based on geography, age and smoking status. Insurers must offer coverage to anyone. The law also limits out-of-pocket cost-sharing and insurance plans must include government defined essential health benefits and multiple coverage levels.

2015

- **Small business health insurance tax rises to** $11.3 billion.
- **Individual mandate tax penalty** increases to $325 or 2 percent of income, whichever is greater.

2016

- **Small business health insurance tax remains** $11.3 billion.
- **Individual mandate tax penalty** increases again, to $695 or 2.5 percent of income, whichever is greater.

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** may allow large employers to enter the exchange.

2018

- **Cadillac tax** begins on high-cost plans.
- **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

Individual Mandate Tax and Minimum Essential Coverage

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

Failure to demonstrate and maintain minimum essential coverage 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. In 2015, it rises to $325 or 2 percent. In 2016, it reaches $695 or 2.5 percent. (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 2014, the healthcare law requires "large" employers—businesses with 50 or more full-time equivalent (FTE) employees—to either provide minimum essential coverage or pay a penalty. If a "large" employer *does not* offer minimum essential coverage to full-time employees, and one or more full-time employees are eligible for a subsidy on the individual exchange (income below 400 percent of the federal poverty level), then the employer will be subject to a $2,000 per full-time employee penalty (minus the first 30 full-time employees). If a "large" employer *does* offer minimum essential coverage to full-time employees, but it is deemed unaffordable (self-only employee premiums exceed 9.5 percent of 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).

Full-Time Employees
For purposes of defining a full-time employee, PPACA defines a full-time employee as anyone who is employed an average of at least 30 hours per week (130 hours per month).

Employers may determine each current employee's full-time status by looking back at a defined period of not less than three but not more than twelve consecutive months to determine whether the employee average at least 30 hours of service per week.

Large employers must offer minimum essential coverage to full-time employees or pay employer mandate penalties.

Seasonal Employees
Under PPACA, an employer is not considered "large" (and thus, subject to the employer mandate) if the employer has 50 FTE employees for 120 days or fewer during a calendar year. The Internal Revenue Service (IRS) and Department of Labor (DOL) continue to 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."

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 and subject to the employer mandate. Conversion is done by adding up all of the hours worked by employees who are not full-time employees and dividing the total by 120. For example, if 6 employees each work 5 hours per week, they will count as if the firm has one additional full-time employee, calculated monthly (6 employees x 5 hours per week each = 30 hours per week x 4 weeks = 120 hours/120 = 1 FTE employee).

Large employers will not be required to offer minimum essential coverage to part-time employees, but

their hours will be used to determine whether the employer is “large” and subject to the requirements and penalties of the employer mandate.

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-timers 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; and (3) whether one or more employees qualify for 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 premiums exceeds 9.5 percent of income or if the insurance does not meet the 60 percent minimum value threshold.

Here are some scenarios:

Large Non-Offering Firms:

- More than 50 FTE employees.
- Does not offer minimum essential coverage. One or more full-time employees are receiving premium subsidies.
- Penalty = $2,000 per full-time employee (minus the first 30 full-time employees).
- For example, in 2014, Employer A does not offer coverage and has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in an individual exchange. Employer A owes $2,000 per full-time employee, 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.[i] Therefore, the employer would pay a monthly portion of the total penalty (1/12 of the total each month) or $11,666.66 per month.

Small Non-Offering Firms:

- 50 or fewer FTE employees.
- Does not offer minimum essential coverage.
- No penalty.

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

- More than 50 FTE employees and offers minimum essential coverage.
- One or more full-time employees receiving premium subsidies because premiums exceed 9.5 percent of income affordability test or does not meet the 60 percent minimum value test.
- Penalty equals the lesser of $3,000 per subsidized employee or $2,000 per full-time employee (minus 30 full-time employees).
- For example, in 2014 Employer B offers health coverage and has 100 full-time employees, 20 of whom receive a tax credit for the year for enrolling in an individual exchange because self-only premiums exceed 9.5 percent of 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 amount of the penalty 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.[ii] Therefore, Employer B would pay a monthly portion of the total penalty (1/12 of the total each month) amounting to $5,000 per month.

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

- More than 50 FTE employees.
- Offers minimum essential coverage 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:

- **Waiting Periods**: Beginning in 2014, there are extra penalties for businesses that have a waiting period exceeding 90 days before employees are eligible for minimum essential coverage.
- **Auto-Enrollment**: Beginning in 2014, employers with more than 200 employees would have been required to auto-enroll employees in the employer's health plans, though the employee may opt out. Guidance from the IRS has indicated this auto-enrollment requirement will be delayed beyond 2014.
- **W-2 Reporting Requirements:** Beginning in 2013, businesses with more than 250 employees will have to report the cost of coverage under an employer-sponsored group health plan. 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 employer reporting requirement until the IRS issues further regulations.

Factors Affecting All Employers Offering Health Insurance, Whether or Not They 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.

These markets have historically been regulated at the state level. Currently, differences exist in how the individual market and small group market function. The 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.

Essential Health Benefits

Beginning in 2014, all non-grandfathered individuals and small group market health insurance plans must cover a broad list of ten mandated benefit categories known as essential health benefits. U.S. Department of Health and Human Services (HHS) has mandated that states to 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.

The law outlines benefit categories that will be required to be included in any package deemed to meet the essential health benefits. Section 1302 of the PPACA specifies that all plans meeting these requirements 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 will have to be supplemented with additional services to comply with the law. The more costly, supplemented plans will be called Essential Health Benefit-Benchmark Plans.

There will be limits on annual cost sharing and they are tied to current HSA limits ($5,950 for individual and $11,900 for a family). The Secretary of the HHS will be allowed to review and update the Essential Health Benefits package annually beginning in January 2016.

Prohibition of Pre-existing Condition Exclusion

Changes to the pre-existing condition exclusion for children apply to all plans except grandfathered individual market plans.

- Children: Beginning on September 23, 2010, children under the age of 19 cannot be denied from coverage based on pre-existing conditions.
- Adults: Beginning on January 1, 2014, health insurers will be prohibited from denying coverage based on pre-existing conditions for all individuals.

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 today have a $1 million dollar lifetime cap on the amount an insurance company will pay out on a policy. The prohibition on lifetime limits will be phased in and takes full effect on January 1, 2014. Until then, lifetime limits on coverage are allowed at discretion of the Secretary of the HHS. 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.

Rescissions

Beginning on September 23, 2010, insurers were prohibited from rescinding coverage except in cases of fraud. This will apply to all plans.

Dependent Coverage

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

Coverage of Preventive Services

Beginning on September 23, 2010, all plans that are not 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 the HRSA (to be issued no later than August 1, 2011).

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. HHS has proposed the deductible limits may be exceeded if a health insurance plan cannot reasonably reach the 60 percent actuarial value minimum without exceeding the deductible limits.

Minimum Value

Beginning in 2014, all non-grandfathered health insurance plans must meet a 60 percent minimum actuarial value threshold. 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. Proposed regulations indicate annual employer contributions to HSAs and amounts newly made available under 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)

The states, along with the Secretary of the HHS, will be responsible for developing standards for geographic rating areas. The Secretary of the HHS, in collaboration with the National Association of Insurance Commissioners (NAIC), will develop the "age bands" used for the age rating process.

To obtain more information on how these changes affect your health insurance plan, please contact your agent or broker, or call your health insurer. You can also find information on your state insurance commissioner's website
http://www.naic.org/state_web_map.htm

For more information, including updates from the HHS, please go to http://www.hhs.gov/.

To access the timeline for implementation of the healthcare law, please see Reform Timeline
http://www.nfib.com/business-resources/healthcare/reform-timeline.

---

[i] 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
[ii] Ibid, p. 40

PPACA Tax Information

Small Business Health Care 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 is 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 more than 25 employees and/or $50,000 in average annual wages are not eligible for any credit.

The rules and calculations to determine eligibility for the credit are complicated. 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.

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

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 a 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.

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.

Expanded 1099 Information Reporting

In 2012, businesses would have been required to provide Form 1099-MISC for additional business-to-business transactions. In 2011, this provision of the healthcare law was repealed. However, previous 1099 reporting requirements still exist.

Medical Device Tax

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

Limitation of Deduction Medical Expenses

Currently, an individual may deduct the cost of medical expenses exceeding 7.5 percent of the taxpayer's adjusted gross income (AGI) on their individual tax return. Beginning in 2013, the medical expense threshold is increased to costs exceeding 10 percent of the taxpayer's AGI.

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

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) will be 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' rate 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 will be assessed on certain investment income. The tax is assessed on the lesser of net investment income or the modified adjusted gross income (MAGI) over the threshold amount of $250,000 for a joint filer, $200,000 for an individual filer, or $125,000 for a married individual filing a separate return. Net investment income includes income from interest, dividends, annuities, royalties, and rents. Income in these categories derived from a trade or business is not subject to the tax, unless ownership in the trade or business is considered passive.

Small Business Health Insurance Tax

In 2014, a new tax on fully insured health insurance products will begin. The small business health insurance tax will cost small businesses and their employees $102 billion in the first 7 years, and over $200 billion in the following 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

Tax on Cadillac Health Insurance Plans

Beginning in 2018, insurers 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 must create and distribute the SBC to employees.

W-2 Reporting Provisions

In 2013, Section 9002 of the Patient Protection and Affordable Care Act (PPACA) will require employers to calculate and report the aggregate cost of employer-sponsored insurance coverage on employees' Form W-2s for their 2012 benefits. 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 information 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 2014, Section 1514 of the PPACA will require any "offering employer" and "non-offering 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]

Requirement of Written Notice for Individual Health Insurance Exchange Availability

In 2014, the healthcare law will require employers to provide a written notice to employees on 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.

For more information, including updates from the HHS process, please go to http://www.hhs.gov/.

To access the timeline for overall implementation of the healthcare law, please visit our reform timeline http://www.nfib.com/business-resources/healthcare/reform-timeline.

---

[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/advocacy/healthcare

NFIB Research Foundation Employer Mandate Crib Sheet
http://www.nfib.com/research-foundation/cribsheets/employer-mandate

NFIB Research Foundation Individual Mandate Crib Sheet
http://www.nfib.com/research-foundation/cribsheets/individual-mandate

NFIB Research Foundation Small Business Health Insurance Tax Crib Sheet
http://www.nfib.com/research-foundation/cribsheets/health-insurance-tax

Employer Mandate Resources:
IRS Guidance for Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage http://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 http://www.irs.gov/pub/irs-drop/n-11-73.pdf
- IRS FAQs from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods http://www.irs.gov/pub/irs-drop/n-12-17.pdf

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 Proposed Rule on Essential Health Benefits Package
http://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

Primer on Reform: healthreform.kff.org/

Summary of Reform: www.kff.org/healthreform/8061.cfm

Health Reform in the States-State Legislative Action: www.ncsl.org/default.aspx?tabid=20231

NAIC Health Reform Resource Center: www.naic.org/index_health_reform_section.htm

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/

New Regulations: www.regulations.gov

Glossary related to PPACA: www.naic.org/documents/index_health_reform_glossary.pdf