Affordable Care Act

Recent IRS guidance affecting employer health benefit plans
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In Notice 2015-17, the IRS offers relief from excise tax under the Affordable Care Act (ACA) for health reimbursement arrangements (HRAs), including insurance premium reimbursement arrangements, available to the employees of small employers and to S-corporation shareholders.

Specifically, the notice generally provides these taxpayers with relief from certain Affordable Care Act rules that would impose excise taxes on employers that sponsor those arrangements, unless the arrangement at issue is offered in connection with another employer group health plan. The notice addresses fact patterns that were not previously addressed and generally gives taxpayer-favorable transition relief.

This guidance resolves technical questions for S-corporation shareholders and for small employers for which offering a group health plan may not be feasible. The limited transition period means that smaller employers will have to monitor this issue for a period after June 30, 2015.

Background

In the fall of 2013, the IRS issued Notice 2013-54, concluding that stand-alone HRAs and other reimbursement arrangements designed to pay for or reimburse an employee for the cost of health care coverage purchased on the individual market (referred to as an “employer payment plan”) fail to comply with certain Affordable Care Act market reform requirements (including the annual dollar limit and preventive service requirements), unless the employer payment plan is integrated with another group health plan. Although Notice 2013-54 did not affect existing tax rules permitting an employer to reimburse an employee on a pretax basis for the purchase of health care coverage on the individual market, it overshadowed these favorable tax rules by concluding that such an arrangement fails to comply with the Affordable Care Act market reform requirements. The result under Notice 2013-54 is that the employee could continue to receive reimbursement tax-free, but the employer would be subject to an excise tax under IRC §4980D of $100 per day, per affected participant.

Unlike other provisions of the ACA, the IRC §4980D excise tax and the market reform requirements are not limited to large-employer plans. Many smaller employers have traditionally accommodated their employees' need for health care coverage by agreeing to reimburse them for the purchase of coverage on the individual market.

This guidance resolves technical questions for S-corporation shareholders and for small employers for which offering a group health plan may not be feasible. The limited transition period means that smaller employers will have to monitor this issue for a period after June 30, 2015.
Small employers get transition relief from ACA excise tax for reimbursing the cost of individually purchased health insurance

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Transitional relief for small employers and 2% shareholder employees

Notice 2015-17 provides transition rules for certain employer payment plans and also clarifies the tax treatment of some of these arrangements.

1. Transition relief for small employers

   The notice provides that, for a limited transition period, an employer that is not considered an applicable large employer (ALE) (i.e., an employer with 50 or fewer full-time equivalent employees) that reimburses employees for individual health policy premiums, or Medicare Part B or Part D premiums, will not be subject to the IRC §4980D excise tax. The transition relief applies (i) for 2014 to employers that are not ALEs for 2014 and (2) for January 1 through June 30, 2015, to employers that are not ALEs for 2015.

   This transition rule provides helpful relief for small employers. Nonetheless, after June 30, 2015, employers that offer employee payment plans will be liable for the §4980D excise tax, unless they have purchased group health coverage by that date or have discontinued the arrangement.

2. Transition relief for S-corporation arrangements for 2% shareholder-employees

   The notice provides that, until future guidance is issued on the taxation of an arrangement to reimburse the individual health insurance coverage of a 2% or more shareholder-employee, the employer will not be subject to the IRC §4980D excise tax for maintaining such an arrangement. This transition relief will apply at least through 2015.

   Under existing guidance (Notice 2008-1), if an S corporation establishes a policy of paying for, or reimbursing premiums for, individual health insurance coverage of a 2% or more shareholder-employee, the payment or reimbursement is included in the shareholder-employee's income but generally is not considered wages subject to Social Security and Medicare taxes. The payment or reimbursement of a 2% or more shareholder-employee’s individual health care coverage premiums is treated for income tax purposes like a partnership guaranteed payment. Similar to payment of partnership health care coverage, 2% or more shareholder-employees may deduct the amount of the premiums under IRC §162(l), provided other specified criteria are satisfied.

   S-corporation owners have questioned the application of Social Security and Medicare taxes to the payment or reimbursement of individual health care premiums following the release of Notice 2013-53. The IRS may be considering additional guidance to address this issue.

   The notice reiterates that the Affordable Care Act market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year.
Arrangements covering only a single employee

The notice reiterates that the Affordable Care Act market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year. (See IRC §9831(c).) If an employer reimburses the individual insurance coverage for only one employee, it would not be subject to the market reform rules and therefore would not be subject to the IRC §4980D excise tax. The notice clarifies, however, that the arrangements are treated as a single arrangement and would be treated as covering more than one current employee, if the corporation maintains more than one reimbursement or health care arrangement.

Increases in employees’ compensation to assist with payments on the individual market

The notice clarifies that an employer will not be considered to have established an employee payment plan if the employer merely increases employees’ compensation but does not condition the increased compensation on the purchase of health coverage (and the employer does not otherwise endorse a particular policy, form or issuer of health insurance). The implication is that if an employer is paying premiums directly or receiving substantiation of premiums and reimbursing those premiums for two or more active employees, the arrangement is a group health plan. In contrast, an increase in compensation is merely a taxable payment that may approximate, but is not tied directly to, the employee’s purchase of insurance coverage.

Treatment of employer payment plan as taxable compensation

The notice reiterates that the payment or reimbursement of an employee’s individual health care policy is considered an employee payment plan subject to the Affordable Care Act market reform provisions, whether the reimbursement is provided on a pretax or post-tax basis.

Medicare premium reimbursement arrangements and TRICARE-related HRAs

The notice provides that arrangements under which an employer reimburses some or all of Medicare Part B or Part D premiums for employees or some or all of the medical expenses for employees covered by TRICARE constitute an employee payment plan that is subject to the Affordable Care Act market reform provisions. The notice provides, however, that these types of employee payment plan arrangements will be treated as integrated with a group health plan (and likely would comply with the Affordable Care Act annual limit and preventive care requirements) if (i) the employer offers a group health plan (other than the employee payment plan) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value; (ii) the employee participating in the employer payment plan is actually enrolled in Medicare Parts A and B, or TRICARE, as applicable; (iii) the employer payment plan is available only to employees who are enrolled in Medicare Part A and B or Part D, or TRICARE, as applicable; and (iv) the employer payment plan is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums, or to TRICARE cost-sharing or excepted benefits, as applicable.
Proposed guidance now available on ACA “Cadillac” tax for higher cost health coverage

Currently, qualified employer group health coverage is generally exempt from federal income tax (FIT), Social Security/Medicare (FICA) and federal unemployment insurance (FUTA) regardless of the employer’s price tag.

While the FIT, FICA and FUTA rules haven’t changed, starting in 2018, the Affordable Care Act (ACA) calls for a nondeductible business excise or “Cadillac” tax under IRC §4980I when the value of employee health benefits exceed a certain value.

The ACA already imposes an excise tax on employer reimbursements for health insurance purchased by employees (see page 10), a fact that has already caused some businesses to alter the way in which health benefits are offered to their employees.

Proposed regulations issued concerning Cadillac tax

The Department of the Treasury and IRS recently issued Notice 2015-16, providing some guidance and requesting comments on IRC §4980I, which is set to take effect for tax years beginning after December 31, 2017. IRC §4980I imposes a 40% nondeductible excise tax on the amount by which the aggregate cost of “applicable employer-sponsored coverage” provided to an employee exceeds a statutory threshold amount.

Notice 2015-16 addresses and requests comments on substantive issues, such as the definition of “applicable employer-sponsored coverage”; how the cost of applicable employer-sponsored coverage may be determined, including the interaction with the COBRA applicable premium rules; and when adjustments may be made to the threshold amount for qualified retirees, high-risk professions, age and gender.

Treasury and IRS plan to issue a second notice that will address procedural and administrative issues related to the calculation and assessment of the excise tax. This process will provide stakeholders with multiple opportunities to provide comments on the implementation and administration of the excise tax before Treasury and IRS issue proposed regulations.

Background

Beginning in 2018, providers of applicable employer-sponsored coverage (applicable coverage) may be subject to a 40% nondeductible excise tax under IRC §4980I on the aggregate cost of the coverage in excess of a “threshold” amount (excess benefit).

The threshold amount for 2018 is $10,200 for self-only coverage and $27,500 for all other coverage. (The 2018 threshold amount may increase if the per-employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (FEHBP) for plan year 2018 exceeds a specified percentage.)

For 2019, the threshold amount is indexed to the Consumer Price Index (CPI-U), plus 1%. In 2020 and beyond, the base amount is indexed by CPI-U, rounded to the nearest $50.

Starting in 2018, IRC §4980I imposes a 40% nondeductible excise tax on the amount by which the aggregate cost of “applicable employer-sponsored coverage” provided to an employee exceeds a statutory threshold amount.
The threshold amounts may be adjusted for age and gender and increased for workers in “high-risk professions” and retirees who have attained age 55 and are not yet eligible for Medicare.

In addition, coverage provided under a multiemployer plan is treated as other-than-self-only coverage. Thus, multiemployer plans may always use the higher dollar threshold amount.

The excess benefit – the cost of the plan above the threshold amount – is based on the “aggregate cost” of an employee’s applicable coverage and is determined on a monthly basis. The excise tax is assessed if the aggregate cost for any month exceeds 1/12th of the threshold amount for the calendar year including that month.

The cost of applicable coverage is determined under rules “similar” to the rules for determining the COBRA applicable premium under IRC §4980B(f)(2)(C). Under COBRA, the amount a plan may charge for continuation coverage is limited to 102% of the “applicable premium,” which is the cost of coverage for a specified period for similarly situated beneficiaries who are not eligible for COBRA.

Two methods are permissible to determine the COBRA applicable premium for self-insured plans:

1. The actuarial basis method, under which the cost equals a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries, determined on an actuarial basis, taking into account factors prescribed by Treasury and the IRS in regulatory guidance (to date, no guidance has been published setting forth the factors that may be taken into account)

2. The past cost method, which may be used by the plan administrator, other than when a significant change occurs in coverage under the plan or in employees covered by the plan

The current COBRA regulations provide that plans and employers must calculate the COBRA applicable premium in good faith compliance with a reasonable interpretation of the statutory requirements.

The statute provides that, in determining the cost of applicable coverage, the amount attributable to the IRC §4980I excise tax is not taken into account for purposes of determining the cost of coverage.

Special rules apply for determining the cost of health flexible spending arrangements (health FSAs), health savings accounts (HSAs) and retiree coverage.

Liability for the excise tax is imposed on the insurance issuer, the plan administrator for self-insured plans, or the employer itself if the plan is both self-insured and self-administered (the coverage provider).

Even if the tax is not imposed on the employer, however, the employer is the party responsible for calculating the excess benefit subject to the excise tax and apportioning the excess benefit to each coverage provider. The obligation to calculate the excess benefit applies to all employers, regardless whether they are private companies, nonprofits or governmental employers.

For 2018, and subject to change, the threshold amount above which the Cadillac excise tax applies is $10,200 for self-only coverage and $27,500 for all other coverage.
A. Definition of applicable coverage

IRC §4980I defines applicable coverage, with respect to “employees,” as coverage under a “group health plan” that the employer makes available to the employee and that is excludable from the employee’s gross income under Section 106 or would be excludable if it were employer-provided coverage. A group health plan meeting the basic definition of applicable coverage is considered applicable coverage “without regard to whether the employer or employee pays for the coverage.” In addition, coverage may be considered applicable coverage whether the employer provides the coverage to the employee on a pretax basis or the employee pays for the coverage with after-tax dollars.

For purposes of IRC §4980I, an employee includes any “former employee, surviving spouse, or other primary insured individual.” Accordingly, applicable coverage includes retiree applicable coverage.

In addition, applicable coverage includes coverage under a group health plan for self-employed individual, within the meaning of IRC §401(c) (e.g., partners), if a deduction is allowable under IRC §162(l) for the cost of the coverage.

In addition to a comprehensive medical health group health plan, the following types of coverage are included in the definition of applicable coverage:

1. Health flexible spending arrangements (Health FSAs)
2. Health spending accounts (HSAs) and Archer MSAs, if amounts are contributed on a pretax basis
3. Governmental plans
4. On-site medical clinics, unless only de minimis medical care is provided
5. Multiemployer plans
6. Certain “excepted benefit” coverage, including coverage only for specified disease or illness, and hospital indemnity or fixed indemnity insurance, if payment for the coverage is excluded from gross income or is deductible under IRC §162(l)

The following types of coverage are explicitly excluded from applicable coverage:

1. Coverage (whether through insurance or otherwise) described in IRC §9832(c)(1) other than coverage for on-site medical clinics; the exclusion includes:
   (a) Accident or disability income insurance
   (b) Coverage issued to supplement liability insurance
   (c) Workers’ compensation
   (d) Automobile medical insurance
   (e) Other similar coverage that is secondary or incidental to other insurance benefits
2. Coverage for long-term care
3. Coverage for specified disease or illness described in IRC §9832(c)(3), if offered as an independent, noncoordinated benefit and paid for with after-tax dollars
4. Hospital indemnity or other fixed indemnity insurance described in IRC §9832(c)(3), if offered as an independent, noncoordinated benefit and paid for with after-tax dollars
5. Coverage under a separate policy, certificate or contract for insurance for treatment of the mouth or eye

The notice addresses a number of open issues related to the types of coverage included in the definition of applicable coverage and requests comments on specific issues, some of which are discussed below.

HSAs/Archer MSAs

Recently, many employers have moved employees to high-deductible health plans (HDHPs) in an attempt to manage their rising health care costs. Frequently, the HDHPs are combined with an HSA. It is expected that employers will continue to use HDHPs to lower the cost of their health care plans to avoid the application of the IRC §4980I excise tax. Because of the increased use of HDHPs, employers may be particularly interested in how HSAs would be treated under IRC §4980I.

IRC §4980I treats employer contributions to an HSA as applicable coverage. The notice answers the open question about how employee contributions to an HSA would be treated, concluding that employee pretax contributions to an HSA are treated in the same manner as employer contributions because they are excluded from income under IRC §106. Employee after-tax contributions to an HSA and Archer MSA, however, are excluded from applicable coverage.
On-site medical clinics

Some large employers have also established on-site medical clinics to manage their health care costs and maintain a productive workforce. IRC §4980I includes on-site medical clinics in the definition of applicable coverage.

The notice indicates, however, that forthcoming proposed regulations will likely provide that applicable coverage does not include on-site medical clinics that offer only de minimis medical care to employees. The notice cites existing Treasury regulations for COBRA continuation coverage in explaining the circumstances under which an on-site medical clinic does not constitute a group health plan subject to COBRA.

The clinic is not a group health plan if:

1. The health care consists primarily of first aid that is provided during the employer’s working hours for treatment of a health condition, illness or injury that occurs during those working hours.
2. The health care is available only to current employees.
3. Employees are not charged for the use of the facility.

Treasury and the IRS seek comments on how they should treat clinics that meet this criteria but provide services in addition to first aid, such as immunizations, injections of antigens provided by employees, provision of aspirin and other nonprescription pain relievers, and treatment of injuries caused by accidents at work (beyond first aid). They also seek comments on how to treat medical care provided at on-site medical clinics and how to determine the cost of coverage provided by an on-site medical clinic that is part of applicable coverage.

Excepted benefits

As discussed previously, IRC §4980I excludes some, but not all, excepted benefits from the definition of applicable coverage.

IRC §4980I excludes “any coverage under a separate policy, certificate, or contract of insurance” that provides limited scope dental and vision benefits. This statutory language leaves open the question whether self-insured limited scope dental and vision coverage must be included as applicable coverage subject to IRC §4980I.

The notice indicates that Treasury and the IRS are considering using their regulatory authority to propose an approach to self-insured, limited-scope dental and vision coverage that would qualify as an excepted benefit under the recently amended, excepted-benefit IRC §9831 regulations.

The approach under consideration would exclude such self-insured, limited-scope dental and vision coverage from applicable coverage for purposes of IRC §4980I.

Similarly, Treasury and the IRS are considering excluding from applicable coverage employee assistance programs that meet certain criteria under the recently amended, excepted-benefit regulations.
B. Determination of the cost of applicable coverage

The notice puts to rest the question of whether the cost of applicable coverage for purposes of the excise tax is the aggregate cost of the coverage:

1. That is “made available” to an employee
   Or
2. In which the employee is “enrolled”

Although certain subsections of the statute refer to coverage “made available,” the notice concludes that the operative language of IRC §4980I explicitly provides that the applicable coverage that must be compared to the threshold limit for purposes of determining the excise tax is the coverage in which the employee is “enrolled.”

The cost of the applicable coverage in which the employee is enrolled generally is determined under rules similar to the IRC §4980B(f)(4) COBRA applicable premium rules. The notice acknowledges that future guidance regarding the COBRA applicable premium likely will be needed to harmonize the COBRA rules with the rules under IRC §4980I.

Notice 2015-16 outlines an approach under consideration that would rely on a standard for similarly situated individuals that is similar to the standard used for COBRA.

Treasury and IRS seek comment on the approach, including provisions related to:

- **Aggregation by benefit package.** Treasury and IRS are considering an approach that would initially aggregate similarly situated employees covered by a particular benefit package provided by the employer. (All employers in a controlled group would be treated as a single employer for this purpose.)

- **Mandatory disaggregation (self-only coverage and other-than-self-only coverage).** After aggregating all employees covered by a particular benefit package, the employer would then be required to disaggregate the employee enrolled in self-only coverage or other-than-self-only coverage.

- **Permissive aggregation within other-than-self-only coverage.** Treasury and the IRS are considering an approach under which an employer would not be required to base its determination of the cost of applicable coverage for employees receiving other-than-self-only coverage on the number of individuals covered, in addition to the employee (e.g., employee plus one, employee plus two or family coverage), even if the actual cost of the coverage varied on this basis.

- **Permissive disaggregation.** Employers may be allowed but not required to further subdivide the group of employees that would be treated as similarly situated.

For employers that offer self-insured coverage, the notice seeks comments on issues related to the calculation of the cost of coverage based on the COBRA applicable premium methods, the actuarial-basis method and the past-cost method.

In addition, Treasury and IRS are considering a rule that would require a plan to use the valuation method that it chooses (actuarial-basis method or past-cost method) for at least five years unless there is a significant difference between periods in coverage under the plan or in employees covered by the plan.

The notice seeks comments on a number of issues with regard to HRAs, including:

- Whether the cost of applicable coverage under an HRA should be based on amounts newly made available to a participant each year
- Whether the cost of applicable coverage under an HRA should be determined by adding together all the claims and administrative expenses attributable to HRAs (separately for each level of coverage if the employer allocation differs by employee election) for a particular period and dividing that sum by the number of employees covered for that period (at that level of coverage)
- Whether the cost of applicable coverage should exclude an HRA that can be used only to fund the employee contribution toward coverage
- Whether the cost of applicable coverage should exclude an HRA that can be used to cover a range of benefits, some of which are not applicable coverage for purposes of the excise tax
- The implications of providing multiple methods for determining the cost of applicable coverage under an HRA

C. Applicable dollar limit

The notice seeks comments on adjustments for the dollar limits of the excise tax based on adjustments for qualified retirees, high-risk professions, age and gender. Notably, Treasury and the IRS seek comments on “whether it would be desirable and possible to develop safe harbors that appropriately adjust dollar limit thresholds for employee populations with age and gender characteristics that are different from those of the national workforce.”
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