Quickfinder®

Health Care Reform Quickfinder® Handbook (2021 Edition)

Updates for Year-End Developments

Instructions: This packet contains "marked up" changes to the pages in the *Health Care Reform Quickfinder® Handbook* that were affected by developments occurring after the *Handbook* was published. Additionally, changes were made based on other guidance issued after the Handbook was published. To update your *Handbook*, you can make the same changes in your *Handbook* or print the revised page and paste over the original page.

Health Insurance Mandate for Individuals

Tab 1 Topics

Overview

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (P.L. 111-148), signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, signed March 31, 2010, is collectively referred to as the Affordable Care Act (ACA).

Individual mandate. Under the ACA, taxpayers were subject to a shared responsibility penalty beginning in 2014 for any months during which they didn't have minimum essential coverage (MEC) or qualify for an exemption. The Tax Cuts and Jobs Act reduced the individual shared responsibility penalty to zero, effectively eliminating the individual mandate, for months beginning on or after January 1, 2019. The individual mandate under IRC Sec. 5000A is still in effect; however, because the penalty for violations is zero, the IRS is not enforcing the mandate for years after 2018.

Note: In response to the reduction of the penalty to zero, the individual mandate was challenged as unconstitutional because it no longer triggers a tax. In December 2019, the Fifth Circuit affirmed the decision of the trial court in finding that the individual mandate is unconstitutional (*Texas v. U.S.*). The case was appealed to the Supreme Court, which agreed to review this case and another case, combining the two. Oral arguments were held in November 2020. A decision will be announced in 2021. Until the case is decided by the Supreme Court, all provisions of the ACA remain in effect.

State Individual Health Coverage Mandates

Although the federal penalty for not having individual health insurance coverage has been reduced to zero for months beginning after 2018, several states have imposed an individual health care coverage mandate. When this *Handbook* was published, California, Massachusetts, New Jersey, Rhode Island, Vermont, and Washington, D.C. had mandates in place that require individuals to have certain health insurance coverage. As additional states are currently considering legislation to implement their own state health care mandate, this will be an important area to monitor.

An overview of the state mandates currently in place follows:

- *California*. Effective January 1, 2020. Residents and their dependents must have MEC, qualify for an exemption, or pay a penalty equal to the greater of 2.5% of gross income above filing threshold requirements, or $695 per adult and $347.50 per child, up to $2,085 per family. Employers that have any employees in California must comply with reporting requirements for that employee. IRS Forms 1094/1095 are used for state reporting. See Tab 8 for guidance on completing Forms 1094 and 1095.
- *Massachusetts.* Effective July 1, 2007. Residents over age 18 who are deemed able to afford health insurance must have minimum creditable coverage (MCC), which is a higher level of coverage than the MEC standard, or pay a penalty. For 2020 coverage, the penalty ranges from $22 per month to $135 per month depending on income, age, and family size. Employers are required to report annually. Employees with private insurance receive a Form MA 1099-HC with information used to report their coverage.
- *New Jersey.* Effective January 1, 2019. Residents and all family members must have MEC, qualify for an exemption, or pay a penalty equal to 2.5% of household income above the filing threshold or $695 per adult, up to $2,085 per family. Employers are required to report annually using IRS Forms 1094/1095. See Tab 8 for guidance on completing Forms 1094 and 1095.
- *Rhode Island.* Effective January 1, 2020. Residents and their dependents must have MEC, qualify for an exemption, or pay a penalty equal to the greater of 2.5% of household income, or $695 per adult and $347.50 per child, up to $2,085 per family. Information on employer reporting was not yet available.
- *Vermont.* Effective January 1, 2020. There is no penalty for 2020 if a resident does not have compliant coverage.
- *Washington, D.C.* Effective January 1, 2019. Residents and their dependents must have MEC, qualify for an exemption, or pay a penalty equal to the greater of 2.5% of family income above the federal tax filing threshold, or $695 per taxpayer. Employers are required to report annually, within 30 days after the IRS filing deadline. Forms 1094/1095 are used for state reporting. See Tab 8 for guidance on completing Forms 1094 and 1095.

Qualifying for a General Hardship Exemption

An individual who, for any month, is determined to have suffered a hardship in obtaining MEC under a QHP is an exempt individual for that month [IRC Sec. 5000A(e)(5); Reg. 1.5000A-3(h)(1)]. Individuals who obtain a hardship exemption or an affordability exemption from a state marketplace are eligible to purchase catastrophic coverage through the marketplace even if they do not otherwise qualify for catastrophic coverage. The application to apply for the exemptions is available at **www.healthcare.gov**.

A hardship exemption may apply for a specific month, a period of months, or an entire calendar year. Additionally, it can apply for periods that are in more than one calendar year (for example, from July–June). The hardship exemption usually applies for at least the month before, a month or months during which, and the month after, an individual cannot obtain coverage under a QHP due to any of the following reasons [HHS Reg. 45 CFR 155.605(d)(1)]:

1) The individual experiences financial or domestic circumstances, including an unexpected natural or human-caused event, such that he has a significant, unexpected increase in essential expenses.
2) The expense of purchasing a QHP would cause serious deprivation of food, shelter, clothing, or other necessities.
3) The individual has experienced other circumstances similar to items 1 or 2 that prevent him from obtaining coverage under a QHP.

Generally, an individual experiencing any of the following circumstances for one or more months can qualify for a hardship exemption:

- Being homeless.

Continued on the next page

- Being evicted or facing eviction or foreclosure.
- Receiving a shut-off notice from a utility company.
- Experiencing domestic violence.
- Experiencing the death of a close family member.
- Experiencing a fire, flood, or other natural or human-caused disaster that results in substantial damage to the individual's property.
- Filing for bankruptcy.
- Having medical expenses that could not be paid.
- Experiencing unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member.
- Claiming a child as a tax dependent when that child has been denied coverage in Medicaid or CHIP, and another person is required by court order to provide medical support to the child.
- Having no (or inadequate) coverage while awaiting an appeals decision from the marketplace.
- Having been determined ineligible for Medicaid in a state that didn't expand Medicaid coverage.
- Living in a county in which no QHP is offered.
- Living in a county in which only one issuer offers coverage.
- Living in a county in which all affordable plans offered provide coverage of abortion and such coverage is contrary to the individual's beliefs.
- Experiencing personal circumstances that create a hardship, such as when no affordable plans provide access to needed specialty care.
- Experiencing a hardship not listed that prevented the individual from getting health insurance.

An affordability exemption can be granted for 2021 coverage if an individual's cost of health coverage exceeds 8.27% of his projected household income.

What Is Minimum Essential Coverage?

The concept of minimum essential coverage (MEC) was essential to administering the individual mandate. However, the concept is also used for purposes of determining eligibility for the premium tax credit (see Tab 3) and determining if employer-sponsored coverage meets certain requirements to avoid an employer shared responsibility penalty (see Tab 5).

MEC is health insurance coverage under [IRC Sec. 5000A(f); Reg. 1.5000A-2(a); HHS Reg. 42 CFR 156.600]:

1) A government-sponsored program,
2) An eligible employer-sponsored plan,
3) A plan in the individual market,
4) A grandfathered health plan, or
5) Other health benefits coverage specified by HHS.

MEC does not include coverage under plans that offer only excepted benefits or other limited-scope benefits offered under a separate policy [Reg. 1.5000A-2(g)]. See *Coverage That Does Not Qualify as MEC* on Page 1-3.

See the *Minimum Essential Coverage (MEC) Chart* on Page 1-4 for a list of coverage that is considered MEC.

Government-Sponsored Programs

Government-sponsored programs include the following [Reg. 1.5000A-2(b)]:

- The Medicare program under part A of Title XVIII of the Social Security Act.
- The Medicaid program under Title XIX of the Social Security Act. Limited Medicaid coverage or optional coverage (for example, tuberculosis-related services) is generally not included.
- The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. CHIP "buy-in" coverage offered to individuals or families with income exceeding the eligibility level with little or no government subsidy for the premiums is MEC if the benefits provided are at least identical to the benefits provided under a state's regular CHIP coverage.
- Medical coverage under Chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program.
- The medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705.
- The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781.
- The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam veterans and veterans of covered service in Korea who are suffering from spina bifida.
- A health plan under Section 2504(e) of Title 22, U.S.C. for Peace Corps volunteers.

Eligible Employer-Sponsored Plan

In general, an *eligible employer-sponsored plan* means a group health plan or group health insurance coverage offered by an employer to the employee that is [IRC Sec. 5000A(f)(2); Reg. 1.5000A-2(c)(1)]:

- A governmental employer plan offered by a state, local government, or federal employer.
- Any plan or coverage offered in the small or large group market within a state.
- A grandfathered health plan (that is, a group health plan that was in existence on March 23, 2010) offered in a group market. See *Grandfathered Health Plan* on Page 1-3.
- A self-insured group health plan (offered in the large or small group market in a state), offered by, or on behalf of, an employer to the employee.
- COBRA or retiree coverage.
- Coverage under an expatriate health plan for employees and their family members.
- The Nonappropriated Fund Health Benefits Program of the Department of Defense.

Plan in the Individual Market

A *plan in the individual market* means health insurance coverage offered to individuals not in connection with a group health plan, including a qualified health plan (QHP) offered through the state insurance marketplace [Reg. 1.5000A-2(d)]. However, coverage under a short-term, limited duration individual policy is not MEC.

Qualified Health Plan (QHP). A *QHP* is a health plan that (1) meets certain criteria of the marketplace through which it is offered, (2) provides an essential health benefits package, and (3) is offered by a health insurance issuer that is licensed and in good standing [Reg. 1-5000A-1(d)(14).]

Health insurance coverage. The term *health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any (1) hospital or medical service policy or certificate, (2) hospital or medical service plan contract, or (3) health maintenance organization contract offered by a health insurance issuer.

Medical care. *Medical care* means amounts paid for [IRC Sec. 213(d)(1)]:

1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

tobacco users and non-tobacco users, the premium that applies to non-tobacco users is used in the calculations.

Premiums in the individual market may vary based on age, using age bands (for example, 20–29, 30–39) to set the premiums. An employer can choose to use the plan that offers the lowest-cost silver plan in the youngest full-time employee's age band to determine the lowest-cost silver plan to use for affordability purposes for all full-time employees in the same applicable location [Prop. Reg. 54.4980H-5(f)(7)(iii)(C)]. The employee's age band under that plan is used to determine the premium cost to use for each employee.

Note: When determining affordability for traditional employer-sponsored coverage, the employer uses the premium cost of one employer-sponsored group plan, which generally doesn't vary by employee. In contrast, the affordability test for ICHRAs can vary depending on the employee's location and age. This difference imposes additional complexity with respect to determining if an ICHRA provides affordable coverage for an employee.

An ALE that wants to contribute one set amount to ICHRAs for all full-time employees that would provide protection from a Section 4980H(b) penalty can choose to base the set amount on the lowest-cost silver plan with the most expensive premium for self-only coverage that applies for any of its full-time employees (nationally or based on multiple rating areas or states). However, this will result in employees who reside in locations with lower premiums receiving a benefit beyond the minimum required to protect the employer against the penalty (and therefore, a higher cost to the employer than necessary to protect against that liability). This method of determining the ICHRA contribution would also permit employees in the lower-cost areas to purchase more generous plans than employees living in areas with higher-cost premiums.

Example: Clay Technology is an ALE with offices in three cities in Florida. The company offers all full-time employees an ICHRA for 2020. Clay wants to be sure that each employee's ICHRA is considered affordable coverage for Section 4980H(b) purposes. Clay's youngest employee is 34 years old, and the lowest-paid employee earns $40,000.

Clay determines that the lowest-cost self-only silver plan annual premiums for a 34-year-old are $7,000 in Jacksonville, $7,600 in Miami, and $8,000 in Orlando.

For 2020, an employee earning $40,000 must pay no more than $3,912 ($40,000 × 9.78%) for health insurance to meet the Section 4980H(b) affordability requirements. Clay makes 2020 ICHRA contributions to each employee of $4,200 ($350 per month). With an ICRHA of $4,200, an employee in Orlando, which has the highest premium for self-only coverage for a 34-year-old individual, would pay $3,800 ($8,000 − $4,200) for coverage. This funding ensures that Clay will not be subject to a Section 4980H(b) penalty for any full-time employee for 2020.

Employers in states that have state marketplaces using the federal platform (**www.healthcare.gov**) can download a premium look-up table to find the premium for the lowest-cost silver plan. Tables are available for premium costs for 2021, 2020, and 2019, to accommodate employers using the monthly measurement method and the look-back measurement method. The tables can be accessed at **www.cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Employer-Initiatives.html**.

Affordability Safe Harbors for ICHRAs

Premiums for coverage in the individual market vary based on an individual's place of residence and age. An employer offering ICHRA coverage is faced with making an affordability determination for each full-time employee, which can be a complex and time-consuming undertaking. To simplify affordability determinations for an ALE, general safe harbors can be used for determining an employee's household income and contribution amount. Additional safe harbors solely for determining if ICHRA coverage is affordable are also provided [Prop. Reg. 54.4980H-5(f)]. The ICHRA safe harbors can be used individually, in combination with each other, or in combination with one of the general safe harbors.

Note: The ICHRA safe harbors apply to the affordability determination solely for Section 4980H(b) penalty purposes, with respect to coverage offered to a full-time employee. They do not affect the determination of whether coverage is considered affordable for premium tax credit (PTC) purposes. Instead an employee should use the Section 36B affordability rules (see *Affordable Coverage* on Page 3-3) to determine eligibility for a PTC because affordable coverage is not available.

Use of the safe harbors are optional. However, if one or more of the safe harbors are used by an ALE for a particular class of employees, it must be applied on a uniform and consistent basis for all employees in that class [Prop. Reg. 54.4980H-5(f)(2)].

Using the general safe harbors. An ALE can use one of the general affordability safe harbors (see *General Affordability Safe Harbors* on Page 5-3) either alone or in conjunction with one or more of the ICHRA safe harbors when determining if an ICHRA is affordable for a full-time employee. When using a general safe harbor to determine if an ICHRA is affordable, the employee's required HRA contribution, as determined taking into account any other applicable safe harbors, is used [Prop. Reg. 54.4980H-5(f)(5)].

Using the look-back month safe harbor. This safe harbor allows an employer to use the premium for a prior month to determine affordability. This helps the employer to determine its ICHRA contribution for a plan year before actual premiums for the year are available. For calendar-year plans, the employer uses the monthly premium for the applicable lowest-cost silver plan for January of the prior calendar year. For fiscal-year plans, the employer may use the monthly premium for January of the current calendar year. Additionally, the employer can use one of the general safe harbors to determine the employee's income and contribution amount.

Example: Marvel Company offers all full-time employees and their dependents ICHRAs for calendar year 2020. It contributes $6,000 ($500 per month) to each employee's ICHRA, regardless of the employee's family size. All of Marvel's employees live in the same city and the entire city is in one rating area in the state marketplace. Marvel chooses to use the look-back month safe harbor. Additionally, Marvel uses the rate-of-pay safe harbor (see *Rate of Pay Safe Harbor* on Page 5-4) to determine an employee's required contribution.

Adam is 40 years old on January 1, 2020. Using the rate-of-pay safe harbor, Adam's monthly wages are $2,000. For coverage to be considered affordable for Adam for 2020, his required HRA contribution must be no more than $196 ($2,000 × 9.78%). The lowest-cost silver plan for a 40-year-old individual in the city's rating area on January 1, 2019 (the look-back month) was $600.

For Section 4980H(b) penalty purposes, Marvel's ICHRA is affordable for Adam because Adam's required HRA contribution is $100 ($600 premium − $500 ICHRA contribution) using the look-back month safe harbor.

Applying the location safe harbor. The location safe harbor available specifically for ICHRAs allows an ALE to use the lowest-cost silver plan premium for the full-time employee's primary site of employment (instead of using each employee's residence) when determining if the ICHRA is affordable. The location safe harbor can be used in conjunction with the look-back month safe harbor and the general safe harbors previously discussed.

An employee's primary site of employment generally is the location at which the ALE reasonably expects the employee to perform services on the first day of the plan year. For an employee who is not eligible for the ICHRA on the first day of the plan year, the employer uses the first day an ICHRA may take effect for that employee. The primary worksite changes if the location at which the

Maximum Credit

The maximum tax credit is 50% of premiums paid by eligible small business employers and 35% of premiums paid by eligible tax-exempt organizations.

FTE and wage limit. The maximum credit is only available to employers with 10 or fewer FTE employees paying average annual wages of $27,600 or less for tax years beginning in 2020 ($27,800 or less for 2021). The credit is completely phased out for employers that have 25 or more FTEs or that pay average wages of $55,200 or more in 2020 ($55,600 or more for 2021).

Note: When calculating the credit, wages are rounded down to the nearest $1,000. Therefore, average annual wages of $27,001–$27,999 are rounded down to $27,000, and the $27,600 phase-out limitation does not affect the credit calculation until average annual wages exceed $27,999. Similarly, the credit is not completely phased out until average annual wages reach $56,000 because average annual wages of $55,001–$55,999 are rounded down to $55,000.

Practice Tip: Because the eligibility rules are based in part on the number of FTEs, not the number of employees, employers that use part-time workers may qualify even if they employ more than 25 individuals.

Eligible Small Employer

To be an *eligible small employer*:

- The employer must have fewer than 25 FTEs for the tax year,
- The average annual wages of its employees for the year must be less than $55,200 per FTE (for 2020) and
- The employer must pay a uniform percentage of at least 50% of the total premium cost for each employee who enrolls in the coverage offered. Coverage must be purchased through the SHOP.

Eligible nonprofits. The credit is available to a tax-exempt eligible small employer, defined as "any organization described in IRC Sec. 501(c) and which is exempt from taxation under IRC Sec. 501(a)." Tax-exempt organizations that are not both described in IRC Sec. 501(c) and exempt from taxation under IRC Sec. 501(a) are not eligible to claim the credit.

A tax-exempt employer's credit cannot exceed the total amount of the employer's applicable payroll taxes. Specifically, the credit is limited to the total amount of the employee federal income tax withholding (FITW), along with the employer's and employees' share of the Medicare taxes withheld during the calendar year in which the employer's tax year began.

Household employers not engaged in a trade or business. The statute does not require the employee to perform services in a trade or business [Reg. 1.45R-2(a)]. Thus, an employer that otherwise meets the requirements does not fail to be eligible merely because its employees are not performing services in a trade or business. For example, a homeowner who employs household help could claim the credit provided they otherwise satisfied the requirements.

Farm cooperatives. A Section 521 farmers cooperative that is subject to tax under IRC Sec. 1381 is eligible to claim the credit as a taxable employer, if it otherwise meets the definition of an eligible small employer.

Online Tools

Several helpful tools can be accessed at **www.healthcare.gov/small-businesses/choose-and-enroll/tools-and-calculators/**. The available tools include a SHOP FTE calculator, small business health care credit estimator, and a minimum participation rate calculator.

Steps to Determine Eligibility for the Credit

The following steps must be followed to determine whether an employer is eligible for the small business health insurance credit:

1) Determine if the employer has paid a uniform percentage of at least 50% of covered employees' insurance premiums. See *Step 1: Meeting the Uniformity Requirement* on Page 6-4.
2) Determine the employees who are taken into account for purposes of the credit. See *Step 2: Determining Employees Taken Into Account* on Page 6-6.
3) Calculate the number of hours of service performed by those employees. See *Step 3: Calculating Number of Hours of Service* on Page 6-7.
4) Calculate the number of the employer's FTEs. See *Step 4: Calculating the Number of FTEs* on Page 6-7. If the number of FTEs is 25 or more, no credit is allowed.
5) Calculate the average annual wages paid per FTE. See *Step 5: Calculating Average Annual Wages* on Page 6-8.

Controlled Groups/Affiliated Service Groups

All employers treated as a single employer under IRC Sec. 414(b), (c), (m) or (o) are treated as a single employer for purposes of IRC Sec. 45R. Thus, all employees of a controlled group or an affiliated service group except for excluded employees are included in the credit calculation [Reg. 1.45R-2(b)].

Step 1: Meeting the Uniformity Requirement

To receive the small business health insurance credit, an eligible small employer must pay a uniform percentage (not less than 50%) of the premium for each employee enrolled in health insurance coverage offered by the employer. This section provides rules for applying the uniformity requirement.

Note: Meeting the uniform percentage requirement is straightforward for small employers that offer only one QHP and offer insurance coverage only for employees (that is, self-only coverage). However, for employers that offer coverage in two or more QHPs, offer insurance coverage for an employee's family or pay varying amounts depending on the coverage each employee selects, calculating whether the employer has met the uniform percentage requirement can be quite complicated and time consuming.

Determining if an employer meets the uniformity requirement depends on the type of billing used by the insurance company and the tiers of coverage offered:

- *Composite billing.* With composite billing, a uniform premium is charged for each covered employee or a single aggregate premium is paid for the group of covered employees. The aggregate premium can be divided by the number of covered employees to determine the per-employee premium [Reg. 1.45R-1(a)(2)].

The tax return information a tax return preparer can disclose or use depends on obtaining consent from the taxpayer, or whether the Treasury Department provides an exception to the general prohibition (Reg. 301.7216-2).

The regulations permit tax return preparers to use a list of client names, addresses, email addresses, phone numbers and each client's income tax form number to provide clients general educational information, including general educational information related to the ACA.

Observation: A tax return preparer may mail general educational information to all clients regarding health care enrollment options available through a state insurance marketplace without obtaining consent. However to use tax return information to solicit and facilitate health care enrollment services, the preparer must first obtain taxpayer consent.

Solicitation to offer health care enrollment services by all tax return preparers, including volunteer preparers, using tax return information, requires taxpayer consent. (See Rev. Proc. 2013-14, as modified by Rev. Proc. 2013-19, for requirements for consents from taxpayers who file a return in the Form 1040 series.)

Caution: Tax return preparers must use the mandatory language in Rev. Proc. 2013-14 (Rev. Proc. 2013-19).

Example: Return Preparer Zack would like to use tax return information to solicit and facilitate enrollment of eligible clients into QHPs available through the insurance marketplace in his state. Zack must obtain taxpayer consent prior to using information for solicitation and enrollment purposes.

Patient-Centered Outcomes Research Trust Fund Fee

The Patient-Centered Outcomes Research Institute (PCORI) is partially funded by a fee imposed on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans. The PCORI assists patients, clinicians, purchasers and policy-makers in making informed health decisions through research and by advancing the quality and relevance of evidence-based medicine.

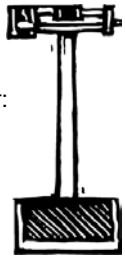
The fee originally applied to policy or plan years ending before October 1, 2019. However, the Further Consolidated Appropriations Act, 2020 extends the PCORI fee for 10 years. Therefore, the fee is applicable for policy or plan years ending before October 1, 2029. The fee, which is based on the average number of lives covered under a policy or plan, is reported annually on the second quarter Form 720 and must be paid by its due date, July 31.

See the *Application of the Patient-Centered Outcomes Research Trust Fund Fee to Common Types of Health Coverage or Arrangements* on Page 8-13.

The fee amount. The amount of the fee equals the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. For policy and plan years ending on or after October 1, 2019, and before October 1, 2020, the fee amount is $2.54 per covered life (Notice 2020-44). The fee for policy and plan years ending on or after October 1, 2020, and before October 1, 2021, is $2.66 per covered life (Notice 2020-84).

Example: Sponsor Chad maintains Plan X, which is a self-insured health plan with a fiscal year ending June 30, 2020 and is responsible for the PCORI fee. The Form 720 that must be filed for this plan year is due no later than July 31, 2021. The fee is calculated by multiplying the average number of covered lives by $2.54 (the applicable dollar amount in effect for plans with plan years ending on or after October 1, 2019 and before October 1, 2020).

Issuers of specified health insurance policies are required to use one of four alternative methods to determine the average number of lives covered under a specified health insurance policy for a policy year. This discussion deals with the rules for plan sponsors.



Plan sponsors (self-insured). Plan sponsors are required to use one of three alternative methods to determine the average number of lives covered under the applicable self-insured health plan for a plan year:

- The actual count method,
- The snapshot method or
- The Form 5500 method.

Counting. All individuals who are covered during the plan year must be counted in computing the average number of lives covered for that year. Thus, an applicable self-insured health plan must count an employee and his dependent child as two separate covered lives unless the plan is an HRA or FSA. See *Special rule for FSAs and HRAs* on Page 8-11.

Actual count method. The average number of lives covered can be determined by adding the total number of lives covered for each day of the plan year and dividing that total by the number of days in the plan year [Reg. 46.4376-1(c)(2)(iii)].

Example: AAA Tree Service is the plan sponsor of a calendar year self-insured health plan. AAA calculates the sum of lives covered under the plan for each day of the plan year as 3,285,000. The average number of lives covered under the plan for that year is 9,000 (3,285,000 ÷ 365). To calculate the IRC Section 4376 fee, AAA must multiply 9,000 by the applicable per-life fee amount.

Snapshot methods. A plan sponsor may determine the average number of lives covered during a plan year by adding the total of lives covered on one or more dates during the first, second or third month of each quarter of the plan year and dividing by the number of dates on which a count was based.

Each date used for the second, third and fourth quarter must be within three days of the date that corresponds to the date used for the first quarter. If a plan sponsor uses multiple dates for the first quarter, the plan sponsor must use dates in the remaining quarters that correspond to the dates used for the first quarter. Dates chosen within three days of the original date are considered corresponding dates. All dates must fall within the plan year [Reg. 46.4376-1(c)(2)(iv)].

The 30th and 31st day of a month are treated as the last day of the month for determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31 is used for a calendar year plan, June 30 is the corresponding date for the second quarter).

The number of lives used for the snapshot may be determined based on either the snapshot count method or on the snapshot factor method.

Snapshot count method. Under the snapshot count method, the number of lives (that is, each employee, spouse and dependent covered under the plan) covered on a date equals the actual number of lives covered on the designated dates.

Example: Bob's Big Rig (BBR) is the sponsor of a calendar year self-insured health plan. BBR uses the snapshot count method to determine the average number of lives covered.

On January 4, the BBR self-insured health plan covers 2,000 lives.

On April 5, it covers 2,100 lives.

On July 5 it covers 2,050 lives.

On October 4, it covers 2,050 lives.

The total lives counted equal 8,200 (2,000 + 2,100 + 2,050 + 2,050). The total lives counted are divided by the number of days selected to obtain the snapshot total of 2,050 lives (8,200 ÷ 4). The snapshot total of 2,050 is multiplied by the applicable per-life fee amount.

Market Reforms

Tab 9 Topics

Overview

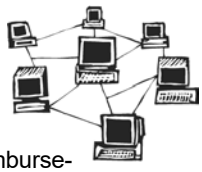
The Affordable Care Act (ACA) includes a number of provisions that reform the health insurance market. These market reforms apply to most major medical health insurance policies and plans, including employer-sponsored group health plans.

Caution: The market reform requirements apply based on the type of plan, not the size of the employer. Hence, an employer does not have to be an applicable large employer to be subject to the market reform provisions.

Which Plans Are Subject to the Market Reforms?

Type of Plan or Benefit	Subject to Market Reforms?
Group health plans covering at least two employees.	Yes
Health reimbursement arrangements (HRAs)	Yes, with few exceptions (see *Health Reimbursement Arrangement (HRA)* on Page 9-3)
Health savings accounts (HSAs)	No
Health flexible spending accounts (Health FSAs)	No, if qualifies as an excepted benefit
Qualified small employer health reimbursement arrangements (QSEHRAs)	No
Excepted benefit HRAs (EBHRAs)	No
Employee assistance programs	Yes, if significant benefits in the nature of health care are provided
Dental plans	No, if certain requirements are met
Vision plans	No, if certain requirements are met
Retiree-only plans	No
Expatriate health plans	No
Short-term limited duration plans	No
Accident-only coverage	No
Excepted benefits	No

See *Summary of the Market Reform Provisions for Employer-Provided Group Health Plans* on Page 9-6 for a listing of the market reform provisions. As you will note, the market reform requirements are numerous. However, of particular importance for this tab is that employer health plans (1) cannot impose annual dollar limits on certain health benefits and (2) must provide preventive health services at no cost to the employee.



Generally, employers that sponsor fully-insured health plans can be sure that the insurer is complying with all market reform requirements. Problems are much more likely for employers that sponsor self-insured health plans, or employers that have used medical reimbursement arrangements to reimburse employees for the premiums paid for individual health insurance policies.

Caution: Violation of the market reform requirements can result in the imposition of a $100 a day per employee ($36,500 per year per employee) penalty under IRC Sec. 4980D. See *Penalty for Failing to Meet Market Reform Requirements* on Page 9-5.

Note: Grandfathered plans are not subject to all the provisions of the ACA. See *Grandfathered Plans* on Page 9-1.

Grandfathered Plans

Grandfathered Health Plan Coverage

A *grandfathered health plan* is a group health plan in which any individual was enrolled on March 23, 2010, has continuously provided coverage to any individual since that date, and has not done anything that would cause it to lose its grandfathered status.

Grandfathered plans are subject to only specified provisions of the ACA. See *Summary of the Market Reform Provisions for Employer-Provided Group Health Plans* on Page 9-6 for a listing of the provisions applicable to grandfathered plans.

Certain changes to a plan can cause it to lose its grandfathered status. However a plan can maintain grandfathered status as long as it continues to meet the requirements (Reg. 54.9815-1251).

Maintaining Grandfathered Status

Grandfathered health plans can make certain allowable changes without losing their grandfathered status. A plan does not cease to be grandfathered merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010.

Additionally, a plan will not lose its grandfathered status merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010. (For example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer.)

Note: Although the number of grandfathered health plans has declined each year since enactment of the ACA, a significant number remain. To assist the remaining plans in maintaining their status, the IRS has issued ~~proposed~~ regulations that are effective beginning on June 15, 2021 and will provide greater flexibility for grandfathered health plans to make certain changes without losing grandfathered status [~~Prop.~~ Reg. 54.9815-1251(g)].

Changes that cause a plan to lose grandfathered status. Grandfathered health plans that make the following changes lose their grandfathered status:

- Elimination of all or substantially all benefits to diagnose or treat a particular condition or elimination of any necessary element to treat a particular condition.
- Increase in cost-sharing percentage.

Continued on the next page

- Increase in fixed-amount cost-sharing requirement that exceeds an inflation rate plus 15%.
- Increase in fixed-amount copayment that exceeds an inflation rate plus 15%.

  Note: Recently issued final regulations that are effective beginning on June 15, 2021, provide an alternative method for determining increases for fixed-amount cost-sharing and fixed-amount copayments.
- Decrease in employer's contribution rate by more than 5% below the rate in effect on March 23, 2010 (unless the employee's fixed-dollar contribution doesn't increase).

A plan's grandfathered status is lost on the effective date of the change that causes it to lose its grandfathered status, regardless of when the plan amendment making the change is adopted. For example, a plan amendment adopted on July 1, 2020 eliminates a benefit effective for the plan year beginning on January 1, 2021, and, therefore, causes the plan to lose its grandfathered status. Grandfathered status is lost on January 1, 2021, the effective date of the benefit change.

Disclosure of grandfathered status. To maintain grandfathered status, the plan must include a statement that it is a grandfathered plan in the summary of benefits provided under the plan. It also must provide contact information for questions and complaints [Reg. 54.9815-1251(a)(2)].

Documentation of plan or policy terms on March 23, 2010. To maintain grandfathered status, the plan must maintain records documenting the terms of coverage in effect on March 23, 2010. The documentation must be adequate enough to verify, explain or clarify grandfathered status. These records must be available for examination upon request.

Change in group health insurance coverage. When a plan enters into a new policy it must provide sufficient documentation so that the new insurer can determine if a change in the grandfathered status has occurred. Documentation includes information concerning plan benefits, employer contributions, cost sharing and annual limits [Reg. 54.9815-1251(a)(3)].

Mergers and acquisitions. If the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

Note: Health plans are subject to Public Health Service, ERISA and IRS rules, which are beyond the scope of this publication. Please see *PPC's Guide to Health Care Reform* for more information in this area.

Medical Reimbursement Plans and Employer Payment Plans

Medical reimbursement plans are funded entirely by the employer, and typically reimburse out-of-pocket health care costs of employees up to a certain limit each year. The plan may define the categories of health care costs, but generally the terms will allow reimbursement of any deductible medical expense, such as out-of-pocket co-pays, health insurance premiums, dental and vision costs and similar medical outlays. Under IRC Sec. 105, these employer reimbursements are a tax-free fringe benefit to the employee. Typically, small employers have offered medical reimbursement plans as an alternative to providing employer-sponsored health insurance.

An *employer payment plan* is an arrangement under which the employer reimburses an employee for some or all of the premiums for an individual health insurance policy or directly pays all or a portion of those premiums. The plan may also reimburse for out-of-pocket expenses up to a certain amount each year. For income tax purposes, these benefits are tax-free to the employee and deductible by the employer (Rev. Rul 61-146).

Market Reforms and Their Effect

A medical reimbursement or employer payment plan that uses employer funds to reimburse employee premiums or other out-of-pocket health costs generally is not permitted unless it is integrated with (that is, offered in conjunction with) other group health insurance offered by the employer that meets the market reform mandates. The tax-free fringe benefit status of these plans is unchanged, but offering these plans on a stand-alone basis violates some of the market reform provisions. This subjects the employer to the Section 4980D $100 per employee/day penalty. See *Penalty for Failing to Meet Market Reform Requirements* on Page 9-5.

Specifically, if an employer offers only a medical reimbursement or employer payment plan without also offering a group health plan, the employer is deemed to be providing a group health plan. And, that health plan violates the requirement that no annual limits can be set for essential health benefits. This is the case because the arrangement can only reimburse up to the amount that is in the employee's account. Additionally, the requirement that certain preventive services be provided with no cost sharing is violated.

Instead of offering a medical reimbursement or employer payment plan, an employer can increase the employee's taxable wages to provide funds to help an employee purchase individual health insurance coverage. However, the employer cannot require the funds be used for that purpose. Employers can also provide employer-sponsored coverage through a SHOP plan (see Tab 6).

Direct Primary Care Arrangements

A direct primary care arrangement (DPC) is a contract between an individual and a primary care physician, where the physician agrees to provide certain medical services for a fixed monthly (or annual) fee. The typical arrangement includes medical services such as preventive care, basic lab services, and/or chronic disease management. Health insurance claims aren't filed because the contract is between the individual and the provider.

Under current rules, DPC fees are not considered payments for medical care under IRC Sec. 213(d), so they are not deductible or allowed to be reimbursed through a health savings account (HSA) or health reimbursement arrangement (HRA). However, in June 2020, the IRS issued proposed regulations that would allow DPC fees to be considered amounts paid for medical care under IRC Sec. 213(d), and deductible under IRC Sec. 213(a). Because an HRA generally may reimburse expenses for medical care, the proposed regulations would also allow DPC fees to be reimbursed by an HRA (Prop. Reg. 1.213-1).

Individuals participating in a DPC arrangement generally wouldn't be allowed to contribute to an HSA because the DPC provides coverage before the minimum annual deductible is met. However, there are limited circumstances where an individual wouldn't be prohibited from contributing to an HSA based on DPC participation.

Health Care Sharing Ministry

A health care sharing ministry (HCSM) is an organization whose members share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs. The members must retain membership in the HCSM even after they develop a medical condition.

An HCSM is an organization (1) described in IRC Sec. 501(c)(3) and exempt from tax under IRC Sec. 501(a), (2) in existence at all

- Coverage that is only for excepted benefits (for example, dental or vision coverage).
- Health care sharing ministry. (Note, however, that proposed regulations may change this for future years).
- Group health coverage, including coverage offered through a spouse's employer.
- TRICARE.
- Multiple employer welfare arrangements, including association health plans.

ICHRAs are considered MEC for purposes of the employer shared responsibility provisions (see Tab 4). To be considered affordable, the employer-contributed funds must allow the employee to be able to purchase an individual policy with the employee's contribution toward the premiums being less than the individual's household income for the tax year multiplied by the required contribution percentage (9.78% for 2020; 9.83% for 2021). An ICHRA that is affordable is deemed to provide minimum value. See Tab 5 for further information on determining if coverage is affordable.

Employees and their dependents who are offered ICHRA coverage are not eligible for a PTC for any month they are eligible for coverage that is considered affordable (see *Individual Coverage HRAs (ICHRAs)* on Page 3-3). Additionally, if the employee enrolls in the ICHRA coverage, the individual and any dependents are not eligible for a PTC for any month they are enrolled, even if the ICHRA coverage would be considered unaffordable.

Excepted Benefit HRAs

Employers of any size can offer HRAs that qualify as excepted benefits (EBHRAs) for plan years beginning on or after January 1, 2020. EBHRAs can only be offered to employees who also are offered a traditional group health plan. However, employees are not required to enroll in the traditional group health plan to be eligible for the EBHRA [Reg. 54.9831-1(c)(3)(viii)].

Employer's can contribute an annual maximum of $1,800 to each participant's EBHRA for plan years beginning in 2020 and 2021 (Rev. Proc. 2020-43). The amount is indexed annually for inflation. Amounts in an EHBRA can be used to reimburse out-of-pocket medical expenses such as cost-sharing related to individual insurance or group plan coverage. Additionally, an EHBRA can reimburse the amount paid for premiums for limited-scope coverage; COBRA coverage; or short-term, limited-duration insurance. However, the funds cannot be used to pay premiums for individual health insurance coverage or group coverage.

Qualified Small Employer Health Reimbursement Arrangements

Employers that are not applicable large employers (see Tab 4) and do not offer group health insurance coverage to any of their employees can offer a qualified small employer health reimbursement arrangement (QSEHRA). A QSEHRA is similar to a regular HRA [see *Health Reimbursement Arrangement (HRA)* on Page 9-3], but must meet other requirements. Providing QSEHRA benefits may be a good option for small employers that previously offered medical reimbursement or employer payment plans, because under a QSEHRA, an employer can provide funds to help an employee pay for individual health insurance coverage [IRC Sec. 9831(d)].

A QSEHRA generally is not treated as a group health plan. Therefore, the Section 4980D penalty for failure to comply with certain market reform requirements does not apply. (See *Penalty for Failing to Meet Market Reform Requirements* on Page 9-5.)

The employer must provide QSEHRA benefits to each eligible employee, which is broadly defined as any employee of the employer. However, the employer can elect to exclude employees who (1) have not completed 90 days of service, (2) are under age 25 or (3) work part-time or seasonally. Additionally, employees covered by a collective bargaining agreement can be excluded, if accident and health benefits were the subject of good faith bargaining between the employee representatives and the employer.

A QSEHRA must be funded entirely by the employer and provided on the same terms to all eligible employees. No employee salary reduction contributions are allowed. For 2020, the maximum permitted benefit is $5,250 per year for self-only coverage and $10,600 for family coverage (Rev. Proc. 2019-44). For 2021, the amounts are $5,300 and $10,700, respectively (Rev. Proc. 2020-45). The annual limits are prorated if an employee is not covered by the QSEHRA for the entire year.

Payments and reimbursements can be made from the QSEHRA to the employee for medical care expenses [as defined in IRC Sec. 213(d)] incurred by the employee and the employee's family members. Premiums for individual health insurance policies can be paid or reimbursed by a QSEHRA. A QSEHRA may not impose a deductible or any other cost-sharing requirements that must be met before the QSEHRA will reimburse medical expenses (IRS Notice 2017-67).

Before paying or reimbursing an employee for medical expenses, the employer must confirm that when the medical expense was incurred, the covered individual was enrolled in minimum essential coverage (MEC) (see Tab 1). If an employee is mistakenly reimbursed for an expense when the covered individual was not enrolled in MEC, the reimbursement must be included in the employee's compensation and reported in box 1 on Form W-2. However, it is not considered wages for FICA purposes.

The current year QSEHRA benefit is reported in box 12 of Form W-2, using code FF. The amount reported is the total permitted benefit made available for that tax year, even if the employee did not receive the total permitted amount as reimbursement for medical expenses.

Married employees with same employer. When two eligible employees work for the same employer, each must be provided separate permitted benefits, without regard to whether they are covered under the same policy. However, an expense can only be reimbursed one time (IRS Notice 2017-67, Q-19).

Example: John and Janet both work for Conrad Properties and are eligible employees for QSEHRA benefits provided by the company. Under the QSEHRA, employees with self-only MEC are provided with benefits to pay for insurance premiums and deductibles up to $5,000. Eligible employees with family coverage are provided with benefits up to $10,000 to pay for insurance premiums and deductibles.

John and Janet enroll in family coverage in the individual market that provides MEC. The policy premiums are $12,000 a year, and each has a deductible of $2,000. Conrad's QSEHRA must provide both John and Janet with the family coverage permitted benefits of $10,000 for the year. John uses his $10,000 benefit to pay the premiums of the policy. Janet's benefits can be used to pay the remaining $2,000 premiums and to pay for any medical expenses incurred during the year that are not paid by the health insurance.

Self-Employed Health Insurance Deduction

Self-employed taxpayers are allowed an above-the-line deduction for 100% of the cost of providing medical, dental and qualifying long-term care insurance for themselves and their family [IRC Sec.